General Dental Council

GDC consultation response

DHSC consultation on proposal for a ‘tie-in’ to NHS dentistry for graduate dentists

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1. About the GDC

1.1. The General Dental Council (GDC) is the UK-wide statutory professional regulator of over 122,000 members of the dental team, including around 45,000 dentists and around 78,000 dental care professionals (DCPs). In England specifically, we regulate over 35,000 dentists.

1.2. An individual must be registered with the GDC to practise dentistry in the UK. Unlike other health professional regulators, we register the whole professional team, across the four nations of the UK, including dental nurses, clinical dental technicians, dental hygienists, dental technicians, dental therapists, orthodontic therapists and dentists.

1.3. Our primary objective is to protect the public, and in doing so to:

- Protect, promote and maintain the health, safety, and well-being of the public.
- Promote and maintain public confidence in the professions regulated.
- Promote and maintain proper professional standards and conduct for members of those professions.

1.4. All patients should be confident that the treatment they receive is provided by a dental professional who is properly trained, qualified, and meets our standards. To achieve this, we register qualified dental professionals, set standards for the dental team, investigate complaints about dental professionals' fitness to practise, and work to ensure the quality of dental education.

1.5. We understand that this consultation supports delivery of the Dental Recovery Plan, which aims to improve access to NHS dental services in England for people who need it, especially in underserved parts of the country.

1.6. Dental access is relevant not only to public health, but also to public confidence in the dental profession. For example, in the GDC's most recent public research, nearly a quarter (23%) of public survey respondents reported that their confidence in the way dental care is delivered had decreased over the past year; and of those, 44% reported that this was due to access issues (e.g. not being able to get an appointment), and 12% reported that it was because there were not enough dentists.

2. How we have responded to this consultation

2.1. The GDC has no role in relation to the commissioning or provision of NHS services. We do not have powers to determine whether registrants work in the NHS or private sector, nor is it a function of our regulatory system to influence registrants' choices around where to work. For these reasons, we have not addressed the consultation questions directly.

2.2. Nevertheless, the proposal may have important implications for regulatory outcomes around patient safety and public confidence, which should be taken into account as this work progresses. Therefore, in our response we have set out the key risk considerations from a regulatory perspective, organised under the following headings:

- The risk of limitations around improvements to NHS dental access
- Risks arising from the method chosen to influence professionals' career choices.
- Risk considerations around equality, diversity and inclusion.

2.3. We would be happy to discuss these areas further with DHSC.

2.4. We note that DHSC's work appears to be at a very early stage, with the proposal containing the broad principles of the tie-in scheme, but minimal detail about how it would actually operate. It is also unclear whether any work has been done to assess the range and extent of impacts a tie-in policy would have – for example, on dental access, workforce distribution and migration, dental education, and career choices. A detailed understanding of this will be important to properly weigh up the risks and benefits of the scheme.

2.5. Consequently, the comments in our response are relatively high-level. Until more detailed proposals are developed, it will be difficult for us to develop fully formed views on tie-in arrangements and their impact on public protection.

3. Consultation response

3.1. The risk of limitations around improvements to NHS dental access

3.1.1. Widespread difficulties in accessing NHS dental care persists, posing clear risks for patients and their oral health. It is in the public interest to ensure that the NHS has the dental professionals it needs working for it, and that dental professionals choose to make their careers – in whole or in part – providing NHS care.

3.1.2 Almost all UK-trained dentists start their professional careers working in the NHS through foundation training, meaning that the key workforce challenge is not bringing dentists into the NHS, but making sure they are retained in the longer term.

3.1.3 It is unclear whether the government has undertaken any work to assess the effects of a tie-in policy on NHS dental access – in terms of workforce availability and corresponding service capacity – in England (where the tie-in would apply after graduation from an English university), as well as Scotland, Wales and Northern Ireland.

3.1.4 The GDC's 2023 working patterns data are presented below. The figures provided represent proportions of responding dentists who were working in England and who had qualified in the UK. Please see Annex A for supporting information.

3.1.5 Amongst dentists responding to the working patterns questionnaire who had qualified in the UK and reported currently working in England:

- Of those who had **qualified in the last 6 years**, 64.8% reported working fully or predominantly (at least 75% of the time spent) in NHS dental care, 21.8% reported working a mix of NHS and private dental care, and 13.5% reported working fully or predominantly (at least 75% of the time spent) in private care.
- Of those who had **qualified 7 or more years ago**, 37.7% reported working fully or predominantly (at least 75% of time spent) in NHS dental care, 19.5% reported working a mix of NHS and private dental care, and 42.8% reported working fully or predominantly (at least 75% of the time spent) in private care.

3.1.6 Amongst dentists responding to the working patterns questionnaire who had qualified in the UK and reported currently working in England:

- The proportion of responding dentists who reported working fully or predominantly (at least 75% of time spent) in NHS dental care decreased based on the number of years since qualification (from 84.1% for those 1 to 2 years since qualification, to 49.1% of those 5 to 6 years since qualification, and to 36.5% of those 11 or more years since qualification).
- The proportion of responding dentists who reported working fully or predominantly (at least 75% of time spent) in private dental care increased based on the number of years since qualification (from 4.9% of those 1 to 2 years since qualification, to 22.5% of those 5 to 6 years since qualification, and to 44.7% of those 11 or more years since qualification).

3.1.7 Amongst dentists responding to the working patterns questionnaire who had qualified in the UK and reported currently working in England:

- Of responding dentists who had **qualified in the last 6 years**, 78.6% worked for at least 30 hours per week.
- Of responding dentists who had **qualified 7 or more years ago**, 50.8% worked for at least 30 hours per week.

3.1.8 The percentages provided in sections 3.1.5 to 3.1.7 indicate that among UK qualified dentists who are earlier in their career, a higher proportion are working predominantly in the NHS and are working a higher number of hours a week, than is the case for UK qualified dentists later in their careers.

3.1.9 These findings suggest that there would be value in the government undertaking further work to measure the difference a tie-in arrangement would make to NHS dental access (in terms of workforce availability and corresponding service capacity), given the relatively high NHS commitment already demonstrated by recently graduated dentists compared to their more experienced colleagues.

3.1.10 More critically, the factors driving dentists' decisions to spend less time in the NHS (e.g. managing high NHS demand within limited capacity, frustrations with the NHS dental contract, challenges around workforce training and development – all indicated by oral evidence in the 2023 Health and Social Care Committee Inquiry into NHS Dentistry) must be understood and addressed to promote the growth of

a sustainable NHS workforce who willingly contribute to appropriate levels of NHS service delivery throughout their careers.

3.1.11 Otherwise, whilst mandating a period of NHS practice for graduate dentists may improve access challenges in the shorter term, there is a risk that the effect of the tie-in policy would be only to defer movement out of NHS practice rather than change the underlying behaviour of dentists. If the impact of the tie in period were to accelerate moving away from NHS work after the end of the period, there is a risk that the overall impact of a tie-in on the NHS workforce may be limited or even negative.

3.1.12 We therefore welcome the commitment set out in the consultation proposals to review what wider actions could be taken to make NHS dental care an attractive career choice; and we emphasise the importance of making NHS careers rewarding in a variety of ways to retention challenges.

3.1.13 Beyond the quantification of the proposed service commitment, the following factors are also relevant to the overall impact on NHS dental access:

i. The tie-in is not designed to address NHS workforce distribution issues, meaning that whilst undertaking their minimum NHS service requirement, dentists would not necessarily be working in currently underserved areas, or with underserved patient groups. This could inadvertently result in persisting or worsening NHS access inequalities across certain areas or patient groups.

ii. The NHS service capacity associated with dentists' minimum service requirement would need to be supported by the other dental professions. For example, dental nurses work with dentists to provide chairside support, and dental technicians construct dental appliances to the prescription of dentists. It is unclear how the availability of dental care professionals to work with dentists in the NHS would be coordinated or ensured.

iii. Please see our comments in section 3.1, which explain the potential risk of more dentists leaving or committing less time to the NHS after fulfilling the tie-in requirement, meaning longer term workforce retention issues may continue.

iv. There may be a risk that tie-in arrangements in England have a negative effect on NHS dental access in Scotland, Wales and Northern Ireland. This is because people who study dentistry in England would have to fulfil the minimum service requirement in England, even if they would otherwise have gone to work in another UK nation soon after graduation. This effect may be compounded if recent dentist graduates of universities in Scotland, Wales and Northern Ireland opt to work in England, rather than elsewhere in the UK (for example, if some dentists' preferred job opportunities are in England).

3.2. Risks arising from the method chosen to influence professionals' career choices

3.2.1 The proposed tie-in approach poses the risk of wider unintended behavioural effects, as explained below.

3.2.2 Particularly in the context of challenges experienced by the NHS dental workforce (as indicated by the findings of the 2023 Health and Social Care Committee Inquiry into NHS Dentistry), dentists may feel a mandatory tie-in scheme to be punitive if it does not come with any particular support mechanisms or additional benefits to improve their experience of working in the NHS, or to be unfair in being uniquely imposed on dentists. In addition, dentists may perceive that the need to restrict their freedom of choice around where to work is evidence or acceptance that working in the NHS is not as desirable as working in the private sector.

3.2.3 These factors may lead to:

i. Increased stress and reduced morale amongst NHS dentists, the behavioural consequences of which may have implications for the quality and safety of patient care, as well as professional wellbeing.

ii. [We flag here that although the Government has stated that the morale and wellbeing of the dental workforce is of utmost priority, the proposal could potentially work against this.]

iii. More dentists choosing to leave or commit less time to NHS dentistry once they have fulfilled the minimum service requirement – potentially at an accelerated rate - countering efforts to retain dentists in the NHS in the long term.

iv. Prospective dental students choosing to train in universities outside of England (in other UK nations or abroad) to avoid being subject to the tie-in scheme.

3.2.4 To avoid these types of unintended effects, it may be much more advantageous to strengthen and rely upon dentists' professional commitment and provide positive incentives for working in the NHS, rather than making NHS work mandatory. This would support the growth of a sustainable workforce with high morale – promoting ongoing benefits towards registrant wellbeing, patient safety, dental access and public confidence in NHS dentists.

3.2.5 To do this, the government, working with wider sectoral stakeholders, would need to address the reasons behind dentists' decisions to dedicate less time to the NHS – for instance, through contract reform, opportunities for career progression, appropriate support for patients with vulnerabilities or complex needs, and other sorts of positive incentives.

3.2.6 Improving NHS retention beyond any tie-in period can be achieved only by increasing the attractiveness of NHS work for dental professionals, compared with the other choices open to them. That would also align with regulatory approaches which trust registrants to use their professional judgement in decision-making.

3.3. Risk considerations around equality, diversity and inclusion

3.3.1 The proposal suggests that graduate dentists would be expected to repay some or all of the public funding invested in their training if they did not fulfil the minimum NHS service requirement. We note that some individuals or groups of dentists, including those with certain protected characteristics, may be disproportionately affected by barriers to fulfilling that requirement – for example, dentists with disabilities or health issues, dentists with caring responsibilities, and dentists who are pregnant or on parental leave. It would be important to ensure that there is flexibility in arrangements to support such groups and ensure they are not inappropriately or disproportionately penalised.

3.3.2 Please see our comments at section 3.1.13.i, which mention the risk of inadvertently reinforcing NHS access inequalities if workforce distribution issues are not addressed.

18 July 2024

Annex A

The GDC dentists' working patterns data was collected via 10 questions added to the annual renewal process for dentists in December 2023.

The information presented in this consultation response relates to responses from dentists who:

- completed the working patterns questionnaire and reported that they worked in England exclusively or in combination with other locations (in combination with Wales, Scotland, Northern Ireland or outside the UK), and
- qualified in the UK.

For information on type of dental care provided (sections 3.1.5 and 3.1.6), percentages exclude dentists that responded: 'I don't know', 'Not applicable', or 'Prefer not to say'.

For information on working hours (section 3.1.7), percentages exclude dentists that responded, 'Prefer not to say'.

'Time since qualification' is shown in years. Working patterns data was collected in 2023. One year since qualification means that the dentist qualified in 2023, two years since qualification means that the dentist qualified in 2022, three years since qualification means that the dentist qualified in 2021, and so on.

The analysis which the statistical information in sections 3.2.4 - 3.2.6 has been drawn from can be provided on request.

We note that the working patterns data in this consultation response represents a snapshot in time.