House of Commons

Health and Social Care Committee

Oral evidence: NHS dentistry, HC 964

Tuesday 25 April 2023

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 65-141

Witnesses

I: Chris McCann, Director of Communications, Campaigns and Impact, Healthwatch England; Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire; Jo York, Managing Director, Hampshire and Isle of Wight Integrated Care Board.

II: Neil O'Brien MP, Parliamentary Under-Secretary of State for Primary Care and Public Health, Department of Health and Social Care; Sara Hurley, Chief Dental Officer, NHS England; Dr Amanda Doyle, National Director for Primary Care and Community Services, NHS England.

Examination of witnesses

Witnesses: Sarah Fletcher, Chris McCann and Jo York.

Chair: Good afternoon. This is the Health and Social Care Committee, and this is the final public oral evidence session of our inquiry into NHS dentistry. We have heard from a range of witnesses and have taken a great deal of written evidence, which has informed our work. We will be producing a report, as we always do, to inform the Minister, who is coming in later today.

It is worth saying, contrary to certain media reports this morning, that this inquiry was not launched in response to any media outlet doing surveys on this subject. This inquiry was launched because we as Members of Parliament—every single one of us, regardless of our political allegiance—have received contact from constituents in respect of access to NHS dentistry. We, as a cross-party Select Committee, reflect what we hear from our constituents and what we hear across the House. We launched this inquiry in December 2022, and we are concluding it with today's session.

Before we get under way and introduce our witnesses, I will declare an interest that I am a Hampshire MP—it will become clear why I have declared that in just a moment. Do any other colleagues wish to declare an interest?

James Morris: I was a Minister in the Department of Health and Social Care responsible for dentistry last year.

Dr Johnson: I am a Lincolnshire MP.

Q65 **Chair:** We have two panels today and we are grateful to everyone for coming. Starting panel No. 1, we have Chris McCann, who is the director of communications, campaigns and impact at Healthwatch England; thank you very much for being with us. We also have Sarah Fletcher, who is the chief executive officer at Healthwatch Lincolnshire, and Jo York, who is the managing director at the Hampshire and Isle of Wight integrated care board, which obviously covers my constituency—hence my declaration.

Let us start with you, Jo. Hampshire was one of the early adopters—along with Buckinghamshire, Oxfordshire, Berkshire, Frimley, Greater Manchester, Kent and Medway, and Surrey and Sussex—in taking dentistry commissioning into its family. Does that mean you are ahead of the game, and have control of matters in Hampshire?

Jo York: I think we recognise the challenges with access in certain parts of Hampshire, which is why we were keen to be an early adopter. Most of the south-east region went ahead as early adopters to maximise the benefits, both from continuing to commission at scale across the region and from a more localised commissioning approach. We are quite excited about that delegation, and our ability to be more flexible, to commission more on a local needs base, and to build relationships with our local

providers, which is perhaps easier for ICBs to do than for NHS England at the regional level. We are combining the skills and expertise that the NHS England regional team has with the ICB's local knowledge.

Q66 **Chair:** You have said why you wanted to do it, but does being an early adopter mean that you are ahead of the pack and in a better place than all the other ICBs?

Jo York: I think we perhaps have a better understanding of the issues and challenges, and how we can work to influence within the national contract and provide a more flexible approach. We have some particular challenges with access in Portsmouth, Southampton and the Isle of Wight around some of the workforce issues, and the demographic and health inequality issues. We knew that this was a real issue for our residents and local authorities. We have tried to get underneath that, and work with the four healthwatches locally to really understand what is driving people, and think about what we can do in a flexible, more innovative way within the national contract to support dentist services.

Q67 **Chair:** Do you think there is any part of your ICB that is wondering, "What on earth have we taken on here?"

Jo York: I think there are certainly some challenges with dentistry. We know that the workforce challenges are across the board, but we have challenges in other areas. GP access is one area, and some of our hospital provision. We want to try to improve access where we can for all our residents to all NHS services. We do that as best we can for all services, including dentistry.

Q68 **Chair:** Right. Chris, what does Healthwatch have to say about improving access to dentistry, and whether this brave new world of the ICBs is going to shepherd in a new dawn?

Chris McCann: In terms of ICBs, this Committee's own report has already shown that the systems are relatively untested and need time to bed in. We would be interested to see what level of dentistry commissioning expertise from within NHS England is delegated to ICBs, particularly having seen the recent efficiency drive that has happened at NHSE. The NHS Confed report says that ICBs need better data to have an understanding of the oral health needs of their footprint.

While it is right and important that healthcare decisions are being taken at a local level, a lot of this will not be within an ICB's control—for instance, things around the shape of the dental contract—but we have been encouraged by some of the ideas that we have seen raised by the profession during previous sessions, like innovative schemes where a dentist can work more closely with GPs through primary care networks, or the potential for outreach preventive programmes through schools. Fundamentally, it is too early to say what impact commissioning moving to an ICB level has had or will have.

Q69 **Chair:** You have made a fair point. Would it be fair to say, then, that of all the services that ICBs commission, dentistry is one that they, if anything,

have the least control over? You just mentioned a couple of those things there, not least the contract.

Chris McCann: Absolutely. ICBs will have control over what happens locally with commissioning, but there will be areas where they will have limited influence in terms of the shape of things around workforce, funding, and, as I mentioned, the shape of the contract.

Q70 **Chair:** Sarah, to give you an early run-out, as they say, how do you think patients in Lincolnshire are feeling at the moment about this new arrangement?

Sarah Fletcher: I don't think they actually know there is a new arrangement; I don't think they can sense that there is. The lack of dentistry is something that, as a healthwatch, we hear about every day. Our team are in despair. They do not know what to tell people when they contact us. In the last year alone, we have had over 700 inquiries and experiences shared with us. As of today, no one in Lincolnshire can say that they have seen an improvement in NHS dental services in our county. If anything, it has got worse.

Q71 **Chair:** Why would they need to know that there has been an arrangement? Bluntly, our constituents do not care who drives this particular bus; they just want to know that it will be there when they want to get on it.

Finally, Jo, imagine you are the patient of an NHS dentist in Hampshire, and you receive a communication to say that that dentist is no longer doing NHS work; I have constituents who are in that exact boat in Hampshire right now. What possible hope can you give them in the short term?

Jo York: In the short term, we are continuing to work with local providers. I think that you are absolutely right, Steve; we do have some significant issues with dentists handing back some of their NHS contracts. We are working really closely with those providers and looking to see what we can do flexibly within the current contract to look at flexing the UDA rate, because we have some issues where the UDA rate is different in quite small local patches and that has a huge impact given the workforce challenges. We are really working very closely with them and NHS England to see what we can do about that, to review those UDA rates and, where we can, improve or bring them up to a stable level. We are particularly looking at doing that in the Isle of Wight, where we have some particular challenges.

Where those contracts are handed back, we are going out to procure for those. There are not necessarily immediate fixes. It is not like a GP practice where patients are registered with a GP practice and, if it closes or hands back the contract, we have to find those patients a new practice. That is not the same in dentistry, unfortunately, but we will work to get as much procurement in as possible.

With NHS England over the last year, we have commissioned 222,000 new UDAs. In particular, there are new practices coming in around Portsmouth,

Havant and Southampton. We unfortunately did not have anyone take up the procurement for the Isle of Wight. The other thing we are trying to do is develop a dental bus service to go around those areas that are hard to reach. That will be a bit of a quick fix. There is also the urgent and emergency dental care through NHS 111.

Q72 **Chair:** Say there is an NHS dentist in Havant today, in Hampshire, and they are planning on ending NHS work. Do you have sight of that?

Jo York: It is very early days for us; we have only been doing this for the last nine months. The dentists themselves are now aware of us and we are strengthening our team. We would definitely hope so. We have had conversations with some dentists recently who are saying, "We have some problems. We are thinking of handing back the contract." We are trying to step in at that point. Until recently, the notification was with the NHSE team that they want to hand back the contract.

Chair: You can get in early—

Jo York: We try to get in early. Yes, that would be our aim.

Chair: And try to implement some prevention. All right; that sets the scene. It is a big challenge for you.

Q73 **James Morris:** I want to continue on that theme. You say you try to intervene to stop a dental practice withdrawing the contract. What kinds of things can you do to stop that?

Jo York: Again, it will depend on what the issues are, but sometimes it can be around the UDA rate. We would try to work flexibly if we can within the contract and with NHS England to look at reviewing that UDA rate to ensure that there is equity with local dentists in a local area.

Some of the challenges, though, are more around recruitment; if the dentists cannot recruit or retain the NHS dentists, that can make it really difficult. The way the contract works means that they get paid in advance, so if they cannot recruit a dentist or they lose a dentist, they cannot perform the activity and then the money is taken back at the end of the year.

We are working closely with the University of Portsmouth Dental Academy to look at some long-term solutions on recruitment and retention, particularly of hygienists and dental therapists, as well as for the University of Portsmouth to become a centre of dental development.

Q74 **James Morris:** I think we all recognise that there are workforce challenges, but would you agree that you are describing a fundamental problem—that, irrespective of who is commissioning dental services, unless the contract is fundamentally reformed and moves away from this UDA structure to something else, which we might come to talk about, around incentivising prevention, it doesn't really matter who is commissioning services, because it ain't going to change the landscape?

Jo York: I think there are things we can do locally within a national contract framework. ICBs, and CCGs before that, have had success around that with GMS—general medical services. Having that locally commissioned service allows you to be more innovative and flexible around local needs, but we have to work within the national contract, so we would welcome those reforms as they come through NHS England.

Q75 **James Morris:** Chris, obviously dentistry is a very challenged landscape. What do you think a good, locally commissioned dental service might look like, in terms of patients and what they actually need?

Chris McCann: For us, as a starting point, there needs to be almost a national oral health assessment that establishes what the needs are for the nation's oral health across the country, where there are areas of the greatest inequality, and where there are what are being referred to as dental deserts. What we really need to see is a reformed system where everyone is guaranteed a point of entry, because access is a real issue.

We would like to see a situation where people have the same kind of relationship with a dentist that they have with their GP, so that people immediately know where to go when they have an issue with their oral health. That is the first point: that point of entry needs to be the thing that is fixed first, so that people know where they can go and they are not, as we have seen in many cases, having to ring around 10 or 12 dentists to find somebody who will take them on, or finding massive waits at the dentist they are registered with.

Q76 **James Morris:** Sarah, do you have any thoughts about what a good, locally commissioned dental service might look like?

Sarah Fletcher: Obviously, everywhere probably wants something slightly different. For Lincolnshire, what we do accept and understand is that we have people living right across the county—we are slightly unique in that fact—and it is a large county, and travel is always an issue. We need more availability for NHS dentists and maybe some sort of prioritisation for certain groups.

We have heard a lot from pregnant women, children and young people, cancer patients, people with long-term health conditions and disabled people. We have heard from veterans and Travellers. We have heard from lots of people who are really struggling health-wise anyway, and from people on lower incomes, particularly given the cost of living at the moment; that has been a real impact for them.

Some kind of means-tested service that enables some priority for some people in our communities would be welcomed. At the moment, if there are any available appointments, which are few and far between, there is no priority or there doesn't appear to be that priority, so it is just the next person on the list who happens to be lucky enough to get that NHS dental appointment.

From our county's point of view, we would like to see points of accessibility across the country as well.

Q77 **James Morris:** Jo, in terms of the commissioning work that you do for dentistry, do you have dental representation on your board?

Jo York: Not currently, no.

Q78 **James Morris:** Why is that?

Jo York: ICBs are new organisations. We have only been in place since July. We do have one of our GPs who works closely with dentistry and has a portfolio to look at dentistry. I suspect, as the ICB becomes more established, we may well look at that and the wider primary care representation.

Q79 **Chair:** That is quite devastating. You are an early adopter of dentistry commissioning and you don't have them on your board.

Let's play devil's advocate here. Let's pretend I am a dentist. What message do you think you have just sent to me? Here I am, Dentist Brine, standing by the chair. Radio 2 is on in the corner. It's a classic dentistry scene. You have just told me I am not very important, haven't you?

Jo York: I certainly do not think that is what we are saying. The integrated care board has to be quite a small committee and made up of a certain number of people. If it gets too big, it becomes challenging. We have good representation from local authorities on the ICB and from hospitals, and we try to represent primary care as best we can. We are also developing relationships with our local dental committee and we continue to work closely with providers to build those relationships. While I can understand that it might be disappointing that they were not on the ICB board in this early stage in the first year, there are lots of other ways that we can build those links and represent dentists.

Q80 **Chair:** So they might come on to it?

Jo York: Potentially. The ICB will continue to review the structure of the board after the first year to make sure it has the right people and representation for what it needs to do. Again, we were still developing and coming up with whether or not we would take dentistry as an early adopter while the board was being established this time last year.

Q81 **Chair:** Sarah, do you happen to know whether the ICB in Lincolnshire has dentistry on its board?

Sarah Fletcher: It does not.

Q82 **Chair:** Strike two. Let's go for three in a row. Chris, I know you cannot speak for any one in particular, but do you know any boards that do?

Chris McCann: I am not aware of any instances of ICBs that have a dentistry representative on the board, but I cannot say with any certainty that there is not one somewhere in the country.

Chair: The Cabinet table is not that big in No. 10. The Department for Work and Pensions spends more in an hour than some Departments probably spend in a week, but they all sit around the table. If they said,

"We are not putting DCMS around the table because it is a smaller Department", that would be a curious decision to make. As is obvious, I am quite surprised at this. Anyway, over to you, Rachael Maskell.

Q83 **Rachael Maskell:** Thank you ever so much for coming in this afternoon. I think what I have heard so far is that we have lots of structures and we are looking at them, but we are not looking at outcomes. I want to look at the flexibilities you could use to achieve outcomes. In the light of us knowing that the biggest reason why children are going into hospital is to have teeth extracted, what flexibilities do you need in order to have a children's/school NHS dental service? Have you got the workforce to deliver it, and have you got the means to deliver it?

Jo York: I think the challenge around workforce is really significant, particularly recruiting and retaining NHS dentists. Having said that, some of the work we are doing with the University of Portsmouth and the centre of dental development is to look at the role of dental hygienists and dental therapists, who can be particularly useful in oral health preventive work. Again, we are working closely with local authorities, including by having an integrated, joined-up approach across health and social care, and we are working with our public health and children's teams to see how we can go into schools and pre-schools more easily to support people to have good oral health. That also applies, at the other end of the spectrum, to care homes. There is lots within the current flexibilities that we can do to build on an integrated approach between health and social care, including using flexibilities around pooled funds. Building on the better care fund, for example, could enable us to work with local authorities to commission services around oral health prevention for children. We need the workforce to be able to deliver that, and that is one of our challenges.

Q84 **Rachael Maskell:** If I can turn to Sarah and perhaps ask the same question through the prism of older people. We know that malnutrition is a major reason why older people deteriorate, and indeed have falls and end up in hospital. If we were going to put a service in for older people, what would have to change to achieve that?

Sarah Fletcher: That is quite difficult in Lincolnshire, given the fact that, obviously, we would need a new, robust service that would perhaps travel to the homes and be available. It is not always feasible for care homes to have the staff to take residents out to linked practices, so we would need something that enabled a regular check-up service. One area that we know is particularly challenging is around care homes and dental support in care homes. It is not necessarily for us, as a healthwatch, to know whether the local system has the capacity, but, certainly, a priority would definitely be around providing some kind of mobile system that went out to care homes and treated people.

Q85 **Rachael Maskell:** Chris, if I can turn to you and say that you have got your dentists—we keep being told that there are enough dentists out there; we will test that maybe a bit later—can you flex your UDAs sufficiently, or even trade them in, to create the kind of NHS services that different communities require?

Chris McCann: Well, you are not going to fix this by trying to fix one element and then another element—fixing it for old people, then fixing it for children. What we have seen, really, is that there is a capacity issue in almost every area of the country. After Healthwatch first came into existence, around 2014, we would hear stories of people having to ring around maybe a dozen dentists to try to get treatment for pain, then ending up at A&E. However, at that stage, 5% of the overall feedback that we got around all health and care services was about dentistry. That figure has continued to rise. It spiked during the pandemic, when it went up by 450%. However, that was not just a covid spike; covid was exacerbating existing issues. As it is now, currently 15% to 20% of all the feedback that we hear from across the entirety of the sector is related to dentistry, and in a report that we did in 2021, eight in 10 people told us that they found it difficult to access an NHS dentist.

From a local healthwatch point of view, we know that there have been more than 400 insight reports done by local healthwatch, showing the breadth of the issue across the country. I know that the Chair will be able to talk about the fact that people at local healthwatch are hearing these stories. That is actually why this Committee inquiry has had more direct engagement from local healthwatch than any of its previous inquiries. There is a broad capacity issue that needs to be addressed, and it cannot be done piecemeal—addressing matters for old people then addressing them for young people. Until it is addressed in the round, the problem is not going to be fixed.

Q86 **Taiwo Owatemi:** I am particularly interested in addressing oral health inequalities. Sarah, this year the patient charge increased by 8.5%. That is a lot, especially in the midst of a cost of living crisis. How would you say that that will impact patients, especially those who are already struggling to access dental health?

Sarah Fletcher: Massively. We have been told, time and again, that people are having to make difficult choices—almost impossible choices—between their heating and maybe dental. Obviously, dental is then the one that they choose not to go with because they just cannot afford it. We have families that are having to travel hundreds of miles to go to an NHS dentist. They have the cost of that on top of everything else and maybe a day off work. I just think that it will deter more and more people from accessing what is the only available choice in Lincolnshire, which is now private dentistry, just about.

People’s health—not just oral, but physical and mental—is going down drastically. That is what they are telling us all the time. They are in acute pain; that pain is not being addressed; they cannot afford to have the treatment; they have gone many years without treatment. Therefore, when they do manage to get to a dentist, there is so much work that needs to be done that, actually, even under the NHS, it is often not affordable. When those charges are going up, I think it would just put more and more people off wanting to access dental services altogether. That will obviously be a massive health inequality for all.

Q87 **Taiwo Owatemi:** Chris, from a Healthwatch perspective, what funding changes would you like to see to help reduce the barriers to attendance for these patients?

Chris McCann: I suppose that again it is about the overall capacity. We see so many examples of inequalities, and it is fair to say that the crisis of access and affordability is not just a health crisis but a social equalities crisis, and those who are already being impacted by health inequalities are most affected.

We see so many examples. We see women who tell us that they are not able to access their legal right to dental care via the maternity exemption because they cannot find a dentist who will see them during the time that they are eligible for that. We see that people from low-income families and minority ethnic backgrounds are twice as likely to avoid dental care due to costs as their white peers, and we see that children living in deprived areas are four times more likely to need to go to hospital and have teeth removed under anaesthetic than young people from more affluent areas.

Again, everything comes back to this initial point of access. Sarah made the point that the longer people leave it, the more work there has to be done. We see people waiting a long time on painkillers and antibiotics, and their condition worsens. In the end, they end up at A&E, which ends up increasing pressures on the NHS. So it is an issue about increasing capacity in the round, but, as I said earlier, what really needs to be done is a fundamental oral health needs assessment nationally in England. Then, when you know where the areas of need are, the resource should start to be based on that. Whereas, as it is at the minute, there is a budgetary envelope of resource and the NHS is expected to fix all the problems within that, which obviously is not working.

Q88 **Taiwo Owatemi:** Yes, the NHS just does not have the ability to do that.

Jo, I wanted to circle back to a point that you made. When you were explaining the patient registration to dentistry access, you talked about how it is not the same as GPs, but many patients do think it is like that. I have constituents writing to me all the time saying, "Why isn't my dentist allowing me back on?" when they haven't seen their dentist in three or four years because they have not necessarily needed to go. Do you think there needs to be an awareness campaign to let people know exactly how NHS dentistry works so that the patients who do have access to it are better empowered in utilising the service?

Jo York: I think so. One of the things that we have been doing is working with our four local healthwatches to see the work they are doing and to hear from residents, and a lot of what they have heard and are telling us—alongside the access issues, of course—is that people do not understand those issues. People are confused about how to access NHS dentistry and the information available to them is not very helpful. So, again, with our comms team's support, we are trying to work with local providers and healthwatch—it is not us taking the problem and going to work on a solution—and we have a meeting in a month or so to look at how we could improve the information available. People do not necessarily understand

that you are not registered forever and, therefore, if you do not receive the treatment, that registration can come to an end. So providing more information so that people are more empowered would be really helpful. There is lots that we can do locally around that within ICBs.

Q89 **Taiwo Owatemi:** Public awareness and empowering patients goes a long way in their treatment.

Jo York: Yes.

Q90 **Dr Johnson:** Sarah, what proportion of the issues raised with you about health in Lincolnshire relates to NHS dentistry?

Sarah Fletcher: The greatest proportion. Right from maybe 2014-15, we have heard more about dental and access to NHS dental services than any other issue that our healthwatch has ever heard. Percentage-wise, I cannot say, but probably 50% to 60% of the comments that we get back are about access to NHS dentistry or experiences around the dentistry service. It is really significant for us, and we hear from people daily about it; most are asking us to help them find a dentist. Yesterday I talked to one of my team, who said, "I have palpitations now when people ring up and say, 'Can you help me find an NHS dentist?', because I just know that I can't help them and there is nothing I can say or do, other than signpost them to NHS practices that might put them on a waiting list." That is the best that we can offer, even around emergencies. Yes, emergency dentistry is available, but it is on a first-come, first-served basis, so people have to ring up at 8 o'clock in the morning. If they do not quite catch the one or two appointments that are available, that's it—they have to wait till the next day. It is a major issue for us in Lincolnshire, particularly at the healthwatch.

Q91 **Dr Johnson:** That is sobering to hear. You might be aware of the campaign for a centre of dental development in Lincolnshire. To what extent would a centre of dental development help?

Sarah Fletcher: I think massively. It would be reassuring for people to know that we are going to grow our own and keep our own. There is always something about people wanting to settle in the area where they have trained. It is a really positive message that people are taking the issue seriously by wanting to bring something like a centre of dental excellence to the county. That would be very reassuring. Okay, one of the big messages is that people are not going to come out immediately—it is going to be quite a long process—but it would still be a really positive message if that were happening.

Q92 **Mrs Hamilton:** Mine is a really simple question, and I am going to ask all three of you. You will give simple answers, I hope. What is the one thing that the Government could do to improve dental deserts? Let's start with Sarah.

Sarah Fletcher: It has to be more NHS dental appointments and access for patients most in need.

Chris McCann: The first point is to get an understanding of the need, because I think there is a missing piece of the puzzle, whereby local systems do not have sight of what the oral health needs are within their area. Unless you have an understanding of what the needs are, where the gaps are and who is missing out the most, you cannot begin to fix the problem until you know exactly the scale and type of the problem that you are facing.

Q93 **Mrs Hamilton:** I would have gone straight to you, Jo, but I have a follow-up for Chris, who can give us a really quick answer. Why do you think we lack an understanding of what the need is, when it is so blatantly obvious from every report we have been given?

Chris McCann: I just think it has been a long time since a national snapshot has been taken, and there is an opportunity to do that. That piece of work just has not taken place. The sooner that it is done, the better, because once we understand the scale and nature of the problem, it allows the systems, the NHS and the Department to come up with solutions to fix it.

Mrs Hamilton: Thank you. Jo?

Jo York: We have done a local health needs assessment, so we are clear where our areas of priority are. We really welcome the national reforms that are coming, and we can do a lot locally. We want to do a lot, have more flexibility and be able to work on the basis of local need, but some of this is bigger than us. We would really welcome some support around the workforce challenges, training and making it easier to access NHS dentistry.

Mrs Hamilton: Workforce challenges and training. Thank you.

Q94 **Chair:** That's great, Paulette; thanks very much. You know that we have the Minister in next. What would you ask the Minister, Jo? You are an ICB, and you are commissioning dental services. What would you ask the Minister?

Jo York: I think that if we can do more to work with Ministers and MPs like yourselves and understand how the national picture is developing, and if they can hear from us about the challenges, we will come up with better solutions. I don't think we have the answers, but we would certainly be able to share some of the challenges that we are facing and explain how we want to work more flexibly. We would really welcome the opportunity for the Minister to hear that and take it into consideration in decisions.

Q95 **Chair:** What would Healthwatch Lincolnshire say to the Minister? What would be your message?

Sarah Fletcher: Sit and listen to the people who are really struggling. Listen to what their experience is and how it is impacting them. One person said to us, "How would they know?" If you can afford private dentistry, you have no idea what it feels like to not be able to get to an NHS dentist because you cannot afford it. Not only can you not get in there, but you actually cannot afford private dentistry. It is important to

sit and listen, and really understand the impact of having to take a day off work and drive hundreds of miles to access the nearest NHS dentist that you can get to, the impact of being a pregnant lady and not being able to get the NHS dental treatments that you need, or the impact on children who are four or five years old with tooth decay. My message would be to sit and listen to what the impact really is.

Chair: Thanks. The final question is from Paul Bristow, and then we will move on.

Q96 **Paul Bristow:** I want to ask you a quick question, Jo, on something you said earlier. You said that you have an element of flexibility, but you have to work within a national contract. If you could change anything about that national contract, what would it be?

Jo York: It is really difficult, because we are so used to working within those national constraints and trying to be as flexible as possible. It would be helpful to have incentives within the national framework to support people where they have not accessed NHS dentistry or a dentist for a while, which means there is more work that needs to be done. Having incentives for that and for urgent and emergency access would really help.

Chair: Great. It is very kind of you to come and give evidence to us. We will close this panel here. Thank you to Chris McCann from Healthwatch, Sarah Fletcher from Healthwatch in Lincolnshire and Jo York from the Hampshire and Isle of Wight ICB for giving evidence. We will take a short break while we change the panel, and then we will continue.

Examination of witnesses

Witnesses: Neil O'Brien MP, Sara Hurley and Dr Amanda Doyle.

Q97 **Chair:** We are continuing our final evidence session on our inquiry into NHS dentistry. We are pleased to have Neil O'Brien MP, who is the Parliamentary Under-Secretary of State for Primary Care and Public Health in the Department of Health and Social Care. Thank you for coming, Minister. We also have Sara Hurley, who is the chief dental officer at NHS England, and Dr Amanda Doyle, who is the national director for primary care and community services at NHS England. I declare an interest: I was the dental Minister some time ago, so I worked with Sara Hurley who was the CDO also then. You have outlived me.

May we start with you, Minister? What I am trying to understand—you heard some of the evidence that was given just now—is what your ambition is when it comes to access to NHS dentistry. What is the retail offer?

Let me read this to you: "working with the British Dental Association, everyone within the next two years will be able once again to see an NHS dentist just by phoning NHS Direct"—that probably dates the quote a bit. That was then Prime Minister Tony Blair at the Labour party conference in 1999. Now, it never happened, but it was a retail offer. It almost fit on a leaflet. It wouldn't fit on a tweet, because that didn't exist, but it was a

retail offer. I know it didn't happen, but what is your ambition? What is your offer?

Neil O'Brien: Thank you for having all of us today. It is a very timely inquiry because, as you know, we are in the middle of drawing up not just our dentistry plan but our longer-term workforce plan.

On your question, I am not sure I would think of it as a retail offer. Our ambition is clearly to recover to pre-pandemic levels of activity and improve the service. There is a lot to fix in NHS dentistry. I am the first person to say that; I am not here to tell you that everything is perfect. On the other hand, it is worth saying that levels of activity are recovering. We had about a fifth more patients seen in the year to March than the year previously, so levels of activity are going up, but there is a lot more to do.

The reforms that we are starting to make give you a flavour of where we are going. A lot of them are about making NHS dentistry more attractive to dentists so they want to do more of it. Partly, that is about fitting the payments that they get better to the activity that they have done, so they are being fairly paid—hence the creation of more UDA bands. We can look further at that.

Jo York said at the end of your last session that the No. 1 thing she would be interested in is measures to improve access for people who do not currently have a connection to a dentist. Funnily enough, that is probably the No. 1 thing on my mind too, and indeed is the presiding spirit of this inquiry, so we are all thinking about the same thing.

There are a lot of other challenges. We have brought in minimum UDA value, which helps where the UDA values are lower. That tends to be in coastal and shire areas. We will continue to look at that. We are also thinking about the process of commissioning. We have introduced the ability to go to 110% delivery of your UDAs, so that those who want to do more can do more. We are thinking about the commissioning of services. For a long time, it has been very difficult to performance manage the contract that was drawn up in 2006. People were persistently not delivering their UDAs. It was very difficult for ICBs and their predecessors to take those UDAs back and deploy them elsewhere to people who did want to deliver.

There is a core set of things about access, and we can talk a lot more about how we achieve that. There is also obviously a whole bunch of things about prevention that we are interested in. Obviously, you want people not to have to go to the dentist for serious treatment in the first place. Subject to consultation, we are rolling out fluoridation in the north-east and are looking at whether we can go further, and we are thinking about what more we can do with children's dentistry.

My ambition is to get back to a good level of provision and do quite a thorough overhaul of the contract and the current system, because that is what is needed now. We are not into small tweaks. We are prepared to

work in an incremental way, but the system does need quite a lot of overhaul.

Q98 **Chair:** So it is not that everyone will have access to NHS dentists. As you put it in your own words—I am not trying to change your words—it is not fair to say that the ambition is that everyone will have access to an NHS dentist.

Neil O'Brien: We do want everyone who needs one to be able to access an NHS dentist—absolutely. As part of thinking about that, we are particularly focused on how we make sure the people who do not currently have a relationship can access a dentist. That is the thing that is most on my mind at the moment.

Q99 **Chair:** In your heart of hearts, do you really think that we are going to get to a position where everyone who needs one has access to an NHS dentist?

Neil O'Brien: I think that is achievable, yes.

Q100 **Chair:** Okay. If that is the ambition, that is perfectly reasonable. Then it is about how you get there. I know you are very methodical and practical in thinking about how we get from A to B. Do you agree that, as the British Dental Association said to us, the reform of the dental contract so far has been just tweaks and tinkering? It said: "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." I am sure you meet the BDA, as I used to when I did your job, and I do in this role. We have heard from officially on the record with evidence that we are just tweaking the contract; we are not fundamentally changing it and getting away from the UDA system.

Neil O'Brien: I would say two things. The first is that the reforms we have made so far have been pretty widely welcomed by the profession, particularly the splitting of band 2. Sandra White, in your previous session, said they were some of the best changes we have seen in 10 years. They have been pretty widely welcomed. Ditto the other things I mentioned about the 110% and the minimum UDAs.

I would be the first to say that those are only a start, but I don't agree that they are nothing. I agree with the BDA that we want to have quite fundamental reform. In terms of capitation as a way of doing that, I completely understand what they are driving at. As you will know, the Department did an experiment with a part-capitation system over recent years.

The problem was that, in that experiment, you saw a substantial decline in access. You saw about 9% fewer patients being seen in those pilot practices, compared with 3% more in the non-pilot ones. So, there was a clear problem, which is why we have not simply rolled out that system everywhere.

I do think there is the germ of a really important point there, which I do agree with them about. There is a type of patient who has particularly high needs, for whom the current system, set up in 2006, based on almost one-off courses of treatment, does not fit them well. They need such a lot of work and stabilisation that they need something longer term.

In various places, ICBs have innovated and brought in sessional payments. That has been part of the solution to that, but we are absolutely looking at whether there are other ways. As we make the system different, and move on from the old UDA system, as well as better fitting the payment to the cost of doing the work, we can also think further. The UDA is all about a particular course of treatment or activity and paying for that, rather than managing a patient who might have complicated needs.

The reason why in general practice—I have a GP sitting next to me—we have a part-capitation and part payment by activity system, is to blend the best of both worlds. You see that across lots of different fields of policy. In science policy, there is a dual funding system, which is partly about research councils and partly about universities. Council tax is a hybrid of the old poll tax and old rates. You have got a blended system.

Bringing in some elements that let you deal with those more complicated patients is a solid point that we are currently looking at. As for a pure capitation system, the experiments are not encouraging.

Q101 **Chair:** Okay. Before we move on to bring in my colleague Paulette Hamilton, can I share a worry with you? You know how I worry. The NHS dentists who are deciding that they are not going to do NHS work any more—I gave an example to Hampshire ICB a moment ago—do not take that decision lightly, as you know.

It is a huge wrench for them to do that but, once they have taken that decision, it is pretty final. I have spoken to dentists who are in that position who say, "It's been really hard for me to make this decision. I came in to do NHS dentistry; I can't stick it because of the contract." Therefore, they have made that change.

My worry is that, even if tomorrow we had a completely different system that addressed all of those concerns, they have gone, and they have made that decision. It is going to be very difficult to get them to change those decisions. Is that a "worry bead, Steve", or have I got a legitimate concern there?

Sara Hurley: No, Steve, I completely agree that it is a worry bead, and one that is not new to any of us here. In the conversations that I have with practices and, more importantly, associates who are in practice working to a UDA system and construct, they are looking for a change. They are also looking for different ways of working. That is why I look at the ICBs and the flexibility that will be offered.

The ability to work within a contract might offer an opportunity for more of a portfolio clinical career. There would be the ability to do more days with

community dental services, where you are treating higher-needs patients under a salaried scheme, and working back in practice where you may be doing a little cosmetic work.

We know that there is a lot of interest now in what I hear referred to by my younger colleagues as "aligners, bleaching, bonding and repeat". That is not something available on the NHS but it is quite a lucrative part of some of the private work that is being delivered. However, it is not NHS dentistry and it is not meeting the needs of our patients.

Trying to create an environment in which individuals feel that they are valued by the NHS in the work that they are delivering and that they are valued by the practices they work for, which might be moving away from the self-employed contract, the terms and conditions of service of which are dictated by the practice and not by NHS England—that is probably something worth understanding. Although NHS England pays a contract value to a practice, the terms and conditions in which our associates and our dental care professionals work are actually set by the practice. That is the very nature of the dynamic there.

So there needs to be a change on all levels in order to encourage, recruit and retain individuals. And I think it is time for us to think about different models and different ways. There are some great examples of that starting around the country, which are building on the salaried service that the community dental services have used. I am certainly impressed by the work that is going on in the east of England and more importantly down in the south-west, where community interest companies are now offering employment—salaried work—and getting away from a UDA treadmill set by the practice-owner and providing opportunity-portfolio careers. I think it is time to think about things differently.

That is perfectly placed to work with our integrated care boards—the flexibility and the commissioning options they have—and to be able to think about the wider portfolio of oral services that need to be delivered. So, while you have general dental services over on this side with your payment—your funded payment—from Parliament, local government authorities working with ICSs then say, "We do want to run something in the schools". And actually there will be individuals—extended duties dental nurses, oral health promoters—who will be able to go into schools and run the supervised tooth-brushing schemes, which we know are evidence-based in improving the health outcomes for children.

Chair: Okay. I worry a little bit less, but I still worry.

Sara Hurley: Worry, but innovate.

Chair: Yes, yes—I'm the worried well.

Q102 **Mrs Hamilton:** My question is specifically the first question targeted at you, Sara. You have frequently noted that your goal as chief dental officer was to put the mouth back in the body—those are your words.

Sara Hurley: Absolutely.

Q103 **Mrs Hamilton:** Okay. As far as health policy is concerned, this Committee has already heard about the exodus of dentists, especially NHS dentists, since covid. We have also heard—no, I won't say that.

I would like to take you to your longer-term view. Since you have come into office, in the first four years of your term we saw a 44% increase in dentists leaving the NHS. As we headed into the pandemic, the Government contributions in the NHS dental budgets were also lowered and they were the lowest for a decade. And "access to" problems have been with us for years but are now universal. We have even seen a mass exodus of organisations and chains, like BUPA. Also, recent data shows that after four years of progress, we have ceased to see improvements in child oral health and potential widening inequality.

Now, going back to your point—putting the mouth back in the body—can you outline just how far your office and NHS England have come in achieving the headline objectives?

Sara Hurley: That is a very good question and it is lovely to hear my phrase echoed back to me, and to have the mouth put back in the body politic here. That is indeed the vision: it is political support for the programmes we have done.

The first one that I would like to bring your attention to is the Starting Well project and the Dental Check By One, where we worked effectively, with the support of Alistair Burt, who was the Minister at the time, to be able to co-produce, with both local groups and our regional directors of dental care, to ensure that we were utilising what looked like forecast underspend to support outreach projects, to enable us to work with groups of children and families who were seldom heard and seldom seen, and give them access to dental care.

That then also worked in concert with a fabulous programme called Dental Check By One, whereby we were able to work across the country with practices, so that we increased the access of children under the age of two by 17%. More importantly, however, within three years that had an impact of a 10% reduction in children being admitted to hospitals for the removal of tooth decay.

It was a start. One of my urgent pleas post covid would be that we restart the Starting Well programme with our ICBs, and reinvigorate Dental Check by One. At the other end of the age spectrum we work very effectively with Health Education England to develop a programme called Mouth Care Matters, which went into care homes and into the acute sector. The dividend of being able to provide Mouth Care Matters in the acute sector was its impact of reducing delayed discharge. In an era when we are thinking about how we support our acute sector, the dividends and returns of that programme, which was successfully deployed across 13 hospitals in the south-east, need to be replicated across every acute sector. It is about dignity in care, predominantly for those who are elderly and frail, but certainly for those who find themselves in intensive care units.

We were able to demonstrate that for every £1 invested in a programme such as Mouth Care Matters, we got a £12 return in terms of the health resources relieved, but if I want to take quality of life, the National Audit Office methodology showed us that we were producing a £32 return on investment for both patients and services. So there is a great programme that we need to pick up and reinvigorate with our ICBs and provide collaborations across the acute sectors. At ICB regional level we have a real opportunity to make a change.

On the work taking place in care homes, again, that was predominantly focused on elderly care homes and dignity in care, where we were able to put in extended duties dental nurses and local dental teams to support the care providers in these care homes at induction and afterwards, to be able to do simple "lift the lip". Similarly, we were able to work with antenatal and social care, making sure that children who are on the looked-after care pathway could be connected to a provider. There are some fabulous pilots in the south-west and in Yorkshire and Humber.

Q104 **Mrs Hamilton:** Are they continuing now?

Sara Hurley: The models are there. It is up to the ICSs. Indeed, I have worked very closely with Claire Fuller, from the Fuller Stocktake report, to do exactly what you asked me to do: put the mouth back in the body. There are strategies here for maternity, oncology, CVD, diabetes, vulnerable patients, and patients in special educational school settings, where we can do a remote check-in—let's call it that rather than a check-up—to be able to establish real needs and make sure that we get that child or young adult on a seamless journey to the right provider. That might be a high street provider, a community dental service provider, or a provider that has the appropriate sensory settings to be able to support the family group in accessing care.

Far from doing nothing, I am a woman on an agenda with a plan, absolutely, to put the mouth back in the body. I have a lifetime of working at strategic level putting plans into actions, improving oral health. I did it in the military; I can do it here in the NHS. The plans are there and it is really great to hear that the Minister and his dental plan are taking on many of those ideas—and, ideally, a fully funded plan is what I am looking for.

Q105 **Mrs Hamilton:** Awesome answer. That's what I like: a woman who knows her role. You know I will say it publicly. The question I am now asking is, why are half of these things currently not happening?

Sara Hurley: There are many issues in terms of the priorities out there. As much as I am the advocate for patients and for oral health and, as you have noticed, a very passionate one—and yes, I have made a number of Ministers' ears bleed, including your Chair's—getting that political traction over the last seven years has not been easy. I have expended an extraordinary amount of shoe leather. I take my hat off to Jo Churchill, who was extraordinary in being able to drive the agenda, and the current Minister, whose ears have also been bleeding. This is what it takes:

personal drive and commitment. But there are political priorities that override my passion. I have got us here in this room: 2008 was the last time that there was a Health Select Committee meeting on this. During covid, I spoke to the previous Chair, encouraging him to make sure that we maintained progress on planning for this Committee. He was true to his word and he obviously handed it over to his successor. I really welcome this Committee, because it keeps oral health for the nation on the political agenda and, hopefully, on a funding agenda.

Q106 **Mrs Hamilton:** Fantastic. My next question is for the Minister. You have lined it up well, Ms Hurley. Minister, what are your three key objectives—I always say three, because three sounds good—that you would like to deliver on, from the plans that Sara has absolutely flowed forth with this afternoon?

Neil O'Brien: In terms of the key priorities, the first I have mentioned so far is improving access for new patients to NHS dentistry, to ensure that people who do not currently have a relationship with a dentist can get treatment. The second is to grow the overall level of activity that NHS dentistry is delivering, and particularly to do that by making NHS work more attractive in lots of different ways by fundamentally overhauling the contract that has been there since 2006, which is now showing its age pretty badly.

The third is to drive forward on prevention. There are multiple different parts of that. The CDO has just touched on some of the exciting opportunities and the things that are already happening, but there is more that we can do in that space. The prevention agenda is something that everyone always talks about and agrees is important, so it has to be front and centre in terms of our forthcoming plan.

Q107 **Mrs Hamilton:** I will ask the same question that Steve did. In your role as Minister in this area, how are you going to do that when there is a 44% increase in dentists leaving the NHS? What you are saying is admirable, but how are you going to drive ICBs when you do not have the staff?

With the first panel, we were clear that the challenges were around workforce and training, more appointments and understanding the need. Though what you have said is admirable, how are you going to assure this panel that you can meet those challenges?

Neil O'Brien: That is a good question that has two parts to it. One is the workforce, and then there is how much NHS work the workforce does. On the former, there are about 6.5% more dentists doing NHS work than in 2010; about 2.3% more than last year. We know that the number of people seen is up by about one fifth on the year to March, compared with the year before. There are not a fifth more dentists than there were a year ago, but they are doing more NHS work. Because of the nature of NHS dentistry, dentists are constantly able to choose between doing NHS work and the kind of Instagram dentistry that the CDO just talked about. We need to make NHS work attractive in that context. That is about contracts, about how much people are paid, and about fair payment.

Absolutely, we are thinking about the workforce, but not just the dentistry workforce; the long-term plan for the NHS workforce will also cover hygienists and therapists. As well as thinking about the total number and driving up numbers, we also want to encourage everyone to be able to do more. We have changed the guidance on hygienists and therapists, so that everyone is clear that they can initiate courses of treatment.

There was a big problem with the sector: a perception that only dentists could do those things. We are currently in the process of looking at whether we could reform the human medicines regulations, which would enable staff to start using things such as local anaesthetics and fluoride varnishes without a dentist being there. That would again enable hygienists and therapists, who are highly qualified people, to be able to do more and fulfil their potential in the dentistry workforce.

We are thinking about the workforce, and also about how we can encourage the workforce to do more for the NHS, rather than privately. That includes thinking about the international routes as well, and how we can make that as hassle-free and smooth as possible for people who want to come here and do NHS work. Perhaps we will come on to that.

Q108 **Mrs Hamilton:** Thank you for that. My last question is to Dr Doyle. I specifically asked the first panel what Healthwatch would like to see if they had a point they wanted to highlight. They highlighted understanding the need—I say it again—which was strongly articulated. It was about more appointments, workforce challenges and training.

I assume you are working really closely with primary care, ICBs and others. That is where we make change happen. What have you been doing to help in some of the areas that have been talked about this afternoon? We have this issue with dental deserts. It is not that dentists are not there; they just don't want to work there. It is not profitable for them, so they don't want to work there. What is it that you can do differently, using the challenges that Healthwatch has put forward this afternoon, to make a difference?

Dr Doyle: We have already started. As people have mentioned, last summer we introduced the first changes to the contract since 2006, and that is already starting to show early green shoots of improvement in delivery. We have introduced a minimum UDA rate. There is huge variability across the country in what dentists or dental providers are paid for each unit of dental activity; it is not consistent nationally. We have introduced a minimum rate of £23.50 so that places that were paying lower UDA rates are now paying more, which should encourage more dental activity provision.

We made the band 2 changes to incentivise dentists effectively and pay them more fairly for carrying out complex or time-consuming courses of treatment. One issue that dentists told us about was that it is not at all cost-effective to carry out very complex courses of treatment. Since we introduced those changes, which came into effect in the autumn, we have already seen a significant rise in the number of more complex courses of

treatment. That is really important, because a lot of the people who are wanting to—

Q109 **Mrs Hamilton:** But have you seen a rise in dentists coming back because of it?

Dr Doyle: We have seen a rise in dentists providing NHS services. However, more importantly, the pandemic hit dental services really hard, as you know. The nature of the services means that infection prevention and control restricted what dentists could do, so we saw delivery plummet. Activity has been really slow to recover since, so we are still not back to delivering the amount of dental activity that we were delivering before the pandemic. We made the changes to the contract in early autumn last year and we saw more dentists delivering NHS activity last year, but more importantly, the recovery in activity has increased.

In the December just gone, 71% of the commissioned activity was actually delivered, and that has increased month on month since. In March, 101% of commissioned activity was delivered. That is really important. The backlog and the difficulties that people have been having in accessing dental services, particularly since the pandemic, have not been because we were not commissioning as much as dental activity, but because dental providers were not delivering all the activity that we were commissioning. As I say, that is getting back to about 90% of what it was pre-pandemic. The increase has been since the changes were introduced in the early autumn, which is positive. They are just a start.

Q110 **Mrs Hamilton:** That's a great place to end, because there are lots of others.

Dr Doyle: Did you want me to pick on the dental deserts?

Mrs Hamilton: No, we can pick that up after. I am happy with the answers.

Chair: We are going to have to speed up a little bit. Rachael Maskell.

Q111 **Rachael Maskell:** At all the sessions we have held, the workforce has been the issue that has really come to the fore. Dr White said, "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." Workforce is clearly at the heart of it all, and having good data is the start. How is the workforce being measured? In response to questions, we often hear that we don't need to train more dentists because we have enough, but how do we know that we have enough when we don't even know the hours they are working and the work they are doing? Could you respond to that, Minister?

Neil O'Brien: In dentistry, we have something that we don't have in the rest of the system, because we can see how many UDAs are being delivered. Instead of just having a look at the workforce headcount, you can see how much activity they are doing. Obviously, we don't have units of hospital activity, but we do have UDAs. We are able to see the numbers

that Amanda mentioned going up month on month, and the total amount of NHS work being done is measured in quite a precise way. That is the measure I would use. Obviously, it is attractive to have a larger workforce, but we also want to think about how we get the workforce that exists already to do more for the NHS, rather than privately. That goes across the workforce, be it dentists, hygienists or therapists. We absolutely are thinking about the flow of new people into all these different professions: dentistry and hygienists and therapists as well. However, we absolutely need to think about how we make it attractive for the much larger stock of existing dentists, hygienists and therapists to do NHS work and that is partly about reforming that contract.

The British Dental Association is absolutely right to centre the contact as a thing that needs to be looked at again, because it is now long in the tooth. It locked in levels of spending where they were in 2006. It locked in individual rates for UDAs where they were in 2006 and fundamentally, compared with the system in Scotland where you have something like 400 different rates of payment, there are really quite broad bands. Even though we have made them more finely toothed, there is still a feeling for many dentists that they do not feel that they are getting the fair cost of the work they are doing. We have to change that. So yes, absolutely, thinking is part of the plan about how we can increase the workforce but also thinking how we can get the workforce to do more for the NHS.

Q112 **Rachael Maskell:** Building on my first question, do we know what workforce we need to deliver a comprehensive NHS dental service to people across our country and what the differential is between what we have and what we need?

Neil O'Brien: I could make a start on this and then I am pretty sure I can throw it over to the CDO. My first thought on that would be that the nature of NHS dentistry and the fact that there has always been a large private sector and many dentists working in it but also working partly in the NHS, means that it is not the same as, for example, general practice. Where half the time you are working for a private provider and half the time for the NHS, we absolutely need to think about how we incentivise NHS work. You can see, because there are such big changes with the same workforce in the amount that is being done for the NHS—a fifth in one year when we do not have a fifth more dentists—you can see that that is just as important as the size of the workforce. The answer to how many dentists in total you need in the country to deliver a certain NHS service can only be given if you know how the contract works and how attractive it is for those dentists to do NHS rather than private work. So it is just a caveat to your question, but the CDO will give you a better answer.

Sara Hurley: I was quite surprised by Sandra's comment because she was working for Public Health England at the time in 2017 when we started the work on the Advancing Dental Care review programme, which set out to create a blueprint for dental education training, predominantly in England but clearly, we need to think about our devolved Administrations because people cross borders, as patients do. That work actually did start some data collection, and indeed it surfaced some of the

difficulties with data collection. So we went out to the acute sector, to the hospitals and the specialist societies, to understand who was out there, who had a specialist qualification or a specialist interest, who was registered as a consultant and where they were working. Health Education England absolutely brilliantly mapped for us all the specialists across all the district general hospitals, the dental hospitals and where they were working, and gave us a really good understanding of where people were, what skill sets they had and, more importantly, where they were in their career. That allowed us then to take a real hard look at who is in training, what are they training to be and what is the likely outcome and the time it will take. We understand there are family and social pressures that mean that people do not complete training in the defined period of time.

That work was allowing us to build on a preceding piece of work we had done with Jenny Gallagher at King's College London, where we were able to understand the future oral health needs of our population, our ageing population and, importantly, our ageing dentate population. We now know that not only are people living longer but they are living longer with their teeth and, more importantly, with some very complicated dentistry in there. So when you are in your care home, as regards the skills sets of those who are looking after individuals in the care home—to that I mean the nursing staff and auxiliary staff, not just dental care staff—what are you doing on a day-to-day basis to give dignity in care and make sure people are getting the basics, such as getting their teeth brushed or their dentures removed, or they are getting the implant care they need from a hygienist or a therapist? So that work was done. We did not go into this blindly. That created us a fabulous blueprint.

In 2019, Advancing Dental Care produced its first set of reports, and then in 2021 we set out with Wendy Reid at Health Education England to produce the dental education reform programme, which has beautifully set the conditions for the NHS long-term work plan—so, who do we need to train and where do we need them to train, ideally, so they can move into rural and coastal areas? There are some infrastructure issues there. Again, there are some novel ideas as to how we might approach those areas to be able to provide care and employment and deliver that as outreach in conjunction with the ICSs. I think, with regard to a lot of your concerns, because we don't talk about dentistry a lot—it doesn't get that service—maybe that is why you haven't heard about these great programmes that are already being done.

We are evidence-based practitioners; we become evidence-based policymakers. That evidence base is being put together by the profession and offered back into NHS England and Parliament in order to be able to drive the innovations that our patients desperately need. I absolutely get that, but you can't just throw something at it because it might have worked somewhere else. You need to move forward with a strategy for workforce, delivery and infrastructure, and for the contract. This is not just about a contract for professionals; it is about system reform for patients, who have to sit at the heart of this. That is what drove our assessment of the workforce and then the delivery of the workforce training and

education plan. More importantly, it allows us to use the full scope of the dental team—our hygienists and therapists. I welcome the regulation changes that have allowed us to use our dental therapists and hygienists, extended duties dental nurses and clinical technicians—individuals who have skillsets that can be utilised to the benefit of patients. We need to think outside the silo of dentistry and think about the broader dental workforce, where it can work, and how it can deliver the best effect for patients.

Q113 **Rachael Maskell:** The challenge back is that it is clearly not delivering in certain areas of the country. I represent York, which is another desert. There are many deserts in this country. We have seen a significant fall; UDAs in that area are down 126,130 over a four-year period. We have peopled handing back their contracts and three practices closing down. We have five-year waits to see an NHS dentist. Why is your plan, which you say has been so well sketched out, not delivering on the ground?

Sara Hurley: I wish I held all the levers. I don't. We can offer a plan and give you the evidence base, but ultimately, to deliver, it requires pace and funding and, as we have here, political pressure and ambition. I have given you a plan. There is aptitude and attitude to do this. I absolutely understand that while there are some problems in York, there are different ways of thinking about delivery. I urge the ICS in York to have a word with the ICSs in Suffolk, Norfolk and the East of England, where they have been very innovative. I hold my hand up here, because I am fully supportive of the particular programme they are delivering. They are going to set up a community interest company. Its ambition is a 10-surgery NHS-only practice on the waterfront in Ipswich, delivering NHS only care, clarity for those salaried within it to employ and deliver care and clarity for patients. This is ordinary dentistry delivered with extraordinary care. There is no reason, if we can get success with political support, that this model, once proven, could not then address some of the other dental deserts where we have deserving patients in underserved areas.

Q114 **Rachael Maskell:** What I am hearing back from the ICB and the dental community is that they do not have the flexibilities they require in order to deliver such a service. The UDAs are getting in the way of being able to provide the care and the whole service that people need, and particularly seeing people in urgent need, from children to older people, to people who clearly cannot afford private dentistry and people who do not want to go private for personal reasons. I hear that it is working in one area, but there is clearly a problem in the contract around retention of the workforce and delivery of what dentists believe they could deliver if only they were given that opportunity.

Sara Hurley: It was interesting to sit in here for the previous session and heard Jo. I work very closely with Claire Fuller at Surrey Heartlands ICS. I will be giving Jo a phone call, because there are a number of flexible options open to her. There is a document on the FutureNHS website called "Transformation for a better future", which contains all those flexible options that are available to a GDS contract holder in negotiation with their local commissioners. More importantly, I would really urge

conversations across the ICSs, within the context of NHS Confederation, to share best practice and innovation. This is about the art of the possible, and I get that. I know there is some nervousness, but it takes conversations. There is an extraordinary amount that can be done.

Q115 **Rachael Maskell:** My final question is about primary care versus secondary care. In secondary care there are clear specialisms and career pathways. In primary care there is less structure, from completing foundation stage right through. What consideration has there been of putting in an early careers' framework for salary dentists, so that people can consolidate their profession with the support, mentoring and oversight of experienced dentists? I am talking purely about NHS work—a kind of training bond to maintain service while consolidating the skills required for someone to progress in a career in the direction they would choose.

Sara Hurley: You just reiterated that in advancing dental care, which is now under delivery with the dental education reform programme— that exact piece—there is the opportunity for portfolio careers. We have seen it with individuals who work in community dental services, then take time out and work with the oral surgery department in the local district general hospital and then maybe two days a week go back into a primary care practice. That might again be focused on cosmetic work rather than the NHS dentistry we would like to see. So it is there. There is no difficulty in doing that. It is supported.

I run my own CDO's clinical fellowship programme, which allows people to take a year out and supports them to become not quite policy specialists, but people who understand the complications. Similar leadership programmes are run by Health Education England, and there is support for individuals that can be on a step in, step off-type career programme. Again, that is all contained within our dental education reform programme. Everything you've described there is possible. Not everybody wants it. Many people want to focus on a primary care career—buying a practice, setting it up and running it. For others, those who want variation and a portfolio, the art of the possible is there, but it does need the infrastructure behind it. Therein lies the issue. If we are relying very much on a high-street provider or a set of corporates, that restricts their business model in terms of what their ambition is. That is why we need to think about doing things differently.

Q116 **Rachael Maskell:** And the infrastructure part of that will be about the regulator's oversight of primary care dentists?

Sara Hurley: I am not quite sure I understand the question.

Q117 **Rachael Maskell:** The professional portfolio and so on for primary care dentists. Currently the scrutiny they have is very different to that of other clinical professionals—to be on the register with the GDC.

Sara Hurley: To be on the GDC register you can be a hygienist, therapist, dentist, clinical technician or dental technician. There are absolutely a number of requirements you are expected to fulfil. Those still do not stop

you having a portfolio career, but if you are going to expand and provide specialist care, one of the things we have set up with NHS England and Health Education England is the ability to put people on a career pathway, develop skillsets and give them the accreditation so that they can carry out what we call tier 2 complex care under contract by the NHS. That means we are not necessarily sending someone into a hospital setting or a dental hospital. Again, these are variations on a theme that are available to the ICSs to commission.

Q118 **Paul Bristow:** I want to follow on from my colleague Rachael's questions. I will ask the Minister first. You said a couple of times that there has been an increase in the number of dentists performing NHS activity, That is clearly not happening across the board. Peterborough is, I would say, one of these dental deserts as well. The second-biggest complaint to my local healthwatch is a lack of dental services. I was told that literally today by Stewart Francis from Cambridgeshire and Peterborough's Healthwatch. I hear some of the things that are going on in particular parts of the country and I have a couple of questions. First, yes, there is innovation happening elsewhere, but what are you specifically doing to ensure that innovation is spread? What are you going to do if that innovation is not spread, that is, if a particular ICB is not doing what it should be and incentivising dentists to perform more NHS dental activity?

Neil O'Brien: Excellent question. I have been doing a lot of thinking about those things. While, in general, in pretty much every ICB the levels of activity are recovering and going up, I would say that the level of variation between ICBs has increased since the pandemic. There was always some variation, but the recovery is much faster in some areas than others. I would broadly characterise that as between the urban centres, where UDA rates are quite high, and the more shire and coastal areas, where they tend to be lower. We are thinking about that.

Some of that is long standing, and some of it is about where dental schools are. We are thinking about that in the context of the workforce plan. We are also thinking about where people train. The CDO has done a brilliant job of galvanising the so-called centres for dental development, which are about where people do their foundation training. There are plans for those developing in places like Norfolk, Suffolk, Cumbria and so on where there is no dental school and there is a historical problem there about attracting people.

That is part of the story, but we obviously also need to think about the contracts—what kinds of rates of payment people are getting for UDAs in different places in order to make it attractive to move to the places that are struggling. I think the shift from the region to the ICB in terms of being the commissioner will be helpful. As part of the plan, we are thinking about how we can accompany that with increased transparency and accountability.

Of course, you—us as MPs—all of us need the data to be able to see how our ICB is doing compared with other places. The shift from a region that is generally pretty big—all of the midlands, which is a huge region with 10

million people in it—to something much more local will enable greater accountability. Then people will say, "Okay, well up in Lancashire they are doing great things to make sure that they don't have under-delivery by using access and sessional contracts."

Q119 **Paul Bristow:** And that is actually happening?

Neil O'Brien: Yes, there are these innovations that are happening in different places. Your question was, "How will you make sure that good innovations spread?" First, by shifting from the region to the ICB as the commissioner, we now have lots more people who are much more locally accountable at a much more local level. As we increase the transparency about the levels of delivery in different places—you know, they only took over this responsibility two weeks ago, it is very new—people will start to say, "Okay, hang on a minute. I heard about this great thing that is happening in another part of the country. Shouldn't we be doing this here? I see in these statistics that my ICB"—it might be Cambridgeshire and Peterborough—"is delivering at quite a low level. Why is that? What are you doing about it?"

I think that the shift to a more accountable and local system will be helpful, and it will help to spread some of these very good innovations that are happening in different bits of the country.

Q120 **Paul Bristow:** In the NHS, I think there is often a cultural aversion, really, to—that is the wrong word, it is not a cultural aversion. I just think that the NHS is poor at learning from other parts of the country, and historically it has been. That is why we have bodies such as the National Institute for Health and Care Excellence—I know we are moving away from dental—in order to try to demonstrate best practice and get it right the first time as well. There is another example—GIRFT—but it has been poor. How is this going to be any different?

Sara Hurley: Two things: NICE does have dental guidance in it, and one of those clear pieces of guidance is about recall. Recall guidance has been out there since 2004 that clearly identified that the default setting of one size fits all, with the six-month recall, is not applicable. In fact, many of our adult patients at low risk should be coming back 12 months plus. It is interesting.

I have a data piece to offer you. You talked about NHS access; 50% of NHS claimed courses of treatment are band 1. So, 50% of the activity is for a check-up, but between 70% and 77% of those attendances for a check-up are within 12 months when there is no dental decay and no gum disease that needs to be treated.

Neil O'Brien: That is a good example of the way innovation can in effect be driven by the centre, where we have made effectively a new checkbox on the form so that everyone is forced to say, "Hang on a minute. Am I following NICE guidance here? Am I recalling people too often?"

That is one way we can spread it, but we can also do so just by having some local commissioning. In truth, as well as not having those local

commissioners, even if they had been there before, it would have been quite difficult to do commissioning properly, because there is no ability to move UDAs around the system because of the permanence of the contracts.

Giving people both the power and the flexibility locally is very important in enabling innovation to spread, as well as doing what we can to replicate good practice from the centre.

Q121 **Paul Blomfield:** Minister, in answering the Chair's question earlier you said the Government's ambition is for everybody to have access to an NHS dentist. That is a very big policy commitment you have made to us today, because we are about halfway there, with coverage at around 50% at the moment. When do you expect to get there?

Neil O'Brien: Sorry, we may be talking at cross-purposes. I said that we wanted everyone who needed or wanted an NHS dentist to be able to access one. That is not the same as saying that every single person should be seeing an NHS dentist every six months, obviously. I am not quite sure what the statistic you allude to is. If it is patients seen per 12 months, then we have just had a conversation about why that is not necessarily the right measure. NICE's guidance is really clear that healthy adults only need to be checked up on once every two years. We need to be clear about how we are measuring access.

One of the things that I am very struck by at the moment with those who experience problems accessing a dentist when they want to is the greater difference between those who have an existing relationship with an NHS dentist and those who don't. That is one thing that I am absolutely keen to focus on: tackling the problem of people who cannot get an NHS dentist and improving it. We can measure that. We can see at the moment how many people are taking on new patients, and we want to drive that up.

Q122 **Paul Blomfield:** I do not think we are at cross-purposes. We want to know how many people are able to access an NHS dentist when they need it. You said the Government's ambition is for everybody to be able to do that. Information we were given at the last evidence session was that roughly half—slightly less—of the population can do that at the moment. I absolutely welcome the Government's commitment to achieve that. When do you anticipate you will get there?

Neil O'Brien: I see what you mean. One of the challenges in getting the right metric for this is about how far you have to go. It is no good saying, "Oh well, you could access an NHS dentist if you are prepared to drive umpteen miles." That is one of the things we are thinking about as we work on our dentistry plan. As we think about how we make interventions to improve matters where access is clearly worse, there are a whole bunch of different metrics we can look at to understand how the NHS dentistry service is doing, but there are definitely patterns in the data where there are some places that are struggling on a bunch of different measures—

Q123 **Paul Blomfield:** Forgive me for interrupting; there certainly are areas that are worse. We talk about dental deserts. Most of the rest of the

country is barren ground—there are no green pastures. Every MP is reporting constituents coming to them saying that they simply cannot get an NHS dentist. You have set out an ambition today that the Government want to ensure that everybody has access to an NHS dentist. My question is: when do you intend to achieve that by?

Neil O'Brien: As soon as possible is the only possible answer to that question. My point back to you, and I am not being obtuse, is that in terms of measuring the quality of access, how long people have to travel to get access, and therefore how easy it is, we need to get the measures of it right. There are other measures as well that one can use to see how easy access is. If we are going to base focused interventions on different measures, we need to ensure that we are calibrating that in the right way so that we do not distort things.

There is actually quite a lot of variation around the country between places where people are not having to travel long distances, and some places where they are having to travel too far. We want to reduce that variation and improve access, particularly where access is weak.

Q124 **Paul Blomfield:** I accept that metric, and that you have pointed out the unacceptability of having to travel long distances. When you set out an ambition like everybody should have access to an NHS dentist, the expectation would be that that was in reasonable travelling distance. It is your ambition to achieve that as soon as reasonably possible. Clearly, the dental contract is critical to that, because we are haemorrhaging dentists from NHS service—Dr Doyle is nodding.

Neil O'Brien: I am not sure what that is based on. The number of people doing NHS work has gone up. The question is how much NHS work they do and that is best measured by the delivery of UDAs and the number of patients seen, and both those things are going up.

It is true that the service took a tremendous hit—more than any other medical service—during the pandemic, because of the nature of what it is.

Q125 **Paul Blomfield:** I think we would find it helpful if you could give us the data to confirm what you've just said, because—

Neil O'Brien: Absolutely.

Q126 **Paul Blomfield:** Because the evidence that we've had is that actually we are losing dentists from NHS delivery and Dr Doyle was nodding when I made that point.

Neil O'Brien: I don't think she was nodding, actually.

Dr Doyle: We know that just above 70% of dentists on the register are offering some NHS service. Again, as the Minister said, the difficulty is that we don't know how much private activity dentists are carrying out; all we can measure is how much is NHS.

What we do know, which is starting to improve things, is that when we look at patient satisfaction with access and the number of patients who

access dental care, what is really clear is that people who already have a relationship that is established with a dentist, even though dentists no longer register patients as such in the same way that GPs do, but people who have an established relationship found it very much easier to access care when they needed it than people who didn't have an established relationship.

However, we are starting to see some improvement, partly because of the ways in which—we have all talked about this—we are trying either to increase capacity or to make the best of the capacity we've got. We know that in February of this year 86% of dental contractors saw at least some new adult and child patients. So, 86% of all dental providers saw some patients who were new to them and who didn't have an established relationship with them.

Our aim is to catch up with the backlog of people who are trying to access care and obviously those are more likely to be people who have a dental need, rather than people who are just trying to have a check-up, for example. We are starting to see some recovery in that.

Q127 **Paul Blomfield:** I appreciate that, but it would be useful if you could provide the Committee with the statistics to back that up, because it conflicts with some of the evidence that we have had.

Neil O'Brien: Of course.

Q128 **Paul Blomfield:** Let me just continue pursuing that, if you don't mind, because I thought you made some very good points, Minister, critiquing the current dental contract. You said, and I wrote it down, that you think we should "fundamentally" overhaul the contract and I would certainly agree with you, because the reforms that were made last July were just kind of tweaks at the edges.

Could you just give me, say, three points that you think would be central to a fundamental reform of the contract, so we get a proper sense of where you're going?

Neil O'Brien: Absolutely, although I would dispute that what's been done so far are just "tweaks"; they are important, but they are only a start.

I think that things that are important as we try to overhaul the contract are, first, to think about unjustified and unhelpful variation in how much people are getting paid for the same amount of work. Everyone knows about the variation in UDA rates, potentially even along the length of one street but particularly between different regions. That is the first thing.

A second thing that we need to address is this problem that I raised right at the start of the session about the complex patient who might be more suited for capitation of a kind. And people, or rather places, are starting to address that with solutions like sessional and access payments. But I do want to think further about whether we can do something that is not just about a one-off course of treatment and, bang, you're done, but is about looking someone over a longer period who has a more complex need.

I think the third thing is just fundamentally to try to further improve the match between the cost of providing the work and the cost that dentists are then reimbursed for. When I talk to dentists, they are very conscious of this and they feel very hard done by if they feel like they are doing NHS work at a loss, even though a lot of them are incredibly public spirited.

In particular, when I talk to them about taking on new patients, it is clear that their fear of taking on new patients is, in some cases, that they will get a very complex patient who will require very complicated work and that the current contract will not sufficiently remunerate them for that not to be a loss-making exercise for them. Tackling that is quite central to tackling the question of taking on new patients.

That would be my take on it, but I am sure that others on the panel would have—

Sara Hurley: One of my disappointments is that we have made a policy, supported by the Government and currently published on the NHS webpage, which absolutely deals with how a practice can support a high-needs patient through what is currently called phased courses of treatment, but which is actually a personalised care pathway. That guidance has been there since 2017. It allows an approach that supports a patient with high needs.

That is not just, "You need three fillings." That might be a patient who needs to be disease-managed, for want of a better description—who needs to be supported from stabilisation to functional restoration to definitive restoration. That is possibly going to take a practice a year to work with that patient.

Under the old system, if you just did it, that was three units of dental activity, and possibly 12. But, since 2017, we have laid out quite clearly how that approach can be taken. You can take a patient through a series of phased courses, where the practice receives a remuneration, but with the recall required for these high-risk patients, so that actually doesn't trigger a second or third payment. Up to three quarters of the treatment can be provided for that patient in a year. That has been there. We revised it, coming out of covid in 2021, to also encompass the work for gum disease. Again, that is another piece of work.

It is to my disappointment, despite the BDA sitting round the table when we designed that policy, that less than 0.1% of the claims that go through BSA are for that phased course of treatment. That is an opportunity that practices currently have to be able to take on a high-needs new patient. I can take the horse to water, but the practices need to be making these decisions, given the facilities and the policies we have made available to them.

I have already discussed the capacity that we are utilising at the moment in terms of—dare I say?—a discretionary or possibly even an unnecessary check-up, which is some 70% to 77%. That is capacity that could be used for high-needs patients and patients in need.

There is flexibility at practice level. There is flexibility at provider level. There is flexibility at ICB level, increasingly, to be able to support that.

Q129 **Paul Blomfield:** But the contract has to incentivise dentists to do that. I wonder if I could just push the Minister further on UDA rates in particular. You talked about the importance of sorting out the disparities, and I agree with you. But you talked about it in the context of regional variations. When Paul was talking earlier, you said it was about getting dentists to move to different parts of the country.

I could take you to two practices, a couple of hundred yards away from each other in my constituency. One has a UDA rate of just over £20; the other has one of about £35. It is a similar demographic—they are only a couple of hundred yards away.

That has an impact on which of those practices feels that it can continue to do NHS work, and which feels it cannot. In your fundamental overhaul of the contract, do you intend to sort out those disparities and normalise the UDA rates?

Neil O'Brien: Before I answer your question directly, it is important not to lose the importance of what the CDO was just saying about phasing, because, in theory at least, we have the solution to this problem about the costs of treatment being an obstacle, because you can use phasing, and the guidance was updated by the CDO to do that. You can consecutively run courses of treatment and get paid as much as it takes to make a person better dentally. Whether the route to fixing that problem involves us doing something further with phasing, or something else, is an open question in my mind. I am extremely interested in whether we could make more of that. It is something I have talked to dentists about quite a bit.

On your point about the UDA rates, at the time when the last Government brought in the system in 2006, it was based on—although dentists didn't know this at the time—what activity they had done over the last year, in 2005. The further away you get from that period in time, obviously, the less it reflects the reality of their case load and the more the case gets stronger to try and do something, particularly where the UDA values are low.

We have already brought in the minimum UDA value, at £23, which is helpful. Obviously, what happens with that in the future is something we are thinking actively about at the moment, because a system that has been sort of frozen in time since 2006 increasingly becomes out of whack with the need in the practice locally.

Q130 **Paul Blomfield:** I have one final question. Assume we got the perfect contract and all the dentists we need willing to undertake the sort of NHS service that we would want for everybody in the country, is there enough money to fund it?

Neil O'Brien: In recent years, the challenge has been to try to reform the contract in order to stop an under-delivery and therefore an underspend, so at the moment—

Paul Blomfield: Assume we get that right: is enough resource devoted to NHS dentistry at the moment to provide the sort of service that we want?

Neil O'Brien: It is interesting to see how, over recent years, in real terms, broadly speaking, the total spend has probably kept pace with inflation and is roughly the same as it was in previous years, but we have seen a huge drop-off in activity around the pandemic that has taken a long time to recover from.

As we think about the next spending review and about how much is put from the centre into NHS dentistry, we need to take account of the relative attractiveness of working in the private sector and the growth of cosmetic dentistry that the CDO mentioned. We will need to think about that, but at the moment the challenge is to stop the under-delivery, to make the attractiveness of the contract greater and to get the money that is there in the NHS spent.

One of the things that we have done, as we have moved to the ICB level, is that we have ringfenced the dental budget. We have made it very clear to the ICB commissioners that they should not be taking underspends and under-delivery and turning them into spending on something else. In the first instance, they absolutely must look to reinvest that in NHS dentistry, so that we deliver what the money is there to deliver.

Paul Blomfield: With which I absolutely agree, but you also would agree that going forward we need to think about the overall resource allocated to dentistry. Thank you, Minister.

Sara Hurley: May I come back—

Chair: We have to move on. We are going to vote at some point, so we will try to finish in the next 10 to 15 minutes, but not before we have heard from Mr Morris and Dr Johnson.

Q131 **James Morris:** Thank you, Chair. I have a quick follow-up on the point about the £400 million underspend in ’22-23, Minister. Given all the challenges that we have been talking about today and the close to half a billion in underspend, how did we get into the situation?

Neil O'Brien: It is a combination of the huge hits to dentistry from covid—worse hit than any other bit of the medical system—and how commissioning used to work regionally rather than locally and with a lack of flexibility to move UDAs on to those who will deliver for the NHS. It is partly a lack of accountability and transparency, and the shift to ICBs should help that. As part of our plan, we are looking at how we increase the transparency of what is being delivered, because as you would be the first to say, what gets measured gets managed—

Q132 **James Morris:** Are there not other parts of the NHS that are thinking, “Look at that £400 million. We could be using that”? That has not happened, has it?

Neil O'Brien: I mentioned that, for the coming year, we have brought in the ringfence, exactly to stop resource that is intended for dentistry from—

Q133 **James Morris:** How can you enforce a ringfence on ICBs?

Neil O'Brien: In the first instance, by telling them that they have to spend it on dentistry and to look at whether they are delivering the amount of dentistry that they are supposed to be delivering.

Dr Doyle: I would add two things. First, it is not an underspend in the way that we understand it when we talk about other services. The entirety of the dental budget is committed to legally binding contracts with dental providers at the start of the year. That figure you are referring to emerges because the money that is committed in contract is paid in 12 instalments up front to dentists throughout the year—

Q134 **James Morris:** What I am trying to get at is that none of that £400 million in '22-23 was diverted to other NHS commissioned services that were not dentistry.

Dr Doyle: We do not have the detailed final year figures for '22-23, but certainly now—for '23-24—a ringfence has been applied by NHS England, so no ICB can spend a dental allocation on anything that is not NHS dentistry.

The trouble is, we do not know up front at the start of the year the size of the clawback that will be available, because we do not know the extent of under-delivery by dental providers. We have now introduced measures whereby we are actively reviewing and intervening on providers that are delivering less than 30% of their month-on-month contracted activity, so we can try to free up some of that funding earlier in the year and then commission locally to find alternative ways of providing dental activity.

Chair: Interesting. Thank you, James, for bringing that up.

Q135 **Dr Johnson:** We have so far talked quite generally about patients, and I want to ask you about two more specific groups. The first is military professionals and their families. The Minister knows—we have talked about this before—about my concern about military families who move around the country, usually with their spouse or a parent who is serving in the armed forces. They sometimes find that they could access the dentist in one place, but they cannot in the new location. By the time they get towards the top of the list, they have moved on to another location because of the service of that member of the military personnel.

I thought to myself, "What if we got the military dentists to do some of the work?" I asked the MOD a written question about that, and I discovered that, as of 1 March 2023, there are 22,138 members of the UK armed forces who are categorised as NATO category 2 or 3, which means that they require either preventive or interventive treatment to achieve optimal dental fitness. Some of them may not be deployable because they have such severe problems. I would like to know what work, if any, you are doing to support the MOD in ensuring that all our military service personnel have the dental care they need. Secondly,

what is being done to ensure we meet the military covenant, which is now enshrined in law?

Neil O'Brien: Before I bring in the CDO, who is better placed to answer that question, I will say two things. I can help with the first part of that question, about the families of military personnel. It is something I am very seized of. We are having conversations with the MOD about that because of course they move around. While the serving member gets treatment via the force's own service, their family needs to find an NHS dentist, so we are trying to work out whether there is something we can do to make that more seamless, and we are having those conversations.

The MOD's own service is not something that the DHSC is responsible for. These are serving members of the forces providing it; it is their own internal service. I saw the data that you generated. We are very happy to talk between Departments about how we can fix some of these challenges.

To answer your first point, I am very seized of this point about forces families. That must be extremely relevant in Lincolnshire, I would have thought. Yes, I am keen to have conversations about how we can improve that.

Q136 **Dr Johnson:** To clarify, you have not been asked, and are not in discussions with the MOD, about how you can ensure that military personnel themselves have that access.

Neil O'Brien: We are in constant dialogue with them. The point I was making is that we are not the employer of that bit of the dental workforce. They are their own people; they are serving people. We have literally the world expert here.

Sara Hurley: In my previous role as Chief Dental Officer for the Army, I was not just responsible for the hands-on, wet-fingered delivery of dental care to serving personnel and their families when we were serving abroad in places like Germany, Hong Kong and a number of other places that have now been handed back. The MOD has a dental workforce that is both uniformed and civilian. It is a salaried service. It has successfully run the risk-based recall, and one of the initiatives that I ran, in terms of service reorientation, was to take the new recruits into the military, and in the first 24 weeks we would aim to provide at least stabilisation and functional restoration. We would get these individuals as fit as they could be, both physically for the military and dentally.

When I started the scheme, the military were running at about 45% dental fitness as a population. In a period of three and a half to five years, we were able to take the Army to 85% dental fitness as a result of this particular reorientation of the strategy. Our Project MOLAR was then adopted by the RAF, which interestingly it called it MOL(AIR)R. It has also been adopted in the Royal Navy.

This is a Defence Medical Services integrated oral health programme for recruits. It gets people fit early on. We do a lot of prevention work. We use hygienists. We put them out in the field when they are on training. Of

course, the art here is prevention. Although we might be fixing holes for that recruit when they walk through the door, the idea is to keep them fit over the duration of their time in the military.

Most recruits who come into the Army stay with the military for only about four to four and a half years. It is not a long time. I happened to do nigh on 30, but most people leave after about four to four and a half years. That dentally fit recruit, now with service experience, goes back into the civilian population with better teeth than they entered with in some cases—not all. We have certainly seen an increase in the improved oral health of many of the individuals joining the military.

I mentioned earlier on that I do system strategy and reform. There is an ability now to take some of that innovation, be it on the risk-based recall or the reorientation of services, and—while Paulette has left—dare I say it, put the mouth back into the body of the military. We can do it in the rest of the era. It takes an integrated approach.

Earlier on you mentioned—I was going to interrupt—the use of dental services and whether we can afford them. The art of affording dental services is to do prevention. It is cheaper to preserve good oral health. That does not necessarily happen in a dental chair alone. It is about some upstream activities, be they community water fluoridation or the sugar tax. There are risk factors for oral health that are common with those things that cause diabetes or cardiovascular disease. If we think about oral health and how we can preserve it, good oral health will give you good general health. You will get more bang for your buck, and you will probably end up spending less on intervention. You still need to have check-ups, but they need to be done in line with the NICE guidance, so those with the greatest need get access to care when they need it. That is what the Minister wants to be able to offer.

Q137 **Dr Johnson:** That is very interesting. When we say that there are over 22,000 members of the armed forces who have teeth issues and need dental care, you are saying that that is an improvement on where we were.

Sara Hurley: What I am saying is that the health of the military was not great back in the 1990s. There had been a legacy of issues. It has improved. Now, the armed forces is, what, 130,000? You have mentioned 22,000—I would expect around 15% to 20% of the population. I think you will probably find that that is—of course, we do not have the adult dental health survey—a pretty good reflection, or possibly even an improvement, on what we have in society. I do not have the figures, so I cannot give you the accurate comparison—it would only be an anecdote.

The armed forces have a dental service—a salaried dental service. They have an infrastructure. They have health centres, and they have an integrated oral and medical record. The dentists and dental teams in the military have continuity of care for that patient, wherever they are. Whether you are seeing a patient in the hospital in Bastion in Afghanistan, in Tidworth garrison, or in Fallingbostel in Germany, there is a continuity

of healthcare record, which is another real bonus. There is electronic prescribing for the dentists in the military. We do not have electronic prescribing currently in NHS dentistry. We have 5.2 million paper scripts each year. E-prescribing would be one of my asks of the Minister.

Q138 **Dr Johnson:** I can definitely echo that, because e-prescribing for secondary care professionals is something that I have certainly berated and lobbied his fellow Minister who deals with that about.

Minister, can I ask you a question about veterans and families? Does the Department have any figures for how many veterans and families there are, and how many of them have access to dentistry and how many do not? Do you have any rough proportions?

Neil O'Brien: I don't, off the top of my head. I am happy to look into it further, but I do not have a figure off the top of my head.

Q139 **Dr Johnson:** Thank you. Could you write to us about that?

Neil O'Brien *indicated assent.*

Q140 **Dr Johnson:** The other group I want to talk about is pre-school children. We have talked about education and how teachers can talk about brushing teeth; people can go into schools and help with that. We know that quite a number of children have pretty terrible teeth by the time they start school, so what is being done specifically to look at the pre-school-age child?

Neil O'Brien: There are different levels at which we can answer that. In terms of prevention, we are driving forward with the first serious expansion of fluoridation since the 1960s. We are taking it to about another 1.6 million people in the north-east and looking at whether we can go further on that. We are also very keen to expand preventive activities of the kind that we have talked about in this session, particularly aimed at children. So the first part of the answer is clearly about prevention.

In terms of treatment for younger children, we recognise that that is more complicated—treating the very young is a great art. I think there has been an expansion through HEE, which is now part of NHSE, of various specialisms and postgraduate training, which I think the CDO alluded to before, including paediatric specialisms. That should help to increase the workforce, in terms of those with a particular specialism and expertise in treating the very young.

Q141 **Dr Johnson:** Thank you. It is more than just when a young child goes to the dentist, though, isn't it? There is more to it than that. There is also what is going on at home, what food and drink is being consumed in what particular way, how often the teeth are being brushed, and whether people realise that baby teeth need brushing, which some people, it seems, do not. What work is being done with midwives, health visitors and other professionals who see families to ensure that the message of good dental healthcare gets in very early?

Sara Hurley: We did a lot of work—this was pre covid—with the Royal College of Paediatrics and Child Health. We also worked with midwives and antenatal staff. We have provided a wealth of information. Again, you do not need to take a dentist or a dental team out of a surgery. The information is there. A wealth of information has been produced at local government authority level. Sometimes there is a duplication of effort, and it would be great if we could have that all in one place so that it is accessible, standardised, and put into the different formats that are easily accessible by different groups.

We would love to see oral health—again, putting the mouth back in the body—as part of those antenatal classes, talking about maternal oral health and the child. With the Dental Check by One initiative we were trying to see children before they got their teeth. Excuse the pun, but it was gums on seats rather than bums on seats. That really did chime. As I say, we got parents in. Often it was not about examining the child; it was about having a conversation with the parent group or the carer about diet and toothbrushing.

There are a number of initiatives, but again they are local government authority-funded and local government authority-delivered. Toothbrushes for the under-fives and the over-fives and toothpaste are available. We did a lot of work on the swapping of bottles, so that we would move children from a Tippee cup into something that was basically going to try to deal with what I call the early childhood caries, which created that very sad loss of a child's smile as they lose those front teeth. Of course, if you lose those front teeth, that has an impact on your ability to do your phonics. If you are trying to learn to read and you cannot do your [t] and your [f], one of the issues is that the child does not enjoy learning to read. They feel self-conscious.

Again, if we get oral health right and prevent poor oral health, the dividends for child development as well as oral health are significant. I would not insult my midwifery colleagues by saying that they do not understand and appreciate the value of putting oral health into their programmes. We have a brilliant programme across NHS England called "Making Every Contact Count". We worked with the Royal College to talk about lifting the lip. There is nothing to stop a GP, when they come and do those first early assessments of a child, lifting the lip. What I would love to be able to see is GP practices, and dental practices locally, really coming together and understanding the offer that is there for patients and the support.

We are now moving into the era of the integrated care system. We have talked about system, place, neighbourhood and primary care networks. I am encouraged by what I am seeing. I know that Jo had a different vision, but certainly in Surrey Heartlands we have our GP leads already talking to the dentists. There is a dentist sitting on a board. I happen to sit on the Surrey Heartlands board as a non-executive director, getting my feet under the table. If I can do it, I know that a number of my healthcare colleagues, dentally qualified, can also get themselves around that table.

It is not a one-way dialogue. We can encourage our teams and our local dental committees to really pick up the baton and put dentistry around the table at ICB level to drive not just commissioning but the oral health agenda across all the other activities in that ICB.

Dr Johnson: That is the end of my questions, but I should declare, because it was mentioned, that I am a member of the Royal College of Paediatrics and Child Health.

Chair: Of course. That is fine. I do not think that we can better "gums on seats" so we will leave it there. That concludes our work on NHS dentistry. We will now consider all the evidence that we have taken, including today's, and we will compile our report as always for you and your colleagues, Minister, which I know you will be looking forward to. Minister O'Brien, thank you very much. Dr Amanda Doyle, thank you. Sara Hurley, the Chief Dental Officer for England, thank you so much for joining us.