RAINDROPs

shaking up dentistry?

A radical reshaping of the NHS dental budget which includes eliminating the routine scale and polish procedure has been recommended by researchers from Newcastle University. If commissioners act on the recommendations, a greater role for team members may follow.

Dr Chris Vernazza

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The role of the project was to study priority setting for the NHS dental budget, with patient input at the heart of the process. The research team, which reported its findings last month, recommends that NHS England should save £319m by cutting three dental treatments. These are orthodontics for young people with mild malocclusions (IOTN 3.6), adult orthodontics and the scale and polish.

The recommendations have been made by the RAINDROP project – Resource allocation in NHS dentistry: recognition of societal preferences – which has been run from Newcastle University's School of Dental Sciences. The work was funded by the National Institute for Health Research (NIHR) which was established in 2006 to improve the health and wealth of the nation through research.

The money saved would, if their recommendations are adopted, fund other services. The four areas recommended for new investment are:

- Greater access at some dental practices (£135m)
- local authority oral health promotion contracts (£5m)
- an online NHS 111 link - so patients can book appointments directly with a dental practice £2m
- Dental provision in care homes £13m.

Key to the work was a decision-making panel of ten people, comprising patient representatives, dental network chairs, dental lead commissioners, dental public health consultants and an academic. A workshop was held to come up with ideas and then the panel decided on the list of services to be analysed which included examinations, oral surgery, out of hours emergency appointments, molar endodontics and orthodontics.

Together they assessed the current funding model and services, exploring more effective models of care. Four waves of data collection delivered the views of the public and were based around Willingness to Pay, or WTP. Due to cost, the panel decided not to fund preventative advice (£659m) while both cost and lower scores meant dental care for the homeless (£190m) and therapy for dental phobics (£824m) were not recommended for investment.

Irene Soulsby, one of the two patient representatives on the panel, speaking at the event in the City of London, was very positive of her experience of the dentist, saying access and continuity of care compared favourably to GP services. She expressed her discomfort that prevention could not be funded.

Dr Chris Vernazza, Clinical Senior Lecturer and the lead researcher on the RAINDROP project, said the publication

of their findings was just the start of an evolving process. There would be more meetings with stakeholders and future recommendations and he predicted that there would be discussions around skill mix.

He added: 'It may be that any changes need to be made as part of ongoing and emerging processes, such as dental contract reform, which is currently scheduled for roll-out next year.'

'Our RAINDROP project shows much of the dental budget is spent on high street dentistry but significant amounts are also spent on specialist oral surgery and orthodontic services, with very little spend on oral disease prevention.'

Peter McCallum, Director of External Relations for the British Orthodontic Society, expressed concern that some under 18s as well as adult orthodontic cases would no longer be funded. He said: 'If this funding was redistributed to improve access for other orthodontic patients, there could be a case to be made. However, it is a wholly different situation with the proposal that the money is lost from orthodontics altogether, further compounding the well-documented pressures and access challenges within existing services.'

DOI: 10.1038/s41407-019-0072-z