National Audit Office

Dentistry in England

A National Audit Office memorandum to support a Health and Social Care Committee inquiry

This PDF is **INTERACTIVE**

February 2020

Dentistry in England

This submission is in response to a request of support from the Chair of the Health and Social Care Committee of the 2017–2019 parliament to the Comptroller and Auditor General for the Committee's Dentistry Services inquiry. It covers the commissioning of NHS dentistry services, financial flows relating to NHS dentistry, dentistry workforce, and access to NHS dentists.

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DP Ref: 11919-001

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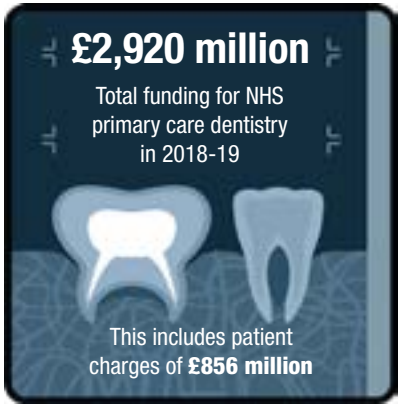
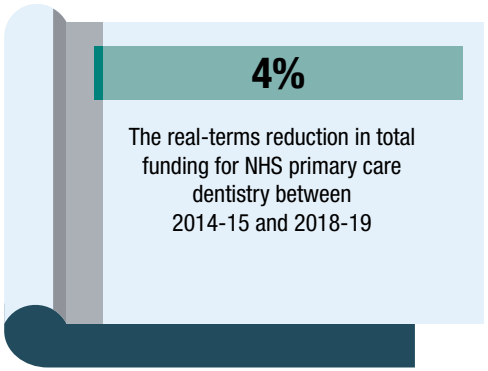
At a glance





5.3

The total number of practising NHS dentists per 10,000 people in the UK in 2018. This is fewer than in France, Germany or Italy

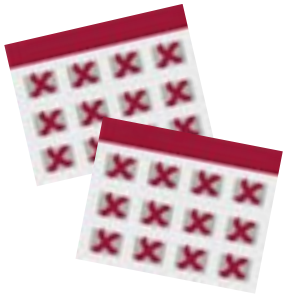
Within England, the number of NHS primary care dentists varies from 12.6 dentists per 10,000 in Bradford City to 3.4 per 10,000 in West Norfolk and North Lincolnshire

For more on funding, see page 6

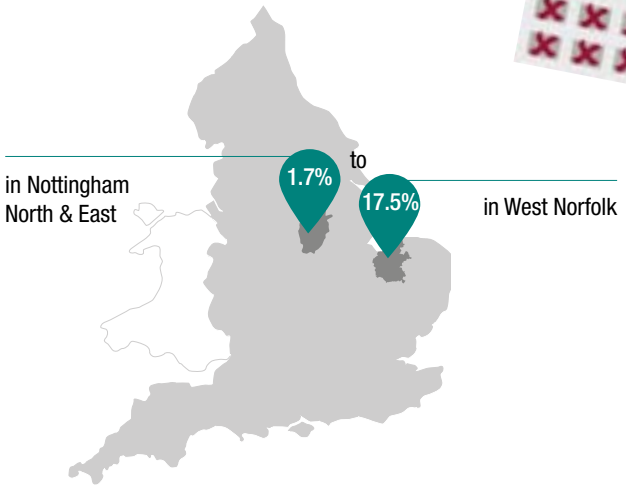
For more on the dental workforce, see page 11

6%

The percentage of patients who were unsuccessful when trying to get an NHS dental appointment in England in the past two years.



Within England the number varies from:



in Nottingham North & East

in West Norfolk

For more on accessing NHS dentistry, see page 13

25,702

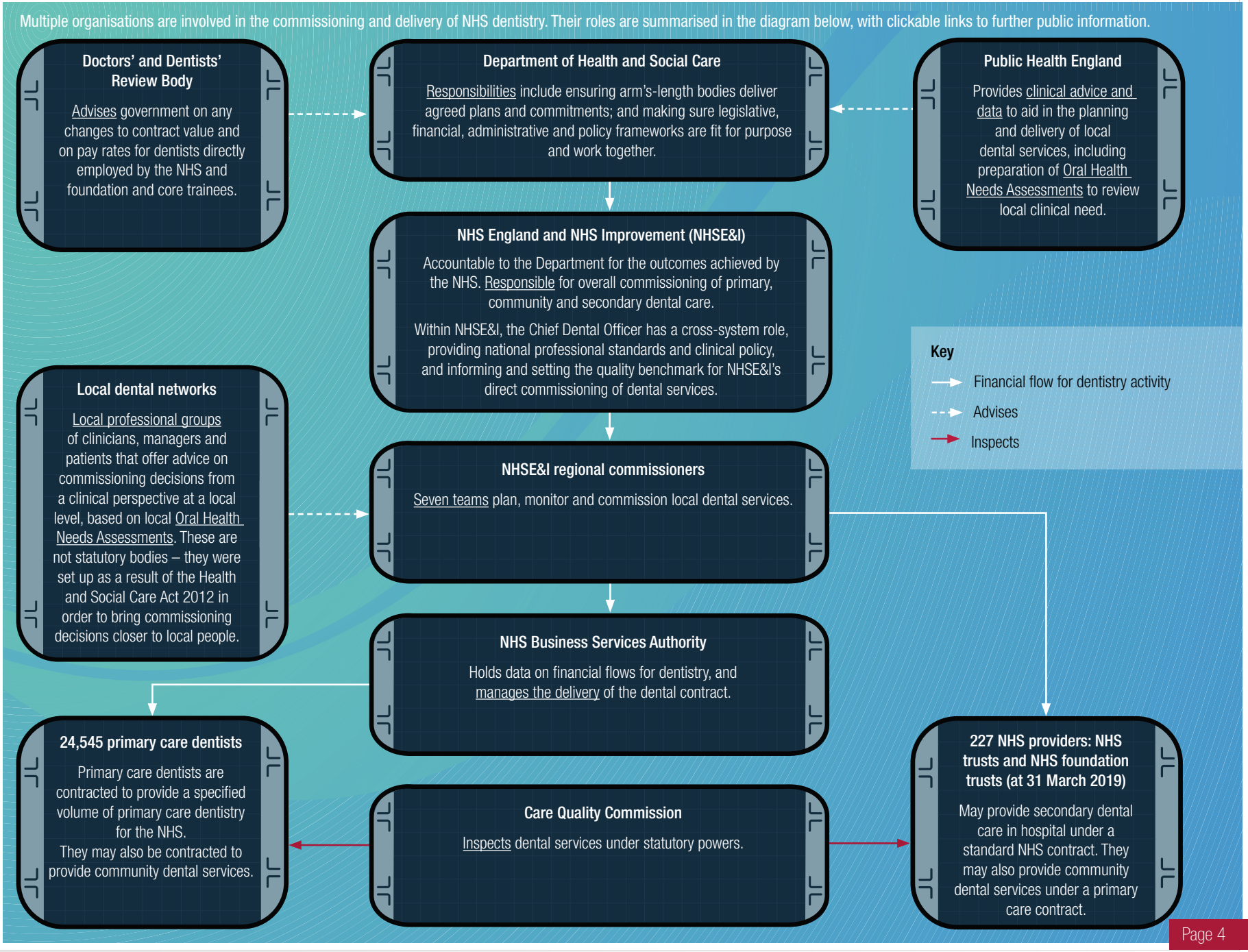
The number of Finished Consultant Episodes for children aged 5 to 9 admitted to hospital in 2018-19 with an 'ideally completely preventable' diagnosis of tooth decay

The next highest primary diagnosis on admission for 5- to 9-year olds is acute tonsillitis (11,811 episodes)

For more on NHS dentistry in hospitals, see page 15

Organisations involved in NHS dentistry in England

Multiple organisations are involved in the commissioning and delivery of NHS dentistry. Their roles are summarised in the diagram below, with clickable links to further public information.



Commissioning of NHS dentistry

NHS England is legally responsible for ensuring the provision of primary dental services throughout England and it carries out this duty at a regional level. NHS England and NHS Improvement started to act together as a single organisation from April 2019.

NHS England and NHS Improvement: Aims

Aims to:

achieve excellence and consistency in the commissioning of dental specialties in England to reduce inequalities, improve care for patients to ensure they are receiving the highest-quality dental care in the most appropriate setting, delivered by professionals with the required skill set, resulting in improved outcomes and ensuring value for money for the taxpayer.

Develops policies and guidance for regional commissioners.

NHS England and NHS Improvement: Regional commissioners

- Regional commissioners plan, commission and monitor dentistry services across their region. NHS England and NHS Improvement told us that its goal is for commissioners to secure high-quality provision that meets expressed demand in their areas.
- Unlike for medical services, clinical commissioning groups and local authorities are not involved in commissioning.
- Primary care dentistry is provided under one of three types of contract (see page 19).
- Community dental services are commissioned to address access issues for particular groups such as residents in care homes, those in refugee centres, and vulnerable patient groups (for example, people with learning difficulties, patients requiring anxiety management). These are generally provided by secondary care trusts under separate primary care dentistry contracts.
- Secondary NHS dental care is provided in NHS hospitals under a standard NHS contract.

NHS England and NHS Improvement: Guidance

- A Commissioning Guide provides information and guidance to regional commissioners.
- Specific detailed service guides exist for various areas including orthodontics and oral surgery. These guides highlight good practice and are produced in collaboration with Health Education England, Public Health England, specialist societies and the public.
- NHS England and NHS Improvement is now focusing on producing other guides to support service delivery in areas identified in the NHS Long Term Plan (in particular for children with disabilities, care homes and vulnerable groups).

Commissioning

- Primary care dentistry, once commissioned, is accessed by patients directly, typically at high-street dental surgeries.
- Urgent and emergency dentistry may be provided in both primary and secondary care settings; patients may access this via 111 or through Accident and Emergency departments.
- All other secondary care dentistry is by referral only.
- Specialist care is predominantly provided in secondary care but dependent on case complexity may be via an accredited primary care provider.
- Dentistry for the armed forces is commissioned separately by the Armed Forces team.
- The Health and Justice team of NHS England and NHS Improvement commissions dentistry in prisons. These services are not covered further in this memorandum.

Private dentistry

- Dentists may provide both NHS and private dentistry services.
- Dentists may offer private dentistry as an alternative to NHS treatment in its entirety or in part.
- Dentists carrying out private dentistry can refer into primary and secondary NHS services.
- NHS England and NHS Improvement expects dentists who hold an NHS contract to explain which treatments are available on the NHS.

Annual funding and patient charges in NHS primary care dentistry, 2014-15 to 2018-19

From 2014-15 the total funding for NHS dentistry has decreased by 4% in real terms, while the charges individual patients pay to access NHS dentistry have increased by 9% in real terms.

Primary care dentistry funding

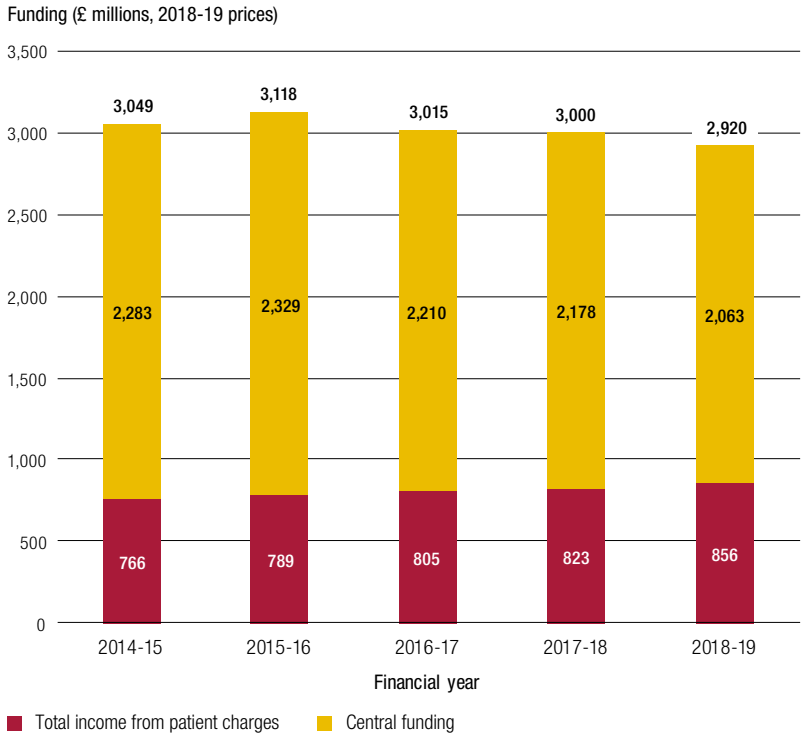
Dentistry is funded by a combination of payments from NHS England and NHS Improvement (via the NHS Business Services Authority) and patient charges.

Figure 1 shows the total funding (NHS funding plus the income received from patient charges) for primary care dentistry over the five years from 2014-15 to 2018-19.

The published accounts show that total funding has decreased by 12% in real terms (i.e. after allowing for inflation) from 2014-15 to 2018-19, but applying an accounting change to the figures for 2014-15 and 2015-16 reduces this decrease to 4% in real terms, from £3,049 million to £2,920 million. Using these adjusted figures, the contribution of NHS England funding to this total has fallen by 10% in real terms over the same period.

The total income from patient charges has increased from £766 million to £856 million, or 12%, between 2014-15 and 2018-19.

Figure 1: Primary care dentistry funding and total income from patient charges (adjusted for inflation)



Source: NHS England, *Annual reports 2015-16 to 2018-19* contain the income from patient charges and, from 2016-17, the central funding amounts. Central funding amounts for 2014-15 and 2015-16 were separately provided to us by NHS England to reflect "the improved allocation of costs between primary care and secondary dental services", which enhances comparability between years. Totals may not sum due to rounding. Cash prices are adjusted to 2018-19 prices using GDP deflators from gov.uk, GDP deflators at market prices, and money, September 2019.

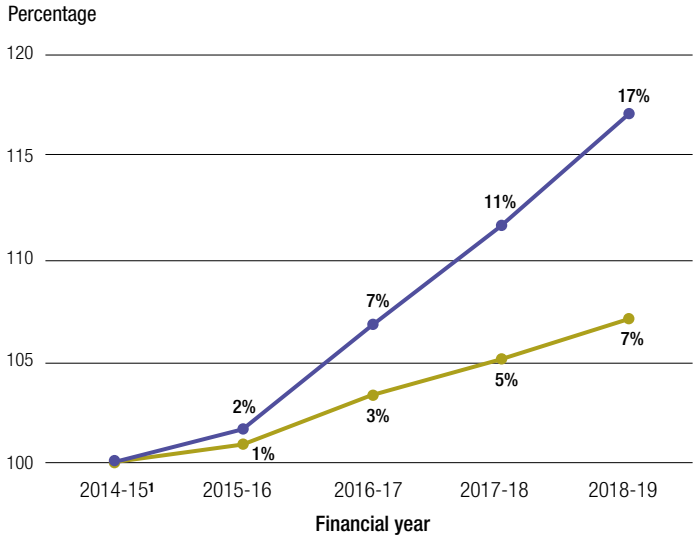
Patient charges

Since 1951, some patients have been charged at the point of care for primary care dentistry, accounting for 29% of total funding in 2018-19 (£856 million) (up from £766 million and 25% of the total in 2014-15).

Similar to prescription charges, there are exemptions and the charges are split into bands depending on the level of treatment required (see page 9). In 2018-19, the charges for Band 1 and urgent treatment were £22.70, Band 2 treatment £62.10 and Band 3 treatment £269.30.

These individual patient charges have increased by 9% in real terms between 2014-15 and 2018-19. This equates to a cumulative and nominal 17% increase (i.e. in cash terms) between 2014-15 and 2018-19, relative to the cumulative 7% increase in general inflation over the same period (**Figure 2**).

Figure 2: Change in dental patient charges and inflation, 2014-15 to 2018-19



Note
1 2014-15=100.

Source: Patient charges from NHS England Annual Reports for the years 2016-17 to 2018-19 and from written statements to Parliament for the years 2014-15 and 2015-16. General inflation is from gov.uk, GDP deflators at market prices, and money, September 2019. See page 9 for further information on patient charge bands 1,2 and 3.

Regional NHS spending on dentistry, 2018-19

Analysis of regional expenditure shows unexplained variation in levels of funding and activity per head of population.

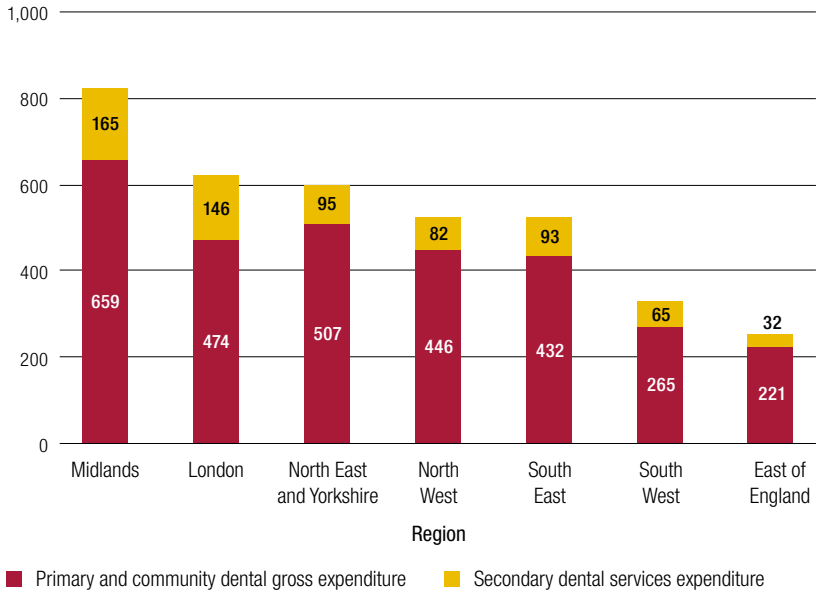
Dentistry spending varies by region

The total gross expenditure (primary, secondary and community, including NHS England expenditure before income from patient charges is considered) by region (**Figure 3**) and total gross expenditure per person by region (**Figure 4**) follow a similar pattern. This shows greater amounts of total and per capita spending in the Midlands than in other regions, and the lowest amounts in the South West and the East of England.

These contractual payments paid for 40 million courses of treatment and 83 million 'units of dental activity' (UDAs) nationally in 2018-19, with variation in activity between regions after accounting for regional populations (**Figure 5** overleaf).

There will likely be some differences in the unit cost of inputs between regions. For example, the NHS tends to pay above-average cost for a UDA in London compared with the rest of England, which may be why London delivers below-average activity per head but still has one of the higher costs per head.

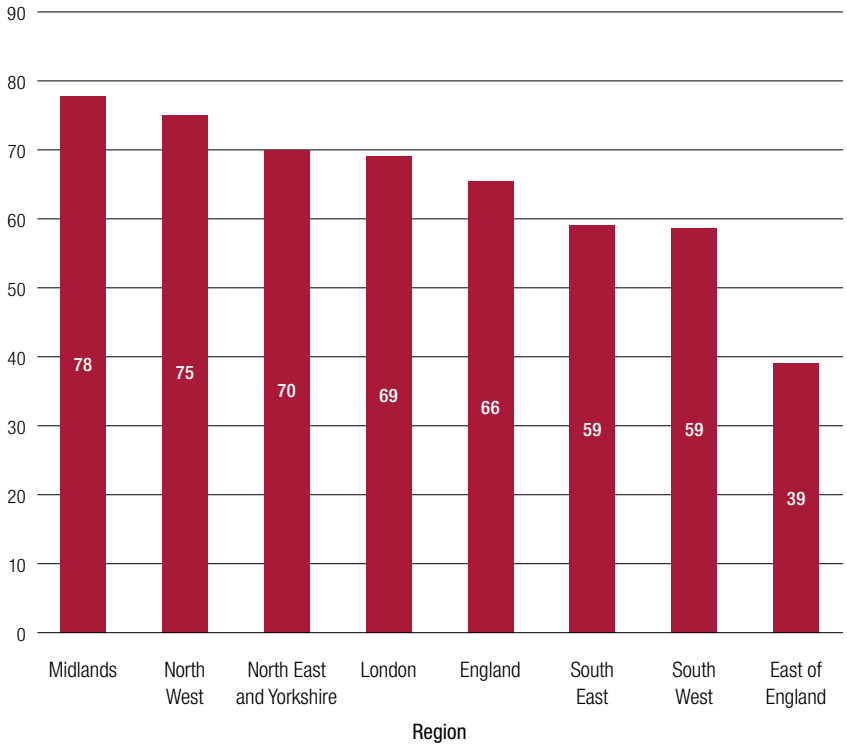
Figure 3: Total gross expenditure on dentistry by region, 2018-19



Note
1 Gross expenditure is for primary and community dental services before subtracting income from patient charges (which offsets expenditure). According to NHS England's management accounts, gross expenditure by the regions totalled £3,004 million. NHS England explained this differs from the £2,920 million total in the audited accounts (page 6) primarily because the regional figures include community dental services provided by trusts.

Source: NHS England (unpublished data)

Figure 4: Total gross expenditure per head of regional population, 2018-19

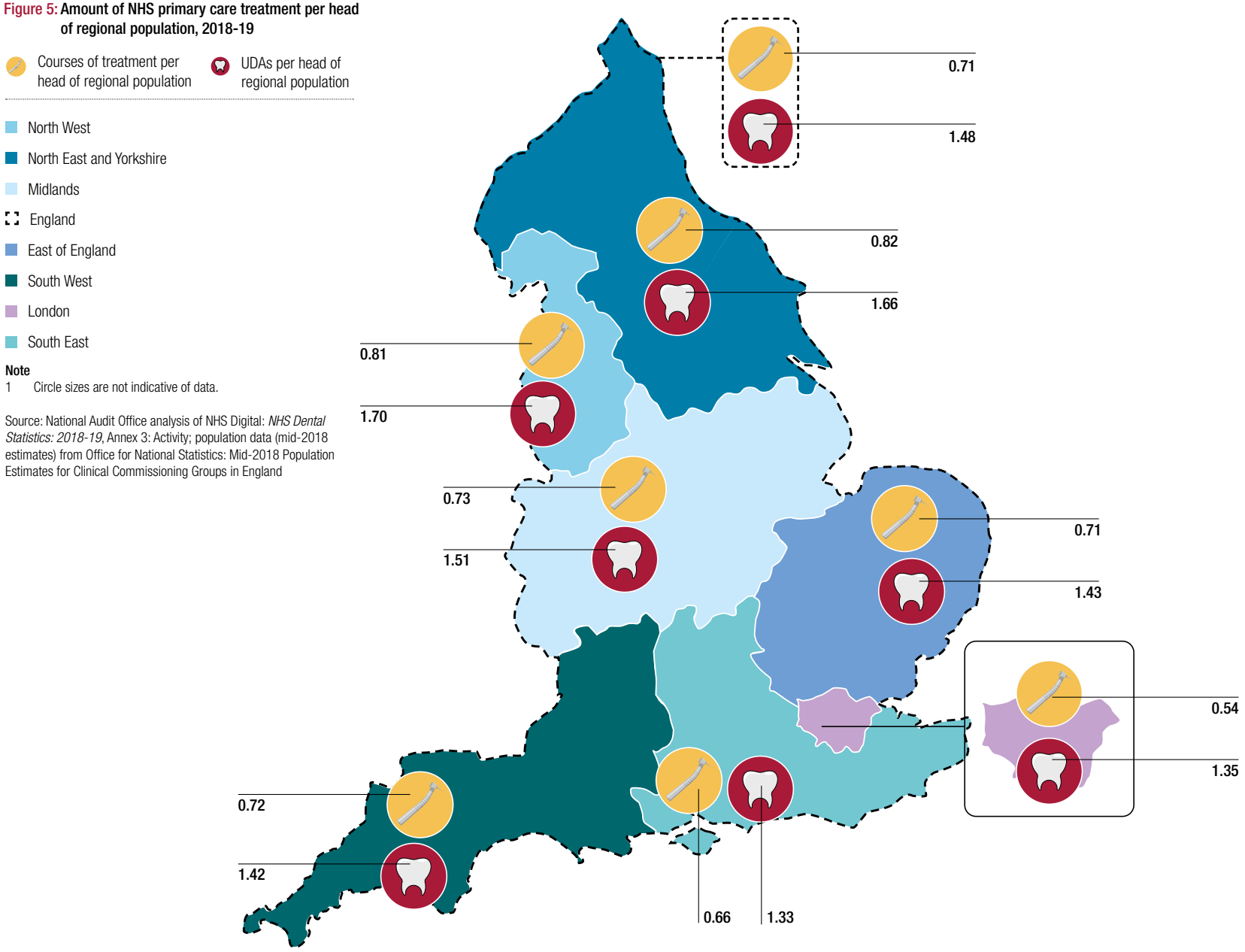


Notes
1 Total gross expenditure on dentistry is expenditure on secondary care dental services plus gross expenditure for primary and community dental services.

Source: National Audit Office analysis of NHS England (unpublished data) and Office for National Statistics data; population estimates are from Office for National Statistics, 2019, Clinical commissioning group population estimates.

Regional NHS spending on dentistry, 2018-19 *continued*

Figure 5: Amount of NHS primary care treatment per head of regional population, 2018-19



Note
1 Circle sizes are not indicative of data.

Source: National Audit Office analysis of NHS Digital: *NHS Dental Statistics: 2018-19*, Annex 3: Activity; population data (mid-2018 estimates) from Office for National Statistics: Mid-2018 Population Estimates for Clinical Commissioning Groups in England

Units of dental activity and charges, 2019-20

Primary care dentistry activity is recorded in Units of Dental Activity, which are awarded to dentists for providing treatment. There are four bands of treatment, and these attract different patient charges.

The various treatments patients receive from dentists attract different patient charges and are also assessed as representing different numbers of Units of Dental Activity (UDAs). The single UDA value is based on the complexity and urgency of the treatment required (see diagram right).

A course of treatment gains a single UDA value based on the most complex element of treatment provided. The actual amount of treatment required within a single band does not affect the UDAs a dentist records. Thus, treatment requiring one crown attracts the same number of UDAs as treatment requiring eight crowns – in both instances 12 UDAs for a Band 3 course of treatment.

Primary care dental providers are expected to collect patient charges on behalf of the NHS. Patient charges are also collected by community dental service providers. Secondary care providers of dental care do not routinely collect patient charges.

Some categories of patients (including children, pregnant women and new mothers, and those in receipt of low-income benefits) are exempt from payments, along similar lines to prescription charge exemptions.

Urgent

Patient charge: £22.70

1.2 units of dental activity

Emergency care such as pain relief or filling

Band 1

Patient charge: £22.70

1 unit of dental activity

Examination, diagnosis and advice

Band 2

Patient charge: £62.10

3 units of dental activity

Covers all treatment in Band 1, plus additional treatment such as fillings, root canal and extractions

Band 3

Patient charge: £269.30

12 units of dental activity

Covers all treatment in Band 1 and 2, plus more complex treatment such as crowns, dentures and bridges

UDAs and dentists' contracts

- UDAs are the basic unit of dentists' contracts. Dentists have contracts that allocate them a specific number of UDAs each year.
- Contracts do not stipulate from which band UDAs must come – this is left to the discretion of the dentist based on an assessment of individual patients' needs.
- The monetary value of a UDA varies across practices and regions.
- UDA values were first fixed in 2006, with subsequent annual uplifts as recommended by the Doctors' and Dentists' Review Body. The initial values were based on prevailing market forces and are not in the public domain.

Further information on UDAs

- UDAs are awarded to dentists for treatments for all patients entitled to NHS treatment, whether they pay patient charges or are exempt from payment. Patient charges therefore offset the total cost of treatment for NHS England: the actual amount paid to dentists for treatment relates to UDAs and not to patient charges.
- Patient charges are paid to NHS England, and do not affect the amount of money dentists receive for each treatment. Every treatment is paid by UDA value from NHS England, irrespective of whether patients have paid the patient charge.
- Patients never pay for certain treatments, but UDAs can be claimed by dentists: denture repair (1 UDA); arrest of bleeding (1.2 UDAs).
- Patients do not pay for continuation treatment (which is considered to be treatment provided within two months of the completion of a course of treatment). Providers, however, can claim UDAs for such treatment.

Total NHS dentistry activity in England, 2018-19

The primary care activity data show differences between the activity profiles of non-paying and paying adults.

Patients seen by NHS dentists

As at 30 June 2019, NHS dentists had seen 22 million adults in the preceeding 24 months, or 50% of the adult population; and seven million children (aged 0–17), or 59% of the total 0–17 population.

Paying adults account for just over half of NHS primary care dental activity

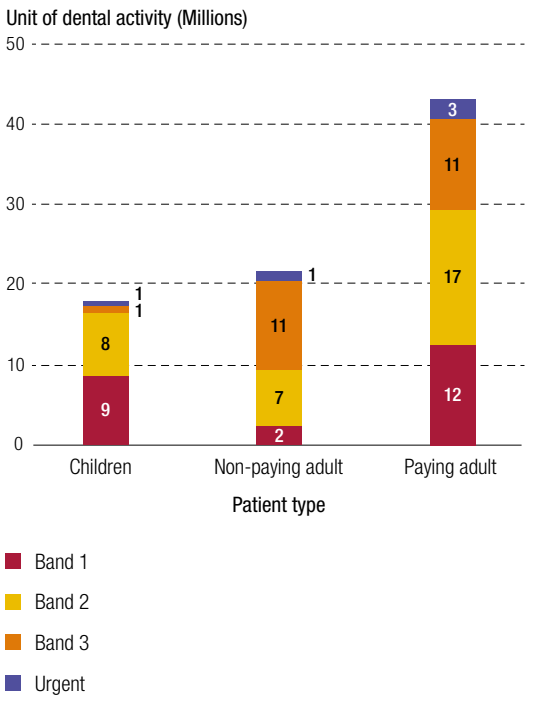
The activity measured by Units of Dental Activity (UDAs) in 2018-19 can be broken down into children, non-paying adults and paying adults. **Figure 6** shows that 43 million UDAs were recorded for dentistry provided to paying adults in 2018-19, while the total for exempt adult patients was 22 million and for children, who are also exempt from payment, 18 million.

There are differences in the patterns of treatment received by the three types of patient

Figure 7 presents the same information but with the relative treatment band profiles shown as percentages. This highlights apparent difference between patient types. Some difference in profiles is to be expected because dental treatment needs differ by age.

For instance, children may have their teeth checked more frequently than adults, which may help to explain the greater proportion of Band 1 activity. As there is no further public data on differences between non-paying adults and paying adults – such as age profile and gender – we cannot use such variables to try to explain the differences in treatment bands here.

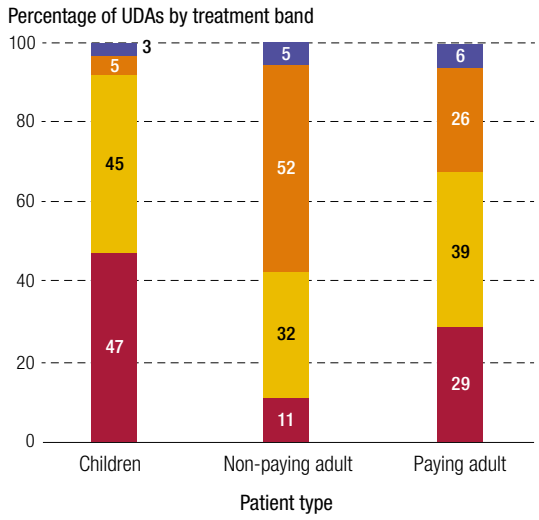
Figure 6: NHS primary care dental activity by patient type, 2018-19



Note
1 See page 9 for further information on patient charge bands and exemptions.

Source: NHS Digital, *NHS Dental Statistics: 2018-19*, Annex 1, table 2c

Figure 7: NHS primary care dental activity by patient type (%), 2018-19



Note
1 See page 9 for further information on patient charge bands and exemptions.

Source: *NHS Digital, NHS Dental Statistics: 2018-19*, Annex 1, table 2c

Dentists per head of population – international and intra-UK comparisons

There are limitations to different data sources, but triangulating these sources indicates that the UK has relatively low numbers of dentists per head of population compared with other advanced European economies, and that England has the lowest number of NHS dentists per head of population in the UK.

The Organisation for Economic Co-operation and Development (OECD) reports standard workforce statistics submitted by countries. These show that, compared with similar large European countries, the UK has fewer dentists per head of population.

The UK has lower numbers of dentists per person than other large European countries. **Figure 8** compares against the other European countries which are also members of the Group of Seven (G7), 'the world's leading industrial nations'. The UK reported an estimated 35,000 practising dentists in 2018, which is 5.3 practising dentists per 10,000 people. The numbers are higher in France, Germany and Italy.

While international comparisons can never be perfect, different analyses produce a similar message.

The data the UK submits to the OECD includes primary care dentists and dentists employed in hospitals. This data excludes those who work only in private sector dentistry.

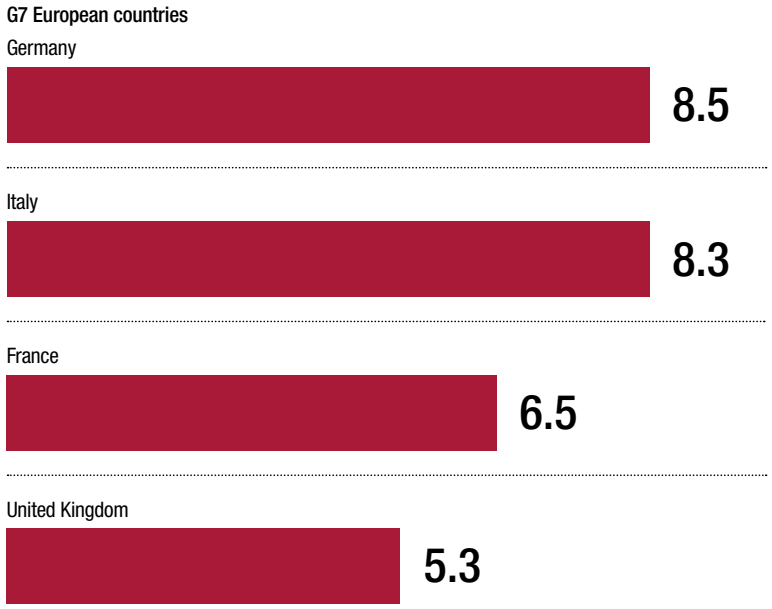
To look specifically at England: England had 24,545 dentists performing NHS primary care activity in 2018-19, equivalent to 4.4 dentists per 10,000 population.

To give an indication of the total number of dentists in England (NHS primary and secondary care, plus private-only dentists), the General Dental Council reported that at March 2019 there were 32,501 registered dentists in England. Although some might not be practising (working instead in research or overseas, for example), this equates to 5.8 dentists per 10,000 population, which is higher than the 'practising' number provided to OECD but still below the G7 European comparators in Figure 8. Comparing this registered number to the closest analogous OECD figures for Germany and Italy (those 'licensed to practise'), their figures are 11.8 and 10.2 dentists per 10,000 respectively. Triangulating across sources, therefore, presents a similar message of fewer dentists per head of population than comparable countries.

England has fewer NHS primary care dentists per person than the other nations of the UK.

Figure 9 shows that the 4.4 NHS dentists per 10,000 population in England compares with 6.2 per 10,000 in Scotland, 6.0 per 10,000 in Northern Ireland and 4.8 per 10,000 in Wales.

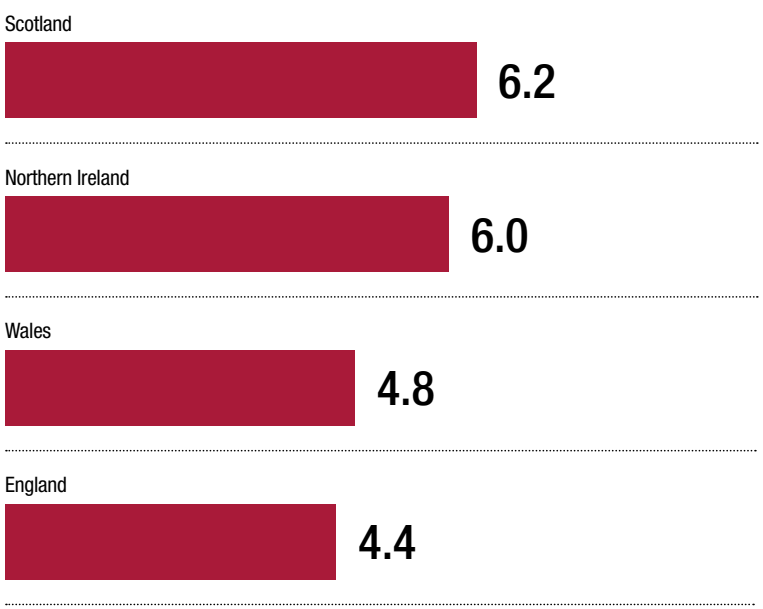
Figure 8: **Practising dentists per 10,000 population, G7 European countries (2018 or nearest year)**



Notes
1 Italy, France and UK figures are for 2018, Germany figures for 2017. Figures for Italy and UK are estimates.
2 UK data do not include dentists who work exclusively in the private sector.

Source: National Audit Office analysis of Organisation for Economic Co-operation and Development Healthcare Resources statistics, available at: https://stats.oecd.org/index.aspx?queryid=30177

Figure 9: **NHS dentists per 10,000 population, UK countries, 2018-19**



Note
1 All figures are as at March 2019, and all are for primary care dentists.

Source: Scotland, Information Services Division, Dentists (March 2019); Northern Ireland, HSC Business Services Organisation, Family Practitioner Services Statistics 2018-19; Wales, NHS Dental Statistics in Wales, 2018-19; England, NHS Digital, NHS Dental Statistics for England 2018-19

Dentists per head of population – variation within England

There is considerable variation in the number of NHS dentists per head of population within England.

NHS Digital reports NHS dentists who perform activity by local area, so there is some double counting of dentists between areas. Ideally, data would show their relative contribution to each area, but comprehensive and full-time equivalent data on dentists are not available. Despite its limitations, the data shown here highlights that large geographical areas of the country have very low levels of NHS dentists per head of population.

Figure 10 shows the distribution of these NHS dentists by area in 2018-19 relative to the population of the area. The extremes of this variation are from 3.4 dentists per 10,000 people in West Norfolk and North Lincolnshire to 12.6 dentists per 10,000 people in Bradford City (**Table 1**).

It should be noted that NHS England and NHS Improvement commissions dentistry through its seven regional areas (shown on the map with bold boundary lines). Although we have used clinical commissioning groups' (CCGs') geographic areas for this analysis, as they are appropriate-sized areas for assessing access to NHS dentistry, CCGs themselves do not commission primary care dentistry.

NHS England and NHS Improvement considers that dentists willing to work within the current NHS contract and terms and conditions of service are not evenly distributed across England, and that the resulting shortfalls in provision have been most notable in more remote, rural areas.

Table 1: Practising NHS dentists per 10,000 population in local areas in England, 2018-19

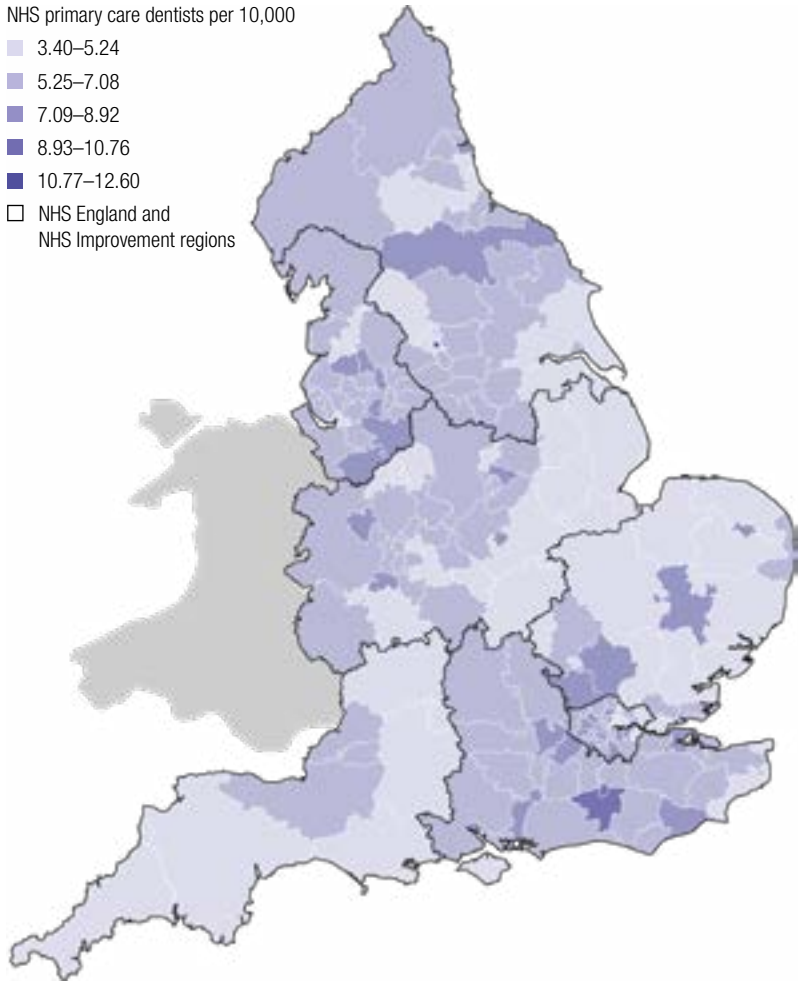
Top 5 local areas for dentists per 10,000 population

1	**12.6**	Bradford City
2	**9.7**	Horsham and Mid Sussex
3	**9.2**	Crawley
4	**8.8**	Hammersmith and Fulham
5	**8.6**	South Tyneside

Bottom 5 local areas for dentists per 10,000 population

1	**3.4**	West Norfolk
2	**3.4**	North Lincolnshire
3	**3.6**	East Riding of Yorkshire
4	**3.7**	North Staffordshire
5	**3.8**	South Lincolnshire

Figure 10: Headcount of NHS primary care dentists per 10,000 population, local areas in England, 2018-19



Notes

1 Variation shown by equal intervals from a range of 3.4 to 12.6.

2 Data is presented at clinical commissioning group level as an appropriately-sized area for analysis whilst noting that CCGs do not themselves commission primary care dentistry.

Source: National Audit Office analysis of dentist headcount from NHS Digital: *NHS Dental Statistics: 2018-19*, Annex 3: Workforce; and CCG Population data (mid-2018 estimates) from Office for National Statistics Table SAPE21DT5: Mid-2018 Population Estimates for Clinical Commissioning Groups in England

Accessing NHS dentists – activity once accessed

There is local variation in the activity provided to people accessing NHS dental services

Dental activity in local areas varies considerably even after population differences have been accounted for.

Figure 11 and **Table 2** shows the extent of this variation, from 2.4 Units of Dental Activity (UDAs) per person in South Tyneside to 0.8 UDAs in Richmond. These differences are likely to be explained by many factors, including in some cases a shortage of dentists overall and in some cases the availability of private dental care to meet local needs.

The NHS activity statistics cannot tell us, however, the extent to which NHS activity plus private dental care meets demand for dentistry, or the extent to which demand for NHS care is different due to underlying oral health in different areas.

It should be noted that NHS England and NHS Improvement commissions dentistry through its seven regional areas (shown on the map with bold boundary lines). Although we have used clinical commissioning groups' (CCGs') geographic areas for this analsis, as they are appropriate-sized areas for assessing access to NHS dentistry, CCGs themselves do not commission primary care dentistry.

Table 2: **Primary care dental activity (UDAs per head of population) by local area, 2018-19**

Top 5 local areas for NHS dental activity

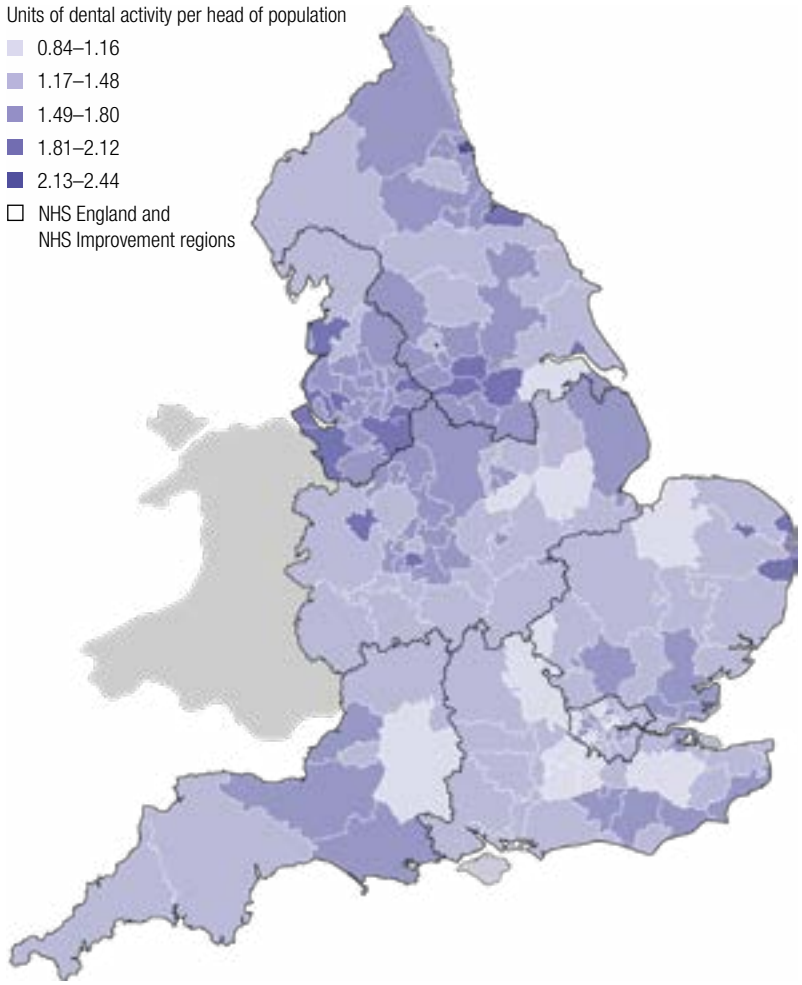
1	**2.44** South Tyneside
2	**2.35** Bradford City
3	**2.08** Southport and Formby
4	**2.03** Norwich
5	**2.00** Great Yarmouth and Waveny

Bottom 5 local areas for NHS dental activity

1	**0.84** Richmond
2	**0.96** West Norfolk
3	**1.01** West Kent
4	**1.01** Surrey Heath
5	**1.02** Tower Hamlets

Note
1 UDAs are explained on slide 9.

Figure 11: **Variation in NHS primary care dental activity delivered per head of population in England, 2018-19**



Notes
1 Variation shown by equal intervals from a range of 0.84 to 2.44.
2 Data is presented at clinical commissioning group level as an appropriately-sized area for analysis whilst noting that CCGs do not themselves commission primary care dentistry.

Source: National Audit Office analysis of NHS Digital: *NHS Dental Statistics: 2018-19*; Annex 3: Activity; and CCG Population data (mid-2018 estimates) from Office of National Statistics: Mid-2018 Population Estimates for Clinical Commissioning Groups in England

Accessing NHS dentists – ease of access

There is local variation in the success people had when trying to access NHS dentistry

An indication of variation in unmet demand for NHS dental care is provided by the GP Patient Survey, which asks a number of questions about dentistry and highlights geographical differences in ease of access

The GP Patient Survey undertaken between January and March 2019 reported that, nationally, 92% of patients who tried to get an NHS dental appointment in the preceding two years were successful in getting an NHS dental appointment, with 6% unsuccessful and 2% unable to remember.

Locally, the results demonstrate considerable variation between areas, **Figure 12** and **Table 3** shows this variation, which ranges from 17.5% in West Norfolk to 1.7% in Nottingham North and East.

It should be noted that NHS England and NHS Improvement commissions dentistry through its seven regional areas (shown on the map with bold boundary lines). Although we have used clinical commissioning groups' (CCGs') geographic areas for this analsis, as they are appropriate-sized areas for assessing access to NHS dentistry, CCGs themselves do not commission primary care dentistry.

Dental capacity

A central list of NHS dentists, and their capacity, is available online. However, NHS England and NHS Improvement South West's submission to the Health and Social Care Select Committee stated that "historically, there has been a reluctance to allow the commissioner to 'advertise' dental capacity, as this may result in large numbers of currently private patients requesting NHS treatment that cannot be met from existing budgets".

Table 3: **Percentage of patients unsuccessful when trying to get an NHS dental appointment, by local area, 2019**

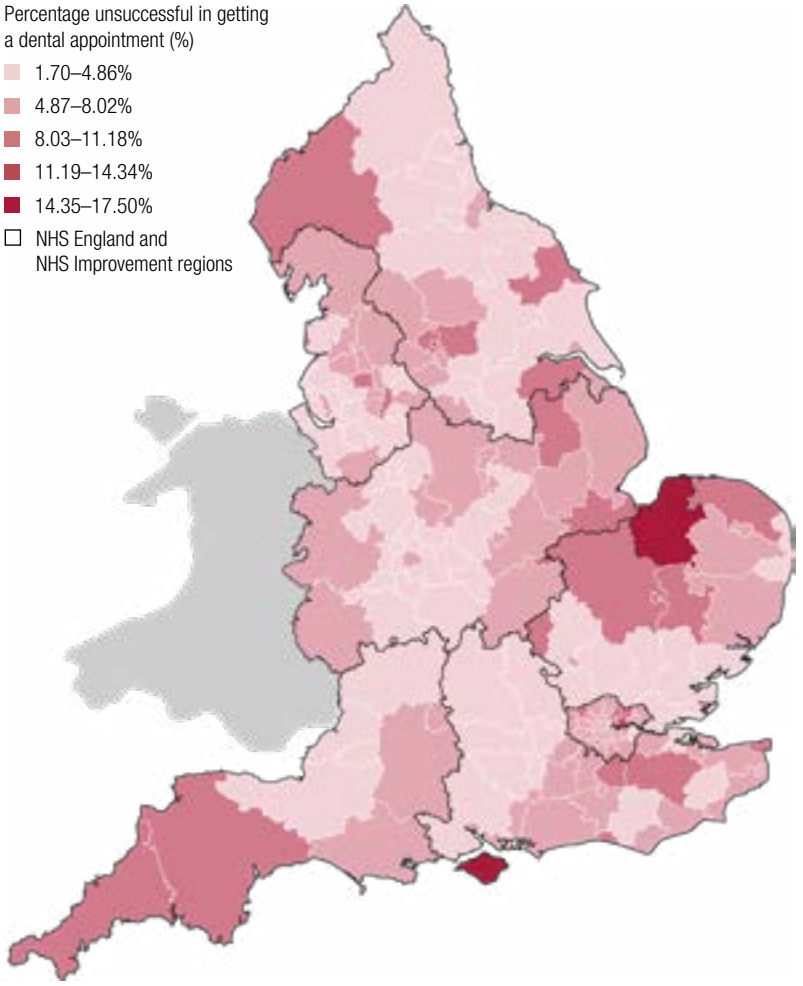
Top 5 (lowest unsuccessful percentage) areas

1. **1.7%** Nottingham North and East
2. **1.8%** South Tyneside
3. **2.0%** North Staffordshire
4. **2.1%** Dudley
5. **2.1%** Bassetlaw

Bottom 5 (highest unsuccessful percentage) areas

1. **17.5%** West Norfolk
2. **14.5%** Isle of Wight
3. **13.7%** Bradford City
4. **12.1%** Newham
5. **11.1%** Kernow

Figure 12: **Percentage of patients unsuccessful when trying to get an NHS dental appointment in the preceding two years, by local area in England, 2019**



Notes

1 Variation shown by equal intervals from a range of 1.7 to 17.5.

2 Data is presented at clinical commissioning group level as an appropriately-sized area for analysis whilst noting that CCGs do not themselves commission primary care dentistry.

3 Responses are to the GP survey question "Were you successful in getting an NHS dental appointment?" The base is "all patients who have tried to get an NHS dental appointment in the last 2 years and answered the question, excluding 'can't remember'".

Source: National Audit Office analysis of GP Patient Survey, July 2019, results by clinical commissioning groups, shown by equal intervals

Access over time and hospital activity

NHS dentistry is providing a reducing proportion of primary-care dental activity to non-paying adults, compared with children and paying adults. Tooth decay does cause admissions to NHS hospitals, with more 5- to 9-year-olds admitted for tooth decay than for any other reason.

Adults who are exempt from charges are receiving less primary care dental treatment than they were 10 years ago

Figure 13 shows the percentage change in Units of Dental Activity (UDAs) by patient type and band between 2008-09 and 2018-19. It shows large decreases in activity with non-paying adults, particularly for Band 2 treatments, over this time. It is unclear from the available data whether this change represents a reduction in the proportion of adults eligible for free treatment, an increased reluctance on the part of some dentists to treat exempt adults, a change in the availability of NHS dentistry in areas with high concentrations of exempt patients, or something else.

Some dentistry-related hospital costs may be avoidable

Some of the demand for oral health ends in hospital care. **Figure 14** shows admitted care (Finished Consultant Episodes, FCEs) in hospitals in 2018-19 by five-year age bands for dental caries (tooth decay). "Dental caries is a disease that ideally is completely preventable".[1] These 25,702 episodes are the largest single primary diagnosis for 5- to 9-year-olds, with acute tonsillitis the next largest primary diagnosis for admitted patient care for this age group, at 11,811 FCEs.

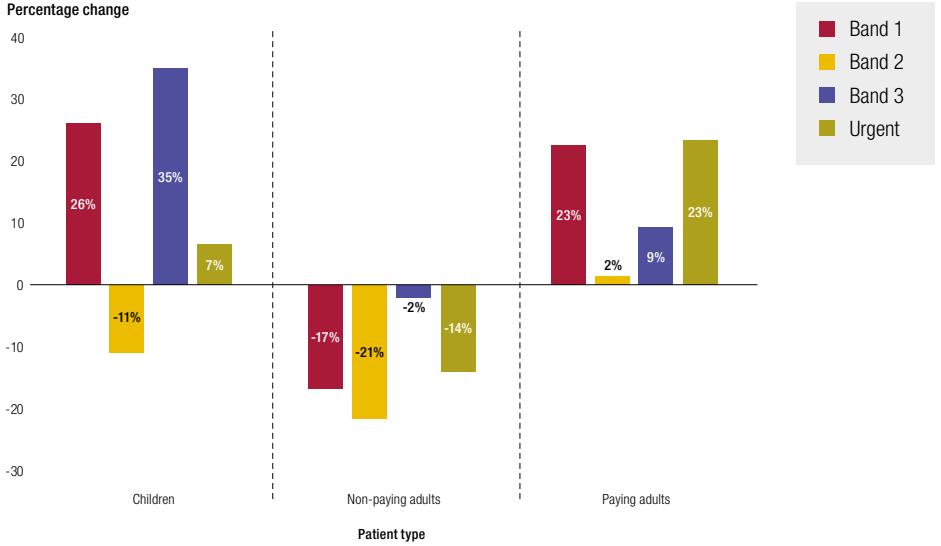
From the data on hospital procedures, and specifically for the 5- to 9-year-old age band, there were 22,330 'extraction of multiple teeth' at a national tariff cost of £630 in 2018-19. The total cost of this activity was around £14 million. For these 5- to 9-year-olds, some of this activity might have been avoidable through better oral health.

For 5- to 9-year-olds, the dental caries figures do show improvement between 2014-15 and 2018-19 as the episodes have decreased (by 4%) at a time when the total population of 5- to 9-year-olds has increased (by 8%). In 2014-15 there were 26,708 FCEs with a primary diagnosis of dental caries (this gives a crude 8.2 episodes per 1,000 5- to 9-year-olds, in England) compared to 25,702 (7.3 episodes per 1,000) in 2018-19.

Note

1 Alijafari et al, 'Failure on all fronts: general dental practitioners views on promoting oral health in high caries risk children – a qualitative study', *BMC Oral Health* (2015) 15:45.

Figure 13: Percentage change in primary care dental activity by patient type and band, between 2008-09 and 2018-19

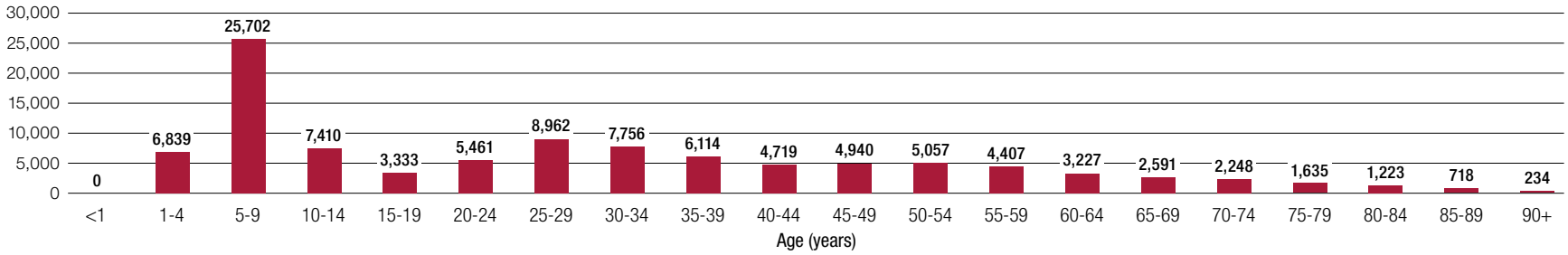


Note

1 Bands are explained on page 9. Band 1 activity is the most straightforward and Band 3 is the most complex.

Source: NHS Digital, *NHS Dental Statistics: 2018-19*; Annex 1, table 2c

Figure 14: Hospital activity - dental caries (tooth decay), 2018-19



Source: NHS Digital, *Hospital Episode Statistics*, 2018-19. 3-character primary diagnosis by age band

Activity and contract delivery

Analysis of publicly-available data has limitations but highlights variations in delivered compared with contracted NHS dental activity.

To carry out a dental contract-level analysis, the National Audit Office matched data on contracted activity with delivered activity by postcode and compared the two. We could not match every practice but the method allowed a comparison covering 88% of Units of Dental Activity (UDA) delivered in 2018-19. This analysis uses only publicly-available data and is limited because the data do not allow us to exclude practices which are delivering additional activity (for example through service lines such as 'out of hours') or to identify trust-led and/or community dental services, or to see where contracts changed hands, which may also skew the results.

Despite these limitations, this initial analysis does raise questions about the mechanisms by which equitable access to dental services are monitored or addressed by NHS England and NHS Improvement, and whether there is any further non-public analysis of these datasets that feeds back into commissioning or assessments of the comprehensiveness of NHS dental services provision.

Where the practices match, the analysis finds that the highest frequency of practices (2,000 or 35%) were delivering between 100% and 104% of their contracted activity but 16% of practices (937) were delivering less than 85% of their contracted NHS activity.

This under-delivery in 937 practices may make it harder for patients to access NHS dental services. For these practices, the comparison shows that 13 million UDAs were commissioned and nine million UDAs were delivered.

On over-delivery, according to NHS England (see page 18), dentists are only permitted to provide up to 102% of contracted UDAs, or 104% if agreed in advance. We are unclear how and whether this substantially increased UDA delivery is paid to dentists.

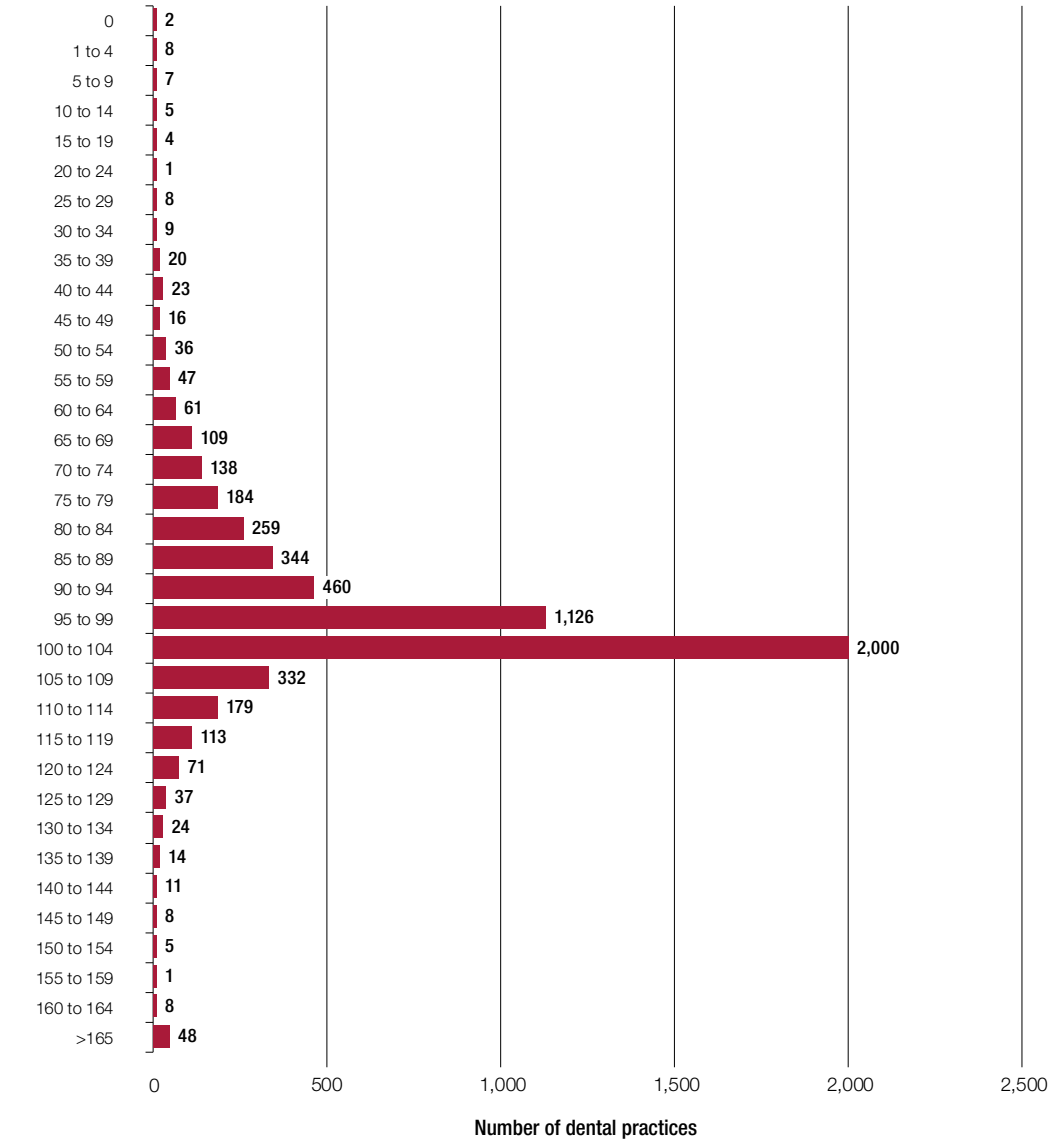
A breakdown of the analysis by constituency, showing the highest and lowest rates of activity compared with contacted activity, is shown on page 17.

Methodology note

Two public data sources hold information on contracted NHS dental activity (NHS Business Services Authority) and delivered NHS dental activity (NHS Digital). Using postcodes, we were able to match contracted to delivered activity for 6,407 of the 8,581 practices (75%) listed in the NHS BSA data and this covers 96% of the contracted activity and 95% of the delivered activity.

To allow a more reasonable comparison, practices which deliver orthodontic activity were then excluded (as they are contracted for units of orthodontic activity), as were practices that delivered UDAs without a corresponding contracted UDA. This results in a comparison between contracted and delivered activity for 5,718 (67%) practices listed in the NHS BSA data and covering 89% of the contracted UDAs and 88% of the delivered UDAs.

Figure 15: Activity levels compared with contract, by practice, 2018-19



Note
1 The analysis is based on matchable data only, and this accounted for 88% of delivered UDAs.

Source: National Audit Office analysis of NHS Digital for delivered activity (NHS Digital: *NHS Dental Statistics: 2018-19 – Activity*) and NHS Business Services Authority for contracted activity (NHS Business Service Authority: *NHS payments to dentists*, 2018-19)

Top and bottom areas for delivery of contracted NHS activity, by Parliamentary constituency

There are variations between constituencies in the delivery of contracted NHS dental activity in 2018-19.

The median level of delivery by constituency is 96% of the contracted level. Dentists overall in 10 out of 533 constituencies in England delivered more than 110% of contract value, and dentists overall in 109 constituencies delivered less than 90% of contract value.[3]

Table 4: Highest percentage of delivery of contracted NHS dental activity by Parliamentary constituency

Constituency name	Dental contract value (for practices that match in both datasets) (£000)	Percentage of contracted activity (UDAs) actually delivered[2]
Houghton and Sunderland South	641	125%
Wimbledon	3,578	120%
Bolsover	2,712	118%
Thirsk and Malton	1,922	117%
Faversham and Mid Kent	7,962	117%
Mid Dorset and North Poole	3,173	115%
Islington South and Finsbury	3,959	115%
Havant	4,512	114%
Manchester, Withington	3,249	113%
Rugby	2,665	111%

Table 5: Lowest percentage of delivery of contracted NHS dental activity by Parliamentary constituency

Constituency name	Dental contract value (for practices that match in both datasets) (£000)	Percentage of contracted activity (UDAs) actually delivered[1]
Blackpool North and Cleveleys	1,907	61%
Copeland	2,713	62%
North West Norfolk	4,169	65%
Sleaford and North Hykeham	1,235	69%
Waveney	3,962	69%
South Dorset	3,901	70%
Newton Abbot	4,803	72%
Kingston upon Hull East	3,700	73%
Kettering	3,551	73%
Sunderland Central	7,725	74%

Note

1 The analysis is based on matchable data only, and this accounted for 88% of delivered UDAs.

2 This partial and limited analysis uses only publicly available data and is limited because the public data do not allow us to exclude practices that are delivering additional activity (through service lines such as 'out of hours') or to identify trust-led and/or community dental services or to see where contracts changed hands, which may also skew the results. See page 16 for a description of the methodology.

3 This is a partial and limited comparison between contracted and delivered activity for 5,718 practices (67%) listed in the NHS BSA data and covering 89% of the total contracted Units of Dental Activity (UDAs) and 88% of the total delivered UDAs in the NHS Digital data. Not all dentists are included because of difficulty matching the two data sources.

Source: National Audit Office analysis of NHS Digital for delivered activity (NHS Digital: *NHS Dental Statistics: 2018-19* – Activity) and NHS Business Services Authority for contracted activity (NHS Business Service Authority: *NHS payments to dentists*, 2018-19), using 2018 ward and parliamentary constituency boundaries from geoportal.statistics.gov.uk

Dentistry contracts – the basics

Contractual arrangements

The current contractual arrangements have been in place since 2006. The contract cannot be changed unilaterally either by the NHS or dentists.

General Dental Services contracts are usually held in perpetuity, with a set number of associated Units of Dental Activity (UDAs). Most of the primary care dentistry budget is, therefore, predetermined each year unless new services are commissioned or current contract holders terminate their contracts.

Dental practitioners can transfer their NHS contract to another practitioner by the formation and subsequent dissolution of a joint partnership. This means that contract values held in perpetuity may be provided by a new dentist who has formed such a partnership.

Primary care dentists are not NHS employees and act as self-employed under contract from the NHS, in a similar way to GPs and pharmacists. However, as noted, their contracts are mostly held in perpetuity.

Dentists in direct NHS employment (for example, secondary care) or Foundation and Core training are paid on a national scale with rates set centrally following advice from the Doctors' and Dentists' Review Body.

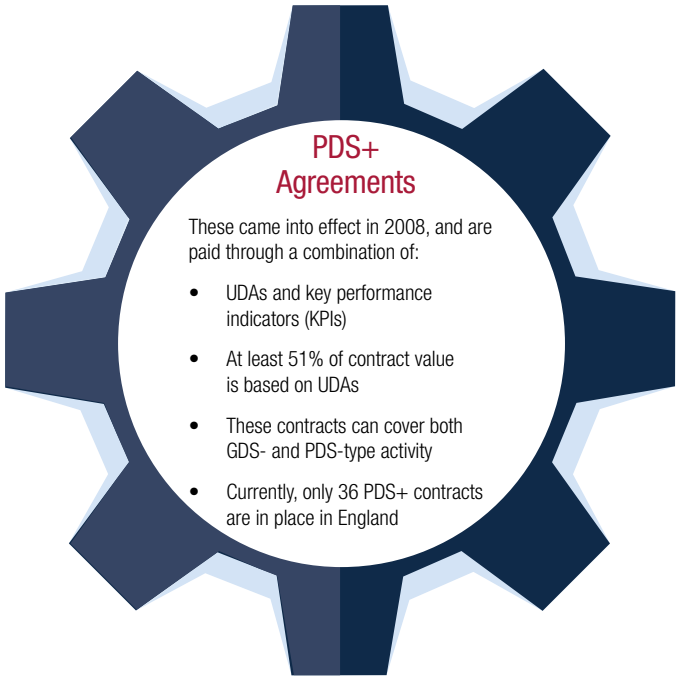
Contract delivery and management

The NHS Business Services Authority (BSA) acts as paymaster for the main dentistry contracts. BSA uses the Compass system to manage the contract. It is the joint responsibility of commissioners and practices to monitor delivery. A key principle is that all treatments must be clinically necessary and justifiable to commissioners. The following key processes apply (although we have not examined the extent to which they are adhered to):

- Practices must send in an FP17 claim form per course of treatment within two months.
- Practices must provide an FP17DC form to patients if they are given Band 2, 3 or private treatment, or if they request it.
- Contracts are paid on a monthly basis and reconciled at year end.
- Providers can deliver 96%–100% of the contract limit without financial penalty, but performance below this attracts clawback up to 100% of contract value.
- NHS BSA claws back funds within three months of contract year end – it is recovered in full within a year, with the aim of not putting providers into financial difficulties.
- There are a very small number of contract terminations each year. New procurement takes around 9–12 months.
- Dentists can provide up to 102% of contract activity, and they are either paid for this or count it against the following financial year. If agreed in advance with commissioners, this can rise to 104%.
- Practices are monitored for cost-effectiveness, to avoid frequent re-call and re-attendance.

Dentistry contracts – primary care (2006–present)

	Contract type	
	General Dental Services contract (GDS)	**Personal Dental Services Agreement (PDS and PDS+)[3]**
Proportion of primary care contracts	85% of primary care contracts	15% of primary care contracts
Length of contract	Contracts generally held in perpetuity	Contracts are normally five years in duration, and must be re-procured after this time. Some contracts are extended to seven years
Services provided	Provides mandatory services – the typical range of services which must be provided by all dentists[1] GDS contracts may also be used to provide additional services including advanced mandatory services if required[2]	Solely provide advanced mandatory services.[2] Providers do not need to hold a GDS contract
Basis of payment	Both contracts are paid using Units of Dental Activity (UDAs)	
Community services	Community services can be provided on either a GDS or a PDS contract	



Practices can choose what proportion of their NHS income they use to pay their labour and materials costs

While both are delivered by contracted providers, primary care dentistry differs from primary care medical services (for example, GPs) in that there is no capitation payment (a payment for retaining patients on practice lists)

Notes

1 In a small number of cases (numbers are not publicly available), pre-2006 contractual arrangements continue, meaning some practices still only treat particular groups such as children. No new such contractual arrangements have been issued since 2006.

2 There are three levels of complexity of treatment envisaged – primary care dentists are expected to provide Level 1, and some may provide Level 2 care. The remainder of treatment is carried out in secondary care. These levels are not intended to map onto the bands of treatment described on page 9. Advanced mandatory services may include primary orthodontic or intermediate oral surgery, conscious sedation, and so on, which may be required for community services.

3 Contractors holding PDS or PDS+ agreements and who provide mandatory services have a right to a GDS contract subject to contractual regulations.

Dentistry contracts – new prototype contracts

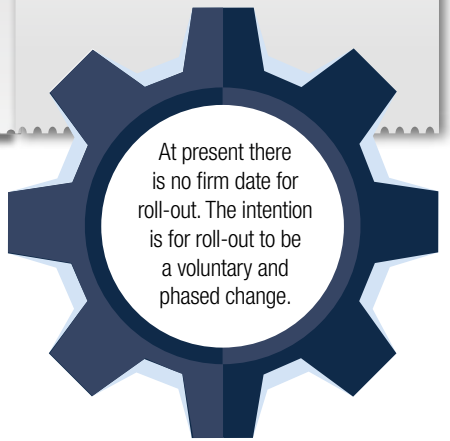
The Steele Review (2009)

The Steele Review was an independent review into NHS dentistry carried out as the government's response to a previous Health Select Committee report. The Review recommended changes to dentistry contracts to improve continuity of care, favour prevention and improve access.

Since 2011, a number of variations to the dental contract have been piloted. In 2015, prototype contracts were launched by the Department of Health & Social Care on a limited scale to address some of these issues.

The intention of the prototype contract is to improve oral health and access to NHS dentistry.

1



Prototype contracts

Under existing contractual arrangements, there is no incentive for continuity of care focusing on prevention and adhering to NICE guidelines on dental recall. Recommended recall periods are 3–24 months (adults) and 3–12 months (children).

The prototype contract aims to recognise preventive care by introducing a form of capitation rate – rewarding dentists for retaining patients on their practice lists and engaging them in preventive care.
Patients continue to have choice of dental provider. If they have substantive care at another practice (excluding urgent or emergency care) while on a practice's capitated list, they will be removed from that list.

As at September 2019, 102 practices are operating on the prototype contract.

2

There are two blends of the prototype:

Blend A: UDA paid for Bands 2 and 3 (capitation payments replace Band 1).

Blend B: UDA paid for Band 3 only (capitation payments replace Bands 1 and 2).

Oral Health Assessment

Oral Health Assessments are not part of the existing GDS and PDS contracts. They have been introduced to the prototype contract as part of capitation and prevention.

Patients are assessed and given a RAG (red, amber, green) rating of their oral health. Patients are then given a treatment plan, which aims to focus on preventive measures rather than treatment alone.

Units of Dental Activity (UDAs) are not claimed for the Oral Health Assessment – dentists are paid for this as part of the capitation payment.

Oral Health Assessments are intended to promote prevention and follow the NICE guidelines, leading to a more focused preventive approach rather than frequent and unnecessary check-ups.

At present the Dental Quality Outcomes Framework is being used as one way to evaluate these new prototypes using the categories of patient safety, clinical effectiveness, patient experience and data quality. This is similar to how the Dental Assurance Framework (page 18) is used to benchmark current services.

3

Satisfaction with NHS dentistry

Of people surveyed through the GP Patient Survey, 85% responded that their experience of NHS dental services was good, with some local variation reported.

The GP Patient Survey, undertaken between January and March 2019, reported that 85% of patients had a good (either fairly good or very good) experience of dental services. **Figure 16** also shows that, nationally, 7% had a poor experience (either fairly poor or very poor). This question was answered by respondents who are patients and had tried to get an NHS dental appointment in the preceeding two years.

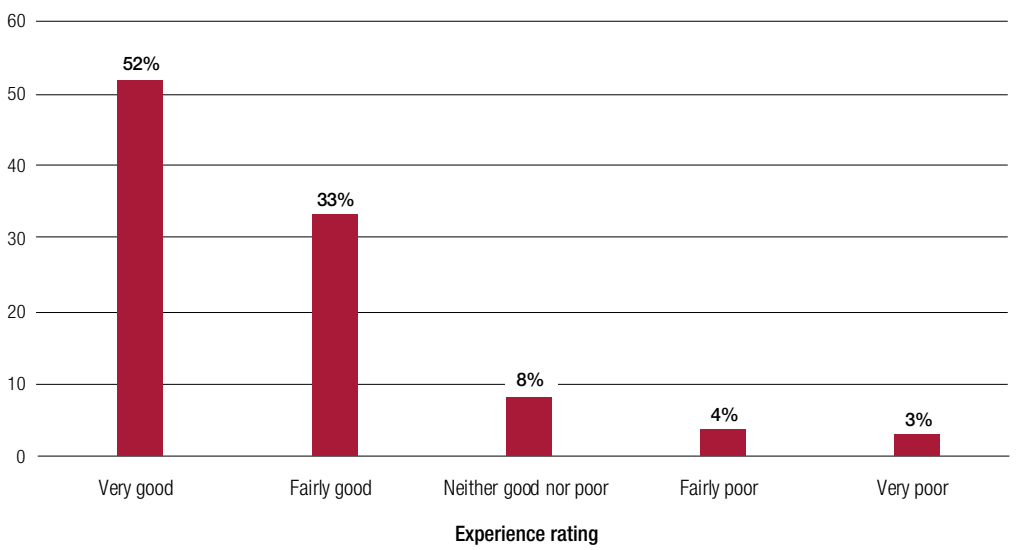
Locally, the results demonstrate variation between local areas, **Table 6** shows this variation, which ranges from 70% in West Norfolk to 93% in South Tyneside.

It should be noted that NHS England and NHS Improvement commissions dentistry through its seven regional areas (shown on the map with bold boundary lines). Although we have used clinical commissioning groups' (CCGs') geographic areas for this analysis, as they are appropriate-sized areas for assessing access to NHS dentistry, CCGs themselves do not commission primary care dentistry.

Table 6: Overall good experience of NHS dental services by local areas, 2019

	Top 5 Local areas	Percentage good
1	South Tyneside	93%
2	South Warwickshire	92%
3	North Staffordshire	92%
4	Dudley	91%
5	Rotherham	91%
	Bottom 5 Local areas	**Percentage good**
1	West Norfolk	70%
2	Thanet	75%
3	Bradford City	76%
4	Isle of Wight	76%
5	Tower Hamlets	76%

Figure 16: Overall experience of NHS dental services, 2019



Note
1 Respondents are patients who had tried to get an NHS dental appointment in the two years prior to the survey.

Source: National Audit Office analysis of GP Patient Survey 2019, fieldwork January to March 2019

Note
1 Response options were: Very good, fairly good, neither good nor poor, fairly poor, very poor. We have added the first two of these to produce a figure for 'good'.

Source: National Audit Office analysis of GP Patient Survey 2019