The Faculty of Dental Surgery Manifesto, May 2024

Introduction

The Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh was established in 1982 to promote excellence in oral health through education, examination and engagement. Today, we have over 8,000 Members and Fellows in over 100 countries, helping improve dental care throughout the world.

Waiting lists and waiting times are increasing in dentistry just as in other parts of the NHS. In 2022 the BBC reported that nine out of ten dental practices were not accepting new adult NHS patients and eight out of ten not accepting new child NHS patients.[1] This means that 1 in 5 Britons (22%) are currently not "registered" with a dentist[2] and 1 in 10 (10%) have admitted to attempting their own dental work[3]. Dental problems are also the most likely reason for children to be hospitalised.

Adding to this, NHS dentistry has significant difficulties with staff recruitment and retention with stress and burnout increasingly common with 87% stating they have experienced symptoms of stress, burnout or other mental health problems.[4]

Whilst there have been a number of positive developments, such as the NHS England Dental Recovery Plan and plans to further restrict smoking and vaping, significant problems remain. The General Election therefore provides an opportunity to focus on improving dental health and helping create a more resilient and sustainable dental workforce.

Reform the Dental Contract

The current NHS dental contract, introduced in 2006, sees dental providers agree to complete a set amount of dental activity per year, measured in units of dental activity (UDAs). Whilst this means that the NHS can 'claw back' money from dental practices that under-deliver on their number of UDAs, there is little scope for dental providers that have capacity and time to provide more NHS care. This is why some patients are told their dentist cannot see them for an NHS appointment but can see them as private patients.

Whilst legislation was introduced in May 2023 that allows the NHS to permanently and unilaterally change a dental contract where a dental practice fails to deliver its contracted activity over three consecutive "non-COVID-19 years", many dental practices continue to reduce their NHS commitments. This is largely because UDAs disincentive practices from seeing new patients and does not

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[1] BBC News, *"Dentists to get cash incentives for NHS patients,"* 6 February 2022. (available online at https://ww.bbc.co.uk/news/uk-politics-68171168#:~:text=The%20state%20of%20NHS%20dentistry,for%20treatment%20on%20the%20NHS)

[2] Health and Social Care Committee, "*NHS dentistry; Ninth Report of Session 2022–23"*, 14 July 2023 (available online at https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html)

[3] Ibid.

[4] BDA, "Nearly half of dentists severing ties with NHS as government fails to move forward on reform", 24 May 2022 (available online at https://www.bda.org/media-centre/nearly-half-of-dentists-severing-ties-with-nhs-as-government-fails-to-move-forward-on-reform/)

acknowledge the longer time it takes to treat those NHS patients with complex problems. It also does not reward dentists who provide training nor encourage dentists to provide preventative services.

We are therefore calling for:-

- the dental contract to be reformed.
- the UDA should be on a per-head basis rather than "per unit of dental activity" in order to better allocate payments to practices with the greatest patient need.
- UDAs to include incentives to promote preventative measures.
- the estimated £400m underspend in primary dentistry be ringfenced past 2024 and directly recycled back into dental services.

Better Workforce Planning and Recruitment

The UK has the lowest per capita spending (inclusive of public and private) on oral health care[5] and oral health workforce ratio in the G7[6]. Further, the UK has a relatively low number of dentists per head of population compared to France, Italy, and Germany, with England having the lowest number of NHS dentists per head of population in the UK.[7]

Whilst the Government states that the number of NHS dentists has increased over the past year, numbers have actually gone down over the past three years. Fewer dentists are joining the GDC register than a decade ago.[8]

Moreover, headcount alone does not reflect how much NHS work dentists are undertaking or the fact that the lack of dentists undertaking NHS work is the main driver behind both lack of access to appointments for patients, and the underspend in primary care dentistry.

As the UK requires a significant increase in the number of NHS dentists, we are calling for further incentives to attract and retain dentists undertaking NHS work. These could include:

- the reintroduction of NHS commitment payments.
- incentive payments for audit and peer review.
- the introduction of late career retention payments.
- the possible development of a careers framework, including on-going education, supervision and support.
- increased availability of less than full time and flexible working.
- improved access to mental health support, such as the National Wellbeing Hub and Helpline.

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[5] Bupa Global & UK, *"Written evidence submitted to the Health and Social Care Committee's inquiry into access to NHS dentistry (DTY0024)"* (available at www.committees.parliament.uk/writtenevidence/116365/pdf/)

[6] Ibid.

[7] National Audit Office, *"Written evidence submitted to the Health and Social Care Committee's inquiry into access to NHS dentistry (DTY0103)"* (available at www.committees.parliament.uk/writtenevidence/119311/pdf/)

[8] Nuffield Trust research has found that new additions to the GDC register have fallen from 2,500 in 2011 to 1,600 in 2020 with a significant decline from EEA countries and UK registrants. Source: Association of Dental Groups, *"Written evidence submitted to the Health and Social Care Committee's inquiry into access to NHS dentistry (DTY0038)"* (available online at www. committees.parliament.uk/writtenevidence/117135/pdf/)

- more flexible entry routes into training, such as dental apprenticeships, to diversify and promote the concept of a local dental workforce approach.
- distributing postgraduate training posts so they are better aligned with areas that have the highest levels of oral health inequalities.

Whilst the pay of senior dental trainees (ST4/5) in England matches that of their medical and surgical trainee equivalents, the contracts for dental trainees in Northern Ireland mean they are paid £8,000 a year less than their dental equivalents in England.[9] Such unfair discrepancies must be addressed immediately.

This should form part of a wider package, accompanied by a communications drive, to entice professionals to return to NHS dentistry, particularly in areas where there are significant shortages of dentists. This should include other dental professionals, such as Tier 2 dentists, Dental Therapists and Hygienists, who also need support to develop their professional skills and competencies so they can provide care and triage other serious problems such as oral and throat cancer.

We also want to enable more dentists from low- and medium-income countries to work in the UK and develop skills and competencies they can then use in their own countries. This means clearing applications for the Overseas Registration Exam in a timely manner and speeding up changes to the process of international registration for new applicants seeking to work in the NHS.

Address Health Inequalities

There are marked inequalities in oral health and tooth decay is the most common oral disease affecting children and young people in England. Children from disadvantaged backgrounds are disproportionately more likely to be admitted to hospital to have teeth extracted and in England, almost one-fifth of such admissions were for children from the most deprived tenth of the population[10].

We believe that a reformed dental contract and a more systematic approach to workforce planning and reward will help direct resources to the areas of greatest need. They will also help increase the ability of dentists to provide preventive care.

In order to maximise the impact of preventatives measures, we support the tightening of restrictions on tobacco and vapes as well as tighter regulation of the amount of sugar added to drinks and food.

We also support:

- more targeted supervised-tooth brushing in childhood settings.
- community-based fluoride varnish schemes.
- integration of oral health into targeted home visits by health and social care workers.

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[9] McGuckin, B. "NI pay disparity," British Dental Journal, **229**, 211–212 (2020). (available online at https://doi.org/10.1038/s41415-020-2075-8)

[10] Richard G Watt, Stefan Listl, Marco Peres and Anja Heilmann "Social inequalities in oral health: from evidence to action", International Centre for Oral Health Inequalities Research & Policy, March 2015 (available online at https://media.news.health.ufl.edu/misc/cod-oralhealth/docs/posts_frontpage/SocialInequalities.pdf)

- targeted provision of toothbrushes and toothpaste by health visitors.

There is also evidence that water fluoridation as a whole population intervention reduces oral health inequalities with a greater benefit for those living in more deprived areas.[11]

Conclusion

We believe the above suggestions will go some way to improve access to dentistry and workforce morale. Our sole aim is to help improve the quality of dental care, so we look forward to working with policy makers to achieve this.

For more information, contact the Faculty of Dental Surgery at dental@rcsed.ac.uk.

[11] Public Health England, *"Inequalities in oral health in England"* 19 March 2021 (available online at https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary#document-summary)