Unconfirmed

Minutes of a Meeting of the **Scrutiny Committee** held in the Conference Room, Riverside, on **Thursday, 21 October 2021** at **6.30pm**

Members of the Committee present:
Councillor Edward Back, Councillor David Beavan, Councillor Stuart Bird, Councillor Judy Cloke, Councillor Linda Coulam, Councillor Mike Deacon, Councillor Andree Gee, Councillor Louise Gooch, Councillor Colin Hedgley, Councillor Keith Robinson, Councillor Caroline Topping

Other Members present:
Councillor Peter Byatt, Councillor Janet Craig, Councillor Tony Goldson, Councillor Chris Mapey, Councillor Mary Rudd, Councillor Ed Thompson

Officers present: Sarah Davis (Democratic Services Officer), Matt Makin (Democratic Services Officer), Nicole Rickard (Head of Communities) and Nicola Wotton (Deputy Democratic Services Manager).

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1 Apologies for Absence and Substitutions

Apologies were received from Councillors Green and Lynch. Councillors Mapey and Goldson attended as their substitutes.

2 Declarations of Interest

Councillor Hedgley declared a local non pecuniary interest in item 4 as he was an acquaintance and neighbour of Mr Norfolk, one of the guest speakers.

3 Minutes

RESOLVED

That the minutes of the meeting held on 16 September2021 be approved as a correct record and signed by the Chairman.

4 Review of NHS Dental Provision in East Suffolk

The Chairman reminded the meeting that, in response to the apparent concerns of many residents, the Committee agreed Councillor Gooch's Scoping Form in July 2021 to review the current situation and challenges with regards to the access

of National Health Service (NHS) dental provision across the district. He explained that a number of relevant people had been invited to speak, each of whom had a different perspective and hopefully this would give Members different evidence and assessments. He stressed that the issue was not within the Council's remit so any gathered evidence and suggested actions would be reported to the Suffolk Health Scrutiny Committee by East Suffolk Council's nominated representative Councillor Back. The Chairman went on to explain the format for the meeting and introduced the invited guest speakers.

Councillor Deacon stated that he was pleased the Committee had the opportunity to scrutinise this appalling situation where many constituents were not able to access a dentist. He thanked all the guest speakers for agreeing to attend and clarified that this review had not been informed or prompted by any pressure groups as the issue had been informally discussed at the June Committee meeting and the Committee had then formally agreed to conduct the review at the July meeting.

The Chairman invited each guest to speak in turn as follows:

1. Jason Stokes - Norfolk Local Dental Committee

Mr Stokes explained that he was the Secretary of the Norfolk Local Dental Committee (LDC) and had worked in a primary high street dental care for nearly 30 years and all that time had been an NHS performer. He continued that his role as LDC Secretary meant he interacted with a wide range of primary care dentists, the majority of whom were based in Norfolk.

Mr Stokes explained that the suspension of routine care due to the pandemic restrictions meant that, across England, 30m appointments had been lost for dental patients, in Suffolk that amounted to half a million courses of treatment or interactions of patients with their dentists but it was clear that NHS dentistry was in crisis long before Covid. Recruitment and retention problems were endemic and it was not unusual for practices in the region to have vacancies for over two years. These problems had caused some practices to hand back NHS contracts or close completely.

The Committee was informed that the NHS national contract had a very negative impact on delivery of care across the region, pushing talent out of the NHS and, in some cases, out of dentistry all together. The current NHS national contract came in to place in 2006 and since then the dental profession no longer had the ability to set up dental services in response to local need. Before 2006, any dentist could set up an NHS practice where there was need or perceived need and a business case could be made for viability of the practice to whoever was going to loan them the finance. The funding would then be based on the level of NHS dental work completed at the site. Since 2006, however, the NHS itself directly controlled the placement and size of dental contracts. Commissioning of NHS dental contracts did not directly involve the dental profession. The amount of money spent on NHS dental provision and the location of those services was a commissioning choice made currently by NHS England. NHS England had the option to conduct needs assessments to determine the areas of most dental need. These assessments were not regularly conducted. NHS dental funds were not ringfenced so they could choose to spend more or less money depending on the overall health needs of the population.

Mr Stokes reported that in all areas, in every year, some NHS dental practices underperformed to the contracts they had, usually completely unrelated to the demand for dental services in the area. This underperformance related to several factors. Modern dental techniques and legal requirements made it increasingly difficult to provide the same amount of dentistry in the same amount of time. This had not been reflected in any changes in the historic targets associated with NHS contracts. Another major factor related to underperformance was a practice's inability to recruit which was particularly difficult in coastal and rural areas such as Norfolk and Suffolk. The money that would have been spent on the delivery of services that went undelivered by these practices was returned to NHS England in a process called clawback and they could then choose to spend it elsewhere. East Anglia had seen some extremely high levels of clawback in recent years. In 2019/20, almost £11.5m was returned by dental practices to NHS England which was 9% of the total value of NHS dental commissioning in the area, that was almost double the average clawback rate across England. Practices currently able to deliver more care could take up the slack in this situation but this required NHS England to redirect the funding during the financial year. NHS dental practices were not able to overperform significantly no matter what level of local shortages there were, without the express permission of NHS England and if a practice had extra capacity to treat patients and NHS England could not or would not agree to use the clawback monies then practices could only provide extra care to patients privately.

Members noted that, over time, many practices had found it increasingly difficult to meet their NHS targets. Initial targets were set in 2006 and since then contracts had generally failed to keep pace with inflation and population growth and some practices had had a permanent reduction in their NHS contract called rebasing as they could not consistently hit the original targets set for them. Other practices had withdrawn from providing NHS activity completely. The money released by these changes to NHS contracts meant there was less commissioned dental activity being delivered to patients but the money could be redirected to patient care if NHS England wished to use the money in that way. In East Anglia, the commissioning of new dental activity using money from clawback in the short term or rebasing money in the long term, or even new money provided for the purpose, could occur but it was not common. In the last few months, however, the process for procuring seven new lots of dental services for the Eastern Region had started with the aim of these extra services being available to patients in early summer 2022. Any new commissioned NHS activity had to be welcomed but the quality of the procurement process would inevitably impact on the quality of the service commissioned and delivered to patients. Mr Stokes expressed concern that the current process for commissioning was flawed because the contracts being offered were only for an initial period of four years and nine months with the possible extension of a further three years, but he felt that offering contracts of less than eight years made it either unattractive or impossible for practices to finance over the short timescale and patients might be surprised that they would only be in existence for a relatively short time. The procurement asked that contractors deliver services from 8am-8pm 365 days per year but whilst sounding like a boon for patients this was an irrelevancy because it was impossible to deliver that type of care in almost all practices. Insisting on this level of provision would make recruiting and retaining staff difficult and possibly impossible.

Mr Stokes stated that in relation to reducing problems for patients, commissioners need to be encouraged to reinvest any clawback monies direct into the NHS budget. In Greater Manchester commissioners had been creative with allocating funds for emergency care and producing a different type of contract through flexible commissioning. He added that it needed to be made clear to the Secretary of State for Health and Social Care that the current contract was not fit for purpose, as discussed in Parliament the previous evening, and if we continued down this line then these problems would only escalate and even when we got past the acute problems of Covid and recruiting staff from outside the country, the changes in place since 2006 would only develop further.

The Chairman thanked Mr Stokes and asked Members if they had any questions.

Councillor Goldson asked for confirmation that if the units of activity were not reached, money would be taken back but could be given to another dental practice that needed the extra work. Mr Stokes confirmed that monies would automatically be taken back by NHS England but then NHS England had to make the decision to reallocate those resources to other practices. Cllr Goldson also asked if patients were registered and if units of activity were based on what was required, how many dentists undertook root canal treatments. Mr Stokes explained that, under the 2006 dental contract, patients were not registered with an NHS dental practice so did not have an ongoing contractual relationship with the practice as far as the NHS was concerned. He added that, once a course of treatment had been completed, the practice did not have a long-term relationship with the patient, although most dentists would strive to develop and maintain a long-term relationship even though there was no contractual obligation to do so under the current NHS contract. In relation to root canal treatments, he confirmed that it was an NHS band 2 course of treatment but he was not aware of any practices that failed to deliver that care, although there was a level of complexity for this particular treatment and he suggested it might be that some practitioners were unable to deliver the complexity of care that some patients required. He added that there were moves to develop a wider range of services called Level 2 provision where NHS dental practitioners with enhanced skills could provide more complex treatment to patients but it was a process that was within its early stages.

Councillor Goldson clarified that he was aware of dentists that declined to undertake certain treatments under the NHS but would do them privately. Mr Stokes responded that he was not aware that this happened but if it did then it should be flagged with NHS England, especially if the dentist said they had the skills to do it as he could not see how they could then make a case for not doing it under their NHS contract unless they had used up all their units of activity which could happen towards the end of the year, although this reset itself in the new financial year.

Councillor Robinson queried if the shortness and looseness of the contract affected investment for the long-term commitment to invest in the area. Mr Stokes responded that most dental practices had a General Dental Services Contract which was open ended and as long as they met the contract provisions eg the delivery of Units of Dental Activity (UDAs), they kept their contract in perpetuity, but this was increasingly difficult. He added that the contract was actually very complex rather than loose and stipulated an enormous number of requirements for NHS dentists. The complexity of the contract was often noted by practitioners leaving the NHS. In relation to patient

registration, he explained that not including this in the contract had been a deliberate decision by the Government at the time and had not been changed since.

Councillor Topping queried if she had not been a registered patient since 2006 and this was confirmed by Mr Stokes. He added that there had not been a contractual obligation for practices to see a patient since 2006 and he reiterated that this was a Government decision. He stressed, however, that most practices tried to maintain a relationship, but this was not supported by the contract. Councillor Topping stated that she had noticed her practice no longer did a clean at the same time as her check-up appointment. Mr Stokes responded that this could be due to Covid restrictions and was a decision for each individual practice as to how and when to provide care in the most appropriate way.

Councillor Hedgley asked for further clarification in relation to the difficulty of recruiting dentists. Mr Stokes stated that, whilst his practice had not had to recruit for years, he was aware that other practices were finding if very difficult to recruit dentists and further auxiliary staff. He added that when dentists were first qualified they tended to remain close to the site where they obtained their qualification and this region did not have a dental hospital nearby. Also, rural areas did not tend to attract or retain dentists, especially younger ones.

Councillor Gooch queried if clawback was happening systemically, especially across more than one year, if Mr Stokes felt NHS England was not doing enough analysis of the issues as to why this region was almost permanently in this clawback position. Mr Stokes responded that there could be short term factors such as staff being ill, maternity/paternity leave etc that led practices to struggle for a single year to hit their targets and undergo clawback. He explained that if they underwent clawback for more than two years then they could rebase their contract to a lower level. He added that he understood it was difficult for NHS England because of the variable amount of clawback money they had and it was difficult to change contracts quickly but when a contract was rebased there was no reason to not re-use this money and he suggested that the NHS representative later in the meeting might be able to provide some data on this. Councillor Gooch asked how long a contract would need to be to be attractive. Mr Stokes responded that the issue with having short term contracts were that it was either cash rich businesses or practices that were part of a corporate provider that tended to be attracted to them. He added that some of the practices that had left the region at relatively short notice were those run by corporate providers and if the business did not work they could be quite cut throat and simply withdraw. If a local dentist went to a bank for a long term loan they would be keen to stay in the area so the shorter the procurement timescale the more likelihood there was that it would be corporate providers that were attracted to them rather than local dentists with a long term history in the area. He was aware that corporate providers had recently closed a number of practices in the region due to problems with recruitment.

2. Paul Rolfe - Suffolk Local Dental Committee

Mr Rolfe stated that he had been a dentist in Ipswich for 22 years with a four surgery practice and that during most of that time they had taken on NHS patients. He added that he had been the Secretary of the Suffolk LDC for 18 years and had a close relationship with other practitioners in Ipswich and the wider Suffolk region.

The Committee was informed that, it had been accepted for many years, the NHS dental contract was not fit for purpose. Mr Rolfe stated that, over the years, successive Governments had piloted various options for changing NHS dentistry, and although these pilot options had come up with some very useful working practices that would make dentists' lives more easy and patients would be helped along their care pathway, the changes would take twice as long at least and would double the NHS dental budget, which he did not feel any Government would agree to, so it was unlikely to ever get signed off. The current contract was very restrictive given it was not possible to know what a dentist was facing until they had seen the patient. The process for gaining UDAs was points based eg 1 UDA point for a check-up, clean or x-ray; 3 points for 1 or any number of fillings, root canal treatments etc; and 12 units for laboratory work including dentures and crowns etc and again it did not matter how many crowns. He stressed, therefore, that it was a risk ridden business model that was not attractive for many practices. It was also very difficult to understand why some practices suffered from clawback because some of those practices might be seeing high need patients so they might be providing a different type of work for patients that did not tick over as many UDAs eg seeing more patients and doing more work on them but that would not translate to more points. He added that, for a practice which had a more stable patient list, it was easier to achieve the targets but it was a lot harder for a practice with many very high needs patients. He stated that adding in staffing issues, made it even harder to achieve the targets.

Mr Rolfe explained that 31 March was the cut off day so if a practice hit 96% on 31 March the target would not be met and it did not matter if there had been an issue recruiting staff etc there was no scope to extend that timeframe. If the NHS was minded to provide extra money in practices, the difficulty was often that, by the time the decision was made that extra funding was available, it was probably December and practices only had three months left which was their busiest time of the year anyway as they were chasing their targets.

In relation to recruitment, which Mr Rolfe felt was the biggest issue, he pointed out that the East of England was about the equivalent size of Wales with twice the population, but they had a dental school and this region did not. He explained that the difficulty with dentistry was that people tended to either work where they qualified or where they were from and unfortunately there were not many people from the East of England going to dental school because they had to travel a long way and as a result there were not many people trained from the region who were likely to want to come back. He added that previously a trainee dentist could choose where they wanted to apply to spend their first year of vocational training and they would get a job where they wanted to work. Now it was a national recruitment process and dentists were sent to a location depending on where they were ranked from 1 to however many had qualified that year, so there was no longer a pathway through which vocational trainees, who might have previously chosen to come to Suffolk because it was only an hour and a half from London, could decide where they wanted to work and then they might have stayed. He added that this change meant it was now much harder to recruit to this region.

Mr Rolfe explained that it was also difficult for a foreign trained dentist who might live in the area to get on the NHS Performer List eg he was aware of a trained dentist from

New Zealand who was looking to work in a private practice because even though she was registered with the General Dental Council, she could not work at an NHS dentist because she could not get on the Performer List.

The Chairman thanked Mr Rolfe and asked Members if they had any questions.

Councillor Deacon asked if there were any mobile dentist surgeries. Mr Rolfe responded that there had been one previously but that he did not think they would meet current CDC requirements so, although they did exist and had been used in rural Wales in the past, it was not really a solution because there was now a lot of add on requirements that had arrived in dentistry since 2006 for example sterilisation now had to take place in a separate room. In relation to his statement that contracts were not fit for purpose, Mr Rolfe confirmed that he had said this, adding that it had also been stated in Parliament by politicians from both sides. Councillor Deacon queried if there was a quick fix. Mr Rolfe stated that if the money was doubled to fund the whole NHS so they could see half as many people again then yes but he then pointed out that there would need to be four times the number of dentists to see the whole population because currently only 50% of people went to a dentist. He clarified that the whole population only got 50% of funding it would need if everyone was going to see a dentist and if the NHS wanted to do dentistry how the pilots had shown dentistry could be done, it would need twice as much money. He stated that another difficulty was that it took so long to train a dentist – five years training and one year vocational, so although more dentists would come on stream 6/7 years down the line more dentists were needed now. He added that prior to Brexit dentists had come from the EU, prior to that they had come from New Zealand, Australia and South Africa, but Britain had never trained enough dentists for its own needs.

Councillor Beavan asked if Brexit had affected the number of dentists and was there a problem with EU nationals working in dental practices. Mr Rolfe confirmed that it had affected things, he stated that he had lost three of his associates at the same time because of the Brexit vote and they had worked for him for about 11 years and it had taken about 2½ years to recruit them. He explained that prior to that, he had never been short of applicants as long as EU dentists could apply and prior to that the only hope was to go through the vocational training scheme and get young dentists to work at the practice straight from University but it had become apparent that they needed that training to be competent in carrying out treatment.

Councillor Goldson stated that, despite what had been said already about patients not being registered, it was clear on several practices' websites he had viewed that they had a register. He pointed out that if a dentist saw an NHS patient needing Band 2 root canal treatment for example it was £65.20 but privately it would cost about £700 and he queried if there was a simple answer by saying dentists needed more money. Mr Rolfe stated that it was not about increasing pay but was about increasing what dentists needed to do to achieve their targets. Councillor Goldson stated that if a dentist said they could not do work under the NHS but could do privately and the NHS fee was increased it would be more lucrative for practices to carry out more NHS work rather than private. Mr Rolfe stated that the difficulty was not the fee per three UDAs but was that the three UDAs could be six root fillings. He added that prior to 2006 it used to be a fee per item and everyone understood that whereas now it was a fee for an unlimited number of whatever items it was. Councillor Goldson agreed but

suggested if the contract was written in such a way that the money per unit was per activity, dentists would be able to do more NHS work than private because the fee would be the same.

Councillor Gooch queried how the destinations for posting for vocational training worked. Mr Rolfe responded that it followed a similar pattern to junior doctors, in that they had an interview, they were ranked one to 500 say and the person who ranked number one got their first choice of where they wanted to work and number 500 got their last choice. The training practices were also ranked one to 500 and were approved year on year.

Councillor Topping asked what the barriers were for joining the Performer List. Mr Rolfe stated that foreign trained dentists had to jump through lots of hoops to be able to undertake NHS dental work. He explained that to work in this country a dentist had to be registered with the General Dental Council but then to work for the NHS a dentist had to be on the Performer List which meant there was a whole raft of paperwork eg records of experience, vaccinations etc including an application process which was considered by a panel. A dentist could be included on the List with limitations which meant that they could only work at a particular type of practice, or they would have to do Performer List Validation by Experience which meant they had to find a practice to work in with a mentor to help them transition through the differences of working in general practice somewhere else in the world to working here under the NHS. It was hard to find such dentists who would provide that mentoring as there were no lists and it was not the most efficient application process partly as the process only happened twice per year.

3. Tom Norfolk - Dental Practitioner, Joint Chairman of the Local Dental Network (East of England), Local Dental Clinical Adviser (NHS England),Executive Member of the National Association of Dental Advisers

Mr Norfolk explained that he was a general dental practitioner who worked in the NHS some of the time but less so currently as he also worked for NHS England advising, supporting and guiding them in the process as a clinician. He confirmed that workforce was a big issue and morale and retention and recruitment had been made worse by Covid, particularly because this part of the region was very reliant on an overseas workforce and a lot of European dentists had returned home when Covid happened and had not returned.

In terms of solutions, the Committee was informed that the national contract was not fit for purpose and Mr Norfolk pointed out that the previous Minister had said this publicly and various other politicians had said so for some time. He suggested that the solution was to look at a combination of changing the contract to make it more attractive, which local commissioners had the ability to do to some degree, and also, when changing it, to use the wider dental workforce.

Members were reminded that they had already heard about the limitations of recruiting dentists to work in this region who were able to work on the Performer List, so one solution for example was to use dental nurses who were skilled. Mr Norfolk explained that there would be a skills escalator from the most junior dental nurse to the most senior consultant. At the moment, NHS dentistry was very reliant on dentists

on the Performer List but there were many skills and treatments that the wider dental workforce could do. For example, a dental nurse with extended duties could provide oral hygiene instruction and prevention because most of the diseases such as dental decay and gum disease were preventable eg decay was caused by large quantities of refined sugar and gum disease was largely caused by inadequate oral hygiene, and for the vast majority of patients this was preventable. He suggested, therefore, that there was a need to have a big push on prevention, including to children many of whom had decayed teeth by the age of three. He pointed out that they were not born that way but had decayed teeth because of their diet so prevention was key and the wider dental workforce could be used to help address this. Similarly, gum disease could be treated by the wider dental workforce eg hygienists had two years additional training from a dental nurse, and therapists had three years training from a dental nurse. Therapists could do the basic types of dentistry that a dentist could such as examinations, x-rays, simple fillings and extractions etc. They could not do root fillings, dentures, crowns etc but could do a fair amount of work that a dentist could, so he reiterated the need to widen the dental workforce.

Mr Norfolk referred to the Dental Strategy which had recently been written and it was noted that this was the first in the country and could be used as a guide for the national document. The Strategy included a variety of Programmes such as Programme 1A which looked at urgent access eg taking a General Dental Services (GDS) contract and substituting 10% of the units of activity and prioritising them towards urgent care, so patients who had not been to that practice before and were not known to that practice could attend. Programme 1B looked at prevention and stabilisation using the wider dental workforce and this might be another 5-10% of the contract. Mr Norfolk stated that these Programmes would start to address the need for increased access and look at inequalities and prevention. Part of the Strategy was also about linking with wider medical colleagues eg GPs, nurses, pharmacists etc because poor general health was linked to poor dental health. In addition, a variety of programmes were being piloted to look at supporting care homes.

In relation to recruitment and retention, Mr Norfolk explained that this region had the first dental academy in the country which had recently begun and the academy would start to provide training for a variety of skills sets. He added that, whilst at the moment, the academy would not be able to train dentists because of the structure, the academy could train a variety of skills to attract dentists here and keep them, and also train the wider dental workforce. He clarified that it would be similar to how GP surgeries worked in that patients did not always see a GP but could see a nurse, clinical pharmacist etc so the aim was to have the same in dentistry and move away from a reliance on dentists.

Mr Norfolk stated that there were urgent dental centres across the country and this region had been the first to set them up when Covid hit. He added that there were still about 50 active centres across the region which would probably morph into Programme 1A to see urgent patients. He also explained that, due to Covid, throughput was restricted at the moment to about 60-65% because of the generation of aerosols and social distancing, so dentists were working at a slower throughput.

The Chairman thanked Mr Norfolk and asked Members if they had any questions.

Councillor Deacon referred to British Dental Association statistics that nearly half of dentists planned to stop NHS services or reduce their NHS commitment, and over a quarter planned to move to private practice. He queried if the NHS contracts were improved would this position be reversed. Mr Norfolk stated that he did not know about the accuracy of the statistics but he felt a lot of young dentists wanted to do more and expand their skills. He added that the Strategy allowed dentists to do more than they were originally trained to do. He explained that one of the problems for young dentists was that there was a pressure to de-skill very rapidly but the Strategy included the upskilling programme and linking that with the Dental Academy for example had allowed us to bring the world renowned Eastman Dental Institute (EDI) from London into East Anglia, so there were programmes for dentists to attract them to do more complex skills within the NHS. As part of the Strategy, dentists would also be paid more eg Programme 1A paid them more than what they were currently paid for what they were doing, so they were not financially disadvantaged. The Strategy also sought to make the work more interesting and provide a link to the wider medical workforce. Mr Norfolk suggested, therefore, that there was an opportunity to make NHS dentistry more interesting and attractive whilst working within the limitations of the national contract because it was unlikely that would be substantially changed. He added that he did not expect it to be a simple journey but the aim was to make it more attractive for dentists. He reported that 15 dentists were currently undergoing an enhanced skills programme with the EDI to train them up and go through a Level 2 accreditation so they would be able to practice their enhanced skills on NHS patients in this region.

In response to Councillor Goldson's question about what two things he would change in the contract, Mr Norfolk stated that the first would be, as mentioned earlier, to remove the not knowing which caused fear for dentists, as they did not know if a patient required one filling or 20. The second would be giving greater flexibility to local NHS commissioners to move around money and spend it differently. He added that the national team excerpted a lot of authority and some areas were more disadvantaged by having a national contract which was probably too orientated towards cities. Councillor Goldson queried if the extended training for normal dental surgeons who would not be able to do impacted wisdom teeth for example, would be taken more locally than referring them to a hospital. Mr Norfolk stated that we were the first part of the country to develop Level 2 accreditation and this meant that they would take a normal general dentist, see if they had the enhanced skills, encourage them and accredit them to do that work in their practices. Some had already worked in hospitals and others were young dentists who did not want to specialise in hospital-based work but they wanted to work part time in general dental practice because they liked the variety and part time doing things like impacted wisdom teeth. Dentists were provided with education, mentoring, showing them the standard, get them the training and supervision, everything they needed. They then had to show they could do it because it was a merit programme and if they were accredited this allowed them to do the extra skills, and get remunerated for them, within their practice. Mr Norfolk concluded that this approach had now been developed to an advanced level and now included gum and root treatments and it was planned to build that out to develop the wider workforce.

Councillor Gooch queried firstly if people knew about the emergency help available through community pharmacies, where the new dental academy was and why was

there more NHS capacity in Essex. Mr Norfolk stated that pharmacists had helped to supply temporary kits during Covid and signposted patients when access to dentists was very difficult. He explained that the new academy was currently virtual, adding that digital dentistry was already here. He reminded Members of his earlier comment that one of the senior consultants from the Eastman Dental Institute was videoing and coming up to this region and eventually, rather than a big hospital, most skills would probably be developed in practices because that was where the patients were. He referred to the new guidance document from NHS England Advanced Dental Care which talked about doing the training where it was needed especially in the rural areas. He pointed out that a lot of students said the best training they had was when they were out in practice. He stated that this region was the first in the country to have a dental academy but was not sure if it would have a physical home. In relation to Essex, he explained that the distance from London was probably a factor that put dentists off from coming to this area but they were more likely to commute to Essex. He added that there was a need to get dentists to settle here and recruitment and retention was a lot worse the further north you got and coastal areas were more problematic, although this appeared to be far less of an issue in Essex.

4. Alex Stewart - CEO, Healthwatch Norfolk

Mr Stewart stated that, even before the pandemic, it was apparent that NHS dentistry provision in Norfolk was in crisis. In October 2020, Healthwatch Norfolk published a report collating the experience of residents relating to access to emergency and non-emergency NHS dental care in Norfolk. The report highlighted the signposting queries received since about January 2020 and detailed some reviews of practices collected by their Engagement Team and other investigations into accessing dentistry for patients that had never historically tried to join any practice or received any treatment.

Healthwatch had raised concerns with NHS England and Norfolk Health Scrutiny Committee as well as making frequent briefings to the press. Mr Stewart explained that the worse thing was public dissatisfaction and the perceived gulf in provision of NHS dental care which was still palpable. He commented that, throughout the pandemic, the issue had increasingly become a focus for national media outlets. In December 2020, HealthWatch England had released a report detailing the experience of some 1300 people in relation to NHS dentistry and the report found that seven in 10 people, approximately 73%, found it difficult to access support when they needed it, compared to one in 10 that could access other forms of care fairly easily. It was also found that even those who were already registered with a practice or were aligned to a practice were struggling to book routine or emergency appointments.

Mr Stewart stated that he had sympathy with dentists but Healthwatch's fear was that the industry was still facing critical capacity issues. Many people had spent extended periods on waiting lists and were not able to access dentists, and dentists were not able to take on new NHS patients. Healthwatch were worried that vulnerable people were missing out on treatment, especially those with learning difficulties, autistic, or people in care homes. He stated that few practices had waiting lists and people were frustrated about the situation.

Mr Stewart suggested that the nuances from central Government had caused problems as they were signposting people to Healthwatch to find a dentist and people did not

understand the problem of virality and people accessing services easily, or at least the possible barriers. He confirmed that patients were being forced to go private and he commented that some dentists did not keep their websites up to date, or they advertised that they accepted NHS patients but, when contacted, people were told the lists were closed. He stressed that, whilst the pandemic had further restricted access to dental appointments, this was an ongoing problem. He referred Members to some of the solutions they had heard tonight to address the situation but suggested there was also a need to explain to the public what the issues were and that there was not a quick fix solution.

The Chairman thanked Mr Stewart and asked Members if they had any questions.

Councillor Gooch asked what could be done to improve communications with patients and possible patients, especially about the registration process and duty of care. Mr Stewart responded that he felt there should be a comprehensive media campaign to explain the registration process as Healthwatch received many queries from people saying they had been de-registered and dentists should keep their websites up to date as that would help.

Councillor Beavan asked if there were any statistics on the number of children not going for routine preventative care and Mr Stewart stated that he had no figures to hand but having spoken to the Director of Public Health for Norfolk recently she had not been overly concerned that children were being neglected.

Councillor Goldson asked if Healthwatch included people with special needs when they surveyed patients eg with dyslexia, mental health or physical disabilities etc. Mr Stewart confirmed that, during the pandemic, they had changed their ways of working by using social media to access specific communities of interest. All surveys were automatically translated to easy read so people with learning difficulties could understand what they were being asked and use was also made of reading newspapers for the blind and local deaf organisations to hold specific focus groups for people unable to hear. Healthwatch also sought out asylum seekers and people with mental health problems and staff would go into the acute and Community Trusts and leave surveys or make use of any newsletters to include hyperlinks to any surveys Healthwatch were running. Councillor Goldson also asked if it was fair that a dentist seeing a patient with special needs, who might require more time, would only get one unit of activity even though they might take up three patients' time. Mr Stewart confirmed that he was sympathetic to the dentists as the contract was unfair on this and he commented that people should not have to work for nothing.

Councillor Robinson commented that dentists seemed to have changed their habits because previously if someone needed more than one filling they would have them all done at the same time but now it seemed only one was done and another appointment was made, and he queried if this was a way of playing the points system. Mr Stewart commented that he was not sure and would defer to the dentists as he was not a practitioner.

5. Kerry Overton - Community Development Officer, Healthwatch Suffolk

Ms Overton stated that it was helpful for Healthwatch Suffolk to know what the challenges were for dental professionals because they prided themselves on seeing the big picture not just hearing things that were affecting individuals in a singular form. This approach had helped Healthwatch on signposting which is where a lot of the evidence in the briefing report previously circulated to Members came from. She added that Healthwatch had also changed the way they worked in the last year and now took a lot more phone calls, the majority of which, particularly in the early part of the year, had been dental related. She explained that not every conversation had been recorded but at least 222 people had called about access to dentistry, partly down to people googling them and another reason was that NHS England had kindly put on their website that people could contact Healthwatch to access a dentist! This had put Healthwatch in a very difficult position but with the information they had, they could inform people of the situation, so whilst people did not get what they wanted, once they knew the situation, they felt slightly differently about things. She suggested that communication was key about many of the themes identified – over 200 people had said they had been de-registered and she pointed out that the term was being used by clinicians too, so patients were expecting just the same as they had with their GP practice, that they could access a service who they considered themselves to be registered with, so better communication, using the right terms, would be extremely helpful particularly about registration and how dental services actually operated.

The Committee noted that where patients had been able to access treatment, either by finding it themselves or by calling 111, they were then told to get another dentist to carry on with the treatment, which led them to think they had to go private and a lot of people had said they were very worried about that especially as some practices had said they could not do work under the NHS but could do privately and the briefing report gave details of what some people had been quoted ranging from £400-£4K for treatment. Another issue that had not been spoken about was the impact on other parts of people's health because if someone had a problem with their mouth they were more likely to be self-conscious, not want to go out, became isolated and it could affect their mental health which had a knock-on effect. She added that Healthwatch was very aware of the need for prevention.

Ms Overton stated that another issue was how the contract for community dental was now commissioned because access to it had changed and people now needed to be referred by a general dental practitioner. She explained that people who generally used community dental were those with disabilities who were averse to going to a normal practice. She added that community dental gave much more time to people which could not happen in a general practice. She referred to an example in the briefing report of a lady with a daughter in a wheelchair who could not find a general practice that had wheelchair access.

The Chairman thanked Ms Overton for her attendance and the briefing report circulated before the meeting and asked Members if they had any questions.

Councillor Deacon referred to the 222 cases over the months from January to October and commented that on top of that were the calls NHS111 had received and he suggested, therefore, that this was just the tip of iceberg. Ms Overton agreed, explaining that the figure did not take account of community meetings where similar feedback was coming through, plus some calls would have been missed off the system

when they had so many coming through. She concluded that Healthwatch knew this was a very big issue.

Councillor Goldson asked if Healthwatch had a profile of patients who had been de-registered by age or ethnicity etc. Ms Overton stated that the organisation did not take down personal information under GDPR from calls but if they were doing a specific project they would. She added that if people had been accessing community dental, then Healthwatch were aware they likely had some issues. Similarly, the information in the briefing report was from across the whole of Suffolk as Healthwatch did not take down a postcode so could not provide data just on East Suffolk.

In response to Councillor Gooch's query, Ms Overton explained that this particular report had been collated for the benefit of Healthwatch's CEO who attended the Health Scrutiny Committee and other meetings. She added that the details might also be used for their Comms Team and published elsewhere but at this stage she was unsure exactly who would receive it. Councillor Gooch queried if Healthwatch was asked by NHS England to feedback annually about patient concerns and experiences given it was very harrowing reading. Ms Overton responded that the CEO talked with NHS England regularly but she would take the comment back and discuss where else the information could be shared.

Councillor Beavan queried if access for children and families was worse this year or if it had always been like that. Ms Overton responded that, previous to the pandemic, she was not aware of getting as many calls around dental so she suggested the pandemic had thrown that into the spotlight more due to the various restrictions dental practices had to work under and the figure had increased due to the access limit. She concluded that Healthwatch would continue to monitor this.

6. David Barter - Head of Commissioning NHS England (East of England)

Mr Barter confirmed that he regularly met Healthwatch colleagues with fortnightly meetings during the early days of the pandemic. He added that he found these meetings informative and hopefully passed information both ways.

The Committee was remined that the process of restoring dentistry and dental access was ongoing because on 24 March 2020, effectively high street dentistry ceased for a couple of months due to the dangers of Covid. Mr Barter stated that, following the announcement on 8 June that practices could see patients face to face again, we were the first region in the country to successfully set up a network of urgent dental centres to deal with the most urgent patients. Even from 8 June onwards, it was acknowledged that, because of the fallow time, the need to let the aerosols settle before the cleaning of the dental suite and the next patient coming in, this had dramatically reduced the throughput of patients, and also the need to follow Infection Control Protocol (ICP), meant dentists who would have seen 20-35 patients per day were limited to seeing 4-6 per day. Dentists had, therefore, been allowed to deliver as a minimum 20% of their throughput and that stayed in place until the end of the year and then, in the first quarter of this year, it was raised to 45%, then raised again to 60% and was currently at 65%. Mr Barter stressed that, over the last year, access to dentistry had drastically reduced and was only now just over half what it would have been in a normal year.

Mr Barter explained that the Dental Strategy sought to increase access for patients, reduce health inequalities and improve the oral health of the population through the ability this region had to flex the national contract. Programme 1A of the Strategy was to invite practices, to provide urgent sessions of treatment where they could see patients with high oral needs eg those that presented with pain and discomfort, rather than just delivering UDAs. Practices were then remunerated in the contract at a higher rate so it made it clinically and physically more worthwhile for them to see patients. He added that this was the first region in the country to flex contracts. He stated that there was a need to move away from patients expecting 6 monthly check ups and he highlighted the NICE guidelines which outlined that it was quite appropriate to see a dentist every year to 2 years where a patient's oral health was good. He suggested that the profession needed to move away from churning through orally healthy patients to seeing them at greater periods of time, and this would then free up more of their contractual activity to see patients of a higher need.

Mr Barter explained that the Strategy had eight workstreams. Workstream 1B was about oral health stabilisation so, whilst it was important to see a patient who was in pain and get them out of it, dental disease was nearly entirely preventable and usually those presenting in pain meant their oral health was not good over a period of time. Therefore, dentists needed to get patients out of pain and on a course of oral health stabilisation to improve their oral health and reduce the risk of other episodes of high need. This approach would reduce the burden going forward for the NHS and also be a better journey for the patient. Another workstream included a dental check by the age of one so seeing children at a very early age on their parent's lap so they could get used to seeing the dentist and they had better oral health through their entire life; he highlighted that a lot of the Strategy was about prevention.

Mr Barter added that the commissioning team had done a lot of work to flexibly commission the contract so it was more fit for purpose and represented the region. In terms of the procurement for the new contracts mentioned earlier, he confirmed that, although those contracts were from 8am-8pm 365 days per year, providers were being asked to provide healthcare in a slightly different way. He explained that, previously, it would only have been the dentist that could deliver UDAs but the new contracts allowed all dental clinical professionals in the team, overseen by the dentist, to provide good oral care for patients. Similar to a GP practice, within their clinical skillset and capacity, other dental clinical professionals could be part of the clinical team delivering care to patients in contracts that had many more hours in a day and at weekends, so that would increase access for patients.

The Chairman thanked Mr Barter and asked Members if they had any questions.

Councillor Mapey queried if there would be an issue where dentists were hit by clawback at the end of the financial year given the contracts had been adjusted in recognition that they could not see the same number of patients per day. Mr Barter responded that the minimum delivery targets acknowledged that the throughput of patients was much slower for the dental team because of fallow times and ICP, but dentists providing NHS contracts had their income guaranteed and were remunerated at their pre-Covid level so they would get 100% of their contract paid to them even though it was acknowledged they were not seeing the same level of patients. This was in recognition that they were working very hard to deliver care to patients eg having to

wear full PPE, changing between patients, extra cleaning etc. Councillor Mapey clarified that he was seeking assurances that practices would not have an issue at the end of the financial year if they had a shortfall in the number of UDAs given the Covid situation was exceptional. Mr Barter responded that the minimum delivery targets had been agreed nationally and confirmed that, in one particular month, a dentist might only deliver 20% but they would receive 100%. He added that pretty much every practice in the region had met the thresholds and so it was unlikely there would be any clawback issues next year.

Councillor Back expressed concern that dentists would miss identifying patients with oral cancers etc due to the lack of throughput. On behalf of Mr Barter, Mr Norfolk responded that patients were risk assessed. He explained that the NICE guidelines, which determined the recall interval, would look at a variety of things such as decay, gum disease as well as cancer risk so the dentist would bring the patient back more frequently according to that risk, so those coming in less frequently were of a lower risk.

Councillor Topping queried if it was feasible that the upskilled dental nurses could be used to carry out basic dental check-ups in nurseries and school settings as this would allow more children to be seen and help dentists to achieve their targets. Mr Barter responded that the Strategy included upskilling dental professionals to provide outreach to schools and also practices were being asked to buddy with care homes to teach the carers to look after their residents' oral health.

In response to Councillor Gooch's comment, Mr Barter stated that his team did not get to see who Freedom of Information requests had originated from. Councillor Gooch asked what was being done by whom to address the lack of accurate information on the NHS website as so many registered practices did not report if they were accepting NHS patients. Mr Barter responded that there was not a contractual obligation for a practice to update its details, however, the Dental Commissioning Team within the Eastern Region worked with contract holders and the Local Dental Committee (LDC), to try to highlight the importance of being able to keep their information accurate and up to date. Under part of the flexible commissioning 1A, where a practice would have urgent slots of activity available for very high needs patients, part of the process was that a practice would have to agree to update the Directory of Services which informed NHS111 so when patients called 111 they would be signposted to one of the practices that had the urgent slots. In relation to practice websites, Mr Barter commented that it was up to them but his team tried to influence them to keep them updated through the LDC and other channels.

Councillor Beavan referred to an NHS England graph published in the EDP recently about the number of patients per NHS dentist in Norfolk and Waveney from 2011-21 and he quoted that, in 2014-15, the area had exceeded the average for England and since then had got even worse, so the problem was ongoing and not just related to Covid. Mr Barter referred to earlier comments from Mr Norfolk made about the Dental Academy, and his own comments regarding upskilling dental clinical professionals. He reiterated that there was a difficulty attracting dentists the further north a place was from London and confirmed that NHS England were trying to attract good dentists to the region and the Strategy acknowledged that there was a need for more upskilled dental clinical professionals. He explained that the University of Essex had the biggest

cohort of dental therapists currently being upskilled and trained so they could go into practice. He added that other clinical team members were more likely to be local recruits who were liable to stay in the area which helped with retention and sustainability of practices.

7. Peter Aldous – MP

Mr Aldous reported that this had been a problem for about 20 years which had reached melting point for several reasons including the closure of 2 dental practices in Lowestoft and Leiston, and Covid had drastically reduced throughput. He referred to the following statistics relating to the Norfolk and Waveney CCG area:

- Based on figures published in March 2020 before Covid, 38% of new patients could not get access to an NHS dentist, compared to an average figure for England of 26%.
- Only 26% of child patients were seen by a dentist as a percentage of the population in the 12 months to June 2021 which was a decline from the previous year's figure of 50%.
- In August 2021, the CCG area had the lowest number of dentists per 100,000 population, at 38, which was the lowest in the East of England.

In relation to short term solutions, Mr Aldous suggested that NHS dentists needed more throughput but he acknowledged that this was a challenge because of Covid. More UDAs/funding needed to be provided for NHS dentistry locally and he stated that this was happening thanks to the work of Mr Barter and other colleagues but it was not the whole solution. He explained that additional resources had been provided in the area for the period up to July 2022 and this was allowing more patients to be seen. With regard to the new four year, nine month contracts, Mr Aldous stated that he had found the comments about needing longer term contracts interesting and had realised this must be because the kit needed was very expensive. He reported that the main feedback he received from NHS dentists was the problem with the 365 days per year from 8am-8pm because of concerns about whether any tenders would be submitted on that basis as there were challenges to get people to work then. He explained that the preference was to have a normal working week with bank holidays and weekends available for emergencies. Mr Aldous stated that his understanding was that there would be tenders for the Lowestoft contract but Leiston was outside his area so he did not know about that.

In terms of longer-term solutions, Mr Aldous stated that the first was funding because over the last 15 years there had not been the additional funding required to go into NHS dentistry and none of the Governments since had provided the necessary funding. He referred to a letter which he believed had been sent yesterday to the Chief Secretary to the Treasury, Mr Clarke, from Sir Robert Frances, Chair of Healthwatch England and Eddie Crouch, Chair of British Dental Association, highlighting that, of the additional £5.4bn funding coming back from Covid, none was coming towards NHS dental services despite it being very badly hit. This was likely to be followed up in the next few days by a cross party letter from MPs highlighting this problem to the Chancellor in advance of the comprehensive spending review taking place shortly. Mr Aldous stated that he would be signing this letter and he anticipated that a number of his colleagues would do so as well.

In relation to the 2006 contract not being fit for purpose, Mr Aldous explained that there had been a succession of ministers over that period who all wanted to get it reformed and there was supposed to be a new contract in April 2022. Jo Churchill, who was the dentistry minister until the latest reshuffle, had been determined to make sure that happened. He concluded that whilst he was not sure if additional funding would be provided, he pointed out that speakers today had outlined how the existing contract could be improved.

With regard to increasing the workforce capacity of NHS dentistry, Mr Aldous highlighted the following six suggested actions made by the Association of Dental Groups:

- Increase the number of training places – a dentistry school in this area would help to recruit and retain local people because it was challenging getting local people back to this area but it would not be set up overnight.
- In the meantime, need to recognise the role played by EU trained dentists and should continue to provide access for EU trained professionals.
- It was also important to recognise overseas qualifications from outside the EU and the General Dental Council's recognition of those qualifications through approved schools should be extended.
- Speeding up and simplifying the process to complete the Performer List Validation by Examination - that needs to be improved.
- There were a lot of professionals in a dental surgery and should look at a system, where appropriate, that allows the whole team to initiate treatment.
- New dental contract needs to include and embrace a strategy that retains workforce.

In addition, Mr Aldous referred to water flouridation and explained that where this happened particularly in deprived areas, it improved the overall dental health of an area, prevented dental decay and was part of the wider prevention agenda.

Finally, Mr Aldous stated that there needed to be greater accountability and possibly changes to the procurement arrangements. He referred to the Health and Social Care Bill which put Integrated Care Systems (ICS) on a statutory footing and suggested that an ICS needed to have a greater role in terms of accountability and possibly in commissioning.

The Chairman thanked Mr Aldous and asked Members if they had any questions but, firstly, he wished to ask if the experts and MPs all knew there was a problem with the contract, why were Ministers not doing anything about it and scrapping it. Mr Aldous responded that the issue was always down to money, although he thought it was possible it might be different this time around because now it was critical and the industry was in crises, so much so that a debate had been held in Parliament last night on NHS dentistry in Lincolnshire, a similar debate had been held earlier in the summer on dentistry in Waveney and there was a crisis in Cornwall and it tended to be there were problems in rural areas. He concluded that the problem now was that there was a crisis and he hoped the Government would listen.

Councillor Deacon commented that there were three other MPs representing East Suffolk and he explained that Felixstowe was experiencing the same issue as people could not access a dentist. He referred to Dr Caroline Johnson who took part in the Parliamentary debate last night and had secured a meeting with the Minister, and he urged Mr Aldous and the other three MPs to meet with Dr Johnson and explain the problems experienced in East Suffolk. He concluded that he had been very interested in the remarks about EU dentists as he knew several professionals that had returned to their own countries.

Councillor Gooch queried if Jo Churchill MP had been invited to this review and it was confirmed that she had, although no response had been received. In response to a question about how widespread the all party group was, Mr Aldous responded that he was not a member of the all party group but the letter was being put forwarded by the British Dental Association and would be cross party and have a wide geographical spread.

8. Mary Rudd - East Suffolk Council Cabinet Member with responsibility for Community Health & Nicole Rickard - Head of Communities

The Head of Communities reported that her Team had worked with communities who had lost dentists, particularly Leiston, over the last few months. Also, she and the Cabinet Member had recently spoken to Messrs Barter and Norfolk about this issue.

In relation to what East Suffolk Council was doing, the Head of Communities stated that the Health Projects Officer and Integration Partnerships Manager were undertaking a lot of work about prevention eg creating a pilot project with the Integrated Neighbourhood Team working with children in the Aldeburgh, Leiston and Saxmundham Community Partnership area to improve their diet and learn about effective brushing, which could be expanded. There were also opportunities to work with the Economic Development team on a campaign to attract dentists and other sector professionals to live and work in East Suffolk.

The Head of Communities explained that a lot of work had been done already around rurality through the Community Partnerships' rural proofing work and she pointed out that, whilst the Committee had heard about specific problems in rural communities, there were also challenges for coastal communities. She suggested that communication was key and East Suffolk could use its Residents magazine and social media to try and ensure the right messages were being put across eg the debate about registration, information about the frequency of check-ups and using networks to talk about some of the things discussed this evening such as problems with the contracts, ease of access to the Performer List etc.

The Head of Communities stated that Mr Barter and Mr Norfolk had also raised the issue of the planning process and opportunities for dentists to access town centre locations where they were at the heart of the communities.

The Cabinet Member stated that changing people's minds about having six monthly check-ups would help other people to access practices.

The Chairman thanked the Cabinet Member and Head of Communities for their attendance and asked if Members had any questions.

Councillor Gooch referred to a review undertaken by Salford Health Scrutiny Committee in May 2019 about dental health and in particular the education programme they had put in place to ensure good practice for children, and she suggested that East Suffolk might like to consider something similar. She concluded that prevention was key.

The Chairman invited the guest speakers to make any final remarks.

Ms Overton stated that Healthwatch's ethos was about co-production and she stressed that if everyone worked together then nothing was too big.

The Chairman stated that the recurring message seemed to be about the contract and he queried if the contract was such an insurmountable problem that if it was not changed, then the situation would not really change. Mr Stokes responded that, personally, he felt unless the contract changed fundamentally, the problems there had been over many years would continue, even if the acute problems of a changing workforce and Covid might improve, there would still be a downward trajectory.

Mr Stokes continued that, every year, the cost to NHS patients if they paid, rose and became an increasingly large percentage that funded NHS dentistry. He added that the contribution by patients was growing and there should be an acknowledgement that, for some people, this might be a barrier to accessing NHS care. He queried, therefore, if fundamentally the NHS should be free at the point of access or not.

Councillor Topping queried who sat on the group that decided on the national contract. Mr Aldous responded that he did not know precisely, however, Ministers would look at it and making the ultimate recommendations taking into account the views of a range of organisations including NHS England.

Councillor Goldson referred to the Integrated Care System (ICS) which would take on the commissioning of some dental services and queried how the Norfolk and Suffolk approach differed. Mr Barter responded that, if the legislation passed, then the ICS Boards would come into existence from April 2022. They would commission GPs and in time dentistry, pharmacy and optical as well which Mr Barter suggested would be really good because it allowed care pathways for patients through all aspects of primary and secondary care, mental health and social services to be more joined up. He added that part of the legislation was to repeal S75 of the NHS Act which was the duty to follow Public Contracting Regulations 2015 which meant that there was currently a long arduous procurement process to bring in providers, but hopefully it would become easier and more streamlined to engage with providers and bring them into place in a swifter way.

Mr Aldous clarified that the ICS legislation was going through parliament and should come back to the House of Commons before Christmas. He assured Members that he would take on board the points raised at this meeting and emphasise them. He explained that ICS in Norfolk and Suffolk was currently in a state of flux but was recruiting a Chairman and Chief Executive and when that process was out of the way,

the process to map things out could begin. He agreed that the contract was of critical importance and acknowledged that there was a worry about Ministers who were committed to this, being reshuffled but he hoped the new Minister was on board. He suggested that the Committee had been given enough evidence that it might want to re-emphasise the importance of contract reform to the new Minister, and he and other colleagues in Suffolk and Norfolk could re-emphasise the point too. He also agreed that there was a public health role as prevention was the best solution long term. Mr Aldous referred to the Head of Communities' comment regarding the planning process and stated that Jo Churchill had been concerned about obtaining planning permission for facilities when she had been the Minister.

Mr Rolfe referred to the earlier comment regarding fluoridation of water and clarified that Suffolk had about half the optimum level naturally, so the benefits for Suffolk might not be as all changing as it would be in other parts of the country.

The Chairman picked up on Mr Aldous' suggestion and recommended that a letter be sent to the Minister summarising the Committee's findings and expressing the wish that the contract be revisited as there was unlikely to be sufficient progress if it was not.

In response to Councillor Topping's query, Mr Norfolk clarified that the Performer List did not come under the contract but was under the Performer List Regulations. The Chairman agreed that this should be raised as a separate issue within the letter to the Minister.

Councillor Gooch referred to the tenure and duration of the contracts mentioned earlier and queried if it would be possible in the letter to ask for the contracts to be extended to say 10 years. Mr Barter stated that the procurement was already out for those contracts and he clarified that it was not to enter into a General Dental Services contract but for a Personal Dental Services Contract which under Regulations could be novated into a General Dental Services contract which were in perpetuity, so effectively the current procurement allowed for break clauses which was good for both sides, but it did not mean that they could not be in perpetuity as they could then move into a GDS contract.

The Committee was reminded that, under the Council's Constitution, a vote needed to be taken to agree the meeting could go beyond three hours. It was proposed by Councillor Bird, seconded by Councillor Beavan and unanimously

RESOLVED

That the meeting be extended beyond three hours.

Councillor Beavan referred to a proposed recommendation he had emailed to the Chairman and the Chairman responded that it had not been intended that this Committee would make any formal recommendations but the review findings would be passed by Councillor Back to the Suffolk Health Scrutiny Committee. Councillor Beavan acknowledged this and suggested instead that the Suffolk Health Scrutiny Committee call for an urgent campaign to train hygienists and dental nurses to

administer preventative dental care to our children, funded by an increase in the sugar tax.

Councillor Gooch stated it was also about what we could do as a District and suggested that the Council should investigate an early years programme through the Community Partnerships to safeguard the teeth of young children. She added that communication was key and also suggested writing to local NHS practices to request that their information was up to date on the NHS website so patients were not wasting valuable time and money contacting practices who did not have any capacity despite what it said on their website. The Cabinet Member agreed to discuss how best to do this with the Head of Communities who added that it might be better to talk to partners who had connections with dental practices.

Councillor Topping suggested that space should be unlocked in schools to enable dentists or nurses to go in. Councillor Goldson stated that the cost of taking dentists into schools was astronomical and was not economically viable.

Councillor Deacon referred to the fact that the Committee had heard about obesity of young people and the impact on their oral health and he suggested that as obesity was already a priority for the Community Partnerships, this could be something that could be promoted.

Councillor Gooch stated that the County Scrutiny Health Committees should explore the possibility of the area having a dental school attached to one of the local universities. Mr Norfolk suggested writing to the universities about this.

Ms Overton offered to send a website review of dental practices undertaken this year which the Committee might find useful.

Councillor Deacon thanked Councillor Gooch for all her hard work on the original scoping form and the Chairman thanked all the guest speakers for their valuable contribution to the review.

RESOLVED

1. That Councillor Back be asked to report back to the Suffolk Health Scrutiny Committee on the findings of this review.

2. That a letter be sent to the Minister emphasising the importance of creating a new national contract as soon as possible.

3. That a letter be sent to the Universities of East Anglia and Suffolk regarding the creation of a dental school in the region which could be attached to the universities.

4. That the Cabinet Member and Head of Communities discuss potential interventions the Council could make, possibly through the Community Partnerships, including an early years programme to improve oral health and contacting practices regarding better communication.

The Committee adjourned for a comfort break at 9.30pm and reconvened at 9.40pm.

5 Scrutiny Committee's Forward Work Programme

The Scrutiny Committee received and reviewed its current forward work programme, together with a Scoping Form from Councillor Beavan in relation to a final review of the Covid emergency with particular attention to the community response and grant schemes.

Reference was made to the recent Waste Management review and a suggestion was made that it would be useful to receive a brief update on the latest position with regards to the two bin collection rounds in Lowestoft.

RESOLVED

1. That the Work Programme be updated to include a review of the Covid Emergency on the 17 February 2022 with the addition of the Cabinet Member for Community Health as one of the witnesses, and the proposed Cabinet Member Update item be deleted to ensure there was sufficient time to undertake the review.

2. That the Head of Operations be asked to provide a brief update to Committee Members outside of a meeting, in relation to the two collection rounds in Lowestoft raised as part of the recent Waste Management review.

The meeting concluded at 9.50pm.

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Chairman