**Written evidence submitted by Dr Andrew Bell (DTY0043)**

I have been a ‘Dental Associate’ working within Primary Care, the old fashioned ‘High Street’ Dental Practice, since my graduation in 2013. Alongside this role I am a Partner within an independent group of 11 practices. I have been Educational Supervisor (ES) for Dental Foundation Training (DFT) in Norfolk and Waveney for the past 5 years and I also mention Performers List by Validation (PLVE) candidates and Conditionally Included Dentists (formerly VTE). In addition, I am involved in the political side of Dentistry and have the role of Vice-Chairman of the Norfolk Local Dental Committee (LDC) and I am the Norfolk representative on the General Dental Practice Committee (GDPC) at the British Dental Association (BDA).

I have only ever worked within the Units of Dental Activity (UDA) system. This system has been deemed ‘not fit for purpose’ by the 2008 and 2022 Health and Social Care Committees and still nothing has been done.

The system is quite perverse - we are paid to essentially collect points (UDAs). This does not equate to good patient care. We are not remunerated for educating patients to improve their own oral care…we are just paid to fix things and NOT prevent them. The treatment of gum disease is a good example – a single course of treatment takes in the region of 2 hours and I get paid 3 UDAs. This works out at about £35 in total or £17.50 per hour. Then we have to take on average 35% off of that for tax and we probably shouldn’t get started on the cost of indemnity or the cost of living crisis!
The recent ‘marginal changes’ have meant we have been able to be paid more for doing the more complex and time consuming procedures, such as root canal fillings (RCTs). This is great but it means getting through our points faster within any year and therefore actually reduces access to NHS dentistry because if you have run out of contract, you’re not getting paid.

Nationally, as evidenced in the most recent DDRB report, there has been real terms cut in the dental budget (and therefore salary) year on year as it is well below the rate of inflation.
The estimated earnings for the average associate in England in 2008/09 was £67,800. By 2019/20 new estimates show that figure had fallen to £58,100. When factoring in inflation that figure was the equivalent of just £42,942, a 37% fall – what other profession has seen this? - certainly not members of our government….
To take us back to 2010 levels of funding there would need to be an approximate £850 million injection into NHS dentistry. Also, if we are discussing the state of dentistry nationally then we can be positive that there is a record number of dentists on the GDC register, unfortunately we lost 3000 NHS dentists during the COVID-19 pandemic due to the demands, working conditions and stress so they have converted to private practice.
Dentists are not moving away from the NHS to earn more money. They’re moving away from the NHS to work in a system where they can deliver patient care, as they deem appropriate in a temporal environment that supports their mental and physical health and wellbeing. This will again be amplified by the upcoming clawbacks, abatements etc etc which will bankrupt many NHS practices.

In our area 100% of practices are not accepting new adult or child NHS dental patients. We are in a dental desert. On top of this we have had numerous practices close completely, hand back their NHS contracts due to the strain or because of early retirements. There is nowhere for these thousands of patients that now do not have a dentist and cannot afford to pay for private dental treatment. The remaining NHS practices are at complete capacity, they are unable to even squeeze in dental emergencies which then lay their burden at General Medical practices or A&E departments. How on earth adding in the ‘£50 million for additional sessions’ was deemed a good idea is beyond me. You have dentists and staff working themselves to depletion for an ever ungrateful, aggressive and demanding public cohort so to ‘increase access’ we will find some funding to let you work during lunch breaks and for longer than your contracted hours….bonkers. No wonder less than 30% was used.

For my personal lists of patients, I am still seeing patients every day who have not had an appointment since before the COVID lockdown. I am booking 6 months ahead for treatment. More people have required treatment, its more complex than it would have been if there wasn’t such a lag in appointments and often the treatment plan needs to change when they then come back in. I don’t get paid until the course of treatment is completed and closed and if these patients need further appointments, then I won’t receive any payment for some time. In addition, many of these courses have been opened before the introduction of the marginal

changes so it's completely soul destroying. You can also imagine how the patients are feeling now that they must wait for treatment and risk not being able to be seen if they have an emergency.

Within our group we have lost around 15% of our workforce – both dentists and staff. This decreases our capacity significantly and leaves us short on several our contracts. Recruitment and retention is a huge crisis within our area. This is all down to the pitiful pay and working conditions for a career that is know for having to make the most important micro-decisions in a day compared to any other profession while getting a woeful pay deal and in an environment where there is no respect or appreciation from those you work for (the NHS) and form those you are trying to help (the patients). Oh and lets also add onto that the daily risks of litigation and the home-life pressures of the cost of living crisis…Is it any wonder it's the profession is at breaking point? (and that it ranks as the profession with the highest suicide rate….just look at the GDP fitness-to-practice freedom of information statistics regarding this).
The NHS offer is rubbish and that's why we cannot recruit dentist. Who wants to work in what I've described above? The talk of NHS funded 'golden hellos' is great but is a sticking plaster on an arterial bleed. Does it commit dentists to staying in an area for the long-term (and long-term isn't 2 years, it's 10)? What about those dentists who are already willing to stay in an area to care for their existing patients? An absolute kick in the teeth for them.

I have tried to rack my UDA fried brains for any positive that have occurred in our area. It's been difficult. The prototype and pilot contracts were heading the right direction and likely only needed a couple more iterations to be nationally functional – patients were getting prevention, there was access, dentists had a steady income and were able to supplement this with additional private treatments without impacting their NHS capacity. That was until it was pulled from under our feet at very short notice without warning. What an utter waist of time. In all honesty we need to completely move away from any type of UDA system, all it incentivises is working as quickly as you can to collect your point – it is not cost effective for the government and there are no positive health outcomes for patients. It's the 21st century, we should be preventing dental problems not fixing them when they occur. As dentists we treat 2 main diseases, dental decay and gum disease, both COMPLETELY PREVENTABLE!

NHS dentistry is in a sad state of affairs, its crumbling before our eyes. ICSs can help by really *knowing* their areas. Learning where there are high needs and seeking to take action to reduce these inequalities – these will be in crappy areas so what will be done to make this attractive to the workforce? Supporting pilot programs like 'child friendly dental practice' or 'trauma networks. Encouraging continuing professional development by supporting CPD programs and supporting those practitioners who want to progress to Level 2 accreditation. They need to address integration of primary and secondary care communication routes and even support those practitioners who want to commit to sessions in their local hospitals or community departments. There needs to be a huge overhaul of supporting anyone who works in dentistry with their mental and physical health, well-being and resilience. These, admittedly, are idealistic but without change NHS dentistry will disappear – we are all feeling the gravity of this black hole that will chew us up, and in some cases won't spit us out. All of this requires true contract reform and a long-term injection of capital which we all know that any government will not agree to.

We hold our NHS on a pedestal, that pedestal now sits on rocky foundations and NHS dentistry will be the first thing to fall off.

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