Briefing for MPs: Opposition Day Debate on NHS dentistry, 9 January 2024

Key points

- Decades of policy neglect have left the future of NHS dental care hanging in the balance, with the result that universal NHS dentistry has most likely gone for good.
- Funding for NHS dentistry has not kept pace with inflation. The dysfunctions of the contract regularly mean that hundreds of millions of pounds for dentistry in England go unspent: this year they have been moved to shore up wider NHS services.
- Compared to England's 4.3 dentists per 10,000 population in 2021/22, Northern Ireland had 6, Scotland had 5.9 and Wales had 4.6. In England, the number carrying out NHS work per head of the population has not risen in a decade.
- Children's oral health is a particular concern: tooth extractions remain the primary reason for hospital admissions for 6-10-year-olds, and more deprived children suffer most.
- There is significant geographical variation in the availability of NHS dentists, with rural and coastal areas experiencing the fewest NHS dentists per head.
- Radical action will be needed to prevent its further decline: extensive reforms to dental contracts combined with a huge boost in staffing are essential.
- Even with these measures it is likely that politicians will need to re-evaluate the core NHS dentistry "offer" of universal, comprehensive care, which has already been lost in practice.
- It may be time to move to a model where free check-ups and prevention are still offered universally, and are genuinely available, but NHS dental treatment and orthodontics are means tested for those not in vulnerable or high-risk groups.

Introduction

NHS dentistry is at its most perilous point in its 75-year history. Our December 2023 report 'Bold Action or Slow Decay' provided a comprehensive look at the state of NHS dentistry in England, drawing on routine and publicly available data on funding, activity, access, staffing and oral health.

We concluded that NHS dentistry is plagued with a troubling array of problems, from poor and worsening access to dentists, to a dysfunctional financing regime and problems in attracting dentists to carry out NHS work. The pandemic hit NHS dentistry hard, exacerbating pre-existing problems such as a broken contract and a funding squeeze.

Our report outlines actions that policymakers should take to stabilise the service in the short, medium and longer term. This briefing summarises the main points, ahead of Tuesday's Opposition Day Debate on NHS dentistry.

In some initial areas existing Government policy, and plans put forward by the Labour Party, cover key actions. Ultimately, however, we point out that universal access to NHS dental care has likely gone for good unless an unfeasibly large sum is spent to restore it. The urgent imperative is to restore a basic core service for children, older people, and people who cannot afford private care.

How much money is spent on NHS dentistry?

Funding for NHS dentistry in England was £3.1bn in 2021/22. This represents a fall of £525m in real terms since 2014/15. Of this £3.1bn, 20% (£0.63bn) came from charging and 80% (£2.47bn) came from NHS England. Prior to the pandemic, charging accounted for a quarter of overall funding.

The NHS has consistently failed to spend its full budget on dentistry every year apart from 2020/21 (the year of the pandemic) with the British Dental Association estimating a projected underspend of £400 million in 2022/23, amounting to around 13% of the overall budget.

These underspends are symptomatic of the wider problems in NHS dentistry: they occur money is clawed back from practices if activity is not delivered or there are no contractors to deliver the activity.

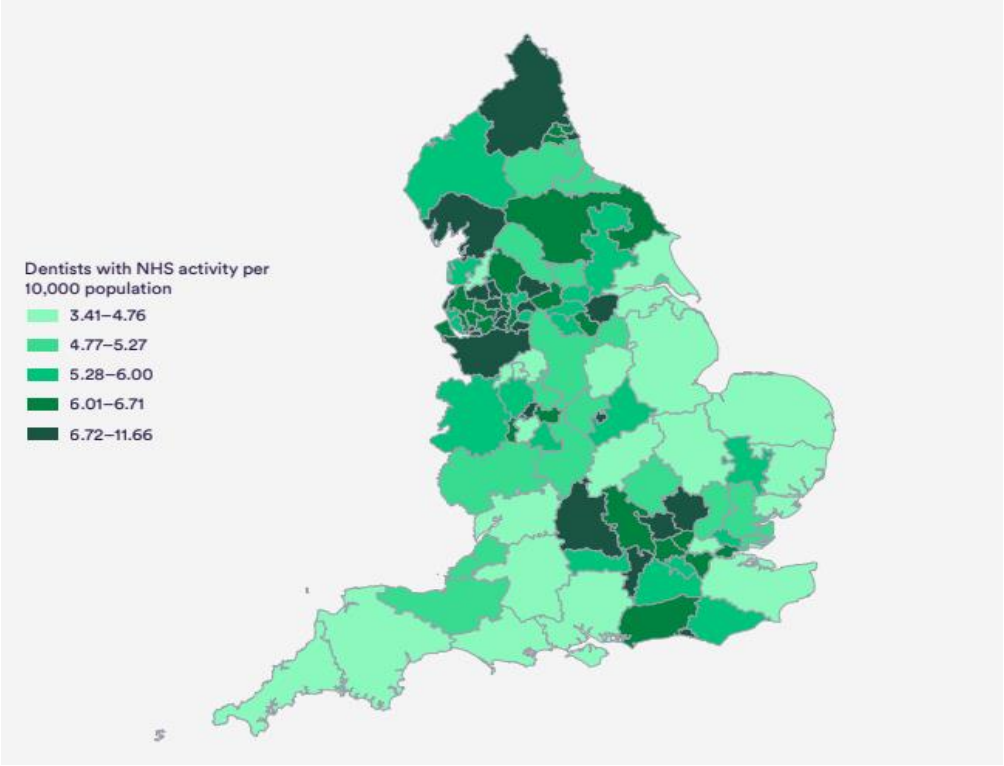
The Government recently confirmed that local NHS Integrated Care Boards have been allowed to “retain underspends to balance their bottom line and any other pressures” (Government response to Health and Social Care Committee’s Ninth report of Session 2022/23)

Who is not getting to see an NHS dentist?

In 2019/20 more than half of all adults had not seen an NHS dentist within the previous 24 months and more than two in five children had not had an appointment in the previous 12 months. This suggests that NHS dentistry is really only covering about half the population.

There is huge geographical variation in the availability of NHS dentists, with people in some areas finding it virtually impossible to find a dental practice accepting NHS patients. The lack of dentists in rural and coastal areas is a particular concern. Our analysis found there is as much as 3-fold variation between areas with the most and least numbers of NHS dentists per head. The Trafford area of Greater Manchester and South Tyneside have the highest numbers (11.7 and 9.13 per 10,000 respectively) and the East Riding of Yorkshire and Norfolk and Waveney have the fewest (3.41 and 3.60 per 10,000 respectively). The England average is 4.3 dentists per 10,000 population.

Variation in headcount of NHS primary care dentists by sub-ICB area in 2022/23



Some of those missing out the most are people in deprived communities, where oral health concerns are worst: The recent Oral Health Survey of 5-year-old children found that children living in the most deprived areas of the country were 2.5 times more likely to have experience of tooth decay than those living in the least deprived areas.

Public Health England have shown that people from Black, Asian and minority ethnic groups were less likely than White people to report that they had been successful in getting an NHS dental appointment in the last 2 years.

It seems that universal access to an NHS dentist has gone for good and in its place is a three-tier system**:** one for those who can afford private care, one for those lucky enough to find access to scarce NHS services and then those shut out of dental care. This is the unfair consequence of a slow decay in NHS dentistry over many years.

How much NHS dentistry is being carried out?

NHS dental activity had been falling for many years prior to the pandemic. In 2014/15 there were 88.7 million Units of Dental Activity (UDAs) delivered in England, covering all activity of varying complexity – from check-ups to fillings, extractions to crowns. On the eve of the pandemic, this had fallen 11% to 78.8 UDAs.

The wholesale closure of NHS dentistry for three months during the pandemic had a dramatic effect on activity. UDAs fell to a low of 57.1 million in 2021 and climbing to 70 million in 2022/23 – still below pre-pandemic levels and a long way below 2014-15 levels. Courses of treatment (which may involve multiple UDAs) fell from 39 million pre-pandemic to just 11 million in 2020/21 and have recovered to 32.5 million – still six million lower than pre-pandemic.

While some of the overall drop off in NHS dental activity may be down to improvements in oral health, it is likely that a large amount is driven by poor and worsening access to an NHS dentist.

What is happening to children’s oral health?

As with the adult population, there are concerning disparities in children’s oral health, likely driven by poor access to NHS dentists, wider health inequalities and public health issues like

sugar consumption. Children eligible for free school meals had worse overall dental health and had poorer attendance for dental check-ups than ineligible children.

The Office for Health Improvement and Disparities has reported that tooth decay is the most common reason for a hospital admission for six- to ten-year-olds in England. They also show that there is geographical variation in rates of tooth extraction in 0-19 year olds, with Yorkshire and the Humber experiencing the highest rates (378 per 100,000 population) and the East Midlands experiencing the lowest rates (71 per 100,000 population). We found that during the pandemic children under the age of ten from the most deprived areas had the biggest fall in rate of tooth extractions in hospital.

Inequalities in children's oral health have changed little over recent years and Public Health England has noted that inequalities in the amount of tooth decay in five-year-olds increased between 2008 and 2019.

What is going on in the NHS dental workforce?

The numbers of NHS dentists in England have barely grown in a decade. In 2022/23 there were 24,151 dentists with NHS activity, which equates to 43 dentists per 100,000 population and each NHS dentist had on average 2,342 patients. This compares to just under 23,000 dentists with NHS activity in 2011/12: the increase has only matched the growth in population.

In international context, the UK appears to have lower numbers of dentists per head than other countries and within the UK, England had only 4.3 dentists doing NHS work per 10,000 population in 2021/22. Northern Ireland had 6, Scotland had 5.9 and Wales had 4.6.

Dentistry has been relatively slow to move towards using a different blend of staffing groups (known as skill-mix) where professionals like dental nurses, therapists, orthodontists and hygienists work together to expand what dentists alone could provide. In fact, the estimated number of dental nurses in employment in England dropped from nearly 41,000 in 2010/11 to just under 38,000 in 2020/21. Dental practices themselves are often relatively small-scale – nearly half (46%) of dental practices have 4 or fewer employees, which makes bringing in, training and supervising new types of staff difficult.

There has been a long-term drift from NHS work towards private work, which no Government has actively sought to prevent. The structuring of the dental contract, which uniquely allows a mix of NHS and private work, has facilitated this trend. A BDA survey

suggests that one in two dentists in England (50.3%) have reduced their NHS commitments since the start of the pandemic.

The NHS Long-Term workforce plan sets out a laudable aspiration to increase the numbers of full-time-equivalent NHS dentists and dental care professionals from 8,000 FTE dentists and 500 dental care professionals now to 23,000 in total in 2036/37. Around 7,100 of these dentists will come from improving the participation rate of dentists in NHS services, which may be driven by a tie-in scheme to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation.

The Plan also anticipates that a small amount will be driven by international recruitment (500 full-time dentists by 2036/37), and a portion (up to 900 FTE dentists and up to 2,600 dental therapists and hygienists) will be driven by training and enhanced skill mix.

It is hard to see how these aspirations can be met with the ongoing drift of dentists away from NHS provision and the limited progress bringing in other types of staff.

What immediate actions can be taken to revive NHS dentistry?

Our report outlines three areas where action can immediately be taken to tackle the unfair consequences of decades of policy neglect in NHS dentistry. These are:

1) **Making use of "flexible commissioning" to target additional activity**

   In areas where providers are struggling to deliver their allocated number of UDAs (usually because of workforce constraints), the capacity could be reallocated better serve those most in need of dental care – for example to run specific outreach sessions such as mobile services in areas with the greatest unmet need.

   However, this is only a viable option if dental underspends are not being used to plug wider NHS budgets, and will require skilled local commissioning.

2) **Using international recruitment and developing skill-mix to shore up the workforce**

   In the short-term it is hard to see how the numbers of additional staff needed can be brought onstream without a drive on international recruitment. In addition, there should be a concerted effort to tempt dental therapists into the NHS. This staff group are central

to tackling the access challenges of the service, and yet mainly work in the private sector. We suggest focused work to understand what measures would make NHS work attractive to this group.

3) **Moving checkups further apart**

Traditionally, patients are encouraged to book regular dental checkups every six months. However, the National Institute for Health and Care Excellence's (NICE) guideline recommends that the intervals between checkups should be tailored to patients' disease risk, with a minimum interval of three months and a maximum of 24 months for over-18s.

NHS England should work with the profession to extend the recall interval to at least one year for adults unless clinically indicated. This should be accompanied by a public awareness campaign (jointly between Government and profession) explaining that this is neither an unacceptable clinical risk or a cut by the back door.

Much work is already underway to better use flexible commissioning, develop the workforce and the Government has expressed its support for extending recall intervals. This is of course welcome, but much more fundamental change is still needed.

What longer-term actions are needed?

Our report sets out a range of options that should improve the current model of NHS dentistry. These include:

1) A new needs-based contract based on patient lists

The current contract was introduced in 2006. It was intended to be a transitional step to longer-term arrangements with a greater emphasis on prevention and maintenance, and was never fit for purpose as a long term solution.

The system of fixed payments by "Units of Dental Activity", or UDAs, rewards quantity over quality and fails to recognise that some patients cost more to treat. In addition, the huge variation in the value of UDAs is largely unadjusted since 2006.

The continued move away from NHS work demonstrates that change is needed. NHS England, and the Labour Party in Opposition, have both indicated consideration of significant reform, but details remain unclear. The existing contract is seen by providers as disincentivising taking on the care of those with poorer oral health. The goal should

remain a move towards arrangements that facilitate and incentivise modern preventative care.

We recommend moving to a model based on patient lists, with payment for each person on the list based on their risk and needs as GPs receive. This could cover check-ups and high-volume, simple care such as checkups and fillings. A fee-for-service approach would only be used for low-volume, high-cost and complex procedures.

Lessons from the evaluation of pilot schemes should be heeded to ensure that needs-weighted funding directs higher quality, more intensive treatment for those who need it, and puts more focus on prevention among groups at high risk.

2) Measures to attract and retain NHS dentists, including a loans forgiveness scheme

The Long-Term Workforce Plan is right to target improved skill-mix to deliver the NHS dentistry workforce of the future. We would like to see more definite proposals to address the need for better and more fulfilling career paths in NHS dentistry and the development of clinical leadership in dentistry.

We also suggest that an incentivised approach might be more effective than the current proposed tie-in scheme. Our proposal outlined last year involved gradually writing off student loans, with 30% of a student's loan balance being written off after three years of service, 70% written off after seven years and 100% after 10 years. Such an approach should be considered for dentists.

3) Invest in dental public health

Given the stark inequalities present in both access to dental care and in oral health in England, and the reality that much dental disease is preventable, more attention needs to be paid to comprehensive public health programmes and interventions which can deliver benefits for long-term health and limit the requirements for dental intervention.

Programmes like the Start for Life Family Hubs which include oral health should be prioritised for broader availability and ICBs should develop, measure and monitor strategic and operational plans for dental commissioning and oral health improvement.

Time to look at the NHS offer?

Even if the short-and long-term actions described above are implemented, we argue that politicians will still need to take a clear-headed look at the NHS dentistry offer. At present, dentistry in England offers the population a package of services with some explicit exclusions. But NHS dentistry is increasingly unable to deliver equal access to this package of services across the country, meaning that this approach is breaking down.

There are two broad options:

1) **Restore the offer through increased spending**

An obvious way to enhance the NHS offer would be to spend more on dentistry. However, the shift towards the private sector, of both patients and dentists, creates a policy dilemma. Any large expansion of access which is not targeted at underserved areas or parts of the population could lead to a return of people to NHS services. This represents a 'deadweight' cost – that is to say, money would be spent providing care for a large number of people who are already paying privately and who, in many cases, may be happy to do so.

Prior to the pandemic, out-of-pocket expenditure on dental practices was in the region of £4bn. Bringing much of this cost back onto the public sector, with little benefit to overall oral health, would be difficult for a government to choose at a time of squeezed public finances. Increasing charges is also not likely to be a viable strategy.

2) **Limit the NHS offer and means-test eligibility**

This option would be to deliberately move resources and target only those with the most difficulty in getting access and affording dentistry. It might be that free check-ups and prevention are offered universally, but that NHS coveragefor dental treatment and orthodontics is means tested for those not in vulnerable or high-risk groups.

An excellent core service for those in need – children, pregnant women, older people and those who cannot afford private care – is a standard we currently do not meet: NHS dentistry is failing those with the greatest need. Focusing care on priorities such as this is likely to mean removing some of the rights to NHS services which people currently enjoy in theory – but usually go without in reality.

What happens if we continue to muddle through?

If this Government and the next Government duck the challenge of setting out a clear, strategic and long-term approach to NHS dentistry, we will be left with a continuation of current policy: to allow the steady decline of NHS dentistry, with a relentless drift of patients and dentists to the private sector, punctuated by occasional minor initiatives and changes untethered to any strategic purpose. This has been the policy adopted since at least the mid-2000s, if not since 1992. It was not viable then and, as the evidence shows, it is even less so now.

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