Written evidence submitted by Bupa Global & UK (DTY0024)

Background

1. Bupa Dental Care has almost 450 dental practices across the UK, offering NHS and private dentistry to 2.3 million patients. Over 60% of our patients, 1.4 million, are treated through our provision of NHS dental services at 300 practices across England.

2. Bupa Global & UK is the UK's leading health insurance provider, supporting three million customers in managing their health and wellbeing. We are also an important health and aged care provider with: a network of 49 health clinics; 130 care homes, the Cromwell Hospital, a complex care hospital in London that provides care for insured, self-pay, NHS, and international patients; and are one of the UK's largest dental providers.

3. Our submission focuses on the NHS dentistry system in England. A senior member of our team can give oral evidence, if helpful.

UK oral health

4. Bupa is committed to helping our patients live longer, healthier, happier lives and making a better world, including promoting good oral health. However, our analysis of WHO data shows worrying trends in the UK population's oral health compared to other developed economies:[1]

    - **The UK has the lowest per capita spending (public and private) on oral health care (US$143) and oral health workforce ratio (5.2 per 10,000 of population) in the G7.**
    - **The UK has the third highest incidence rate for lip and oral cavity cancer of the ten nations analysed (5.1 per 100,000 of population in 2020).**
    - **The five main oral diseases cost the UK economy 11,205 million US dollars in lost productivity, higher than Australia, Canada, Italy, New Zealand, and Spain.**

5. **A focus on preventative oral health care is needed to improve our population's oral health. Greater access to NHS dentistry for those who need it most is key,** especially in the wake of the pandemic, where one in ten of those needing dental advice or treatment did not receive it.[2]

Private dentistry

6. The poor state of UK oral health results in-part from the long-term failure of the system to ensure access to quality dental care at the point of need. This inquiry is an opportunity to develop constructive solutions for improving access to NHS dentistry for those most in need and press ahead with much-needed reform.

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[1] In November 2022, the World Health Organisation (WHO) published their 'Global oral health status report' and individual 'Oral Health profiles' for each member country. Bupa compared the WHO Oral Health Country Profiles, published by the WHO on 22 November 2022, of the following countries: Australia, Canada, France, Germany, Italy, Japan, New Zealand, Spain, the United Kingdom, and the United States. We used the following elements from the Oral Health Country profiles for our analysis: *Prevalence of untreated caries of deciduous teeth in children 1-9 years (%); Prevalence of untreated caries of permanent teeth in people 5+ years (%); Prevalence of severe periodontal disease in people 15+ years (%); Prevalence of edentulism in people 20+ years (%); Number of new cases and incidence rate (per 100,000 population) of lip and oral cancer; per capita availability of sugar (g/day); Prevalence of current tobacco use, 15+ years (%); Per capita alcohol consumption, 15+ years (litres of pure alcohol/year); Total expenditure on dental healthcare in million (US$); Per capita expenditure on dental healthcare (US$); Total productivity losses due to 5 oral diseases in million (US$)*; and all oral health workforces figures.

[2] Office for Health Improvements & Disparities, The impact of COVID-19 on access to dental care: a report from the 2021 Adult Oral Health Survey, 21 December 2022.

7. **However, we must acknowledge the importance of private dentistry. Under the existing budget, there is only enough funding to provide NHS general dental services for around 50% of the population.[3] At least half of patients depend on private dentistry for treatment, a fact that has been true for many years and under previous versions of the dental system.**

8. The General Dental Council (GDC) found that the proportion of adults receiving dental care under the NHS fell from approximately half (48%) in 2013 to just over a third (36%) in 2021.[4]

9. Many patients part-fund their NHS dental treatment through paying charges, increasingly since the introduction of the current system. Patient charge revenue received by the NHS for UK dental services rose by nearly a third (31.7%) in real terms from 2006/07 to 2019/20. In addition, the proportion of those over 15-years-old receiving free NHS dental treatment (being exempt from patient charges) fell from 31% in 2012 to 22% in 2017.[5]

10. While private dental treatment is not an option for everyone, it is increasingly integral to the wider dental system as NHS budgets are squeezed. The NHS spends around £3.75 billion a year on oral health and this has eroded in real terms since 2010.[6] Total UK spending on NHS dentistry only grew by 0.6% in 2020/21.[7] Economic and fiscal headwinds mean the chances of a significant new public cash injection are slim.

11. **The Government and NHS England (NHSE) must ensure that the NHS dental contract is fit for purpose, the necessary resources are available to deliver reforms and the exodus of NHS dentists is reversed.**

12. Systemic contract model problems and low levels of funding not matching rising treatment costs and needs meant that the NHS dentistry system was already struggling before the pandemic. This was exacerbated by COVID limiting patients' access to NHS dental care and increasing levels of poor oral health.[8] Workforce pressures from a drop-off in EU dentist numbers,[9] the increased treatment loads and poor levels of remuneration have resulted in more dental professionals reducing their NHS commitments because they are not fairly compensated for increasingly complex treatments. This is a perfect storm for NHS dentistry.

13. **There are not enough dentists choosing to provide NHS care in the UK. We need to train more dentists at home, make it easier for overseas dentists to work in the NHS and make NHS dentistry a more attractive option to improve retention of existing clinicians.** The latest NHS statistics show 24,272 dentists did some NHS work in England in 2021/22, but 15% of the workforce, almost 4,000 dentists, did no more than one patient course of NHS treatment a month on average.[10]

14. Most of Bupa's dental practices across England are 'mixed', providing NHS and private dentistry. Because of the pressures outlined, our practices are increasingly dependent on revenue from

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[3] LaingBuisson estimated the value of UK 'high street' dentistry market to be £8.3bn in 2020/21. NHS dentistry spending was around £3.75bn (or 45%) of this spend, whilst private dentistry spending accounted for £4.6bn (or 55%). Source: LaingBuisson, Dentistry: UK Market Report: Sixth Edition, p5.
[4] Source: Patient and public survey 2013–2020, General Dental Council.
[5] Statistics taken from LaingBuisson – 'Dentistry – UK Market Report' Sixth Edition, November 2022. UK patient charges received by the NHS in 2006/07 were £750,000,000. Patient charge revenue for 2019/20 was £984,000,000. All figures are given in real terms at 2020/21 prices. Source: Patients and Public Survey, 2012 to 2020, General Dental Council; Adult dental health survey 1998 and 2009, Office for National Statistics.
[6] LaingBuisson – 'Dentistry – UK Market Report' Sixth Edition, November 2022.
[7] LaingBuisson – 'Dentistry – UK Market Report' Sixth Edition, November 2022.
[8] Office for Health Improvements & Disparities, The impact of COVID-19 on access to dental care: a report from the 2021 Adult Oral Health Survey, 21 December 2022.
[9] The Nuffield Trust, 'The costs of Brexit make severe challenges even harder for the NHS and social care', 19 December 2022.
[10] NHS Digital, NHS Dental Statistics for England, 2021-22, Annual Report, 1 April 2021 to 30 June 2022.

private dentistry to be financially viable. Even then, the difficulties with current NHS contracts mean some practices are loss-making, a position that cannot be sustained long-term.

15. Dentistry has always been a mixed market, with NHS and private provision working together. **Private practice plays a vital and complementary role in supporting NHS dentistry.**

What steps should the Government and NHSE take to improve access to NHS dental services?

16. Incremental changes to the NHS dental contract and registration process for overseas dentists and dental professionals brought forward over the last year, including, changes to Band 2 Units of Dental Activity (UDAs), introducing minimum UDA values, and streamlining the registration process, are moves in the right direction. However, the Government's announcement of further reforms, due in April 2023, shows these steps to be marginal.

17. The NHS dentistry system is failing patients who need it most. Wholesale reform of the NHS dental contract model is required and there are immediate changes to be made.

18. The Association of Dental Groups, the trade body for dental providers, identifies their 'Six to Fix' solutions, including:[11]

    - Increasing the number of training places in the UK.
    - Ensuring continued recognition of EU trained dentists.
    - Recognising requisite overseas qualifications for dentists and dental care professionals (DCPs).
    - Simplifying and speeding up the Performer List Validation by Experience (PLVE) process.
    - Allowing whole teams to initiate treatments.
    - Reforming the 'broken' UDA contract model.

19. Whilst small progress has been made on some measures, political, professional, and public confidence in the UDA system has been shattered. Without significant reform, public and professional trust in the system will not recover. **The Government and NHSE must look at a new dental contract.**

20. The last decade was a lost one for NHS dentistry. Despite numerous replacement dental contract prototypes trialled since 2010, providers feel let down by the abrupt ending of the process with little apparent regard for any learnings and how they may inform any future contract review. **The Committee should press the Government and NHSE on what lessons were drawn from these pilots and why these were not carried forward.**

21. For the remainder of this Parliament, the Government and NHSE must make the existing system work as well as possible, including the following steps.

22. Firstly, **raising the minimum UDA rate from £23 to at least £30 using the underspend in the dental system.**[12] Workforce pressures mean that dentists and DCPs are seeking higher rates from providers to reflect the high-quality NHS care they wish to deliver. We cannot meet these requests under the current minimum UDA rate whilst remaining commercially viable.

[11] The Association of Dental Groups (ADG) – 'Our "Six to Fix" England's Dental Deserts' briefing note, January 2023
[12] Clawback is applied by the NHS where a practice is not able to deliver a certain percentage of their contracted Units of Dental Activity (UDAs) and Units of Orthodontics Activity (UOAs). The funding is returned to the NHS and is not reallocated foe dentistry.

23. In Point 39, we show that a £23 minimum UDA value affects only 2% of NHS dental contracts held by the seven Integrated Care Boards (ICBs) already responsible for commissioning dental services. A more realistic minimum UDA of £30 would help providers attract more dentists by offering appropriate rates of compensation for delivering NHS care. It would also help address the often-absurd local variations in UDA rates.[13]

24. Secondly, at the end of the spending year, the NHS applies funding clawback to providers not able to deliver a certain threshold of their contracted UDAs. The funding is returned to the NHS and not guaranteed reallocation for delivering dental services. This means there is an underspend in the system. In 2017/18, the NHS collected £84.7 million from providers of NHS high street dentistry in the UK unable to deliver contracted obligations.[14] **Any funding returned to commissioners should be ringfenced for delivering NHS dentistry.**

25. Many dental practices are unfairly penalised for failing to meet contractual obligations because the current contract and UDA rates do not support recruitment. We are engaging with NHSE at present to rebase contracts in many parts of England to more attainable levels of service to maintain access to NHS dentistry. Unfortunately, our discussions with NHSE are not always facilitated by productive conduct. We have found Local Area Teams (LATs) have a narrow appetite for change and our efforts have had only limited success. In many cases, the only alternative is to hand back contracts.

26. Point 34 details how decisions by NHSE Midlands LAT could negatively affect patient access to NHS dentistry. **Devolution of commissioning will be meaningless without a shift in attitudes and approach through proper accountability and representation for dentistry within ICSs. In addition, commissioning teams must produce and publish impact assessments on patient access to NHS dentistry with each decision.**

27. Thirdly, **the PLVE process, which all dentists not qualifying in the UK must go through to practice in the NHS, needs standardising, simplifying, and streamlining.** Dentists and DCPs are already required to register with the regulator, the GDC, to practice. The extra layer of bureaucracy to gain a performer number creates a disincentive for dentists to practice in the NHS by not requiring one to practice privately. Reforming the PLVE process would level the playing field between the two arms of the dental sector. The Government is reviewing the performer list regulations. It should provide a set timeline for dentists to receive their performer list number through a centralised approvals system with a dedicated support scheme for mentors and mentees going through the process.

28. Fourthly, **the GDC must improve its collection of workforce data. This would aid in planning and projecting demands for all dental professions by ensuring the records exist to produce comprehensive oral health workforce needs assessments.** Ministers should require the GDC to ensure that records are regularly updated as part of the registrant annual renewal process, including listing the numbers of dentists and DCPs actually practising, both full and part-time. They do not presently collect this information.

29. Fifthly, **each ICB should undertake an annual oral health census of their population to pinpoint the geographies with the highest oral health needs.** This would remedy a shortcoming of the UDA system where NHS treatment rates offered to dentists are based on outdated information collected in 2005. By identifying the oral health needs of different communities, ICBs will be able

[13] Bupa has two dental practices in Worcester, only a twenty-minute walk apart. Bupa Dental Care Worcester City has a UDA rate of £23.47. Bupa Dental Care Worcester St Johns has a UDA rate of £27.20.
[14] Source: analysis from Mansfield Advisers. Figures used in LaingBuisson 'Dentistry: UK Market Report', Sixth Edition, November 2022.

to offer UDA rates to dental practices that reflect their patient base. This must be done alongside setting a realistic minimum UDA rate.

30. Finally, **the Government's forthcoming NHS workforce plan can set specific, achievable targets for the recruitment of overseas dentists and DCPs.**

31. In his recent report, the Prime Minister's health adviser, Bill Morgan, identified overseas recruitment as one of three top-level solutions integral to solving wider NHS workforce issues.[15] The need is acute in dentistry, where it takes six years to train a dentist. **Overseas dental professionals are key to addressing the workforce pressures and ensuring access to NHS dentistry.**

32. These targets would be supported by streamlining the GDC processes for accepting individuals onto the register. This would be achieved by the UK striking more mutual recognition agreements for dental qualifications with countries of comparable standards and creating more places for the Overseas Registration Exam (ORE). Additionally, the GDC's current 'mutual recognition' of EEA-qualified dentists is vital in boosting short-term applicant supply. If removed, this would only increase pressures on the already depleted UK talent pool.

What role should ICSs play in improving dental services in their local area?

33. Bupa welcomes transferring commissioning of oral health services to ICSs. For ICSs to succeed in improving oral health outcomes, proper representation and accountability for dentistry must be embedded within them. The LAT model had regional teams responsible for huge geographies leading to commissioning decisions divorced from the reality on the ground.

34. In 2022, we made suggestions for constructive adjustments to several NHS contracts held by Bupa to the Midlands LAT. We believed these would increase access to NHS dentistry locally. The LAT then decided to tender for additional services in the locality of one contract held by our practice, as opposed to applying our suggested changes to all existing contracts in the area. The outcome will likely be a reduction in access to NHS dentistry locally and significant disruption to two valued local practices with large NHS patient bases.

35. ICSs inherit considerable difficulties in delivering good oral health. In December 2022, there were seven ICBs responsible for delivering dental services (Buckinghamshire, Oxfordshire & Berkshire (BOB), Frimley, Hampshire & Isle of Wight, Kent & Medway, Surrey, Sussex, and Greater Manchester). Most of these have large rural and/or coastal populations, the types of areas the Local Government Association identified as most likely to struggle in accessing dental services.[16] These seven accounted for over one in five of the UDAs delivered in England in 2021/22 and represent a significant sample of the NHS dental treatment distributed to the wider population.[17]

36. ICSs face a challenge in fully deploying all NHS dental treatment capacity in their areas. According to an FOI request from Bupa to NHSE in December 2022, there were over half a million (528,724) unallocated UDAs across six of these ICSs. Almost one in ten (8.8%) of UDAs in one ICS, NHS Hampshire & Isle of Wight, were unallocated.[18] These figures underestimate the

[15] Bill Morgan for The King's Fund and Engage Britain – '*NHS staffing shortages: Why do politicians struggle to give the NHS the staff it needs?*', 24 November 2022.
[16] LGA – 'NHS "dental deserts" persist in rural and deprived communities – LGA analysis', 1 October 2022.
[17] Source: NHS Digital, NHS Dental Statistics for England, 2021-22, Annual Report, 25 August 2022. Around 16.7 million UDAs were delivered in England in 2021/22, according to the NHS's figures.
[18] Source: Freedom of Information request to NHS England by Bupa Global & UK, December 2022.

actual level of unallocated UDAs because the FOI only covers dental contracts returned to the local NHS by providers.

37. A key issue is ending disparities in the NHS dental contract treatment rates within ICS areas. Our FOI request revealed the following differences between the highest and lowest indicative UDA values for every dental contract held by the seven ICBs responsible for commissioning dental services in December 2022:[19]

    - NHS Greater Manchester - £39.80
    - NHS Surrey Heartlands - £21.04
    - NHS Sussex - £19.95
    - NHS Frimley - £15.48
    - NHS Hampshire & Isle of Wight - £13.84
    - NHS Kent & Medway - £13.58
    - NHS Buckinghamshire, Oxfordshire & Berkshire (BOB) - £12.43

38. The mean difference between the lowest and highest indicative UDA rates across all seven ICBs was £19.47, highlighting the problem in ending geographic disparities in the rates offered to NHS dentists for performing treatments. Our highest staffing costs as a dental provider often arise where some of the lowest NHS treatment rates are, including the South of England and the Home Counties especially. Here we have to pay higher salaries to attract essential practice staff, including practice managers, dental nurses, and receptionists.

39. **The current minimum UDA value of £23 is not effective. Only 29 of almost 1,400 NHS dental contracts held by the seven ICBs (2%) benefitted from its introduction. Setting a minimum UDA value of £30 would affect nearly two-thirds (62%) of this NHS dental contracts sample. This should allow providers to offer more competitive rates to attract staff to practices most in need.**

Does the NHS dental contract need further reform?

40. Yes, but despite widespread consensus about reforming the NHS dental contract, there is little agreement over direction. The reforms being pursued may not restore patient trust in seeking dental care. Without a system patients trust; we will not address the poor state of our national oral health.

41. **Implementing a new dental contract must be a priority. Building on the pilots undertaken over the last decade, a new system could be in-place by 2028, allowing time to assess if reforms to the UDA system are effective.**

42. Any new system must put access to oral health care based on patient need at its centre using the following components:

    - **Acknowledging that the dentistry system in England is 'mixed', dependent on NHS and private dentistry working together.**

The total of unallocated UDAs in each ICB area is made up of terminated contracts and contracts being recommissioned, but not yet mobilised. NHSE says: *'Greater Manchester does not have any unallocated UDAs but does have some finances following temporary rebasing of contracts during 2022/23. Arrangements are being made to offer local dental practices additional non-recurrent funding to provide non-recurrent activity during 2022/23 to new patients at those practices.'*

[19] Source: NHSE UK FOI request by Bupa. Rates included of only mandatory dental service contracts and rounded to two decimal points; community dental services, sedation and tier 2 oral surgery & complex restorative referral services have been excluded as they are atypical. Figures given are the difference between the highest indicative UDA value of every NHS dental contract held by the ICB and the lowest.

- **Enabling patients to seek private treatment, where appropriate, to free up NHS resources for those most in need.**
- **Inserting a right to 'accessing quality dental care at the point of need' into the NHS Constitution for England.**

What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?

43. As one of the UK's largest dental providers, the biggest challenge Bupa faces is the shortage of qualified dentists and DCPs. As of December 2022, there were over 600 vacancies for all roles across our practices in England, with 30% open for more than 6 months.[20]

44. We are taking several steps to support recruitment and retention among our practice staff, including:
    - Bringing forward and vastly increasing our pay review for salaried staff.
    - Increasing referral bonuses to encourage recommendations for all roles.
    - Expanding overseas and EEA-based graduate recruitment, doubling our 2022 intake.
    - Establishing links and working relationships with UK dental schools to increase awareness within early careers and to develop a higher intake of Foundation Year Dentists, along with increasing our internal recruitment for mentors to facilitate training opportunities.

45. **The NHS must work closely with providers to learn from and share examples of best practice for recruiting and retaining dental professionals. Training is an integral aspect and specific incentives must be developed by the NHS to encourage dental practitioners to train and mentor new entrants into their professions. The burden cannot fall on providers alone.**

Jan 2023

[20] Source: Bupa Dental Care, December 2022.