House of Commons

Health and Social Care Committee

NHS dentistry

Ninth Report of Session 2022–23

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 11 July 2023

HC 964
Published on 14 July 2023
by authority of the House of Commons

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

Steve Brine MP (*Conservative, Winchester*) (Chair)

Lucy Allan MP (*Conservative, Telford*)

Paul Blomfield MP (*Labour, Sheffield Central*)

Paul Bristow MP (*Conservative, Peterborough*)

Martyn Day MP (*Scottish National Party, Linlithgow and East Falkirk*)

Chris Green MP (*Conservative, Bolton West*)

Mrs Paulette Hamilton MP (*Labour, Birmingham, Erdington*)

Dr Caroline Johnson MP (*Conservative, Sleaford and North Hykeham*)

Rachael Maskell MP (*Labour (Co-op), York Central*)

James Morris MP (*Conservative, Halesowen and Rowley Regis*)

Taiwo Owatemi MP (*Labour, Coventry North West*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

Committee staff

The current staff of the Committee are Joanna Dodd (Clerk), Sandy Gill (Committee Operations Officer), Libby McEnhill (Senior Committee Specialist), James McQuade (Committee Operations Manager), Stephen Naulls (Clinical Fellow), Anne Peacock (Media and Communications Manager), Yohanna Sallberg (Second Clerk), Emma Stevenson (Committee Specialist), Katherine Woolf (Parliamentary Academic Fellow), and Catherine Wynn (Committee Specialist).

The Specialist Adviser for this inquiry was Janet Clarke MBE.

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

You can follow the Committee on Twitter @CommonsHealth

Contents

Summary

NHS dentistry is facing a crisis of access, resulting in a decline in oral health. The Government needs to undertake urgent and fundamental reform if people are to receive the dental and oral healthcare they need. It is frustrating to have to return to recommendations made by our predecessor Committee fifteen years ago that still haven't been implemented.

Rarely has an inquiry been more necessary. Throughout the course of this inquiry, as well as in our roles as constituency Members of Parliament, we have heard stories of people in pain and distress due to being unable to see an NHS dentist. This is totally unacceptable in the 21st Century.

We were encouraged and surprised to hear the Parliamentary Under-Secretary of State for Primary Care and Public Health, Neil O'Brien MP, say that the Government's ambition for NHS dentistry is: "We do want everyone who needs one to be able to access an NHS dentist - absolutely". We fully endorse this ambition. As a matter of urgency, the Government must set out how it intends to reform NHS dentistry services to deliver on this. We are concerned that any further delay will lead to more patients being unable to access dental check-ups and the routine or urgent dental care they need. More people, including children, are experiencing poor oral health, and this has a subsequent impact on their physical health and social wellbeing, and leads to dependency on expensive secondary care interventions, placing further pressures on secondary care.

The Government has begun to act. Some initial changes were made to the dental contract in July 2022, and we have had assurances of further "quite fundamental reform" by the Minister. A fundamentally reformed contract must be implemented at the earliest possible stage. This should represent a move away from the current system of Units of Dental Activity (UDAs), in favour of a weighted capitation-based system which provides financial incentives for seeing new patients and those with greater dental need, in turn prioritising prevention and person-centred care. Failure to do so risks more dentists stopping NHS work, or not starting it, and exacerbating the issues patients are experiencing accessing care.

Nevertheless, even with fundamental reform of the contract, we are concerned that this will be too little too late for those dentists who have already left the NHS. We are concerned that the Government and NHS England have not fully grasped the scale of the challenge for the workforce, and the need to urgently provide compelling incentives to attract new and existing dentists to undertake NHS work. Neither is there sufficient acknowledgment of the lack of accurate data about the dental workforce and the amount of NHS work they are undertaking, which is vital for assessing provision in short and long-term workforce planning.

Integrated Care Boards (ICBs), with their new responsibility to commission NHS dentistry, offer an opportunity to improve access locally, to better integrate services around patients and to address inequalities. Nevertheless, we are concerned that many ICBs do not have adequate resources, tools or expertise to address these issues and are restrained from undertaking more flexible commissioning under the current contract.

Whilst we recognise that they are still in their early stages, and that dentistry poses one of the greatest commissioning challenges for them, it would be disappointing if the opportunity to improve access to local services were not taken.

During the course of the inquiry, the Minister announced a forthcoming recovery plan for NHS dental services. The plan has yet to be published. We hope the plan has the scope to meet the Government's ambition and is accompanied by the necessary funding and swift implementation.

It is important not to forget the repercussions of not resolving this crisis. Being unable to see a dentist at regular intervals can have implications for wider oral, physical health, mental health and social wellbeing. It also places additional pressures on already stretched NHS general and urgent health services and resources. Without rapid and timely action, we are concerned about the future of NHS dental services and the patients who desperately need access to them.

1 Access

A crisis of access

1. The British Dental Association (BDA) argues that NHS dentistry is facing a "genuine crisis" of access, with many patients unable to see an NHS dentist, or forced to pay to see one privately if they can afford to do so.[1] Research undertaken by the BBC and BDA published in August 2022, showed that 90% of practices across the UK were not accepting new adult NHS patients.[2] Through the course of their investigation, they found that there are areas of the country, known as "dental deserts", where no practices are taking on new NHS patients, although access is a problem in almost every part of the country.

2. According to a recent YouGov survey of 2,104 people across the UK on 22 March 2023:[3]

- 1 in 5 Britons (22%) are currently not "registered" with a dentist[4]
  - of those who were not "registered" 37% said this was because they couldn't find an NHS dentist and
  - 23% said it was because they could not afford to pay for treatment
- 1 in 10 Britons (10%) admit to attempting their own dental work
  - of those who say they've performed DIY dentistry most (56%) did so within the last two years including 36% within the last year
  - 20% did so because they couldn't get a timely appointment, and
  - 18% said they did so because they couldn't get registered with a dentist
- 46% of Britons have seen a dentist in the last six months
  - this rises to 70% in the last two years
  - 27% have not been within the last two years, and
  - 8% admitted it's been more than a decade since they went to the dentist

3. We received written evidence from just under 30 Healthwatch groups across the country. Case studies provided by Healthwatch Lincolnshire exemplify the experiences of patients unable to access NHS dentistry represented in the evidence:[5]

> [Case study 1] I cannot get a dentist, I cannot afford private, I had to pull a problem tooth out myself with pliers.

1 British Dental Association (DTY0078)
2 Whilst our report is focussed on England only, the problems with access exist across the UK. See: BBC, Full extent of NHS dentistry shortage revealed by far-reaching BBC research, 8 August 2022, accessed on 21 June 2023
3 YouGov, One in ten Britons have performed dentistry on themselves, half in the last two years, 22 March 2023, accessed on 21 June 2023
4 Under the current system there is no such thing as being formally "registered" or "de-registered" with a dentist
5 Healthwatch Lincolnshire (DTY0077)

> [Case study 2] I moved to Lincolnshire in 2021 and have been unable to find an NHS dentist for myself and 2 children. We have to travel to Bedfordshire to see a dentist which is a 5hr round trip.
>
> [Case study 3] I have found it impossible to register myself or my children with an NHS dentist despite frequently trying numerous (more than 10) different practices repeatedly over the last 2.5 years including at a time I was pregnant. I have even found it difficult to find a private practice with space although have succeeded but in order to get an appointment I have to pay 3 months fees before being allowed to book the first appointment. This means my 4.5 year old son has not seen a dentist since he was a baby when we lived in a different city.

4. In June 2023, we held a roundtable with people with lived experience, campaigners and representatives from patient organisations.[6] We heard first-hand of patients extracting their own teeth at home, people forced to travel hours to appointments, a young person not able to get timely orthodontic treatment, individuals experiencing severe social isolation due to their worsening oral health and the toll this can take on their mental health and social wellbeing. This is totally unacceptable in the 21st century.

Inequalities of access

5. There is significant regional variation in access to NHS dental care. The Local Government Association highlights that people living with the highest levels of deprivation are more likely to miss out on NHS dental provision.[7] Analysis of data published by the then Public Health England (PHE) in 2021, examining oral health inequalities, shows that post-pandemic geographic inequalities have been widening.[8] PHE also stressed that the impacts of poor oral health disproportionally affect vulnerable and socially disadvantaged individuals and groups in society.

6. Those affected by unequal access to oral health include:

- people who are entitled to free treatment on the NHS, including children and young people, pregnant women, and those in receipt of low-income benefits;[9]
- people from ethnic minority backgrounds;[10]

6 See Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'

7 Local Government Association (DTY0047). See, also: Professor Jennifer Elizabeth Gallagher (DTY0097)

8 PHE, Inequalities in oral health in England: summary, 19 March 2021, accessed on 20 June 2023

9 See, for example: See Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'. See, also: Healthwatch East Riding of Yorkshire (DTY0015); Healthwatch Liverpool (DTY0027); Healthwatch Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex (DTY0048); Healthwatch Hull (DTY0051); Healthwatch Sheffield (DTY0053); Healthwatch Norfolk (DTY0055); Healthwatch York (DTY0060); Healthwatch Isle of Wight (DTY0067); Healthwatch Richmond (DTY0068); Healthwatch Bolton (DTY0072); Healthwatch Lincolnshire (DTY0077); Toothless in England (DTY0079); Healthwatch Kent and Healthwatch Medway (DTY0088); National Network of Parent Carer Forums (DTY0092); Healthwatch England (DTY0094)

10 See, for example: Oral Health Foundation (DTY0065). See, also: The Care Quality Commission (DTY0083); General Dental Council (DTY0091); Healthwatch England (DTY0094)

- people with additional or complex needs including those with SEND and autism;[11]
- people from vulnerable groups including refugees and asylum seekers;[12] and
- people who are homeless.[13]

7. Government statistics from the 2021 Adult Oral Health Survey highlight people from the most deprived areas (57%) are less likely to contact their dentist when they need treatment compared with those from the least deprived (78%).[14] Similarly, the statistics also show that more people in deprived neighbourhoods have pain (41%) or broken or decayed teeth (40%) compared with those living in the least deprived neighbourhoods (25% and 30% respectively) .

8. A 2021 poll from Healthwatch England found that of those respondents from lower socio-economic backgrounds, fewer ethnic minority people (26%) than white people (41%) said they were planning to go to a dentist for regular check-ups, post-pandemic. Healthwatch England also report that ethnic minority people from lower socio-economic backgrounds were also twice as likely to avoid dental treatment because of costs, compared to white people from lower socio-economic backgrounds.[15]

9. A theme from the written evidence is the additional impact the increasing cost of living has had on people's ability to pay either NHS or private dental charges.[16] In their January 2023 report into the impact of rising cost of living on people's access to appointments and prescriptions, Healthwatch England expresses concern that this may disincentivise people further from seeking treatment, particularly those on low incomes, and subsequently lead to poorer oral health outcomes.[17]

10. More recently, in their March 2023 report, the Care Quality Commission (CQC) found that, when they looked at 50 care homes between April and June 2022, 25% of the providers reported that their service users could 'never' access NHS dental care, compared to 6% in 2019.[18] Similarly, those providers reporting that they could 'always or mostly always' access NHS dental care dropped to 35% in 2022 from 67% in 2019. These findings

11 See, for example: The Challenging Behaviour Foundation (DTY0064). See, also: See Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'; Healthwatch Norfolk (DTY0055); Oral Health Foundation (DTY0065); National Network of Parent Carer Forums (DTY0092); Healthwatch England (DTY0094)

12 See, for example: Cambridge Refugee Resettlement Campaign (DTY0100). See, also: Healthwatch Liverpool (DTY0027); Healthwatch Worcestershire (DTY0037); Healthwatch York (DTY0060); Healthwatch England (DTY0094)

13 See, for example: Healthwatch Liverpool (DTY0027). See, also: Healthwatch Cambridgeshire and Peterborough (DTY0032); Healthwatch Worcestershire (DTY0037); Toothless in England (DTY0079); NHS Confederation (DTY0087); Healthwatch Kent and Healthwatch Medway (DTY0088)

14 OHID, The impact of COVID-19 on access to dental care: a report from the 2021 Adult Oral Health Survey, 21 December 2022, accessed on 20 June 2023

15 Healthwatch England (DTY0094)

16 See, for example: Healthwatch England (DTY0094). See, also: Mr Vijay Sudra (DTY0014); Healthwatch Liverpool (DTY0027); Healthwatch Southend (DTY0039); West Yorkshire Joint Health Scrutiny Committee (DTY0045); Healthwatch Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex (DTY0048); Healthwatch Kent and Healthwatch Medway (DTY0088); Healthwatch Bristol, North Somerset and South Gloucestershire (DTY0095)

17 Healthwatch England, Health and the cost of living, 9 January 2023

18 Care Quality Commission, Smiling Matters: oral health in care homes, 20 March 2023

are of additional concern, given the additional treatment needs of many older people and the complexity of providing such care. For example, in the elderly, poor oral health can lead to malnutrition.

The ambition for access

11. We were pleased to hear the Parliamentary Under-Secretary of State for Primary Care and Public Health, Neil O'Brien MP, describe the Government's ambition for NHS dentistry as follows: "We do want everyone who needs one to be able to access an NHS dentist—absolutely."[19] Furthermore, the Minister set out that he wishes to reduce variation and improve access where it is particularly weak.[20] We were encouraged to hear the Minister believes this is both "achievable"[21] and that he intends to do so "as soon as possible".[22] This ambition is a welcome one which we fully endorse.

12. On 25 April 2023, the Minister announced a forthcoming recovery plan for NHS dental services. At the time of writing, the plan has yet to be published. The plan must have the scope and ambition required to immediately address the crisis of access people across the country are experiencing. This should be accompanied by the necessary funding and a plan for swift implementation.

13. **We believe there is a crisis of access in NHS dentistry. Many people are unable to access an NHS dentist or are travelling significant distances to get to one. Access varies across the country and is being experienced unequally by different groups. We believe everyone should be able to access an NHS dentist when they need one, wherever they live.**

14. ***We welcome the Government's ambition for everyone who needs an NHS dentist to be able to access one. This ambition must ensure access within a reasonable timeframe and a reasonable distance. The Government must set out how they intend to realise this ambition and what the timeline will be for delivery. It is vital that this ambition is the central tenet of the Government's forthcoming dental recovery plan. Once the plan has been published, we will revisit the recommendations in this report to assess it against this criteria.***

Public awareness

15. Many patients are not aware of what they are entitled to under the current system. Healthwatch England and the CQC have called for policymakers to ensure that the public are better informed about NHS dentistry.[23] For example, people are not necessarily aware that dental practices do not operate in the same way as GP surgeries, that they are not formally "registered", and that they do not need to live in a catchment area to go to a specific practice.[24]

19 Q98
20 Q123
21 Q98
22 Q123
23 Healthwatch England (DTY0094); The Care Quality Commission (DTY0083)
24 Healthwatch England (DTY0094)

16. During our roundtable, we were told that some people are worried about dropping off dentists' books if they do not book appointments at sufficiently regular intervals. We heard that sometimes people are removed from dentists' lists if they don't have an appointment in an 18-month period.[25] This is complicated by the fact that many practices set arbitrary time limits after which they "de-register" patients, with some dentists requesting they attend every six months, despite NICE guidance stating recall can be up to 2 years.[26] The Nuffield Trust has called for a specific campaign to raise awareness of this amongst the public and the profession.[27] This would in turn, as the Chief Dental Officer, Sara Hurley, told us, free up a significant number of appointments and capacity to enable access for new patients, higher risk patients and those with additional needs:

> 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.[28]

17. We also received evidence that there is a lack of awareness about which services are available through the NHS and privately,[29] as well as who is exempt from patient charges. This is in part due to a lack of up-to-date information on practice websites, as well as common misconceptions about how NHS dentistry works.[30]

18. ***A lack of public awareness about NHS dental services and how practices operate is contributing to access issues. The Government and NHS England should roll-out a patient information campaign with the aim of improving awareness of how NHS dentistry will work and ensure the public are better informed about what they are entitled to. This should clarify common misconceptions, for example, about patient registration, recall periods, and NHS dental charges and exemptions.***

19. ***Practices should abide by NICE recall guidelines of up to two years for most adult patients, recognising the need for more regular recall for some, but people should not automatically be removed from dentists' registers of NHS patients without good reason. This should be monitored by NHS England to ensure it is being carried out.***

25 See Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'
26 NICE, Dental checks: intervals between oral health reviews, 27 October 2004, accessed on 21 June 2023
27 Nuffield Trust (DTY0098)
28 Q128
29 Healthwatch Newcastle and Healthwatch Gateshead (DTY0081)
30 See, for example: The Care Quality Commission (DTY0083). See, also: Healthwatch Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex (DTY0048); Healthwatch Norfolk (DTY0055); Healthwatch Leeds (DTY0085); Healthwatch England (DTY0094)

2 The Dental Contract

The 2006 dental contract

20. The current contract for NHS dentists was introduced in 2006. The then Government stated that its goal for the contract was that patient access to NHS dental services would improve.[31] Over fifteen years later, this goal has not been achieved.

21. The 2006 reforms comprised three key areas:

- responsibility for planning and securing NHS dental services was devolved to local commissioners (then Primary Care Trusts);[32]
- the system of patient charges was changed, resulting in a reduction in the possible number of charges from around 400 to just three; and
- the mechanism by which dentists are paid to deliver NHS services was changed from one based on fees for items of service to one where providers are paid an annual sum in return for delivering an agreed number of "courses of treatment" weighted by complexity.

22. The 2006 contract is based around the number of "Units of Dental Activity" (UDAs) that must be delivered by a dentist each year and that form the basis for remuneration by the NHS. There are different core bands, which are based on the complexity and urgency of treatment required and determine the number of UDAs the dentist accrues. UDAs are awarded for a course of treatment provided rather than for every item of treatment.

23. Each band also corresponds to a specific patient charge. Some categories of patients (including children, pregnant women, and those in receipt of low-income benefits) are exempt from charges, along similar lines to prescription charges (a major and misunderstood difference is that over-60s get free prescriptions but do not automatically get free NHS dental check-ups and treatment). The bands and what can be provided, together with the corresponding patient charge, are shown below:

Table 1: UDAs and dental charges by band

Band	Patient charge 2021/22[33]	Patient charge 2023/24[34]	UDA rate	Example
Urgent	£23.80	£25.80	1.2	Emergency care such as pain relief or filling
Band 1	£23.80	£25.80	1	Examination, diagnosis, and advice

31 Health and Social Care Committee, First Report of Session 2007–8 'Dental Services', HC 289-I, para 3

32 It is worth noting that in 2013, NHS England became responsible for commissioning primary dental care services before then being devolved to Integrated Care Boards in April 2023.

33 NHS England, Understanding NHS dental charges, 7 February 2020, accessed on 5 June 2023

34 Statutory Instrument, The National Health Service (Dental Charges) (Amendment) Regulations 2023, 27 March 2023

Band	Patient charge 2021/22[33]	Patient charge 2023/24[34]	UDA rate	Example
Band 2	£65.20	£70.70	2a = 3 2b = 5 2c = 7	Covers all treatment in band 1, plus additional treatment such as fillings, root canal and extractions (recent changes mean in some cases 5 or 7 UDAs are awarded where more, or more complex, treatment is required)
Band 3	£282.80	£306.80	12	Covers all treatment in band 1 and 2, plus more complex treatment such as crowns, dentures, and bridges

Source: NHSBSA, How many units of activity (UDA / UOA) does a course of treatment (COT) receive?, accessed on 30 June 2023

24. Although there is a standard patient charge, there is no standard UDA rate and UDA rates were set based on historical practice data. These rates do not relate to the number of patients, patient need, geography, or levels of deprivation.

25. During the Covid19 pandemic there were significant changes made to the delivery of NHS dentistry, including the way that it was delivered, due to public health requirements. As a result of this, the number of UDAs required significantly reduced, in particular due to fallow times and recognising the nervousness of patients attending dental appointments. This varied across the four jurisdictions of the UK.[35]

The case for reform

26. When the new system was introduced, it was heavily criticised by dentists, patient groups and public health specialists alike. Common criticisms at the time included:[36]

- the lack of piloting;
- UDA targets had been set at unrealistic levels;
- the new system failed to reduce dentists' workloads as claimed by the Government at the time;
- the financial consequences for new dentists who missed their contracted UDA target, including penalties for dentists who overdelivered on their contract, as well as underdelivered, who were required to pay back money given to them by their commissioners;
- the treatment bands were too wide;
- the system did not reward dentists who provide training; and
- there was no payment for delivering preventative services.

35 House of Commons Library, Dentistry in England, 25 April 2023, p 6
36 Health and Social Care Committee, First Report of Session 2007–8 'Dental Services', HC 289-I, para 162

27. It is frustrating to have to return to recommendations made by our predecessor Committee fifteen years ago that still haven't been implemented. Our predecessor Committee advocated for reform to NHS dental contracts in 2008. They noted that the Department argued that a UDA system gave dentists an incentive to switch the focus of their treatment from active treatment of patients to prevention.[37] However, Shawn Charlwood, Chair of the BDA's General Dental Practice Committee, told us, the UDA system remains a "barrier to prevention".[38] It does so by disincentivising the seeing of new patients, including those who have higher levels of disease and therefore require more time to treat, due to the lack of appropriate renumeration. He told us:

> We have a higher award for treating three or more teeth, but many of the new patients presenting to dentists and their teams now have far more disease than that. People have not been able to present. They are presenting much later; they have far more disease and the disease is often more complex to treat.[39]

28. In our report 'Workforce: recruitment, training and retention in health and social care', we explored the link between UDAs and the dental workforce. We concluded: "The current UDA-contract system is not fit for purpose, and urgent reform is needed to boost recruitment and retention in NHS dental services."[40]

Primary care dental underspend

29. NAO analysis of NHS Digital statistics demonstrates that the total number of UDAs delivered decreased by 6% between 2011–12 and 2018–19, the last full year before the COVID-19 pandemic. There was an absolute reduction in UDAs in 2020–21 and 2021–22, which equates to a 71% and 31% reduction respectively against 2018–19 levels.[41]

30. The overall reduction of 31% in UDAs in 2021–22 is unevenly distributed by patient type and band of treatment. The NAO highlight the greatest reduction has been across UDA band 1 treatments (examinations, diagnosis, and advice) for all types of patients and there is growth only in urgent treatments for non-paying adults and children.[42]

31. Under the terms of the current contract, if less than 96% of the contracted number of UDAs are delivered, the NHS can and does initiate "clawback" of funds. Dentists cannot currently exceed 110% (subject to local commissioner approval on a non-recurrent basis) of their contractual UDAs, even if there is increased demand and capacity to meet it.

32. In a report in the Health Service Journal from February 2023, data obtained by the BDA from freedom of information requests revealed the primary dental care underspend for 2022/23 is expected to reach £400 million.[43] The underspend is driven by a reduction of NHS dental contract activity and a lack of dentists to meet demand. Professor Nick Barker, a General Dental Practitioner and Professor of Oral Health Sciences at the University of Essex, set out an explanation for this underspend:

37 As above, para 175
38 Q29
39 Q2
40 Health and Social Care Committee, Third Report of Session 2022–23 'Workforce: recruitment, training and retention in health and social care', HC 115, 25 July 2022, para 108
41 National Audit Office (DTY0103)
42 As above
43 HSJ, 'NHSE set for £400m dentistry underspend despite 'access crisis'', 21 February 2023, accessed on 5 June 2023

> The £400 million underspend is related to the fact that practices are not able to contractually provide what they are expected to provide. Therefore, the option is to carry on trying to muddle through or to say, "I'll hand this contract back," or, "I'll hand an element of this contract back," which is how we then end up in the underspend.[44]

33. Dr Sandra White, Clinical Director at the Association of Dental Groups (ADG), added that the underspend is also intrinsically linked to a lack of dentists and dental care professionals: "If you do not have the workforce, you cannot provide the work."[45] The Nuffield Trust highlight, "these regular [spending] shortfalls are indicative of the need for a fundamental and urgent rethink of NHS dentistry, what is offered, how it is commissioned and whether it can be made more sustainable."[46]

34. When we asked the Minister about the underspend, we heard him acknowledge the link between UDAs and the underspend. He told us: "the challenge has been to try to reform the contract in order to stop an under-delivery and therefore an underspend."[47]

35. Shawn Charlwood set out the BDA's concerns about this funding being diverted away from dentistry:

> Practices are worried about the underspend being moved to other parts of the NHS. You can imagine a situation where an ICS is short of money at the end of the year and, because of the contract, there is an underspend in dentistry. That money potentially gets lost to dentistry. It potentially gets lost year on year, unless we get a contract in place where people can start to deliver NHS dentistry.[48]

36. We were concerned to hear that this underspend could be directed away from NHS dentistry by ICBs, to plug gaps in other budgets. We sought clarity on this from the Director of Primary and Community Care at NHS England, Dr Amanda Doyle. She told us:

> 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.[49]

37. Later in this report, we will address the flexibilities available to ICBs to reinvest any underspend in NHS dental services and make the case for them to do so.

---

44 Q25
45 Q25
46 Nuffield Trust (DTY0098)
47 Q130
48 Q21
49 Q134

38. ***We welcome the fact that to try and address the underspend, NHS England is applying a ringfence for 2023/24, to ensure that no ICB can divert funding away from NHS dentistry. We recommend that this ringfence applies permanently, and NHS England puts in place transparent scrutiny to ensure compliance.***

39. **We also welcome measures by NHS England to intervene on providers who are under-delivering on contracted NHS activity. We look forward to an update on how this work is progressing. We welcome this funding being used flexibly, however there cannot be further delays in doing so.**

"Reforms" to date

Dental Contract Reform Programme

40. The 2009 Steele Review into NHS dentistry recommended changes to the dental contract to improve access and continuity of care and focus on prevention.[50] This was taken forward in 2011, when the Department embarked on a Dental Contract Reform Programme that involved a series of pilots, in which, at its peak, the NHS Business Services Authority (NHSBSA) was working with over 100 "prototype" practices testing a new approach to delivering and paying for NHS dentistry, including a largely capitation-based payment model, a system which renumerates by the number of patients seen.[51]

41. The programme came to an end in March 2022 following an evaluation by the NHSBSA which suggested there would be significant challenges in implementing the current prototype model more widely. The NHSBSA cited a lack of evidence that, if implemented, the contract would maintain dental access, reduce oral health inequalities and be sustainable within available resources for the NHS.[52] The BDA argues that the prototype model was limited by the continued usage of UDAs and that payments were not weighted based on patient need.[53]

42. Reports from professionals working in prototype practices showed some positive indicators of improved oral health among patients, and more time spent on prevention.[54] The Association of Dental Groups (ADG) describe the last decade as a "lost one for NHS dentistry". They argue that providers feel let down by the abrupt ending of the prototype pilot process "with little apparent regard for any learnings and how they may inform future contract review."[55] This is echoed by the BDA who have concluded that the prototype model "provided a basis on which to develop a contract that was fit for rollout".[56]

50 NHS England, NHS dental services in England. An independent review led by Professor Jimmy Steele, 22 June 2009, p 51
51 NHSBSA, Dental Contract Reform in England, accessed on 22 June 2023
52 As above
53 British Dental Association (DTY0078)
54 Dentistry UK, The impact being in a prototype has had on my practice and patients, 7 June 2019; Association of Dental Groups (DTY0038)
55 Association of Dental Groups (DTY0038)
56 British Dental Association (DTY0078)

2022 Amendment to the Contract

43. On 19 July 2022, NHS England announced the result of contract negotiations with the BDA, leading to what NHS England described as "the first significant change to the contract since its introduction in 2006".[57] The reforms include:

- modification of UDA awarding, so that 3 or more fillings or extractions (both previously included in Band 2, accruing only 3 UDAs) are now awarded 5 or 7 UDAs, to reflect increased treatment time;
- advising risk-based recall periods for adults with good oral health, in line with NICE guidelines (up to 24 months, rather than a standard 6 months); and,
- increasing the frequency with which practices must update their websites to make information up to date for patients.

44. A recurring theme in the evidence is that the changes to the contract so far constitute tweaks rather than anything close to "reform".[58] When asked about these recent changes, Shawn Charlwood of the BDA said they did not represent reform: "In essence, what we are doing at the moment is rearranging the deckchairs on the Titanic while the service slowly slips into the sea".[59]

45. The Minister acknowledged that he agrees with the BDA that further "quite fundamental reform" is needed, and that the Government is "currently looking at" what that may look like.[60] We agree that fundamental reform of the contract is urgently needed.

A new dental contract

46. In 2009, the Steele Review recommended transitioning "from dental activity to oral health as the outcome of the NHS dental service".[61] The BDA has since been calling for a "capitation-based" system which rewards and incentivises "per-head" rather than "per unit of dental activity", as well as a focus upon prevention. This capitation element would involve lump-sum payments being made to providers based on the number of patients that they treat.

47. Dr Sandra White of the ADG told us that a weighted capitation-based system would be a way to "level-up inequalities".[62] It does so by giving commissioners more flexibility to weight payments according to patient need. New patients and those with more dental disease who take longer to treat, would command a larger capitation payment. Data relating to the deprivation, age and other key indicators of need can give an idea of whether, and by how much, payments to practices need to be adjusted.[63]

57 NHS England, Letter from the Director of Dentistry NHSE and CDO for England to all dental practices in England, 19 July 2022

58 See, for example: British Dental Association (DTY0078). See, also: Birmingham LDC (DTY0023); Dr Andrew Bell (DTY0043); Healthwatch Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex (DTY0048); Healthwatch York (DTY0060); Denplan (DTY0071); Local Dental Committee Confederation (DTY0073); Paul Batchelor (DTY0074); Toothless in England (DTY0079); Derek Watson (DTY0102)

59 Q2

60 Q100

61 NHS England, NHS dental services in England. An independent review led by Professor Jimmy Steele, 22 June 2009, p 5

62 Q13

63 Newcastle University School of Dental Sciences (DTY0066)

48. Professor Barker, who previously ran a prototype practice which was primarily capitation-based, made the case for why, from his experience, such a system provides greater incentives than the current one: "it works because it also incentivises the entire team to work under that capitation system rather than just the dentist, which is what the UDA system does. You can actually start to get integrated care."[64]

49. We recognise that the proportion of payment that is based on capitation and the proportion that is linked to activity is contentious. This would require modelling or rapid piloting, but it is vital that the payment models tested through the Dental Contract Reform Programme protypes are appropriately taken into account here, as the BDA and ADG have urged.[65]

50. **Fundamental reform of the dental contract is essential and must be urgently implemented, not only to address the crisis of access in the short-term, but to ensure a more sustainable, equitable and prevention-focussed system for the future. We are concerned that any further delay will lead to more dentists leaving the NHS and exacerbate the issues patients are experiencing with accessing services.**

51. ***We welcome the Government's recognition of the need for dental contract reform. The Department and NHS England must urgently implement a fundamentally reformed dental contract, characterised by a move away from the current UDA system, in favour of a system with a weighted capitation element, which emphasises prevention and person-centred care. This should be based on the learnings from the Dental Contract Reform Programme and in full consultation with the dental profession.***

Patient registration

52. The 2006 contract ended formal patient registration. In 2008, our predecessor Committee recommended the reinstatement of patient registration as a means of monitoring access and encouraging long-term continuing care.[66] The argument then was that "dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship". Fifteen years later, the BDA states that a reformed contract could restore the link between dentist and patient.[67]

53. Written evidence to the current inquiry makes the case for reintroducing patient registration, on the grounds of increasing access, as well as continuity of care to manage and improve patients' oral health.[68] Professor Paul Batchelor, Honorary Clinical Professor at the University of Lancaster, who was a specialist adviser to our predecessor Committee, notes in his evidence that to achieve greater access and reduce inequalities, reform of the contract "should centre on a capitation-based payments with long-term registration arrangements."[69]

54. **We believe patient registration under a reformed capitation-based contract will better enable those patients who currently can't access a dentist to be able to do so.**

64 Q10
65 See: British Dental Association (DTY0078); Association of Dental Groups (DTY0038)
66 Health and Social Care Committee, First Report of Session 2007–8 'Dental Services', HC 289-I, para 218–219
67 British Dental Association (DTY0078)
68 See, for example: Professor Paul Batchelor (DTY0074). See, also: Healthwatch Liverpool (DTY0027); Gill Furniss (Member of Parliament for Sheffield Brightside and Hillsborough at UK Parliament) (DTY0028); Toothless in England (DTY0079); Healthwatch Portsmouth (DTY0084); Healthwatch England (DTY0094)
69 Professor Paul Batchelor (DTY0074)

55. ***We uphold the recommendation from our predecessors' 2008 report into Dental Services, that the Department should reinstate the requirement for patients to be registered with an NHS dentist.***

3 Workforce

56. In 2008, our predecessor Committee warned there could be "trouble ahead" for recruitment and retention in NHS dentistry due to the contract. They noted fears that more dentists would leave the NHS as well as the Department's assurance that no exodus of dentists will occur. Our predecessor Committee noted that officials could not provide "the evidence on which to judge the more likely outcome" and recommended "the Department monitor closely the career plans of NHS dentists."[70]

Data on the workforce

57. In May 2022, the BDA reported 3,000 dentists had stopped providing NHS dental services since the start of the pandemic and their survey of high street dentists found nearly half (45%) reported reducing their NHS commitment since the onset of the pandemic.[71] 75% said they were likely to reduce their NHS commitment in the next year. According to the ADG, fewer dentists are joining the GDC register than a decade ago.[72]

58. Bupa analysis concludes that the UK has the lowest per capita spending (inclusive of public and private) on oral health care and oral health workforce ratio in the G7.[73] Similarly, analysis by the NAO of OECD statistics for the four European members of the G7 (UK, France, Italy, and Germany), reveals that in 2020 the UK had a:

> relatively low number of dentists per head of population compared with other advanced European economies, and that England had the lowest number of NHS dentists per head of population in the UK. This assessment is unchanged by the latest statistics.[74]

59. On 8 March 2023, the Prime Minister stated that "The number of NHS dentists has increased by about 500 over the last year".[75] Data from NHS Digital shows the figures this is based on:[76]

- In 2018–19 there were 24,545 dentists with recorded NHS activity in England;
- In 2020–21 there were 23,733 dentists with recorded NHS activity in England; and
- In 2021–22 there were 24,272 dentists with recorded NHS activity in England.

60. The Prime Minister's statement about an increase in dentists is based on an increase in headcount between 2020–21 and 2021–22, whereas the headcount dropped by 273 between 2018–19 and 2021–22. The ADG and others have warned that this data does not refer to full-time equivalent dentists, but only to those who do "some" NHS dentistry.[77]

70 Health and Social Care Committee, First Report of Session 2007–8 'Dental Services', HC 289-I, para 86
71 British Dental Association (DTY0078)
72 Association of Dental Groups (DTY0038)
73 Bupa Global & UK (DTY0024)
74 National Audit Office (DTY0103)
75 PMQ, 8 March 2023, c295
76 NHS Digital, NHS Dental Statistics, 25 August 2022, accessed on 22 June 2023
77 Association of Dental Groups (DTY0038)

61. We were struck by the lack of accurate data available on the dental workforce. Ian Brack, Chief Executive and Registrar of the General Dental Council (GDC), said:

> I can tell you that at the end of 2021 there were 43,292 dentists. There were 59,399 dental nurses. There were 4,378 therapists. I do not know if that is actually what the UK needs. I just know that that is what there were. I do not know where they work. I do not know what they are doing. I do not know how many hours they work. That is all I know.[78]

62. Dr Sandra White of the ADG commented:

> We do not even have workforce data. We have headcounts, but we do not know how many are part time, full time, NHS or private. We do not even know if they are in this country, and yet we have the headcount. We really need some robust workforce data to have a robust workforce strategy.[79]

63. Malcom Smith, Chair of the Advancing Dental Care Review and Dental Education Reform Programme, has been calling for a "dental workforce survey", but added: "Nobody wants to commission it".[80] He told us why a review is necessary:

> We need to know what workforce we have available to us; we need to know what workforce we need to deliver the service that the NHS wants; and there needs to be a bit of intelligent thinking between the two things, in my view, to marry them up. If we ever get that right, we might well be in a good place.[81]

64. The Minister confirmed that the Government's understanding of the amount of NHS work undertaken is "measured by the delivery of UDAs and the number of patients seen". He stated that the rate of both had increased post-pandemic.[82] We asked the Minister to provide us with evidence to support this statement. We received a response on 6 July, which listed the NHS Digital Statistics accounting for the number of dentists performing NHS activity, referenced above. They also shared NHS Digital Statistics on the number of adults and children seen, and courses of treatment delivered. They were unable to share any further data on the workforce, beyond what is already publicly available, and which we heard from witnesses is not sufficiently robust.[83] Amanda Doyle confirmed:

> 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.[84]

65. The Chief Dental Officer said that as part of the Advancing Dental Care Review (ADCR), Health Education England "did start some data collection, and indeed it surfaced some of the difficulties with data collection." She went on to say that a series of evidence-gathering exercises and data collection was then undertaken to inform the Dental

78 Q61
79 Q13
80 Q60
81 As above
82 Q124
83 Supplementary written evidence, Department of Health and Social Care (DTY0104)
84 Q126

Education Reform Programme (DERP).[85] Whilst we acknowledge that these sound like worthwhile initiatives, we emphasise the comments of the Chair of the ADCR and DERP above, which indicate the continuing absence of useful workforce data.

66. It was encouraging to hear the Secretary of State agree about the importance of data and understanding supply and demand in NHS dentistry when he gave evidence to us on 20 June 2023. In response to our calling for more robust data on NHS dentistry, he said:

> I absolutely share your desire. We all recognise that it has to be data that drives decisions, not data for its own sake, but that is exactly what is being done by Neil O'Brien, who has been spending a considerable amount of time on the dental recovery plan, much more so than perhaps was the case previously. He is delving into the data; he is looking at that blend of the workforce, the number of patients and which sorts of treatments are being prioritised. When we bring out the recovery plan, we will be able to say more about what we are doing on the data side.[86]

67. **The Government states that the number of NHS dentists has increased over the past year. However, while the headcount has gone up over the past year, it has gone down over the past three years, and moreover headcount alone does not reflect how much NHS work these dentists are undertaking. We heard repeatedly that a lack of dentists and dental care professionals undertaking NHS work is the main driver behind both lack of access to appointments for patients, and the underspend in primary care dentistry.**

68. ***The Government and NHS England should commission a dental workforce survey to understand how many full-time and part-time-equivalent dentists, dental nurses, therapists and hygienists are working in the NHS, and how much NHS and private activity they are undertaking, alongside demographic data such as age and location.***

69. ***The Government and NHS England must improve the routine data that is collected on the number of NHS dentists and the wider dental team, and the levels of NHS activity they undertake, as well as data on demand, to assist with workforce planning and identifying gaps in provision. This must be addressed in the forthcoming dental recovery plan. Until such a time, the Government should focus on statistics which show the levels of NHS dental activity.***

Incentivising recruitment and retention

70. As discussed above, there is widespread agreement in the evidence received that fundamental reform of the contract would be the greatest incentive for dentists and their teams to undertaken NHS work.[87] The Faculty of Dental Surgery (Royal College of Surgeons of England) argues that there needs to be a shift in the focus of the dental profession towards prevention and improving access for those in need of treatment.[88] A capitation-based system, focussed on prevention, is more in line with the way graduate dentists have been trained to deliver care.

85 Q112
86 Oral evidence, HC 1093, 20 June 2023, Q118
87 See, for example: Q1-Q3; Q6–11; Q23–24; Q33
88 The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063)

71. However, we are concerned that any reform will almost certainly be too late for those dentists who have already left the NHS or are considering doing so in the near future. We believe the Government must provide other incentives to attract dentists to undertake NHS work. We received a number of suggestions about how the Government could do this:

- monetary incentives including the reintroduction of NHS commitment payments, the introduction of late career retention payments, as well as the reintroduction of incentive payments for audit and peer review etc;[89]
- greater emphasis upon continued professional development and developing a careers framework, including mentoring and more recognition of skill development from NHS England and ICBs;[90] and
- making greater use of the wider dental team and increasing the skills mix of the team: for example, drawing on expertise of dental therapists to free up time for dentists to perform the more complex work they are trained to deliver.[91]

72. ***Any contract reform now will almost certainly be too late for those dentists who have already left the NHS or are considering doing so in the near future. The Government must urgently introduce incentives to attract and retain dentists to undertake NHS work. These should include, but not be limited to, the reintroduction of NHS commitment payments, incentive payments for audit and peer review, and the introduction of late career retention payments. The development of a careers framework should be considered, including on-going education, supervision and support. This should form part of a wider package, accompanied by a communications drive, to entice professionals to return to NHS dentistry.***

73. ***The Government, NHS England and ICBs must ensure that the reformed contract ensures that full use is made of the skills of the whole dental team.***

Workforce and dental deserts

74. Latest workforce figures, published in the NHS Annual Dental Statistics Report August 2022 reveal the continuing workforce shortages in known "dental deserts".[92] The table below shows the five Integrated Care Boards (ICBs) with the lowest number of dentists with NHS activity per 100,000 of population.

89 See, for example: Q25–26. See, also: British Dental Association (DTY0078); Agi Tarnowski (DTY0089)

90 See, for example: Q25–26; Q33–34; Q62. See, also: Mr Philip Martin (DTY0008); Dental Protection (DTY0033); Jan Cuerden (DTY0036); The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Denplan (DTY0071); Agi Tarnowski (DTY0089)

91 See, for example: Q14; Q24; Q54; Q57. See, also: Healthwatch Norfolk (DTY0055); The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Oral Health Foundation (DTY0065); Newcastle University School of Dental Sciences (DTY0066); Healthwatch Newcastle and Healthwatch Gateshead (DTY0081); The Care Quality Commission (DTY0083); Healthwatch Portsmouth (DTY0084); General Dental Council (DTY0091); SpaDental group (DTY0096)

92 NHS Digital, NHS Dental Statistics for England 2021–22 Annual Report, 25 August 2022, accessed on 22 June 2023

Table 2: Dentists with NHS activity by ICB

Area	Dentists with NHS activity (not full time equivalent and per 100,000 population)
Humber & North Yorkshire ICB (North Lincs)	31
Humber & North Yorkshire ICB (NE Lincs)	34
Humber & North Yorkshire ICB (East Riding)	39
Lincolnshire ICB	39
Norfolk & Waveney ICB	40

Source: NHS Digital, NHS Dental Statistics for England, 2021–22, Annual Report, Annexe 2, Table 2A, via Association of Dental Groups (DTY0038)

These numbers compare against an England ICB average of 43 dentists with NHS activity (not full time equivalent and per 100,000 population).[93]

75. In 2021, HEE's final report of their 'Advancing Dental Care Review' reported that the geographical distribution of the dental workforce "does not match the need or demand for dentists and specialists".[94] The uneven distribution of dentistry schools–six in the North, two in London, two in the South West, one in the Midlands and none in the East of England–has made it difficult to maintain the workforce in remote areas. The report states:

> There are difficulties in attracting trainees at any level to more remote areas, including Cumbria, Lincolnshire, East Anglia and some parts of the South West. Retaining dentists in these areas on completion of foundation training can be problematic after foundation training. There is evidence from medicine that the longer a trainee is based in an area, the more likely they are to 'put down roots' and remain.[95]

76. The report recommended more flexible entry routes into training, supporting the development of apprenticeships "to diversify and promote the concept of a local dental workforce approach", and distributing postgraduate training posts so they are better aligned with areas that have the highest levels of oral health inequalities. The report also recommended exploring the establishment of Centres of Dental Development. Malcolm Smith, chair of the review, told us:

> We have dental schools not necessarily concentrated in the right areas. Again, that is an historic issue. If we are looking to put more dental schools and only train dentists in areas where we do not have a school, I think we are missing an opportunity. We have an opportunity to create much smaller hubs, including outreach from existing dental schools, that might be quite remote.[96]

93 As above
94 HEE, Advancing Dental Care Review: Final Report, 21 September 2021
95 As above
96 Q40

77. Sarah Fletcher, Chief Executive at Healthwatch Lincolnshire, explained what it would mean to local people to have a centre established in their area:

> 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.[97]

78. At the roundtable we held with patients and campaign groups, we were told that any positive outputs from these new centres will take some time to be realised. They told us that immediate incentives, like those listed above, are required to ensure dentists are attracted to undertake NHS work, especially in known dental deserts.[98]

79. **We support the implementation of the work of the Advancing Dental Care Review. Centres for Dental Development could have the potential to change how we approach training dentists in the UK to meet the needs of the populations who most require care. However, these are in their early stages and their outputs will need to be assessed. We also recognise that incentives are required in the short-term to address the immediate challenges with supply and demand.**

Overseas recruitment

80. According to the General Dental Council, almost a quarter of dentists registered in the UK gained their dentistry qualification overseas.[99] For dentists who qualified overseas, the primary means of assessment to get onto the GDC register is the Overseas Registration Examination (ORE).

81. Once dentists have passed the ORE and are on the GDC register they still have to undertake either foundation training or an equivalent in order to get a performer number and be able to provide NHS dentistry. Being on the GDC register without a performer number only entitles them to work privately.[100] The lack of a streamlined pathway for overseas dentists to be able to practise in the NHS was a recurring theme in the evidence.[101]

82. The Minister acknowledged the need to make the registration route "as hassle-free and smooth as possible for people who want to come here and do NHS work".[102] Following a consultation in the summer of 2022, in November 2022, the Government announced legislation to reform the processes for registering international dentists and dental staff. The changes aim to speed up the process of international registration and give more flexibility to the GDC "to ensure that international processes are proportionate and

97 Q91
98 Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'
99 General Dental Council (DTY0091)
100 As above
101 See, for example: Newcastle University School of Dental Sciences (DTY0066). See, also: Bupa Global & UK (DTY0024); The Dental Defence Union (DTY0029); Dental Protection (DTY0033); Association of Dental Groups (DTY0038); The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Denplan (DTY0071); The Care Quality Commission (DTY0083); Agi Tarnowski (DTY0089); SpaDental group (DTY0096); Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'
102 Q109

streamlined, whilst continuing to robustly protect patient safety".[103] The Section 60 Order relating to international registration took effect on 8 March 2023, however, as Ian Brack of the GDC told us, this will not take effect until a year later.[104]

83. We were concerned to hear from the GDC that as of March 2023 there were around 1,700 dentists waiting to sit the ORE. Dr Sandra White from the ADG told us that some of their groups have waited as long as 18 months for qualified dentists to be able to treat patients on the NHS.[105] This backlog is unacceptable and must be resolved as soon as possible.

84. Whilst we acknowledge that relying too heavily upon international recruitment is not a sustainable strategy in the long term,[106] there is a significant opportunity in the short-term to plug the gap in NHS provision, and therefore address the immediate crisis of access for patients. As we set out above, a long-term strategy for the workforce and rigorous data are needed alongside this.

85. **The backlog of applications for the Overseas Registration Exam is unacceptable and resolving this represents an opportunity in the short term to increase the number of dentists working in the NHS, and therefore create more appointments to enable patients to access much-needed services.**

86. ***The Government must work with the General Dental Council to ensure the backlog of applications for the Overseas Registration Exam is cleared in a timely manner, and to speed up changes to the process of international registration for new applicants seeking to work in the NHS.***

Long Term Workforce Plan

87. NHS England published their long-awaited NHS Long Term Workforce Plan on 30 June 2023. We were pleased to see the publication of this plan: it is something we have long been calling for. Amanda Pritchard, Chief Executive of NHS England, states that the Plan sets out "a strategic direction for the long term, as well as concrete and pragmatic action to be taken locally, regionally and nationally in the short to medium term to address current workforce challenges."[107] The Plan identifies three priority areas, under which the actions fall: "train", "retain" and "reform".

88. In the case of NHS dentistry, the Plan includes the following actions:

- For the next three years there is no plan to increase the number of dental school places.[108] NHS England has committed to expand dentistry training places by 40% to 1,100 places by 2031/32. To support this ambition, NHS England has said it will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places;[109]

103 Government, Consultation outcome: 'Changes to the General Dental Council and the Nursing and Midwifery Council's international registration legislation', 28 November 2022
104 Q48
105 Q30
106 See, for example: British Dental Association (DTY0078)
107 NHS England, NHS Long Term Workforce Plan, 30 June 2023, p 5
108 As above, p 130
109 As above, p 8

- NHS England will explore measures with the Government such as a tie-in period "to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation";[110]
- The upcoming Dental Plan, will provide more detail on the work underway to establish Centres for Dental Development in areas where there is a shortage of workforce relative to population need;[111] and
- NHS England states that they will aim to deliver 15% of dental activity through dental therapists and dental hygienists, as opposed to the current estimate of 5%. A national Return to Therapy programme is being developed to enable dental therapists working as hygienists to fulfil their full scope of practice.[112]

89. Whilst the ambitions in the Plan to increase the numbers of training places, and incentives for the wider dental team are valid, the fact that the Plan does not mention, let alone address, the dental contract is concerning. The Government has committed to further reform, as referenced above. However, we believe there is a missed opportunity by NHS England to make explicit to the profession and the sector the link between workforce recruitment and retention in NHS dentistry and the need for urgent dental contract reform.

90. **We are concerned that the absence of explicit mention of the dental contract in the Long Term Workforce Plan reflects the lack of priority given by the Government and NHS England to contract reform. We believe it indicates a lack of recognition of the urgent need for reform before any other workforce initiatives can be implemented.**

91. Some of the written evidence explores ideas that are similar to NHS England's proposal to explore a "tie-in" for new graduates. Plymouth Community Dental Services argues for all dental graduates to "complete a set number of years working within an NHS setting", and if not "repay their training costs".[113] Most of the evidence around tie-ins, however, calls for one linked to financial incentives such as the waiving[114] or subsidising[115] of tuition fees, or providing a bursary towards training costs.[116] The BDA, in response to the Plan, has argued against a tie-in. In a press statement, Eddie Crouch, Chair of the BDA, said: "Ministers need to make the NHS a place young dentists would choose to work […] Not handcuff the next generation to a sinking ship."[117]

92. **Given the varying views expressed regarding a tie-in for new graduates into NHS dentistry, we urge NHS England and the Government to ensure full consultation with professionals and representative bodies, as they seek to explore the potential merit of such a policy, although its success depends on fundamental contract reform, and should be accompanied with a careers framework.**

110 As above, p 79
111 As above, p 86
112 As above, p 96
113 Plymouth Community Dental Services (DTY0069)
114 Toothless in England (DTY0079); Agi Tarnowski (DTY0089)
115 Oral Health Foundation (DTY0065)
116 Healthwatch York (DTY0060); Healthwatch Liverpool (DTY0027).
117 BDA, Latest News Articles Workforce plan is the latest attempt to fill the NHS' leaky bucket, 30 June 2023, accessed on 3 July 2023

93. We received written evidence from stakeholders, setting out what they would have expected from the Long Tern Workforce Plan. The Faculty of Dental Surgery and Healthwatch Liverpool both stressed that the Plan should address health inequalities and map workforce planning according to levels of oral health needs.[118] The plan does not make any explicit reference to oral health inequalities. It should also have a significant emphasis on prevention.

94. We welcome the mapping of current and projected supply and demand in the Plan.[119] However, this analysis is based on data referenced above that we deem unsuitable for the purpose of comprehensive workforce planning. We encourage NHS England to take forward our recommendation above to improve the routine data collected and to undertake a workforce survey to ensure that these projections are consistent with the most accurate data. This is in order that patient need is met in the NHS, as well as supply of dentistry capacity comprehensively understood.

118 The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Healthwatch Liverpool (DTY0027)

119 NHS England, NHS Long Term Workforce Plan, 30 June 2023, Table 4, p 124

4 Integrated Care Systems

Delegation of commissioning

95. On 1 July 2022, following the successful passage of the Health and Care Act 2022,[120] nine "early adopter" Integrated Care Boards (ICBs) assumed the commissioning functions for primary care medical services, and some pharmacy, optometry and dental services (POD). Seven of these took responsibility for dentistry: Buckinghamshire, Oxfordshire and Berkshire West ICB; Frimley ICB; Greater Manchester ICB; Hampshire and Isle of Wight ICB; Kent and Medway ICB; Surrey ICB; and Sussex ICB.

96. On 1 April 2023, responsibility for commissioning dental services was delegated to the remainder of ICBs by NHS England, which has said it will work with ICBs to provide tools and resources to support transformation, commissioning, and effective contract management to ensure the best use of NHS resources.[121] Prior to this, NHS England was responsible for commissioning dental care services to meet local needs and priorities, managed through its local area teams.[122]

97. The NHS Confederation, in their report published on 3 April 2023, note that of the three POD services, dentistry "arguably poses the greatest immediate challenge for systems", in large part due to current contracting arrangements and workforce challenges. They state that several early adopter ICBs reported that the dental contract "still holds back desired transformation" and that it is not clear that new flexibilities are necessarily well understood.[123]

Representation of the profession

98. A recurring theme in the evidence has been the importance of ensuring dentistry has a strong voice on ICBs, and the need for greater connectivity between commissioners and the dental profession.[124] The Health and Care Act 2022 sets out the minimum membership of ICBs. They are required to include representatives from NHS Trusts, Primary Care and Local Authorities, and are expected to ensure they have appropriate clinical advice when making decisions.[125] In their evidence, the Department stress that the inclusion and involvement of dentists and other dental care professionals with ICSs "will be critical".[126]

120 Under the Health and Care Act 2022, every part of England is covered by 42 statutory Integrated Care Systems (ICSs). Each ICS includes an Integrated Care Board (ICB) (an NHS organisation responsible for managing the budget and arranging provision of services in an area) and an Integrated Care Partnership (ICP) (a committee of organisations and partner responsible for producing a strategy to meet the needs of their population). For more information, please see our recent report on ICS: Health and Social Care Committee, Seventh Report of Session 2022–23 'Integrated Care Systems: autonomy and accountability', HC 587, 30 March 2023

121 Department of Health and Social Care (DTY0099)

122 House of Commons Library, Dentistry in England, 25 April 2023

123 NHS Confederation, From delegation to integration: Lessons from early delegation of primary pharmacy, optometry and dentistry commissioning to integrated care boards, April 2023, accessed on 6 June 2023

124 For example, see: Local Dental Committee Confederation (DTY0073). See, also: Birmingham LDC (DTY0023); Healthwatch Hertfordshire (DTY0030); Local Government Association (DTY0047); Healthwatch Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex (DTY0048); Hertfordshire Local Dental Committee (DTY0058); The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Paul Batchelor (DTY0074); British Dental Association (DTY0078); The Care Quality Commission (DTY0083); NHS Confederation (DTY0087); See Appendix 1: 'Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023'

125 Health and Care Act 2022, Schedule 1B, Part 1

126 Department of Health and Social Care (DTY0099)

99. All ICBs will have a number of Local Dental Committees (LDCs) within their boundaries: these are statutory local representative committees for dentists and are used to being a negotiating voice for local dentists with commissioners.[127] Most ICBs will also have several Local Dental Networks (LDNs), with a dental chair who will work collaboratively to plan and commission services.[128] Many LDNs will have specialist Managed Care Networks (MCNs) which bring together commissioners and the dental specialists to plan specialist care pathways, for example orthodontics.[129] There are many extant mechanisms for ICBs to actively engage the profession.

100. It has been encouraging to read that many Integrated Care Systems (through their ICBs and Integrated Care Partnerships) are "beginning to engage with primary care dentistry in ambitious ways", according to the Local Dental Committee (LDC) Confederation. The LDC Confederation maintain, however, that it is important for ICBs to engage with LDCs as key stakeholders.[130] Professor Barker, who also serves as Chair of Essex LDN, told us about the importance of ICBs engaging LDNs and MCNs. He argued there was also a need for those networks to proactively bring their expertise and knowledge into ICBs, to inform decision-making.[131] Sara Hurley, the CDO, set out how this can be done: "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 other activities in that ICB."[132]

101. Jo York, the senior commissioning lead for POD for the Hampshire and Isle of Wight, told us about how her ICB is involving dentists in decision-making, but made it clear that this currently didn't involve having a dentist on the ICB:

> ICBs are new organisations. We have only been in place since July [2022]. 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.[133]

102. When asked why this was this the case, she explained: "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".[134]

103. We asked Shawn Charlwood about the BDA's concerns regarding dental expertise on ICBs and he told us:

> It is not guaranteed. The board does not have to have a dental representative, and in most cases it does not. The board will be very devoid of expertise on dentistry because typically nobody has been dealing with dentistry in that sense.[135]

127 British Dental Association, 'Local Dental Committees', accessed on 21 June 2023
128 NHS England, 'Local dental networks', accessed on 21 June 2023
129 NHS England, Clinical guide for dentistry, 28 October 2022, p 6
130 Local Dental Committee Confederation (DTY0073)
131 Q20
132 Q141
133 Q78
134 Q79
135 Q19

104. In our recent report, 'Integrated Care Systems: autonomy and accountability', we recommended that the Department should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise, by 1 October 2023. We also recommended the Department should review it with a view to understanding whether the policy of keeping mandated representation to a minimum is providing the necessary expertise and whether any specialties are especially under-represented.[136] We emphasised the need for the Government to centrally collect this data, and monitor and evaluate whether the approach is yielding the results it intends. The Government rejected this recommendation on the basis that they would be duplicating information available publicly on ICBs' websites.[137] We reiterate that recommendation, because we think it is important that this information is centrally gathered and thus readily available.

105. We note in the Department's response to our 'Integrated Care Systems' report, they state: "local areas can, by local agreement, go beyond the legislative minimum requirements to address their local needs".[138] Whilst we agree it is important that ICSs have the freedom to "create the architecture and governance" of their Boards, to enable them to best serve their populations, in the case of dentistry there is a risk that there will not be the expertise required to make informed decisions around contracting and commissioning.

106. ***The dental profession should be represented on Integrated Care Boards to ensure they have the necessary expertise to inform decision-making around contracting and flexible commissioning. This should include wider engagement with the profession locally, for example through Local Dental Committees and Local Dental Networks.***

107. ***We contest the Department's rejection of the recommendation in our 'Integrated Care Systems: autonomy and accountability' report, and reiterate that they should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise. We also recommended the Department should review that information with a view to understanding whether the policy of keeping mandated representation to a minimum is the right one and whether any specialties are especially under-represented. We believe this is particularly relevant in the case of NHS dental services.***

Flexible commissioning

108. The NHS Confederation highlights that the new commissioning arrangements offer the ability for different geographical areas to do things differently, according to local need.[139] The Association of Dental Groups identify the move towards ICBs as an opportunity for greater flexible commissioning and more innovative approaches to the use of dental contract funding in local areas.[140] This should include prioritising groups such as children, and pregnant and nursing mothers, when building back services.

136 Health and Social Care Committee, Seventh Report of Session 2022–23 'Integrated Care Systems: autonomy and accountability', HC 587, 30 March 2023, para 72–73

137 Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability', CP 860, June 2023, p 13

138 As above

139 NHS Confederation (DTY0087)

140 Association of Dental Groups (DTY0038)

109. Flexible commissioning is an approach which uses the existing contractual framework, by converting "units of dental activity to activity which focuses on priority areas, such as improving access to urgent care or targeting high risk patient group."[141] This has always been possible within the current contract, even prior to the establishment of ICBs.[142] However we received evidence which argues that this has been used infrequently and unsystematically across the country. For example, Healthwatch York informed us that no known dentists or practices were providing treatment through this route in their area.[143]

110. The evidence drew attention to the opportunity for ICBs to improve dental services in their local area, in terms of both access and quality, and to address health inequalities and prevention.[144] The Chief Dental Officer, Sara Hurley, told us that at an ICB level "we have a real opportunity to make a change." She provided more detail about some of the "flexible options" open to ICBs to do this:

> 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.[145]

She referred us to NHS England's "Transformation for a better future", a toolkit which contains the flexible options that are available to commissioners under the current contractual arrangements.[146]

111. During our inquiry into Integrated Care Systems, Matthew Style, Director General for NHS Policy and Performance, confirmed ICBs "will have flexibility to target resources as the needs of their communities across their patch require."[147]

112. The Chief Dental Officer set out how flexible commissioning could prevent or reinvest forecast underspend in NHS dentistry. She noted from her owns experiences how this could be utilised to fund "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."[148]

141 PQ 53345, 21 September 2022
142 Simon Hearnshaw, 'Flexible Commissioning - a new approach', BDJ in Practice, Vol 35:12, 5 December 2022, p 18
143 See, for example: Healthwatch York (DTY0060). See, also: Oral Health Foundation (DTY0065); Agi Tarnowski (DTY0089)
144 See, for example: ADG (DTY0038). See, also: Local Government Association (DTY0047); The Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063); Local Dental Committee Confederation (DTY0073); Healthwatch England (DTY0094); Professor Jennifer Elizabeth Gallagher (DTY0097)
145 Q101
146 Q114
147 Oral evidence, HC 587, 7 February 2023, Q169
148 Q103

113. The Minister provided further detail on how "sessional contracts" to promote access, could ensure ICBs do not under-deliver.[149] Options available to ICBs could include offering financial incentives to dentists to provide NHS services in the community on either a sessional basis, or through sending their practice teams into the community, for instance to schools or care homes. As noted above by the LDC Confederation, it is important that LDCs, and LDNs, are at the centre of decision-making about what will work locally.

114. Whilst we acknowledge the opportunities available to ICBs to do things differently, we are also conscious of the comments made by Professor Barker who told us that, of early adopter ICBs, only "a very small percentage" are engaging in any flexible commissioning.[150] This is reinforced by the findings of the NHS Confederation's review of the commissioning experiences of early adopter ICBs. The review concluded:

> It is possible that ICBs may be able to develop local solutions, given the right contracting levers, but it is unlikely that new leadership of POD commissioning will be able to develop such approaches without clarity on contracting arrangements and support to address short-term capacity issues.[151]

115. ***We welcome the initiatives outlined by the Chief Dental Officer to help ICBs commission dental services in a way that best meets the needs of their local populations. NHS England should provide evidence of the effectiveness of these initiatives, so that ICBs can see for themselves which options they could most usefully pursue and best practice is spread.***

116. ***In light of the current national contracting arrangements, NHS England must provide clarity to ICBs about what flexibilities they have with regard to commissioning NHS dental services and targeting resources according to the needs of their populations.***

Oral health needs assessment

117. Two of the core purposes of ICSs are to "improve outcomes in population health and healthcare" and "tackle inequalities in outcomes, experience and access".[152]

118. The Department emphasises that: "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."[153]

119. Bupa, LDC Confederation and Healthwatch England stress the importance of ICBs conducting local oral health needs assessments (OHNA).[154] The aim of an OHNA is to provide an overview of the oral health of a local area and of the currently commissioned

149 Q118
150 Q22
151 NHS Confederation, From delegation to integration: Lessons from early delegation of primary pharmacy, optometry and dentistry commissioning to integrated care boards, April 2023, accessed on 6 June 2023, p22
152 NHS England, 'What are integrated care systems', accessed 15 June 2023
153 Department of Health and Social Care (DTY0099)
154 Bupa Global & UK (DTY0024); Local Dental Committee Confederation (DTY0073); Healthwatch England (DTY0094)

dental services. This should be used to identify gaps in provision and inform future commissioning decisions. Ideally this should be done in consultation with local authorities, local professional networks and service users among others.[155]

120. Guidance for ICBs includes providing evidence of oral health needs assessments being undertaken as evidence of compliance with their statutory duties within the Health and Care Act 2022.[156] It is essential that there is NHS England oversight to ensure this is being done, and being done effectively, by ICBs.

121. **ICBs have been delegated responsibility for commissioning dental services by NHS England. They offer an opportunity to improve access locally, better integrate services around patients and address inequalities.**

122. ***By the end of July 2024, every ICB should have undertaken an oral health needs assessment, in consultation with service users, patient organisations and the profession. NHS England should provide support to ICBs to undertake this, including sharing examples of best practice and learnings from other ICBs. NHS England must also ensure each assessment is sufficient to meet its intended purpose.***

155 An example of an OHNA can be found here: NHS England, Oral Health Needs Assessment: Main Report, South West of England, January 2021

156 NHS England, Primary care commissioning assurance framework, 14 April 2023, accessed on 21 June 2023

Conclusions and recommendations

Access

1. We believe there is a crisis of access in NHS dentistry. Many people are unable to access an NHS dentist or are travelling significant distances to get to one. Access varies across the country and is being experienced unequally by different groups. We believe everyone should be able to access an NHS dentist when they need one, wherever they live. (Paragraph 13)

2. *We welcome the Government's ambition for everyone who needs an NHS dentist to be able to access one. This ambition must ensure access within a reasonable timeframe and a reasonable distance. The Government must set out how they intend to realise this ambition and what the timeline will be for delivery. It is vital that this ambition is the central tenet of the Government's forthcoming dental recovery plan. Once the plan has been published, we will revisit the recommendations in this report to assess it against this criteria*. (Paragraph 14)

3. *A lack of public awareness about NHS dental services and how practices operate is contributing to access issues. The Government and NHS England should roll-out a patient information campaign with the aim of improving awareness of how NHS dentistry will work and ensure the public are better informed about what they are entitled to. This should clarify common misconceptions, for example, about patient registration, recall periods, and NHS dental charges and exemptions.* (Paragraph 18)

4. *Practices should abide by NICE recall guidelines of up to two years for most adult patients, recognising the need for more regular recall for some, but people should not automatically be removed from dentists' registers of NHS patients without good reason. This should be monitored by NHS England to ensure it is being carried out.* (Paragraph 19)

The Dental Contract

5. *We welcome the fact that to try and address the underspend, NHS England is applying a ringfence for 2023/24, to ensure that no ICB can divert funding away from NHS dentistry. We recommend that this ringfence applies permanently, and NHS England puts in place transparent scrutiny to ensure compliance.* (Paragraph 38)

6. We also welcome measures by NHS England to intervene on providers who are under-delivering on contracted NHS activity. We look forward to an update on how this work is progressing. We welcome this funding being used flexibly, however there cannot be further delays in doing so. (Paragraph 39)

7. Fundamental reform of the dental contract is essential and must be urgently implemented, not only to address the crisis of access in the short-term, but to ensure a more sustainable, equitable and prevention-focussed system for the future. We are concerned that any further delay will lead to more dentists leaving the NHS and exacerbate the issues patients are experiencing with accessing services. (Paragraph 50)

8. *We welcome the Government's recognition of the need for dental contract reform. The Department and NHS England must urgently implement a fundamentally reformed dental contract, characterised by a move away from the current UDA system, in favour of a system with a weighted capitation element, which emphasises prevention and person-centred care. This should be based on the learnings from the Dental Contract Reform Programme and in full consultation with the dental profession.* (Paragraph 51)

9. We believe patient registration under a reformed capitation-based contract will better enable those patients who currently can't access a dentist to be able to do so. (Paragraph 54)

10. *We uphold the recommendation from our predecessors' 2008 report into Dental Services, that the Department should reinstate the requirement for patients to be registered with an NHS dentist.* (Paragraph 55)

Workforce

11. The Government states that the number of NHS dentists has increased over the past year. However, while the headcount has gone up over the past year, it has gone down over the past three years, and moreover headcount alone does not reflect how much NHS work these dentists are undertaking. We heard repeatedly that a lack of dentists and dental care professionals undertaking NHS work is the main driver behind both lack of access to appointments for patients, and the underspend in primary care dentistry. (Paragraph 67)

12. *The Government and NHS England should commission a dental workforce survey to understand how many full-time and part-time-equivalent dentists, dental nurses, therapists and hygienists are working in the NHS, and how much NHS and private activity they are undertaking, alongside demographic data such as age and location.* (Paragraph 68)

13. *The Government and NHS England must improve the routine data that is collected on the number of NHS dentists and the wider dental team, and the levels of NHS activity they undertake, as well as data on demand, to assist with workforce planning and identifying gaps in provision. This must be addressed in the forthcoming dental recovery plan. Until such a time, the Government should focus on statistics which show the levels of NHS dental activity.* (Paragraph 69)

14. *Any contract reform now will almost certainly be too late for those dentists who have already left the NHS or are considering doing so in the near future. The Government must urgently introduce incentives to attract and retain dentists to undertake NHS work. These should include, but not be limited to, the reintroduction of NHS commitment payments, incentive payments for audit and peer review, and the introduction of late career retention payments. The development of a careers framework should be considered, including on-going education, supervision and support. This should form part of a wider package, accompanied by a communications drive, to entice professionals to return to NHS dentistry.* (Paragraph 72)

15. *The Government, NHS England and ICBs must ensure that the reformed contract ensures that full use is made of the skills of the whole dental team.* (Paragraph 73)

16. We support the implementation of the work of the Advancing Dental Care Review. Centres for Dental Development could have the potential to change how we approach training dentists in the UK to meet the needs of the populations who most require care. However, these are in their early stages and their outputs will need to be assessed. We also recognise that incentives are required in the short-term to address the immediate challenges with supply and demand. (Paragraph 79)

17. The backlog of applications for the Overseas Registration Exam is unacceptable and resolving this represents an opportunity in the short term to increase the number of dentists working in the NHS, and therefore create more appointments to enable patients to access much-needed services. (Paragraph 85)

18. *The Government must work with the General Dental Council to ensure the backlog of applications for the Overseas Registration Exam is cleared in a timely manner, and to speed up changes to the process of international registration for new applicants seeking to work in the NHS.* (Paragraph 86)

19. We are concerned that the absence of explicit mention of the dental contract in the Long Term Workforce Plan reflects the lack of priority given by the Government and NHS England to contract reform. We believe it indicates a lack of recognition of the urgent need for reform before any other workforce initiatives can be implemented. (Paragraph 90)

20. Given the varying views expressed regarding a tie-in for new graduates into NHS dentistry, we urge NHS England and the Government to ensure full consultation with professionals and representative bodies, as they seek to explore the potential merit of such a policy, although its success depends on fundamental contract reform, and should be accompanied with a careers framework. (Paragraph 92)

Integrated Care Systems

21. *The dental profession should be represented on Integrated Care Boards to ensure they have the necessary expertise to inform decision-making around contracting and flexible commissioning. This should include wider engagement with the profession locally, for example through Local Dental Committees and Local Dental Networks.* (Paragraph 106)

22. *We contest the Department's rejection of the recommendation in our 'Integrated Care Systems: autonomy and accountability' report, and reiterate that they should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise. We also recommended the Department should review that information with a view to understanding whether the policy of keeping mandated representation to a minimum is the right one and whether any specialties are especially under-represented. We believe this is particularly relevant in the case of NHS dental services.* (Paragraph 107)

23. *We welcome the initiatives outlined by the Chief Dental Officer to help ICBs commission dental services in a way that best meets the needs of their local populations. NHS*

England should provide evidence of the effectiveness of these initiatives, so that ICBs can see for themselves which options they could most usefully pursue and best practice is spread. (Paragraph 115)

24. *In light of the current national contracting arrangements, NHS England must provide clarity to ICBs about what flexibilities they have with regard to commissioning NHS dental services and targeting resources according to the needs of their populations*. (Paragraph 116)

25. ICBs have been delegated responsibility for commissioning dental services by NHS England. They offer an opportunity to improve access locally, better integrate services around patients and address inequalities. (Paragraph 121)

26. *By the end of July 2024, every ICB should have undertaken an oral health needs assessment, in consultation with service users, patient organisations and the profession. NHS England should provide support to ICBs to undertake this, including sharing examples of best practice and learnings from other ICBs. NHS England must also ensure each assessment is sufficient to meet its intended purpose*. (Paragraph 122)

Appendix: Summary Note—NHS dentistry roundtable held in Westminster on 7 June 2023

The following points were made by participants:

Access

- People are having difficulties getting appointments, with some patients unable to see an NHS dentist for years. This includes children who have never seen a dentist. One particular example involved someone who had been waiting eight years to find an NHS dentist for them and their children. Some people are able to choose to go private, but those who cannot are losing out. People shouldn't be denied dental care due to a lack of means.
- Even when patients are able to secure an appointment, many subsequently have appointments cancelled. Sometimes appointments are repeatedly cancelled.
- Even emergency dental appointments are difficult to secure and are often as short as 15 minutes.
- Some people are worried about dropping off dentists' books if they don't go regularly enough, with some dentists requesting they attend every six months, despite guidance stating recall can be up to 2 years. Sometimes people are removed from dentists' lists if they don't have an appointment in an 18-month period. People who have an NHS dentist are frightened not to go every six months in case they get taken off the list.
- People across the country are travelling significant distances to attend appointments if they are fortunate enough to get one, for example people are travelling almost two hours by car. Other people are being told of dentists that are 50 or 60 miles away, with some travelling hundreds of miles to Scotland for appointments. Travel is expensive and time-consuming and not an option for many.
- People are being told that their only hope of finding an NHS dentist is to ring every week in case an appointment became available.
- There are repeated accounts of pregnant women being unable to access the routine dental care they are entitled to free under the NHS.
- Parents of children with SEND are having particular difficulties accessing dentists who could meet their children's needs. There are SEND specifics to dental care that SEND children are also missing out. It is difficult to find a list of dentists who specialise in treating children with SEND. All dentists should be given access to training on how to provide services to children with SEND. SEND children should be able to see a dentist through the 'ACCESS' service,

however many are being refused. General Dental Practitioners should be more empathetic to those who struggle with the dentist so that ACCESS can be just for this cohort.

- It's important for patients to have a choice of going NHS or private if they wish to.
- People should be entitled to the same standard of care regardless of whether they were seeing a private dentist or an NHS dentist. At the moment, the difference was like chalk and cheese. The skills being utilised in private practice were different from those being used in the NHS.

Consequences of lack of access

- Many people are living in pain due to lack of access.
- Lack of access is leading to more people presenting to A&E and GPs, but they already have enough on their plate.
- It is important not only to think about medium and long-term solutions, but to focus on how to help people who can't access an NHS dentist right now and are having to live with the consequences. In the short term, solutions include making greater use of mobile surgeries.
- As a result of not being able to access an NHS dentist, some people have teeth crumbling in their mouth and are in severe physical and mental pain, and begging for morphine.
- Not being able to access a dentist also makes people feel self-conscious about their teeth and this can affect work and social interactions, and those of other family members. It affects how people feel as they walk down the street and whether they want to talk to other people. In one instance, wearing a mask during the pandemic was seen as a positive thing because it made the person less worried about their teeth and what other people would think.
- Being unable to see a dentist at routine intervals can have implications for wider oral, physical health, mental health and social wellbeing—"a healthy mouth is a healthy body".
- The consequences of not being able to get an appointment to see a dentist are potentially severe. In one case, the consequences involved an emergency hospital stay of nearly three weeks for a lung problem related to gum disease. This in turn had severe knock-on impacts on caring responsibilities and family life, including the mental health of family members. There is a financial cost to the NHS to these kinds of consequences as well.
- Lack of access is impacting on the wider resources and places further pressure on the NHS, for example with patients developing conditions like diabetes, sepsis, oral cancer etc as a result of lack of routine care and treatment

Workforce

- The problem is not that there aren't enough dentists, but that dentists working in private practice need to be attracted to work in NHS dentistry.
- Many dentists do not work in the NHS, even if ideologically they would want to, due to the current system not being fit for purpose.
- There is a disparity between the work that dentists undertake in the NHS compared to private practice, for example more time is spent with patients and there is a greater emphasis on prevention for dentists practising privately—impacting on both the dentists themselves but most importantly on the care and service NHS patients receive.
- It will take time to feel the positive effects of developing new dental schools or increasing places for trainees–immediate actions are required now to incentivise the workforce and provide solutions for people who seeking NHS dental appointments.
- The GDC process for overseas dentists can be time-consuming and cumbersome. There are overseas dentists working as Uber drivers, due to delays in being able to take the necessary exams.
- There is an issue with finding mentors with the necessary experience to take on trainee dentists.
- There is also an issue with people getting an NHS contract if they are dental technicians, rather than dentists.

Data

- No one is monitoring the provision of NHS dental care.
- There is data about the overall number of dentists, but not on how much NHS work they are undertaking.
- There is also limited data on the dental needs of populations.
- There isn't the data available to show the longer-term consequences of not being able to access a dentist. For example, if someone presents at hospital with a problem ultimately caused or exacerbated by poor oral health, that is not necessarily recorded as a dental problem–only the proximate cause is recorded. This makes it hard to track the long-term implications and costs of the current access problems.

ICBs

- More flexibility is needed for ICBs to effectively commission services that meet the needs of their populations.

- It's vital to ensure there is accountability for ICBs in the effectiveness of their commissioning, in meeting the oral health needs of their populations and in addressing the difficulties their populations are experiencing in accessing NHS dentistry.
- There's a requirement for ICBs to consult directly with service users to understand patient need, inform decisions around commissioning and embed co-production. ICBs need to work closely with patients, carers and patient organisations such as patient carer forums, Healthwatch and Toothless.
- More guidance is needed for ICBs around their new responsibility to commission dentistry as well as information sharing with other ICBs.
- ICBs should have dentistry represented on their Boards.
- Some ICBs lacked relevant information—e.g., a list of NHS dentists in their ICS area.

Formal minutes

Tuesday 11 July 2023

Members present:

Steve Brine, in the Chair

Paul Blomfield

Paul Bristow

Chris Green

Mrs Paulette Hamilton

Dr Caroline Johnson

Rachael Maskell

James Morris

Draft Report (*NHS Dentistry*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Summary agreed to.

Paragraphs 1 to 122 agreed to.

Appendix agreed to.

Resolved, That the Report be the Ninth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134.)

Adjournment

Adjourned till Wednesday 12 July 2023 at 2.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 21 March 2023

Professor Nick Barker, General Dental Practitioner and Professor of Oral Health Science, University of Essex; **Shawn Charlwood**, Chair, British Dental Association General Practice Committee; **Dr Sandra White**, Clinical Director, Association of Dental Groups — Q1–32

Ian Brack, Chief Executive and Registrar, General Dental Council; **Dr Abhi Pal**, President, College of General Dentisty; **Malcolm Smith**, Chair, HEE's Advancing Dental Care Review and Dental Education Reform Programme, and Postgraduate Dental Dean, Health Education England North East — Q33–64

Tuesday 25 April 2023

Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire; **Chris McCann**, Director of Communications, Insight and Campaigns, Healthwatch England; **Jo York**, Managing Director, Hampshire and Isle of Wight Integrated Care Board — Q65–96

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 — Q97–141

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

DTY numbers are generated by the evidence processing system and so may not be complete.

1 Anonymous (DTY0006)

2 Anonymous (DTY0003)

3 Association of Dental Groups (DTY0038)

4 Bannister, Mr R (Dentist, Swan Dental Practice) (DTY0020)

5 Barker, Robert (DTY0005)

6 Batchelor, Professor Paul (Professor Clinical Medicine, UCLan) (DTY0074)

7 Bell, Dr Andrew (Associate, John G Plummer and Associates) (DTY0043)

8 Birmingham Local Dental Committee (DTY0023)

9 British Dental Association (DTY0078)

10 Bupa Global & UK (DTY0024)

11 Cambridge Refugee Resettlement Campaign (DTY0100)

12 Care Quality Commission (DTY0083)

13 Collins, Doctor Hazel (DTY0093)

14 Cuerden, Jan (DTY0036)

15 Denplan (Simplyhealth - WA Communications) (DTY0071)

16 Dental Protection (DTY0033)

17 Department of Health and Social Care (DTY0099)

18 Elizabeth, Professor Jennifer (Newland-Pedley Professor of Oral Health Strategy/Hon Consultant in Dental Public Health, King's College London) (DTY0097)

19 Faculty of Dental Surgery, Royal College of Surgeons of England (DTY0063)

20 Field, Helen (DTY0086)

21 Furminger, Mr Michael (DTY0034)

22 Furniss, Gill (Member of Parliament for Sheffield Brightside and Hillsborough, UK Parliament) (DTY0028)

23 General Dental Council (DTY0091)

24 HealthWatch England (DTY0094)

25 Healthwatch Bolton (DTY0072)

26 Healthwatch Brighton and Hove; Healthwatch East Sussex; and Healthwatch West Sussex (DTY0048)

27 Healthwatch Bristol, North Somerset and South Gloucestershire (DTY0095)

28 Healthwatch Cambridgeshire and Peterborough (DTY0032)

29 Healthwatch Derbyshire (DTY0041)

30 Healthwatch East Riding of Yorkshire (DTY0015)

31 Healthwatch Hertfordshire (DTY0030)

32 Healthwatch Hull (DTY0051)

33 Healthwatch Isle of Wight (DTY0067)

34 Healthwatch Kent; and Healthwatch Medway (DTY0088)

35 Healthwatch Leeds (DTY0085)

36 Healthwatch Lincolnshire (DTY0070)

37 Healthwatch Liverpool (DTY0027)

38 Healthwatch Middlesbrough & Healthwatch Redcar and Cleveland (Healthwatch South Tees) (DTY0016)

39 Healthwatch Newcastle; and Healthwatch Gateshead (DTY0081)

40 Healthwatch Norfolk (DTY0055)

41 Healthwatch North East Lincolnshire (DTY0052)

42 Healthwatch North Lincolnshire (DTY0057)

43 Healthwatch Northumberland (DTY0021)

44 Healthwatch Portsmouth (DTY0084)

45 Healthwatch Richmond (DTY0068)

46 Healthwatch Sheffield (DTY0053)

47 Healthwatch Southend (DTY0039)

48 Healthwatch Staffordshire (DTY0031)

49 Healthwatch Surrey (DTY0077)

50 Healthwatch Worcestershire (DTY0037)

51 Healthwatch York at York CVS (DTY0060)

52 Hertfordshire Local Dental Committee (LDC) (DTY0058)

53 LDC Confederation (DTY0073)

54 Local Government Association (LGA) (DTY0047)

55 Lucas, Caroline (Member of Parliament for Brighton Pavilion, UK Parliament) (DTY0061)

56 Martin, Mr Philip (Director , Whitehouse Dental Surgery) (DTY0008)

57 Martins, Dr Eurico (Associate General Dental Practitioner, Self employed) (DTY0002)

58 NHS Confederation (DTY0087)

59 National Audit Office (DTY0103)

60 National Network of Parent Carer Forums (DTY0092)

61 Newcastle University School of Dental Sciences (DTY0066)

62 North Yorkshire County Council (DTY0046)

63 Olney, Mrs Sarah (Member of Parliament for Richmond Park, Liberal Democrats - UK Parliament) (DTY0090)

64 Oral Health Foundation (DTY0065)

65 Parliamentary and Health Service Ombudsman (DTY0040)

66 Plymouth Community Dental Services Ltd (DTY0069)

67 Rogerson, Dr Connor (Senior Research Associate, University of Cambridge) (DTY0001)

68 SpaDental group (DTY0096)

69 Sudra, Mr Vijay (Practice Principal Dental Surgeon (NHS practitioner), Shard End Dental Pactice) (DTY0014)

70 Tarnowski, Agi (Densist, Sample Group of General Dentists from Kent Surrey and Sussex) (DTY0089)

71 The Challenging Behaviour Foundation (DTY0064)

72 The Dental Defence Union (DDU) (DTY0029)

73 The Nuffield Trust (DTY0098)

74 The Royal College of Surgeons of Edinburgh (DTY0049)

75 Toothless in England (DTY0079)

76 Turver, Mr Martin (Retired, Licensee) (DTY0009)

77 University of East Anglia (UEA) (DTY0101)

78 Watson, Derek (DTY0102)

79 West Yorkshire Joint Health Scrutiny Committee (DTY0045)

80 Wrigley Oral Healthcare Programme (DTY0076)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
4th	The future of general practice	HC 113
5th	Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB	HC 843
6th	Follow-up on the IMMDS report and the Government's response	HC 689
7th	Integrated Care Systems: autonomy and accountability	HC 587
8th	Digital transformation in the NHS	HC 223
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	Evaluation of Government commitments made on the digitisation of the NHS	HC 780
5th Special	Government Response to the Committee's Report on Follow-up on the IMMDS report and the Government's response	HC 1286
6th Special	Government Response to the Committee's Report on Workforce: recruitment, training and retention in health and social care	HC 1289
7th Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce: Government Response	HC 1290
8th Special	Government Response to the Health and Social Care Committee's Expert Panel: evaluation of Government's commitments made on the digitisation of the NHS	HC 1313

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311