Written evidence submitted by Hertfordshire Local Dental Committee (DTY0058)

What steps should the Government and NHS England take to improve access to NHS dental services?
Make NHS GDP an attractive work environment; currently, it is not. These are just some of the areas of concern to our members:-

1) Financially viable
Addressing the wide discrepancy in UDA, for example, in Hertfordshire, rates range from £19.25 per UDA to £49.30 per UDA.
An example from one Herts provider:
My practice UDA rate is low - £25.37/UDA
The practice hourly break-even rate has increased from £279/h (£93.04/surgery) in 2019 to £369/h (£123.98/surgery)in 2022.
Increased costs related to the following (this is not a complete list):
Staff cost - average nurse salary in 2019 was £10.50/h; this increased to £15/h in 2022. With lower hourly pay rates, retaining well-trained and experienced staff is almost impossible. Running a practice with apprentices and agency staff is ineffective, does not promote good patient care or experience, and is not in a patient's best interest.
Energy costs - May's fixed rate energy contract came to an end in November 2022 and the price has exponentially increased - November 2022, it was on average £258/month, increased in December 2023 to £697
Material costs have significantly increased since Brexit.
Laboratory costs have risen significantly.
As a very minimum, there should be a universal UDA rate of no less than £35 per UDA.
Consider the more "NHS" dentistry a practice delivers the higher the UDA value becomes (could be based on the NHS/Private percentage that we send for rates rebate).

2) The present contact is too target-driven, not patient-centred.

3) UDA numbers have been fixed in time; does not allow for practice growth in patient care.

4) The system needs to be less burdensome. UDAs are locked to contract holders, not easily shared with other providers and lack flexibility. There might be enough UDAs to go around if they were easily transferable, either as non-recurrent or recurrent.

5) Remove the fear newly qualified dentists have of things not going totally to plan and litigation from patients.
Take away the hostile environment e.g.

i) dentists being struck off for failure to fill in the GDC annual forms and not being reregistered for months,
ii) the legal environment in which we are guilty until and sometimes even if proven otherwise.

6) Remedy why newly qualified dentists do not see a future in NHS GDP.

7) There needs to be a systemic improvement at the undergraduate recruitment level. Recruitment should focus on recruiting from areas where there is a need for dentists not from areas well supported. Some may return to their home areas. Increase the number of places at dental school so that eventually more dentists graduating. Efforts should be made to recruit students from a wider socio-economic background.

8) Seeing new patients takes up a disproportionate amount of time compared to the financial reward.

9) Regarding access, part of the problem is appointments are not kept. If there were fewer appointments not kept more patients could be seen. Patients should be more responsible; if not, allow Practices to fine people for wasting NHS practice time. Fines did work pre-2006. (In private dentistry, patients can be fined). Or consider awarding UDAs for the time wasted by patients missing appointments.

10) The practical experience of newly qualified dentists needs to be improved; there should be more accountability by the dental schools for the experience provided for students.
An example from one of Herts LDC members:-
In 2021-2022 My FDs who qualified from Kings College in London had prior to arriving at the practice:-
Never actually seen a child patient - only theoretic lectures on treating children was provided
Prepared one crown in the 4th year; only other experience was preparations on plastic teeth in phantom head teeth
Made one partial acrylic denture
Completed portion of 3 root canals (someone would access them, she prepared one canal and filled another)
Only placed amalgam restorations in phantom head teeth

11) Make it easier for foreign dentists to take the UK test rather than making it easier to pass the test.

What role should ICSs play in improving dental services in their local area?
Until the problems of non-dentists dictating and advising how dentists should practice, they will be no better than our current commissioners. They first need to gain knowledge and an understanding of dentistry and the running of a dental practice. Until then, ICSs should be made to rely on dentists to decide how best additional dental services can be delivered locally via funded dental committees.

How should inequalities in accessing NHS dental services be addressed?
If you want to encourage seeing high-need patients, the dentist needs to be not economically disadvantaged by doing so. In our current system, replace the UDA treadmill with well-funded sessional fees for those with high needs.

Does the NHS dental contract need further reform?
No, it needs to be scrapped and replaced. It is impossible to provide a quality service within the current contractual structure and administrative burdens.
The NHS needs to transparently decide what it wants to achieve and change the incentives towards this. The era of pretending everything is available to everybody at a high standard and low cost has to end. Remember, Dentists can walk away from the NHS, which is precisely what those who can have done or will do, which is leading to a massive skills loss.

What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?
Private dentists earn similar amounts as those who undertake full-time NHS dentistry; they, however, see fewer patients than NHS dentists; this needs to be corrected. Private dentists work in a less stressful environment, enjoy their work, and feel well rewarded and respected by their patients makes for a better quality of working life experience. If the NHS could offer a working life experience similar to Private dentistry free from any treadmill, retention would be much greater.
The more skills you have, the more you should earn. In hospitals, consultants are paid more than junior doctors. If a dentist invests in themselves by obtaining additional skills through self-funding training or investment in new equipment, the current NHS contract does not reward them for doing so; perversely, their income goes down.
Provide Crown Indemnity for those undertaking NHS dentistry similar to that offered to GPs.

Those dentists and staff undertaking NHS dental care should receive similar contractual conditions as those working in other parts of the NHS funded by enhanced payments to the contract holder.
A Catch-22 observation from a Herts LDC committee member:
Talking to numerous practice owner colleagues, there is a smaller and smaller pool of associates that we are competing to recruit to do NHS work. I know of three young associates who gave up dentistry altogether last year.
I won't be able to complete 96% of UDAs this year because I have had such trouble finding maternity cover for an associate. I think enforced contract reductions due to persistent reduced NHS activity will be inevitable for many practices in the next 3-5 years. You can't do the NHS work if we don't have the workers. We are also competing with private practices for quality nurses, receptionists etc., so we have to rapidly grow the private side of our businesses to pay and retain staff appropriately, which will mean reduced NHS activity.

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