ADULTS AND HEALTH SELECT COMMITTEE

16 February 2023

Access to NHS Dental services in Surrey

Purpose of report: To advise the Committee of the current position regarding access to NHS Dental services in the county and actions being taken to improve access.

1. Introduction

1.1 Access to NHS Dentistry has been one of the key challenges facing the NHS over the last 20 years, both in primary care and for referral services.

1.2 National programmes to improve access to primary care services and reduce waiting times in hospital in the first decade of the 21st century proved successful, but both have been under significant pressure in recent years and have been severely impacted by the coronavirus pandemic.

1.3 This paper provides some general information and intelligence to support understanding of dental services commissioning and contracting, outlines the impact of recent events upon services, and describes the recovery process and changes to commissioning arrangements for NHS dental services which took effect in July 2022.

2. Commissioning arrangements for NHS Dental services

2.1 NHS England acted as the commissioner of NHS Dental services in the period 2013 following the implementation of the 2012 Health and Social Care Act.

2.2 On 1 July 2022 Integrated Care Boards (ICBs) were established. In some areas (the South-East and Greater Manchester) some ICBs agreed to act as pathfinders to take on delegated commissioning responsibility for the commissioning of Pharmacy, Optometry and Dental (POD) services whilst the local authorities retained responsibility for the commissioning of dental public health services.

2.3 The Surrey Heartlands and Frimley ICBs took on delegated responsibility for Dentistry, alongside Pharmacy and Optometry for the county of Surrey. The Frimley ICB covers Surrey Heath and the Farnham part of the Waverley Local Authority (plus North-East Hampshire and Berkshire East). The Surrey Heartlands ICB covers the rest of Surrey.

2.4 Delegation to the Integrated Care Boards (ICBs) has an explicit intent and ambition to improve health outcomes for their whole population by empowering ICBs to integrate services and enabling decisions to be taken as close as possible to their residents. The ICBs are working to ensure their residents can experience joined up care, with an increased focus on prevention, addressing inequalities and achieving better access to dental care and advice.

2.5 The ICB will discharge its responsibility for dental commissioning alongside officers who continue to be funded and employed by NHS England who provide operational leadership within ICB governance structures.

2.6 At present there is a Delegation Agreement and MOU between NHSE and the respective ICBs in the SE region that describes the accountabilities and responsibilities of the ICBs subject to delegation and separate to the reserved functions that have been retained by NHSE.

2.7 The existing teams and staff employed via the NHSE POD Team continue to perform their roles as subject matter experts (SMEs) with contracts managers, and commissioning managers in the form of a “Hub Team” model, engaging and working alongside the ICB teams to impart knowledge, learning and guidance and enact the transactions and forward work-plan with the ICB Teams to ensure efficiencies are created and maintained by working under a single Operating Model.

2.8 Decision making rests with each ICB who meet monthly as Committees in Common (CiC) to support collective review and aligned decision making where this is appropriate and support streamlining of information and intelligence sharing and collective use of SMEs.

2.9 This model is transitional and supports understanding and continuity whilst systems work together on the development of a new Operating Model to protect and optimally apply the knowledge and resources across Regional and Local Teams. This is in support of the key aspiration for delegation to ICBs which is to avail of the opportunities brought about through local collaboration and integration with partners across the ICS and the bringing together of Primary and Community care providers to work together to share local data and intelligence and shape plans for the future commissioning and delivery of both preventive and treatment services within each place. Thus,

enabling seamless pathways which provide a more holistic approach and support residents to access and experience more joined up care, with an increased focus on addressing inequalities and achieving improved access to dental care and advice.

2.10 Local intelligence can help identify key groups and vulnerable populations and Places could choose to focus on homeless communities, care home residents or young children and jointly develop the significant opportunities that exist by including oral health as part of a wider prevention agenda; for example, dental decay cannot occur without sugar, and sugar reduction should form part of healthy weight and diabetes programmes.

2.11 There are further possibilities for using dental practices to support a broader health promotion agenda, particularly lifestyle issues. Dental practitioners are well-placed to start conversations about healthy eating, smoking and alcohol consumption as all of these are linked to oral health. Through the integration of dental providers into the primary care networks, there could be opportunities for dental care services not only to consider the oral health implications but also to refer people to appropriate services – such as weight management and smoking cessation, which in turn may have broader health benefits.

2.12 By way of example: In Surrey Heartlands we are presently in discussions with a Consultant in Special Care Dentistry to review options for collaborative working with partners from the ICS to support the vulnerable with high levels of frailty and comorbidities, that are being admitted to hospital, and who are experiencing very poor oral health including severe dry mouth, poor oral hygiene, severe decay, and gums disease. Good oral care helps keep people free from pain – especially important for those who have communication difficulties and may find it difficult to alert others to where it hurts. For those with chronic conditions, good oral care can help make sure they can take the medicines they need to prolong health. Good oral health can also reduce the risk of malnutrition, which is thought to affect around 1.3 million older people. Furthermore, it can reduce the risk of acquiring aspiration pneumonia, particularly in residential settings. Many people are often in their last year of life and these conditions can lead to people becoming frailer and can be fatal.

2.13 In addition to the training initiative aimed at improving the oral health of hospitalised adult patients, the intention is to collaborate with the dental teams from primary care to extend the training to colleagues working in the Care Home setting too.

2.14 Oral health promotion and oral health surveys became the responsibility of local authorities in 2013 and consequently NHS England/ICB do not commission community preventive programmes or epidemiological surveys.

2.15 The LA has an important statutory responsibility for surveillance in assessing local oral health needs and commissioning evidence based, oral health programmes appropriate to those needs. Local authorities have an obligation to improve health and reduce inequalities in their populations and this includes oral health.

3. Oral Health in Surrey

3.1 Tooth decay remains the leading reason for hospitals admissions among 5 to 9-year-olds in England. Tooth decay and gum disease are two of the most common diseases in the world in adults. Tooth decay doesn't occur in people who don't consume sugar and reducing both the amount and frequency of sugar consumed reduces the risk.

3.2 Gum disease is caused by bacteria in plaque gradually destroying the gums and bones around teeth leading to tooth loss. People who smoke are far more likely to suffer from gum disease. People who brush twice a day with a fluoride toothpaste are less likely to suffer from tooth decay or gum disease.

3.3 Oral Cancer research suggests that more than 60 out of 100 (more than 60%) of mouth and throat cancers in the UK are caused by smoking and around 30 out of 100 (30%) are caused by drinking alcohol. The combination of smoking and alcohol use increases the risk of oral cancer further, and poor diet is another risk factor.

3.4 The recommended time between dental 'check-ups' is between 3 months and 2 years depending on risk factors for oral disease. Dentists check for early signs of decay, gum disease, oral cancer, and other abnormalities so people who don't attend often have more severe disease.

3.5 Children who live in deprived areas are far more likely to suffer from tooth decay than children in less deprived areas. This is mainly due to differences in sugar consumption, tooth-brushing habits, and dental attendance. In addition to pain, toothache can cause children to stop eating and sleeping, and reduces concentration and/or school attendance. All these effects can increase existing inequalities between children in the most and least deprived areas. Dental Decay is the most common reason for 6 -10-year-olds to be admitted to hospital in England.

3.6 Older people are far more likely to have lost teeth due to gum disease and dental decay. This is because gum disease increases with age, and fluoride (which protects teeth from decay) only became widely used in the UK in the 1970's.

3.6.1 The oral health of people in care homes was the subject of a national Care Quality Commission (CQC) report, *Smiling matters: Oral Health Care In Care Homes*.

Older people in care homes are particularly at risk of oral pain and disease because:

- People needing residential care are often less able to brush their teeth effectively and there is variation in how well care staff provide toothbrushing.
- People in care homes often increase the frequency and amount of sugar in their diet, and tooth loss/pain can make it more difficult to eat nutritious food.
- Access to dental services for people in care homes is highly variable, and dentists are limited in the amount of dental surgery (extractions etc.) they can provide outside of CQC regulated practices.

3.7 The influence of ethnicity on oral health People from non-White groups have poorer oral health overall than people in White groups. However, deprivation is the key factor for poor oral health and people in non-White groups are more likely to live in more deprived areas.

In contrast with most health inequalities, when the effects of deprivation are removed, people from non-White groups in England were found to have better oral health than people in White groups. The differences could be partially explained by reported differences in dietary sugar.

3.8 Other priority groups People with Severe Mental Illness are estimated to be 2.8 times more likely to have lost all their teeth compared with the general community.

3.8.1 National and international research, summarised by the UK Health Security Agency, shows that people with learning disabilities have poorer oral health and more problems in accessing dental services than people in the general population. People with learning disabilities may often be unaware of dental problems and may be reliant on their carers/paid supporters for oral care and initiating dental visits. Supporters are often inadequately trained for this and may not see oral care as a priority

3.8.2 Evidence consistently shows that people with learning disabilities have:

- higher levels of gum disease
- greater gingival inflammation
- higher numbers of missing teeth
- increased rates of toothlessness
- higher plaque levels

- greater unmet oral health needs
- poorer access to dental services and less preventative dentistry.

3.8.3 Adults with Learning Disabilities are identified from the GP records and an annual health check is carried out which includes oral health questions and if necessary, the practitioner will signpost to an appropriate dental service.

3.8.4 People in prison are likely to have worse oral health yet have less experience of using dental services prior to sentence.

3.9 Oral Health in Surrey

3.9.1 Data is collected on the number of children being admitted to hospital for dental decay. This gives an indication of the areas where severe decay is more common. The highest proportion of 6 -10-year-olds having dental extractions needing to be admitted to hospital for dental decay is in Spelthorne (0.9%), followed by Runnymede (0.7%). This is almost always for extractions of decayed teeth under General Anaesthetic. Waverley and Elmbridge had the lowest proportion (0.3%). The highest in England is Doncaster where 2.8% of all 0–19-year-olds needed to be admitted to hospital for dental decay.

Finished Consultant Episodes (single admissions to hospital) as % of Population with caries (decay) as the primary diagnosis)

LA Name	Age 0-5yrs	Age 6-10yrs	Age 11-14yrs	Age 15-19yrs	Total 0-19yrs
Elmbridge	0.1%	0.3%	*	*	0.2%
Epsom and Ewell	0.2%	0.4%	*	*	0.2%
Guildford	0.2%	0.5%	0.1%	*	0.2%
Mole Valley	0.2%	0.4%	*	*	0.2%
Reigate and Banstead	0.2%	0.5%	0.1%	*	0.2%
Runnymede	0.3%	0.7%	*	*	0.3%

LA Name	Age 0-5yrs	Age 6-10yrs	Age 11-14yrs	Age 15-19yrs	Total 0-19yrs
Spelthorne	0.3%	0.9%	0.3%	*	0.4%
Surrey Heath	0.2%	0.4%	*	*	0.2%
Tandridge	0.4%	0.5%	*	*	0.3%
Waverley	0.1%	0.3%	*	*	0.1%
Woking	0.3%	0.5%	*	*	0.2%

3.9.2 Because dental decay is so strongly linked with deprivation, deprivation data gives a far more localised indication of where there is increased dental decay in children. Many targeted oral health programmes in England are focussed on the most deprived 5% or 10% of areas in England but none of these areas is in Surrey.

N.B. Data on the proportion of children with dental decay is not regularly collected in Surrey currently.

3.9.3 **Oral cancer** - between 2017 and 2019 in Surrey, 4.2 people per 100,000 died of oral cancer. This is lower than the rate for England (4.7) and very slightly higher than the rate for the Southeast (4.1). See Table 2 below. The actual numbers of people who died of oral cancer varies in Districts and Boroughs between 5 and 29 and the numbers are too small to make useful comparisons. The table shows that for every 100,000 people in Surrey, 14.5 people were diagnosed (registered) with oral cancer between 2017 and 2019. This is slightly lower than the rate for England (15.0) and the South-East (14.1). The dental decay data ('dmft' – or 'decayed, missing and filled teeth') is not available in Surrey.

Table 2: Oral Cancer Deaths per 100,000 Population

	Surrey					
Period	Count	Value	95% Lower CI	95% Lower CI	South East	England
2008-10	80	2.6	2.1	3.3	3.2	3.9

Period	Surrey				South East	England
	Count	Value	95% Lower CI	95% Lower CI		
2009-11	105	3.4	2.8	4.1	3.6	4.0
2010-12	131	4.1	3.5	4.9	3.8	4.0
2011-13	146	4.5	3.8	5.3	3.8	4.1
2012-14	137	4.2	3.5	4.9	3.9	4.3
2013-15	123	3.7	3.0	4.4	3.8	4.4
2014-16	129	3.8	3.2	4.5	4.0	4.6
2015-17	137	4.0	3.3	4.7	4.1	4.6
2016-18	153	4.4	3.8	5.2	4.2	4.7
2017-19	145	4.2	3.5	4.9	4.1	4.7

4. NHS Dental services in Surrey

4.1 **Primary Care** Primary and community dental services are commissioned via national contracts which fall within the NHS (General/Personal) Dental Services Regulations 2005. Some of these services provide direct patient access and others are accessed via professional referral. Secondary care (hospital) providers deliver services on referral under NHS standard contracts. These contracts were implemented in England and Wales on 1st April 2006.

4.2 Providers of NHS primary care services are independent contractors in receipt of cash limited financial allocations from the NHS. All practices also deliver private dental care. Some provide NHS services to all groups of patients, but some are for children and charge exempt patients only. The providers are required to deliver pre agreed. planned levels of activity each year, known as Units of Dental Activity (UDAs). The UDAs relate to the treatment bands delivered by the practices.

4.3 Patients are not registered with practices, as with GP (General Medical Services) but are encouraged to attend at regular intervals with the regularity of attendance based upon their assessed oral health needs. There is only guarantee of continued access to treatment at the same practice whilst you are undergoing a course of treatment.

Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist

4.4 NHS Patient Charge Regulations apply to the contracts falling within the 2005 Regulations, but not to services provided under NHS standard contracts for service delivered in acute hospital settings. The patient charges relate to the bands of treatment delivered in primary care. Services are delivered under treatment Bands 1, 2 and 3. The link below provides more details:

https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/

4.5 Dental surgeries have a set capacity of NHS dental provision under their contract and many of them do not have capacity to take on new patients onto the practice NHS list. A dental practice will maintain a list of 'regular attendees' and they may also maintain a waiting list for patients who have contacted the surgery for an appointment. However, as there is no obligation under the terms of the GDS/PDS contract for this information to be reported to the Commissioning Authority, there is no data available that can be shared regarding waiting times for access to NHS Primary Care Dental Services.

4.6 In addition to the services delivered in primary care there are other NHS dental services. They are:

- Unscheduled Dental Care (UDC) – most 'urgent' treatment needs are met by the local dental practices. In addition to this there are services that provide back-up in the day and on evenings, weekends, and bank holidays. Urgent dental care *can* be accessed via the practice normally attended by a patient or via NHS 111.

- Orthodontics - these services are based in 'primary care' but are specialist in nature and provide treatment on referral for children for the fitting of braces.

- Community Dental Service – a service for patients who have additional needs which makes treatment in a primary care setting difficult. This includes treatment both in clinic and in hospital for extractions carried out under General Anaesthetic. The providers of these service also provide out of hours dental care for the county.

- Hospital services – for more specialist treatment needs delivering Oral and Maxillofacial Surgery and Orthodontic services.

- Tier 2 Oral Surgery (more complex extractions) and Restorative (Root canal, treatment of gum disease and dentures) – provide more complex treatments than in primary care but do not require treatment in hospital.

The tables below detail NHS Dental services available in Surrey

4.7 Primary Care services:

Service	**Number**	**Units of Activity**	**Contract value**	**Funding per head (Surrey)** **Popn: 1,196,236**	**Funding per head (South-East)**
GDS contracts	161	1,318,995	£38.4m	£29.11	£37.21

Expenditure on primary care services per head is lower than the South-East average mainly because the % of the population accessing primary care services is below the South-East average; 37.07% of the Surrey Heartlands population v 40.09% for the South-East.

4.8 Orthodontics

Service	**Number**	**Units of Activity**	**Contract value**	**Funding per head (Surrey)** **Popn: 1,196,236**	**Funding per head (South-East)**
PDS contracts (Surrey)	17	107,636	£6.65m	£5.56	£5.03

Expenditure is roughly in line with the South-East average following the re-procurement of the time limited PDS contracts in 2019. There are a small number of General Dental Service primary care providers with non-time limited GDS contracts with higher unit prices that fell out of scope of the 2019 re-procurement.

4.9 Referral services

Service	**Number**	**Units of Activity**	**Contract value**	**Funding per head (Surrey)** **Popn: 1,196,236**	**Funding per head (South-East)**
Community Dental Services	2		£5.2m	£4.35	£4.48
Hospital services	4		£14.7m	£12.28	£11.25
Tier 2 Oral Surgery services	14		£555k	£0.46	£1.25

Expenditure on Community Dental services is in line with the South-East average. Expenditure on community-based tier 2 services is lower than the South-East average with a correspondingly higher spend on hospital services.

Current commissioning arrangements for Community Dental Services are under review and opportunities to strengthen community-based alternatives to hospital are under consideration for tier 2 Oral Surgery and Restorative services.

5. Impact of the coronavirus pandemic on Dental services

5.1 NHS dental practices were closed for face-to-face appointments for a significant period with the onset of the COVID-19 pandemic. Following this, enhanced infection control procedures were in place until 2022 which drastically reduced the number of patients practices were able to see. These enhanced infection control procedures, necessitated by the types of procedures carried out in dental surgeries, led to reduced dental capacity. This reduced access to services and increased waiting times for treatment. The delays in providing treatment have also led to many patients' treatment needs having increased which has meant that in many cases, treatment is taking longer to complete. Service capacity has been very gradually increasing as infection rates have dropped, under strict guidance aimed at keeping patients and staff safe. Primary Care services returned to 100% capacity in July 2022, but a significant backlog of treatments

has built up over the 2-year period of reduced capacity. The effects of this are likely to be observed for several years.

5.2 The challenge has been the same for all dental services, including hospital services where there has been a growth in the number of patients waiting more than the NHS constitution standard of 18 weeks.

5.3 The backlog of care from earlier in the pandemic means that many patients, including those with a regular dentist, have struggled to access routine care. Whilst patients are not registered with dental practices, many patients have historically booked a dental check-up on a 6 monthly basis. The National Institute for Health and Care Excellence (NICE) guidance states this is not clinically necessary in many instances and clinically appropriate recall intervals are between 3 to 24 months dependent upon a patient's oral health, dietary and lifestyle choices.

5.4 Practices provide urgent dental care as part of their core service offer to patients. However, it may be necessary for patients with an urgent need to contact more than one practice as each practice's capacity will change daily dependent upon the number of patients seeking urgent care. This may require patients to travel further to access care.

5.5 The most recent data pre-dating COVID-19 (Jul-Dec 2019) gives the percentage of adults and of 0-17s accessing NHS dental services in that period. Information on the 0-17s group is more useful as there are fewer 0-17s who chose to use private dental services. In Jul-Dec 2019, an average of 48.4% of 0–17-year-olds in Surrey accessed NHS dental services. In Woking, 49.9% of 0-17s accessed NHS dental services in this period, but access was lower than the South East average in all other Surrey Districts and Boroughs. The lowest was in Mole Valley (40.3 %). The figure for Spelthorne, the most deprived area in Surrey, was 46.5% and this was the fourth highest figure in Surrey. The figures suggest that access to NHS dental services in Surrey was not a source of inequalities in this period in Surrey.

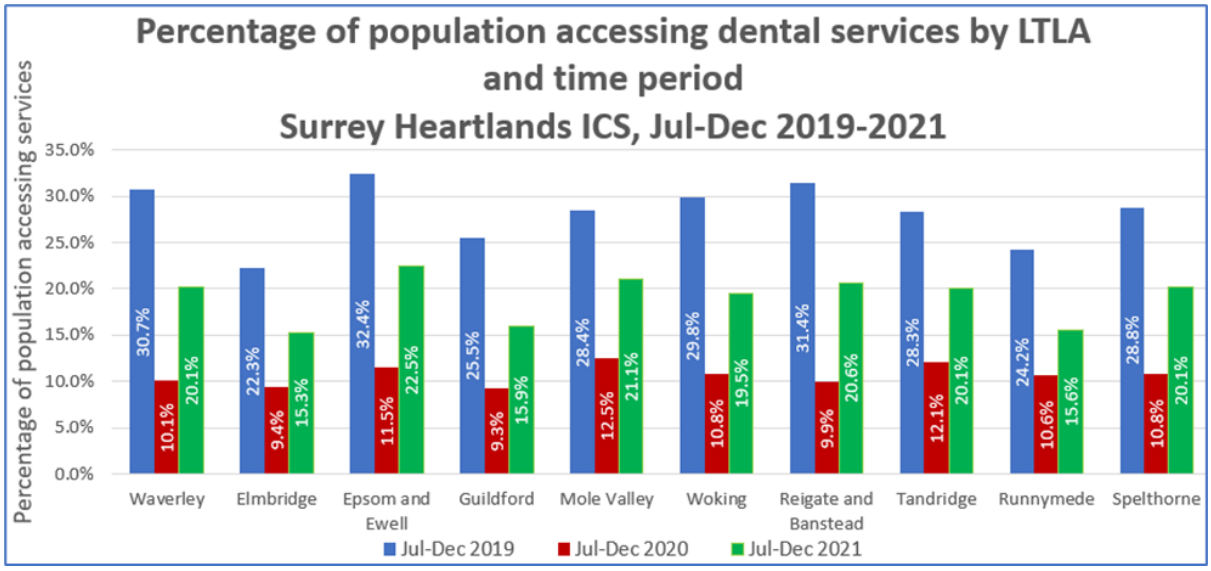
5.6 Comparing access to NHS dental services in Jul-Dec 21 with the same period for 2019 is useful in reviewing the 'recovery' of districts and boroughs in Surrey from the COVID-19 pandemic in terms of dental access:

- An average of 30.3% of 0-17s in the South East saw an NHS dentist in Jul-Dec 2021.
- In Surrey, the value was higher for all districts and boroughs in Surrey than the South East average.
- In Jul-Dec 2019, Woking was the only area in Surrey with a higher figure than the South-East average.

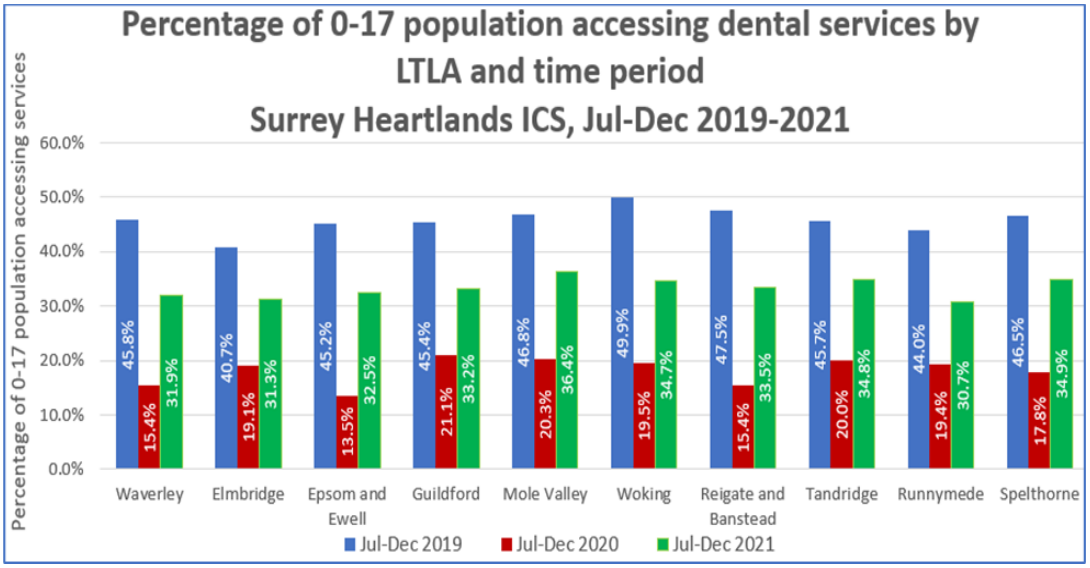
In terms of inequalities:

- The highest percentage of 0-17s accessing NHS dental services in Jul-Dec 2021 was in Surrey Heath (37.2 %).
- The lowest was in Runnymede (30.8%).

5.7 There is some evidence that recovery in terms of access to NHS dental services has been slower in the most deprived areas. This likely reflects differences in 'health literacy'. Unlike GPs, anyone is free to choose where they see an NHS dentist. With limited access to NHS dental services, it is likely that people in less deprived areas have been more able to identify where appointments are available, and to travel further for appointments if needed.



Notes: local authorities are arranged from least to most deprived (IMD).



Source: ONS mid-year population estimates (2019 and 2020) and Business Services Authority. Jan - June 2020 excluded due to co-occurrence with first national lockdown

5.8 Access has been particularly challenging for patients who have not attended a local NHS practice in recent years. This may be because they have recently moved to the area or choose not to attend regularly. In order to help to address this, additional funding was offered to all practices in the South East region in December 2020 to provide sessions outside normal contracted hours for patients who did not have a regular dentist and had an urgent need to receive dental treatment.

5.9 The graphs shown above at 5.7 provide an illustration by Lower Tier Local Authority (LTLA) of the percentage of population accessing dental services for the period July 2019 to December 2021. Accepting that there are small specific areas of deprivation across the county, the list at Appendix A drills down further and provides the Lower Super Output Areas in Surrey that these wards encompass with their respective Index of Multiple Deprivation Ranking – the lower being the more deprived.

5.10 There are 5 practices in Surrey, detailed below, that currently have the staffing levels to safely undertake additional sessions for urgent care, specifically for patients that would be new to the practice.

- Sunbury Dental Practice, 145 Green Street, Sunbury-on-Thames, Surrey, TW16 6QL, tel: 01932 783208
- Parkside Dental Surgery, Goldsworth Park Health Centre, Denton Way, Woking, Surrey, GU21 3LQ, tel: 01483 766355
- Together Dental, Hamsey Green, Limpsfield Road, Warlingham, Surrey, CR6 9RH, tel: 01883 627764
- Cromwell Dental Practice, 1 Cromwell Road, Walton On Thames, Surrey, KT12 3NL, tel: 01932 269199
- Synergy Pyrford Dental Centre Unit 10/11 Marshall Parade, Woking, Surrey, GU22 8SW tel: 01932 352333

These practices deliver a total of 49 hours of additional access per week.

These services can either be contacted directly or via NHS 111.

5.11 The offer of funding additional sessions remains open so that should other practices subsequently determine they have the staffing levels to safely deliver additional NHS sessions, these will be established. Should any patient need urgent dental care, or they have been able to access temporary urgent care and still require further treatment to stabilise their oral health or need dental treatment before undergoing certain medical or surgical procedures or be a Looked After Child they will be able to contact one of the above practices to obtain treatment. This relates to urgent need, which remains the priority while the backlog of routine care is addressed, and these practices may not be able to provide routine care for patients that do not have an urgent clinical need.

5.12 Whilst access to primary care is showing signs of improvement there remain on-going challenges re access to primary care services.

- Following the Transitional Provisions Order 2005, the existing NHS dental contractors had an automatic right to an NHS dental services contract. This came into effect from April 2006 and the majority of GDS dental contracts once issued continue in perpetuity. For this reason, most dental services are in areas that the market has chosen and not necessarily the areas of greatest need.

- Prior to the pandemic many practices were unable to deliver full contract provision for a variety of reasons, mainly due to challenges with recruitment, and so there has been historic under delivery which has been further exacerbated due to the pandemic as described at 5.1 of this report.

- Dental practices have found it difficult to maintain their workforce to deliver NHS services. Many Dentists prefer to work fewer days on the NHS and therefore deliver less activity. This would enable them to focus more of their time on private work and in some cases, Dentists are either leaving the NHS or opting not to join at the start of their career.

  The Dentists and practices are citing a number of reasons for leaving the NHS. These include:

- The focus on treatment with limited focus on oral health improvement, with implications this has on time to be made available to patients
- Delays in proposed changes to the dental contract at national level
- The level of nationally implemented annual financial uplifts to the contracts when compared to the costs of running their services
- The limited flexibility within the contract to use greater skill mix to deliver care
- The extent of patient dissatisfaction with access to care

5.13 So far in 2022-23 6 practices in Surrey have handed back their contracts, totalling 43,136 UDAs. Arrangements are being made to replace this activity on a temporary basis before seeking to find permanent new replacements via a procurement process.

5.14 The situation in Surrey reflects the national position. For many years work has been ongoing by the Department of Health and Social Care alongside the Office of the Chief Dental Officer to understand the challenges with the dental contract. In 2022 the first significant Contract Reforms to the contract were introduced since its introduction in 2006. The changes start to address many of the

challenges voiced by frontline dental teams during the engagement period and will make a real difference to patients with a shift in the emphasis of financial reward, and the re-orientation of clinical activity to those patients who need it most, with a focus on improving access to NHS dental care and support for the dental teams. The changes will increase NHS capacity by;

- allowing payment for higher levels of performance,
- increasing payments for more complex treatments,
- issuing updated advice about recall intervals for patient check-ups,
- supporting the use of more skill mix and,
- providing more information to patients about access to NHS services.

These measures are a first phase of a programme designed to support patient access and improve oral health.

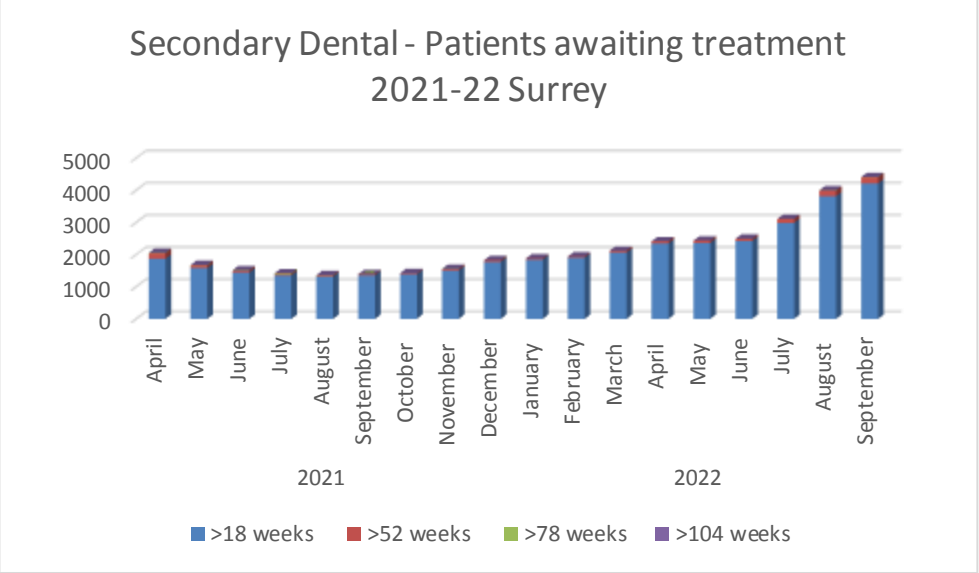
5.15 The Planning and Operational Guidance for 2023-24 states that the NHS:

Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels

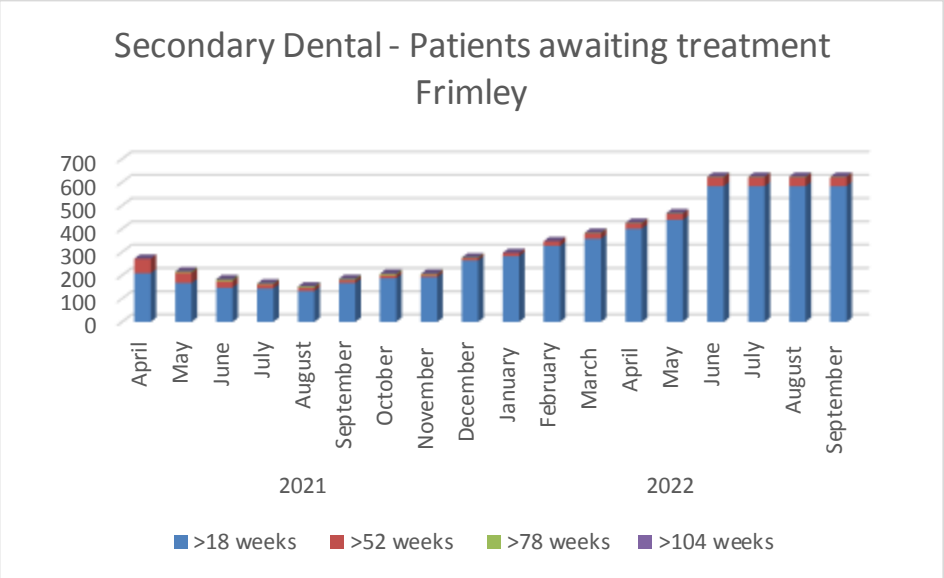
Across the South-East, there are discussions about 'flexing' Dentists' contracts during 2023 to provide more capacity to help those patients who have struggled to achieve access. This will be done by reducing the activity targets they are required to achieve and using that capacity to provide access sessions for new patients as described at 5.10 and 5.11. This will provide more time for the Dentists to meet the greater treatment needs likely to be presented. The aim is to test this approach over the year to see it meets the objective to improve access. It will also start to look at whether this model can then be applied to improve the oral health of patients more likely to have greater oral health needs.

5.16 There has been a similar impact for referral services with increased waiting times for treatment and backlogs of referrals that need to be addressed. Hospital services have targets to eliminate the number of patients waiting more than 104 weeks by July 2022 and those waiting more than 78 weeks by March 2023.

5.17 Surrey Heartlands ICB - The graph below reports on progress for the Trusts located in the Surrey Heartlands area (Ashford and St Peter's NHS Foundation Trust; Royal Surrey County Hospital NHS Foundation Trust and the Surrey and Sussex Healthcare NHS Trust). The national target in terms of no patients waiting more than 104 weeks has been achieved. Good progress was made in reducing the number of patients waiting more than 18 weeks in the period April to November 2021, but the numbers have been climbing since then.



5.18 Frimley ICB - The Frimley Health NHS Foundation Trust is located within the Frimley ICB area which includes the provision of services for patients living in the parts of the ICB that fall within Surrey. It has also achieved the national target of no patients waiting more than 104 weeks for treatment but has similar challenges in terms of the number of patients waiting more than 18 weeks for treatment. The Trust has also had IT issues regarding data capture following changes made at the Trust, which it aims to resolve shortly.



5.19 The Planning and Operational Guidance for 2023-24 states that the NHS should:

Eliminate waits of over 65 weeks for elective care by March 2024

Community Dental Services are provided by the Surrey and Sussex NHS Healthcare Trust for East Surrey (covering Reigate and Banstead and Tandridge) and HCRG Care Community Services Ltd who cover the rest of Surrey, including the parts of the county that fall within the Frimley ICB. They provide care for vulnerable patients, such as adults with learning disabilities and children. Restoration and Re-set funding has been invested into the HCRG service for the period up to 31st March 2023. This has helped reduce the number of patients waiting for treatment in clinic.

5.20 The Planning and Operational Guidance for 2023-24 states the NHS should:

Continue to address health inequalities and deliver on the Core20PLUS5 approach

The Core20PLUS5 targets are about reducing health inequalities for children and young people and include a specific reference to oral health in terms of addressing 'the backlog for tooth extractions in hospitals for under 10s'.

There are community-based tier 2 service for Oral Surgery in Surrey Heartlands designed to provide treatment for patients whose needs are too complex to treat in primary care but who don't need to go to hospital.

6. Conclusions

6.1 The Coronavirus pandemic has had a significant impact on NHS Dental services both for patient and dental service providers. The pandemic has created a significant backlog in terms of waiting times for treatment in primary care and for referral services. Service providers have had to introduce new arrangements to ensure safe treatment for patients and are having to address the impact for their workforce. Some practices have decided that the provision of NHS services is no longer viable for them and have left the NHS. National contract changes have been introduced in late 2022 to try to address these concerns and local action is being taken to seek to improve access, particularly for people who have struggled to find a way into the dental system.

6.2 Access to NHS services has been improving since early 2022, but access does remain an on-going challenge and it is likely that more NHS practices are considering whether to remain within the system. The section below details the actions being undertaken to support recovery from the pandemic. They will need on-going review to assess their effectiveness both in improving access and maintaining NHS provision.

7. Next steps

- Engagement with our local population, partners, and stakeholders to develop a Surrey Dental Improvement Strategy with a focus on priority groups and targeted access to oral health improvement programmes
- Maintain Additional Access sessions and review approach required in to 2023-24
- Continue to monitor access to primary care dental services with the aim of maintaining improvements in access
- Implement national dental contract changes at local level taking effect during 2022-23
- Review impact of Restoration and Re-set investment and review approach required for 2023-24
- Implement Planning and Operational Guidance in relation to dental services in 2023-24
- Work with the dental profession to consider whether greater flexibilities can be applied locally to the dental contract to facilitate access and support them with workforce challenges
- Implement programme of re-commissioning key referral services to achieve sustainable access and to meet needs of key patient groups, such as children, patients with more complex treatment and management needs and older patients
- Continue to engage with stakeholders such as Healthwatch, supporting them to provide information to patients about access to care
- Work with other stakeholders to strengthen oral health improvement arrangements through contribution to other health improvement programmes and other interventions that may impact such as water fluoridation
- Review challenge of improving children's dental health as part of Core20PLUS5 approach
- Embed and integrate clinical dental voice into wider ICS work on population health improvement and reduction in inequalities

Surrey Heartlands and Frimley Integrated Care Boards

APPENDIX A

Lower Super Output Areas in Surrey ranked on IMD scores

Lower Super Output Area (ranked on IMD score)	IMD Decile (lower is more deprived)	Electoral Ward/Key Neighbourhoods	District / Borough	Primary Care Network	Health Areas Surrey Heartlands/ (SH) Frimley
1. Reigate / Banstead 008A	2	Hooley, Merstham and Netherne	Reigate and Banstead	Horley	East Surrey (SH)
2. Woking 004F	2	Canalside	Woking	WISE 3	NW Surrey (SH)
3. Guildford 012D	2	Westborough	Guildford	GRIPC	Guildford and Waverley (SH)
4. Guildford 007C	2	Stoke	Guildford	GRIPC	Guildford and Waverley (SH)
5. Spelthorne 001B	3	Stanwell North	Spelthorne	SASSE Network 3	NW Surrey (SH)
6. Mole Valley 011D	3	Holmwoods	Mole Valley	Dorking	Surrey Downs (SH)
7. Reigate / Banstead 005A	3	Tattenham Corner & Preston	Reigate & Banstead	Banstead Healthcare	Surrey Downs (SH)
8. Epsom and Ewell 007A	3	Court	Epsom & Ewell	Epsom	Surrey Downs (SH)
9. Spelthorne 002C	3	Ashford North and Stanwell South	Spelthorne	SASSE Network 3	NW Surrey (SH)
10. Woking 005B	3	Goldsworth Park	Woking	WISE 3	NW Surrey (SH)
11. Runnymede 002F	3	Englefield Green West	Runnymede	Windsor	Windsor and Maidenhead (Frimley)
12. Elmbridge 004B	3	Walton South	Elmbridge	Walton	NW Surrey (SH)
13. Reigate and Banstead 018D	3	Horley Central & South	Reigate and Banstead	Care Collaborative	East Surrey (SH)
14. Waverley 002E	3	Farnham Upper Hale	Waverley	Farnham	North East Hampshire and Farnham (Frimley)
- Spelthorne 001C	3	Stanwell North (already included above)	Spelthorne	SASSE Network 3	NW Surrey (SH)
15. Waverley 010A	3	Godalming Central and Ockford	Waverley	East Waverley	Guildford & Waverley (SH)
16. Runnymede 006D	3	Chertsey St. Ann's	Runnymede	COCO	NW Surrey (SH)
17. Reigate and Banstead 010E	3	Redhill West & Wray Common	Reigate and Banstead	Care Collaborative	East Surrey (SH)
18. Guildford 010C	3	Ash Wharf	Guildford	Surrey Heath	Surrey Heath (Frimley)
19. Elmbridge 008A	4*	Walton North	Elmbridge	Walton	NW Surrey (SH)
20. Elmbridge 017D	4**	Cobham and Downside	Elmbridge	Leatherhead	Surrey Downs (SH)

Lower Super Output Area (ranked on IMD score)	IMD Decile (lower is more deprived)	Electoral Ward/Key Neighbourhoods	District / Borough	Primary Care Network	Health Areas Surrey Heartlands/ (SH) Frimley
21. Surrey Heath 004C	4**	Old Dean	Surrey Heath	Surrey Heath	Surrey Heath (Frimley)

* Overall IMD decile 4 and in decile 1 (highest 10% nationally) for IMD supplementary index on Income Deprivation Affecting Children

** Overall IMD decile 4 and in decile 1 (highest 10% nationally) for IMD domain Education, Skills and Training.

Appendix B

Supplementary Information - Frequently Asked Questions

1. How do I find an NHS Dentist?

You can search for an NHS Dentist near you on Find a dentist - NHS (www.nhs.uk)

There is not a registration process with a dentist in the same way as with a GP because you are not bound to a catchment area. You find a dental surgery that's convenient for you, whether it's near your home or work, and phone them to see if there are any appointments available.

Dental surgeries will not always have the capacity to take on new NHS patients. You may have to join the practices waiting list, look for a different dentist who is taking on new NHS patients, or be seen privately.

Once you find a dental surgery, you may have to fill in a registration form at your first visit, which is just to add you to their patient database. However, this does not mean you have guaranteed access to an NHS dental appointment in the future.

2. How do I access dental emergency and out-of-hours care?

If you have a regular dentist and require an urgent appointment you should contact your usual dentist in the first instance as some surgeries offer emergency dental slots and will provide care if clinically necessary.

If you do not have a regular dentist or your surgery does not offer emergency slots or you are calling out of hours, you can contact NHS 111, who can put you in touch with an urgent dental service.

3. When should you go to A&E?

Only visit A&E in serious circumstances, such as severe pain, heavy bleeding, injuries to the face, mouth or teeth

If you're not sure whether you should go to A&E, contact NHS 111, who will be able to advise you.

4. Why are there treatment bands and what does each band cover?

When you attend the practice, the dentist will carry out an examination and assess what treatment is clinically necessary and discuss the options. You can have the treatment needed to keep your mouth, teeth, and gums healthy and free of pain through the NHS.

Treatments that are not clinically necessary or are cosmetic, for example sport guards and teeth whitening must be paid for privately.

When you are undergoing NHS Dental Treatment, you will only pay one charge even if you need to go to the dentist more than once to complete your course of treatment.

Band 1 course of treatment

The current charge is £23.80 in England

Treatment covers:

- an examination, diagnosis and care to prevent problems
- if necessary, X-rays, scale and polish and planning for more treatment

Band 2

The current charge is £65.20 in England

Treatment covers:

- all necessary treatment covered by band 1
- treatment such as fillings, root-canal treatments, or removal of teeth/extractions

Band 3

The current charge is £282.80 in England and £203.00 in Wales.

Treatment covers:

- all necessary treatment covered by band 1 and 2
- more complicated procedures such as crowns, dentures, or bridges

Read more details regarding the bands in the National Health Service (Dental Charges) Regulations 2005 as per the link below:

The National Health Service (Dental Charges) Regulations 2005 (legislation.gov.uk)

5. Will I have to pay again if I am referred to another dentist?

If your treatment needs are complex, your NHS dentist may need to refer you to another dentist or specialist to complete your treatment. The treatment is still under the NHS but might be at another practice or in a hospital setting. You can also ask to be referred to a Private dentist.

Your dentist will explain why you need to be referred and will complete all the other dental treatment you need.

If you pay for your NHS dental treatment the charge you pay depends on where you are referred to:

If you are referred to another dentist to complete your treatment, you will only have to pay once to the original dentist.

If you are referred for treatment under Sedation, you may have to pay an extra charge to the dentist you are referred to.

If you ask to be referred to a private dentist, you must pay for any NHS Treatment plus the private charge for the treatment carried out by the Private dentist.

6. Will I have to pay again if I return to my practice within two months of treatment?

If you have to go back to your dental practice within two calendar months of completing a course of treatment and need further treatment from the same charge band or lower, you do not have to pay.

For example, if you had a filling last month but need an extraction one month later, you do not have to pay again as both treatments are in the same charge band.

If the additional treatment is in a higher charge band (for example a crown), you must pay in full.

If you did not complete your first course of treatment or if it was for emergency treatment, this does not apply

7. Who can have NHS dental treatment?

If you live permanently in the UK, you can access NHS dental treatment.

8. NHS orthodontic treatment

NHS orthodontic treatment is free for people under the age of 18 who meet the eligibility criteria for treatment.

A rating system called Index of Orthodontic Treatment Need (IOTN) is used to assess your eligibility for NHS treatment.

The IOTN is used to assess the need and eligibility of children under 18 years of age for NHS orthodontic treatment on dental health grounds.

NHS orthodontic care is not usually available for adults, but it may be approved on a case-by-case basis if it's needed for health reasons.

9. Who's entitled to free dental care?

If one or more of the criteria listed below applies to you when your treatment starts, you'll be entitled to free NHS dental care.

You're entitled if you are:

- aged under 18, or under 19 and in qualifying full-time education
- pregnant or have had a baby in the previous 12 months
- staying in an NHS hospital and your treatment is carried out by the hospital dentist
- an NHS hospital dental service outpatient – but you may have to pay for your dentures or bridges

You're also entitled if you or your partner – including civil partner – receive, or you're under the age of 20 and the dependant of someone receiving:

- Income Support
- Income-related Employment and Support Allowance
- Income-based Jobseeker's Allowance
- Pension Credit Guarantee Credit
- Universal Credit and meet the criteria

If you're entitled to or named on:

- a valid NHS tax credit exemption certificate – if you do not have a certificate, you can show your award notice; you qualify if you get Child Tax Credits, Working Tax Credits with a disability element (or both), and have an income for tax credit purposes of £15,276 or less
- a valid HC2 certificate

People named on an NHS certificate for partial help with health costs (HC3) may also get help.

You will not be exempt from paying because you receive any of the following:

- Incapacity Benefit
- contribution-based Employment and Support Allowance
- contribution-based Jobseeker's Allowance
- Disability Living Allowance

- Council Tax Benefit
- Housing Benefit
- Pension Credit Savings Credit

Medical conditions do not exempt patients from payment for dental treatment. You'll be asked to evidence written that you do not have to pay for all or part of your NHS treatment. You will also be asked to sign a form to confirm that you do not have to pay.

10. Is dental treatment free for pregnant women and women that have had a baby in the last 12 months?

Pregnant women and women who have had a baby in the last 12 months get free NHS dental treatment. You may have to show proof, such as a maternity exemption certificate (MatEx), a maternity certificate (MATB1), or your baby's birth certificate.

If you gave birth more than 12 months ago, you will not be entitled to free NHS dental treatment. The MatEx only gives exemption from NHS prescriptions.

11. When do I tell the dentist that I do not have to pay?

Tell your dental practice you want NHS treatment when you make an appointment. When you arrive for your appointment, you'll be given a form to fill out – if you do not have to pay, put a cross in the appropriate box.

If you have a valid HC2 certificate or tax credit exemption certificate, write in the certificate number.

If you have a valid HC3 certificate, write in the certificate number and the maximum your certificate says you can pay. You'll pay either what appears on the certificate or the actual charge, whichever is the least.

Dentists are not responsible for advising patients on exemptions, and it's the patient's responsibility to know if they're exempt.

You'll need to show proof of your entitlement to help with dental costs. If you are not sure whether you're entitled to help, you must pay. You can claim a refund, but make sure you keep all receipts.

12. How can I claim a refund?

You cannot claim a refund for the cost of private dental treatment or sundry items like toothbrushes on the NHS.

If you had a mixture of NHS and private treatment, you can only get a refund for charges that were part of your NHS treatment.

If you're on a low income and find it difficult to pay the charge, you can apply to the NHS Low Income Scheme.

You can submit a claim for a refund at the same time as you apply to the Low Income Scheme.

Refund claims must be submitted within 3 months of the date on which you paid.

The NHS Low Income Scheme (LIS) may provide partial help with the cost of your dental care for those who do not qualify for full help but still have a low income.

Detailed information is also provided on the NHS Business Services Authority (BSA) website.

The BSA has an online tool that helps you check to see if you are exempt from NHS charges.

Each year, the NHS loses significant funds due to people claiming free or reduced cost dental treatment they weren't entitled to. This directly reduces the money available for core patient care.

The NHS Business Services Authority carry out checks on patient claims. If they cannot confirm during their checks that a patient was entitled to claim free NHS dental treatment or help towards the cost of their dental treatment, they will be sent an enquiry letter asking them to confirm their entitlement.

If they do not respond within 28 days, they'll be sent a Penalty Charge Notice.

No data is available to the NHSE SE Regional Team or the ICB regarding the Penalty Charge Notices as the process is managed by the NHS Business Services Authority.

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