HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: NHS dentistry, HC 964

Tuesday 21 March 2023

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Watch the meeting

Members present: Steve Brine (Chair); Lucy Allan; Paul Blomfield; Chris Green; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 1 - 64

Witnesses

I: Professor Nick Barker, General Dental Practitioner and Professor of Oral Health Sciences, University of Essex; Shawn Charlwood, Chair, British Dental Association General Dental Practice Committee; and Dr Sandra White, Clinical Director, Association of Dental Groups.

II: Ian Brack, Chief Executive and Registrar, General Dental Council; Dr Abhi Pal, President, College of General Dentistry; and Malcolm Smith, Chair, Health Education England's Advancing Dental Care Review and Dental Education Reform Programme, and Postgraduate Dental Dean for HEE North East and North

Examination of witnesses

Witnesses: Professor Barker, Shawn Charlwood and Dr White.

Chair: Good morning. This is the Health and Social Care Select Committee. This is the first session of our inquiry into NHS dentistry. Just before I set out the work that we are doing here, there are a couple of declarations of interest from colleagues. I was the Public Health and Primary Care Minister, with responsibility for dentistry, between 2017 and 2019—an age ago in the lifetime of this Parliament.

James Morris: I was a Minister in the Department of Health last July, and was responsible for signing off the changes that the Government were introducing to dentistry, including presentation of the written ministerial statement.

Q1 **Chair:** As I said, this is our first public evidence session in our NHS dentistry inquiry. The aim of the inquiry is to deepen our, and therefore Parliament's and hopefully the public's, understanding about the problems people are having accessing NHS dentistry, which is a very complex subject.

We are going to explore what steps the Government, NHS England and the integrated care boards, which take responsibility for commissioning dentistry from 1 April, should take to improve access to NHS dental services. We will talk about the extent to which the current dental contract disincentivises or incentivises—Discuss?—NHS dental activity and then, obviously, what further reform of that contract is needed and the challenges in the NHS dental workforce. Over the course of the inquiry, we hope to really get to the bottom of what is a real issue for many of our constituents. It is a constant issue raised in Parliament at Health questions and in debates in the House and in Westminster Hall. It is very much a live issue and it touches every single one of us.

We have two panels this morning. Our first panel is in place. Professor Nick Barker is a general dental practitioner and professor of oral health sciences at the University of Essex. Shawn Charlwood is chair of the British Dental Association general dental practice committee, and Dr Sandra White is a clinical director at the Association of Dental Groups. Thank you all very much for giving up your time and coming to give evidence to us this morning. We have lots of colleagues here, who have lots of different questions about some of the subjects that I have already outlined.

To kick off, Professor Barker, to what extent do attempts at reform of the dental contract constitute tweaks or a tinkering around the edges, or have they been something more worth while?

Professor Barker: Probably more the former in the main, I would say. It is tweaks because the contractual framework is where it is, and anything that you try to introduce is based on the existing dental contract. Possibly one of the best ways of demonstrating that is that the contract marks on

activity. Your performance is about activity. The activity that you do scores certain points: units of dental activity.

The issue is that the larger units of dental activity gatherers are the more complex pieces of treatment, which is effectively what we want to try to avoid. We want to put the prevention in first rather than go for the greater units of activity. The prevention score is usually just a single unit of dental activity, and therein lies the issue. To try to tweak that, you cannot build up the number of units of activity for the prevention. Eventually, ultimately, everybody is just aiming for higher numbers of units of dental activity, which is really a perverse incentive. Realistically, it will need a re-look, where it is prevention focused on patient care and patient risk assessment, and not just what the presenting disease is and what will score the most points for treating that disease.

Q2 **Chair:** Mr Charlwood, this is tweaks—a wash and brush-up—versus something more significant. Does it require something more significant, in your opinion, from the BDA?

Shawn Charlwood: Absolutely. The recent changes are not reform. I want to make that very clear. The recent changes do not come close to a reformed contract. They are minor tweaks. They will not stop the exodus of dentists and their teams from the NHS, and that is really important.

The fundamental perversities of this system are unchanged. I will give you an example. Since the marginal changes, dentists have had to record whether their website offers appointments to new patients on a regular basis. That takes time to do. Given that BBC research in August indicated that nine in 10 practices were not accepting adult NHS patients, and eight in 10 NHS practices were not taking on children as patients, all it does is underline the paucity of dental access in England. It does nothing else. We warned them of that, and it just demonstrates how weak the system is.

We have a higher award for treating three or more teeth, but many of the new patients presenting to dentists and their teams now have far more disease than that. People have not been able to present. They are presenting much later; they have far more disease and the disease is often more complex to treat.

The current changes, although welcome, do not go far enough. The perversity of the UDA system remains baked into the system. Less complex work will be rewarded; more complex work will not. There is no new money. None of these changes has new investment attached. In essence, what we are doing at the moment is rearranging the deckchairs on the Titanic while the service slowly slips into the sea. Without fundamental reform, away from the UDA—we are proposing a capitation-type system, where prevention is rewarded—the service will not meet the demands of the British people.

Q3 **Chair:** Thank you. I am going to give Dr White a chance to come in and

then I will hand over to my colleague Paul Blomfield, who can maybe explore the capitation system in a bit more detail with you, Shawn.

Dr White, the Government say that they are committed to implementing further reform. From what we have heard, we have not really had any reform so far. Would you concur?

Dr White: There have been some useful tweaks, but I agree. I am sitting here, not as myself but representing 20 of the biggest groups that are committed to offering NHS dentistry, and many of them are. That is 10,000 dentists and 10 million patients. I am sitting here with that remit. They are really struggling. The current system does not help them to provide holistic, individual care for their patients. That impacts on access, with only 36% of adults being seen and 46% of children being seen. It is not good enough.

In terms of tweaks rather than total reform, our dentists have been waiting 10 years for real reform. They want it. They are losing hope. Unless we give them some hope for the future, they will not want to continue to provide NHS care.

Q4 **Chair:** Finally on that, the concern being expressed to me as a constituency MP, and in this job, is that with practitioners leaving NHS dentistry—not something they do lightly; it is a huge wrench because they have a mission that they want to serve the public—and they have made that decision to leave, it is going to be very hard for them to return even if everything that you are saying happens next week.

Dr White: Yes.

Q5 **Chair:** Is that fair comment, or am I being characteristically glass half empty?

Dr White: No; that is very fair comment. I echo some of the answers from my colleagues. If you want to offer preventive care and ask about tobacco, alcohol and give advice on diet, smoking and breastfeeding, you need the time to be able to do that and to reassure patients. They need the time, but they are struggling. Those who are left in the NHS are trying to pick up the pieces because a lot of their colleagues are leaving. We have a demotivated, unhappy workforce, and that is not good for anybody. It is not good for patients.

Chair: It is striking that all three of you have mentioned prevention in your initial comments. You will know that we have just launched a major prevention inquiry, which we are very interested in. It works alongside this inquiry, so thank you for that. I am going to bring in Paul Blomfield.

Q6 **Paul Blomfield:** We are 10 minutes in and you have painted a comprehensively bleak and challenging picture, which I think reflects all our experience in talking to constituents. I have a question about the varying UDA rates between practices and what difference that made. I have a couple of practices—local dentists—within 100 yards of each other, one on a rate of around £20 and one on a rate of about £35, based

on historical data 17 years ago. Does it make any sense at all?

Shawn Charlwood: No, none at all. The UDA system is unfit for purpose. This Committee said in 2008 that it was unfit for purpose. I appeared in front of this Committee last year. Again, it was said that it was unfit for purpose. I think we are getting the message, but it is what we are going to do about it, frankly. We need a decisive break from the UDA system. It is perverse that in the time of an access crisis, and we are in an access crisis now for your constituents and for NHS dentistry, we are on track for an underspend of £400 million this year. That is £400 million that will not be spent on NHS dentistry. I think our patients and your constituents will be scratching their heads, thinking, "How can this be when we can't gain access to NHS dentistry?"

Chair: Hold that thought on the underspend. Rachael Maskell is going to come in on that later in a bit more detail. I want to focus, if I may, on the contract, at the top, with Paul.

Q7 **Paul Blomfield:** I want to ask about the capitation system, but first I want to ask a question that I guess most people will be thinking. We had a poor contract before 2006. We introduced a new contract in 2006, which was quickly recognised to be flawed, so we had the Steele review, which recommended fundamental change. What have been the barriers to that change that have prevented us from making the moves that were needed for 15 years?

Shawn Charlwood: The fundamental barrier has been funding. In essence, there is only enough NHS dentistry commissioned in this country for 50% of the population. Can you imagine if that was general medical practice? There would be rioting. Over the years we have plastered over the cracks. Dentists in the NHS have kept their practices going. There was unmet need before covid of about 4 million patients. There is currently unmet need of about 11 million. We have a system that does not work.

You ask what has taken 15 years. We have had prototypes and pilots—we may talk about that later—but fundamentally the Treasury have dragged their feet in order to commission enough service to meet the demands of the population.

Professor Barker: Perhaps I could go to the same thing, and the UDA rate as well, just to make a point. An example is that as clinical lead for east of England we put out for an increased UDA rate to mop up some of the UDAs missing. Nobody offered to provide them. The UDA rate is immaterial. The contractual problem is the whole problem.

If you are working with something that is not workable and nobody wants to do it, therein lies the problem. In order to change it, in the 15 years, it needs a blank canvas. It needs to be completely rewritten to be workable.

Q8 **Paul Blomfield:** I will come back to the calculation in a minute. Dr

White, everybody says that there has been a problem. It is recognised by everyone. I am interested in what the barriers to change have been. Mr Charlwood says it is money. What is your view?

Dr White: It is difficult. The Chair used the word "complex". We are not naive enough to think that there is a simple solution. There are never simple solutions. We need system change. It needs to be a collective responsibility for change.

In terms of the tweaks, could you remind me of the question? What do you really want to get to? The specifics?

Q9 **Paul Blomfield:** We know the contract is a problem. It has been a problem for 15 years. What have been the barriers?

Dr White: Sometimes it is decisions. I know that is a simple one, but there were some changes made last year that were some of the best changes we have had in 10 years. Although it will not suit everybody, there were some positive changes on how people paid for fillings and about the workforce, and encouraging dental care professionals and dental therapists to work within the team. There were some encouraging things, but we have had 10 years of indecision and not using some of the learning from the pilots. We have the ability in this country to have what is called flexible commissioning, where some really good things are happening around access clinics for people who need a dentist and who are new patients. There is lots of learning out there. We need some good leadership, some system working and some decisions.

Q10 **Paul Blomfield:** I have one final question. Starting with a blank canvas and thinking again, and if there was some of the leadership you are talking about, Dr White, how would a capitation system change the landscape? Can I ask you, Professor Barker?

Professor Barker: Certainly. The capitation is about moving things around to supporting a head of patients. Clearly the treatment is built within it. The capitation itself will say that, okay, there is a certain head of patients that will allow that. Having been a prototype practice, working under a blend B, which was primarily capitation based, I can say that, yes, that clearly works. Exactly as Dr White pointed out, it works because it also incentivises the entire team to work under that capitation system rather than just the dentist, which is what the UDA system does. You can actually start to get integrated care.

Not only that, but if we can use a capitation system, we have the integrated care systems that are coming on board—the primary care networks—and it would allow practices to start feeding into the primary care network systems as well and integrate dental health into general health and oral health, which it does not do. There is an awful lot to be said for capitation-based or patient-centred care—the term I prefer—which is about putting the patient at the centre of the care and deriving it from a prevention base, building upwards to the care and not starting at

the state we have currently: "There's some disease. Let's just treat the disease and forget everything else."

Paul Blomfield: I am sure you all have useful views, but I am conscious that I am eating into a lot of time, so I hand back to the Chair.

Chair: Thank you. We are very systematically moving through the issues, which is great.

Q11 **Lucy Allan:** In the remuneration rate, are you saying that need, geography and deprivation should be the basis, Mr Charlwood?

Shawn Charlwood: Absolutely. I think a 21st-century model for NHS dentistry is based around a prevention-focused capitation system. Within that you can have weighting for need. That may be based on a postcode. We did quite a lot of work in the prototypes around that. You could have weighting for new patients, much as you do in general medical practice, because typically new patients require more time and more treatment than established patients who have been coming on a regular basis.

Just as a GP would be paid per patient on the list, so those who needed us most would be able to gain access. That is one of the conundrums at the moment. Perversely, those who need us most struggle the most to access the NHS system. As I say, new patients would be weighted. That would start to address some of the fundamental problems that we have at the moment.

With capitation, weighting and a national tariff we would try to get rid of the discrepancies that Mr Blomfield spoke about earlier, not just between practices on the same street; actually the same dentists in some practices have different UDA rates. It is as bizarre as that. You can see how, in a recruitment and retention crisis, if you are trying to attract a new dentist and you can only offer half the UDA rate that somebody down the road can, it is a challenge.

Q12 **Lucy Allan:** That is my next question. In incentivising a new dental graduate, how do you encourage them to work in a dental desert?

Shawn Charlwood: It is not just about money. Money is always important and we should not shy away from that, but a lot of new graduates are not happy to work in the NHS system at the moment because it is not the way they wish to deliver dentistry. There is no prevention; they do not have enough time; and they do not wish to work in it. We have done surveys on new graduates and new dentists. There is a further problem coming. That is where the urgency is. If we do not do something about this, we are going to lose a generation of dentists and then we might lose the service. Who is going to take over?

Q13 **Lucy Allan:** Professor Barker, how do we incentivise new graduates to work in dental deserts?

Professor Barker: Primarily, the undergraduate training is of prevention-focused care, so you put a prevention-focused system in. It is

as simple as that. It is as if you have been taught to ride a bike, and then you are given some weird scooter thing to carry on with. It is illogical, and therein lies the problem.

With this weighting system, the other thing we have to look at is that patients change. Their demographics change naturally themselves. One of the biggest problems is their oral health. Somebody who turns up with poor oral health can improve their oral health by simple prevention mechanisms. Therefore, what you need to build into the system is something where, at one end, you take the patients in, you change their values, their behaviours and whatever, and then you take them into a maintenance system to try to keep them on the road. There have to be incentives on both sides, for the maintenance as well as the prevention. Then there will be a small element that will be about keeping the advanced care.

The system itself is fairly simple. That is what the undergraduate system teaches. The trouble is that the current contract does not provide for that.

Dr White: I would like to agree about the weighted capitation because it is a way to level up and a way to reduce inequalities in this country. One in 10 three-year-olds and one in four five-year-olds has dental decay, and we know that that is three times worse in deprived areas. We must do something about it.

I would like to add something about the workforce. You want to get people into those dental deserts, as you call them, but we are finding within the groups, and in some of the independent practitioners, that they cannot find dentists and dental care professionals. We do not get the workforce, along with other professions in this country, I am sure. It is a real struggle. Because of that, you have a few left doing the work of many.

We do not even have workforce data. We have headcounts, but we do not know how many are part time, full time, NHS or private. We do not even know if they are in this country, and yet we have the headcount. We really need some robust workforce data to have a robust workforce strategy.

Q14 **Lucy Allan:** Dentists are leaving NHS dentistry, but we don't know how many?

Dr White: No, we don't. The Business Services Authority can tell us how many people are doing some NHS work, but the NHS work could be seeing a friend once a year. I am on the dental register, and I have not worked clinically—only in public health—for 20 years. Just the headcount is not good enough. We need the data, and then we need a good strategy for getting dentists over here. That includes growing our own, but that will take six or seven years. We can keep the door open to our EU colleagues because they have been really helpful in the past for us. There

has been a big influx and they were valued. We need to look at overseas dentists as well.

It is a global market now. It is not easy getting overseas dentists. Given what Canada, America and Australia are offering, we have to make it attractive. We cannot ask them to come over and work in a system where there are not very many NHS dentists and the contract is not very good. We really have to make it attractive for them.

Shawn Charlwood: The contract is the key. We talk about a leaking bucket scenario. You can bring lots of dentists in, possibly, but if you put them into an NHS system that, frankly, they do not like after a number of years and they think, "This is not for me," they will either move into the private sector or go back to where they came from.

Unless we fundamentally address the NHS contract and fill the gaps in the leaking bucket, topping it up with more and more people is not the answer. We have to get the fundamentals right, not only for people from overseas to come into the system but for our new graduates and our existing graduates to want to work in it. Yes, there is a recruitment problem, but there is an enormous retention issue as well in NHS dentistry. Without contract reform we will not address that.

Professor Barker: Could I come in on one final point? It is also important. We are talking about bringing in dentists, but we need the entire dental workforce in there. We need the therapists, the hygienists and the extended duties dental nurses as well as the dental nurses. They are an important integer of care. There is no point in paying a dentist to do something that one of the other dental care professionals can do as well as them, if not better than them, arguably, in many situations.

Therein lies some of our problem. The University of Essex has the largest cohort of undergraduate hygienists and therapists, but yet again the medical tariff for their training is on a non-medical tariff basis. They are not trained or able to be trained to the level they should be. We need to have a look at the undergraduate level, building the people coming out so that we have a greater cohort of the wider skill mix rather than just the dentists. That is how the system will work.

Q15 **Chair:** I don't know who is best placed to answer this, but is it the case that there are plenty of people wanting to train as dentists?

Shawn Charlwood: It is very oversubscribed.

Q16 **Chair:** Is it the case that where you train, you tend to stay, so dental deserts are the opposite when mapping where there are dental schools? Is that fair comment?

Shawn Charlwood: It is interesting. The dental schools in the south-west, the peninsula, and in Lancaster have not seen all of the benefits of new dental schools in those particular areas. They still have a significant

shortage of dentists. There is some evidence that those graduates are drifting back, either to their home towns or even to the big cities.

Professor Barker: Also on training, the University of Essex has a retention rate of between 66% and 71% for its undergraduates staying in the region afterwards. That is good, but it has also looked at a placement-based system. Originally, dental schools tended to train in the dental school, whereas the placement means they are using a hub and spoke model, going out into the wider community and studying there. Again, that is a model we could look at to determine how it would work better.

Chair: Talking of models, I mentioned ICBs in my introduction. We are going to explore them now and what they can do to help, given that they are in the hot seat very soon.

Q17 **Chris Green:** Dr White, to start with the integrated care board systems and partnerships, do you think they have the necessary expertise and funding to undertake dental commissioning?

Dr White: No. There are good things about local commissioning. You can commission to need. We have talked about the inequalities across the country, so that is marvellous. If you can get a dental voice there, that is great and really important.

Q18 **Chris Green:** What would be a block to getting the dental voice, that kind of primary care voice?

Dr White: The ICBs do not automatically have a dental representative on them so that is not terribly helpful, although you can apply to go on them. There will be a steep uphill learning curve for them, in the same way as it was when PCTs were started. I was around in 2006, when it was suddenly, "Oh, now you're commissioning." Dental commissioning is quite a niche thing to actually be able to understand and commission. It is not easy to move money around the country. The dentists are given a contract value. There are all sorts of challenges for them.

Q19 **Chris Green:** In terms of the voice, the representation, which is so important, integrated care systems are still relatively young. They will be developed in different ways around the country. On those boards, the dental service is not always represented by dentists, is it?

Shawn Charlwood: It is not guaranteed. The board does not have to have a dental representative, and in most cases it does not. The board will be very devoid of expertise on dentistry because typically nobody has been dealing with dentistry in that sense.

One of the issues we have is for boards actually to access expertise, perhaps from local dental committees. Local dental committees represent dentists in their particular area. What we find is that those who have good links with their LDCs are getting good advice, but some are not. It is for the ICS structures to reach out to local dental groups to get that

expertise. We have seen good creativity in some areas, with opportunities for urgent sessions to be paid for through additional and substitutional UDAs. There have been some good local initiatives, but I do not think we can escape the fact that local innovation will not overcome an unviable national contract.

I do not think the two are exclusive. We need a national viable contract in order that ICBs can work with it, and then bring local innovation to their area. That is what is required. We are not going to come up with 42 different solutions to the national contract. Why should we? We need a national contract that is viable, and then for ICBs to go ahead and work.

Q20 **Chris Green:** One of the aspects of the challenge with the integrated care systems is how much you cascade from the centre, or how much they innovate locally. In terms of the improvement, you have the LDCs where they have formed. Are there any particular models around the country? Certain integrated care systems are more advanced than others. Is there good best practice somewhere?

Shawn Charlwood: I am from Lincolnshire. Our LDC is particularly involved with the integrated care system and brings expertise and knowledge. That works both ways. It is about relationships. It is about forming relationships, and some are more developed than others.

Professor Barker: In East of England I have six ICBs that I work with in order to do this. There are various levels of development with them. Some are very good and some have other priorities. That is not pejoratively intended in any way, but they have other things that they need to focus on. If we are trying to get the dental voice there, they say, "We have these other things to worry about." The ICBs need to be working together to share that degree of understanding. We can share those things, so we need LDCs, local dental networks and managed clinical networks as well to work in ICBs to help inform them. That is something we need to encourage with the ICBs, as much as in the dental professions.

Dr White: Can I add something about scrutiny? It is important that the ICBs are held to account. What is the quality of the services? What is the equity and access? That is a really important thing. They are out there; they are going to need some support and some hand holding, but they then need to be held to account.

Q21 **Chris Green:** On flexibility in commissioning, are the ICBs in the right place at the moment to be able to have the flexibility they need, particularly if they want to focus significantly more on the prevention side of things? Could they really lead on that in the way that they perhaps ought to?

Dr White: There has been some flexible commissioning around tooth-brushing schemes for children and access slots for people who cannot find a dentist. They can be used creatively. Certainly, you do not want to

lose the £400 million that we are just about to lose. There are ways of using it better. We can aim on prevention, but we have to remember that there are people out there with toothache. Everybody in this room will know family or friends who have not been able to find a dentist. I am sure that your constituents will tell you that.

Prevention is really important. I am a public health practitioner, but people need access for care. If they have toothache, it is important that they have that access too.

Shawn Charlwood: Practices are worried about the underspend being moved to other parts of the NHS. You can imagine a situation where an ICS is short of money at the end of the year and, because of the contract, there is an underspend in dentistry. That money potentially gets lost to dentistry. It potentially gets lost year on year, unless we get a contract in place where people can start to deliver NHS dentistry.

Q22 **Chris Green:** Lost within the integrated care system?

Shawn Charlwood: No, it would be lost from dentistry. That is one of the risks. Practitioners are worried about that. If those funds are underspent because we cannot recruit NHS dentists, or we cannot deliver the contract value because people are presenting with more complex needs, where will that money go? You can see the temptation for ICSs to move the money into a deficit account.

I really want to flag that up. We are very worried about continual erosion of the dental budget. We have seen an erosion in the last decade in real-terms spend for dentistry. There has been a 38% decline in real-terms spend on dentistry. We spend less as a share of our national health budget on NHS dentistry than any other European nation. Even within the four devolved nations, England is an outlier. Surprisingly, it spends less per head than any other of the four nations. You can see, particularly for English dentists—but it is a national problem as well—that we are really concerned about the level of funding, the degree of urgency in contract reform and quite how we are going to retain and recruit new dentists.

Professor Barker: In answer to your question, yes, there is the ability to use flexibility to an extent in the ICBs, but if you look at the ICBs that are actually employing it, a very small percentage of all the ICBs are doing so. Again, that is part of the wider sphere of the interest in access to dentistry versus the contractual framework that is currently there and how you get flexibility to actually go into place, and also the learning or understanding that is currently in the ICBs and integration with dental voices.

Q23 **Chris Green:** As a closing point on the disparities in the UDA rates, Greater Manchester has £39.80, but NHS Buckinghamshire, Oxfordshire and Berkshire has £12.43 on average for the UDAs. What impact does that have in delivery of a service?

Shawn Charlwood: It makes it really difficult to run the service. It is financially unviable in many cases. Non-NHS work in a practice has for many years been supplementing NHS work. That is the first impact.

It reduces investment in a practice and, crucially, it does not support recruitment and retention. If you are a young dentist who is being paid a low UDA value, no matter how much you love your principal, your practice and all the rest of it, in the end you are going to look at a practice that could offer a higher UDA value. Then, when you try to advertise for a new dentist, you cannot recruit them because your UDA value, as I said earlier, is significantly less than the practice down the road.

Q24 **Chris Green:** If it is three times as high in Greater Manchester as Buckinghamshire, Oxfordshire and Berkshire, the retention and performance should be higher in Greater Manchester.

Shawn Charlwood: I question your figures a little bit—the idea that Manchester has that UDA value, and £12 for a UDA sounds a bit low to me.

Professor Barker: Yes.

Shawn Charlwood: There are discrepancies in the UDA that are really important in terms of the issues that I have discussed.

Professor Barker: I go back to the point that even when they are offered a higher rate, the uptake is very low. There is very little interest because it is based around the UDA, so much so that it is not only dentists who are not interested, but the dental care professionals, the wider skill mix, are also less interested in those sorts of things. They can work far better under private contract than they can under an NHS contract.

Chair: On the subject of underspends, we are going to pick it up and explore it more with Rachael Maskell.

Q25 **Rachael Maskell:** Good morning. My constituents listening today will be infuriated when they hear that there is a £400 million underspend when they are sitting in a dental desert and cannot get access to healthcare. Could you briefly, Professor Barker, explain for their benefit why we have got into the situation of a £400 million underspend, and why you cannot spend that money?

Professor Barker: The £400 million underspend is related to the fact that practices are not able to contractually provide what they are expected to provide. Therefore, the option is to carry on trying to muddle through or to say, "I'll hand this contract back," or, "I'll hand an element of this contract back," which is how we then end up in the underspend.

Very simply, practices are financially not able to make it viable to work within themselves. Therefore, the £400 million is brought back in, either

on a clawback or hand-back basis, and then it goes out to advert. Because of the basis on which it then goes out—the same contractual system—there is not the interest to do so. That is the simple answer.

Dr White: For the groups, and certainly some of the independents, it is a real struggle to get dentists and dental care professionals. If you do not have the workforce, you cannot provide the work. That is one of the real problems.

I agree with Shawn about filling the holes in the bucket, but as it is still leaky at the moment there are no staff in the bucket, if you want to use that metaphor, so how do you provide the service? As I said before, the people who are left are then picking up the stresses and the strains of not doing it. We need to encourage more workforce.

Dental therapists can do simple fillings and extractions. They are a valuable resource. We can look to the medical model, where nurse practitioners can do X-rays and see people in the emergency department. We need to learn some things from that. Our therapists are hampered. They cannot write prescriptions. They cannot take X-rays without a dentist prescribing things. We need to look at the legislation and the support for our therapists to be able to do the job, and to develop them. Some of them may have trained when they did not diagnose and treat, so they will need development as well.

It is more complex, but there is definitely something about understanding the workforce and encouraging and supporting them when they are in there. In the old days, when I was a dentist, we used to have payments for audit and peer view. We used to have mentoring support. All of those things—the touchy-feely pastoral things—are helpful. It is not going to help in a completely broken contract, I agree; but looking to the future and how we can support our dental teams to provide the kind of care they want to provide, we have good dental schools in this country. They are teaching them well. They really want to do a good job. That is the truth of it.

Q26 **Rachael Maskell:** Shawn Charlwood, the word that I keep hearing is "flexibility" and being able to use that resource flexibly. If the criteria around that underspend, for instance, were for children's oral health, could that money be put into the prevention that you talk about, and early intervention, and ensuring that every child in our country could see a dentist on the NHS by next year?

Shawn Charlwood: Yes, that would be a good news story, but it needs to be incorporated in a contractual arrangement. Dentists will deliver what you are describing if contractually they are financed to do it. I agree with you. I think that your constituents will find it perverse that there is a £400 million underspend—10% of the budget—and not because there isn't patient demand. Quite the opposite. It is about practices not being able to recruit and retain NHS dentists, not being able to deliver their

contract for those reasons, and the complexity of care. Dentists would love to work in a system where prevention was rewarded.

Touching on some solutions and ideas for the future—some positivity—how about reintroducing NHS commitment payments? We used to have those before 2006—a sliding scale where the more you were committed to the NHS in terms of the number of UDAs and the number of patients you were seeing, the more you were rewarded on top of that with a commitment payment. How about some late career retention payments for leaders and dentists who have worked in the system for a long time and who have lots of experience and are often mentors and educators for teams? How about giving them a retention payment? We used to have that as well, but that was abolished. How about an occupational health service for dentists and their teams, which is not available for dentists and their teams? How about some of the protected learning time that we used to have, like peer review and clinical audit? That was all taken away from us as well.

I think you can start to see why NHS dentistry is not a popular place to live. All of the good things in a system that used to keep people in the NHS system have been removed. Are you surprised that NHS dentists are leaving the system? It really is not rocket science. Improve the terms and the conditions, increase the commitment to NHS dentistry through proper and sustainable funding and you will have NHS dentists again.

Q27 **James Morris:** We have talked a lot about prevention. I may be being a bit stupid, but how do we build prevention into the contract?

Professor Barker: Prevention has two elements. It is about behaviour management as much as anything. It takes a while. The way to do it is to measure the health outcome from it, which is something we do not have at the moment.

Q28 **James Morris:** At local population level or something of that nature?

Professor Barker: Yes, whichever way. Very simply, you put in a prevention message, and then you measure how values and behaviour have changed in the patient.

Q29 **James Morris:** How does that translate into a contractual relationship between the dentist and a commissioner?

Professor Barker: You measure the outcome. If the outcome is improving, it clearly derives that there is prevention that works. Prevention does not work in every instance, as we know from the prototypes, but it is very simple, in that prevention takes place over time. It is not a one-off fix. If you measure how things change, you can, by simple clinical data collection, derive the fact that things will change and that a certain percentage of the population will improve.

Shawn Charlwood: You could pay for sessions for dentists, or even the dental team, to go into schools and talk about toothbrushing, diet advice,

fluoride application, fissure sealant application or oral cancer. All of those things can be done. You could do that through a sessional basis, but not through the UDA system. The UDA system is a barrier to prevention. It is quite the opposite.

Dr White: If I can focus on children, there is strong evidence over decades that water fluoridation improves oral health. It is safe, effective and reduces inequality. There is really good evidence around supervised toothbrushing in schools. It not only increases skills but reduces inequalities. We know this from Scotland and Wales because they are doing it.

In the practice, we need to get children young. We need to get them access. With the under-ones you think, "Why does baby need to go to the dentist?" They don't, but their parents need to go to the dentist. Their parents need to go with that little tot to start getting them used to seeing the dentist, who can give parents advice on breastfeeding, give them advice on sugar control and give them advice on what toothpaste and how to brush. That takes time. I used to treat little squirmy ones, and it is not on the chair, off the chair and off you go. It takes a bit of time. You need to be able to remunerate fairly for that, so that they have the time to do it.

I go back to the fact that one in 10 three-year-olds has dental decay. These are little tots that have only just got their teeth. I used to do clearances under general anaesthetic for three and four-year-olds. They would go to school with no teeth. In this country, in this day and age, it should not be this way. I will get off my soap box now. It needs a system approach. The dental practices really want to be able to give good, preventive advice and they want to be paid fairly for doing it.

Chair: Don't worry about being on a soap box. You are literally invited to be on a soap box. If ever there was a moment, this is it.

Q30 **Taiwo Owatemi:** I am particularly interested in the workforce. Sandra, you spoke about how we have difficulty in being able to recruit dentists, particularly international dentists. What can we do to make us more competitive in that area?

Dr White: If somebody is coming from abroad, it depends where they are coming from. If they are coming from Europe, they have recognition of their dental degrees, so it is a bit more straightforward. If they come from overseas, they have to pass an overseas registration examination.

The GDC, because of the section 60 order, are being supported a little more with the overseas registration examination, but it has been a real barrier. There are lots of people still waiting on the list to be seen. It is so frustrating when you are trying to find dentists that they are sitting on a list somewhere. That is a problem. Once they have been signed off as a registrant in the GDC, they then, if it is work for the NHS, have to get on to a performer list. There have been barriers to that in the past. Some of

our groups have waited 18 months to get a qualified dentist to treat on the NHS.

Q31 **Taiwo Owatemi:** What is causing that queue?

Dr White: I think you are going to be speaking to all of those other people, so I should not answer for them. They need to be supported. They need to be resourced. All of that helps. Legislation and all of those things will help. You need to ask them that question.

Q32 **Taiwo Owatemi:** Would you say that that barrier is enough to put off international dentists from even considering joining the NHS?

Dr White: One of our groups was in Pakistan recently. They were talking about what Canada was offering—citizenship and £100,000. We can offer, "Well, we can't offer you any of that but we can give you a contract that we don't really like, and actually lots of people are leaving it." It is a global market. We have to sell ourselves in England, and we need to be able to show that we will support people and give them a good contract to work to.

Chair: Thank you very much. I am told that it is the first day of spring. I don't think it has brought a huge amount of cheer, but this was meant to be brutally honest and show the situation as it is. I think you have done that brilliantly. That is the end of our first panel. Thank you, Dr Sandra White, Professor Nick Barker and Shawn Charlwood of the BDA. Thank you very much for giving evidence.

Examination of witnesses

Witnesses: Ian Brack, Dr Pal and Malcolm Smith.

Chair: Welcome back. This is our second panel of our first session in our NHS dentistry inquiry. We are joined by Ian Brack, the chief executive and registrar of the General Dental Council; Dr Abhi Pal, president of the College of General Dentistry; and Malcolm Smith, chair of HEE's Advancing Dental Care Review and Dental Education Reform Programme, and postgraduate dental dean for North East and North Cumbria—our business card winner of this week.

Thank you very much for coming. I know you heard the evidence that was given in our excellent first panel, so no pressure. I am going to bring in my colleague Lucy Allan to open us up.

Q33 **Lucy Allan:** Good morning. We have just heard some very powerful evidence about the difficulties of recruitment and retention of dentists. What should the Government and NHS England, and now the ICBs, be doing to ensure that graduates are attracted and incentivised to work in NHS dentistry? Malcolm Smith, could we start with you?

Malcolm Smith: It is not my role to tell NHS England how to run their processes, or the ICBs, if I am perfectly honest. The role of HEE is to

deliver a workforce, and not just a dentist workforce, which is capable of delivering NHS care in whatever situation that contract sits.

Yes, there are things that we can talk about. We can talk about incentives. We can talk about improving education and training programmes. We can look at models to retain in areas where we need retention. We can look at a workforce model that will actually deliver the most effective care.

Dr Pal: I heard the evidence early on. I have, first of all, to concur with my colleagues about the state of the contract and dental contract reform, which is sorely required. It is not just a question of contract reform, while that is very important. It is also a question of making dental professionals' careers more fulfilling and providing some degree of recognition for what they do.

Everyone goes into dentistry to provide the best care they can. It is worth pointing out that beyond dental core training, which is some two years post-qualification, there is no effective career pathway or structure for dentists to follow. A large void is left there. There is also little recognition from the NHS for dentists who have sometimes invested significant quantities of money in order to enhance their skills. There is little recognition for that in the NHS. If the working conditions in that sense, and the recognition, could be made better, the NHS would be seen as a more attractive place for particularly younger dentists and international dentists, as I am sure you will come to later, to come and work.

Malcolm Smith: Can I add to that? You will not, I hope, be surprised to hear that the dental education reform programme is already working with the college to look at how we might build that recognition into career prospects to help to retain, and to give dentists, particularly in primary care, the opportunity to have career progression in a meaningful way and that can be recognised.

Q34 **Lucy Allan:** Do you find that the postgraduates, because that is your specialism, want to work in the NHS? Would they work in it if there were the incentives of recognition and a better contract?

Malcolm Smith: It is not just dentists. I think the whole dental profession would be keen to work in the NHS, but they find themselves in a situation where that is not the most attractive option.

Q35 **Lucy Allan:** How do we incentivise them, Ian, to go into the NHS rather than go private?

Ian Brack: I cannot really speak on that. We have no remit in that regard. Rather like Malcolm, it is outwith my area. I provide dentists. I provide dental care professionals. We register them. We in the General Dental Council are quite blind to where they are working, which is an oddity.

Q36 **Lucy Allan:** Can you advise us as a Committee to recommend to

Government how we can have a better model, where graduates are incentivised to work in the NHS?

Ian Brack: You have heard this morning what is wrong with the situation. The contract is the problem. We are producing graduates who are trained to carry out dentistry in a certain way. Then they come into the profession and they are not permitted to do that. Allow them to do it.

Lucy Allan: Basically, what we have heard this morning is as full an answer as there can be. Thank you.

Q37 **Dr Johnson:** I should declare that I have met Mr Smith before. I have a question about the training. The Government have trained more dentists than ever before. I appreciate that there is competition for places and we could do with some more dental schools, but we have trained more dentists than ever before and there are more dentists per capita.

We have heard that the contract is the main reason for them not working in the NHS, but could you expand on the postgraduate training section? Most doctors work in the NHS, even if they do private practice. It is relatively unusual to do solely private practice in the way that we see in dentistry. With a doctor, you usually spend about 10 years learning to be a consultant before you do private practice. To what extent does the lack of postgraduate qualification and a lack of postgraduate pathway mean that people go into dentistry in the private sector very early and then just stay there, or do you think it has no impact at all?

Malcolm Smith: We do, of course, have postgraduate pathways for specialty training. They are fairly well defined, but specialty delivery in dental care is relatively small compared with medicine, where it is almost all a specialism. Even being a GP is a specialism, or a specialist part of the training. We do not have that for primary care.

We need to develop those models for a young dentist. I qualified a million years ago. You could be working in general dental practice, delivering the same thing, for 40 years or longer. We need to change that. For the younger generation that is not acceptable. That is what they have told us through our events and our dental care report. They are young, highly qualified and highly intelligent people. We need to stimulate them. We need to offer them opportunities. That is partly by providing better training in the current situation, but it is also working better with other colleagues and developing models that will provide that recognition and provide those incentives. The challenge then for the health service is to recognise those incentives.

We have doctors with special interests in medicine, and that is less common in dentistry. Maybe that is something else. How do we develop a primary care dentist to feel as though they are an integral part? But it is not just that. I go back, I am afraid, to the word "team". There is a huge opportunity for the rest of the dental team to free up our dentists to deliver the things that they are uniquely able to deliver.

Q38 **Dr Johnson:** Why do we have such a shortage of specialist dentists? Certainly, in Lincolnshire, it is quite difficult to find an NHS dentist to do orthodontics. It is challenging to find an NHS dentist to do very technical specialist treatment. It is difficult to find ones that are helpful and have specific expertise in dealing with special educational needs. If there is a desire for a pathway, is it that the pathway is not there or that people do not want to do it?

Malcolm Smith: The opportunities are not there rather than the pathway. That is largely traditional.

Q39 **Dr Johnson:** What is the difference? Can you explain the difference between the opportunities and the pathway?

Malcolm Smith: If there is no job for a specialist to undertake in a particular area, so there is no service being provided, it is very hard to train somebody to deliver that service. To train, of course, we need somebody who is specialised in that service. That is the reason why you end up with areas where there are a particular number of people in specialty training and other areas where there are very few. I am well aware that the midlands and the east is one of those areas. We are trying to address that by increasing the numbers of specialty training places, but you have to link the two. You cannot train without a service to train in.

Q40 **Dr Johnson:** We have discussed before that there is no dental school in the east midlands or East Anglia at all, which may contribute to the problems in the east of the country. How do centres of dental development work, and how would they help with this pathway?

Malcolm Smith: I am so glad you asked that because that is one of the planks of the report, and one of my babies as it happens. We have dental schools not necessarily concentrated in the right areas. Again, that is an historic issue.

If we are looking to put more dental schools and only train dentists in areas where we do not have a school, I think we are missing an opportunity. We have an opportunity to create much smaller hubs, including outreach from existing dental schools, that might be quite remote. In these days, with IT, they could very easily be more remote, but they bring in a local workforce. They also bring in an opportunity to train after you have done your undergraduate work, if we are smart. You can go into foundation training. You could go into a specialty training pathway, or get recognition of the work in primary care practice that Abhi is talking about.

It is a question of having the right model to allow workforce development, rather than having some monolithic structure that costs a fortune and takes a long time to build. We can actually get those local hubs. The current universities are very keen to work on and be part of hubs, but we want them to be part of local delivery for local requirements. There is no one size fits all in that.

I'm sorry; now I am on my hobby-horse. We need to be flexible. We need to develop the hubs, I guess through the ICBs now, and we are developing guidance for ICBs on those centres. It is actually bringing in a local workforce. There is a proposal in north Cumbria, which is on my patch, to open a dental therapy school. We are going to piggy-back on that. We are hoping, working with our commissioners, to develop a service out of that particular hub. We will start to place our young foundation dentists in that hub, but working with the practices around it as well. They are smaller practices, for good reasons in those areas; the population density is quite low. If we are really smart, we can bring those things together and deliver what the local population needs for those areas. It could be something relatively small or it could be something bigger. It depends on the need.

Q41 **Dr Johnson:** You will be aware that I would like a centre of dental development in Sleaford to serve my constituents, which we have mentioned before.

The other question I want to ask is about registration of dentists who have come from overseas. If you are a dentist who has trained in France, for example, and you have been there for 10 years treating people's teeth, and then you come to work in the UK, you can register to become a dentist and work in private practice. My understanding is that you would need to undergo extra training and get another certificate to be able to work in the NHS. Is that right, or am I mistaken?

Ian Brack: No, that is correct.

Q42 **Dr Johnson:** Is that not somewhat illogical?

Ian Brack: Yes, it probably is. No, I do not think it is. That was a glib answer. The General Dental Council runs the overall register for all dental practitioners in the UK. Our job is to ensure that those practitioners are safe to practise. There is a curiosity, which is that we are required to automatically register dentists from the EEA. We check that they are who they say they are, that they have the qualification that they say they have, and that they can speak English to a level which is satisfactory. Those are the checks that we carry out.

That derives from the treaty obligation that the UK Government entered into. There are currently transitional arrangements which continue that, but it is still mandatory. With the rest of the world, you go through a process of validation that is done through the overseas registration examination, so we say, "Safe to practise."

What that does not say is that you understand the national health service and that you are trained in the way the national health service works. It is important to understand that dental training is very varied, even across Europe. One cannot automatically assume that one set of qualifications will cover the full panoply of skills that the NHS requires. We can say they are safe, but the NHS will want more. That is what registration is for, as I

have always understood it. It is the training for, if you like, doing it the NHS way.

Q43 **Dr Johnson:** Such a dentist could come across, open a high street dentistry and start taking patients immediately, but they could not take any NHS dental patients.

Ian Brack: Correct, yes.

Q44 **Dr Johnson:** Who is responsible for that particular set of rules?

Dr Pal: It comes from the legislation. It is in the Health and Social Care Act.

Q45 **Dr Johnson:** It is the legislation.

Ian Brack: Different sets of legislation. Yes.

Q46 **Dr Johnson:** It is helpful to know that. The other question I want to ask is about input into the NHS generally. We know that if you have toothache, you will have poor sleep. You may have time off work. You may have poor mental health. Having poor dental health can mean you have poor cardiac health, for example, and poor general wellbeing. To what extent does the unmet need that we have in the population impact on the overall wider NHS budget? Do you have any assessment of that?

Dr Pal: Yes. The link between systemic health and dental health is well established, and increasingly more so. If more prevention is focused on dental health, fewer of the other illnesses may become apparent. There may be elements of flexible commissioning that can be used to address it. The overall statistics of exactly how much of the NHS budget could be reduced if oral health was vastly improved are unknown to me, but there is no doubt that there is a very strong link, and a strong case to be made, if the service is appropriately funded, to put in preventive measures that might reduce the impact on secondary healthcare.

Q47 **Dr Johnson:** My last question is on fluoridation as a preventive health measure. If you look at a map of Lincolnshire—I represent a part of Lincolnshire—part of the county has fluoridated water and part of the county does not. Overlying that, you can see an improvement in oral health among people who live in the area that has the fluoridated water as compared with the area that does not. To what extent would having fluoridated water reduce the amount of need for dentists across the UK, and therefore improve the capacity issues?

Dr Pal: I am not sure if it will absolutely reduce the need, but what it will reduce is the overall amount of dental disease, particularly at the higher end where we are see very sad stories of the number of general anaesthetics that are required for children. It will reduce the amount of oral health, but remember that the whole population is not being served by dentists, and attendance is low. There will always be a need for dentists, but the impact will be vastly greater on the level of oral disease.

Q48 **James Morris:** Could I come back to the registration of international students, Mr Brack? My understanding is that the Government were proposing some changes to make it easier and quicker for international dental students to be registered. I think there was going to be a statutory instrument laid and there may have been a delay around it. Do you think that will have a materially positive impact on the supply of dentists for the UK?

Ian Brack: Yes, but not immediately. The section 60 order relating to international registration took effect on 8 March. It will not actually take full effect until a year from then.

What we will be doing is revising our rules and revisiting how we deliver the overseas registration examination in the short term, because that is the quickest thing we can do. We will have to consult on the rule changes. We will scoop up some other administrative things, but the first transitional set of changes that we will be able to make within the year will make a better fist of the system we have now.

One of the problems we have is that we could not run the examination ourselves. We are required to use a dental authority, so we have to use a consortium and we have to contract for that. In fact, we have to contract again this year. We cannot get out of that. We have to keep running it old system. That has to spool down over time while we look at what we can do more radically. In the short term—I am really talking about the next couple of years—what we will do is make the ORE more effective. We will work to run more sittings and so on, but the big changes cannot come until afterwards.

Q49 **James Morris:** I know this is a bit of a specific question, but how many more international dentists do you think we will have working in the UK in, say, four years' time as a result of the changes?

Ian Brack: Honestly, I cannot possibly answer that because I do not know what the demand is. This is the point which I think has been made repeatedly.

Q50 **James Morris:** When you say that you do not know what the demand is—

Ian Brack: I can tell you that at present we have something in the region of 1,700 people waiting to sit the exams. We will chunter through those quite quickly, but that list will need to be replenished. The question is, who wants to come and work in the UK? That is the bigger driver. That is the thing I cannot control because, as has been rightly said, we run a filtration system. Effectively, the GDC's job is to ensure that practitioners are safe. It is not to find a workforce for the NHS. We do not have the legal powers to do that. All of the things that make the UK an attractive employer are outwith our control.

Q51 **James Morris:** Of the 1,700 in a backlog, are they all dentists? When you said practitioners—

Ian Brack: They will be dentists, for the overseas registrations.

Q52 **James Morris:** When it comes to overseas registration of dental nurses or whatever—not dentists—do you deal with that category as well?

Ian Brack: Yes. They come in through a different way. Overseas numbers for those are lower, but the mechanism is validation through tests. You do not run an examination. We have to individually ascertain.

Q53 **James Morris:** There are fewer barriers? If I am a dental nurse in Australia wanting to come to the UK, is it easier for me to do that than if I am a qualified dentist in Australia?

Ian Brack: It is more bespoke. I would not say it is easier. You do not run through a system of examinations, but I do not think it is easier. There is still bureaucracy. It is still difficult.

Q54 **Rachael Maskell:** We have talked a lot about integration through a sense of dental development, but I want to look at wider integration in the health service. Currently, we have a model of employment predicated on private practices being set up, which then buy in NHS work. If that equation is to be reversed, and we truly see integration back to the NHS, would a model of salaried dentists, for instance, be a model that we could move forward? We are talking about radical change, but I think we have heard today that we need radical change. How would such a model work in seeing greater integration rather than a practice-based model?

Dr Pal: I think that will be difficult because practitioners are already there in practice and have obviously invested quite a lot in setting up dental practices. While the majority of dentists have some NHS provision, most NHS practices, as we heard earlier, have some degree of private provision. In many cases, the private provision offsets the losses that are made by running the NHS service.

If you went for fuller integration, this is not a matter for me but I think the cost to the Exchequer might be considerable in making that switch, given the enormous amount that dentists have invested in their service, and keep reinvesting in spite of the difficulties in the current contract, lack of recognition and so forth. It is one way. It will be a difficult journey, in my opinion.

Malcolm Smith: If you are talking radical change, anything is possible. Harping back, as an example, to oral health, that is not the restrictive domain of the dental practitioners. Anybody suitably trained can deliver oral health. There is a huge opportunity.

The primary care networks that are being developed are currently fixated on the GP. There are opportunities there to integrate. There is a new apprenticeship we have developed called the oral health practitioner who is a dental nurse who goes through an apprenticeship programme to deliver oral health care. In some of the pilots that are starting in that particular field, some of the apprentices not only spend time at a dental

practice as a dental nurse, but spend one day a week attached to a medical practice or a community pharmacy.

My hope, long term of course, is that they will become embedded so that oral health becomes embedded in a primary care environment. If we follow that logic through, we can look at all sorts of things, but we have to get our own profession right first. We are not using the profession we have at the present time in the health service to deliver what they can best deliver. If 70% to 80% of routine care can be delivered by a dental therapist or a dental hygienist, why are we not making use of that facility, thereby freeing our expensive and very highly qualified general dental practitioners to do the things that they are particularly qualified to do? If we do that—we are back to the recognition that Abhi's situation might offer; salaries have dropped for younger dentists—is that something that could then be addressed, if they can demonstrably demonstrate that they are delivering at that level of care?

Q55 **Rachael Maskell:** I agree that we have to seek more integration. Our bodies are integrated, with the mouth, for instance, and identifying oral cancers. As a form of diagnostics we have to look into that area. When we come to talk about the sense of dental development, I want to have an understanding from my constituency point of view about not being able to access dentistry. Why is it taking so long to bring this forward?

Malcolm Smith: Because we had not thought of it before. Short answer. The situation has been drifting, I guess, where we have accepted a steady flow away from the profession in the NHS, and since the pandemic it has suddenly become much more acute. That is focusing minds.

Q56 **Rachael Maskell:** Ian Brack, I will come to you about registration. If you are registering to a standard and we have different entry routes, what kinds of pressures is that putting on the GDC and how is that being addressed?

Ian Brack: What we are trying to do, of course, is to ensure that the UK standard is maintained for all sources of dental professionals. We match overseas dentists to UK-trained dentists. We match overseas DCPs to UK-trained DCPs. We inspect UK providers of undergraduate health education for dentistry and for DCPs.

Trying to do that is problematic. We have suffered the same problem as most people. We have had difficulty keeping staff, just as the dental profession does. Amazingly, not that many people are really attracted to becoming dental bureaucrats. I fail to understand why, but there you are. We have had real difficulty retaining our staff, and that has led us to problems following on from covid. The disruption to the employment market in the UK caused us some problems, so we have some backlogs. We have recruited to the appropriate levels for that. We have brought new people in. We are using reserves to try to beef up our capacity so that we can deal with the throughput we have.

The other thing that has happened, again partially as a result of covid, is that an awful lot of registration is now off model. It used to be reasonably predictable. Seasonality and things like that have been badly disturbed by the disruption to the education process that followed from covid. It is now several years ago, but we still have the knock-ons from that. People are not coming to be registered when we expect them to come to be registered, which means that all of a sudden we have large numbers of registration applications when we do not have the people in place to deal with them and we have to shift people over. That has required us to be fleet of foot.

There is another curiosity. There is a loophole in the legislation which, until 8 March this year, allowed overseas trained dentists to register as dental care professionals in the UK. UK dentists cannot do that. We used not to let overseas dentists do that. We were compelled to do so. There has been an extraordinary change in numbers. Huge numbers have come in over the last few weeks before the closure of that DCP route. I now have meeting rooms in an office in Birmingham completely full of boxes of those applications. I also have some broken cupboards where the shelves collapsed under the weight of them. We are talking hundreds of applications and they will take a very long time to address. We are going to have to spend a significant amount of money to accelerate that, because otherwise it would literally be years before we were able to process them. That is an entirely unintended outcome of the loophole existing and then being closed. It has somewhat overwhelmed us, so we are chucking resource at it now to address the problem. That is what we face at present.

Rachael Maskell: Thank you for sharing that.

Q57 **Chris Green:** Mr Smith, you mentioned flexibility in making better use of dental hygienists. Do you think the integrated care system lends itself to greater flexibility perhaps in that area, or in other areas?

Malcolm Smith: It is more a question that, again, we have focused very much on one element of the profession, valuable though that element obviously is. I speak as a dentist. In point of fact, unlike medicine, we have not taken the opportunities to look at how we deliver the care, because of some of the things that were talked about in the first session; the opportunities do not exist.

The actual cost of training a dental therapist is also an issue, as far as we are concerned. At the current time there is a tariff associated with training a dentist. The actual cost of training a therapist, although for a shorter period—there are fewer years—is not that dissimilar. In fact, in Liverpool they are now training both dentists and dental therapists together for the first two or three years, and then the therapists stay where they are and go into therapy and those who want to be dentists move on to do the final two years.

There are models of flexibility, but we have to align tariff. It is not an incentive to dental schools to train, because they are not getting the same tariff for a dental therapist. There is work being done by the tariff group to look at this, to see what can be done to achieve it. That will also give you more flexibility on how you train long term.

Q58 **Chris Green:** To get integrated care systems to be engaged with flexibility in how they commission, obviously they will need robust and good-quality representation on the board. Do you have any concerns about that at the moment, or does anyone else on the panel?

Malcolm Smith: That is outside my remit, if you don't mind. I don't know whether it is within anybody else's remit either.

Dr Pal: It is important to have representation, but it depends on what barriers there are in achieving that.

Q59 **Paul Blomfield:** I want to explore a little bit more the theme of what the dental workforce might look like. I think you have all concurred with the first panel that we need a fundamental reset of the terms of the dental contract and how you recruit and motivate people to want to come to the country, both domestically and internationally. As part of that reset—you opened this issue up, Mr Smith—what could a future dental workforce look like, which concentrates much more on prevention and looking at oral health in a wider sense?

Malcolm Smith: Again, we are looking at the more specialised end of dentistry. I use that term broadly rather than as "a specialist". Obviously, we need the highly qualified dentist to be delivering at that level. That is part of the process, but there is a lot of stuff in between.

We have talked about oral health and how we can integrate it fairly easily in the system. It is how we look at that and how we deliver those services so that we take full advantage of the skills of the whole workforce that is the key. I am probably not answering your question quite as you want it.

Q60 **Paul Blomfield:** You can answer my question any way you would like to. I am trying to get a sense of how we might rebalance the workforce so that there are different skillsets that might provide for a different approach to dental care.

Malcolm Smith: We need to create the opportunities and have an understanding. I have been asking for a dental workforce survey for the last six or seven years. So far, we do not have one, so I do not actually know what our current workforce are doing. I do not know what their intentions are. We have some good figures about how many, which do not sound too bad, but we do not know whether they are working full time or one day a week, or in the health service or not.

We need more data to deliver that sort of modelling. Then, if we look forward, we need to look at what the service requires and marry the two.

We need to know what workforce we have available to us; we need to know what workforce we need to deliver the service that the NHS wants; and there needs to be a bit of intelligent thinking between the two things, in my view, to marry them up. If we ever get that right, we might well be in a good place, but I am still waiting for the dental workforce survey. Nobody wants to commission it.

Q61 **Paul Blomfield:** Mr Brack, you are nodding.

Ian Brack: Yes. I can tell you that at the end of 2021 there were 43,292 dentists. There were 59,399 dental nurses. There were 4,378 therapists. I do not know if that is actually what the UK needs. I just know that that is what there were. I do not know where they work. I do not know what they are doing. I do not know how many hours they work. That is all I know.

Q62 **Paul Blomfield:** That is a pretty big statement. Dr Pal, do you have observations?

Dr Pal: In order to get the best out of the workforce, I fully appreciate the problems we have of not understanding the number of dental professionals we have out there, but things can be done to help improve the training of our dental workforce so that they can achieve the best that they are able to. Some thought might need to be given. We have talked about incentives in the past. Incentives for staying in the workforce could be support for training and development, such as the development of more dental professional networks. We have heard about peer review in the past. We could have support for mentoring schemes.

All of those things, put together, in addition to contract reform and understanding what the workforce requirements are, will go some way to making the NHS more attractive than it is now. We speak to a lot of early career dentists, who are in the first three or four years from qualifying. Invariably, they say a number of things. One is that they are a little bit lost as to which direction they should go. They see less future in the health service. We have talked about all the reasons. They feel that they cannot work in the best way that their training would allow them to work. There are smaller changes, including contract reform, in terms of supporting professional development, that the NHS could be considering.

Chair: Dr Johnson wants to come back briefly.

Q63 **Dr Johnson:** I have a question on workforce. Is the principle of having a cap on the number of dental trainees that universities can train a sensible one?

Malcolm Smith: It is largely historic. I am not even sure we know who does it. It is a mixture of probably the Department of Health and the authority that funds undergraduate training. Of course, they pay for themselves to some degree too.

The numbers vary. The number that are funded by UK Government is capped, I guess because the Treasury wants it to be capped. There is also opportunity for them to train a small number of overseas dentists at the same time, but those people usually go back home because they are funded by their own Government.

The cap depends upon the capacity. It depends again on what you want to train. At the moment the numbers are predicated by the output of dental schools. The intake is pretty standard and pretty steady. It is around 850 for England. Not everybody gets to the end of the course. Some people drop out and some people do not get to that point, but the number has been reasonably steady. We get the occasional lift. We are going to have a bulge in two years' time. Because of the arrangements around covid and people who were able to take up places in a slightly different way, we are actually going to see a bulge in two years' time. That is not a permanent bulge. Again, without knowing what workforce the health service needs, we do not know whether that is the right figure or not. I keep going back to this; we don't know what we don't know.

Q64 **Dr Johnson:** I looked at the figures and found that between 2008 and 2018 the Government trained 21% more dentists, and the ONS suggests that the population increased by 7% in that period. Theoretically, we have more dentists per capita, although I take your point that we do not know whether they are actually providing dentistry or for how many hours per week.

Should we have a higher cap or should we allow dentists to train in a different funding model perhaps? It is a supply and demand issue. Currently, we have too few dentists, yet we appear to be restricting the number of people who can train to be a dentist.

Ian Brack: Fewer NHS dentists.

Malcolm Smith: Can I challenge that? We do not know whether or not we have enough dentists because we do not have the whole-time equivalents. We may or may not. What we know we do not have is enough dentists working in the health service. That is critical.

What are the incentives to retain more of our young graduates working in the health service? What would reasonably work? Like most of the workforce situation, there are so many different answers. Yes, you could have monetary incentives. You could have tie-ins. You could have a different approach entirely to how you deliver your workforce. Nevertheless, you still have to work out how you will maintain NHS interest. I have to say that contract reform also fits into that particular model. Again, people have to want to work in the environment they are in. What that contract reform would be is outside my area of expertise. Nevertheless, whatever the contract is, it needs to retain people in the workforce, and we need to make sure that that workforce is trained to deliver that contract.

Dr Johnson: Quite clearly, it is contract reform and better data on the workforce. Thank you.

Chair: That concludes our second panel in our first session. Mr Smith, Dr Pal and Mr Brack, thank you so much for giving evidence to us, and to our first panel. We will continue with this inquiry, in which there is obviously significant interest. This has been a really good start. We are grateful to you all for your time this morning.