A PLAN OF ACTION FOR NHS DENTISTRY IN PORTSMOUTH

Produced following the Dental Summit held on the 10th of June 2022

Hosted by the University of Portsmouth

Chaired by the Rt.Hon Penny Mordaunt MP (Member of Parliament for Portsmouth North)

Introduction

On the 10th of June 2022 the Rt. Hon Penny Mordaunt MP convened a meeting between key stakeholders concerned with NHS dental provision in Portsmouth and the surrounding areas referred to as a Dental Summit.

The meeting was hosted by the University of Portsmouth at its Faculty of Creative and Cultural Industries, Eldon Building with attendance (virtually, and in person) from stakeholders representing a range of sectors (primarily from Portsmouth, but also further afield) with the Rt. Hon Penny Mordaunt MP chairing the meeting.

The stakeholders present at the meeting comprised of:

- Dental Providers
- Public Health Officials
- Commissioners (NHS CCG)
- Academia
- Advisory Bodies
- Patient Interest Bodies
- Members of Parliament from across Hampshire

Other stakeholders were also invited to the Dental Summit including representatives from NHS England but were unable to attend.

Background

In 2020 NHS dental providers were required to close for routine care and treatment because of the Covid-19 pandemic and were directed to offer an advisory and or prescription service, with onward referral for urgent treatment to Covid secure dental hubs. This resulted in significant backlogs in respect of routine dental treatment but also in some cases emergency care in particular, with residents reporting that they were unable to secure urgent treatment and, in some instances, resorting to self-treatment at home.

After the requirement to close ended, NHS dental providers reopened but were required to operate in a Covid secure manner, with additional safety protocols. This has reduced the appointment capacity dental providers have been able to offer, and whilst it is increasing residents of Portsmouth are still reporting they are unable to be seen by an NHS dentist.

It is worth mentioning that even before the Covid-19 pandemic residents were struggling to secure routine dental treatment via the NHS. Many reported being directed to NHS providers outside of the city for treatment, or it was suggested that they should secure private treatment at significant cost over and above what would be charged through the NHS banding system. However, the private system was also operating at great stress.

In Portsmouth, the problem is particularly acute owing to a decision by Colosseum (one of the largest providers in the city) to renege on its contract of provision. Patients of Colosseum were transferred to other providers in the city; with temporary service stand up whilst new services were commissioned. The Covid pandemic delayed this commissioning process with one provider in Cosham who had been awarded a contract to address the loss of Colosseum provision still yet to come online. This remains the case as of June 2022.

NHS England are currently undertaking a procurement exercise which is at the tender review stage and contract awards are anticipated to take place early July. Portsmouth could potentially have 104,000 UDAs (Units of Dental Activity). It is anticipated that contracts will commence by April 2023.

In the introduction to the meeting the Rt. Hon Penny Mordaunt MP explained that her office currently held 55 live cases from constituents where they could not get access to an NHS dentist. Of particular concern were the difficulties of very vulnerable residents being able to access an NHS dentist such as pregnant women, who would ordinarily be entitled to an exemption to pay for NHS dental treatment. Other particularly, vulnerable groups cited, were homeless individuals, 'looked after children' and individuals living in high needs areas in the city.

Many of these individuals were unable to afford travel outside of the city for treatment, and many reported phoning numerous dental providers to try and secure NHS or private treatment with no success.

The Rt.Hon. Penny Mordaunt MP has been raising the issue of access to an NHS dentist with Commissioners, Ministers, and other stakeholders since the loss of Colosseum and has continued to do so throughout the Covid pandemic and after. Following conversations with the University of Portsmouth it was agreed a Dental Summit would be convened with a view to developing a plan of action for Portsmouth.

In January 2022, the Government announced additional funding of £50 million pounds to be used through contracting additional hours from dental providers outside of their normal operating hours. Portsmouth was allocated a proportion of this funding; however, only two providers came forward. There were restrictions placed on this funding. Currently, there are three providers in the Southeast region offering urgent treatment through these additional hours. Referral is via NHS 111. None of the providers offering these additional hours operate in the city.

It was indicated during the summit that the Department for Health and Social Care is currently considering the NHS Dentistry contract; however, attendees were not aware of the content of this review and discussions connected to this. There does; however, appear to be an appetite for review within Government.

It is well understood that there is significant unhappiness from dental professionals in respect of the current NHS contract; and changes made to it in 2006, which is resulting in many NHS dentists choosing to transfer to private practice or leave the profession altogether.

As part of the Dental Summit, the Director for the University of Portsmouth Dental Academy, Professor Chris Louca provided a presentation in respect of the activity of its Dental Academy and their long-term aim of opening a Dental School.

One final point to note is that in July 2022 commissioning for NHS dentistry in Portsmouth will move from NHS England to the Integrated Care Service. Some reservations were expressed in respect of this during the meeting; and how well this would work.

Terms of Reference

This report is not intended to cover all conversations which occurred during the Dental Summit which was convened under Chatham House rules. For a full summary of the meeting please view a copy of the agenda and draft minutes included in Appendix A.

The purpose of this report is to set out the actions generated because of the discussions held during the Dental Summit for further comment and discussion. Once reviewed it is intended that the report should be shared with Commissioners and Ministers.

Four key themes were identified during the Dental Summit which generated suggestions and actions as to how to tackle the issue of access to NHS dentistry. The factors underpinning this issue are complex and this document should not be viewed as a comprehensive summary of all factors, rather it is intended that this report should be a starting point to bring about change which could help in resolving both the short- and long-term factors which are preventing individuals from accessing an NHS dentist.

The four key themes identified are:

- Actions we can take now to increase provision
- Structural issues in respect of the current contract for NHS Dentistry
- Training and workforce regeneration, retention, and resilience.
- New opportunities through Public Health work, Integrated Care Systems, and a new approach to Commissioning.

The following information is a summary of the all the actions generated at the Summit according to these key themes.

<u>Actions we can take now to increase provision</u>

- Create a usable database of patients using the NHS 111 service for urgent dental treatment that providers can access in the event of Failure to Attend (FTA). Providers wanted to be able to offer short notice slots to patients requiring urgent treatment but did not have a direct helpline to call NHS 11; nor did they have access to a real time database.

- Review the issuing of NHS Performer numbers in the Hampshire area. Currently waiting times are too long (in comparison to other areas) which is resulting in dentists who have been hired being unable to practice within the NHS, and placing further burdens on providers i.e., costs.

- Bring the Cosham practice (which was awarded part of the Colosseum contract) online and swiftly and identify the barriers which were preventing this. It is thought that planning, covid safety requirements, delays in the issuing of NHS Performer numbers were all contributory factors. By supporting the practice to come online it could potentially release up to 20,000 additional UDAs

- The University of Portsmouth explained that it had 50 dental chairs available which are currently not being used (where they could be to stand up provision), but funding was needed to do so which could only be provided through NHS England. It was

suggested that these chairs could be used by the provider of the Cosham practice (still yet to come online) to stand up services and address urgent need.

- Portsmouth has many high needs patients which results in significant work to stabilise a patient before further routine treatment can occur and take place. This results in complex dentistry which takes up considerable time. Providers felt that treating patients under the UDA system was unfair in respect of renumeration and an incentive was required to accelerate this process. A suggestion was made that this could be done through flexible commissioning by taking 10% of the UDAs currently available and moving to a pay per item system. This would incentivise dentists and allow them to focus on stabilising patients with complex oral health needs.

- We should enable providers to take on additional work during contracted hours.

- We should focus on the most vulnerable to alleviate knock on effects to other services, such as A&E and improve school attendance.

Structural issues in respect of the current contract for NHS Dentistry

- Revision of the current 2006 contract and UDA system. There is great deal of unhappiness within the dental profession in respect of the current UDA system i.e., complex dentistry being carried out and counted as one UDA. This is having a knock-on effect on morale as younger dentists are being overburdened by complex work but are not renumerated appropriately for this. Previous system was on a pay per item basis which incentivised dentists. It was suggested further bands were needed on the UDA system.

- Require providers to keep their details and whether they are open to new patients up to date on NHS websites.

- Simply tendering out at a higher rate per UDA doesn't resolve problem in respect of access but results in dentists moving around to where they can secure better pay further depriving areas of where there are patients with high needs.

- Dentists have experienced a 30% pay cut over the last 30 years. Incentive needs to be provided to encourage and retain dentists and show clear progression within the NHS. It currently cannot compete with private sector because of this i.e., offer re: pay.

- Incentivise good performing practices not just by simply uplifting the number of UDAs but by considering the use of bonuses and other forms of career progression and development. Currently good performing practices receive a 10% uplift, but this leads to them being overburdened with more complex high needs cases. Where is the incentive to do well?

- Use UDAs that have not been utilised by underperforming practices for distribution to other providers where there is availability rather than focus on additional hours which many practices are not going to utilise owing to risk of the potential for burnout.

Suggestion that under performing practices were using funding provided under the UDA system as a means of an informal overdraft.

- We should enable a pay per item approach until patients are dentally fit, after which the UDA system could be reverted to.

- Additional costs being incurred by dental providers in respect of PPE and additional safety measures etc currently not covered by the UDA contract. Dental providers have seen increases across the board in respect of staff pay, medical equipment etc all of which they are having to fund from existing contract.

- Ringfencing of budgets – any money not spent locally – where does this go? How we can protect this to ensure it is used.

Training and workforce regeneration

- Consider altering regulation requirements for dentists seeking to come to the UK. Current process requires dentists to apply in a consecutive way, rather than in tandem. Process needs to be streamlined as it is currently taking too long. Suggestions that as much as a 9 month wait for the CQC element.

- Is it necessary for dentists to have multiple registrations with different regulatory and professional bodies? Could this be encompassed under one route i.e., GDC to practice with the NHS

- Review of ORE requirements. Concerns in respect of changes Brexit has brought. Why are we reinventing the system which has been in place for a long time already i.e., training and experience requirements and ratification of qualifications particularly from Europe. System has worked well in the past.

- Review current requirement for dentists who are returning after a significant career break to work in private sector for three months. This is resulting in many dentists going to the private sector as a consequence.

- Explore the use of salaried dentists. Some dentists particularly younger dentists who have recently entered the profession prefer this model as it provides a guaranteed income. Some concern was expressed whether this was suitable for all, and in areas where housing was more expensive and cost of living higher.

- Consideration to be given to providing an uplift to dental providers for taking on new patients. GPs currently receive this, but dentists do not. Could be used to incentivise.

- Opening more training positions through training practices. Opening training positions will encourage dentists to seek out these opportunities and potentially set down routes in the area.

- Remove barriers to dentists coming in from overseas and reducing red tape associated with this to speed up process for dentists working in the NHS.

- Reduce the timeframe for mentoring to enable more dentists to be mentored more quickly. Current requirement is four years. Suggestion made that this could be

reduced to one year. Providers struggling to find this level of experience to enable mentoring to go ahead.

- As part of mentoring and training dentists are required to spend some time within private practices. Suggestion was that this requirement should be moved as it was resulting in dentists transferring to private practice and not returning to the NHS to practice.

- Develop training and further education opportunities for dental professionals through the provision of a dental school by the UOP. Partnerships could be established between commissioners, academia, and providers to develop and design a through route which would encourage professionals to remain in the area.

- Potential to develop a dental apprenticeship scheme as a means of a quicker route of education, training, and progression.

- Seek to support the Continued Professional Development (CPD of dentists and other dental professionals including dental nurses and hygienists. It is thought that dental nurses and hygienists could carry out approximately 70-80% of the work of a dentist.

- In connection to the above many dentists currently training with the NHS or undertaking graduate training through study (i.e., Kings College Final Year students at Portsmouth) were really interested in developing their skills particularly in respect of orthodontics and other specialist areas of dentistry i.e., minor dental surgery but were unable to do so under the current UDA system. Younger dentists often being overloaded with complex, high need cases under the UDA system which was preventing them from spending time exploring other aspects of the profession. Young dentists needed to see route through NHS and opportunities for career progression.

- Share training and best practice opportunities via dental hubs between dental providers, educational establishments, and other key stakeholders.

- Funding for training for graduate and post graduate qualifications to be provided either by the dentists themselves (might be applicable to dentists abroad as it was suggested there was an appetite for this) through university-based education with a return of service after to the NHS. Problematic, in that a requirement cannot be made for individuals to work in NHS for determined period after.

- Explore other examples of good practice and development. University of Lancaster working on a course to convert qualifications quickly. Share best practice.

New Opportunities through Public Health work; Integrated Care Systems and new commissioning

- To urgently secure a Dental Coordinator for the Integrated Care System. NHS CCG are recruiting for a second time having been previously unsuccessful.

- Focus upon prevention particularly in respect of the need for oral hygiene and care to avoid tooth decay through education partnerships. Flexible commissioning has been

used elsewhere to buddy providers with schools as a means of educating children and young people in respect of the benefits of good oral health.

- Fluoridation of the water could help with prevention of tooth decay and the need for extraction. In Hampshire, high levels of tooth extraction being carried out as a consequence, in comparison to other areas where only small numbers of extractions required because fluoride being used in water in these areas. (Note statement last years from UKCMO: Statement on water fluoridation from the UK Chief Medical Officers - GOV.UK (www.gov.uk) . The local Portsmouth community have previously objected to fluoridisation of the water supply.

- During the Summit several points were made in respect of the opportunities available through flexible commissioning and where this had worked well within other areas for example by buddying providers to schools to create an education pathway.

- Explore more innovative ways of working either through flexible commissioning but also through partnership working.

Further pieces of work

During the Summit it was agreed that it would be appropriate to set up two steering groups to undertake two further pieces of work. These are:

- The production of a road map to increase and retain dental professionals in the city which would include a dental training centre with the potential for developing a Dental School for the Southeast region. It is intended that the Dental School would lead on this in conjunction with other public health professionals and Integrated Care systems to tailor its offer to the needs of patients. A steering group would be needed to mobilise stakeholders, and driver forward these changes.

- A steering group to established to push through the immediate actions suggested by this summit to immediately help meet local needs. This piece of work to be led by commissioners and include local MPs.

The attendees of the summit would be kept informed about both groups.

Appendix A

Dental Summit Meeting Minutes – 10th June 2022 10:00-14:00

Hosted by Penny Mordaunt MP and facilitated by the University of Portsmouth

Location: Held virtually and in person at the Faculty of Creative and Cultural Industries; Eldon Building, University of Portsmouth

Table of Attendees (including abbreviation for minutes)

Penny Mordaunt MP	PMMP	Member of Parliament for Portsmouth North	In Person
Professor Paul Hayes	PPH	Senior Deputy Vice Chancellor	In Person
Professor Chris Louca	PCL	Director of the University of Portsmouth Dental Academy	In Person
Dr Jane Luker	DrJL	Chair of English Dental Deans; Health Education England – North East	Virtual
Dr Malcolm Smith	DrMS	Chair of Advancing Dental Programme; Health Education England – North East	In Person
Helen Atkinson FFPH	HA	Director of Public Health; Portsmouth City Council	In Person
Stephen Morgan MP	SMMP	Member of Parliament for Portsmouth South	Virtual
Bob Seely MP	BSMP	Member of Parliament for the Isle of Wight	Virtual
Alexander Pinney	AP	Staff of Steve Brine MP	Virtual
Professor John Darby	PJD	Dean of Postgraduate Dental Education; Health Education England	In person
Patrick Hague	PH	Staff of Alan Mak MP	Virtual
Matt Kiff	MK	Staff of Alan Mak MP	Virtual
Steve Brine MP	SBMP	Member of Parliament for Winchester and Chandlers Ford	Virtual
Dr Nick Forster	DRNF	Chair Wessex Local Dental Network (LDN)	In Person
Stacey Arundel BA (Hons) Assoc CIPD	SA	Practice Manager, Smile Dental Care	In Person
Pip Dhariwal	PDSmile	Board Director of the Association of Dental Groups; LDC Chair Berkshire and CEO of Smile Dental Group	In Person
Manjovan Dhariwal	MDSmile	Dental Practice Owner; Smile Dental Care	In Person
Glenn Duggan	GDUGG	Staff of Caroline Dinenage MP	In Person
Gill Durman	GDUR	Practice Manager Bupa Dental Care	In Person
James Dyson	JD	Area Manager Bupa Dental Care	In Person
Tanzil Ahmed	TABupa	Tanzil Ahmed Regional Operations Director Bupa Dental Care	In Person
Julia Pitt	JP	Interim Head of Quality and Professions Special Dental Care Services	In Person

Siobhain McCurrach	SMHealthwatch	Healthwatch Portsmouth Manager	In Person
Roger Batterbury	RBHealthwatch	Healthwatch Advisory Board Chair Person	In Person
Jo York	JY	NHS Portsmouth CCG	In Person
Sylvia Macey	SMAC	NHS Portsmouth CCG	In Person
Hayley Cook	HC	NHS Portsmouth CCG	In Person

AGENDA

DENTAL SUMMIT, UNIVERSITY OF PORTSMOUTH 10 JUNE 2022

To be held virtually and in person in the Faculty of Creative and Cultural Industries (CCI), Eldon Building, University of Portsmouth

10am: Welcome from Professor Paul Hayes, Senior Deputy Vice-Chancellor

1005am: Penny Mordaunt MP: purpose of day and local experiences • Policy changes needs to address problems • Immediate solutions to problems

1025am: Other MPs' comments and contributions

1040am-1110am: Q&A

1110-1125am: Coffee/break

1125am-1155am: What the University does on dental care, what else it can do and the barriers that must be overcome if it is to do it (Paul Hayes and Professor Chris Louca, Director of the University of Portsmouth Dental Academy)

1155am-1245pm: A structured session on how to address the problems, in particular: commissioning structures (how can they work more effectively?); new health structures coming online; policy changes; and how we ensure we have the local provision we need now.

1245pm-1pm: Penny Mordaunt MP - summary and next steps

1pm-2pm: Lunch and tour of CCIXR for those who would like it

To ensure there is open discussion the event will operate under Chatham House rules (unless all participants prefer otherwise) and there will be no social media comment during the event

Welcome from **PPL**

PMMP Sets scene – explains situation with Portsmouth – why particularly acute

Explains that Covid pandemic and backlog connected to this not only an issue, but also loss of Colosseum and failure to commission services contributing to real difficulties for constituents in accessing an NHS dentist.

Explained about the impact it is having across services in the city i.e. A&E etc but also constituents unable to work because of pain they are experiencing and impact on their mental health from an aesthetic viewpoint. Some constituents resorting to carrying out own treatments.

Lack of information available i.e., providers – what is available? Very little guidance for constituents and residents about where they can go with people ringing numerous practices sometimes on a daily basis. Cited case examples of this.

PMMP shocked that only available provision available in Alton, Basingstoke, and Fareham. For many residents this wasn't suitable as they were not in position to bear the cost of travel.

Explained that PMMP had been speaking with Commissioners and Secretary of State and Minister with responsibility for dentistry, Maria Caulfield.

Dentistry still not where it needs to be. Accepts that the issue is complex but wanted to convene this meeting with a view to generating a road map for Portsmouth. May alter the agenda to do so.

Four areas for discussion in this section (initially three but this was added to at a later point during the Summit:

- Provision locally cited concerns about pregnant women should be able to receive free treatment and yet unable to access an NHS dentist. What can we do re: immediate situation to stand up services?
- Issues around the workforce and dentists from overseas etc. Train dentists locally and try and retain (part of answer). Possibility of a Dental School for Southeast. Other providers to link up with training offer as a means of providing broader education that could incentivise dentists to remain in the local area.
- Structural issues i.e., contracts. Fees etc; bureaucracy around additional services; standing up more. More local input and potentially creating a pilot scheme for Portsmouth.
- How do we create a new dental system and future proof this system (added at a later point during the meeting)?

PMMP – opens out to other Members of Parliament (some virtual; some present with staff attending in lieu of Member being available)

Other colleagues - MPs

SBMP – Talked about experience of residents and constituents in Winchester and Chandlers Ford. Explained that Integrated Care Service has picked up dentistry locally which is good but there is no quick fix. Routine practice (or what should be) spilling over into the acute sector.

Contract – part of the problem but not whole of the problem and the issue of access to NHS Dentists is a very complex matter to resolve.

Wanted to better understand what the purpose/intention of meeting would be i.e., what is the aim

SMMP

Constituent's reporting, they are unable to register with practices in Portsmouth. Waiting too long for treatment.

Significant issue with retention. Commissioners need to do more i.e., be innovative in their approach in commissioning services

Explained that what is required is overall reform of contract with many viewing dental charges as unfair. Both constituents and dentists.

Would continue to raise these points through his work as an MP with Commissioners, Ministers etc and through questions in the House of Commons.

PMMP

Explained that we are due a further presentation from the University of Portsmouth but would like to hear from others in the room with a view to generate action points to enable a local plan for Portsmouth to be developed.

GD

Explained that not uncommon for constituents to be sent to Southsea and elsewhere for treatment. Many unable to afford the journey. Explained how because of Gosport's location it is often forgotten about i.e., peninsula. Lack of understanding as to how geography impacts commissioning.

DrNF

Explained that Commissioners currently commissioning for Units of Dental Activity (UDAs) across Hampshire and Isle of Wight area. Over 100,000 UDAs across HIOW. Expected to come online April 2023.

Problem is dentists don't want to work on NHS contract. UDA system not conducive to seeing new patients who often have complex needs and require quite a bit of work in order stabilise. Consequently - 3 courses of treatment equate to one UDA through NHS contract. Also concerns in respect of pay dentists have experienced a 30% pay cut over the last 30 years. Stressed that you must pay the dentists to do the UDAs in line with their workload, not as it is currently. Business model flawed. It doesn't work.

JY

Commissioners are looking at contract changes with Minister but other problems still present. In July the current commissioning structure and responsibility for commissioning dentistry will be delegated to CCG as part of the Integrated Care System. Particularly interested in what they can do differently, create innovative ways of operating.

DRNF

Young dentists often get lumbered with the complex cases which is adversely affecting younger dentists who want to have a career in dentistry. Getting overloaded, and seeking to work in the private sector instead, where they get paid in accordance with the level of complexity of the work they are handling.

SMHealthwatch

Key problem for Portsmouth is the delays in bringing contract online that was awarded as part of the recommissioning for the lost Colosseum provision. Dental surgery in Cosham has been contracted and was commissioned. Stuck in Planning, CQC. Very large number of UDAs available which are not being utilised. Should have been open in April 21.

MDSmile (with contributions from DrNF)

Explained just tendering out new UDAs at a higher rate doesn't resolve the problem but simply results in moving dentists around at detriment sometimes of High Needs Areas. Smile spend a lot of time trying to secure dentists who then go elsewhere. Have to take on patients progressively. Can't just do exams but need to do a course of treatment as well.

Hampshire particular difficulties – more than a year to get the NHS Performer Number. Means that dentists who could work are left undertaking other roles which is demoralising. Additional barrier - Mentor must have 4 years of experience before they can mentor. Can't find this level of experience. Suggestion that maybe this need for level of experience could be reduced to speed up the process.

Getting dentists to the area and do training quicker so they can be mentors. Training issue in the area which has a knock-on effect in respect of retention

What incentives do you need?

Need training practices – dentists will work anywhere in the country but need a training position. Opening training positions will encourage people to come and put down roots in a local area. Move training down to one years of training and NHS experience. This could be particularly helpful in addressing high needs issues and areas.

Impractical to see the High Needs patients. Dentally Fit, first before going into UDA system. UDA system was a temporary measure to cap spending on the budget but doesn't work in respect of longer-term care. No incentive to do so.

Need to look at full scope of practice i.e., hygienists and dental nurses and what work they can do and pick up. Education and training is the key here.

Dentists would prefer to be salaried rather than UDA system. Younger in particular as they see a benefit in receiving a salary rather than overworking themselves on the UDA system.

Dentists who have finished their FD year do general practice. Under the NHS system they are losing interest from young dentists entering the profession in minor oral surgery, orthodontics, because simply doing high needs treatment. Need to have an understanding of broader career progression., opportunities available; the benefits of having an NHS career

Salary position can work but you only end up prioritising the emergency patients. Not helpful re: course of treatment.

JP

Salaried service – struggling to recruit. People taking positions where cost of living is not so high or there are incentives for moving etc i.e., bonus payments, or additional perks.

Promotion of dental education. Importance of this re: oral health and wider health to avoid creating high needs communities in the future

HA

We need to do more to promote dentistry and the use of therapists/hygienists etc. Not just solely an issue for dentists/NHS dentistry.

Not just emergency care but focus more on the whole problem through education etc and preventative treatment

So much worse locally, Gosport, Havant, Portsmouth etc. More deprived communities resulting in high needs areas.

Would like to work more closely with UOP

TABupa

UDA system still affects hygienists and therapists. In certain locations with higher needs, it becomes simply about emergencies. There needs to be balance between salary and UDA not seeing the numbers of patients that the contract requires.

Dentists overseas from outside the EEA. Strong appetite to come to the UK but struggle i.e., experience and NHS Performer number issue i.e., length of time. Costs to the business – they can't do NHS for that first year. Only way we can do this is through a salaried model.

Brexit – loss of mutual recognition of qualification for EEA dentists but nothing has materially changed still same qualification.

DrJL

explained that would be concerned about requirements for the above being reduced or changed from what they have seen. Some EEASS lack the experience and qualification to be able to deliver to NHS standards.

98/99% start off in NHS but many do not stay. General Dental Practice is very different to medical practice. Issue is about trying to keep dentists in the NHS. Making them feel part of the NHS family.

RBHealthwatch

Explained about the issues Healthwatch are seeing

Choices between long term work or extraction i.e., what is easier and more affordable for the patient. Often patients choosing extraction when long term work could be carried out because of cost.

Needs to be a higher UDA rate than currently available

Commissioners – not very innovative in respect of contract and how they commission services. Radical change needed.

People simply want an NHS dentist.

Not convinced delegation to ICS will help.

DrNF

Education and preventative steps i.e., water fluoridation key to this. Currently Hampshire doesn't

Hampshire 2019 – 600 extraction – not same in the north. Water fluoridation could make huge difference in level of tooth decay

Commissioners – do have option of flexible commissioning if UDAs not used up but reluctant to do innovative schemes.

MDSmile

Explained about an example of Flexible Commissioning in Slough – Starting Well

Oral health education etc to schools with a dental provider being linked to a school

Allows us to train nurses; carry out work in the community etc

NHS England – Hampshire

Issues with UDA contract and how it operates If a provider has done its UDAs (10% uplift if completed UDAs). Disadvantage of that is if not performing gets taken away, but also little incentive to perform well i.e., continuing to be overburdened with high needs cases.

Explained why they refused the emergency funding released by Govt this year for additional hours. Capacity to do more and money available. Couldn't do more because it had to be out of hours resulting in providers becoming overburdened and stretched.

If they don't win the tender for the new UDAs dentist with no work to do.

Whole raft of dentists who underperform year on year. Use NHS money like an overdraft.

Pre 2006 – grow practices based on the UDAs doing i.e., perform well and grow.

Incentivise practices fee per item i.e., in Scotland. Every time there was a pay rise each item would go up by 3-4%. Now with the UDA system can get a pay rise but practice retains this.

In conjunction with these providers are bearing more costs which are not covered by the UDA system i.e., Wage increase for ancillary staff i.e., receptionist etc

SBMP

What is our action list etc? Keen to understand what we can do as backbench MPs. How are we going to take this forward?

PMMP

Explained she was adding an additional section 4th area to the agenda topics for the meeting

Additional - New dental system, future proofing. Etc.

4 baskets of issues

Intention was to produce a draft plan of asks/things we can do locally in the short term with a view to creating a Master Plan for Portsmouth which could be potentially used as a pilot

PMMP confirmed that the minutes would be shared for consideration and final comments following the meeting.

PMMP introduces University of Portsmouth

UOP presentation

DrCL

UOP applied for permission to open a dental school. Refused but opened a training facility for hygienists etc instead.

Then opened a Dental Academy rather than School in conjunction with Kings School. Graduates spend their final year learning about primary care in the NHS. The purpose and aim of this was and is to try and attract dental students here and to remain here. Hasn't materialised quite as hoped and explained the reasons for this.

Lack of provision for supporting students in their foundation year.

We need to reduce demands on the service and can only do this through health education

Need to use hygienists and therapists to full capacity.

DrCL

provided an Overview of Dental Academy and what it does.

Primary care set up. Clinical training facility. 10,000 UDAs

We train 3 types of professional

Nurses, hygienists, and therapists. In addition, we host 80 final year students from Kings College. We can provide outreach/primary care type practice also.

Most treatment undertaken within clinical facility but also outreach too within schools etc.

Dental therapists can do 70-80% of what an NHS Dentist can do.

UOP have 50 dental chairs that in the evenings and the weekends are not being used, and could be potentially as a short- and longer-term measure to ease issues being seen in Portsmouth; but to do UOP would need sufficient funding, staff, dentists etc. This could only come from NHSE. Ready to help if they can be used.

Concept of centres for dental development will be clinical hubs based in parts of the country for training purposes. In addition to training could also carry out treatment. Access to community hubs could mean more training. Incentivising people to put down roots and remain long after training concluded. Currently UOP limited re: numbers we could train.

UOP would like in longer term to be able train their own dentists. Requires a status to do this.

Training and mentoring of international overseas dentists. Already passed the exam but not yet able to work independently in the NHS.

DrMS

Education and Training is not going to solve the problem on its own. Why 4 years to mentor? Think we need to look at this.

DrCL and DrMS

Centres for Dental Development. Dependent upon partnership work with NHS England. Can't place without a contract in place. Not a panacea. Infrastructure already in Portsmouth. Bring elements together to train and retain people via an academic home.

CPD can be tailored to a particular area.

Contract reform is a must to train and maintain NHS dentists.

CDO – how can we safely take some back into dentistry if they have had significant gap in employment particularly from overseas or elsewhere. Getting them on the NHS Performer list quickly.

DrMS

Timescale of resolving issues – NHS England being very quiet about what is being considered as part of contract review at the moment.

What is needed is a model which you can adapt and use

Work being done on the NHS Performer list also

DrCL

Centre for dental development key to this. Logical for Portsmouth to expand training in Portsmouth but also attracting already qualified dental workforce for further study opportunities and to provide treatment.

NHSE willing to work with UOP to develop. Could produce a document with list of suggestions which could increase training and education plus services too.

University of Lancaster – working on creating a course to convert qualification quickly. Postgraduate course to be trained in the UK. Where does the funding come from? University cannot fund this on its own.

MDSmile

Following on from the University of Lancaster point- Dentists willing to fund rather than the other way around.

PVLE qualification – spend three months in private practice then come back to the NHS. Losing dentists because of this.

Dentists who have done ORE/BDS qualification. CDO how can we bridge the gap?

Why two sets of registration. Why GDC and NHS? Slowing process down to get Dentists in

Why CDD good? Key is the training – Most interested in doing post graduate training.

What is the commissioning solution?

Bursary retainer i.e., we pay, you remain for a set period. Not NHSE it was HEE. We can't mandate it – legally we can't do that.

Brexit – Why change i.e., need for an ORE? Streamline this process – what has changed since Brexit – nothing.

GDC – issues with training – South Africa/Australia but training not substantially different.

Portsmouth cannot award dental degrees. Portsmouth could work towards it.

Connected to mydentist. Unregistered but with mentoring.

No reason why Portsmouth couldn't work towards awarding the degree but that could be difficult without the student in place.

50 dental chairs not being used in the evening and or weekends. Means whereby some of the backlog could be reduced within the city.

Centre for Dental Development – Improve or increase training offer.

Good to be able to train our own dentists to strengthen the offer.

DrCL

Work up a plan so offer could be enhanced and progressed and what would be needed at each stage. Capital funding/vision.

PMMP

Queried whether it would be sensible to establish a working group which MPs which could have sight of plan and chase funding. Would need to understand what order certain requirements/actions need to be in so that this can be communicated to Government.

Group of people to drive and steer this through. Broad agreement from attendees that this may be a good way to go.

Suggestion that this could be brought together with vision that UOP has for medical school however, they are separate processes with no option of join up.

PMMP

began to explain the actions being generated; listed below:

<u>Immediate issues</u>

- 50 chairs available at University of Portsmouth – how do we bring them into use?
- Lack of coherent information re: where a patient can go
- Standing up providers – constituent issues
- Flexible commissioning opportunities (capacity still in practices) i.e., not being able to use dental chairs that could be used and are being left empty.
- New opportunities – new commissioning structures

JY

Interested in looking at how can we do something together i.e., present a business case back to NHSE

Oral prevention as well – dental surgeries attached to schools

What additional capacity we can put in? how can we put a business case together?

Flexible Commissioning might be possible but problem with flexible commissioning 10% can be spent flexibly but lose general practice. It's not 10% on top off.

ICS might be an opportunity to change this approach, i.e., funding, organising etc.

PMMP

Particularly interested in the unmet need and the consequence of not doing anything about it now. There are ways of doing this quickly, changes in primary legislation etc (possible during Covid) what you need to create is the momentum and the argument for this happening i.e., why is this a good thing to do?

DrNF

Solution might be that 10% move to sessional basis to see high needs patients to stabilise them and bring them on as patients on a fee per item basis.

Deals with high needs/urgent care. Fee paid per item; practice wouldn't be losing out overall.

New patients – 10% on a fee per item basis. Attractive in areas of high needs. Easier to mobilise this rather than out of hours and will stop burning out teams.

Move molar endo into band 3. Root treatment in back teeth. More UDAs. More bands – more renumeration i.e., number of fillings. So, few practices took it up because of outside hours and over and above what they are doing.

New patient could be moved off when they have completed their course of treatment. One treatment. Prevention of dental treatment, fix what is fixable and then do more complex treatments at a later point.

GPs – new patients – practice gets an uplift for moving to new practice. Use the under delivery for new patients. You can over perform on contracts.

Portsmouth – relatively sure it is not being spent. £50 million – not about the money. Most dentists don't want to do this because of complex nature of work required.

Ringfenced dental budget – worry with ICS. Any money that isn't spent – where does it go? Not the intention of the ICS. Fair share stage before.

What is needed is innovative people at NHSE – how can I maximise the available funding.

MDSmile

NHS 111 – Failure to Attend. Allocated times etc would be helpful if a data base could be created which dentists could take patients off when a spot becomes available rather than having to ring through.

Backlog is huge – can you send us someone that needs to be seen. List of patients waiting to be seen. Either FTA or cancellations at the last minute. List of people.

Practice – more than happy to see but need a helpline number.

Web page to pull the patients off it. Dental software can do this. Contact patients on the waiting list. Appointment available etc.

Need a coordinator.

PMMP

Need to do this in two phases

What can we do now? Take it and pull it together. Bring this in front of the Minister.

Information for patients – how can we get good information up? How to work better?

DrNF

90,000 UDAs commissioning. Very difficult to deliver the contract for the first year because patients not dentally fit. Pay by fee basis.

Requirement of contract for dentists to provide this information to NHS England i.e., what offer/what available.

Cosham – Non reoccurring UDAs diverted to other practices who could take it up. Further exploration needed as to what is preventing it from operating. Could UDAs be diverted to UOP, with dentist operating from here in the interim.

DrCL

UOP have a few slots for emergency patients.

If the provider who has run the contract cannot deliver – could they not use the University for now to help with the backlog. Tender in place and could be used.

MDSmile

Mobilising is difficult

Cosham Provider deliver this service potentially through UOP in interim.

CQC – 9 months for registration but NHS England can accelerate.

Recruitment of dental nurse. Generally, go to private practice because rates are higher. Smile train through apprenticeships. Career days etc

DrCL explained about the current part time option for the training of nurses and how this might be of benefit re: retention in the local community.

Need to be offered progression.

UOP could offer a Dentist Apprenticeship – possible progression and different branches.

DrNF

Key change – workforce for Hampshire. Hardest place to register a dentist from overseas the workforce is small who works on this.

Series of conditions which they accept.

Follow on process

GDC – then course; then add on etc. Takes too long – waiting long times; can't practice. A pre-approved provider can streamline this process i.e., too many checks and balances. Why do we have to wait for other stages before moving onto the next requirement

DRMS – 5 dentists – 3 months from NHSE to get a reply.

HEE – explained a bit about the part time specialist and in practice scheme in Norfolk.

PMMP – thanks everyone and seeks to close meeting.

Explained that we will produce and circulate the meeting minutes and an action plan/road map for comment. PMMP stressed the following:

- Provide a comprehensive database to enable patients using the NHS 111 service to access dental services quickly, which would improving waiting times and prevent loss from FTAs. NHS 111 and providers in a room to discuss slots and see how it works
- Establish Two working Groups – UOP – develop plans and prospect of dental school and a working group i.e., things we can do now
- Narrow window we can lobby Minister re contract change