Written evidence submitted by Mr Vijay Sudra (DTY0014)

- **What steps should the Government and NHS England take to improve access to NHS dental services?**

There are a multitude of reasons why NHS dentistry is failing to meet demand.

Years of under investment in NHS dentistry has led to this situation where NHS practices are no longer viable. The vast majority of dental practices have a private income to supplement the NHS element. Without this, most practices would fail to remain financially stable and would simply close.

It must be stressed also that the NHS has only ever funded for approximately half of the population to have NHS dental care. Increasing demand for access to that service is impossible under the existing financial envelope.

Provision of NHS dentistry is becoming more challenging over recent years as it has become increasingly difficult to retain dentists within the NHS, recruitment is even more difficult. Without the workforce, access will not improve.

Crucial to why many colleagues no longer want to work in the NHS is the activity driven UDA system that is the bedrock of the 2006 GDS Contract. That contract has destroyed NHS dentistry.

Micromanagement of prescribing data without appropriate clinical assessments of patients is also pushing colleagues out of the service. There may be perfectly sound reasons as to why a dentist's prescribing profile is deemed to be an outlier, yet the affected colleague feels the process is punitive: assumptions have already been made without a fair assessment of the information. Supplementary to this is that very few clinical advisors who provide reports to NHSE on this data actually have any significant commitment to working in the UDA NHS system themselves, this will cloud their input. Access to NHS dentistry will never improve whilst dentists repeatedly feel that they are being hounded as a result of overzealous assessment of activity prescribing data which may be deemed to be out of kilter with the average, these colleagues will simply stop working in the NHS. There is no such thing as an 'average dentist.' Local factors like whether a practice is seeing new patients, especially in higher needs areas will dramatically affect the activity profile.

Another factor is how the delivery of dental services has had to change as a result of the increasingly litigious nature of dentistry. Dentists are spending far more time writing of dental notes than ever before to protect them from the lawyers that widely promote litigation against the dental profession. This makes it necessary to see fewer patients as more time is needed to ensure informed consent is granted and wider discussions are had with the patient, all of this has to be recorded, thus protecting the dentist from being sued. (Dentists get sued more in the UK than anywhere else in the world). Dental indemnity costs have risen dramatically over the past decade.

Many colleagues feel that the modern medicine is centred around promoting prevention and good health practises. In an activity driven system of remuneration, this is impossible thus practitioners feel they are not giving patients appropriate preventative care. This will affect access to the service too.

Many 'new patients' need greater volume of care, the UDA system doe not remunerate appropriately for these groups and this has the effect of deterring practices from seeing these patients, preferring to see and treat their own stable patient base.

- **What role should ICSs play in improving dental services in their local area?**

The ICSs must as an absolute minimum, maintain the current spend on NHS dentistry, but also look to spend significantly more to enable improving access, especially those in vulnerable and higher needs groups. This may mean offering financial incentives to dental teams to manage these patients and rewarding the practices outside of the UDA target model.

- **How should inequalities in accessing NHS dental services be addressed?**

As noted above, many of these new patients need a great deal of work and this is time consuming. The UDA system rewards a maximum of 12 UDAs for any case, this wholly fails to reflect the additional time needed to delivery dental care appropriately for many of these patients. Financial incentives need to be provided to see these new patients, especially where a great deal of work is needed to get the patient dental fit. It is clear that those that may need the service the most are least likely to receive it which is fundamentally wrong.

- **Does the NHS dental contract need further reform?**

Urgently. To continue as we have will lead to the termination of any NHS dental service. Many recent graduates hav

Practice owners in NHS practices are struggling to retain all members of their teams, not just dentists, but nurses and auxiliary staff. Once lost, recruitment is near impossible. The cost of living crisis has further compounded the situation. Reception staff in particular have to deal with angry patients on a daily basis, many are leaving to jobs where they do not have to fear for their safety. Dental practices are working at maximum capacity, the pandemic has brought new challenges to the service, it is terrible that patients cannot access a dental service, they often vent their frustration on the 'front of house' teams.

Recent changes to the contract are way too little, and may indeed be too late. Fundamental reform of the NHS contract is needed, immediately.

- **What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?**

Rather than offering incentives, the NHS offer needs to be made more attractive. If the contract were fit for purpose, dentists would prefer to deliver dental care under the NHS. The contract needs to pay appropriately, not least for delivering care to higher needs patients. The contract also needs

to be clearer about exactly what the NHS offer is too, the contract has many grey areas and interpretation of the narrative, however well-intentioned may be incorrect.

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