Date published: 11 January, 2023
Date last updated: 16 January, 2023

Building dental teams: Supporting the use of skill mix in NHS general dental practice – long guidance

Publication (/publication)

Content

This guidance provides information to dental teams about the use of skill mix in NHS General Dental Practice. Drawing on guidance and advice from professional regulators and bodies, research evidence, engagement with the profession, and practice-based case-studies, it seeks to clarify the regulatory position on dental therapists and dental hygienists providing direct access to patient care within NHS primary dental services.

This guidance:

- confirms that registrants working within the professional scope of practice specified by the General Dental Council can provide NHS care if they are qualified, competent and indemnified to do so.
- sets out the administrative changes that have been made to facilitate dental care professionals recording their contributions to a shared course of treatment, and enabling dental therapists and dental hygienists to open and close a course of treatment when care is provided directly; changes to the FP17 claim form are summarised.
- discusses potential business models that promote the use of skill mix and effective team working.
- confirms that the requirements on indemnity within NHS primary dental services are unchanged by the administrative changes to FP17 forms.

- offers a brief overview of the mechanisms for the supply and administration of medicines by dental care professionals is also discussed, with signposting to additional resources.

Introduction

> “It’s tough being a dentist… you’re on your own; the more we can do, working with therapists… it’s life changing. It makes things so much easier. I think the more we can get people working in this way, the better we’ll all be”.
>
> Dentist, practice owner and NHS contract holder.

There are many pressures on dentists when providing NHS care in general dental practices. As well as focusing on the technical aspects of the clinical activity while navigating patients’ expectations and working to deliver a contract, many dentists are also managing businesses and overseeing human resources arrangements.

In this context, maximising the potential of the wider dental team, particularly through working with dental care professionals (DCPs), has the potential to:

- facilitate delivery of safe, effective, and timely care to a diverse patient population (Macey et al 2015 (https://journals.sagepub.com/doi/10.1177/0022034514567335), Evans et al 2007 (https://www.nature.com/articles/bdj.2007.1111))
- reduce patient wait times by increasing flexibility in care provision
- contribute to efficient contract performance
- enhance working conditions through workload distribution
- improve recruitment and retention in dental teams
- boost workforce wellbeing through team working
- support professional development.

Evidence also shows that delegating diagnostic and treatment work to dental therapists (DTs) and/or dental hygienists (DHs) is positively experienced by patients (Dyer et al 2013 (https://www.nature.com/articles/sj.bdj.2013.275), Sun et al 2010 (https://www.nature.com/articles/sj.bdj.2010.209)). Feedback from practices also suggests that patients have positive experiences when they receive care from dental nurses (DNs) undertaking extended duties.

Dental team working is not a new concept in general dental practice, especially within private practice. It is also extremely common in other healthcare settings and is the dominant model within general medical practice.

However, we recognise that, to date, there have been administrative barriers and misunderstandings about the contractual framework which have seen variable integration of DCPs into the general dental practice team within the NHS.

This document provides guidance for dentists, contract holders, and dental care professionals who wish to explore, implement, or further develop a multidisciplinary way of working.

It is based on research evidence and discussions with dentists and DCPs in focus groups and follow up conversations; it also draws on standards and guidance from independent professional bodies and the professional regulator.

Scope of practice

The General Dental Council (GDC) determines the scope of practice (https://www.gdc-uk.org/standards-guidance/standards-and-guidance/scope-of-practice) that each registrant group within a dental team can work within.

It describes the skills and abilities associated with different roles, though it is not a list of tasks that someone performing that job ought to or must undertake. Rather, it provides boundaries for professional practice in different roles.

The GDC clearly outlines that the scope of practice is evolutionary for individual registrants, since it may change over the course of a person's career, for example because of changes in dental technology or because of development of skills and further training.

Consequently, regardless of whether a task is within the scope of practice for a role, people should only perform that task or make a treatment decision if they are trained, competent and indemnified to do so.

This means that although the 'general' scope of practice for a registrant group is the same, the scope of an individual's practice will be determined by the:

- training they have undertaken
- experience they have had
- confidence levels
- work they are indemnified for.

No-one should be made to undertake work or make decisions outside the scope of practice of their role, competence, and confidence; this is likely to vary between DCPs. The GDC scope of practice guidelines is available on the GDC website (https://www.gdc-uk.org/standards-guidance/standards-and-guidance/scope-of-practice).

Some DCPs, particularly those working as dental therapists, told us that the scope of practice of DCPs is not well understood and/or used by dentists. Research also suggests that awareness of the dental therapist role in particular is low (Dyer T et al 2010 (https://www.nature.com/articles/sj.bdj.2010.1)).

Information about DCP roles can be found on The British Association of Dental Therapists website (https://badt.org.uk/), and the website of The British Society of Dental Hygiene and Therapy (https://www.bsdht.org.uk/), where downloadable communication resources (https://www.bsdht.org.uk/downloadable-resources/) can also be found, among other sources.

In our conversations with DTs, DHs and dentists, we were told that it was common for DTs and DHs, especially those who are newly qualified, to start by providing treatment under the prescription of a dentist.

In private practice, DTs and DHs have started to incorporate independent working over time, offering direct access to patients, alongside continuing to treat under a dentist's prescription and treatment plan. We anticipate that this approach will be common within NHS general dentist practice, even if DCPs do begin to offer direct access.

We also spoke to DTs and DHs who had built up to working to their full scope of practice over time. Importantly, the individual's scope of practice must always remain within the scope of practice for their professional role, but will be influenced by multiple factors, such as the initial training programme they have completed, the level of supervision and support they have been given, the opportunities for experience they have received, and their areas of interest and individual skillset.

Consequently, how long it takes for a DCP to work to their full scope – and what this includes – varies between clinicians and between practices. In focus groups we heard that some DTs contribute to care within the dental practice by treating a lot of children; others treat many elderly patients; others treat particularly high needs patients; others a mixed portfolio (Sun, N. and Harris, R.V. 2011 (https://doi.org/10.1038/sj.bdj.2011.624)).

These roles were shaped by the needs of the practice population as well as the range of skills and interests of the DTs involved and the historic misunderstanding of how their roles fitted within NHS-provided primary care settings. The time it took to develop into these different roles also varies.

DTs, DHs and dental nurses also told us that being able to exercise a full range of clinical skills within their areas of competency and scope of practice was important for job satisfaction and may contribute to their retention in the NHS workforce.

The dentists we spoke to reported high levels of satisfaction in the quality of work undertaken by DTs and DHs. Some dentists told us that DCPs fulfilled a needed clinical niche role within their practice, for example in the type of treatments they excelled in delivering or working with patient groups, such as children.

Patient satisfaction was also reported to be high, particularly when patients could see and hear dentists talking positively about the treatment and care DCPs provide.

Implementation in dental practice

As with all professionals working in clinical environments, DCPs will have varying levels of ability and confidence in their own knowledge and skills.

Inevitably, this will lead to variation in what the DCP role looks like in different practices. It is also likely to vary over time through professional development and gaining more experience.

DCPs should be supported to work within their scope of practice in a way that enables them to use their training and advance their knowledge and skills.

Everyone in the dental team should have an understanding about the scope of practice for each role; people undertaking clinical leadership within practices should also have a good understanding of the ways in which individual DCPs want to operate within their scope and how they may wish to develop over time.

This will enable DCPs to undertake the work that they are trained, competent, and indemnified to do and ensure an appropriate case-mix across the dental team. DCPs should never be asked to undertake work or make treatment decisions outside the GDC scope of practice, and outside the competency and confidence of the individual clinician.

Many teams who have successfully implemented a skills-mix approach have instituted regular and frequent opportunities for discussion, especially through team and one-to-one meetings.

Additionally, existing advice suggests that developing practice treatment protocols with the clinical team can be valuable, as this allows for standardisation of treatments (where appropriate) and creates a shared expectation between different members of the team (Powell and McColl 2022 (https://doi.org/10.1038/s41415-022-4541-y)).

Patient education may help ensure that everyone has clarity about the DCP roles, how they differ to the role of the dentist, and what treatment and care can be undertaken by each member of the team. The downloadable resources from the British Society of Dental Hygiene and Therapy (BSDHT) (https://www.bsdht.org.uk/downloadable-resources/) are a helpful resource.

DCPs in dental practice examples

- Dental therapist – built up their therapist portfolio over several years. Their interest in treating children and dental-anxious patients resulted in them taking a key role providing care for these patients within the dental practice team.
- Dental therapist – felt confident at treating patients and working to their full scope of practice as soon as they qualified. When he joined his first practice, he communicated the desire to work to his full scope.
    - Together, he and the principal dentist came up with a plan to ensure he got the experience necessary for everyone in the team to feel confident in his ability to perform the DCP role to the full scope of practice.
    - He started by undertaking hygiene work and accepting referrals for therapy work from dentists in the practice. Once the wider team were confident in his skills, they felt more comfortable in referring more patients to him.
    - He now works to his full scope as a dental therapist across two practices.
- Dental nurse – has undertaken various training courses while working in practice over several years. Further certifications include the application of fluoride varnish and impression taking, in addition to qualifications in oral health education and radiography.

- Her role in the practice changed after qualifying, and she started performing extended duties with a wide cohort of patients, under the prescription and treatment plan of a dentist. She then became a tutor on a training programme for dental nurses performing extended duties, including supervising students, and also qualified dental nurses who run their own prevention clinics.

Shared and collaborative working and direct access

> "I could not work – certainly as an NHS dentist – without a therapist. I wouldn't go back to working on my own… I like the multidisciplinary approach to dentistry."
>
> Dentist, practice owner and NHS contract holder.

Collaborative working, especially through a shared care model, is a common approach to patient treatment planning and delivery in general dental practice.

Typically, this involves dentists performing initial clinical assessment of patients, devising and writing a treatment plan, and then delegating appropriate treatment activity to DCPs who then undertake clinical work under the prescription of the dentist.

Prior to 2013, 'shared care' was the only permitted model. However, in 2013 the GDC introduced changes that allowed DCPs to work to their full scope of practice without the patient needing to see a dentist first (with the exception of tooth whitening, which still requires this to be undertaken under prescription of a dentist) – a model known as direct access.

Direct access to care from a DT or DH is now commonplace within private practice, including mixed economy private and NHS practices. Direct access operates in various ways depending on practice size, income source (NHS contract versus private provision), patient population, dental team personnel and team composition.

Operating models have different benefits and there is no singular ideal model for implementing direct access and shared care approaches.

Until October 2022, it was commonly accepted that direct access was only possible for privately provided care. This was because there was a widespread misunderstanding that an NHS course of treatment could only be opened and closed by a dentist on the NHS performer list, precluding direct access to dental therapy and dental hygiene work by a DCP.

As part of 2022/2023 NHS dental contract reform, NHS England sought clarity on the effects of the GDC's legal and guidance framework, worked with the Department of Health and Social Care (DHSC) to review the Regulations, and obtained legal advice to clarify legal and regulatory positions about Direct Access for DCPs within NHS primary dental services.

NHS England is satisfied that DTs and DHs can provide direct access to NHS care, where that care is within the GDC scope of practice, if they are qualified, competent and indemnified to do so.

It is acknowledged that administrative barriers made this challenging, practically. Consequently, proposals to update the FP17 were recommended to remove these barriers, following engagement through the contract reform programme, set out below.

To note, these changes to the FP17 do not allow DNs to provide direct access through opening and closing a course of treatment. This is because all NHS banded courses of treatment require a clinical examination, which falls outside the GDC scope of practice for dental nurses, including those with additional training and extended duties.

DCPs in dental practice examples

- A large, mixed NHS-Private practice, employing several DCPs.
    - Private appointments with DTs and DHs are available under direct access for adult patients who have previously been seen by a dentist and who are returning for routine check-ups, or for ongoing periodontal disease treatment and management.
    - New patients and those being treated under NHS provision are always seen by a dentist, who then refer patients to DCPs as appropriate.
    - Reported benefits of the private model used in this practice includes increasing access and reducing waiting times for patients, effective caseload management for dentists, and a

varied case-mix for dental therapists and dental hygienists.
    - Extending direct access for NHS patients in this practice will further increase the flexibility with which the practice provides care.
- A small, mixed NHS-Private practice with a stable dental team, employing one part-time dental therapist who has worked at the practice for several years.
    - When the DT joined the practice team, as a period of preceptorship, initial appointments with new adult patients were shared appointments. The DT and the dentist collaborated to examine patients together and agree necessary treatment.
    - When required treatment was under the scope of the therapist, the dentist prepared a written treatment plan and the DCP worked under his prescription. This approach enabled the DT to develop a relationship with patients at first consultation and facilitated timely delegation of appropriate cases from the dentist to the DCP.
    - Being involved in examination and treatment planning with the principal dentist helped develop the DCP's clinical skills. This has given him confidence to work to his full scope of practice providing direct access for non-NHS patients.
- Private-only direct access clinic with most care, including clinical examination, being delivered by dental therapists and dental hygienists.
    - Patients requiring examination and treatment outside DCP scope of practice are referred to dentists at the sister practice. Both practices are owned, managed, and overseen by the same principal dentist, facilitating effective integration of care across both sites.
    - Benefits for patients include easy access for routine care and hygiene treatment with timely referral and access to additional dental care, when necessary.

Changes to the FP17 Form

Implementation of the first phase of FP17 changes began in October 2022. Before this, if DCPs contributed to providing NHS dental care, there was no mechanism for recording their contribution within NHS contract performance data; only a personal identifier number for dentists (performer ID) was recorded.

From October 2022, where delegation of part of a CoT occurs, the contribution of the DCP to that treatment should be recorded accordingly. The data field should be used to record the clinician/s who have provided one or more components of treatment for the patient (eg dentists, DTs, DHs and DNs if they are performing extended duties).

Other dental staff, for example dental nurses providing chairside assistance, should not be recorded here. Further guidance can be found on the NHS Business Services Authority website (https://www.nhsbsa.nhs.uk/fp17-and-fp17o-changes-1-october-2022).

Dentist-only personal identifiers on pre-October 2022 FP17 forms also acted as a barrier to DCPs providing direct access in the same way as is provided in private practices because they could not claim this activity against NHS contracts.

October 2022 amendments now support the ability of DCPs to open and close a course of treatment, by allowing input of the DCP's role and their GDC number onto the FP17 for the first time.

Until additional proposed changes are finalised and completed, a dentist's 'performer ID' (the performer ID is a number that is issued and used by Compass, the NHS dental contract management system. It is the number that identifies the performer on an FP17. It is not directly related to the performers list. However, a dentist will need to be on the performers list to get a performer ID number in Compass. It is separate from the dentist's number on the GDC register) will still be required on the FP17, separately to the DCP's GDC number, even if DTs or DHs have completed all the CoT.

When all treatment is provided by a DT or DH directly, practices may agree that to fulfil this requirement, the contract holder's Performer ID is input onto the form.

When contract holders do not have a Performer ID, the practice will need to agree a suitable approach.

Offering direct access in NHS primary dental care

As in private practice, offering direct access is not a requirement of being a dental therapist or a dental hygienist. Indeed, the GDC, the BSDHT and The British Association of Dental Therapists (BADT) consider it good practice for newly qualified DCPs to work according to the treatment plan provided by a dentist while they build up their experience and confidence.

Such a period of preceptorship would provide a structured transition from being newly qualified to being an established practitioner and may contribute to higher levels of confidence in offering direct access.

A similar period of preceptorship might also be helpful for DCPs who are interested in building up their dental therapy caseload if they trained before 2002 or have focused primarily on working within the remit of a dental hygienist (British Association of Dental Therapists 2022 (https://badt.org.uk/faq)).

The October 2022 clarifications provide assurance that DCPs can provide direct access to treatment within their scope of practice; it does not mean that they must do so.

It is for individuals and practice owners to work together to find an approach that works within their practice. However, we anticipate that many DCPs and dentists will welcome the opportunity for DTs and DHs to provide direct access to patients receiving NHS care.

DCPs in dental practice examples

- A large NHS-private practice offering an urgent care service for the local area.
    - DCPs triage private patients requiring urgent care, temporise or treat when appropriate, and refer to a dentist for a comprehensive treatment plan when necessary.
    - Direct access will enable DCPs to offer this service to NHS patients requiring urgent care.Community health services

Implementation in dental practice

There are many ways in which work can be assigned to and shared between members of the dental team. It is important to note that shared care approaches and direct access are not mutually exclusive and can complement one another, both within a practice or during a single course of treatment.

When treatment is being delegated to DCPs, advice suggests that the role of the DCP should be explained to patients, alongside what aspects of the treatment plan they will be performing (Powell M and McColl E 2022

(https://doi.org/10.1038/s41415-022-4541-y)). Evidence suggests this increases patient confidence in DCPs, especially when patient care is being shared (Dyer T et al 2010 (https://doi.org/10.1038/sj.bdj.2010.1)).

In our discussions, both dentists and DCPs reported that having good communication was essential to making dental team work as effective as possible, regardless of the approach to caseload management and patient access arrangements.

Having clear referral arrangements and procedures in place between dentists and DCPs was described as a vital component in enabling seamless care for patients, ensuring that everyone works within their scope of practice, and everyone has a suitable case-mix and support.

Developing a delegation model in an iterative way can optimise how care is provided within the context of that practice and considering the skills mix of that dental workforce and their patient population.

Dental therapists and dental hygienists offering direct access can provide comprehensive patient examinations within their scope of practice.

However, there will be occasions when patients require examinations and treatments which fall outside the DCP scope of practice – for example, orthodontics, endodontics, and prosthodontics. DCPs would then use their professional judgement to refer the patient to a dentist, when indicated.

This mirrors existing professional conduct in both NHS and private dental practice, where referral is commonplace between dental practice members (eg DTs to dentists) and to other health services (eg onward referral from dentists in general dental practice to oral surgery services). This is consistent with a shared care model where more than one professional contributes to a course of treatment.

Many DCPs and dentists we spoke to preferred to operate using a mix of referrals from dentists and direct access. This was considered beneficial, not only for patient outcomes but also for team dynamics.

People told us that a dental team approach to care facilitates professional accountability, alongside fulfilling a safety-netting function for all professionals. Moreover, several dentists described dentistry as a profession where isolation, and sometimes loneliness, are commonplace (Plessas A 2021 (https://www.gdc-uk.org/docs/default-source/research/mental-health-and-wellbeing-in-dentistry27973e06-eb0f-4ee2-b92f-7fee3d2baf5b.pdf)).

They highlighted how collaborative working, especially with DCPs, can help to overcome some of the challenges associated with solitary working. Some practice owners also said that being able to share a caseload with a DCP contributed to a good work-life balance.

> “Removing the requirement for my patients to see a dentist first for an examination before undergoing active periodontal therapy, supportive periodontal maintenance and palliative periodontal maintenance will save both patient and NHS clinical time and allow patients to see an appropriate clinician without referral in line with current practice outside the NHS in Dentistry.”
>
> Dental Hygienist, working in a mixed-economy practice.

Operational factors

Business models

There are different approaches to operationalising dental team working and each practice has the autonomy to determine which approach would work best within their practice and wider social context.

However, in our discussions, the following approach (Model A) was described as working effectively in facilitating the development of a well-functioning team, where a range of skills were used collaboratively.

An additional approach (Model B) is highlighted to demonstrate how other practices have organised work across the dental team.

There is scope for variability within each model, some options are highlighted below; this is not an exhaustive description of options.

Model A: DCPs as a practice resource

> “I have a therapist I pay for, and she is employed in my NHS practice… it’s like a complementary service [for the associates].”

Principal dentist and practice owner.

This approach values DCPs as a practice resource, with their payment being funded as a practice expense. Associates are not charged directly for each referral they make to DCPs.

This approach has been implemented by practices to promote shared care and collaborative working between members of the dental team.

Feedback from both private and NHS practices which have transitioned to this model from the ‘paid per referral’ approach, suggest that it has reduced competition and fostered greater co-operation between team members; has enabled greater access for, and throughput, of patients; and contributes to efficient whole-practice caseload management.

Practice owners report that this approach reduces complexity associated with dividing performance-related remuneration methods (ie splitting UDAs between team members, or paying per number of patients seen) and therefore reduces rivalry between Associates and DCPs.

A Model A approach does not preclude DCPs working towards UDA or patient throughput targets but separates targets from payment mechanisms. This is particularly useful when DCPs specialise in treating people who may require longer treatment times, such as patients with severe dental anxiety, or additional behaviour management needs.

Model B: DCPs paid per referral

Practices using this model typically have DCPs working in the practice, but their pay is related to the referrals they receive from dentists or from direct access appointments in private practice.

Direct access payments are paid directly to DCPs, and dentists pay for the DCP’s time whenever they refer a patient for some or all of a required treatment.

Some DCPs charge an hourly rate to dentists regardless of the treatment needed, while others prefer to split the UDAs associated with a course of treatment or charge a fee associated with the treatment provided.

This arrangement seems to be common for DCPs primarily undertaking work within the remit of a dental hygienist.

For DCPs offering direct access in private practice, this model can work well in maximising income because they are remunerated for the work they do; the more patients they see, the higher their level of income.

However, this approach can involve a greater level of risk for DCPs because available work can be limited by the patient population and the scope of practice that the DCP is operating to.

Moreover, in NHS practices, Model B income is predominantly reliant on dentists referring patients to DCPs and a DCP's caseload is often determined by dentists' preferences regarding which treatments they like to deliver.

For example, we spoke to dentists who referred the treatment of all children to the dental therapist in their practice. In these cases, DCPs operate in a role that is focused on a particular type of activity or with a targeted group. When this is mutually agreed, this arrangement can work well.

> "I have been a practice owner for over ten years… I've always worked with a therapist. I can't remember the last time I did a filling!"
>
> Principal dentist and practice owner.

However, we have also been told that associate dentists can be reticent to refer patients to DCPs when they have to pay for their time directly, preferring to undertake treatments themselves to avoid shared allocation of UDAs.

In private practice, this can lead to siloed working; and in NHS practices, it can result in the underuse of DCPs' skills.

Given the complexities of this approach, many practice owners we spoke to have moved away from Model B towards Model A payment methods.

Liability

The administrative changes enabling DCPs to open and close a course of treatment delivered as part of NHS contracts do not alter existing liability arrangements.

Clinicians should continue to ensure that they are appropriately indemnified for the scope of practice they are operating within. Contract holders should also continue to ensure that they have sufficient indemnity in place as dental care providers.

The GDC states (https://www.gdc-uk.org/standards-guidance/standards-and-guidance/direct-access) that where a course of treatment is delivered by a DCP only, that registrant is responsible for the care that they provide. Where care is delegated to them by a dentist, that dentist maintains overall responsibility for the course of treatment.

Additionally, when a dental practice holds an NHS contract, they agree to take responsibility for delivery of that contract, including the quality of care delivered to fulfil their contractual obligations.

Although it is possible, and commonplace, to delegate the actual performance of tasks to a third party (eg associate dentists), the liability for the satisfactory performance of that duty is non-delegable. That is, the duty of care cannot be transferred.

This means that it is the contract holder who maintains overall responsibility for the quality and safety of care delivered under the contract, even when other professionals undertake care delivery on behalf of the contract holder.

Should adverse outcomes occur, contract holders can be held vicariously liable for the work they delegate to others, if this is substandard, unsafe, or negligent.

This is true regardless of which third parties provides treatment – including DCPs– and is unaffected by a third party's employment status.

Supply and administration of medicines by DCPs

Dentists remain the only members of the dental team who can carry out the full range of dental treatments and supply and administer a full range of prescription-only medicines (POMs), including local anaesthesia.

NHS England and DHSC, in collaboration with BSDHT and BADT, are reviewing the Human Medicines Regulations 2012, regarding DTs and DHs supplying and administering certain medicines within their clinical practice and professional competence.

Until further notice, however, POM can only be administered by DCPs under two mechanisms:

1. Patient specific directions

These are typically provided when dentists produce a written treatment plan for patients, including the prescribing of medicines; DCPs can then administer the prescribed medicine once treatment has been delegated to them.

Where DCPs accept referrals and provide care under the prescription of a dentist, we do not anticipate existing medication prescribing arrangements changing.

This remains the only route for DNs with extended duties, who are certified in application of fluoride varnish. This is because they are not listed under the types of healthcare staff who can work under Patient Group Directions (https://www.gov.uk/government/publications/patient-group-directions-pgds/patient-group-directions-who-can-use-them).

2. Patient group directions (PGDs)

These are written instructions for the supply or administration of named medicines by named professionals, for groups of patients, under stated circumstances.

PGDs have been utilised to enable direct access for DCPs. Only DHs and DTs can work under PGDs.

Schedule 19 of the Human Medicines Regulations 2012 lists medicines that anyone can administer in an emergency – these include adrenaline which must be held within all dental practices.

Guidance on developing a PGD can be found on the National Institute for Health and Care Excellence (NICE) website (https://www.nice.org.uk/guidance/mpg2), or at the NHS Specialist Pharmacy Service (NHS SPS) (https://www.sps.nhs.uk/home/guidance/patient-group-directions/).

Summary and next steps

Dental team working where skill mix is widely used has been shown to be beneficial for individual clinicians, teams, practice owners and patients.

Within primary dental care, there is both research and practice-based evidence about the clinical effectiveness, safety, and acceptability of using DTs and DHs to provide preventative and diagnostic care to patients, alongside performing a range of treatments to both adults and children.

Practice owners told us that working with DTs, especially those who offer direct access care, is economical, increases patient access, and promotes efficient division of labour across the dental team.

There are many examples of DCPs being integrated into dental practice teams within private, NHS, and mixed-economy NHS-private practices.

However, some of the greatest benefits and flexibility in terms of skill mix have been in private dental practice where, since 2013, DCPs have been able to work privately to their full scope of practice, providing direct access to patients without people needing to see a dentist first.

Until October 2022, administrative processes have created a barrier to NHS dental teams maximising the full potential of DCPs. Changes delivered as part of NHS dental contract reform have altered the FP17 to enable DCPs to record their contribution to providing NHS care, including to open and close a course of treatment under NHS contract arrangements.

While DTs first started to become an important part of the dental workforce several decades ago, it took many years before they were permitted to work in general dental practice, and currently the use of their skills has been relatively limited in this setting.

NHS England is keen to ensure that NHS practices and staff working in these teams are supported to have the same flexibility in the use of their skills as is possible in private practice.

This guidance and the associated FP17 changes represent an important step in realising the ambition to fully capitalise on the wide range of skills available in the dental workforce.

We recognise that there is more to be done. NHS England remains committed to exploring opportunities for change and continuous improvement, and we will continue to work with the sector to build on this progress over the coming months.

> “I think this could be really exciting for therapists working within the NHS. I think it’s going to be significant for improving access, especially for prevention and for the care of children.”
>
> Dental therapist, working in a hybrid NHS-private practice.

Date published: 11 January, 2023
Date last updated: 16 January, 2023

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