Programme for Government Team,
The Executive Office
Block E, Castle Buildings
Stormont Estate
Belfast
BT4 3SR

17th March 2021

Dear Sir/Madam

Re. **Programme for Government draft Outcomes Framework Consultation**

The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. Our members work in all spheres of practice including general dental practice, salaried primary dental care services, hospitals and universities and the armed forces and include dental students. BDA is recognised by the Government as representing general dental practitioners in negotiations and consultations.

Thank you for the opportunity to provide our views on the draft Programme for Government Outcomes Framework. At the outset, BDA fully supports moving towards a more citizen-focused, Outcomes-based approach in the delivery of public services in Northern Ireland. If fully embedded, this Outcomes Framework will provide a clear vision and statement of intent -a constitution -to guide the policy formulation and decision-making process, and will result in enhanced accountability in how we are governed.

Taken together, we are broadly confident that the nine Outcomes identified are sufficiently broad to be able to take forward the range of government duties and responsibilities. However, unlike previous iterations, we do have some concerns that the emphasis on Wellbeing as the key driver, and the focus on public health appears to have waned in this version.

We welcome the recognition in this document that the Pandemic, '*…has both exposed flaws in traditional models and approaches to public services, while at the same time has progressed thinking and practice around new and different ways of working…and has demonstrated that governments cannot do it by acting alone'.* This certainly rings true within the world of dentistry, and how it has had to adapt in an unprecedented way in response to the pandemic.

We see a unique opportunity to rebuild dentistry according to the Outcomes-based principles enshrined in the PfG. After decades of consigning our population to a life of poor oral health and continued oral health inequalities -we need to see a fundamental shift towards prioritising prevention -and away from purely treatment based funding models, in how dental services are commissioned. This is what moving to an Outcomes based approach will mean in the dental world, and one we very much hope will be taken forward if PfG is to permeate this important aspect of public health.

A significant stumbling block that anyone with experience in the policymaking process in Northern Ireland will point to, is the wholly inadequate apparatus -namely the shortage of sufficient numbers of key policy personnel within the NI Civil Service -to be able to take forward those new policies and strategies which will be essential to achieving meaningful progress on the high-level priorities identified by the PfG Outcomes Framework.

Unlike the situation in England, Scotland and Wales, we have no deputies to support the extensive work of the Chief Dental Officer. The shortage of policy staff extends to the whole-time equivalent workforce administering dentistry within GDOS. Dentistry is no longer directly represented at the top table within DoH. These are issues that simply must be rectified if we are to make the sort of progress necessary on a new GDS contract, and a more strategic approach to oral health.

In addition to personnel gaps, the other major barrier is not having sufficient financial headroom within departmental budgets to be able to look beyond the ‘here and now’, to imagine new ways of achieving better outcomes. Too often, insufficient capacity and budgetary constraints stymie the change and strategic direction that is required.

Northern Ireland has fallen behind in many important policy areas, not least in how long it has taken to devise something as significant as a new Cancer Strategy compared with other nations.

In the area of policy we are most familiar with, we have an Oral Health Strategy that dates back to 2007, and a GDS contract fixated with treatment, not prevention that predates it. In practice, dentistry operates in a policy vacuum, and lacks the strategic direction required to advance on making much needed oral health advances. A lack of policy personnel in DoH continues to pose a major barrier in realising the significant GDS contract reform, and Oral Health strategic refresh that is long overdue.

We very much hope this document represents the start of a new era where policymaking flourishes, and where new ideas and collaboration across old departmental silos -and between stakeholders from all sectors -actually materialises. The pandemic has given us a glimpse of just what can be achieved over a short period of time when we work together; we need to build on this collaborative approach to ensure services which traditionally have not featured highly on departmental priorities -like dentistry -can be rebuilt better.

A bourgeoning policy context that is predicated on government interventions that can, and must be centred on improving the lives of our whole population, and not an approach dominated by budgetary constraints with no strategic vision, is very much overdue.

At this point, we will turn to providing our comments on those individual Outcomes within the Framework that are most relevant to our sphere of interest, as follows:

Our children and young people have the best start in life

BDA fully concurs that this Outcome which places a particular focus on children and young people is worth including in the PfG Framework. Quite simply, this cohort must be a particular focus in how all devolved powers are exercised.

Within our policy sphere, a renewed focus on improving outcomes for children and young people is imperative. It would mean a renewed strategic approach to oral health, underpinned by a fit-for-purpose policy framework/a revised Oral Health Strategy. Among its objectives should be to aim to prevent in excess of 3,800 children each year having 21,720 teeth extracted under General Anaesthetic, of which 19,097 are baby teeth. With dental caries being largely preventable, this an ongoing scandal. Child oral health, and the need for additional action to address oral health inequalities and to see improvements in the oral health of the wider population must necessarily be prioritised under this new Outcomes based approach, and the commissioning of services held accountable to this essential priority.

In responding to the Key Priority Areas outlined under this Outcome, we feel that while Capability and Resilience does mention *'equipping children and young people with the knowledge and support to make safe, healthy and sustainable life choices'…*this does not go far enough. While COVID-19 may be dominating the headlines at present, we continue to face a public health emergency that poses a major risk to the life chances of our children and young people. That emergency includes child oral health, as well as the full range of other conditions, such as childhood obesity and type 2 diabetes that government here must prioritise. Child health, and public health factors need to be given a much more prominent focus within the Key Priority Areas than this document currently provides.

It is worth highlighting that in cases of childhood obesity and type 2 diabetes that are diet related, children present at an early stage to their dentist with decay and pain in their primary teeth. Dentists are in a unique position to identify patients – especially children – who may be more vulnerable to systemic diseases in the future, with the mouth acting as a 'window on the body' where warning signs can manifest early. Under a new GDS contract which should be prevention focused, those children would receive interventions that would not only help prevent avoidable dental decay and the large number of extractions of teeth under General Anaesthetic (GA) annually, but also the problems associated with obesity, type 2 diabetes and other non-communicable diseases with common risk factors in later life.

In addition, an updated Oral Health Strategy for Northern Ireland is crucial to helping inform the key priority areas to give our children and young people the best start in life as this will have significant implications on their oral health across the life course.

We have an equal and inclusive society where everyone is valued and treated with respect

BDA supports the inclusion of this Outcome within the PfG Framework, and its underlying premise of tackling inequality and discrimination.

We do have concerns that health inequalities appear not to register in any significant way in how the Outcome has been currently drafted. Indeed, Department of Health is not even mentioned as having a role to play under the Inclusion and Tackling Disadvantage Key Priority Area, which we feel is a fairly significant oversight.

As socio-economic background continues to represent a significant determinant in health and wellbeing, a point which we see reflected daily within oral health, we need an explicit focus on tackling health inequalities as a Key Priority Area.

We all enjoy long, healthy active lives

We believe it is appropriate that this Outcome should be included. We also welcome the stated purpose of the Outcome as being about, *'enabling and supporting people to maintain their health and lead healthy, active lives, addressing the factors which impact on mental and physical health'.*

With the connections between oral health, and general health and wellbeing becoming increasingly evidence-based, we are supportive of the enabling element within this Outcome.

Oral and systemic non-communicable diseases share a range of modifiable risk factors, including diet, tobacco and alcohol consumption, meaning that there will be synergistic benefits from a preventive approach. Dentists are in a unique position to identify patients – especially children – who may be more vulnerable to systemic diseases in the future, with the mouth acting as a 'window on the body' where warning signs can manifest early.

Associations have been established between oral conditions (particularly periodontal disease) and cardiovascular disease, pulmonary disease and diabetes; some evidence suggests inflammation as a possible common mechanism. Diet, alcohol and tobacco risk factors are shared by oral and a range of other cancers. In addition, HPV is a communicable cause of a variety of cancers including oropharyngeal cancer.

Access to Health is rightly identified as a Key Priority Area under this Outcome, and this also highlights the need to take forward health and social care reform to ensure we can deliver safe, high quality services. Rather than reform being an industry in itself, that process must be inclusive of <u>all</u> HSC services being delivered. It must also recognise the considerable challenges within Primary Care, including the important contribution of dentistry and dental professionals in helping the population lead healthy, active lives.

We are pleased that Inclusion and Tackling Disadvantage is also included as a Key Priority Area, with input from DoH. If we can crack the nut of tackling the issues that lead to disadvantage, it will unlock a myriad of positive outcomes across a wide range of government services.

It is appropriate that the specific health and social care needs of Older People receive a specific mention as a Key Priority Area under this Outcome. We know that there are significant deficiencies in oral health provision at present affecting the older demographic, particularly those who reside in care home settings. As the older population grows larger, so too is the level of challenge to meet the growing complexity of healthcare needs. A lack of good oral health provision has a disproportionate impact on the older cohort, significantly impacting on quality of life, with avoidable pain, adverse impacts on diet and the ability to eat certain foods, which in turn can have extremely debilitating consequences for those most vulnerable.

We trust the work currently being carried out by the Oral Health Options Group on the oral health needs of older adults will ultimately lead to informing important improvements in a way that is very much aligned with the PfG approach.

Once again, we note the absence of the Oral Health Strategy for Northern Ireland in the list of relevant strategies to help deliver these key priority areas. The Aspiration also reinforces

the importance of having an updated Oral Health Strategy that is relevant in contributing to today's challenges, not least those facing our older population.

We have a caring society that supports people throughout their lives

We support this Outcome being included in the Framework, and the underlying emphasis on enabling and empowering citizens to have more influence over their own lives, as well as tackling the issues that lead to disadvantage, and providing the services and support people need, when they need it.

Disability, and Inclusion and Tackling Disadvantage are Key Priority Areas that particularly resonate with our sphere of interest, as well as the health and social care needs of Older People and an ageing population.

The constant theme throughout our submission is the need to invest more in prevention and upstream initiatives to help issues from arising in the first place. This same approach that can be effectively applied to oral health, can also result in better population outcomes in other aspects of society and governance.

A fixation with measuring activity and equating this with good government, as opposed to the positive difference interventions have made in the lives of individuals has resulted in some of the most vulnerable in society not receiving the support they need. A culture-shift is required urgently.

Conclusion

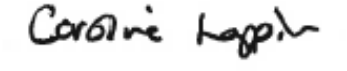
We commend the authors on a draft PfG Framework that is far-reaching, and radical in seeking to align the activities of government with 9 core Outcomes. We support the Outcomes identified, believing they are fit-for-purpose.

We do impress on the Executive the importance of putting in place the resources -both policy personnel and financial -to ensure the policies and strategies needed to underpin this work, can follow.

We can see the positive difference this PfG approach will make here if fully realised in all spheres of policy. We only hope that our shared vision and ambition is not frustrated when it comes to taking forward those long overdue reforms of oral health provision.

We trust our observations are received constructively and will help to inform this important work. We are at your disposal if further engagement on the issues raised would be considered helpful.

Yours sincerely



Caroline Lappin

Chair, Northern Ireland Council