Report for Hampshire Health and Scrutiny Committee to be held on 24 May 2022

The below report is provided to answer the questions raised by the committee. For ease, the questions raised have been included in the report.

- How do commissioners assess the level of need for NHS dental care, how does this then become commissioned activity, and how is this monitored to measure if activity delivered is meeting needs?

Primary dental care is currently commissioned by NHS; England and NHS Improvement; the South East region Integrated Care Boards (ICBs) will be formed in the South East region and this commissioning responsibility will be delegated to the Hampshire and Isle of Wight (HIOW) ICB.

Primary dental care is commissioned as units of dental activity (UDAs) with the number of UDAs awarded to each course of treatment dependent upon the treatment delivered. The number of UDAs a patient will need in a year will depend upon their oral health. Recall guidelines in line with NICE range from 3 to 12 months for children and 3 to 24 months for adults. There is a direct correlation between deprivation and oral health, with those from more deprived households often needing more UDAs a year as they may have more frequent check-ups with higher treatment need identified which attract more UDAs.

The majority of existing primary dental care was introduced in 2006 when the General Dental Services (GDS) Contract and Personal Dental Services (PDS) Agreement were introduced. Contracts specify a defined number of UDAs for a defined contract value, with those issued in 2006 based on treatment proved during a 12-month test period in 2004/5. The test period was during the time when a dental practice could set up where they wished and deliver as much or as little NHS care as they chose. The current dental contract framework and legislation no longer allow practices to set up or provide as much as they wish; for existing practices this is limited to their contracted activity and new NHS practices can only be established after an open procurement process.

GDS Contracts are in perpetuity unless they are voluntarily terminated by the provider or terminated by the commissioner as a result of contractual breaches. A commissioner is not able to reduce contracted activity in one area and move this activity to an area it considers of greater need. There have been marginal increases in dental budget allocations since the 2006 contracts were introduced which has resulted in limited recommissioning of new activity. Therefore, the main change in service provision has been when a contract has terminated and the commissioner

has used the released funding to re-commission. Prior to 2013, Primary Care Trusts commissioned services for their local population which was on a relatively small geographical footprint and so moving activity from one area to another following a contract termination had limited impact. When NHS England was established in 2013 and had a larger footprint, in this area Wessex covered HIOW and Dorset; in 2019 this changed to HIOW only with Dorset becoming part of the South West region. It has only been since that time that recommissioning on a larger footprint and moving from areas of lower to greater need has had a larger impact.

There have been a number of contracts that have terminated in HIOW as a result of providers choosing to hand their contract back. Prior to the pandemic a procurement was undertaken in the areas that were impacted by this the greatest which were Portsmouth, Alton and Tadley (PAT). Where other smaller terminations happened a review of dental provision was required to establish whether this should be recommissioned in the same area or whether there were areas of greater need. The offer of non-recurrent activity was made to all providers in HIOW while this review was to be undertaken, with the uptake on the basis of practices that had the ability to deliver additional activity which was not necessarily in the same areas as the contracts were handed back nor areas that were anticipated to be the greatest need.

The recommissioning of general dental services in HIOW was delayed due to the pandemic, which had paused the PAT procurement. When other priorities during the pandemic allowed recommissioning to recommence, the focus was on the mobilisation of the new PAT contracts rather than the wider review of services. This review was completed by the Dental Public Health team in January 2022 which also took into account further terminations that had occurred during the pandemic. In line with the results of this review, the South East region are commissioning new contracts in the 5 areas of greatest need, based upon deprivation, to increase recurrent UDAs in these areas.

The number of UDAs commissioned will be proportionate to the deprivation of the Local/Unitary Authority so that the more deprived areas have a greater number of UDAs commissioned.

The table below outlines the Index of Multiple Deprivation (IMD) ranking by Local/Unitary Authority.

Local Authority	LA IMD Rank of average score 2019	LA Population all ages mid 2019	Commissioned UDAs per head of LA population
Portsmouth	59	214,905	1.49
Southampton	61	252,520	1.53
Isle of Wight	98	141,771	1.66
Havant	119	126,220	1.59
Gosport	133	84,838	1.56
New Forest	240	180,086	1.52
Basingstoke and Deane	243	176,582	1.36
Test Valley	261	126,160	1.04
East Hampshire	285	122,308	0.97
Eastleigh	287	133,584	1.53
Winchester	292	124,859	1.40
Fareham	298	116,233	1.23

Note that Hart Local Authority is largely based within the Frimley ICS area and is omitted from the above table. For reference, Hart ranks 317 out of 317 in terms of deprivation, i.e. it is the least deprived Local Authority in England.

The budget available to re-commission is derived from what is currently used to commission non-recurrent activity which end on 31 March 2023, the budget released from recently terminated contracts, as well as reserve funding. This will allow 222,000 UDAs to be recurrently commissioned and will give greater choice to patients living and working in the more deprived areas and reduce the need for patients to travel to receive dental care. This will also free up capacity in other areas of Hampshire where patients from these 5 areas are currently travelling to other areas to access care and subsequently receive this closer to home. The areas where activity will be commissioned is as follows: Portsmouth South 78,000 UDA's, Portsmouth North 26,000 UDA's, Southampton East 21,000 UDA's, Southampton West 42,000 UDA's, Gosport 14,000 UDA's, Havant 16,000 UDA's, IOW 25,000 UDA's.

All dental contracts are monitored to ensure they reach their contracted activity. Practices must be within a -4/+2% tolerance at year-end. Practices that under-perform are required to repay the funding for unachieved activity and also receive a breach notice; where practices over-perform by up to 2% this is deducted from their following year's activity requirement. Repeated under-performance without a valid reason would result in discussion to reduce contracted activity to one that is achievable that would enable this activity to be re-commissioned elsewhere. Enforcing a contract reduction is not possible under the terms of the General Dental Services (GDS) Contract and Personal Dental Services (PDS) Agreement and currently a variation in contracted activity must be mutually agreed. Where a provider does not agree to reduce their contracted activity, where repeated under-

performance continues year on year without a valid reason that has resulted in the issue of multiple breach notices, this could result in contract termination (however this is a last resort). Throughout the pandemic, practices have been required to reach minimum thresholds to ensure they were treating as many patients as they safely could.

The dental team, alongside the NHS Business Support Agency (who report data submitted by dental practices) use a Framework to ensure practices are working appropriately and the greatest outliers are highlighted for more in depth contract review. This Dental Assurance Framework (DAF) was paused during the pandemic, however this will re-commence once dental practices are working at 100% (expected from Quarter 2 2022/3) and treatment profiles have returned to normal.

- What levers do commissioners have if there aren't enough dentists willing to undertake the commissioned activity?

A performer (dentist) providing largely full time NHS care delivers approximately 7,000 UDAs per annum, although activity can differ from performer to performer.

Providers that hold an NHS contract are required to engage dental performers to undertake the delivery of the contracted activity; commissioners do not have a contractual relationship with a performer. The Provider is also responsible for employing the appropriate support staff to deliver their contracted activity.

Recruitment and retention of the entire dental workforce is acknowledged as a challenge across the country, but more so in coastal and/or rural areas. One of the reasons for recruitment and retention difficulties is that the profession does not wish to work in a UDA driven service and Dental System Reform (DSR) is required. In March 2022, the Government asked NHSE/I to lead on the next stage of DSR to better support dentists and deliver better outcomes for patients.

The NHS has published six aims of DSR which have been endorsed by the British Dental Association (BDA):

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

The NHS continues to work with the BDA and Government on the next steps of DSR with the ambition to make improvements to the existing contract this year, that will aim to begin to address the issues in the service.

With much of HIOW being coastal, recruitment and retention has had more of an impact than some other parts of the country. In addition to DSR that will be implemented nationally, NHSE/I and HIOW ICS are looking at ways to bring performers into the area. NHSE/I and HIOW ICS has collaborated to develop a new post that will have a strong focus on working with system partners to develop support and deliver sustainable primary care dental services across HIOW with the greatest challenges on recruitment and retention. This post has not been recruited to yet but when filled, will focus on the Isle of Wight, Portsmouth and South East Hampshire initially, due to these being the areas with greatest recruitment and retention challenges.

- What can be done to encourage dentists to offer NHS services in Hampshire and ensure sufficient numbers are in place?

Practices that hold an NHS contract will provide both NHS and private care. Dentists have been reminded to spend an equal amount of time on NHS care as they did pre-pandemic and to not prioritise private care. However, practices will have different levels of dental activity so when a patient makes contact with a practice they may not have capacity to see a patient on the NHS at that time so patients are encouraged to ring more than one dental practice and may also be required to ring on different days as capacity could change on a daily basis.

Since December 2020 NHSE/I has offered funding to practices that have the ability to deliver additional care outside their contracted hours, with a focus on patients with an urgent need. The number of practices that have had the staffing levels to safely deliver this additional service in addition to the normal contracted activity has varied throughout the pandemic. Currently there are 3 practices in HIOW that have the staffing levels to safely deliver this additional service, with 111 being aware of these practices and will direct patients to them.

NHSE/I has incorporated elements of flexible commissioning into the procurement of new contracts which also provide a higher UDA rate in line with the IMD ranking that will assist in supporting the recruitment and retention of dentists.

- Can data be provided on the number of dental practices in Hampshire treating NHS patients and how this number has changed in the past 5 years?

It is noted that the committee has requested data relating to the number of practices in Hampshire who treat NHS patients and how this has changed in the past 5 years. Where the number of practices may have changed over the past 5 years this may not demonstrate the level of dental activity as additional activity has been put in

place where practices have closed. A request has been made to review the dataset of commissioned activity against actual activity achieved, which will give a greater understanding. As mentioned this data has been requested, however at the time of submitting the report the data was not available to be included. Once this data has been collated a supplementary data report will be provided.

- If patients want to register with an NHS dentist and those local to them are not accepting new patients, how can patients find out which dentists do have capacity?

Patients are not registered with a dentist in the same way as they are with a GP. A dental practice is only responsible for a patient's care while in treatment, although many will maintain a list of regular patients so may only have the capacity to take on new patients when patients do not return for an invited check-up or advise they are moving away from the area.

Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist or by ringing 111 who will provide details of local dental practices providing NHS care. At the current time it is anticipated that many practices will not be able to accept new patients for non-urgent care as they are working through the backlog of missed check-ups for their list of regular patients.

- Are infection prevention measures still limiting the number of appointments dentists can offer compared to pre-pandemic levels?

The national Dental Standard Operating Procedure introduced at the start of the pandemic was archived on the 5 April 2022, subject to no significant changes being made to IPC guidance as the NHS moved to align with the Government's Living with COVID-19 strategy. There may still be additional steps some contractors may need to take prior to returning to full contractual delivery and therefore a minimum performance threshold of 95% applies during April to June (Q1) 2022/23. This is in recognition that practices are still required to follow enhanced infection prevention control measures, including a fallow time after treatment, for patients with respiratory symptoms that access dental care.

- what access to dentistry is there for vulnerable patients e.g. those with a learning disability or those who are homeless?

While many patients with a learning disability can receive dental care from the general dental service, patients with a moderate to severe learning disability may require the specialist skills of the Community Dental Service. Referral to this service can be made by a learning disability team, general dental practitioner, GP or other healthcare professional.

Homeless patients and other vulnerable groups such as refugees and asylum seekers can also receive dental care from the general dental service. However,

where a patient has complex medical needs and require the specialist skills of the Community Dental Service, they can be referred to this service by any healthcare professional.

- Are there plans in place to train more dentists?

Health Education England are responsible for education and training of dentists. They have recently published ‘Advancing Dental Care (ADC) Review Report’, the culmination of a three-year review to identify and develop a future dental education and training infrastructure that produces a skilled multi-professional oral healthcare workforce, which can best support patient and population needs within the NHS. The Government is currently considering the next steps.

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