



Policy briefing December 2023

Bold action or slow decay?

The state of NHS dentistry
and future policy actions

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nuffieldtrust

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1 Overview

NHS dentistry in England is at its most perilous point in its 75-year history.

Worsening problems in accessing a dentist, a funding squeeze, the Covid-19 pandemic, and growing inequalities in oral health have created a widespread crisis. The Health and Social Care Select Committee has called for fundamental reform to end the crisis of access, and the government has promised a dental recovery plan.

The wholesale closure of routine dentistry for several weeks during the pandemic exacerbated many problems in NHS dentistry. But these problems have deep roots in a series of poor policy choices, and a general approach which may be charitably described as ‘muddling through’ over several decades. In 2017, we reported on the **state of NHS dentistry** as part of our **QualityWatch** programme with the Health Foundation. We concluded that, while there had been improvements in oral health, there remained persistent socioeconomic and regional variations in dental health and access to NHS dentists. We recommended then that much more needed to be done to embed incentives and other approaches to preventative measures to improve oral health and, importantly, to improve access to NHS dentistry – particularly for more deprived parts of the population.

This report seeks to understand how things have changed and what choices we face if we want a sustainable future for a publicly funded dental service that meets the needs of the population. Focusing on general primary care dentistry for adults and children in England, the analysis mostly looks at NHS-funded work and the role of general dental practitioners who contract with the NHS. We do not discuss orthodontics or more major hospital-based dental activity, nor do we cover community dental services.¹

1 Community dental services are commissioned separately and provide care to people who are unable to access a dental practice due to a disability or medical condition.

Our work draws on the latest available data, including a series of interviews; follow-up conversations with 36 stakeholders including dental professionals, policy makers and regulators, patient representatives, academics and public health specialists; and an expert roundtable in 2023.

We identify serious problems with dentistry in this country, including:

- Growing difficulties with access to dentistry
- Poor public perceptions about access and cost
- Charges growing well above inflation
- Persistent inequalities in access and outcomes
- Wide variations in treatment between regions
- NHS underspending on dentistry, despite issues with access
- Concerns about the workforce and the availability of NHS dentists
- A contract that is unfit for purpose.

We also set out some of the solutions that may be available as policy makers grapple with the current crisis. Much bolder action is urgently needed to address the issues currently faced, even in the short term, if dentistry is to be set on a more sustainable footing. We suggest the use of flexible commissioning to better target additional funding; more creative use of the existing workforce; and extending standard appointment recall intervals to a year.

These recommendations are the authors' own ideas, drawing on discussions held over the course of compiling this report.

But more policy action still is needed if NHS dentistry is to have a long-term future. We conclude that there are no easy ways forward: even immediate actions that can be taken to tackle the problems we identify in this report will not deal with the reality that universal dental care has likely gone for good.

Unless there is the will to reform the dental contract towards a payment model based more on the number of patients in need; strengthen workforce retention and balance significantly; or invest in the public's health more generally, then significant increases in spending on the dentistry service are likely to be required. And if this is not an option, then a more limited NHS offer that further means-tests people for eligibility may need to become the default.

Policy makers need to work out which of a series of politically unpalatable choices they wish to make to secure the remainder of publicly funded dental care for those that need it most: children and the most vulnerable. We hope that this report will focus attention on this most pressing of public policy questions. Failure to do so will result in continued muddling through and, ultimately, the further decay of NHS dentistry.

2 How NHS dentistry is organised

This report focuses largely on primary care dentistry in England. Primary care dentistry (as opposed to dentistry provided in hospital or through community NHS services) operates through a dual system involving both NHS and private dental providers. Dental professionals – comprising dentists and other staff like dental nurses, therapists, technicians and orthodontists – have the choice to work within the NHS, as private practitioners, or a combination of both. In theory patients can opt for NHS dental care or seek treatment from private dental providers. Yet problems in the access and availability of NHS dental care (see below) means that this choice is not available for much of the population.

Unlike GP services, patients are not registered with an NHS dentist and dental practices do not have to hold a list of patients. This means that dental practices can choose whether to offer patients NHS dental services based on their capacity to deliver care. When a patient receives NHS dental care from a dental practice, the provider has to complete the course of treatment. Providers may choose to treat regular patients via regular recalls, but there is no obligation for them to maintain the relationship.

Funding for NHS dental care comes from a combination of government funding and patient contributions. Patients are charged for their dental treatments based on a tiered system known as NHS dental treatment bands, which vary depending on the complexity of the treatment (see Table 1). Certain groups, including children, pregnant women, and individuals on specific benefits are eligible for free dental care.

Table 1: Patient NHS dental charges in England

NHS dental treatment band	Examples of treatment	Current charge
Band 1	Examinations, diagnosis and advice. If necessary, it also includes X-rays, a scale and polish (if clinically needed), and planning for further treatment	£25.80
Band 2	Everything listed in Band 1, plus any further treatment such as fillings, root canal work or removal of teeth, but not more complex items covered by Band 3	£70.70
Band 3	Everything listed in Bands 1 and 2, plus crowns, dentures, bridges and other laboratory work	£306.80
Urgent	Urgent care in a primary care NHS dental practice, such as pain relief or a temporary filling	£25.80

Source: [NHS website](#) (accessed 01/09/2023)

Dental providers are reimbursed for their NHS work based on a system known as Units of Dental Activity (UDAs). UDAs are a measure of the amount of work done during dental treatment. More complex dental treatments count for more UDAs than simpler ones. Providers are paid a set fee for each UDA completed rather than for numbers of patients. This approach has been in place since the 2006 NHS dental contract was introduced.

Up until 2023, NHS England was responsible for commissioning dental care services. However, in April 2023 the responsibility for commissioning was delegated to England’s 42 Integrated Care Boards (ICBs). These organisations are responsible for allocating budgets, setting priorities, and contracting dental providers to deliver services that cater to the oral health needs of their local populations.

Dental professionals must be registered with the General Dental Council (GDC) to legally practise dentistry in the UK.

3 Funding

Funding for NHS dentistry in England comes from two main sources: central funding (from NHS England via the NHS Business Services Authority) and patient charges. In 2021/22 total funding for dental services was £3.1 billion, a **fall of over £525 million** in real terms² since 2014/15.

Prior to the pandemic, funding from NHS England fell by 15% in real terms between 2014/15 and 2019/20,³ and income from patient charges increased by 8%.

Between 2014/15 and 2019/20 the balance of these different funding sources has averaged at around a quarter of funding coming from patient charges and around three-quarters from central funds. The patient charge proportion was steadily increasing up to 2019/20, due to a series of above-inflation charge increases. However, in 2020/21 the proportion contributed by patient charges fell to 9% of the total, reflecting the impact of reduced dental services during the pandemic. By 2021/22 these proportions had recovered, albeit not to pre-pandemic levels: of the £3.1bn spent on NHS dentistry, 20% (£0.63bn) came from charging and 80% (£2.47bn) came from NHS England.

Despite the overall fall in the central budget for dental services, it has consistently been underspent in every year apart from 2020/21, the year of the pandemic. Recent data released by the British Dental Association indicates a projected underspend of £400 million in 2022/23, amounting to around 13% of the overall budget. These underspends, which have been around £150m every year since 2017/18 (apart from 2020/21), occur because the dental contract allocates funding per practice, which is “clawed back” if **activity is not delivered** or if there are no contractors available to deliver the activity at all.

2 Adjusted for inflation using **predicted 2023/24 prices**.

3 Adjusted for inflation using **predicted 2023/24 prices**.

Further significant underspends are expected this financial year, and recent announcements from NHS England have led to these underspends in dentistry being used to shore up wider NHS funding. MPs have recently highlighted **examples** where dental underspends have been targeted to balance NHS wider budgets and the recent government response to the Health and Social Care Select Committee report confirmed that ICBs have been allowed to “retain underspends to balance their bottom line and any other pressures”. The BDA has **said** this indicates that dentistry is seen as a ‘Cinderella’ service and such an approach will mean patients missing out.

4 Activity

Pre-pandemic

Table 2 below shows dental activity in England, by band of payment, in 2013/14 and 2019/20. Band 1 covers an examination, diagnosis and advice. Band 2 covers the same as Band 1, plus additional treatment, such as fillings, root canal treatment and removing teeth. Band 3 covers Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (see Table 1).

This data shows a striking fall in activity in the more complex bands and an increase in the more straightforward activity in Band 1. The share of the total revenue from patient charges that were under Band 1 increased and the share that was under Bands 2 and 3 decreased. The reason for this is unclear: one possibility may be that a greater proportion of patients have used the NHS for initial assessment and some treatment in Band 1 of the ‘units of dental activity’ (UDA) scheme, but have then been treated privately for more significant procedures. Or it may be that there has been a fall in the prevalence of oral diseases over the same period.

Table 2: Number of units of dental activity by NHS dentists in England pre-pandemic, by year and by treatment band

Units of dental activity by NHS dentists in England (million)					
	Total	Band 1	Band 2	Band 3	Urgent
2013/14	88.69	21.69	35.40	26.79	4.62
2019/20	78.83	23.01	29.33	22.00	4.37
Absolute change from 2013/14	-9.86	1.32	-6.07	-4.79	-0.26
Percentage change from 2013/14	-11%	6%	-17%	-18%	-6%

Source: NHS Digital, [NHS dental statistics](#) (accessed 13/10/2022)

Post-pandemic

Under the Covid-19 protective measures, NHS dental practices were told to cease routine dentistry from 25 March 2020 and were subsequently asked to reopen from 8 June 2020. This brought about an unprecedented drop-off in units of dental activity. As Table 3 shows, the amount of activity has increased since then but still not returned to pre-pandemic levels, which were, as Table 2 shows, already lower than in 2013/14.

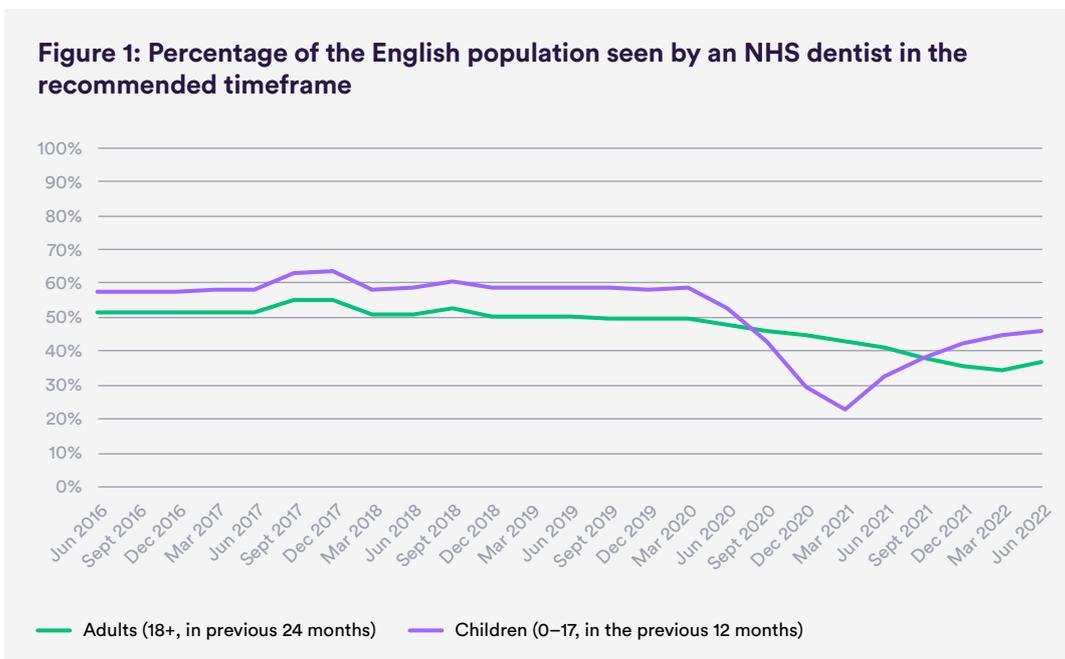
Table 3: Total number of units of dental activity by NHS dentists in England, by year

	Total units of dental activity by NHS dentists in England (million)
2019/20	78.83
2020/21	24.08
2021/22	57.09
2022/23	70.01
Absolute change 2019/20 to 2022/23	-8.81
Percentage change 2019/20 to 2022/23	-11%

Source: NHS Digital, [NHS dental statistics](#) (accessed 02/11/2023)

5 Access

Before the pandemic, the proportion of patients seen by an NHS dentist was very stable (see Figure 1 below), although a large proportion of the population had not seen an NHS dentist within the **recommended timeframes**: in 2019/20 more than half of all adults hadn't seen a dentist within the previous 24 months as is recommended, and more than two in five children hadn't had an appointment in the previous 12 months.



Source: NHS Digital, [NHS Dental Statistics](#) (accessed 13/10/2022)

This data does not capture the other access challenges faced by patients. For example, the metrics available on waiting times and responsiveness of other NHS services are not available for dentistry. Nor does it capture information on who is not seen in NHS dentistry – for example frail elderly people living in their communities and not in care homes.

Access during the Covid-19 pandemic

After 8 June 2020, dental practices were permitted to resume routine dental work. However, personal protective equipment (PPE) shortages, cash flow and childcare made the **return difficult for many**. Moreover, many practices had **reduced capacity** despite their reopening because of infection control measures and Covid-19-related staff absences.

Fewer patients were seen by NHS dentists, with the impact for children being greater than for adults (see Figure 1). In 2020/21 there were just under **12 million dental treatments performed** compared to over 38 million the year before. Some of the care that was delivered during this time was delivered differently (for example remotely⁴ or in urgent dental centres) but it is unclear whether that care met the needs of patients.

The Care Quality Commission (CQC) **pointed out** the huge increases in calls about previous problems with access to dental services. Recent Nuffield Trust **analysis** of calls to the NHS 111 helpline sheds further light on this issue. We found that the number of calls where NHS 111 recommended the caller to seek a dental service more than doubled between March and May 2020. Since then (until March 2023), the numbers of dental service recommendations have decreased slightly, but remain higher than they were before the pandemic. While this data tells us more about demand for dental care than access per se, it is reasonable to infer that the increase in demand points to a wider access problem that has been exacerbated by the pandemic.

This drop in access to dental care was not unique to the UK and many **other EU countries** also saw a decrease in dental activity. In 2019 the EU had an average⁵ of 1.3 dentist consultations per person, and in 2020 this had dropped

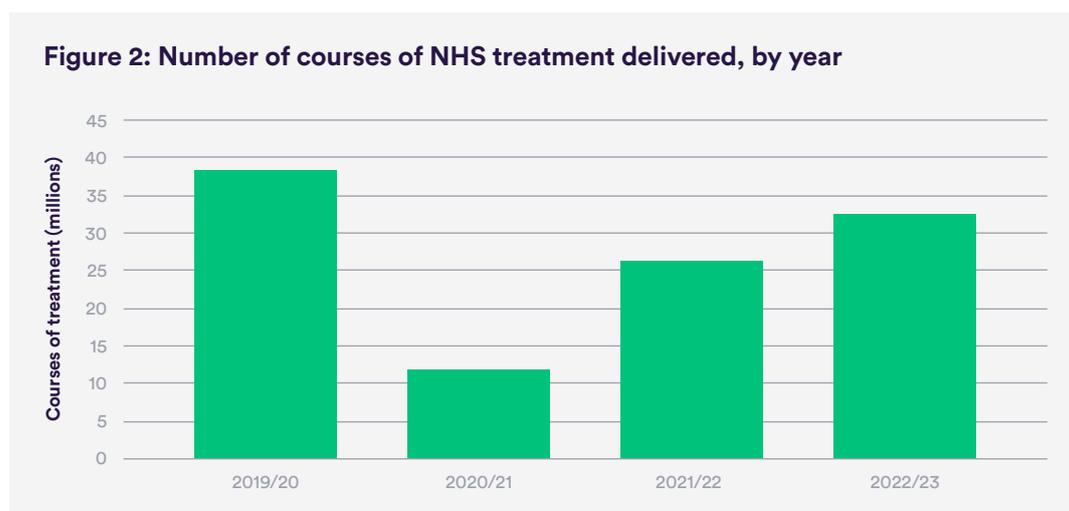
4 Dental appointments delivered remotely are online, video or phone consultations that act as a triage to face-to-face dental care. They can provide **remote prescribing** of medicine for things such as pain control and infections, and can provide advice and preventative and lifestyle guidance. They may involve the use of apps and other technology and/or other equipment to enable practices to make assessments, start treatment and monitor treatment.

5 OECD calculate this as the average of 21 out of the 27 EU countries.

15% to 1.1 consultations. The UK’s activity levels in 2019 were 0.7 consultations per person, which dropped by 71% to 0.2 consultations per person in 2020. While these figures should be treated with some caution as the UK data does not include private consultations, it nevertheless appears that the UK saw larger decreases than other countries.

Dental access since the pandemic

There was a **large drop** in activity and the number of patients being seen during the pandemic, and then the beginnings of a recovery across these metrics by 2022/23 – although still below pre-pandemic levels. There were nearly six million fewer courses of NHS dental treatment⁶ provided last year compared to 2019/20 (see Figure 2).



Source: NHS Digital, [NHS Dental Statistics](#) (accessed 15/09/2023)

6 **A course of treatment** is: (a) an examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and (b) the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient.

The GP patient survey paints a slightly more encouraging picture of access following Covid-19, with over three-quarters (77%) of respondents in 2023 saying they were successful in getting an NHS dental appointment when they had tried to get one in the last two years. However, this data does not offer insight into the timeliness of appointments, or their comprehensiveness. A **survey** by Healthwatch in 2022 highlighted that nearly a third of respondents (31%) said they could not access all the treatment they needed. Almost half (47%) of GP Patient Survey respondents in 2023 **said** they had not tried to get an appointment in the last two years or had never tried to get an appointment, with over one in five of these stating that they did not think they could get an NHS dentist as the reason.

Satisfaction with dentistry has dropped significantly since the pandemic. The latest results of the British Social Attitudes survey showed that in 2022 satisfaction with NHS dentistry services fell to a record low of 27% (6% 'very' and 21% 'quite' satisfied) and dissatisfaction to a record high of 42%. Prior to 2020, satisfaction had been slowly climbing to a high of 60% in 2019. While these findings are not specifically about access to dentistry, the wider NHS findings indicate that a primary reason for dissatisfaction with health services is the time it takes to get a GP or hospital appointment, so it is reasonable to assume that falling dissatisfaction in dentistry is related, in part at least, to access problems.

Although poor dental access is not a major driver of the current pressures on urgent and emergency care, with just a fraction of the circa **23 million A&E attendances** each year driven by dental concerns, there were nonetheless a large number of A&E attendances for dental problems which could have been dealt with at an earlier stage by a primary care dentist or in an **emergency dental care setting**. For example in 2021/22, there were over **83,000 A&E attendances** in England for dental issues.

Access to preventative dental care also suffered during the pandemic: fluoride treatments **dropped by 73%** during the pandemic compared to 2018/19 and have still not recovered to pre-pandemic levels, which risks future oral health.

Access for different groups

National-level data on access to dentistry fails to provide any real understanding of the level of variation that might exist among different geographical and demographic groups.

For example, the 2023 GP Patient Survey showed that across different integrated care systems, the proportion of people who **said** they were successful in getting an NHS dental appointment varied between 64% and 85%. And as Public Health England have shown, people from Black, Asian and minority ethnic groups are less likely to **report** success in getting an NHS dental appointment.

Analysis on access to dentistry during the pandemic by the General Dental Council also highlighted racial inequalities. For example, Black and Asian ethnic groups were more likely to **indicate** concerns about visiting the dentist during the pandemic compared to White respondents. Black and Asian groups were also more likely to say that they would not go to a dental practice unless they had an urgent issue, compared to White respondents.

The Care Quality Commission reports that care home residents still have **difficulties** with access and this is a grave concern in a group where poor oral health significantly increases risks to general health, with compromised chewing and eating abilities, which affect nutritional intake and present a choking risk. People with dementia present a unique challenge for access, particularly if they have not had an oral health assessment and a treatment plan put in place prior to a significant decline in cognitive function (thinking, remembering and reasoning) and behavioural abilities.

Previous **analysis** shows that those with the poorest oral health are also those who are least likely to engage with dental services, and it is likely that this has been exacerbated by the pandemic. For example, in tackling the backlog, dentists **prioritising private patients over NHS** ones could disproportionately affect low-income groups.

We showed that, for children under 10 years old, those from the most deprived areas had the biggest fall in rate of tooth extractions in hospital during the

pandemic. This leaves those children at greater risk of worsening oral health and further complications resulting from it.

Direct financial barriers to access

NHS dental care is not universally free at the point of care. People who are **exempt** from charges include those who receive certain types of government financial support; people under 18 years old (or under 19 years old if they are still in full-time education); and women who are pregnant or have had a baby in the previous 12 months.

Decisions on the amount a patient is charged in England are made annually. The amount that a patient is charged is dependent on the type of treatment they receive and is separated into different bands (see Table 1 at the beginning of this report for examples of treatments within bands and current costs).

Between **2014/15 and 2023/24**,⁷ there was a 7% increase in real terms⁸ for Band 1 treatment charges and an 8% increase for Band 2 and Band 3 treatments. This compares to an 8% decrease in real terms in general **NHS prescription charges**.

Such increases may be making NHS dental care unaffordable for those who have to pay, particularly those just above the eligibility requirements for free dental care. In **one survey** of dental patients, 52% of respondents said they paid for all their NHS dental charges (n=16,392).

Recent analysis by The King’s Fund and the University of York **found** that while the mixed market for dentistry and excess demand for NHS dentistry complicates the picture, there is ‘likely’ a relationship between increased NHS dental charges and reduced access to NHS dentistry. This relationship disproportionately affects the less wealthy and those with poor oral health.

7 The charge for 2023/24 is the charge from the 24th of April 2023, the **date the charges were last changed**.

8 Adjusted for inflation using **predicted 2023/24 prices**.

In the **2023 GP patient survey**, 47% of respondents said that they had either not tried to get an NHS dental appointment in the last two years or had never tried to get one. Of these, a small proportion (5.5%) said that the main reason is because NHS dental care is too expensive. Although this percentage is small, many more may have selected the cost of dental care as a secondary or subsequent reason. Furthermore, it wasn't asked of all survey respondents, and others who had been successful at getting an appointment in the last two years may have also said it was too expensive, so this figure may be under-representative of what people feel about the costs of NHS dentistry.

In a **survey** of dental patients, one in five (21%) of respondents said they would struggle to pay for a Band 2 treatment, and 8% said they would not be able to afford it. For Band 3 treatments, one in four (25%) said they would struggle to pay for it and one in five (22%) said they would not be able to afford it. Unsurprisingly, those in the most deprived areas were more likely to say they could not afford the treatment options. When asked, of those who perceived there would be barriers for their neighbours to get NHS dental care, 40% cited cost as one of the factors.

Other barriers to access

The uptake of dental care services is not simply a question of the direct cost to the patient. There are non-financial barriers that affect the poorest groups disproportionately. For example, the **Health and Social Care Information Centre** found that children eligible for free school meals (a proxy for low-income households) had worse overall dental health and had poorer attendance for dental check-ups than ineligible children, even though dental services are free for children.

In a **2019 dental health survey**, 4% of mothers and 3% of fathers reported that they had taken time off work in the last six months because of problems with their child's teeth, mouth or gums. The time cost, and potential loss of earnings for parents, which is more likely to affect those from low-income households, may be a barrier for children in accessing preventative dental care. The **Child Dental Health Survey** reported that about one in five children did not attend a check-up at all in 2013.

Van der Zande has observed that barriers to planned dental visiting are complex, multi-layered and change over time, constituting a ‘web of causation’. This is important, because the consequent lower levels of preventative visits to dental services is likely to be a key reason why people of lower socioeconomic status are disproportionately affected by poor oral health.

A further problem, identified by **Healthwatch**, is the poor quality of online information about dental practices accepting NHS patients. If practices do not update their status on the nhs.uk website within a 90-day period, then the practice status changes to ‘no information supplied’. Healthwatch cite NHS digital data from 2021 that showed over 3,000 practices were in this category. Recent changes to the dental contract have made explicit the need to update their information every 90 days, but it is not yet clear if this has improved the situation.

6 Workforce

Box 1: the NHS Long Term Workforce Plan

The **NHS Long Term Workforce Plan**, published in July 2023, contains measures to increase training places in dentistry professions, modelling about the anticipated supply and demand for dentists and other dental care professionals, and offers some suggestions on how to retain staff.

Training: The Plan seeks to expand dentistry training places by 40% so that there are 1,130 more places by 2031/32 and expand training places for dental hygienists and therapists from 370 currently to 518 in 2031/32 – also a 40% increase.

Future demand: The Plan's modelling predicts that there will be a need for 23,000 full-time equivalent (FTE) dentists and dental care professionals by 2036/37, from a starting position of 8,800 FTE dentists and 500 dental care professionals in 2022.

It anticipates that a large amount (around 7,100 by 2036/37) of the growth in dentistry 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.

Skill mix: The Plan aims to deliver 15% of dental activity through dental therapists and dental hygienists by 2036/37 compared to the current estimate of 5%.

Dentists

The **estimated number** of dental practitioners (dentists, dental surgeons, orthodontists and periodontists) in employment in England grew from around 29,000 to 37,000 between 2010/11 and 2020/21, which is a 26% increase. The majority of dental practitioners in 2020/21 (61%) were self-employed, and nearly a third worked part-time.

However, despite the overall growth in the number of dental practitioners over the decade, the number of dentists carrying out NHS activity in England **per capita** has changed very little over this period. There were nearly 24,000 dentists carrying out some NHS dentistry in 2020/21 compared to almost 23,000 in 2010/11 – an increase of 6%, which is similar to the population growth over the period. In England 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.

Estimates of the average number of hours that primary care dentists who do some NHS work suggest the amount of time they spend on clinical work and the amount of time spent on NHS dentistry has also changed very little between 2010/11 and 2019/20. In 2019/20, they worked on average 36.6 hours per week, with 81.5% of their time spent on clinical work and 73% spent on NHS dentistry.

Given the broadly static numbers of NHS dentists per capita and the consistency of working patterns, it appears that the current problems facing NHS dentistry may be less a consequence of changing patterns of work and more the result of persistently low numbers of dentists. Looking internationally, **OECD data**⁹ shows that in 2021 the UK had 5.1 dentists per 10,000 population compared with 8.6 in Germany, 8.4 in Italy and 6.6 in France. While the data for UK do not include those working exclusively privately, even when looking at the total number of registered dentists in

9 Figures for Italy and UK are estimates. UK data do not include dentists who work exclusively in the private sector.

the UK, this is still below comparators.¹⁰ The UK figure also masks variation between those countries. 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.

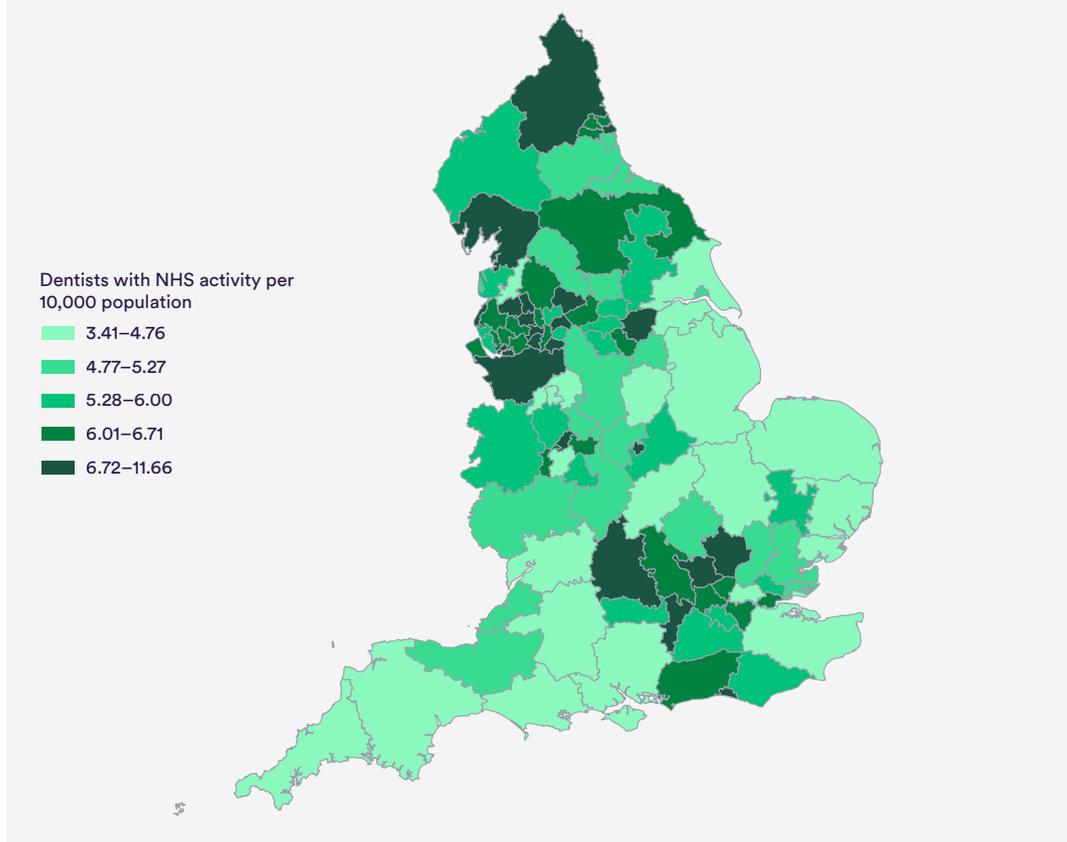
The solution of importing dentists has been **affected by Brexit**, with the number of EU- and EFTA-trained dentists registering to practice in the UK halving for several years after the EU referendum. Although it **recovered in 2022**, this has not been made up by recruitment from elsewhere in the world, which has also been in decline. The General Dental Council (GDC) has had **significant backlogs** of applications, partly caused by the suspension of some exams during the pandemic.

Regional distribution of dentists

The national data for England masks problems with distribution of dentists across the country. The **Association of Dental Groups** reported that a number of areas are experiencing a serious shortage of dentists doing NHS work, and Nuffield Trust analysis of NHS Digital data reveals nearly three-fold variation in the density of NHS dentists in England (see Figure 3). This analysis shows that in some parts of the country there could be just one dentist for just over 2,900 patients, although this data is not adjusted for estimated need in each area. Coastal and rural areas are particularly underserved by NHS dentists relative to the population. Earlier analysis by the **National Audit Office** showed that this maldistribution mirrors the differences in access across the country, with areas where there are fewer NHS dentists per head experiencing the worst access problems.

10 As of 31 December 2021 there were 43,292 dentists in the UK **registered with the GDC**. Using the **2021 mid-year population estimates** (6,702,6292) shows that there were 6.5 dentists in the UK registered with the GDC per 10,000 population. Not all registered dentists will be practising.

Figure 3: Variation in headcount of NHS primary care dentists per 10,000 population by sub-ICB area in 2022/23



Source: Nuffield analysis of NHS Digital, NHS Dental Statistics (accessed 27/07/2023)

Drift to the private sector

There has been a long-term drift towards private provision, as shown in the data in Table 3 above. The structuring of the dental contract, which uniquely allows a mix of NHS and private work, has facilitated this trend. A **British Dental Association (BDA) survey**, published in March 2023, suggests that one in two dentists in England (50.3%) have reduced their NHS commitments since the start of the pandemic. More worryingly, nearly three-quarters (74%) state they intend to reduce, or further reduce, their NHS work in the future. This may have started before the pandemic, with changes in the pattern of the type of NHS work undertaken by dentists beginning before 2020/21 (see Table 2). This trend is particularly concerning given the ambitions

in the NHS Long Term Workforce Plan to fill the shortfall in dentistry by increasing the participation rate of dentists in NHS work by over 7,000 full-time equivalent places. Evidence from **Christie and Co**, an estate agent, on sales of dental practices reports a notable increase in the number of groups that are now focusing solely on the private sector, having previously favoured NHS-led practices.

The nature of the contract (see below) is also increasingly unattractive to many dentists and the private sector can offer **higher pay**. In addition, private practice may offer an environment that is preferred by many dental professionals. NHS Digital's Dental Working Patterns, Motivation and Morale **survey** found that dentists who spent more of their time on NHS work, as opposed to private work, tended to work longer weekly hours and took less annual leave in 2019/20. Even more concerningly, this survey found that the more time dentists spend on NHS work, the lower their levels of motivation.

There has been no explicit policy statement made by any government about this trend, but it is hard to avoid the conclusion that successive governments have at least been content to see this drift take place and have done little to prevent it, even if they have not directly acted to promote it.

Skill mix

Other parts of the NHS have responded to the staffing challenges of low overall numbers and maldistribution through changes in skill mix of the workforce, for example by deploying more health care assistants in hospitals.

The government's aspirations are for similar changes to take place in dentistry. As Box 1 above shows, the modelling in the NHS Long Term Workforce Plan is predicated on a significant shift towards dental therapists and hygienists delivering more of the predicted work in NHS dentistry – 15% in 2036/37 as opposed to an estimated 5% now.

But recent history suggests that there has been a relatively slow move towards a differentiated workforce of dental care professionals to include dental nurses, dental hygienists, dental technicians, dental therapists, orthodontic therapists and clinical dental technicians (a brief description of each role

can be found in Table 4). 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 – a reduction of 2,900 in total. This translates to a decrease from 78 dental nurses per 100,000 population to 67 per 100,000. This decline pre-dates the pandemic.

Table 4: Other registered dental professionals’ scope of practice

Registered dental professional	Brief description of role
Dental nurse	Provide clinical and other support to other registered dental professionals and patients
Dental hygienist	Help patients maintain their oral health by preventing and treating periodontal disease and promoting good oral health practice. They carry out treatment direct to patients or under prescription from a dentist
Dental technician	Make dental devices to a prescription from a dentist or clinical dental technician. They also repair dentures direct to patients
Dental therapist	Carry out certain items of dental treatment direct to patients or under prescription from a dentist
Orthodontic therapist	Carry out certain parts of orthodontic treatment under prescription from a dentist
Clinical dental technician	Provide complete dentures direct to patients and other dental devices on prescription from a dentist. They are also qualified dental technicians

Source: **General Dental Council, Scope of practice** (date accessed: 09/05/2023)

Notes:

- The registered dental professional can only undertake these activities if they are trained, competent and indemnified.
- For brevity, all the tasks a registered dental professional can undertake and additional skills they can develop are not included here. Please see original scope of practice documentation for more detail.
- Dentists can carry out all the treatments listed in the scope of practice.

According to the GDC’s **registration data**,¹¹ there is a mixed picture of changes in additional roles in the UK (see Table 5). The number of dental technicians registered with the GDC decreased between the end of December 2018 and the end of December 2021, while the numbers registering under the other roles increased – although some of these are modest increases over the three years. Overall, these roles make up 17% of the GDC register in March 2023, and in March 2018 they made up 15%. However, it is important to note that this data is based on registrations with the GDC and it is not known how good a proxy this is for deployment of these roles within practice. Furthermore, this is a UK-wide data set, and it is not known how these roles are distributed across the different countries. It is also worth noting that many people are on more than one register (for example many dental therapists are also registered as dental hygienists).

Table 5: Number of registrations on the General Dental Council register, by role and by year

	Dental hygienist	Dental technician	Dental therapist	Orthodontic therapist	Clinical dental technician
2018	7,309	5,927	3,349	633	368
2019	7,563	5,776	3,620	695	375
2020	7,812	5,529	3,938	734	367
2021	8,261	5,289	4,378	822	383
2022	8,669	5,107	4,916	898	395
Absolute difference	1,360	820	1,567	265	27
Percentage change	19%	-14%	47%	42%	7%

Source: General Dental Council, **Registration Statistical Reports** (accessed 04/08/2023)

11 Dentists and dental care professionals (DCPs) must be registered with the General Dental Council (GDC) to practise in the UK. Everyone who joins the registers must be suitably qualified or pass an assessment, and meet the health, character and English language requirements to be considered fit to practise as a member of the dental team.

The size of dental practices is also a limiting factor in how effectively they can improve their skill mix: the bigger the practice, the more scope to bring in additional roles. A large driver of the development of skill mix in general practice, for example, has been the policy shift towards primary care ‘at scale’ and the promotion of networks of GP practices. However, in dentistry the opportunities to scale up are more limited. In fact, data from the Office of National Statistics looking at **UK business size** found that the most common employment size band of VAT and/or PAYE-based enterprises carrying out dental practice activities in 2022 was 0–4 personnel.¹² Nearly half (46%) of all dentistry enterprises were this size and this has increased a little from 2017, where 42% had an employment size band of 0–4. The constraints imposed by the size of premises of many practices is also a barrier for increasing the skill mix, as there is limited physical space for the other dental professionals to practise.

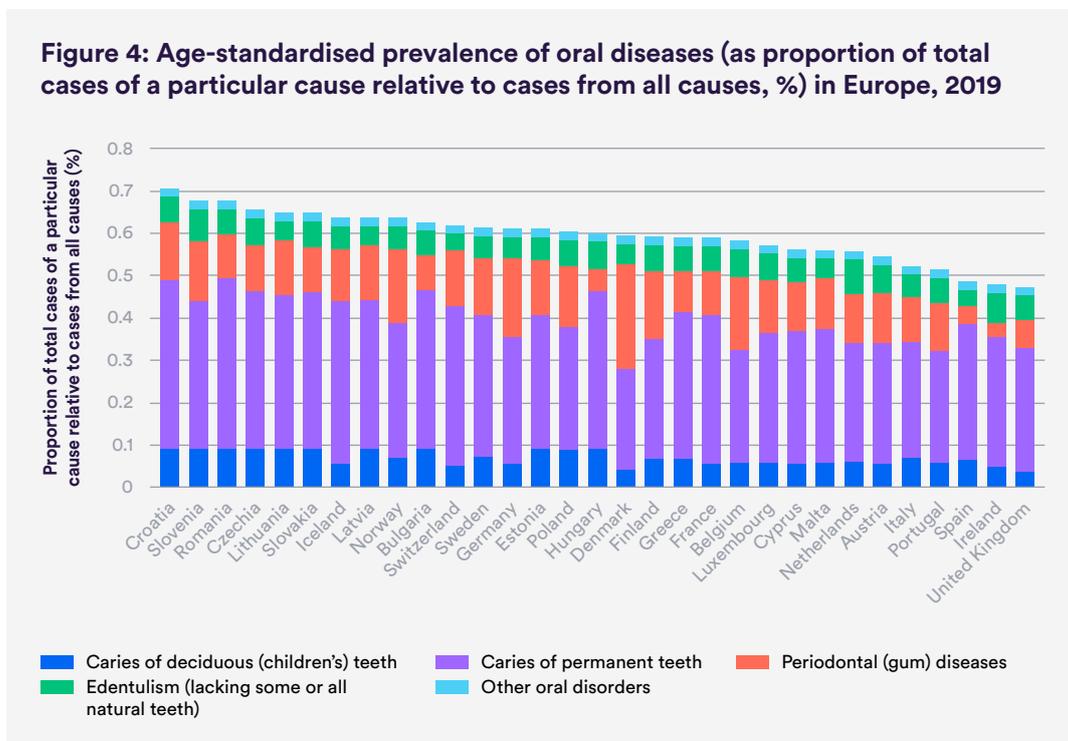
12 An enterprise is the smallest combination of legal units (generally based on VAT and/or PAYE records) which has a certain degree of autonomy within an enterprise group. Dental practice activities are defined by the Standard Industrial Classification (**UK SIC2007**).

7 Oral health

This report has so far examined the available data on the inputs (funding and workforce) and outputs (access and activity) of NHS dentistry.

But a complete understanding of the challenges facing NHS dentistry needs to be accompanied by an understanding of oral health outcomes: how healthy are our teeth, and how has this changed over time? Here, the picture is more positive.

The overall position across the latter half of the 20th century and early part of this millennium is one of significant and sustained improvement in oral health. By international standards the UK is performing very well when it comes to the prevalence of oral diseases like caries (tooth decay) (see Figure 4).



Source: IHME, [Global Burden of Disease](#) (accessed 15/09/2023)

There has been general improvement over time, and while epidemiological and survey data do not show causality, **the evidence suggests** that changes in population behaviour, as well as changes in clinical diagnostic criteria, treatment planning and clinical procedures, are the most likely reasons.

Looking to the future, the need for dentistry will change as older generations who have a history of high levels of treatment will be replaced by those with much better oral health. This means that fewer working-age adults will have complex treatment needs and more will mainly require ongoing monitoring and support to maintain good oral health, so the focus can shift to prevention. **Projections from NHS England** highlight the shift towards healthier teeth over time, with the overall volumes of people with unhealthy teeth declining into the future, which is likely to continue.

Despite the progress made to date in improving oral health overall, persistent inequalities remain: the national picture obscures significant and enduring inequalities between regions across the country and related to people's socioeconomic status.¹³

Adults in lower-income households and living in more deprived areas are **more likely** to have no natural teeth and less likely to have functional dentition.¹⁴ A **survey** of adults attending general dental practices found that poorer oral health disproportionately affected those at the older end of the age spectrum and those from more deprived areas. People with **dementia** are also more likely to have poorer oral health, due to communication difficulties and challenges in managing daily routine tasks like toothbrushing.

13 For most of the protected characteristics there was no available evidence, or inconsistent evidence, on associations between oral health, care services and the protected characteristic. For vulnerable groups including homeless people, prisoners, travellers and looked after children, the available evidence was very limited, with existing studies showing that these populations have considerably poorer oral health across all assessed outcomes and face substantial difficulties accessing dental care.

14 Functional dentition is defined as achieving a threshold of having 20 or more natural teeth.

Analysis of information collected from oral health surveys ¹⁵ of five-year-olds in England showed that deprivation explained **37% of the difference** in the amount of tooth decay and **42% of the difference in severity**. From the survey in the 2021/22 academic year, it found children living in the most deprived areas of the country were 2.5 times more likely to have experience of tooth decay (35.1%) than those living in the least deprived areas (13.5%). They were also more likely to have more severe decay. There was also significant variation in the amount and severity of tooth decay between different ethnic groups for children of this age. Similar inequalities by deprivation and race are seen in children as young as **three**.

Tooth decay can result in tooth extraction, which may occur in hospital. In fact, for **six-to-10 year-olds** tooth decay is the most common reason for a hospital admission in England. And here we also see issues with inequalities. For **children 10 years old or under**, those in the most deprived areas have a rate of hospital admissions for extraction of one or more teeth that is five times higher than the rate for those in the least deprived areas (728 per 100,000 population in 2019/20 compared to 144 per 100,000), which equates to over 6,000 more admissions. For **0–19 year olds** in England the difference in admission rates between the most and least deprived areas was four-fold in 2019/20. In **adults** there were generally higher rates of tooth extractions in those living in the most deprived areas and for people from Black ethnic groups.

Inequalities in children’s oral health are a particular concern given that NHS dental care for children is free and tooth decay and the resulting outcomes are largely preventable.¹⁶ However, inequalities in children’s oral health have changed little over recent years and **Public Health England** noted that inequalities in the amount of tooth decay in five-year-olds increased between 2008 and 2019.

15 Oral health surveys are a visual-only examination looking for tooth decay and are carried out by trained and calibrated clinicians who are typically employed by NHS trusts providing community dental services.

16 Under-18 year-olds, and under-19 year-olds if they are in full-time education, are exempt from NHS dentistry charges.

Furthermore, as Appleby (2016) has **concluded**, the current treatment-dominated, increasingly high-technology, interventionist, and specialised approach is not tackling the underlying causes of disease and is not addressing inequalities in oral health.

Public health may provide an opportunity to tackle some of these underlying causes, through dealing with some of the risk factors for poor oral health (diet, smoking and alcohol, for example). However, the public health grant has been **cut by 26%** on a real-terms per-person basis since 2015/16 and these cuts have disproportionately affected those living in the most deprived areas where they are already more likely to experience inequalities. It is probably too early to see evidence of the impact of this in oral health statistics.

Lack of access is not just an issue for dental health. A recent analysis by the Oral Health Foundation, **shared with BBC News**, points to an increase in deaths from mouth cancer, which they attribute to these cancers not being spotted or treated early enough. This indicates the consequences of poor dental access on wider health outcomes.

Box 2: A brief history of dental policy, 1948–2006

There have been difficulties in contracting with dentists since the inception of the NHS and a tendency to treat dentistry as somewhat separate from the wider NHS. While free dentistry was a part of the NHS's inception in 1948, a combination of a lack of understanding of the level of demand and the financial crisis led to the introduction of charges, initially just for dentures, in 1951.

Little changed in the overall approach to funding dentistry until 1990 when a new contract was put in place to reflect changing attitudes towards oral health and to promote continuity of care. This was a hybrid of capitation, registration and fee-per-item of service. Patients were registered with practices for the first time, and a new capitation-based approach – whereby providers were paid upfront for patients – was used for children.

This contract resulted in an unanticipated increase in dental activity and costs to the government, leading to a 7% fee cut in 1992/93, which created longstanding resentment and led to a decline in the number of dentists working for the NHS. Generally, their patients went with them into the private sector. At the start of the 1990s, 90% of dentists generated

three-quarters of their income from the NHS, but by the end of the decade this had dropped to 60%.

This was followed by a period of reform and experimentation including the establishment of Personal Dental Services contracts (1998) which aimed to move the focus away from activity ('drill and fill') to preventative and oral health-focused service delivery.

Following a pilot in 1998, **Dental Access Centres (DACs)** were established in 2000 to provide fast and flexible access to NHS dentists. DACs did increase capacity but the patient groups using the service were generally not those disadvantaged groups most in need of care, and the **separation of DACs from dental practices** meant that many patients were not then brought into any on-going relationship to support continuity of care and oral health maintenance.

The changes in dental policy in the late 1990s led to an unplanned drop in revenues from patient charges. Growing concerns about access and widespread media reports of queues to register led to the development of a new contract in 2006. The 2006 contract saw a radical change to NHS dental services in England: central budgets (which had not been cash limited) were capped, bringing dentistry in line with other parts of the NHS. The payment shifted from a fee-for-service model to one that required activity targets to be hit to maintain income levels.

The units of dental activity that underpinned this model were developed very rapidly, were not based around robust analysis of activity, and seemed to encourage volume of activity over need and service quality. Moreover, the UDA approach contained incentives to take on certain types of patients or to avoid others – particularly those with high levels of need. UDAs were also bureaucratic to operate, unpopular with dentists and have also been criticised for not improving access or quality. Further damage was done to an already poor relationship between the profession and the government/the NHS.

The broader goal of the 2006 contract was to shift towards a focus on need rather than demand. This would suggest application of a needs-based resource allocation formula and a needs-based approach to both service and workforce planning, but this has not been put in place, possibly because this would be a political decision with some potential risks: there would be clear winners and losers, and to be effective, money would need to be directed away from well-served, more affluent areas.

Again, the experience was marked by unintended consequences. A study in 2012 found evidence of a decrease in NHS use, with reductions in use among populations with previously good access to care and increased consumer transitions from NHS to private practice. This contraction relied upon the ability of the private sector to absorb this group – the realities of the shifting dental market are very powerful; dentists have a choice in how and where they work, unlike other sectors where the NHS predominates.

UDAs were envisaged at the time as a short-term transitional arrangement towards contracting arrangements which would fully promote and incentivise preventative care, maintenance and continuity alongside necessary treatment. The approach aimed to maintain volumes and incomes during this transition, with UDA values varying significantly across practices. However, the transition didn't come about, and policy makers and commissioners' attention shifted elsewhere.

Likewise, the change in commissioning that accompanied the 2006 reforms failed to deliver a localised approach or the resources to use local flexibilities to facilitate and incentivise change. Primary care trusts did not have the capacity, scale or organisational bandwidth to run with the new arrangements. Historical allocations remain largely unchanged; resources have not been moved to address need; and despite a return to national and regional commissioning, large variations in spend and activity persist between regions.

Meanwhile, dentists, further dissatisfied with the NHS, have continued to move their focus into the private sector. Since the 1992 contract, successive governments seemed to be content to let this drift to private provision continue. Those we spoke with could not say whether this was a deliberate policy, but little was done to stop it. Policy makers might have reflected on the low levels of political noise associated with a similar process with long term care in the 1980s. A LaingBuisson report showed that in 2020/21 the UK dental market was worth £8.3billion, of which the NHS element was only £3.7 billion.

There have been some recent changes in the dental contract which have addressed some of the more glaring oddities related to the payment model – so that, for example, more is now paid for a root canal than an extraction – but fundamental problems remain.

8 What needs to happen next?

The data presented in this report show that, despite some improvements in oral health, the general state of NHS dentistry is plagued by a troubling array of problems: poor and worsening patient access; wide regional and socioeconomic inequalities; a dysfunctional financing regime; low growth in numbers of dentists carrying out NHS activity; and **recruitment problems** for dentists and the broader dental workforce. The pandemic hit this troubled service hard, revealing many weaknesses within the entire structure and setup of NHS dentistry.

The NHS is not commissioning enough dentistry to cover the needs of the population. There are major issues with access, which means that many people are effectively denied NHS care. There has not been a plan for post-Covid-19 recovery in the same way as there has for waiting lists, and dentistry is often given only passing consideration in key NHS England policy documents. The 2019 NHS Long Term Plan, which ran to 136 pages, included only a handful of statements about dentistry or oral health specifically. The NHS workforce plan is an exception to this, but by its nature is not going to solve immediate problems. The approach of muddling through with small tweaks to the contract and pots of extra cash is clearly increasingly unviable.

Tackling oral diseases offers enormous potential for improving public health more generally. There are shared risk factors across dentistry and other non-communicable diseases like cardiovascular disease, diabetes and respiratory illnesses, such as diet, smoking and alcohol. These mean that a more holistic and integrated approach makes sense, but integration of oral health into policy, practice and funding remains lacking. It needs to be considered for individuals alongside all their health care needs if we are to minimise the need for complex interventions in, for example, people with long-term conditions or learning disabilities.

The following principles have emerged in discussions with stakeholders and need to underpin action to address the more significant issues with current NHS dental care. The principles are as follows:

- Services should provide continuity of care
- Anyone who needs care should be able to access it
- Perverse incentives should be removed from policy
- Prevention should be incentivised
- Services should demonstrate value for money for taxpayers.

In addition, the experience of dental access centres suggests that policy solutions should, wherever possible, be developed through the lens of addressing health inequalities and should be co-produced with patients. The lack of a strong voice for patients and the public in dentistry is a concern. Our own conversations with National Voices have highlighted that the policy inertia surrounding dentistry is beginning to have an impact on patients accessing other care – for example in cancer care or kidney transplants – because of delays in accessing dental assessments.

Here we set out a series of actions available to policy makers, looking first at things that can be done right now to improve the state of NHS dentistry, and then looking further ahead. There is a need for urgent short-term action to deal with the immediate problems of access to dentistry, but longer-term and more radical reform is also needed to deal with the wider problems and changing patterns of need. Whatever action is taken, it is unlikely to fulfil all principles and therefore some difficult policy choices will need to be made, including how far the NHS aspires to offer a comprehensive and universal service, given that it does not do so at present.

Immediate actions

Options for immediately improving access to dental care are limited, as there are shortages of dentists in some areas and the NHS contracting framework is not well-suited to incentivise additional activity. As set out above, the budget for dentistry was already anticipated to be underspent by £400m in 2022/23 and further underspends were predicted. In theory this should provide some headroom for flexible use and redirection of existing funds

and contracted capacity. However, recent announcements have seen these underspends raided to shore up wider NHS (non-dentistry) services. If future underspending is to continue, the principle that these should be reinvested into dental health services should be adhered to.

Some steps have been taken on the actions below, with guidance on flexible commissioning published and the government’s **recent response** to the Health and Social Care Select Committee indicating further work in the forthcoming Dental Recovery Plan. But it remains to be seen how widespread and swiftly these actions will be taken in the context of the parlous state of NHS dentistry illustrated above and the reality of funding being diverted elsewhere in the NHS.

1. Use flexible commissioning to better target additional funding

Flexible commissioning is where a proportion of a practice’s contract value is used to deliver additional services instead of units of dental activity and offers an immediate way to target local innovation. **Recent guidance** from NHS England on opportunities for flexible commissioning is welcome, but adoption of this approach is not yet widespread. Evidence **suggests** that blended contracts can provide some benefits over the traditional UDA approach in terms of care quality and cost-effectiveness. In the absence of substantive contract reform (see below), more can be done using this approach.

The delegation of commissioning to Integrated Care Boards (ICBs) offers an opportunity to draw on flexible commissioning to develop approaches that address the reasons behind low uptake of dental health care. This is likely to mean providers engaging with local communities affected by poor oral health and developing models appropriate to these population groups – for example actively working with nursing homes to secure better provision in ways that work for those patients through outreach clinics.

Dentists will need to be incentivised and funded to deliver additional activity to increase access and reduce the backlog of work. Using flexible commissioning approaches, UDA capacity can be re-assigned from providers that are having difficulty meeting targets (often due to workforce constraints).

This could be used to:

- Run specific sessions for patients who are having difficulty with access – these should be commissioned at scale by ICBs with support from NHS England. Existing providers already meeting their current commitments or providers not currently doing NHS work might be used for this.
- Invite proposals from providers that would allow them to innovate and develop new ideas for alternative provision that meets needs in their local context. For example, this might include the provision of mobile services in areas of the greatest access difficulties and greater oral health needs.
- Directly deliver NHS services using salaried staff and run by existing NHS providers (for example community trusts). The delivery model should deploy ‘exemplar’ skill mix and be developed with a package of support and professional development to make these attractive for professional staff.

Particular attention may need to be given to services for children, including for school-based delivery of dental prevention education, dental checks and fluoride treatment.

The experience with dental access centres (see box above) suggests that it is important to think carefully about how to provide ongoing care for patients attracted into services that improve access. An important principle should be to ensure that initiatives to improve access are also accompanied by measures to fund follow-on care based upon an oral health assessment. Funding support generally therefore needs to be targeted to pre-existing practices wherever possible.

Flexible commissioning requires engagement with multiple providers and deep engagement with the profession at a local level with the full set of commissioning skills and capabilities available. Yet ICBs already have a daunting list of other priorities. Indeed, the requirement for ICBs to reduce their running costs by 30% raises questions about whether they will be able to mobilise sufficient expertise to take on dental contracting and commissioning. It will be vital to invest, share expertise and ensure that further loss of

organisational memory and experience are minimised. Work to develop and establish local relationships will be needed in a number of cases.

The **NHS Confederation** have recently raised concerns about the ability of ICBs to effectively drive improvements given the constraints of the current dentistry contract. They rightly argue that “NHS England needs sufficient ICB capacity, particularly in relation to dentistry where there is mounting evidence that some dentists have been reducing their NHS activity or ceasing to offer NHS services”.

Even if flexible commissioning approaches can unlock more local innovation aimed at targeting those most in need of dental care, rapid action is required to adjust the current system – in which the onus is put on patients to find a dentist from a list that is potentially out of date.

2. Use the workforce more creatively

Additional workforce capacity is vital for delivering higher levels of activity. The NHS Long Term Workforce Plan has ambitions to increase training places, enhance skill mix and increase the rate at which dentists practise NHS dentistry. Even putting the realism of these proposals aside, in the short-term it is hard to see how additional staff can be brought onstream without a significant boost to overseas recruitment. A drive on international recruitment would need to be facilitated appropriately and safely fast-tracked.

Any actions to address immediate capacity and access pressures should be seen as an opportunity to innovate, experiment and learn with a view towards longer-term application.

Dental therapists’ scope of practice allows them to help swiftly with access challenges – and indeed they are a clear part of the NHS Long Term Workforce Plan’s ambitions to meet the demand challenge for dental care. But currently, dental therapists mainly work in the private sector for financial reasons and tend to be engaged on a flexible basis rather than being formally employed. If the laudable ambitions under the NHS Long Term Workforce Plan to boost participation in NHS dentistry are to be realised, commissioners should consider providing incentives to make NHS work more attractive for this staff

group. Further research is needed to understand what measures, including high pay rates, would be sufficiently attractive to bring dental therapists into the NHS to help with treatment backlogs as a short-term stop-gap measure.

3. Extend standard recall intervals

Traditionally, patients are encouraged to book regular dental checkups every six months. However, the National Institute for Health and Care Excellence’s (NICE) guideline **CG19** *Dental checks: intervals between oral health reviews* recommends that the intervals between oral health reviews (known as recall intervals) should be tailored to patients’ disease risk, with a minimum interval of three months and a maximum of 24 months for over-18s. Recently, practices have been further encouraged by NHS England to consider appropriate extension of recall intervals.

To drive this further and faster, NHS England should work with the profession to extend the recall interval to at least one year unless clinically indicated. This needs to be accompanied by a coordinated public information campaign jointly endorsed by the government and the profession to explain the purpose and benefit of reducing the frequency of check-ups to mitigate against the likely perception that this is driven by rationing as opposed to clinical best practice. The freed-up capacity should be re-allocated into suitably remunerated access-clinic capacity.

Clinical judgement and assessment of patients on the basis of their individual circumstances is important, and the NHS should monitor and assess reasonable adherence to the extension of recall intervals. This might usefully include provision of ‘benchmark’ information to providers on their practices and further review for any extreme outliers. Any such review process should not simply be a spreadsheet exercise and should include proper discussion and engagement.

The Health and Social Care Select Committee **raised the issue** of patients becoming worried about being removed from a dentist’s list if they are not seen for extended intervals, despite the fact that dentists are not required to keep lists of patients. In the longer term, a move to a list-based model paid for using capitation (see below) would help with this. In the short term, the Committee’s recommendation about providing reassurance over this

issue and monitoring compliance is unlikely to be sufficient. More formal contractual arrangements will be required.

Longer-term actions

There are a number of long-term actions which fall into two categories: reforming and strengthening the current model, or more radically looking at what the NHS can offer in terms of dentistry. Unfortunately, even if implemented, it is unlikely they would be able to meet all five of the principles outlined above. The question for policy makers, therefore, is to decide which unsatisfactory and problematic solution they dislike the least.

Action A: Improve the current model

1. Contract reform

As the Health and Social Care Select Committee has said, “fundamental reform of the dental contract is essential and must be urgently implemented”.

Designing and successfully implementing an NHS dental contract that is fit for purpose and meets more aspirational goals will be challenging. However, the key elements of a potential future approach seem clear and enjoy broad support amongst many of those we spoke to. In essence, this would mean moving to a model based on patient lists, and primarily based on weighted capitation. Capitation is the most effective way that funding can be allocated based on underlying population need that supports contracts to set goals based on achieving outcomes for people, as opposed to simply paying for activity.¹⁷ Needs-weighted funding based on lists could cover check-ups and high-volume, simple care supportive of prevention, maintenance and continuity. The fee-for-service approach would only be used for low-volume, high-cost and complex procedures.

¹⁷ Weighted capitation refers to a contracting approach that pays providers per person on a list or register, with the funding per person weighted to incorporate the needs of the particular area.

This funding model should not be relied on as an incentive in itself: it should enable commissioners to make sure dental practices are delivering enough of the right activity to make their goals, knowing that the money is in the right place to make this consistently possible.

The **evaluation of the pilot schemes** for partial capitation begun in England under the Dental Reform Programme showed marked reductions in the number of courses of treatment, and this is a plausible outcome of capitation. Contracts and oversight need to ensure that this risk is carefully monitored and that they use needs-weighted funding to ensure that this is balanced by securing higher quality, more intensive treatment for those who need it, and more focus on prevention among groups at high risk.

For patients, this would mean that:

- Patients would register with a dentist and there would be an initial oral health assessment to determine treatment needs to assist with setting the budget to be given to the dentists and allow the tracking of the patient's oral health over time. This would mean that patients had a relationship with their dentist on the same basis as with their GP, which is not the case at present.
- Patients would have a clear statement of their entitlement, fees payable and a plan for check-ups and prevention.
- Some element of fee-for-service would need to remain for more complex work, which has a risk of incentivising overtreatment just as capitation has risks of undertreatment. While an approach to contracting that relies on trust ought to be the norm, some in the profession believe that a return to something akin to dental reference officers – which operate in **Scotland** to assess the appropriateness and quality of care – may be advantageous as a complement to this. This needs to be based on intelligent and relationship-based commissioning and should not solely rely on data analysis.

The bureaucracy that comes with the stewardship of public funds may make NHS work less attractive than the private sector. In developing new contractual frameworks, the NHS should try to ensure that while accountability is robust, it does not take up an undue amount of time, with mechanisms in place

to understand and respond to the concerns of the profession in terms of oversight and reporting. Standardised coding and automatic collection of data is needed to support this, and support for digital systems in practices may also be required.

Experimentation and refinement, informed by the lessons from the Dental Reform Programme, will be necessary to develop and refine these models.

2. Improve commissioning

A move away from national contracts and the development of a list-based approach that unlocks local innovation needs to be accompanied by a change in the commissioning approach that sees dental health more firmly as part of the overall health service provided by ICBs to their local population.

ICBs should ensure that financial support is available to fund the engagement of dental professionals to support clinical and service development along the lines successfully used for GPs. This will support effective local commissioning, build links with the wider NHS and bring oral health issues to the table, and ensure dental delivery is part of the business of ICBs.

As part of this, enhanced linkage and sharing of data should enable better collaboration and communication between dental professional, medical primary care teams and public health teams. This might include generating a truly integrated health record and should be backed by moves to better incorporate oral health and dentistry explicitly into NHS technology strategies.

The aim should be to create a model that changes the historically ‘semi-detached’ or even disconnected part of the health care system to one in which dentistry is properly integrated into the planning of neighbourhood services and the provision of primary care.

An improved commissioning approach should also facilitate better planning of services across the life-course. **Previous research** has articulated models of care, activity and service-mix requirements across four identified phases of the life-course, with distinct and particular oral health requirements. This work provides a sound basis on which long-term planning can be framed. The

future needs of these groups are the basis on which policy makers can explore and define the models of care required.

3. Strengthen workforce retention and skill mix

The Dental Workforce Advisory Group report sets out a helpful vision of a workforce with enhanced skill mix and this vision is picked up in the NHS Long Term Workforce Plan. As shown in Box 1, the Plan provides the basis for addressing some of the gaps in this area through expanding the number of dental training places, increasing dental therapy and hygienist places – although the provision of dental nurses is not directly addressed as they are trained by individual practices.

Yet the NHS Long Term Workforce Plan has little detail on the mechanisms that will be used to achieve this ambitious shift in the balance of dental care. There is a somewhat vague reference to working with stakeholders to ‘support the wider dental workforce’. It would be good to see more definite proposals in this space, such as to address the need for better and more fulfilling career paths in this area and the development of clinical leadership in dentistry.

The government needs to commit to the resources and mechanisms for delivering this wider dental workforce, which may require changes to the way training institutions are paid in order to provide incentives to do this. At present, training dentists is much more profitable.

The idea of a period of ‘lock-in’ to the NHS following training proposed in the NHS Long Term Workforce Plan appears attractive at first sight, but it is not clear that the NHS will benefit from the forced service of people who would rather be elsewhere – an incentivised approach may be more impactful. A **model of loans forgiveness** and supported professional development for those who see a career in the NHS is more likely to produce a willing and engaged workforce.

There may be an important role for clinical academic expertise in training future dental team members and opportunities to increase academic, educator and supervisor roles to keep dentists in the service and, equally importantly, support the planned growth in training capacity.

In general, more work is needed to understand the reasons why NHS work is not popular with dentists and other dental professionals, to address this and people's increasing desire for better work-life balance and portfolio working.

4. Change the market structure to support scale and resilience

As outlined in the section on the dental workforce, almost half of dental practices consist of four or fewer people. A key issue, therefore, is whether a change in the structure of the delivery model would be required to support the suggested changes.

Implementing change in the dental provider market is complicated when it is being pursued through a large number of small practices, because individually they have limited financial and administrative capacity to develop services and constrained facilities. This limits the enhanced use of dental care practitioners, and the use of a rich and diverse skill mix is also more challenging when working with a smaller population base.

Flexible local commissioning, the development of improved new payment methods and investment in change management offers the opportunity to facilitate change in this area. The NHS might consider direct provision models as an opportunity to showcase and develop modern delivery at scale, including integration and co-location with other services.

ICBs should consider the provision of support with change management to help practices change their working methods and systems to allow the effective deployment of new types of practitioners or to develop shared services between practices where there are space constraints or other reasons why sharing resources could be helpful.

5. Invest in dental public health

More attention needs to be paid to comprehensive public health programmes and interventions which can deliver benefits for long-term oral health and limit the requirements for dental intervention.

Intervention and support in the early years of life is of vital importance in protecting from oral disease and instilling life-long awareness and habits.

Programmes of this sort were significantly reduced in the years of austerity – the current introduction of ‘Start of Life Family Hubs’ in deprived areas is a welcome recognition of this need, although coverage is incomplete with just 75 local authority areas involved in the programme. Programmes like these which include oral health should be prioritised for broader availability. Checks in schools for younger children have been **touted**, but have not yet been implemented.

There is a common set of risk factors for poor oral health and non-communicable diseases (sugar, alcohol and tobacco use, and their underlying social determinants) and there is increasing evidence of the association between **good oral health and health** as a whole. Oral health should be more integrated into public health programmes to achieve improvements in oral health, strengthening the wider messaging and offering potential for improving public health more generally. Wider comprehensive regulation and legislation, such as the **sugar tax**, are needed to address these risk factors.

ICBs should develop, measure and monitor strategic and operational plans for dental commissioning and oral health improvement. These should be developed in close collaboration with public health colleagues in local government.

Consideration should also be given to investment in longer-term preventative programmes and actions, such as using the Secretary of State’s new powers under the 2022 Health and Care Bill on **water fluoridation**, given the longer-term value these will produce.

Action B: Adjust the overall NHS offer

Even if the immediate and long-term improvements detailed in this report are implemented, budget and workforce constraints mean that a return to the original conception of dentistry as a universal service will be very difficult to achieve in the foreseeable future, and may not be possible at all. The question, then, is how to make best use of the limited resources in a way that is fair, targets need most effectively and supports the growth and retention of the workforce.

A useful framework for such considerations is the **WHO's universal health care cube**, which explains health care coverage along three dimensions – the services covered, the people covered and the proportion of costs covered.

This raises the question of whether there should be an explicit statement about what the NHS offers the population. At present, dentistry in England offers the population a package of services with some explicit exclusions. As this report has shown, NHS dentistry is increasingly unable to deliver equal access to this package of services across the country, meaning that this approach is breaking down.

One response to this is that there should be a more explicit statement setting out the 'benefits package'. While the NHS has historically tended to avoid doing this, it may be time for politicians and the public to face the reality that dentistry is not – and will likely never be – a universal service.

Such statements typically cover:

- *What* services are available
- *Who* gets services
- *How much* people pay.

At a minimum, an offer for dentistry might include universal access to emergency care, pain relief and check-ups with preventative work included. It could include more extensive services to particular groups like older people and children. However, this would be a very significant change from the supposed status quo and could still leave a substantial number of people without access to treatments they need. If coverage is to be widened beyond this, then the choices are about how much is spent, who spends this and who is covered. There are two options.

1. Enhance the offer through increased spending

An obvious way to enhance the NHS offer would be to spend more on dentistry, but 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. While this is not a direct proxy for how much it would cost to provide universal dental care (as it includes cosmetic treatment), even if the cost to the state was just half of that, this would be a significant addition to current budgets for dental health. Therefore it would be unlikely to attract political support given the number of other demands on public funds.

This would mean that this option would probably provide little or no net benefit in terms of the oral health of the population, but would potentially be very expensive if a significant number of people came back to the NHS, or rates for dentists had to be increased to attract them back into the NHS. The costs are hard to estimate as some patients would still choose to remain private – but they would be substantial in any scenario.

Targeting resources to areas of high need is a blunt instrument and may, as with the experience of dental access centres, be best taken advantage of by people who have lower levels of need but are better at finding their way round the complexities of the system. It would also generate postcode variation, which is hard to justify to the public. The lessons of the dental access centres show that genuine co-production with groups experiencing the poorest access and lowest levels of oral health care is essential in working through any solution or service change.

Funding an increase in spending through higher user charges is also not a very viable option. Charges are already high: as noted earlier, they have also risen substantially in the last five years and the UK is already paying more out of pocket for dentistry than many other countries. User charges have perverse effects and are generally undesirable, but it seems unlikely that the Treasury will be willing to reduce the reliance of the sector on charges as a funding source. People claiming Universal Credit qualify for free dental treatment if their earnings during their last assessment period were £435 or less, or £935 or less if their Universal Credit includes an element for a child or they have limited capability for work or work-related activity. This is a low bar and, as shown by Healthwatch, many people are already struggling to meet current dental charges. Recent changes in the cost of living will have intensified this.

2. Limit the NHS offer and means-test eligibility

A second option is 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 all access for dental treatment and orthodontics is means tested for those not in vulnerable or high-risk groups. All those over a certain threshold would need to make their own arrangements. This option violates a rather important NHS founding principle of universality – even if free check-ups were offered. As with exemptions for user charges, it also creates cliff-edges – where those who just miss out on eligibility are hit with high costs – and the potential for anomalies which are unpopular. It also would be expensive to administer, and would require investment in anti-fraud machinery.

Making this type of entitlement change would be very difficult and it is likely that there would be significant opposition to such a radical option, not least because it sets up a dangerous long-term precedent for other NHS services and because it seems likely that there would be more losers from this change than winners. Most worrying is that it creates the problem identified by Richard **Titmuss** that “separate discriminatory services for poor people have always tended to be poor quality services”. Nevertheless, despite these significant pitfalls it is hard to see how NHS dentistry can continue without some kind of evaluation of the offer unless there are some major improvements to the way services are contracted and commissioned.

9 Conclusions

The history of NHS dentistry is marked by periodic neglect and often poorly executed policy. Bolder action is urgently needed to deal with both the short-term issues to put the service on a more sustainable footing, but also to address its long-term future and decide what type of service the NHS is going to offer.

In the short term, the ability of ICBs to take responsibility for imaginative commissioning in this area is an urgent challenge that needs to be addressed. Doing this at a time when ICSs are reducing their management costs may prove difficult, and they may need to work together to ensure that there is a critical mass of expertise. NHS England needs to ensure that scarce expertise is not lost in its reorganisation.

In the longer term, there are no easy options left to policy makers in England. Even with extensive contract reform and the full use of new groups of staff, restoring universal access would cost billions each year. Much of this precious funding, which the NHS desperately needs in countless areas, would simply pay for care that people receive anyway through private payments.

If we accept that universal access to NHS dentistry has gone for good, the urgent imperative is to provide enough access for a basic core service – for children, for older people, and for those who cannot afford private care. This is a standard we currently do not meet, 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.

Without these actions there is a default option to add: a continuation of current policy. This appears to be 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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The views, ideas and proposals in this report are our own and we take responsibility for any errors and omissions.

Appendix A: interviewees and roundtable participants

Stakeholder interviews

A range of interviews (and follow-up discussions) were held with stakeholders covering a broad range of perspectives – the individuals involved spanned current dental practitioners, professional bodies and associations, policy makers and senior NHS executives, regulators, patient representatives, academics, educators, journalists, lobbyists, policy advisers, public health specialists and local government officials. Stakeholders gave their time generously and were open and candid in their contributions. The mix of roles and backgrounds of participants was:

- Policy makers and senior NHS executives (7)
- Regulators (2)
- Patient representatives (2)
- Academics/educators (4)
- Journalists/lobbyists/policy advisers (3)
- Professional representatives (3)
- Public health specialists (2)
- Local Government officials (3)
- Dental professionals (10)

The interviews took place between June and October 2022.

Roundtable event

A roundtable event was held in July 2023 at the offices of the British Dental Association, who generously provided a venue and refreshments. 14 attendees were present from the organisations listed below. The discussion was held under the Chatham House Rule. This report's authors presented an overview of the issues as they had understood them, and attendees were invited to reflect on the problems facing NHS dentistry and potential solutions.

Organisations represented at the roundtable included:

- Department for Health and Social Care
- King's College London
- Care Quality Commission
- Healthwatch
- College of General Dentistry
- Association of Dental Groups
- General Dental Council
- British Dental Association
- Royal College of Paediatrics and Child Health

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