Review of commissioned General Dental Services and dental need in Hampshire and the Isle of Wight

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Introduction

This paper reports a desktop review of the current situation around commissioned General Dental Services (GDS) across Hampshire and the Isle of Wight Integrated Care System (ICS) geography. It gives 'Key considerations for commissioners' which form the summary below, the report then outlines the information used to support these considerations.

This review acknowledges that assigning commissioned activity to areas of highest need does not always result in achieved activity in these areas and commissioning decisions need to take this into account. The review is the start of a of a long-term approach to reducing inequalities across the HIoW geography, based on need. It is unlikely that a single procurement exercise will address all issues raised in this review. The report therefore covers more immediate and longer-term issues and also covers issues which require partnership working beyond the role of the dental commissioners.

The 'Key considerations for commissioning' are therefore separated into three main areas:

A) **Short-term considerations for dental commissioners for the upcoming procurement of General Dental Services – these focus on where additional activity should be commissioned in the short-term**

B) **Longer-term considerations for dental commissioners beyond the current procurement**

C) **Considerations for partnership and system working**

Summary: Key considerations for commissioning (Note this is a summary table and a more detailed table is at the end of the review)
A. Considerations for the upcoming procurement of services
1. Commissioned activity (UDA's per head of population) should ideally be highest in the most deprived areas and lowest in the least deprived areas
2. Assigning additional funding to areas where commissioned UDAs per head of population is higher but contracts consistently do not achieve UDA targets should be avoided as this can decrease access across the system
3. Consideration should be given to where additional recurrent activity is most likely to be achieved
4. Increase contracted activity in Portsmouth in line with its deprivation ranking
5. The Isle of Wight has the highest commissioned activity across the HIoW but evidence suggests dental access issues here are the most pronounced – this issue requires system working, involving all parties, and goes beyond simply commissioning additional activity
6. Ensure Southampton maintains significantly higher UDAs per head of population than less deprived areas, and maintain currently achieved activity where possible
7. Ensure the UDAs per head of population in Gopsort is in line with its deprivation ranking
8. Ensure the UDAs per head of population in Havant is in line with its deprivation ranking
B. Longer term considerations for dental commissioning
9. In the longer term/future procurements it may be necessary to review other activity across Hampshire and the Isle of Wight in areas not covered specifically above
10. Other models of delivery may need to be considered outside of traditional General Dental Service (GDS) Contracts
C. Considerations for partnership and system working
11. An integrated approach to reviewing complex issues of recruitment and retention, and other possible methods of delivery, is recommended
12. A system-wide focus on wider oral health improvement beyond issues of dental access is also recommended

Background

The Healthcare Public Health Team in NHSE/I South East was asked to review GDS provision commissioned across the HIoW Integrated Care System and assess whether this was in line with need. This is in advance of a procurement of a number of Units of Dental Activity (UDA's) across the area. Engagement with a number of

stakeholders, including MPs, Clinical Commissioning Groups, local authority partners, local dental professionals, and Healthwatch, have raised the issue of dental access across HIoW. This engagement indicates that Portsmouth, the Isle of Wight, Southampton, Gosport and Havant are seen as areas of focus of dental access issues and increased health inequalities. As the review focuses on need, it also covers health inequalities at the population level which often go beyond dental access issues.

There is a historical, and increasing, issue with activity being commissioned but not being delivered. This is mainly due to issues of recruiting and retaining dentists. There have been very recent national reports in the media, highlighted by the British Dental Association, of large numbers of dentists leaving NHS dentistry. Portsmouth was highlighted specifically as an area of particular concern, although it should be noted that these are media reports using methods which have not been verified. Issues of recruitment and retention of dental professionals are outlined in more detail below.

It is important to clarify the difference between activity which is commissioned but not achieved, and activity which is not currently commissioned. It can be frustrating for stakeholders to hear that there is 'adequate activity' when the actual activity achieved does not meet need or demand.

Aligning dental activity with population need/demand

There is a complex relationship between need, demand and supply of healthcare and this is particularly apparent when considering dental services in HIoW. This is outlined in **Table 1** below.

Table 1: Supply, need and demand for dental services in HIoW

Concept	Definition[1]	Considerations for dental services in HIoW
Supply	- The amount of care that can be made available - Constraints can be budgets, workforce capacity, equipment and time	- There are areas of HIoW where underactivity is common and this is largely related to lack of available dentists/dental care professionals - It's important to understand the reasons for reduced supply through contract hand-backs and under-delivery - COVID-19 has exacerbated issues due to temporary cessation of non-urgent face-to-face appointments followed by infection control guidance requiring lengthy periods between appointments using equipment which generated aerosols – these issues are ongoing and likely to impact on supply for some time
Need	- The level of care required according to externally applied/agreed metrics - Levels of disease in a population are a useful metric	- Deprivation is the recommended indicator for dental disease as it is both very strongly lined and available at small geographies - However, those with the greatest need (dental disease) are often the least likely to access services
Demand	The quantity of health services the population wants	- Demand is often higher in less deprived areas - This leads to a situation where it is possible to fit supply with demand but this does not address need

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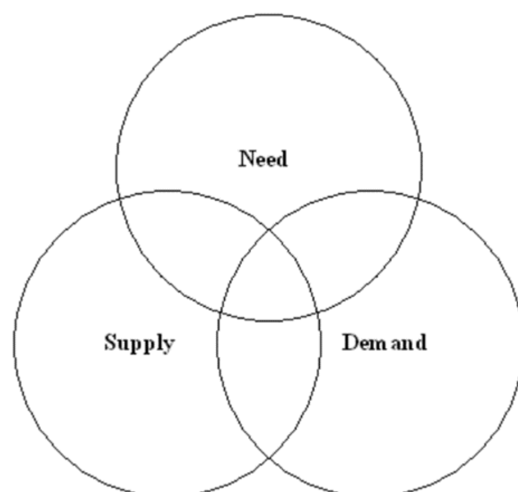
Figure 1 below shows the relationship between supply, demand and need. Ideally, supply, demand and need will have as large a cross-over as possible but in reality this is challenging to achieve. Fitting supply with demand is relatively easier. However, NHS commissioners have a statutory obligation to commission services in way which aim to reduce inequalities in health. This involves ensuring need is considered as a strong basis for commissioning decisions.

[1] https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/measures-supply-demand

Figure 1: The relationship between Demand, Supply, and Need[2]



The main focus of this review is need, based on population level data, with supply covered where relevant.

The aim of this review is to enable commissioners to have a clear focus in terms of what, *ideally,* should be commissioned to ensure supply is planned to meet need. It is acknowledged that there will be areas where need is high (there are lots of people with dental disease) but demand is lower (those people with dental disease do not access dental services). Issues around non-take up of services and failure to attend dental appointments are well documented in more deprived areas. System-wide approaches involving local authorities (with responsibility for oral health promotion) and other healthcare services should be explored wherever possible to address this issue.

Poor oral health, particularly dental decay, is strongly correlated with deprivation. This means people living in more deprived areas are far more likely to have dental decay than people in less deprived areas and this is a known health inequality. People in less deprived areas are also more likely to be able to pay for dental treatment privately. This leads to a situation in which the people most in need of dental care and treatment are the least able to access it (this is known as the 'inverse care law').

There is Guidance for NHS commissioners on how to fulfil legal duties in reducing health inequalities. In line with this, dental commissioners in NHSE/I have ensured

[2] https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/uses-epidemiology-health-service-needs

deprivation is a key consideration in the commissioning of dental services. This has been an important step in reducing inequalities in oral health. However, as outlined above, assigning lots preferentially to more deprived areas can only reduce inequalities if these contracts are successfully bid for and the dental workforce required to fulfil these contracts is available.

Achieved activity versus commissioned activity

There are a number of issues which mean that activity is sometimes commissioned but not achieved. This results in funding being assigned to contracts which are not delivering the maximum amount of dental activity and this reduces access in the system overall.

There are specific issues around **recruitment and retention** of the dental workforce in the South East. Issues include:

- The lack of a dental school in the South East (dental students often continue to live/work near their dental school following graduation due to networks and relationships both professional and social)

- Dental graduates from the EU are now less likely to work in the UK due to Britain's exit from the EU

- Overseas Registration Examinations for dentists from outside the EU have been postponed due to COVID so there are fewer dentists coming from outside the EU and - this backlog will soon be compounded as EU dentists will also be required to take the exam before practicing

- Previous issues with recruitment and retention of dental nurses have also increased recently, likely due to a combination of COVID and Britain's exit from the EU

Dental professionals both locally and nationally report for the following issues in terms of recruitment and retention of dental professionals:

- Some geographic areas are more attractive to dental professionals than others – this can be linked to accessibility in terms of transport etc. (as many dentists now work flexibly across two or more different surgeries), and how attractive an area is to move to/live (particularly to newly qualified dentists)

- This is heightened by geographical disparities in funding for NHS dentistry – tariffs were initially set based on historical rates so areas where dental need is higher do not necessarily correlate with higher rates
- Claims by dental professionals that the current dental contract does not encourage dentists to work in the NHS, or in areas of higher need, is a national issue and there are continued calls by the profession to reform the dental contract

The **Isle of Wight** has seen particular issues around recruitment and retention of dentists which has led to under-delivery of commissioned activity. Local intelligence and engagement suggest that there are insufficient dentists/dental team members who live on the island to deliver the current activity. In some areas nationally this can be addressed by incentivising the workforce to travel further to work. However, having to take a ferry to the island for work can cause additional issues for dental professionals and this contributes to recruitment and retention issues.

There are issues of recruitment and retention specific to the Isle of Wight which are system-wide issues and which should be reviewed and addressed in partnership with all relevant stakeholders

The **Portsmouth area** has also seen a significant number of concerns around dental access raised by key stakeholders. Between 2018 and 2021 a number of contracts across several practices have been handed back by providers resulting in a significant number of unallocated UDA's. Portsmouth is the most deprived local authority in the HIoW system. Portsmouth is split between two parliamentary constituencies separated by a motorway/A road and engagement suggests that additional capacity in both North and South Portsmouth is needed.

Particular concerns around access are also raised in **Southampton.** Southampton is the second most deprived local authority in HIoW. When additional activity was allocated between 2019-2022 providers in Southampton were awarded the largest proportion of additional activity (outlined further below). It is important to ensure that commissioned activity is delivered and to address key issues where contracts are under-achieving.

Havant and **Gosport** are the 4th and 5th most deprived local authority districts in HIoW. Concerns around dental access in these areas have also been raised by local stakeholders.

Assigning additional contracted activity in areas where current activity is commissioned but not achieved will result in an overall reduction in activity across HIoW. Regardless of where need is identified, commissioners should ensure that commissioning intentions are based on recent/current understanding of the local market as well as patient preferences.

Local approaches to recruitment and retention issues

Issues related to recruitment and retention throughout HIoW system, and in particular on the Isle of Wight, may be partly resolved by changes to contracts such as size and value. There are similar issues across England and the South East, and the reasons for specific issues of recruitment and retention will differ by location. These issues often need a more local focus to explore, for example, to review how similar issues in recruitment and retention of GPs and other healthcare professionals are addressed. Local authorities can also have a role in ensuring people understand why their areas are a good place to live and work. Working together to ensure the overall job offer attracts new professionals to the area should be explored.

Currently commissioned activity

A review of commissioned activity is reported here.

Commissioned activity (UDA's per head of population) should be highest in the most deprived areas and lowest in the least deprived areas

Table 2: Local Authority areas in HIoW ranked by UDAs commissioner per head of population

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

Note that Hart local authority area is largely based within the Frimley ICS area and is omitted from this table. For reference, Hart ranks 317/317 in terms of deprivation, i.e. it is the least deprived local authority in England. It has relatively high UDAs per head of population but as the contracts for General Dental Services are life-long it would not be possible to move commissioned activity from this area to less deprived areas.

Table 2 highlights an issue which particularly affects the Isle of Wight. The Isle of Wight has the highest *commissioned* activity anywhere in HIoW, yet as outlined below, both local engagement and published data suggest particular issues around dental access in the Isle of Wight. Viewing this issue solely as one related to the commissioning/procurement of UDA contracts will exacerbate this problem and all parties should work together to find sustainable solutions. This should include dental and healthcare commissioners and providers, local authorities and other components of the Integrated Care System.

Table 3: **Local Authorities ranked by most deprived according to national IMD ranking**

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

Ideally, the highest UDA per head of population should be in the most deprived Local Authority. For example, Portsmouth = the 59th most deprived Local Authority in England and Eastleigh is the 298th local authority in England (out of 317) but Eastleigh has a higher number of UDAs commissioned per head of population than Portsmouth

Note that Southampton and Portsmouth are very similar in terms of deprivation and some rankings place Southampton as the same or more deprived than Portsmouth. These tables use the ‘rank of average score’ for consistency.

Commissioning decisions should initially aim to ensure the rankings in **Table 2** *and* **Table 3** *are the same i.e. the most deprived areas have the highest number of UDAs commissioned per head of population. Once this is achieved it is possible to consider ratios and other variables within this ranking.*

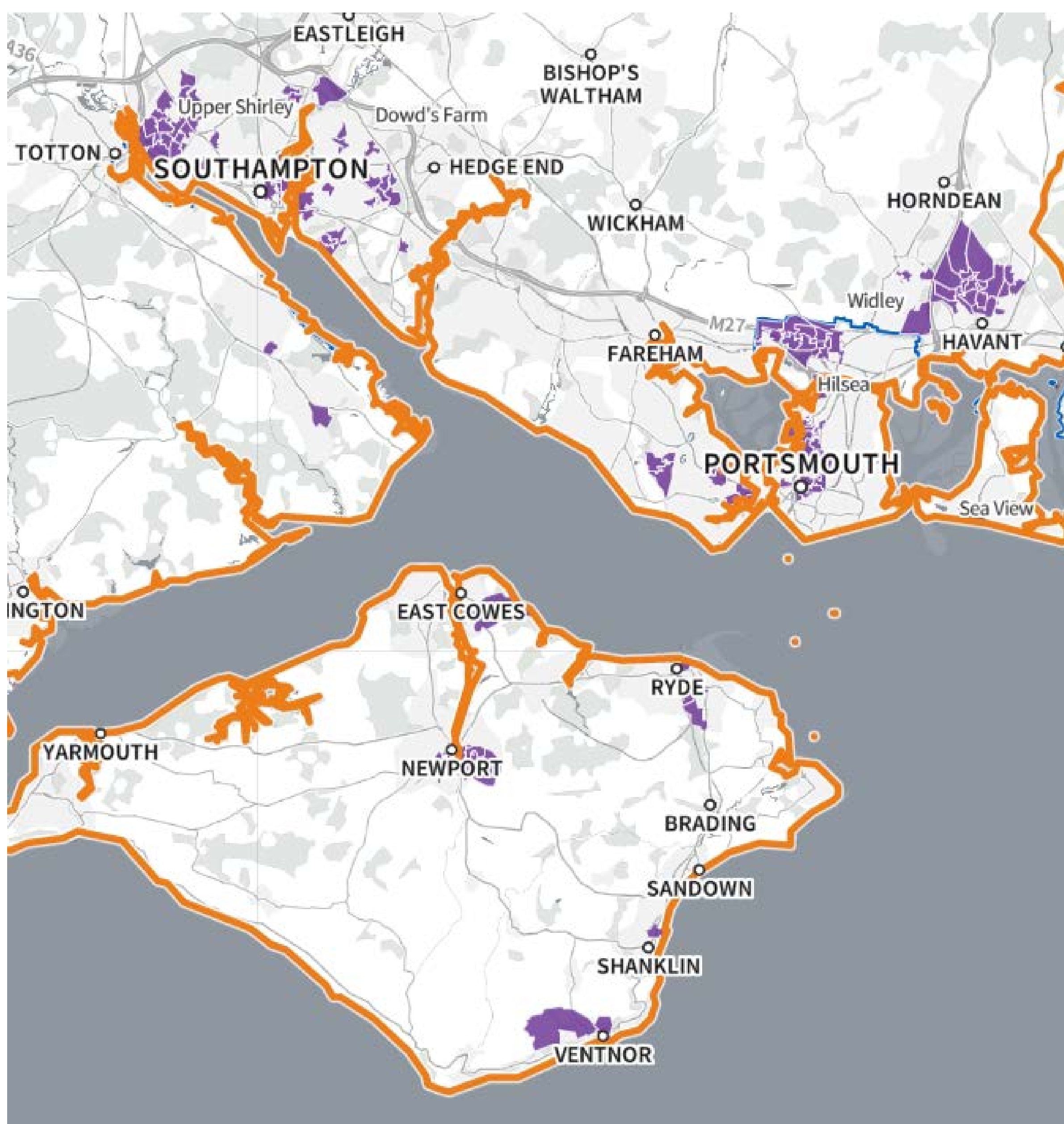
The deprivation rankings above are the rank of each Local Authority within the national rankings from 1 (most deprived) to 317 (least deprived). From this it should be clear that Portsmouth (being 59/317 in England) is considerably more deprived than the New Forest (240/371 in England) even though both Portsmouth and the New Forest are both in the top half of Table 3.

Figure 2: Map of HIoW showing all areas (in purple) in the top 20% most deprived areas of England

Figure 2: Map of HIoW showing all areas (in purple) in the top 20% most deprived areas of England**Figure 2** above shows that the only areas in the top 20% most deprived areas in England are centred around Southampton, Portsmouth, Havant, Gosport. This area is enlarged in **Figure 3.**

Note that there are also four small areas (population of less than 2,000) that are not clearly visible on this map. There are three such areas in the New Forest, one in Test Valley and one in Basingstoke. It should be noted that grouping areas by local authority can be a convenient way to summarise data around deprivation but people living in smaller, more deprived, rural communities experience significant issues with access to healthcare and this should also be considered.

Figure 3: Enlarged map of Figure 2 showing areas (in purple) in the top 20% most deprived areas of England



The 2021 Chief Medical Officer for England's Report points to inequalities in health outcomes in coastal areas specifically. It is interesting to note that the coastal areas of HIoW tend to be more deprived than communities further inland. A national strategy has been proposed to address this.

Population density

Population density becomes an increasingly important consideration where resources are more limited. In order to reduce pressures across the system it is important that services are used to the maximum extent possible. Services in more rural areas can sometimes be underused and, as outlined below, make it more difficult for people without cars to access. This raises a larger issue around differences in rural and urban health outcomes which should be considered when planning larger scale changes.

Figure 4 Population density in HIoW – darker areas are more populous

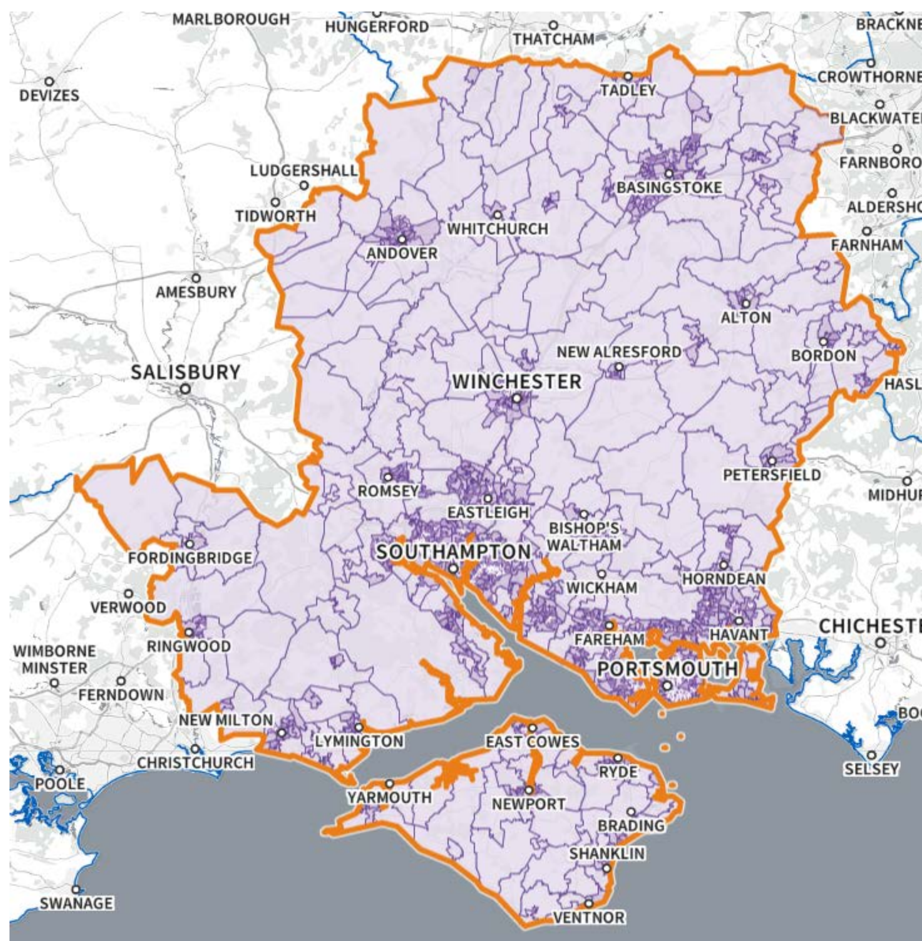


Figure 4 shows that the areas around Southampton, Portsmouth, Gosport and Havant have the highest population density. However, there are other areas with relatively high population density including Winchester and Basingstoke.

Travel

There are two important considerations in terms of travel:

1) The % of households in each area with no car/vehicle

2) How accessible any proposed sites will be to other people in the region

1) The % of households in each area with no car/vehicle is important because these households would find it particularly difficult to access services further from home.

Table 4: Households with no cars/vans by local authority[3]

Local Authority	Number of households with no cars/vans	% of households with no cars/vans
Portsmouth	28,533	33.4
Southampton	28,996	29.5
Gosport	8,097	22.9
Isle of Wight	13,761	22.5
Havant	10,623	20.7
Basingstoke and Deane	10,555	15.2
Winchester	6,705	14.3
Test Valley	6,426	13.5
Fareham	6,257	13.4
Eastleigh	6,928	13.3
New Forest	10,232	13.3
East Hampshire	5,284	11.2

Table 4shows a similar ranking to **Table 3** (deprivation). The number of households with no private transport is indeed usually linked to deprivation and this table further highlights the importance of ensuring services are broadly linked to more deprived areas. However, this consideration should also be given to the households in less

[3] https://www.nomisweb.co.uk/query/construct/ Nb this is based on ONS survey data – 2011 is the latest available as the results of the 2021 survey are not yet available

deprived areas with no cars/vans, as there are small pockets of areas which are both deprived and rural.

2) Accessibility for other people in the region (e.g. via public transport) is important as this increases access for people without cars across the region. It can also offer an alternative for areas where there are more acute issues with access. Larger conurbations such as Portsmouth and Southampton are therefore preferable on this basis when resources are more limited. It is naturally preferable for people to be able to access services as close as possible to where they live/work and patient engagement can be important in establishing where people might be willing to travel to for services. This is particularly important for residents of the Isle of Wight. The long-standing issue of a shortage of NHS dentists willing to work on the island means that it is important to engage with residents around possible 'next best' solutions. As a peninsula, Gosport is relatively isolated in terms of transport, with a ferry required to travel to nearby Portsmouth and the 3rd highest percentage of households with no access to a car/van.

Use of and access to NHS dental services

The following charts examine the percentage of the population, by lower tier local authority, who accessed NHS dental services over five periods of six-month intervals between 2019 and 2021:

- This is based on the postcode of the patient, not of the dental practice
- These are based on unique patient identifiers; if a patient attended for several visits within a period that would be counted once
- The number of people in an area is calculated as a percentage of the (2020) population of that area to give the final figure (as a percentage)
- The charts show either the total population, or 0-17s only from within that population, as 0-17s are less likely to use private dental services and access in this group is an important indicator of inequalities

The charts are ordered according to deprivation (as explained within each chart). The relationship between access to NHS dental services is complex because:

a) People who live in *more* deprived areas tend to have more dental disease, and attend for treatment and/or emergency appointments

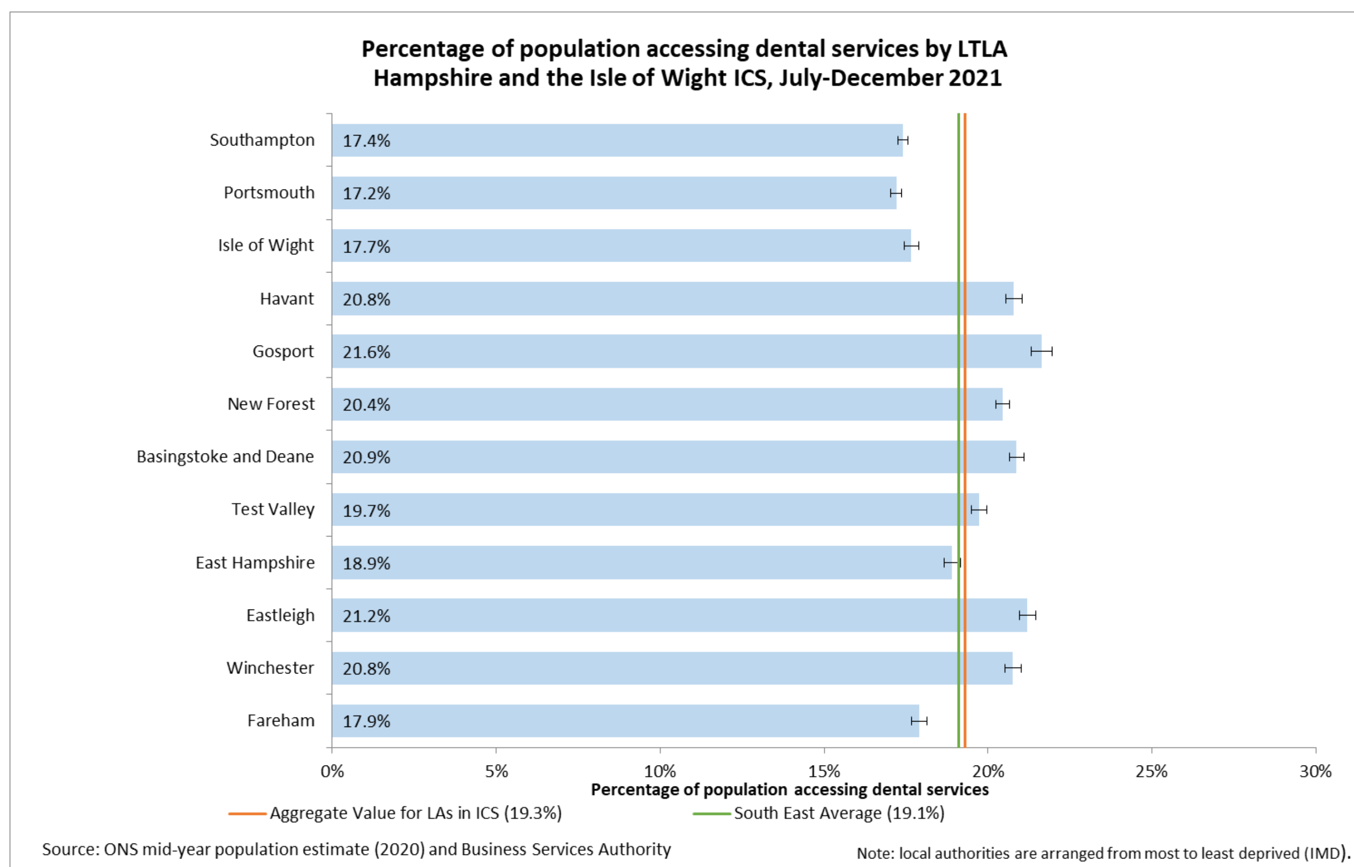
b) People who live in *less* deprived areas tend to attend more for regular preventive appointments ('check-ups') but they are also more likely to see private dentists (and private visits are not included here)

The data often 'levels out' between the most and least deprived areas.

The most concerning areas are where there is high deprivation and low access *compared to the rest of the area*

For this reason the charts below are arranged in order of deprivation, with comparators to the ICS average and the South East average where possible

Figure 5 Percentage of total population accessing NHS dental services in HIoW July-December 2021, compared with HIoW average (green) and South East average (orange)*



*Note that the IMD rankings for Portsmouth and Southampton are very close and interchange depending on the ranking system/timeframe used. Southampton and Portsmouth should be viewed equally as the most deprived local authorities in HIoW.

Figure 5 shows that dental access across the whole population is lowest in Portsmouth, Southampton, Isle of Wight, Fareham and then East Hampshire.

Table 2 is repeated below for comparison.

Table 2 (repeated) Local Authority areas in HIoW ranked by UDAs commissioner per head of population

Local Authority	LA IMD Rank of average score 2019	LA Population all ages mid 2019	Commissioned UDAs per head of LA population
Isle of Wight	98	141,771	1.66
Havant	119	126,220	1.59
Gosport	133	84,838	1.56
Southampton	61	252,520	1.53
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Portsmouth	59	214,905	1.45
Winchester	292	124,859	1.4
Basingstoke and Deane	243	176,582	1.27
Fareham	298	116,233	1.23
Test Valley	261	126,160	1.04
East Hampshire	285	122,308	0.97

Comparing Table 2 with Figure 5 shows that Portsmouth, and to a lesser extent Southampton, have lower commissioned UDA’s per head of population than other areas, are more deprived and have lower access rates.

The Isle of Wight has the highest UDAs commissioned per head, but is third lowest in terms of access in HIoW. Again, this suggests that activity is commissioned but is not delivered.

For Fareham and East Hampshire we see that they are far less deprived than Portsmouth and Southampton and have relatively low UDAs commissioned per head of population. East Hampshire has the lowest UDAs commissioned but is almost at the South East and HIoW average for access. This is likely to reflect the higher use of private dental services in less deprived areas.

Figure 6 Percentage of total population accessing NHS dental services in HIoW over six-month periods from Jan 2019 – Dec 2022

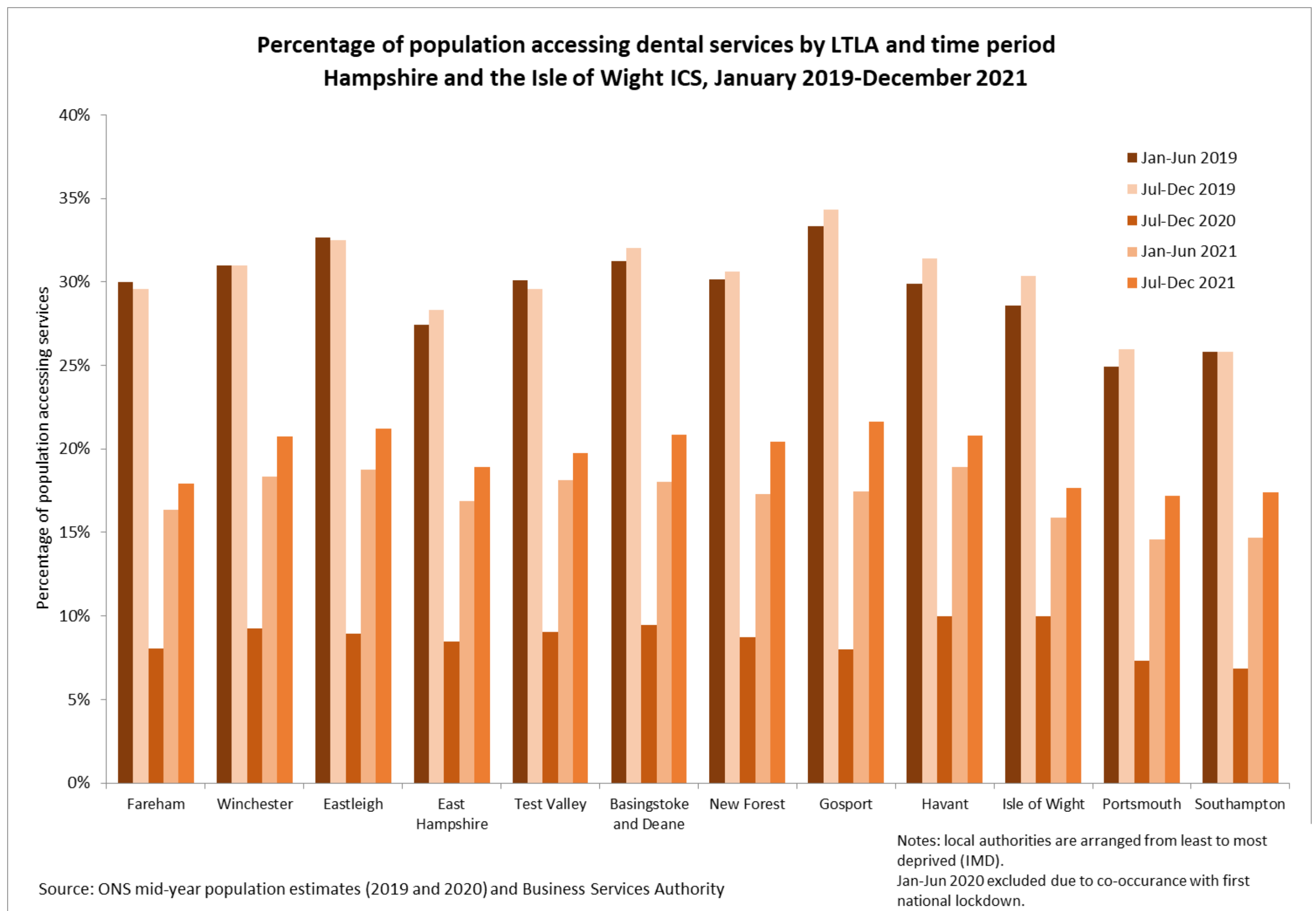


Figure 6 shows that the overall pattern seen in Figure 5 was observed before the COVID-19 pandemic forced practices to end face to face appointments. Of note is that pre-COVID access in Portsmouth and Southampton was considerably lower than the Isle of Wight (where access was roughly sixth lowest in HIoW) but in Jul-Dec 2021 HIoW is now the third lowest for access in the general population. As always, it is important to differentiate between lower commissioned activity and lower delivery of services as the solutions to each are different.

It is also possible to look at the percentage of 0-17s accessing NHS dental services. This can be particularly useful when looking at less deprived areas as adults are more likely than children to only use private dental services.

Figure 7 Percentage of 0-17s population accessing NHS dental services in HIoW July-December 2021, compared with HIoW average (green) and South East average (orange)

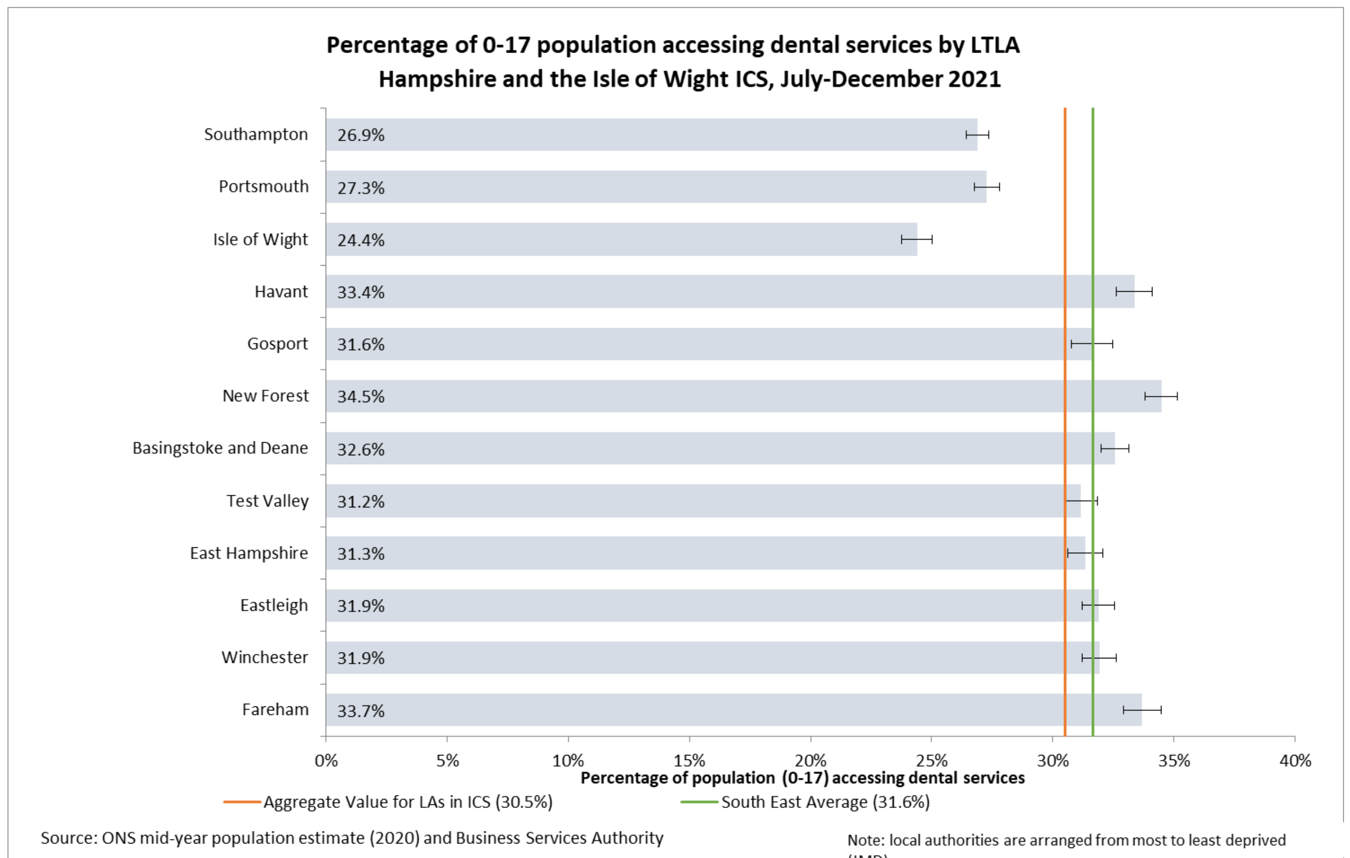


Figure 7 shows more clear differences when comparing the total population and 0-17s population. It clearly highlights that access for 0-17s to NHS dental services is lowest in the top three most deprived areas in HIoW. Southampton, Portsmouth and the Isle of Wight are the only areas where access is significantly lower than the South East, and the rest of the HIoW areas. The Isle of Wight has the lowest access in HIoW for 0-17s for this specific time period.

Figure 8 Percentage of 0-17s accessing NHS dental services in HIoW over six-month periods from Jan 2019 – Dec 2022

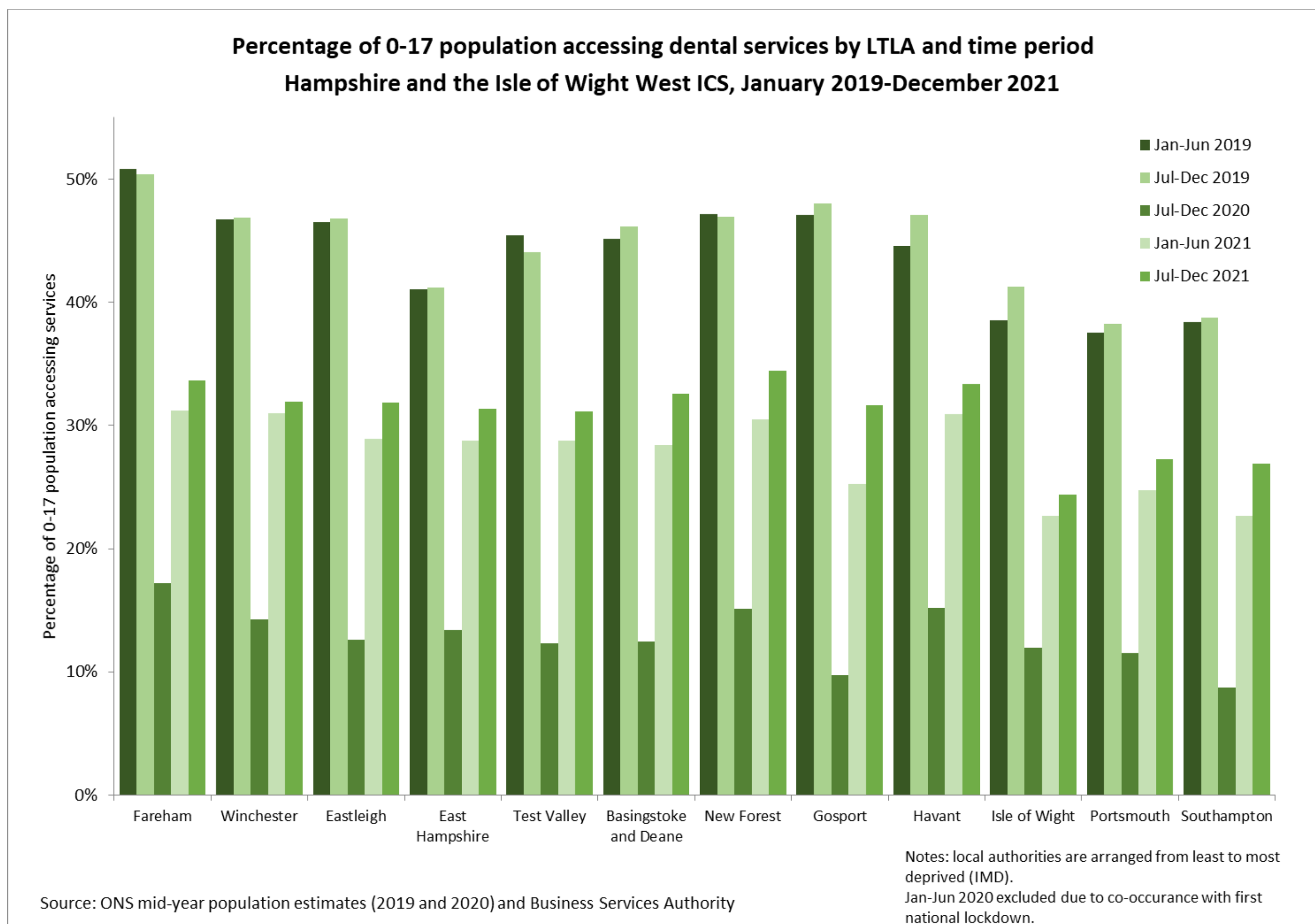


Figure 8 shows that access for 0-17s in the Isle of Wight is showing the slowest recovery to pre-COVID levels. Immediately before the COVID-19 pandemic, the Isle of Wight was the fourth lowest in terms of 0-17s access but was the lowest in the most recent (Jul-Dec 21) period.

It is important to note that data on access to services, as above, does not give an indication of the number of 'demand' i.e. the number of people who want to access services. Some of this information can be taken from the national GP patient survey. This survey is completed by people attending NHS GP appointments in England. This therefore excludes anyone who relies on private medical care.

The GP patient survey' shows, in **Figure 9** below, the percentage of people using NHS GP services who were successful in obtaining an NHS dental appointment during 2018/19. The COVID-19 pandemic meant that most NHS dentists had to

stop face to face appointments for several months and then to leave long spaces between appointments to reduce transmission of viruses between patients. This has led to national issues with access to dental services. Future updates to the dental access questions in the GP patient survey will reflect this. The 2018-2019 responses give a useful indication of dental access in the period before the changes brought in due to COVID-19 and is currently the most recent data available.

Figure 9: The percentage of NHS GP patients in the South East who attempted to obtain an NHS dental appointment and were successful[4]

Access to NHS dental services - successfully obtained a dental appointment New data 2018/19 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	389,663	94.2	94.1	94.3
South East region	–	57,702	93.9	93.7	94.2
Wokingham	–	1,071	98.1	96.4	99.0
Bracknell Forest	–	770	97.8	96.0	98.9
Windsor and Maidenhead	–	959	97.3	95.7	98.3
Oxfordshire	–	4,757	96.2	95.3	96.9
Medway	–	1,623	95.7	94.5	96.7
Buckinghamshire	–	3,226	95.6	94.5	96.5
West Berkshire	–	1,007	95.2	93.0	96.7
Hampshire	–	9,138	94.9	94.1	95.5
East Sussex	–	3,888	94.7	93.7	95.5
Surrey	–	6,919	94.3	93.5	95.0
Slough	–	898	94.2	91.7	96.1
Reading	–	1,065	93.8	91.1	95.7
West Sussex	–	5,636	93.6	92.7	94.4
Kent	–	9,376	92.6	91.8	93.2
Portsmouth	–	1,387	92.2	89.2	94.4
Southampton	–	1,694	91.8	89.4	93.7
Milton Keynes	–	1,557	90.4	88.2	92.2
Brighton and Hove	–	1,804	89.7	87.5	91.6
Isle of Wight	–	927	85.4	82.5	87.9

Note that Milton Keynes is not part of the NHSE/I South East region but is included in the South East GP survey results.

Figure 9 above, shows that the number of NHS GP patients successful in getting an NHS dental appointment in 2018/2019 were slightly higher in Hampshire than the England and the South-East average. In Portsmouth and Southampton, the

[4]https://fingertips.phe.org.uk/search/dental#page/3/gid/1/pat/6/par/E12000008/ati/102/are/E06000036/iid/92785/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

number was slightly lower than the England and the South-East average. The Isle of Wight was an ‘outlier’ in that it was statistically significantly lower than England, the South East and all other local authorities in HIoW. Again, this related to whether people are able to get an appointment, rather than whether there is enough activity commissioned.

The results in Table 5 below also come from the national NHS GP survey.

Table 5 Proportion of people who responded to the NHS GP Patient survey question “When did you last try to get an NHS dental appointment for yourself?”

CCG*	Proportion of respondents who had not tried to get an NHS dental appointment for more than two years
NHS Surrey Heartlands CCG	36%
NHS Berkshire West CCG	35%
NHS Buckinghamshire CCG	34%
NHS Frimley CCG	32%
NHS Oxfordshire CCG	32%
NHS Brighton and Hove CCG	31%
NHS West Sussex CCG	30%
NHS Kent and Medway CCG	30%
NHS Portsmouth CCG	30%
NHS Hampshire, Southampton and Isle of Wight CCG	29%
NHS East Sussex CCG	26%

*Most recent data is from Jan-Mar 21 which is reflected in the CCG area names

This suggests that only around 70% of GP patients who responded to the survey had tried to get an NHS dental appointment. The people who respond to surveys such as these tend to be those who are more likely to use health services in general, and again, this excludes people who use private GP services. The percentage of the whole population who try to get NHS dental appointments is therefore considerably lower than the 70% figure suggested by this survey but the exact figure is unknown.

Table 6 is from the same survey and outlines the reasons why people chose not to use NHS dental services. For comparison it includes Gloucestershire and South Tyneside CCGs as the highest and lowest in England in terms of people who don’t use NHS dental services because they prefer private dental services.

Table 6: Respondents who have not tried to get an NHS dental appointment in the last two years, with the reason for not trying to get the appointment [5]

CCG name	Prefer to go to a private dentist	Not needed to see a dentist	Another reason[1]
NHS GLOUCESTERSHIRE CCG[2]	35%	15%	50%
NHS SURREY HEARTLANDS CCG	34%	15%	51%
NHS BUCKINGHAMSHIRE CCG	34%	17%	49%
NHS DORSET CCG	34%	17%	49%
NHS WEST SUSSEX CCG	32%	14%	54%
NHS HAMPSHIRE, SOUTHAMPTON AND IOW CCG	31%	15%	54%
NHS BERKSHIRE WEST CCG	31%	23%	46%
NHS EAST SUSSEX CCG	30%	18%	52%
NHS OXFORDSHIRE CCG	30%	18%	52%
South East	**30%**	**18%**	52%
NHS BRIGHTON AND HOVE CCG	27%	18%	55%
NHS FRIMLEY CCG	27%	24%	49%
NHS KENT AND MEDWAY CCG	25%	21%	54%
England	**24%**	**23%**	**53%**
NHS PORTSMOUTH CCG	22%	25%	53%
NHS SOUTH TYNESIDE CCG[3]	11%	38%	51%

1. Includes not enough time, not liking going to the dentist, and smaller 'other' categories
2. Highest proportion of people preferring a private dentist in England
3. Lowest proportion of people preferring a private dentist in England

Of those who did not try to get an NHS dental appointment, 34% of people in Hampshire, Southampton and IoW CCG did not try because they prefer a private dentist. The figure in Portsmouth was 22% reflecting the lower use of private dental services in more deprived areas.

[5] https://www.england.nhs.uk/statistics/2021/07/08/gp-patient-survey-dental-statistics-january-to-march-2021-england/

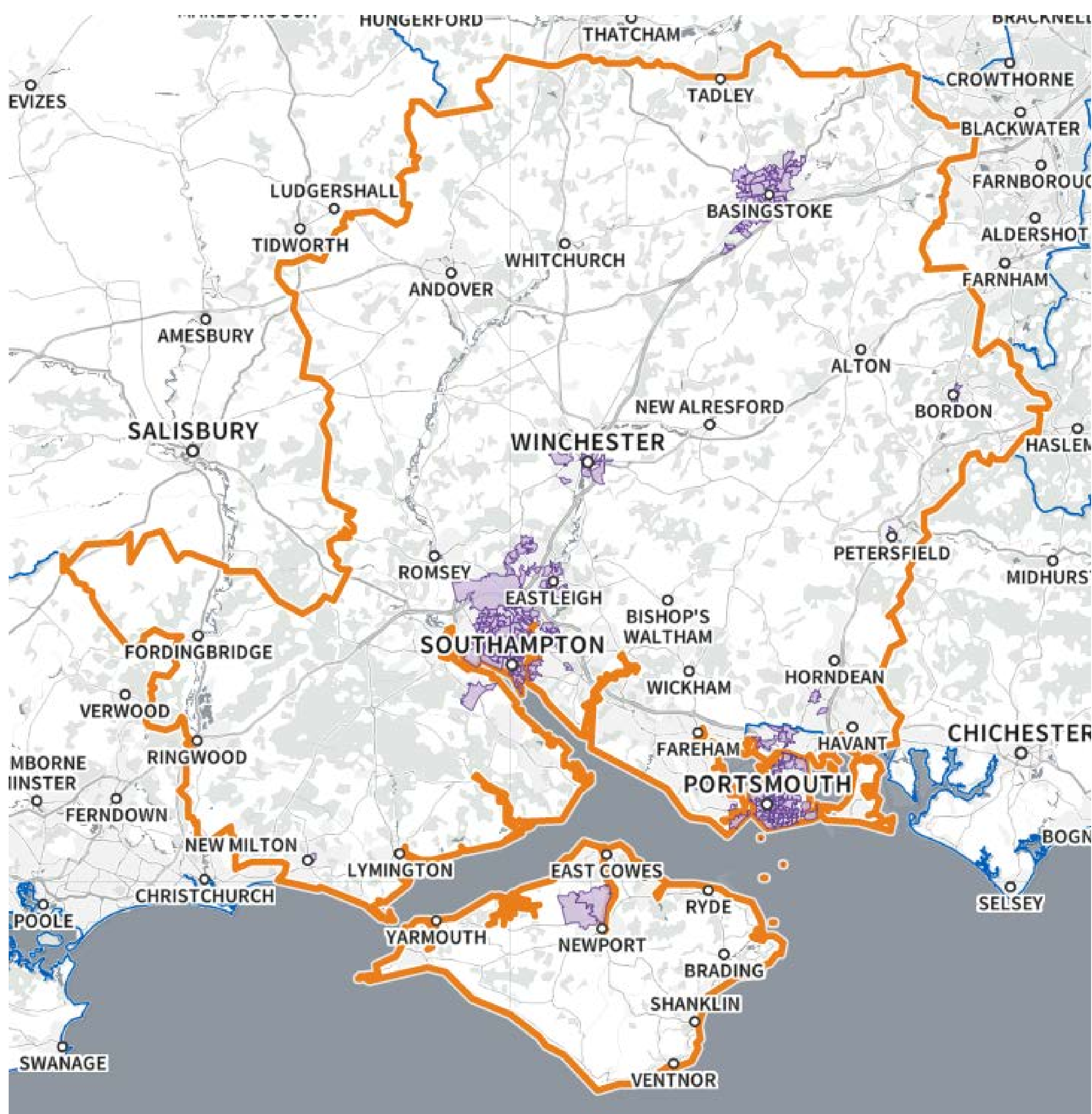
Ethnicity

There is a complex relationship between ethnicity and oral health. Ethnicity itself is a complex concept due to differences in how individuals report their own ethnicity and how information is collected/presented. People who identify as an ethnicity other than white often live in more deprived areas and deprivation is the key factor in oral health[6]. However, when the effects of deprivation are removed, some studies report that, contrary to most health inequalities, oral health was better among non-White groups[7]. This was in spite of lower use of dental services. The differences could be partially explained by reported differences in dietary sugar.

[6] https://pubmed.ncbi.nlm.nih.gov/29888400/
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4942933/

Figure 10 below uses the SHAPE tool to show all areas in HIoW with a population that falls within *lowest* 40% of people in England who identify as white. This is used to indicate that these areas have higher proportions of people of ethnicities other than ‘white’ i.e. there is more ethnic diversity in these areas. Of note is that, in addition to the greater ethnic diversity in Portsmouth and Southampton which is as expected, there are also areas of increased ethnic diversity in Winchester and Basingstoke. Again, there is a much clearer link (a ‘*stronger correlation*’) between dental disease and deprivation, and deprivation is used as the major indicator of need in this review.

Figure 10: Areas of HIoW with the largest populations who describe themselves as an ethnicity other than ‘white’



It is important to note that the use of dental services, particularly for preventive visits such as ‘check-ups’, differs amongst different cultures. Commissioning dental services is just one aspect of reducing health inequalities and local authorities have the responsibility for oral health improvement programmes. It may be necessary for local authorities and commissioners of dental services to work together to increase access for certain priority groups. An example of this is the relatively large Nepalese community in Hampshire. Research suggests that Nepalese people in England have relatively high registration with GPs, but their use of dental services is low[8]. Dental services are accessed in a different way to GPs (through regular courses of treatment with any dentist with availability, rather than through registration with a local GP). Some groups may require additional support in understanding the complexities of accessing dental services in England under the current dental regulations.

Systems can improve health and reduce inequalities

The differences in health outcomes between different groups (‘health inequalities’) are related more to social circumstances (where people are born, how they grow up, where they live and work) than to access to health services[9]. This is true of oral health as for any other area of health. Commissioners of dental services have a very specific role of ensuring the available budget allows access to services for as many people as possible, and that those most in need are more able to access the services they need. Local authorities have some responsibilities for oral health promotion and surveillance. In particular, local authorities can play a key part in ensuring any vulnerable groups they have responsibility for receive additional support in maintaining good oral health and in accessing the relevant healthcare services they need. However, there are opportunities for Integrated Care Systems to work together in improving oral health and reducing oral health inequalities. This could either be by agreeing to tackle oral health issues as part of the wider prevention programme, or by looking at the issues faced by a particular group. These priorities would need to be set by each system, or each ‘place’ (such as a local authority area).

[8] Perceptions and Experiences of Health and Social Care Utilisation of the UK-Nepali Population | SpringerLink

[9] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

‘System working’ should ideally involve:

- Commissioners of healthcare services
- Local authority public health teams; with responsibilities for oral health promotion and surveillance of their populations
- Wider local authority partners, those with responsibilities for children and vulnerable adults for example, as these are often multifactorial issues requiring multi-agency support
- Other healthcare partners (primary medical care teams, health visitors etc.) as oral health issues are often linked to other healthcare issues

Key Considerations

Based on the above, the following considerations should be taken into account when making commissioning decisions. To reinforce key points:

- although this review generally focusses on need, other considerations are important in commissioning particularly when resources such as dental workforce availability are more constrained

- whilst these considerations should inform any upcoming procurements, it is unlikely that a single procurement exercise will resolve all the issues raised in this review and these should inform the longer term aim of reducing inequalities in access to dental services across HIoW

Key considerations for commissioning
A. Considerations for the upcoming procurement of services
1. **<u>Commissioned activity (UDA's per head of population) should ideally be highest in the most deprived local authorities and lowest in the least deprived areas</u>**
2. **<u>Assigning additional funding to areas where commissioned UDAs per head of population is higher but contracts consistently do not achieve UDA targets should be avoided as this can decrease access across the system</u>**
3. **<u>Consideration should be given to where additional recurrent activity is most likely to be achieved -</u>** information about this could come from: a) Areas where large amounts of short-term (non-recurrent) activity was achieved recently – this suggests additional workforce capacity in the area. The temporary activity was based on ability to deliver and not necessarily need, even where this was in areas now identified as of greatest need, procurement legislation does not allow this to be made recurrent. The same, or greater, level of UDAs should be procured to replace the temporary activity in areas of greatest need b) Areas where large numbers of contracts have been handed back - it would be useful to understand why, and address these reasons in any procurement where possible
4. **<u>Increase contracted activity in Portsmouth</u>** a) Additional funding is required to increase recurrent commissioned activity to Portsmouth b) To ensure workforce/premises are available, it may be necessary to consider a staged approach to ensuring Portsmouth has the highest commissioned UDA per head of population c) Note that Southampton and Portsmouth are similar in terms of deprivation so commissioned UDA's per had should be broadly similar for the two d) Explore options for increasing the UDA rate dependent on guidance/regulations/ new commissioning arrangements/any changes to the dental contract etc. e) Carry out engagement with the market in Portsmouth to find out what other aspects of a contract would be attractive to bidders (likely larger contracts with higher UDA rates with broader scope for premises/locations) f) Continue to engage with stakeholders in Portsmouth on this issue, g) Collaboration with local partners (such as colleagues in primary medical care, the Portsmouth Dental Academy or community dental services) may be useful in making contracts/posts more attractive to bidders and dental professionals h) Aim to increase contracted activity in both Portsmouth North and Portsmouth South, however, being highly prescriptive about specific locations within these areas may result in no bids so location needs to be a balance between 4f and 4g above

5. **The Isle of Wight has the highest commissioned activity across the HIoW but evidence suggests dental access issues here are the most pronounced – this issue requires system working, involving all parties, and goes beyond simply commissioning additional activity:**
   Investigate and address issues of dental access/underperformance in the Isle of Wight and consider alternative models of delivery
   a) Issues of dental access are consistently reported in the Isle of Wight and these are linked to issues with recruitment and retention
   b) Addressing this will require a truly systematic approach including identifying root causes of issues and working with all stakeholders to find solutions.
   c) It would be helpful to compare the experience of dental professionals with other healthcare professionals such as primary (medical) care teams on the island
   d) Explore options for increasing the UDA rate dependent on guidance/regulations under new commissioning arrangements/any changes to the dental contract etc.
   e) The Isle of Wight has the highest UDAs commissioned per head of population in HIoW of 1.66 compared to 1.45 in Portsmouth (most deprived) and 0.97 in East Hampshire (lowest UDA per head)
   f) Unfortunately, adding more commissioned activity here before current activity is achieved is unlikely to resolve the issue as this could result in decreased access across HIoW (including where there are ferry links to the IoW) which will further compound issues on the IoW itself
   g) Dental access/workforce issues in the Isle of Wight and Portsmouth are closely linked and these issues should be viewed together (some patients and dental professionals are likely to travel between Portsmouth and the Isle of Wight so increasing access in one place could decrease access in another)
   h) As outlined in Recommendation 4, collaboration with local partners (such as colleagues in primary medical care, the Portsmouth Dental Academy and community dental services) may be useful in making contracts/posts more attractive to bidders and dental professionals
   i) Alternative models of provision (for example delivery models not based on GDS contracts) may need to be explored here

6. **Ensure Southampton maintains significantly higher UDAs per head of population than less deprived areas, and maintain currently achieved activity where possible**
   a) Southampton is the second most deprived local authority district in HIoW and although it has the second highest commissioned UDAs per head it continues to be a particular focus of concern in terms of dental access – ensure that commissioned activity is achieved wherever possible
   b) Southampton received by far the largest increase in additional short-term activity in 2019-2021 indicating additional dental workforce capacity – opportunities to continue to use this capacity should be explored in line with consideration 3 above

7. **Ensure the UDAs per head of population in Havant remains in line with its deprivation ranking**
    a) Havant has similar commissioned UDAs per head of population as the New Forest and Eastleigh but is considerably more deprived
    b) Although ensuring Portsmouth and Southampton move higher up the rankings in terms of commissioned activity is a priority, Havant should also see an increase to ensure it is more in line with deprivation

B. Longer term considerations for dental commissioning

8. **Ensure the UDAs per head of population in Havant remains in line with its deprivation ranking**
    a) Gosport has similar commissioned UDAs per head of population as the New Forest and Eastleigh but is considerably more deprived
    b) Although ensuring Portsmouth and Southampton move higher up the rankings in terms of commissioned activity is a priority, Gosport should also see an increase to ensure commissioned activity is more in line with level of need
    c) As a peninsula, Gosport is also relatively isolated in terms of transport, with a ferry required to travel to nearby Portsmouth and the 3rd highest percentage of households with no access to a car/van

9. **Review other activity Hampshire and the Isle of Wight**
    a) As a broad principle, it is difficult to justify additional recurrent activity in areas ranked over 200 nationally for IMD and with 1.20 or more recurrent UDAs per head of population according to Table 1
    b) Note that Test Valley and East Hampshire are 8th and 9th respectively in terms of deprivation but they have by far the lowest UDA valley per head of population

10. **Other models of delivery may need to be considered outside of traditional General Dental Service (GDS) Contracts**
    a) Competitive tendering for contracts remains the standard way of providing primary care dental services for the general population but other options exist
    b) Opportunities for increasing access through flexible commissioning and changes to procurement regulations should be explored
    c) Partnership/system level working could also offer opportunities to increase access
    d) Individual procurements for general dental services should be part of broader, longer term work to increase dental access across HIoW and the South East.

Considerations for partnership and system working

11. **An integrated approach to reviewing complex issues of recruitment and retention, and other possible methods of delivery, is recommended**
    a) Other parts of the system may be useful to establish what makes an area more attractive to professionals, in addition to the contractual elements

b) Some aspects of delivery, particularly for vulnerable groups, could be delivered outside of a General Dental Services contract and these should be explored c) There could be value in a more local role that crosses a number of organisations within the HIoW system to achieve this
12. **<u>A system-wide focus on wider oral health improvement beyond issues of dental access is also recommended</u>** a) Dental services are not the major factor in inequalities in oral health at the population level; local authorities in particular have opportunities (and some responsibilities) for this b) Working across the whole health and care system (for example, through Primary Care Networks) could offer real opportunities to improve oral health