Written evidence submitted by the Department of health and Social Care (DTY0099)

This evidence has been submitted by the Department of Health and Social Care (DHSC) and includes contributions regarding NHS dentistry from NHS England (NHSE) and Health Education England (HEE). The submission is divided into the five themes set out in the Committee's Call for Evidence. In summary, the evidence sets out the arrangements for commissioning NHS care in England, as well as some of the current challenges. It details improvements made by DHSC and NHSE to the NHS dental contract and the wider dental system in 2022. It provides information on the upcoming phase of reform due to be announced in 2023, which NHSE has been leading and is currently engaging with sector stakeholders on. It explores recent and upcoming training and education improvements led by HEE, through its Dental Education Reform Programme (DERP).

Context

The NHS invests ~£3.7bn annually in dental services, of which the majority (£2.7bn) is spent in primary care. As at June 2019, 22 million adults (50% of the adult population) had seen an NHS dentist in the preceding 24 months and 7 million children (59% of the population). In contrast to General Practice people are not registered with a dentist, and there are no geographical restrictions on access meaning that people can access services convenient to their home or work.

The majority of dentists provide routine primary dental care services, delivering care from independently owned practices frequently located on high streets. Most of these local practices hold NHS contracts of varying volume and value, with the commitment to provide NHS commissioned primary dental care services through General Dental Services (GDS) or Personal Dental Services (PDS) contracts. Very few practices are wholly NHS with most practices offering patients the option for private and cosmetic care from the same premises. This is known as a "mixed practice". It is estimated that circa 10% of dental practices registered with CQC are entirely private. A smaller number of dentists deliver NHS services, under a salaried model, employed by an NHS Trust, a hospital or community provider to deliver specialist dental services, often as part of a multi-disciplinary care plan, meeting the more complex needs of vulnerable groups and or medically compromised patients.

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

Dental access was significantly challenged during the pandemic due to the aerosol generating nature of many dental procedures. With the exception of designated urgent dental care providers, NHS dental services were initially suspended for nine weeks and then were gradually reopened in line with changes to infection prevention and control (IPC) guidance. During this period there was a strong focus on the safe provision of urgent care and ensuring that care was focused on the most vulnerable, with NHS England stepping up over 700 Urgent Dental Centres. From July 2022, dental practices have been expected to deliver commissioned activity to usual contract tolerances (96-102% of annual contract value). In 2020-21 the government and NHS England provided over £1.7bn in income protection to ensure NHS dental practices were sustainable and could continue to provide ongoing patient care as well as other support through the provision of funded Personal Protective Equipment.

We have estimated that due to the necessary constraints on practice arising from IPC there was a loss of ~10.8 million interventions in 2020/21 alone. Given the scale of lost appointments and a

potential backlog in care, NHS England and government have been focused on actions to improve access. As NHS contract holding practices re-opened and routine dental service provision could re-commence, actions were focused upon setting activity requirements for income protection and ensuring there is appropriate prioritisation for patients most in need e.g. patients with an urgent problem and those with higher dental needs. This was supplemented in January 2022 by government and NHS England making available additional funding of £50m to secure additional NHS dental capacity to the end of March 2022. Despite the short timescale for implementation and against a backdrop of a wave of Covid-19 due to the Omicron variant, the NHS was able to secure an additional 20,748 sessions from 731 high street dental providers and 591 sessions from 32 Community Dental Services providers, utilising 30% of the available funding. These sessions resulted in an additional 64,456 people receiving care, 67% of which were for urgent care. Patients seen in these additional sessions were more likely to be exempt from patient charges than those seen in usual care sessions in the same time period.

In addition to this, NHS England offered to fund additional activity from dental contractors who were able to deliver up to 110% of their annual contract value on a fully funded basis.

Despite these actions, we are aware that accessing care remains challenging for many patients and that there are geographical variations in access. The most recent survey, from 2022, shows that the success rate for securing an NHS dental appointment has dropped to 75%. For this reason, addressing access challenges was a key focus for the first phase of dental contract reform in 2021/22.

Dental System Reform 2021-2022

In March 2021 government commissioned NHS England to take the lead on dental system reform and published six aims to frame and focus the programme[1]:

- Be designed with and enjoy the support of the profession;
- Improve oral health outcomes (or where sufficient data are not yet available, credibly be on track to do so);
- Increase incentives to undertake preventative dentistry, prioritise evidence-based care for patients with the most clinical needs and reduce incentives to deliver care that is of low clinical value;
- Improve patient access to NHS care, with a specific focus on addressing inequalities, particularly deprivation and ethnicity;
- Demonstrate that patients are not having to pay privately for dental care that was previously commissioned NHS dental care; and
- Be affordable within NHS resources made available by government, including taking account of dental charge income.

Since then, NHSE and DHSC have been working closely with the sector, including the British Dental Association, to develop a package of improvements to reform the wider dental system. The first phase of improvements was announced in July 2022[2]. These changes are focused upon improving

[1] https://www.england.nhs.uk/coronavirus/documents/nhs-dental-contract-reform-and-arrangements-letter/
[2] https://www.england.nhs.uk/publication/first-stage-of-dental-reform/

access, supporting higher needs patients and making best use of available resources. Specific changes included:

- Ensuring dentists are more fairly remunerated for treating patients who require filling or extraction of three or more teeth and/or root canal treatment.
- A renewed focus on reducing low value care through supporting clinicians to adhere more closely to the National Institute for Health and Care Excellence guidance on recall intervals, which indicate that a healthy patient with good oral health and low risk factors need only see a dentist up to every 2 years and a child every 1 year. Widespread implementation of personalised recall intervals based on clinical risk should provide the resources to deliver additional care required by higher needs patients. This requires some culture change in dental practice, alongside system reform, with patient and public facing communication materials planned.
- Clarification that dental care professionals, including dental therapists and dental hygienists, are able to provide NHS care through direct access as described in recent guidance published by NHS England[3]. Previously this freedom has only been used in the private sector (since 2013). We have worked with NHS Business Services Authority to remove any administrative barriers to more effective use of this skill mix in practices providing NHS care. We anticipate that this will help improve NHS access, support dental care professionals to feel more valued in their role thereby addressing attrition to the private sector and, over time, will enable dentists to focus on more complex care. This has been positively received by many NHS dental teams who see the potential to help revolutionise how they work, with benefits including being able to do more check-ups for children.
- Steps to ensure that those practices who wish to provide more NHS dental care than they are currently contracted for are supported to do so. To incentivise this, we have enabled, subject to commissioner agreement, practices to deliver up to 110% contracted activity.
- Steps to ensure that, where contractors are persistently underdelivering their contracted activity, commissioners can reduce the value of the contract to a deliverable level. This will release resources to be reinvested in contractors who are able to provide this work for the benefit of NHS patients.
- Requiring contractors to maintain and update their details on NHS.uk to support patients to find a dentist who can deliver care.
- Establishing a minimum UDA value of £23, to support recruitment and retention

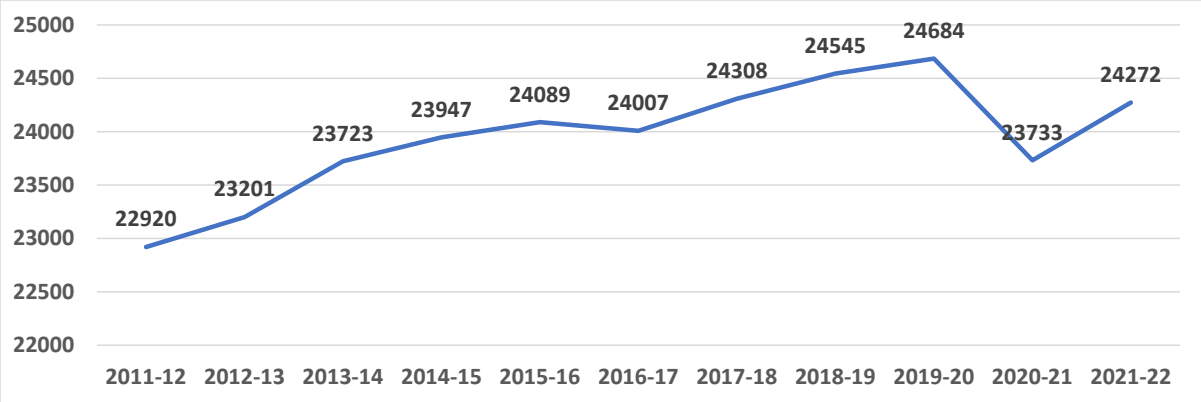
Improving access through recruitment and training

In 2021-22, 24,272 dentists performed NHS activity (an increase of 539 on the previous year, but a reduction on pre-pandemic numbers) under NHS GDS, Mixed, PDS and TDS[4] contracts in primary care. This equates to 72% of all registrants, however it should be noted that these numbers do not necessarily reflect whole time equivalents.

Figure 1: Growth in the number of dentists providing NHS contracted primary care services, 2011-12 to 2021-22

[3] https://www.england.nhs.uk/long-read/building-dental-teams-supporting-the-use-of-skill-mix-in-nhs-general-dental-practice-long-guidance/

[4] GDS = General Dental Services, PDS = Personal Dental Services, TDS= Trust-led Dental Services



Source: NHS Digital

Figure 1 shows that the number of dentists providing NHS contracted primary care services grew by 0.9% per year between 2014 and 2020. Numbers fell sharply by 4% in 2020-21 following the pandemic, before rebounding by 2% in 2021-22. Over 2012 to 2022, numbers grew by 0.6% per year. The implication therefore is that over the period, numbers of dentists providing NHS contracted services in primary care has grown.

Within NHS trusts in England, NHS Digital[5] reported that there were 2,704 dentists plus 3,689 dental care professionals (DCPs) in qualified occupation codes, plus an additional 495 in support occupation codes in the NHS. Electronic Staff Records highlight that, overall, the number of dentists grew by 6% per year between 2014 and 2020. Numbers have since grown more slowly, at 0.6% in 2020-21 and 1.4% 2021-22. Over the whole 2014-22 period, numbers grew by 4.3% per year. When looking at either registrants, contracted or employed staff, the general theme is that numbers in dentistry have increased – albeit at smaller levels compared to other professions on respective registers. Although numbers of dentists have grown by over 4% a year in secondary care, secondary care is very much the minority employer, only employing about 5% of registrants.

As this data demonstrates, most dentists are contracted to provide NHS services but are not directly employed by the NHS. This leads to variation in individual terms and conditions.

Recruitment and retention of dental professionals within the NHS therefore requires multifactorial solutions. In part this is related to contract reform, but also the need for increasing flexibility in future careers from the younger members of the profession particularly wanting options to work part-time or to engage in 'step on, step off' training and development models[6].

Evidence from trainee surveys tells us that more flexible training options would be preferred by many dental specialty trainees, to give them a better work-life balance or to enable them to better

[5] NHS Digital Dental Statistics for England *2021-22*; accessed online at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2021-22-annual-report

[6] Bullock, A, Bartlett S, Cowpe J, Dickenson AJ. The Dental Core Training Experience: the views of trainees and their postgraduate training leads. British Dental Journal 2020; 228: 952-956

manage other commitments. Flexible options for qualified dentists and dental care professionals to increase their knowledge and skills are likely to foster greater professional satisfaction and meet demands for new capabilities and competence, including leadership, management and research. HEE is committed to encouraging the widening of access to all its commissioned training programmes, including specialty training. We are continuing to work with our specialty training providers to ensure that any in-programme, barriers to training are not an obstacle to this commitment. Part-time/ less than full time training posts pilots are currently being undertaken and webinars are being planned to increase awareness of flexible training options.

Additionally, HEE recognises that better use of the skill mix of the dental workforce and multi-disciplinary team working are essential in enabling better matching of patients' needs to practitioners with the appropriate level of qualification and allowing dental care professionals to work to their full Scope of Practice. The Advancing Dental Care Review found that pilots of upskilling or Return to Practice programmes were essential in improving the confidence of DCPs and enabling them to understand and fulfil their role in multi-professional teams when the opportunity arises. The potential for dentists – particularly in primary care – to share workload with DCPs in line with their Scope of Practice and experience is greatly under-utilised. This could potentially open opportunities for securing an adaptive workforce, particularly in rural and coastal areas, where dental access is a challenge.

An important element of the Dental Education Reform Programme (DERP) is to widen access and participation into dental careers to support the growth of a local dental and oral health workforce. There are merits to focusing on the undergraduate route to identify and promote successful initiatives which widen access and participation into dental careers and consider how HEE's regional workforce intelligence and data can inform student recruitment strategies. Widening access into the oral health professions will both help to meet new population demands and be desirable in its own right to help increase social mobility and create a more diverse and inclusive workforce. Other widening access and participation evidence shows a correlation between widening access and participation initiatives encouraging students to train and remain in the geographical area where they grew up[7] [8] [9].

Overall, the DERP is focused on improving the dental education and training linear and inflexible infrastructure, which has been inhibiting the development of multi-disciplinary and multi-professional teams and the upskilling of the workforce post-registration. HEE also aims for these reforms to better fit the lifestyle preferences and needs of today's trainees or workforce, which currently threaten long-term retention in the NHS. Another element that needs to be considered is the opportunity to review the distribution of training posts towards the areas of highest oral health need to mitigate existing NHS workforce recruitment and retention problems.

ICSs and Recruitment & Training

[7] https://www.centreforcities.org/reader/great-british-brain-drain/executive-summary/
[8] Kumwenda, B., Cleland, J.A., Prescott, G.J. et al. Geographical mobility of UK trainee doctors, from family home to first job: a national cohort study. BMC Med Educ 18, 314 (2018) doi:10.1186/s12909-018-1414-9
[9] South Central NHS, Migration Patterns of the Recently Trained Medical Workforce, March 2010

The NHS Long Term Plan actively supports the integration of oral health into care pathways and has set a clear direction for national and local level recognition, calling for the adoption of a more holistic approach to 'good oral health' provision. Furthermore, the Interim People Plan highlights distinct benefits to be realised from integrating dental services into ICSs, particularly as oral health is increasingly recognised to be an indicator for overall health.
ICSs will play a key role in providing a sustainable primary care workforce in the long term. However, these bodies are currently in varying stages of maturity. HEEs work to implement a four-year dental education reform programme will need to work closely with HEE and NHSE regional offices to ensure the inclusion of dental training within ICS workforce plans and ensure the development of place-based approaches to commissioning dental education and training strengthen local dental workforce planning. It is imperative that the design and delivery of future postgraduate dental training models align with the ICS architecture.

Ahead of the transition to ICSs, NHS England Regional Commissioning teams have been exploring innovative solutions to recruitment, in particular: 'golden hello' schemes, support for overseas qualified dentists to access the Performers List and other support where contractors are struggling to recruit.

Does the NHS dental contract need further reform?
The 2006 General Dental Services contract is widely acknowledged as unpopular with the profession and particular concern has been expressed regarding the current activity-based payment model. Following publication of the 2008 Health Select Committee report, government commissioned an independent review of dental services led by Professor Steele and instituted a prototype programme which tested alternative payment models, including capitation. This programme, testing different blends of capitation alongside the usual payment system, came to an end in March 2022 following an evaluation[10] which suggested that the payment model tested was unsuitable for widespread adoption as it had led to reductions in the numbers of patients receiving NHS care, compared to practices not operating to the prototype model.

<u>Further reforms in 2023</u>
The department continues to work with NHSE and the dental sector on further improvements. To support this NHS England has recently undertaken a further round of key stakeholder engagement events supplemented with focus groups with frontline dental staff and their teams on reform of urgent care services, further reform of payment arrangements, addressing the incentivisation of preventative care and issues relating to workforce recruitment and retention. Incentivising care for patients with high needs and reducing inequalities will continue to be a focus. We are continuing to work with stakeholders to understand the issues and concerns around payment reform and will announce a next phase of improvements in 2023.

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

[10] https://www.gov.uk/government/publications/dental-contract-reform-evaluating-the-results-of-the-prototype-scheme

On 1st July 2022, following the commencement of the Health and Care Act 2022, a small number of Integrated Care Boards (ICBs) assumed the commissioning functions for primary care medical services, and some pharmacy, dental and optometry services in the South East region and Greater Manchester.

NHS England intends to delegate the remainder of dental services by April 2023 and will support ICBs as they take on commissioning responsibility across dentistry services from April 2023. NHS England will work with ICBs and provide tools and resources to support transformation, commissioning and effective contract management to ensure best use of NHS resources.

ICBs are expected to work with NHS England through their joint commissioning arrangements to develop delivery plans which identify 3 to 5 key priority pathways for transformation, where integrated commissioning can support the triple aim of improving quality of care, reducing inequalities across communities and delivering best value.

The Health and Care Act 2022 sets out the minimum membership of the Integrated Care Board and they are required to include representatives from NHS Trusts, Primary Care and Local Authorities. ICBs will be responsible for having local processes in place to involve patient groups, and for undertaking oral health needs assessments, to identify areas of need and determine the priorities for investment. The integrated care partnership is advised to map out the different types of providers and practitioners who should be engaged in the development of their initial strategy and then who will be involved in the further development and refresh of the strategy. Additionally, they will need to ensure they have appropriate clinical advice when making decisions. The inclusion of dentists and other dental care professionals into all integrated care structures in local areas, including boards and Partnerships, is welcomed.

Integrated Care Boards will need to ensure they have appropriate clinical advice when making decisions and the inclusion and involvement of dentists and other dental care professionals in Integrated Care Systems will be critical.

How should inequalities in accessing NHS dental services be addressed?

Inequalities in access are influenced by a number of factors including supply of care and workforce, demand for care and environmental factors such as water fluoridation. Tackling these will therefore require a multifactorial approach and partnership between government, NHS England, ICBs, local authorities and patient groups such as Healthwatch to address misconceptions and take a population health management approach to the assessment of oral health and access to services.

On the supply side, there are major variations in the average number of dentists per head of population[11] across England and the amount of dental care commissioned and delivered[12]. Despite growth in the overall number of registered dentists in England, and growth in the headcount of unique performers of NHS-commissioned activity, NHS BSA data[13], shows that there has been a widening in the gap between the care commissioned by the NHS (contracted activity in the table

[11] This data takes account of appointments across all specialities across the whole population

[12] https://www.nao.org.uk/reports/dentistry-in-england/

[13] Access to NHS dental services were greatly restricted from March 25 2020 as a result of the Covid-19 pandemic. As these restrictions affected only five working days of the 2019/20 financial year, we are using 2019/20 as the last year for which dental activity data are valid.

below) and that delivered by NHS dental contractors (UDA gap in the table below). Data for 2020/21 and 2021/22 should be interpreted with caution due to the pandemic as described above. NHS England is working closely with regional teams and under-performing practices through the mid-year review process (which is triggered by a practice failing to deliver 30% of their annual contracted activity) to gain a greater understanding of the reasons for under-delivery. Ensuring that the NHS care which has been funded is actually delivered is a key priority and NHS England and government have already taken action through the 2022 contract changes to start to address this.

Figure 2: Growth in UDAs, gap and capacity provided, 2014/15 to 2021/22

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Contracted Activity	88,352,954	88,123,115	87,602,395	87,083,338	86,761,348	86,873,722	86,581,782	86,659,484
Delivered Activity	84,740,275	83,972,419	83,467,640	81,118,827	81,024,432	77,775,487	23,665,105	56,032,727
UDA Gap	3,612,679	4,150,696	4,134,755	5,964,511	5,736,916	9,098,235	62,916,677	30,626,757
UDA Gap expressed as FTE dental staff	**602**	**692**	**689**	**994**	**956**	**1,516**	**10,486**	**5,104**
% Gap	**4%**	**5%**	**5%**	**7%**	**7%**	**10%**	**73%**	**35%**

Source: NHS BSA

HEE Dental Deans actively engage with service commissioners to encourage dental practices to provide Dental Foundation Training (DFT) places in areas with limited service provision. The recent clarification around the use of Dental Care Professionals to provide NHS care will also create additional staffing options for contractors struggling to recruit dentists.

The distribution of the NHS dental workforce is not aligned to the oral health and dental care needs of the local population which can compound oral health inequalities. To aid the alignment of the future dental workforce to areas with the highest levels of oral health and dental care need, dental training posts should be distributed based on population health and other performance data, both by specialty and geography. To address this, HEE is undertaking scoping work to identify the dataset required to establish a contemporary workforce data collection model.

On the demand side, we know that oral health varies between geographical areas and that expressed demand is not equivalent to actual need since some people do not have access to care or treatment. On top of this there is an equity issue, where more disadvantaged groups who are more likely to have problems with their teeth may find obtaining an appointment more difficult.

There is a national adult oral health survey being carried out at present and results are expected by early 2024. It should be noted that as part of the National Dental Epidemiology Programme for England, Public Health England did however recently undertake large and statistically robust surveys of childhood populations, including of three-year olds (2020)[14] and five-year olds (2019)[15]. Outcomes

[14] Public Health England (2021), Oral Health Survey of three-year-old children 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/987172/NDEP_for_England_OH_survey_3Yr_2020_Results.xlsx

from this data suggest that there exist significant inequalities in the levels of experience of dental decay amongst children in different parts of the country and in different life circumstances. Frequent exposure to free sugars such as those present in sugary food and drink is a key reason why decay in young children occurs – combined with not brushing their teeth with fluoride toothpaste. Levels of experience of untreated tooth decay suggest that there may a substantial number of young children who have not attended or received care at either NHS or private dental services. Evidence based public health interventions will be critical to help address preventable decay.

Recent Healthwatch reports have also highlighted that concern around the level of co-payments may act as a barrier to people accessing care even where supply is available. All individuals accessing NHS services should be provided with a written breakdown of their treatment plan and any associated co-payment to help provide clarity.

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

As set out above, from 2020-21 to 2021-22 the total number of dentists actively delivering NHS services increased from 23,733 to 24,272 (2.3% increase).

Dentist Pay

A 4.5% pay uplift was awarded to dentists in 2022/23 and backdated to 1 April 2022. Whilst each year we recommend that provider-performer dentists apply this to their associate dentists' salaries, as practices are private businesses it falls to them to set employee pay and conditions.

In 2020-21 providing-performer dentists had an average taxable income of £128,800, a large increase from £108,000 in 2019-20. Associate dentists also saw their average taxable income increase, by a smaller amount to £57,400 in 2020-21 compared to £56,900 in 2019-20.

International Dental Professionals

International dental professionals have always been a feature of the UK's dentistry workforce, ensuring that there is more capacity for dental treatment than UK graduates can provide alone. In 2021 39% of new dentists joining the register were from overseas. Registration data shows that the number of new registrants coming from the EEA has increased – 23% of applicants in 2019, 22% in 2020 and 29.5% in 2021.

As set out in our July 2022 package of improvements and Our Plan for Patients, we want to make it easier for people to work in and support the NHS. As part of this, we will review the current NHS systems that authorise dentists to work for the NHS and will be streamlining routes into NHS dentistry for those trained overseas so they can start treating patients more quickly.

As part of the ongoing reforms to healthcare professional regulation, we have identified and amended prescriptive detail which restricts the GDC from modernising its international registration processes. The department is working with the GDC to:

[15] Public Health England (2020), Oral Health Survey of five-year-old children 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/873493/NDEP_for_England_OH_Survey_5Yr_2019_Results.xlsx

- support flexibility for the GDC to ensure that international processes are proportionate and streamlined, whilst continuing to robustly protect patient safety;
- enable the GDC to increase the number of Overseas registration exam (ORE) seats it offers by charging a fee which covers the cost of the exam, explore alternative ORE providers, and make changes to the structure of exam and applicant information which will support an increased pass rate; and
- allow the GDC to explore alternative pathways to international registration, such as recognition of programmes of education delivered outside the UK, or registration based on recognition of the qualification held by an applicant, as it considers appropriate.

Current arrangements ensure that UK regulators continue to automatically recognise relevant European Economic Area (EEA) qualifications of healthcare professionals, including dentists. This enables qualified dentists from other EEA countries to continue to practise in the UK and we want to continue to facilitate their vital contribution to the dentistry workforce. EU Exit legislation places a duty on the Secretary of State to carry out a review of the operation of these provisions at the start of 2023. The system of automatic recognition will not terminate unless further legislation is made to bring the current system to an end.

Recruitment and retention of qualified dental professionals is currently difficult to assess as there is very limited workforce data. There is a real need for reliable contemporaneous dental workforce data collection to fully understand the composition of the existing NHS workforce and to be able to predict the workforce numbers needed in the future. This is particularly relevant currently as the effects of the Covid-19 pandemic on the delivery of dental care, may have implications for the retention and career intentions of the current NHS dental workforce.

NHS England also provides wider health and wellbeing support to dental contractors and their teams as detailed in the table below:

Offer	Description
Looking after You Too	Individual wellbeing and resilience coaching
Looking after Your Team	Coaching to support healthy team working
Looking after Your Career	Coaching to support career fulfilment
Looking after You Too (BAME)	Individual wellbeing and resilience coaching available to diverse ethnic colleagues across the NHS
Mental health and Wellbeing hubs	Clinical assessment and triage service
Practitioner Health	Clinical assessment and support including talking therapy, group support, addiction treatment and relapse prevention
Wellbeing Conversation Training	Access to online training session supporting line managers to hold wellbeing conversations

Jan 2023