The BSSPD 2025 Debate: Sustainability of Dentistry and Prosthodontics – is this an emergency?

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Abstract

Background: 21st century Dentistry in first world countries should be based on sound evidence-based prevention and timely access to relevant dental care, but is not the picture currently portrayed of dentistry within the United Kingdom (UK), by and for the key players involved (e.g. patients/public, government/commissioners, National Health Service [NHS], contract providers and performer workforce).

Aims: To summarise the issues that face the public, dental educators, dental workforce and commissioners of dental care in the UK (England) that were formally discussed at the British Society of Prosthodontics (BSSPD) Conference 2025.

Method: A panel was selected to include experts and spokespeople for the Department of Health / Chief Dental Officer, Dental Public Health, the British Dental Association (BDA), Postgraduate Dental Education and Training, and workforce research, to debate five themes of sustainability in front of an audience of Foundation Dentists (FD), Dental Core Trainees and Educational Supervisors, Speciality Trainees, as well as General Dental Practitioners, Specialists and Consultants in Prosthodontics and Restorative Dentistry.

Conclusion: The discussions of this debate on sustainability confirmed the need for novel approaches/offers with better understanding, funding and delivery of effective prevention models, urgent contract reform, with suggestions for education and health systems that can support (new and existing) dental workforce challenges.

Introduction

Dental disease is common, but for the majority, preventable. Dental caries and periodontal disease are leading causes of tooth loss[1] and oral health has now been described as alarming and urgent, due to the significant impact on the quality of life as well as life chances.[2] Oral diseases have been ranked as the most prevalent conditions globally, and across countries of all levels of income.[2] With an ageing population, polypharmacy and treatment such as radiotherapy to the jaws may lead to xerostomia and increased risk of dental disease.[3-7] There are emerging links between oral health and chronic diseases.[8] For the last few decades, national population oral health surveys have consistently shown increasing tooth retention, potentially due to improvement in population oral health. Some aspects appear not to have improved, such as pre-school caries and the number of hospital-based general anaesthetics, as well as poor oral health in areas of deprivation for teenagers and adults. These, along with life expectancy and quality life years, are closely related to deprivation indices and impact the economy.[9-11]

These issues may also be confounded by NHS dental workforce distribution, with shortages in areas of highest need and more rural areas. These have been referred to as '*dental deserts*' in the UK.[12,13] Many vulnerable individuals in deprived areas in the UK are currently unable to access the NHS care that they need. Evidence suggests that Dentists and Dental Care Professionals (DCPs) often originate from, and therefore, gravitate to live and work in urban environments, where there are both NHS and Private dental care opportunities.[14] Unfortunately, although health policies are changing, significant barriers remain for Dental Therapists to work to a full scope of practice in NHS practice; presenting a missed opportunity to optimise their potential for patient benefit.[15-17] It is important to understand that private care and activities for dentists and DCPs do not solely involve what was traditionally thought of as dentistry. There is now an established market and demand for facial and tooth aesthetics, which

dental registrants can develop skills to provide for patients, thus diverting resources from routine dental care.

The sustainability of dentistry, especially NHS dentistry is dependent upon a workforce that is fit for purpose, accessible and adequately funded. The cost of delivery of this care is increasing and as such the current model of care is unsustainable.

The issues facing the sustainability of dentistry within England was discussed in a panel debate at the BSSPD Conference in London, in April 2025. Mr Peter Briggs (PB) chaired the debate. The panel (Figure 1) consisted of:

- Mr Eddie Crouch, (EC) Elected Chair of the BDA Board, previous Deputy Chair of the BDA
- Professor Jenny Gallagher MBE (JG): Newland-Pedley Professor of Oral Health Strategy and Honorary Consultant in Dental Public Health in the Faculty of Dentistry, Oral and Craniofacial Sciences at King's College London; President Elect International Association for Dental oral and Craniofacial Research (IADR)
- Professor Nick Barker (NB) Deputy Chief Dental Officer for England and Joint Regional Chief Dental Officer for NHS England East of England Region and Professor of Oral Health Sciences for University of Essex, and is also a dental practice owner and a provider of level 2 endodontic and periodontic services in Colchester, Essex
- Ms Sana Movahedi (SM): Regional Postgraduate Dental Dean for London, Kent, Surrey and Sussex, who is also responsible for NHS England Work Force Education and Training.
- Professor Nicolas Martin (NM): Professor of Restorative Dentistry and Consultant in Restorative Dentistry, School of Clinical Dentistry, University of Sheffield.

All panel members and delegates agreed to recording of the session to support publication of this debate. This paper aims to summarise discussions that took place during the debate on the challenges

currently facing dentistry in the UK and particularly in England. It puts forward advice to all stakeholders and policy makers to consider innovative ways to engage with the population and workforce. BSSPD is apolitical and functions as a national charitable learned dental society. Its role is to facilitate education, support research, and facilitate learning and debate, with an emphasis on Prosthodontics. Some recorded comments, from individual panel members, are included within the paper, which appear in *Italic* font, and are not necessarily the view of BSSPD.

Theme 1: what are patient and public experience of dental care?

The debate was commenced by PB, highlighting recent surveys and reports in mainstream media on patient experiences of NHS and private dentistry in the UK and how these have changed in recent years, including reports in the media of patients self-extracting their own teeth.[18] The reports illustrate the difficulty patients have had with access to NHS care in primary care, with fewer concerns about the cost. The size of the problem differs across different geographies, with more challenges in deprived and rural areas. Patients are currently unhappy if they are unable to access NHS dental care, and those who can afford private dental care are happier with the service delivery from the profession. Although, more people are using private dental services, some feel that these are expensive. Patients would generally prefer to be 'enrolled' or 'registered' with a particular NHS dental practice and dentist (of their choice). The General Dental Council (GDC) Community Research Survey Report also echoes these concerns and concluded that, although respondents had confidence in the quality of dental care in the UK, they lack confidence in their ability to access care, with health inequalities and affordability concerns also very apparent.[19] These issues are affecting current public and patient experiences and behaviours, and they are having an increasingly negative impact on confidence in the sector.[18] The recommendations of Health Watch England in 2024 clearly laid down in steps, and include giving

everyone a General Medical Practitioner (GP) style right to be permanently registered with a dental practice for preventative and urgent care throughout their lives.[20]

Is this an emergency for dentistry - is the provision of dentistry in the UK not fit for purpose? The general consensus was yes, and this is a pivotal point for us to make change (Fig 2). Are we as a profession, potentially losing the trust of the public? Patients are more aware of the problems. Although, historically there have been anecdotal views that dentists are being greedy, that view seems to have changed. From the panel discussion, in the main, it was felt that, those that have a dentist seem to think that they have the best dentist and want to keep seeing that dentist. Those that have access to NHS dental care seem to highly regard this care. The public seem to wish for continuity of dental care, within a practice, from a clinician that they know and have built a relationship with. The confidence in the individual dentist is still there but there is loss of confidence in the system.

In England and Wales, do we know the population's oral health needs and the complexity of those needs? This is a pertinent question as the last National Adult Dental Health Survey of England and Wales was carried out in 2009. We do need to know and understand the size and complexity of oral health needs of the population, particularly as aligned to the NHS England commissioning standards in England,[21] to identify relevant training needs of GDC registrants, and to plan a sustainable skills mixed workforce team for the future.

There was broad agreement that this survey should take place every 10 years, as it is hugely valuable data resource that informs research, policy and strategy. Additionally, it should provide a thorough understanding of the complexity of treatment need to enable meaningful workforce planning across primary and secondary care. There is also a need to direct some of the responsibility onto the patient. The audience consisted of a lot of dental foundation trainees, working in high needs areas providing NHS dentistry. This cohort of the profession identified that despite best efforts to contact patients

reminding them of their appointments, there are many wasted hours of time as a result of patients not attending their appointments. Many patients are currently not placing value on attending appointments.

Theme 2: do we have a sustainable workforce?

The current dental workforce consists of new UK and overseas dental graduates (dentists and DCPs). To support complexity of care levels 1 (routine), 2 (moderate complexity) and 3 (complex),[21] a varied skill mix of Dentists, Dentists with Enhanced Skills, Specialist Dentists, as well as a variety of DCPs including Dental Nurses, Dental Nurses with Enhanced Skills, Dental and Orthodontic Therapists, Dental Hygienists, Dental Technicians, Clinical Dental Technicians and Maxillo-facial Clinical Technologists are needed. The supply and retention of Whole Time Equivalent (WTE) staff within the NHS dental services is a significant challenge.

There is evidence from the National Audit Office that the UK, compared to other similar G7 European countries (Germany / France / Italy) has a less favourable number of dentists per 10,000 of population.[22] Using a similar metric, there are significant differences in the four nations of the UK, with England and Wales significantly lower than Scotland and Northern Ireland. The dental workforce is not equally distributed across England. This leads to both inequity and inequality, often in rural deprived areas compared to highly populated, urban areas, widely publicised by the British Broadcasting Corporation.[23] Of course, this does not take into account dental and orthodontic therapists, dental hygienists, or clinical dental technicians who may be providing some dental care. Additionally, it does not take account of the impact of the Covid-19 Pandemic, and the changes that have happened since. Some have indicated that the impact has been 1,100 fewer dentists doing NHS work than before the pandemic, and fewer clinical hours.[24] However, there seems to be a theme that the NHS 'dental desert' dentist workforce shortages are not present near existing dental schools in England.[14] So are more

people leaving the GDC register than joining it? During a poll of the audience, by show of hands of the FD present, a large proportion indicated a desire to work part-time, with the majority wanting to work with the NHS and help shape it. In the last decades, UK dental workforce planners have actively encouraged and become reliant on the use of overseas dentists to plug this deficit in the workforce.[25] Are overseas dentists the solution to our NHS dentist sustainability issues? The general views of the panel are shown in Figure 3.

It was agreed that the current geographical distribution of the dental schools compounds this problem. The current application rate for dentistry is at its highest level, with over 30 applicants for each undergraduate dental position this year, a testament to the quality of dental education in the UK. They are equipped with skills, knowledge and behaviours, but they all require support and encouragement in their on-going careers. '*You do not make a good dentist in 5 years. It is a continuous, longitudinal, iterative process of many years*' (NM). The *dental deserts* exist because the infrastructure does not exist in those areas for a thriving life, for example transport, shopping, schools, etc. Dentists are very expensive to educate and train, so how can we retain the ones that we have trained? The delivery of dentistry is changing, with expansion of the corporate model, and the lobbying of government for more dentists. But '*a dentist from anywhere is not going to stay if the system is not workable*' (EC). Previous visions were to expand the workforce by 40% for dentists and 40% for dental therapists, but dental schools are costly to build. Where is the money going to come from? Is there a potential for expansion of the existing dental schools to minimise the costs, whilst still addressing the issue of manpower? There was real concern about the supply and retention of academic and teaching staff, which would be needed to increase numbers of the workforce.

There was worry about oversees dentists working with limited GDC registration, and in particular about the individual and the level of support they may receive. Much will depend on their undergraduate and post-graduate experience levels, as there is a great variation in skills and knowledge. There were

concerns across the panel about even UK nationals who have trained in European universities and have spent their whole dental education communicating through an interpreter. When they return to work in the UK, there is an issue of communicating effectively with patients. Although, more dentists are needed, there may already be enough dental hygienists and dental therapists but not working to their full scope of practice.[26] The career aspirations of dually trained dental hygienist and therapy students seem to be to work full time (average of 8 sessions per week) in a mixed (private/NHS) environment, spending 3 days on dental hygienist work and 2 days on therapy work. Financial stability, work life balance and gaining professional experience were cited as the most important influences on career choices.[15,17] Supporting existing dental schools to increase their capacity will require a physical expansion of the premises and the right kind of diverse workforce needed for training. The panel agreed that these, and NHS contract reform should be priority targets for increases to workforce numbers to help access to good NHS dental care and prevention.

The panel did not think that the use of non-UK healthcare workers was the answer to a sustainable workforce, both in the UK but also in the countries they come from due to 'brain drain' and the impact on the health care system of the country these healthcare workers emigrate from. The panel voiced that the pre-registered overseas dentists model to deliver more NHS dental care was potentially unsafe for the UK public. There was much enthusiasm from the panel for investment in the skills and knowledge of the current UK workforce to include: enhanced dental nurses, clinical dental technicians and other DCPs to ensure relevant skills and training are used to the benefit of the UK public. The increased reliance on dental corporates to deliver NHS care was thought by many to create additional risk, as failure of a large corporate is likely to have a larger overall impact upon NHS dentistry both for patients and commissioners than loss of a few individually owned practices. Is there any merit in considering limiting the number of corporate dental practices in an area to encourage practitioners to open NHS dental practices without the threat of being 'taken over', thereby giving patients more choice? There is an issue about levelling playing fields in procurement and being under bid. This may

ensure access and stability in any given geography: if a corporate body goes under, there remain a good number of other NHS and Private dental providers for patients.

The panel discussion considered the importance and impact from private practice, which is now a significantly bigger financial market for dentistry in the UK, than the NHS (several times bigger). Stakeholders and policy makers should not ignore this 'elephant in the room', within the current system, as it will affect any decisions made by the workforce, in terms of where and how they want to work. The example raised by panel members was that many trained dental therapists currently work as private dental hygienists. There would need to be significant NHS contractual change to encourage them to work as dental therapists in NHS dental practices, particularly in England. Since this debate, the Government has responded to a consultation regarding reform of the NHS contract for dentistry which does include prevention, reform and incentivisation to maintain and develop access to NHS dental care based on contract reforms that began in 2022.[27, 28]

Theme 3: do we have a sustainable system for the delivery dental care?

The cost of NHS dentistry in the UK is said to be around £3.1 billion with a third of that made up from the patient charges not including secondary care funding.[29] The UK Dentistry Market Report stated that the private market was expected to reach £10.6 billion by 2024.[30] Figure 4 shows the panel views on the sustainability of NHS dentistry in the UK.

There was strong agreement from the panel audience that the current England Unit of Dental Activity (UDA) NHS primary contract is unsustainable, it is 'broken' and not 'fit-for-purpose'. The decline of NHS dentistry in primary care, particularly in England, may now be terminal and unrecoverable, in the future. Morale is also low within the workforce teams and the quality culture of the NHS dentistry is not good. Private care (where affordable) has now filled much of the 'lost' NHS capacity. This is

particularly true in the more affluent areas. Dentistry in many geographies, has now moved into to the cosmetic / beauty business with tailored financial products to support this. Many of the treatments provided are unavailable on the NHS, and remedial treatment may also not be available within the NHS.

There was discussion of political will, investment and the best use of any 'unused' NHS dental funding'. It was suggested that the UK politicians must agree on what they want the NHS dental contract to cover in their country and be honest with the public on what this means. The dental profession can only advise them on the likely implication(s) of their decisions. One option raised was to invest more money that supports better prevention, with incentives for the dental workforce to work in deprived rural areas where there is high clinical need, and strong support for skill-mixed delivery of NHS care. There was also agreement that any 'unused' funding from NHS dental contract performance ('claw back' or unused UDAs) should be returned to dentistry by NHS England, and a system set up to be able to do this in a timely fashion. The general view of the panel members was that Local Dental Networks (LDNs) should have input with how this money is best used. Other ideas included reducing or shrinking the 'reach' and thus expectation of the current contract in England, to essential or 'core' elements of service, which include prevention, emergency care, simple fillings and extractions. This must include a 'means-tested' element for items outside the 'core' service.

Concerns about the 'deal' currently for NHS providers (contract owners) and NHS performers (associates) were raised. It was noted that the balance between the two had changed significantly over the years, with many early years practitioners considering working in 'salaried' NHS posts, in preference to dental associate positions.[31] This suggests workforce apprehensions over current terms and conditions of employment. Very encouragingly, the early years work force present at the conference were keen to work in the NHS for the foreseeable future, although it was noted that some may lack the confidence to move directly into private practice. They were keen also to explore a period

NHS 'buy-in' at the beginning of their career, for example negation of the debt associated with undergraduate fees for a 5-year commitment to NHS dental care delivery. For those in the audience, a 10-year NHS buy-in was less popular. Some would respond positively to an offer of a 'Golden Hello' to work in hard-to-fill areas, and others would not. *'The government might argue that they already heavily contribute to the training of a clinical dental student to the tune of £37,000 NHS funding per student, per year, to support four years of clinical training. This is a huge contribution from the taxpayer. The student loan is a very small part of the cost it takes to train a dental student'* (NM).

A great loss to the primary care NHS system has been the erosion of the traditional pattern of purchasing a practice relatively early in a career, and growing a patient base.[32] There was agreement that encouraging individual ownership and 'building-up' of NHS (and possibly mixed) dental practice capacity, particularly by the young workforce in areas of greatest clinical need and challenging access was of benefit. There was acceptance that this may be unpopular with established NHS practices. To improve the sustainability of NHS services and younger workforce working in primary care, such opportunities may need to be considered by commissioners and 'new' NHS provider contract opportunities supported by 'claw back' monies. NB, the representative of OCDO felt that some of secondary care money could be spent within primary care. Others felt that there is already inadequate funding for NHS secondary care in Dentistry – which makes up no more than 10% of overall spend. The audience posed three questions to the panel about the current system (Figure 5).

Theme 4: what is the role of undergraduate and postgraduate education and training on delivery of a sustainable workforce?

The panel agreed that they both have a huge role for future sustainability, and undergraduate schools should create / build a positive culture towards NHS dentistry and it not be considered a substandard

service, with the issues highlighted are shown in Figure 6. Recruitment into dental schools may need to be broader and consider the wider skills required for delivery of holistic care and prevention, and delivery of high-quality dental treatment, not just consider academic rigour. The four A* method may not be the best discriminator, however, academic achievements consider a wide range of knowledge and development skills that go beyond 'academic content'. All applicants (future dentists) must be able to engage clinically, but also engage in intelligent, knowledge-based, rational decision making processes. The dental team need to be both do-ers and think-ers at the same time. There needs to be some form of metric that will identify a baseline of knowledge and awareness; that currently is through A level grades. Ideally, the application process would also have other metrics that also equate to operative, organisational, social skills. It would be appropriate to agree and develop a National Person Specification of the ideal qualities of a successful dentist and DCPs? These qualities would need ranking in order of importance and robust methods for identifying and testing them will be required.

Undergraduate dental schools should be strongly aligned to the NHS, due to taxpayer contribution to teaching, and must deliver relevant skills for the workforce needs, in a sustainable way. The suggestion was to expose the future workforce early, to the importance of skill-mix working and this model of dental care delivery, learning to work and learn alongside others with the goal of delivering care and having respect for the roles played by each individual, not just in a dental environment but also the wider healthcare system.

There was broad agreement that the current locations of Dental Schools in England does not best support spread of the workforce to all regions. Expansion of existing sites may not be as easy due to the current estates and need for rebuilding some. Recruitment from the ‘dental deserts’ will be essential, however, currently applicants from London and the South East dominate recruitment to English Dental Schools. How do we encourage applicants from the ‘dental deserts’ and encourage the

right people to come into dentistry? One model could be a partnership between clinical delivery sites in the 'dental desert' areas and current schools for pre-clinical and didactic teaching. The clinical teaching delivery sites need good experienced dentists, who understand the principles and tools of clinical education / learning / training. Some current dental schools struggle to deliver the patient volume needed to provide a broad clinical experience and the type and approach of care needed in high needs areas, therefore outreach clinics would be helpful. Educational stakeholders should ensure that they understand the challenges of working in NHS primary care dentistry, and meet the need to develop postgraduate education hubs in areas currently poorly served by dental schools and dental practices, such as support for training for levels 2 and 3 through NHS training.[33]

Theme 5: what is the environmental cost of delivering dental care?

The last of the themes started with a map of the UK with high spots of emissions. Transport is the largest emitting sector of greenhouse gas (GHG) emissions, producing 26% of the UK's total emissions in 2021, and 28% (427 MtCO2e) in 2022.[34] The UK is responsible for approximately 1% of total world emissions with air travel alone responsible for 2% of total world emissions.[35,36] Staff and patient travel is one of the most significant environmental issues. The carbon footprint of the different elements of dentistry has been published, with the largest emissions related to dental examinations, scale and polish, intra-coronal restorations and denture construction.[37] Two important points were raised:

NM: 'The northern part of the country has poor public transport links, with diesel trains. The north of the country needs electric train networks for travel, otherwise everyone will drive. Infrastructure is a problem. The other problem is that patients have to go to the dentist several times for reactive reparative treatment. Prevention is key, but also when treatment is needed, do the job well, so that it lasts longer, (to) reduce or slow down the restorative cycle. Don't start it at all, even better. Treatment

plan in such a way as to maximise the work done in each visit, integrated care with families attending their appointments together or possibly in multi-care centres, and if you do this well, share this good practice with your peers. Engage with patients. Society is becoming aware of the environment and reducing eating meat for example; but we do not talk about the huge knock on effect of not requiring treatment for obesity, smoking, dental treatment. Reducing the need for treatment will have the biggest unintended impact on the environment'.[38]

NB: 'The current clinical guidance for unscheduled care, it actually talks about remote working and remote consultations with patients. This is the first time we have made reference to the fact that patients do not have to come to you'.

The group agreed that effective and successful prevention is the key for dentistry to best support the environment, with the largest cost to the environment being the travel of patients and staff to access dental care.[37] Low-cost population wide and individualised prevention interventions, by all healthcare professionals, focussing on reducing the intake and frequency, especially of free sugars, can reduce the need for costly treatment and re-treatment cycles, with self-care still being the most cost effective method of prevention.[39,40] This echoes the NHS aspirations to move the treatment of sickness to prevention of sickness, making the NHS a more attractive place to work, invest in people and infrastructure and overall investment in people and infrastructure to be able to move care from hospitals to communities.[41,42]

Consider multiuse practices where one episode of travel may mean not only dental treatment, but also a visit to the general medical practitioner, physiotherapist, optician all in the same venue and visit. Staff travel arrangements should also be considered to reduce emissions, such as better public transport, local recruitment and incentives for several members of staff traveling together. Numerous other suggestions were also supported:

- Meetings / conferences consider via online platforms
- Use more digital consultations and Tele dentistry
- Less mercury use – more focus on prevention and greater clarity of when amalgam fillings have significant advantages over resin-based fillings potentially reducing the reparative cycle
- Constantly to be mindful of environmental sustainability, with reference to travel, procurement, energy efficiency, biodiversity, education, waste management and prevention[36]

Discussion

The overriding message from the debate was that prevention of dental disease was the most appropriate way to reduce the NHS dental care provision and cost burden.[43] A focus on targeted Oral Health prevention, working with medical colleagues and targeting the most disadvantaged and vulnerable, with a basic level of dental provision should be considered an essential public service, especially with poor dental health also be co-related to other costly conditions, such as diabetes, cardiovascular disease and Alzheimer's disease. The group supported focus on quality, to ensure high success of the treatment outcome: if treatment is needed, it should be carried out to a high standard to avoid short term failure / infection, and the need for costly revision treatment, although it is appreciated that all dental care will require some level of revision or alternative treatment as long-term failures will eventually occur. On-going prevention support would also reduce this burden. All stakeholders (patients, dental health care professionals, general health care professionals, commissioners, regulatory bodies, policy makers, wider industry and suppliers) need to understand the value and impact of oral ill health to implement up-stream, mid-stream and down-stream actions to prevent population wide dental disease (Figure 7).

The discussions during the debate focussed on encouragement of the workforce to commit to the NHS. Early year practitioners at conference seemed keen to remain within the NHS, although a point was made that this may be related to confidence in their ability to provide private dental care. The idea of an incentive to make a commitment ('lock-in into the NHS') in exchange for negating their student debt seemed to be well met, suggesting a 5-years of 'lock-in' would be acceptable but not 10 years. This begs the question of why the work force is no longer considering a career in NHS dentistry.

There was support for better terms and conditions of employment and salaried NHS working, skill-mix working model, consideration of different models of prevention delivery, and NHS contract reform in England. The size and the composition of the work force may need to change with a different proportion of dentists and dental care professionals. There are dental deserts in England, where patients are unable to access NHS dentistry. The dentists working in these areas are choosing to work outwith the NHS. How can NHS dental care be delivered in these areas?

Many important suggestions were made:

- An urgent debate on the findings of the current (to be published this autumn) adult dental survey in England to include an assessment of the complexity of identified need
- NHS dentistry is under resourced, with much contractual monies lost from 'claw back in recent years. This should be reversed and future 'claw back' retained to dentistry
- Use of a skill-mix Dentist and DCP working model to deliver levels 1, 2 and 3 clinical complexity.
- Establish undergraduate and postgraduate teaching and training hubs in the dental deserts of England, to create an educational community in such areas for the dental workforce.
- Each LDN should consider a dental workforce plan, related to local oral health needs, with dental Foundation training placements and undergraduate dental schools working more closely with the NHS and LDNs, to ensure an adequate supply of workforce to the most deprived areas.

- More Level 2 and 3 training programmes may need to be established in the most deprived areas, to include prosthodontics, and formalised NHS training.
- Consider 'offers' that are relevant to encourage new and existing dental workforce to rural and deprived areas, such as 'golden hellos', striking off student debts and enhanced terms and conditions of employment and wider social integration for them and their families.[14]

Since the debate, the NHS 10-year plan and the Government response to a consultation on dental contract reform have been published, focussing heavily on prevention, and as part of the incoming government pledge, expanding water fluoridation, promising 700,000 more urgent dental appointments, and keeping the incentivisation of skill mix which was introduced in the previous reform changes. There is a requirement of newly qualified dentists to work within the NHS for a minimum period (intended to be 3 years) as well as mandating unscheduled care in every contract, developing complex care pathways for patients with high levels of disease, incentivising skill mix through dental nurses applying fluoride varnish as a course of treatment, increasing UDA acquisition for fissure sealants as a preventive modality, initiation of quality improvement modalities involving clinical audit, as well as peer review and annual appraisals for clinical team members. It supports a broader scope of practice for DCPs, promises to make working within the NHS more financially attractive and make Dentistry part of the neighbourhood health centres to allow all care to be in 'one-stop shops'.[27,52]

Conclusion

Oral health deterioration globally, and the current challenges within NHS Dentistry require urgent attention, but the question of whether this is an emergency is not easy to answer. Contract reform, fairer recruitment and spread of services across the land, and incentives for all dental staff to remain within the NHS are required. However, the dominant message was that prevention of dental disease is

the key to reducing costs and carbon footprint, using the current workforce appropriately and for sustainability of the environment. There were many valid questions, views and ideas put forward to better inform policy of the future. The importance of 'buy in' from the patients and 'self-care' promotion were viewed as paramount. We all need to urgently decide on how the resources allocated to NHS dentistry are used and what is a reasonable expectation from patients. The sustainability of the profession, NHS dentistry, quality of life and improved life chances, as well as the environment requires significant change of attitudes and ideas.

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Figures

The BSSPD 2025 Debate: Sustainability of Dentistry and Prosthodontics – is this an emergency?

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Abstract

Background: 21st century Dentistry in first world countries should be based on sound evidence-based prevention and timely access to relevant dental care, but is not the picture currently portrayed of dentistry within the United Kingdom (UK), by and for the key players involved (e.g. patients/public, government/commissioners, National Health Service [NHS], contract providers and performer workforce).

Aims: To summarise the issues that face the public, dental educators, dental workforce and commissioners of dental care in the UK (England) that were formally discussed at the British Society of Prosthodontics (BSSPD) Conference 2025.

Method: A panel was selected to include experts and spokespeople for the Department of Health / Chief Dental Officer, Dental Public Health, the British Dental Association (BDA), Postgraduate Dental Education and Training, and workforce research, to debate five themes of sustainability in front of an audience of Foundation Dentists (FD), Dental Core Trainees and Educational Supervisors, Speciality Trainees, as well as General Dental Practitioners, Specialists and Consultants in Prosthodontics and Restorative Dentistry.

Conclusion: The discussions of this debate on sustainability confirmed the need for novel approaches/offers with better understanding, funding and delivery of effective prevention models, urgent contract reform, with suggestions for education and health systems that can support (new and existing) dental workforce challenges.

Key points:

1. This debate discussed the acute and current challenges faced by dentistry in the UK, with an open and bold debate making suggestions for improvement for all stakeholders.
2. Prevention of dental disease is the most effective way to reduce costs for the National Health Service, through education and investment.
3. Understanding of the impact of political change on the sustainability of the workforce, and impact of travel on the sustainability of the environment are important considerations in future decision-making.

Introduction

Dental disease is common, but for the majority, preventable. Dental caries and periodontal disease are leading causes of tooth loss[1] and oral health has now been described as alarming and urgent, due to the significant impact on the quality of life as well as life chances.[2] Oral diseases have been ranked as the most prevalent conditions globally, and across countries of all levels of income.[2] With an ageing population, polypharmacy and treatment such as radiotherapy to the jaws may lead to xerostomia and increased risk of dental disease.[3-7] There are emerging links between oral health and chronic diseases.[8] For the last few decades, national population oral health surveys have consistently shown increasing tooth retention, potentially due to improvement in population oral health. Some aspects appear not to have improved, such as pre-school caries and the number of hospital-based general anaesthetics, as well as poor oral health in areas of deprivation for teenagers and adults. These, along with life expectancy and quality life years, are closely related to deprivation indices and impact the economy.[9-11]

These issues may also be confounded by NHS dental workforce distribution, with shortages in areas of highest need and more rural areas. These have been referred to as '*dental deserts*' in the UK.[12,13] Many vulnerable individuals in deprived areas in the UK are currently unable to access the NHS care that they need. Evidence suggests that Dentists and Dental Care Professionals (DCPs) often originate from, and therefore, gravitate to live and work in urban environments, where there are both NHS and Private dental care opportunities.[14] Unfortunately, although health policies are changing, significant barriers remain for Dental Therapists to work to a full scope of practice in NHS practice; presenting a missed opportunity to optimise their potential for patient benefit.[15-17] It is important to understand that private care and activities for dentists and DCPs do not solely involve what was traditionally thought of as dentistry. There is now an established market and demand for facial and tooth aesthetics, which

dental registrants can develop skills to provide for patients, thus diverting resources from routine dental care.

The sustainability of dentistry, especially NHS dentistry is dependent upon a workforce that is fit for purpose, accessible and adequately funded. The cost of delivery of this care is increasing and as such the current model of care is unsustainable.

The issues facing the sustainability of dentistry within England was discussed in a panel debate at the BSSPD Conference in London, in April 2025. Mr Peter Briggs (PB) chaired the debate. The panel (Figure 1) consisted of:

- Mr Eddie Crouch, (EC) Elected Chair of the BDA Board, previous Deputy Chair of the BDA
- Professor Jenny Gallagher MBE (JG): Newland-Pedley Professor of Oral Health Strategy and Honorary Consultant in Dental Public Health in the Faculty of Dentistry, Oral and Craniofacial Sciences at King's College London; President Elect International Association for Dental oral and Craniofacial Research (IADR)
- Professor Nick Barker (NB) Deputy Chief Dental Officer for England and Joint Regional Chief Dental Officer for NHS England East of England Region and Professor of Oral Health Sciences for University of Essex, and is also a dental practice owner and a provider of level 2 endodontic and periodontic services in Colchester, Essex
- Ms Sana Movahedi (SM): Regional Postgraduate Dental Dean for London, Kent, Surrey and Sussex, who is also responsible for NHS England Work Force Education and Training.
- Professor Nicolas Martin (NM): Professor of Restorative Dentistry and Consultant in Restorative Dentistry, School of Clinical Dentistry, University of Sheffield.

All panel members and delegates agreed to recording of the session to support publication of this debate. This paper aims to summarise discussions that took place during the debate on the challenges

currently facing dentistry in the UK and particularly in England. It puts forward advice to all stakeholders and policy makers to consider innovative ways to engage with the population and workforce. BSSPD is apolitical and functions as a national charitable learned dental society. Its role is to facilitate education, support research, and facilitate learning and debate, with an emphasis on Prosthodontics. Some recorded comments, from individual panel members, are included within the paper, which appear in *Italic* font, and are not necessarily the view of BSSPD.

Theme 1: what are patient and public experience of dental care?

The debate was commenced by PB, highlighting recent surveys and reports in mainstream media on patient experiences of NHS and private dentistry in the UK and how these have changed in recent years, including reports in the media of patients self-extracting their own teeth.[18] The reports illustrate the difficulty patients have had with access to NHS care in primary care, with fewer concerns about the cost. The size of the problem differs across different geographies, with more challenges in deprived and rural areas. Patients are currently unhappy if they are unable to access NHS dental care, and those who can afford private dental care are happier with the service delivery from the profession. Although, more people are using private dental services, some feel that these are expensive. Patients would generally prefer to be 'enrolled' or 'registered' with a particular NHS dental practice and dentist (of their choice). The General Dental Council (GDC) Community Research Survey Report also echoes these concerns and concluded that, although respondents had confidence in the quality of dental care in the UK, they lack confidence in their ability to access care, with health inequalities and affordability concerns also very apparent.[19] These issues are affecting current public and patient experiences and behaviours, and they are having an increasingly negative impact on confidence in the sector.[18] The recommendations of Health Watch England in 2024 clearly laid down in steps, and include giving

everyone a General Medical Practitioner (GP) style right to be permanently registered with a dental practice for preventative and urgent care throughout their lives.[20]

Is this an emergency for dentistry - is the provision of dentistry in the UK not fit for purpose? The general consensus was yes, and this is a pivotal point for us to make change (Fig 2). Are we as a profession, potentially losing the trust of the public? Patients are more aware of the problems. Although, historically there have been anecdotal views that dentists are being greedy, that view seems to have changed. From the panel discussion, in the main, it was felt that, those that have a dentist seem to think that they have the best dentist and want to keep seeing that dentist. Those that have access to NHS dental care seem to highly regard this care. The public seem to wish for continuity of dental care, within a practice, from a clinician that they know and have built a relationship with. The confidence in the individual dentist is still there but there is loss of confidence in the system.

In England and Wales, do we know the population's oral health needs and the complexity of those needs? This is a pertinent question as the last National Adult Dental Health Survey of England and Wales was carried out in 2009. We do need to know and understand the size and complexity of oral health needs of the population, particularly as aligned to the NHS England commissioning standards in England,[21] to identify relevant training needs of GDC registrants, and to plan a sustainable skills mixed workforce team for the future.

There was broad agreement that this survey should take place every 10 years, as it is hugely valuable data resource that informs research, policy and strategy. Additionally, it should provide a thorough understanding of the complexity of treatment need to enable meaningful workforce planning across primary and secondary care. There is also a need to direct some of the responsibility onto the patient. The audience consisted of a lot of dental foundation trainees, working in high needs areas providing NHS dentistry. This cohort of the profession identified that despite best efforts to contact patients

reminding them of their appointments, there are many wasted hours of time as a result of patients not attending their appointments. Many patients are currently not placing value on attending appointments.

Theme 2: do we have a sustainable workforce?

The current dental workforce consists of new UK and overseas dental graduates (dentists and DCPs). To support complexity of care levels 1 (routine), 2 (moderate complexity) and 3 (complex),[21] a varied skill mix of Dentists, Dentists with Enhanced Skills, Specialist Dentists, as well as a variety of DCPs including Dental Nurses, Dental Nurses with Enhanced Skills, Dental and Orthodontic Therapists, Dental Hygienists, Dental Technicians, Clinical Dental Technicians and Maxillo-facial Clinical Technologists are needed. The supply and retention of Whole Time Equivalent (WTE) staff within the NHS dental services is a significant challenge.

There is evidence from the National Audit Office that the UK, compared to other similar G7 European countries (Germany / France / Italy) has a less favourable number of dentists per 10,000 of population.[22] Using a similar metric, there are significant differences in the four nations of the UK, with England and Wales significantly lower than Scotland and Northern Ireland. The dental workforce is not equally distributed across England. This leads to both inequity and inequality, often in rural deprived areas compared to highly populated, urban areas, widely publicised by the British Broadcasting Corporation.[23] Of course, this does not take into account dental and orthodontic therapists, dental hygienists, or clinical dental technicians who may be providing some dental care. Additionally, it does not take account of the impact of the Covid-19 Pandemic, and the changes that have happened since. Some have indicated that the impact has been 1,100 fewer dentists doing NHS work than before the pandemic, and fewer clinical hours.[24] However, there seems to be a theme that the NHS 'dental desert' dentist workforce shortages are not present near existing dental schools in England.[14] So are more

people leaving the GDC register than joining it? During a poll of the audience, by show of hands of the FD present, a large proportion indicated a desire to work part-time, with the majority wanting to work with the NHS and help shape it. In the last decades, UK dental workforce planners have actively encouraged and become reliant on the use of overseas dentists to plug this deficit in the workforce.[25] Are overseas dentists the solution to our NHS dentist sustainability issues? The general views of the panel are shown in Figure 3.

It was agreed that the current geographical distribution of the dental schools compounds this problem. The current application rate for dentistry is at its highest level, with over 30 applicants for each undergraduate dental position this year, a testament to the quality of dental education in the UK. They are equipped with skills, knowledge and behaviours, but they all require support and encouragement in their on-going careers. '*You do not make a good dentist in 5 years. It is a continuous, longitudinal, iterative process of many years*' (NM). The *dental deserts* exist because the infrastructure does not exist in those areas for a thriving life, for example transport, shopping, schools, etc. Dentists are very expensive to educate and train, so how can we retain the ones that we have trained? The delivery of dentistry is changing, with expansion of the corporate model, and the lobbying of government for more dentists. But '*a dentist from anywhere is not going to stay if the system is not workable*' (EC). Previous visions were to expand the workforce by 40% for dentists and 40% for dental therapists, but dental schools are costly to build. Where is the money going to come from? Is there a potential for expansion of the existing dental schools to minimise the costs, whilst still addressing the issue of manpower? There was real concern about the supply and retention of academic and teaching staff, which would be needed to increase numbers of the workforce.

There was worry about oversees dentists working with limited GDC registration, and in particular about the individual and the level of support they may receive. Much will depend on their undergraduate and post-graduate experience levels, as there is a great variation in skills and knowledge. There were

concerns across the panel about even UK nationals who have trained in European universities and have spent their whole dental education communicating through an interpreter. When they return to work in the UK, there is an issue of communicating effectively with patients. Although, more dentists are needed, there may already be enough dental hygienists and dental therapists but not working to their full scope of practice.[26] The career aspirations of dually trained dental hygienist and therapy students seem to be to work full time (average of 8 sessions per week) in a mixed (private/NHS) environment, spending 3 days on dental hygienist work and 2 days on therapy work. Financial stability, work life balance and gaining professional experience were cited as the most important influences on career choices.[15,17] Supporting existing dental schools to increase their capacity will require a physical expansion of the premises and the right kind of diverse workforce needed for training. The panel agreed that these, and NHS contract reform should be priority targets for increases to workforce numbers to help access to good NHS dental care and prevention.

The panel did not think that the use of non-UK healthcare workers was the answer to a sustainable workforce, both in the UK but also in the countries they come from due to 'brain drain' and the impact on the health care system of the country these healthcare workers emigrate from. The panel voiced that the pre-registered overseas dentists model to deliver more NHS dental care was potentially unsafe for the UK public. There was much enthusiasm from the panel for investment in the skills and knowledge of the current UK workforce to include: enhanced dental nurses, clinical dental technicians and other DCPs to ensure relevant skills and training are used to the benefit of the UK public. The increased reliance on dental corporates to deliver NHS care was thought by many to create additional risk, as failure of a large corporate is likely to have a larger overall impact upon NHS dentistry both for patients and commissioners than loss of a few individually owned practices. Is there any merit in considering limiting the number of corporate dental practices in an area to encourage practitioners to open NHS dental practices without the threat of being 'taken over', thereby giving patients more choice? There is an issue about levelling playing fields in procurement and being under bid. This may

ensure access and stability in any given geography: if a corporate body goes under, there remain a good number of other NHS and Private dental providers for patients.

The panel discussion considered the importance and impact from private practice, which is now a significantly bigger financial market for dentistry in the UK, than the NHS (several times bigger). Stakeholders and policy makers should not ignore this 'elephant in the room', within the current system, as it will affect any decisions made by the workforce, in terms of where and how they want to work. The example raised by panel members was that many trained dental therapists currently work as private dental hygienists. There would need to be significant NHS contractual change to encourage them to work as dental therapists in NHS dental practices, particularly in England. Since this debate, the Government has responded to a consultation regarding reform of the NHS contract for dentistry which does include prevention, reform and incentivisation to maintain and develop access to NHS dental care based on contract reforms that began in 2022.[27, 28]

Theme 3: do we have a sustainable system for the delivery dental care?

The cost of NHS dentistry in the UK is said to be around £3.1 billion with a third of that made up from the patient charges not including secondary care funding.[29] The UK Dentistry Market Report stated that the private market was expected to reach £10.6 billion by 2024.[30] Figure 4 shows the panel views on the sustainability of NHS dentistry in the UK.

There was strong agreement from the panel audience that the current England Unit of Dental Activity (UDA) NHS primary contract is unsustainable, it is 'broken' and not 'fit-for-purpose'. The decline of NHS dentistry in primary care, particularly in England, may now be terminal and unrecoverable, in the future. Morale is also low within the workforce teams and the quality culture of the NHS dentistry is not good. Private care (where affordable) has now filled much of the 'lost' NHS capacity. This is

particularly true in the more affluent areas. Dentistry in many geographies, has now moved into to the cosmetic / beauty business with tailored financial products to support this. Many of the treatments provided are unavailable on the NHS, and remedial treatment may also not be available within the NHS.

There was discussion of political will, investment and the best use of any 'unused' NHS dental funding'. It was suggested that the UK politicians must agree on what they want the NHS dental contract to cover in their country and be honest with the public on what this means. The dental profession can only advise them on the likely implication(s) of their decisions. One option raised was to invest more money that supports better prevention, with incentives for the dental workforce to work in deprived rural areas where there is high clinical need, and strong support for skill-mixed delivery of NHS care. There was also agreement that any 'unused' funding from NHS dental contract performance ('claw back' or unused UDAs) should be returned to dentistry by NHS England, and a system set up to be able to do this in a timely fashion. The general view of the panel members was that Local Dental Networks (LDNs) should have input with how this money is best used. Other ideas included reducing or shrinking the 'reach' and thus expectation of the current contract in England, to essential or 'core' elements of service, which include prevention, emergency care, simple fillings and extractions. This must include a 'means-tested' element for items outside the 'core' service.

Concerns about the 'deal' currently for NHS providers (contract owners) and NHS performers (associates) were raised. It was noted that the balance between the two had changed significantly over the years, with many early years practitioners considering working in 'salaried' NHS posts, in preference to dental associate positions.[31] This suggests workforce apprehensions over current terms and conditions of employment. Very encouragingly, the early years work force present at the conference were keen to work in the NHS for the foreseeable future, although it was noted that some may lack the confidence to move directly into private practice. They were keen also to explore a period

NHS 'buy-in' at the beginning of their career, for example negation of the debt associated with undergraduate fees for a 5-year commitment to NHS dental care delivery. For those in the audience, a 10-year NHS buy-in was less popular. Some would respond positively to an offer of a 'Golden Hello' to work in hard-to-fill areas, and others would not. *'The government might argue that they already heavily contribute to the training of a clinical dental student to the tune of £37,000 NHS funding per student, per year, to support four years of clinical training. This is a huge contribution from the taxpayer. The student loan is a very small part of the cost it takes to train a dental student'* (NM).

A great loss to the primary care NHS system has been the erosion of the traditional pattern of purchasing a practice relatively early in a career, and growing a patient base.[32] There was agreement that encouraging individual ownership and 'building-up' of NHS (and possibly mixed) dental practice capacity, particularly by the young workforce in areas of greatest clinical need and challenging access was of benefit. There was acceptance that this may be unpopular with established NHS practices. To improve the sustainability of NHS services and younger workforce working in primary care, such opportunities may need to be considered by commissioners and 'new' NHS provider contract opportunities supported by 'claw back' monies. NB, the representative of OCDO felt that some of secondary care money could be spent within primary care. Others felt that there is already inadequate funding for NHS secondary care in Dentistry – which makes up no more than 10% of overall spend. The audience posed three questions to the panel about the current system (Figure 5).

Theme 4: what is the role of undergraduate and postgraduate education and training on delivery of a sustainable workforce?

The panel agreed that they both have a huge role for future sustainability, and undergraduate schools should create / build a positive culture towards NHS dentistry and it not be considered a substandard

service, with the issues highlighted are shown in Figure 6. Recruitment into dental schools may need to be broader and consider the wider skills required for delivery of holistic care and prevention, and delivery of high-quality dental treatment, not just consider academic rigour. The four A* method may not be the best discriminator, however, academic achievements consider a wide range of knowledge and development skills that go beyond 'academic content'. All applicants (future dentists) must be able to engage clinically, but also engage in intelligent, knowledge-based, rational decision making processes. The dental team need to be both do-ers and think-ers at the same time. There needs to be some form of metric that will identify a baseline of knowledge and awareness; that currently is through A level grades. Ideally, the application process would also have other metrics that also equate to operative, organisational, social skills. It would be appropriate to agree and develop a National Person Specification of the ideal qualities of a successful dentist and DCPs? These qualities would need ranking in order of importance and robust methods for identifying and testing them will be required.

Undergraduate dental schools should be strongly aligned to the NHS, due to taxpayer contribution to teaching, and must deliver relevant skills for the workforce needs, in a sustainable way. The suggestion was to expose the future workforce early, to the importance of skill-mix working and this model of dental care delivery, learning to work and learn alongside others with the goal of delivering care and having respect for the roles played by each individual, not just in a dental environment but also the wider healthcare system.

There was broad agreement that the current locations of Dental Schools in England does not best support spread of the workforce to all regions. Expansion of existing sites may not be as easy due to the current estates and need for rebuilding some. Recruitment from the ‘dental deserts’ will be essential, however, currently applicants from London and the South East dominate recruitment to English Dental Schools. How do we encourage applicants from the ‘dental deserts’ and encourage the

right people to come into dentistry? One model could be a partnership between clinical delivery sites in the 'dental desert' areas and current schools for pre-clinical and didactic teaching. The clinical teaching delivery sites need good experienced dentists, who understand the principles and tools of clinical education / learning / training. Some current dental schools struggle to deliver the patient volume needed to provide a broad clinical experience and the type and approach of care needed in high needs areas, therefore outreach clinics would be helpful. Educational stakeholders should ensure that they understand the challenges of working in NHS primary care dentistry, and meet the need to develop postgraduate education hubs in areas currently poorly served by dental schools and dental practices, such as support for training for levels 2 and 3 through NHS training.[33]

Theme 5: what is the environmental cost of delivering dental care?

The last of the themes started with a map of the UK with high spots of emissions. Transport is the largest emitting sector of greenhouse gas (GHG) emissions, producing 26% of the UK's total emissions in 2021, and 28% (427 MtCO2e) in 2022.[34] The UK is responsible for approximately 1% of total world emissions with air travel alone responsible for 2% of total world emissions.[35,36] Staff and patient travel is one of the most significant environmental issues. The carbon footprint of the different elements of dentistry has been published, with the largest emissions related to dental examinations, scale and polish, intra-coronal restorations and denture construction.[37] Two important points were raised:

NM: 'The northern part of the country has poor public transport links, with diesel trains. The north of the country needs electric train networks for travel, otherwise everyone will drive. Infrastructure is a problem. The other problem is that patients have to go to the dentist several times for reactive reparative treatment. Prevention is key, but also when treatment is needed, do the job well, so that it lasts longer, (to) reduce or slow down the restorative cycle. Don't start it at all, even better. Treatment

plan in such a way as to maximise the work done in each visit, integrated care with families attending their appointments together or possibly in multi-care centres, and if you do this well, share this good practice with your peers. Engage with patients. Society is becoming aware of the environment and reducing eating meat for example; but we do not talk about the huge knock on effect of not requiring treatment for obesity, smoking, dental treatment. Reducing the need for treatment will have the biggest unintended impact on the environment'.[38]

NB: 'The current clinical guidance for unscheduled care, it actually talks about remote working and remote consultations with patients. This is the first time we have made reference to the fact that patients do not have to come to you'.

The group agreed that effective and successful prevention is the key for dentistry to best support the environment, with the largest cost to the environment being the travel of patients and staff to access dental care.[37] Low-cost population wide and individualised prevention interventions, by all healthcare professionals, focussing on reducing the intake and frequency, especially of free sugars, can reduce the need for costly treatment and re-treatment cycles, with self-care still being the most cost effective method of prevention.[39,40] This echoes the NHS aspirations to move the treatment of sickness to prevention of sickness, making the NHS a more attractive place to work, invest in people and infrastructure and overall investment in people and infrastructure to be able to move care from hospitals to communities.[41,42]

Consider multiuse practices where one episode of travel may mean not only dental treatment, but also a visit to the general medical practitioner, physiotherapist, optician all in the same venue and visit. Staff travel arrangements should also be considered to reduce emissions, such as better public transport, local recruitment and incentives for several members of staff traveling together. Numerous other suggestions were also supported:

- Meetings / conferences consider via online platforms
- Use more digital consultations and Tele dentistry
- Less mercury use – more focus on prevention and greater clarity of when amalgam fillings have significant advantages over resin-based fillings potentially reducing the reparative cycle
- Constantly to be mindful of environmental sustainability, with reference to travel, procurement, energy efficiency, biodiversity, education, waste management and prevention[36]

Discussion

The overriding message from the debate was that prevention of dental disease was the most appropriate way to reduce the NHS dental care provision and cost burden.[43] A focus on targeted Oral Health prevention, working with medical colleagues and targeting the most disadvantaged and vulnerable, with a basic level of dental provision should be considered an essential public service, especially with poor dental health also be co-related to other costly conditions, such as diabetes, cardiovascular disease and Alzheimer's disease. The group supported focus on quality, to ensure high success of the treatment outcome: if treatment is needed, it should be carried out to a high standard to avoid short term failure / infection, and the need for costly revision treatment, although it is appreciated that all dental care will require some level of revision or alternative treatment as long-term failures will eventually occur. On-going prevention support would also reduce this burden. All stakeholders (patients, dental health care professionals, general health care professionals, commissioners, regulatory bodies, policy makers, wider industry and suppliers) need to understand the value and impact of oral ill health to implement up-stream, mid-stream and down-stream actions to prevent population wide dental disease (Figure 7).

The discussions during the debate focussed on encouragement of the workforce to commit to the NHS. Early year practitioners at conference seemed keen to remain within the NHS, although a point was made that this may be related to confidence in their ability to provide private dental care. The idea of an incentive to make a commitment ('lock-in into the NHS') in exchange for negating their student debt seemed to be well met, suggesting a 5-years of 'lock-in' would be acceptable but not 10 years. This begs the question of why the work force is no longer considering a career in NHS dentistry.

There was support for better terms and conditions of employment and salaried NHS working, skill-mix working model, consideration of different models of prevention delivery, and NHS contract reform in England. The size and the composition of the work force may need to change with a different proportion of dentists and dental care professionals. There are dental deserts in England, where patients are unable to access NHS dentistry. The dentists working in these areas are choosing to work outwith the NHS. How can NHS dental care be delivered in these areas?

Many important suggestions were made:

- An urgent debate on the findings of the current (to be published this autumn) adult dental survey in England to include an assessment of the complexity of identified need
- NHS dentistry is under resourced, with much contractual monies lost from 'claw back in recent years. This should be reversed and future 'claw back' retained to dentistry
- Use of a skill-mix Dentist and DCP working model to deliver levels 1, 2 and 3 clinical complexity.
- Establish undergraduate and postgraduate teaching and training hubs in the dental deserts of England, to create an educational community in such areas for the dental workforce.
- Each LDN should consider a dental workforce plan, related to local oral health needs, with dental Foundation training placements and undergraduate dental schools working more closely with the NHS and LDNs, to ensure an adequate supply of workforce to the most deprived areas.

- More Level 2 and 3 training programmes may need to be established in the most deprived areas, to include prosthodontics, and formalised NHS training.
- Consider 'offers' that are relevant to encourage new and existing dental workforce to rural and deprived areas, such as 'golden hellos', striking off student debts and enhanced terms and conditions of employment and wider social integration for them and their families.[14]

Since the debate, the NHS 10-year plan and the Government response to a consultation on dental contract reform have been published, focussing heavily on prevention, and as part of the incoming government pledge, expanding water fluoridation, promising 700,000 more urgent dental appointments, and keeping the incentivisation of skill mix which was introduced in the previous reform changes. There is a requirement of newly qualified dentists to work within the NHS for a minimum period (intended to be 3 years) as well as mandating unscheduled care in every contract, developing complex care pathways for patients with high levels of disease, incentivising skill mix through dental nurses applying fluoride varnish as a course of treatment, increasing UDA acquisition for fissure sealants as a preventive modality, initiation of quality improvement modalities involving clinical audit, as well as peer review and annual appraisals for clinical team members. It supports a broader scope of practice for DCPs, promises to make working within the NHS more financially attractive and make Dentistry part of the neighbourhood health centres to allow all care to be in 'one-stop shops'.[27,52]

Conclusion

Oral health deterioration globally, and the current challenges within NHS Dentistry require urgent attention, but the question of whether this is an emergency is not easy to answer. Contract reform, fairer recruitment and spread of services across the land, and incentives for all dental staff to remain within the NHS are required. However, the dominant message was that prevention of dental disease is

the key to reducing costs and carbon footprint, using the current workforce appropriately and for sustainability of the environment. There were many valid questions, views and ideas put forward to better inform policy of the future. The importance of 'buy in' from the patients and 'self-care' promotion were viewed as paramount. We all need to urgently decide on how the resources allocated to NHS dentistry are used and what is a reasonable expectation from patients. The sustainability of the profession, NHS dentistry, quality of life and improved life chances, as well as the environment requires significant change of attitudes and ideas.

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P. Briggs current member and former elected committee member and Past President of the British Society of Prosthodontics

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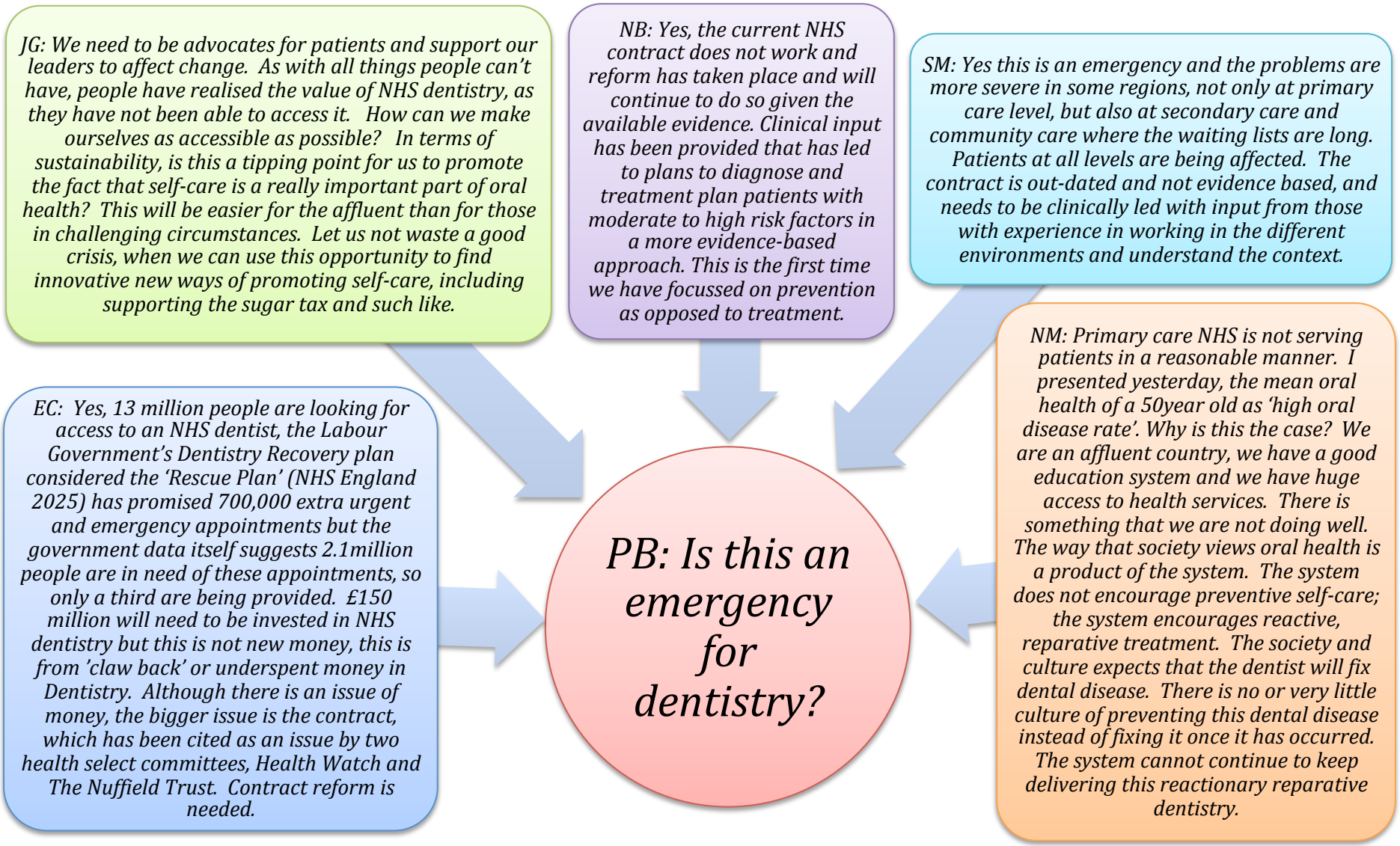
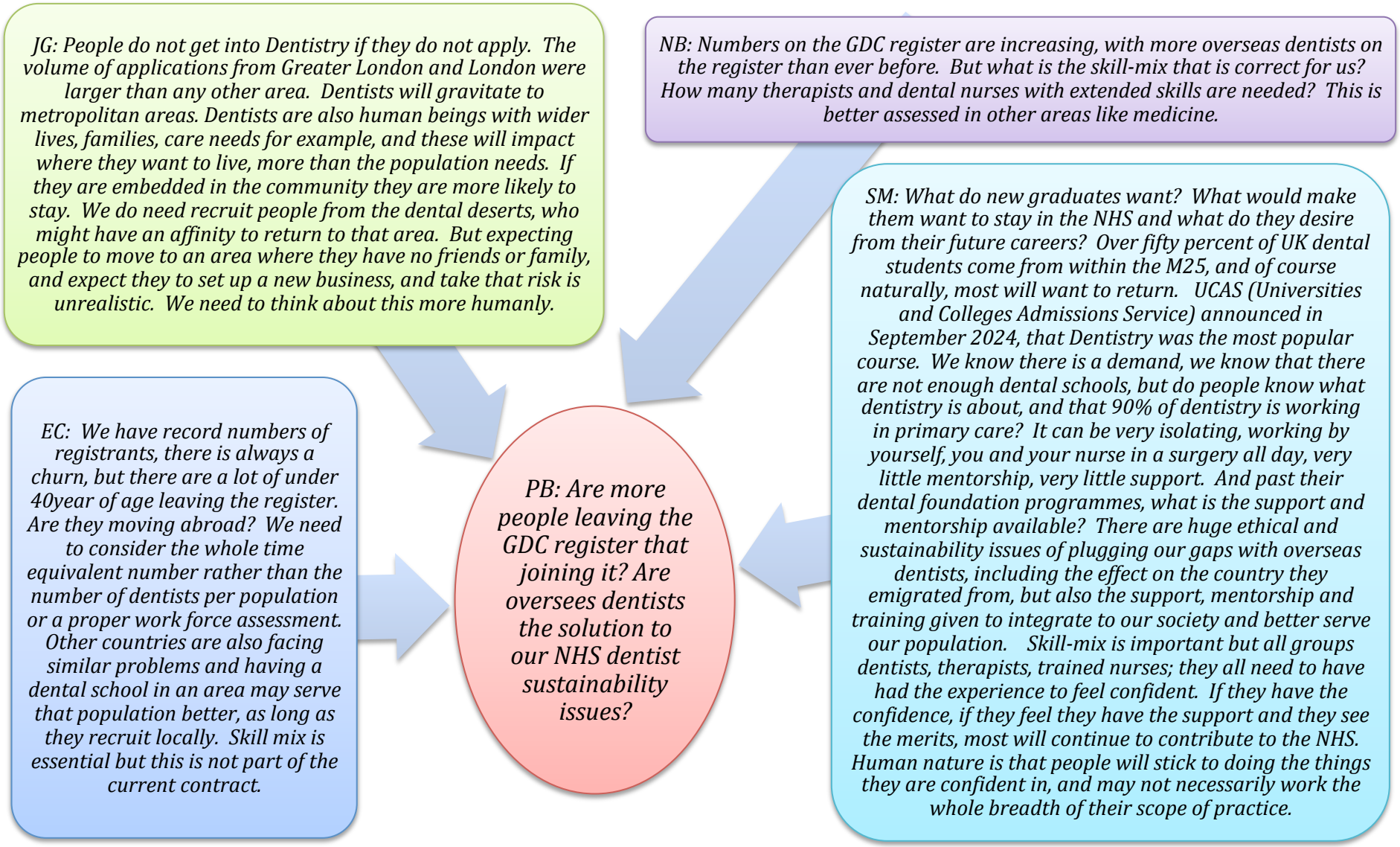
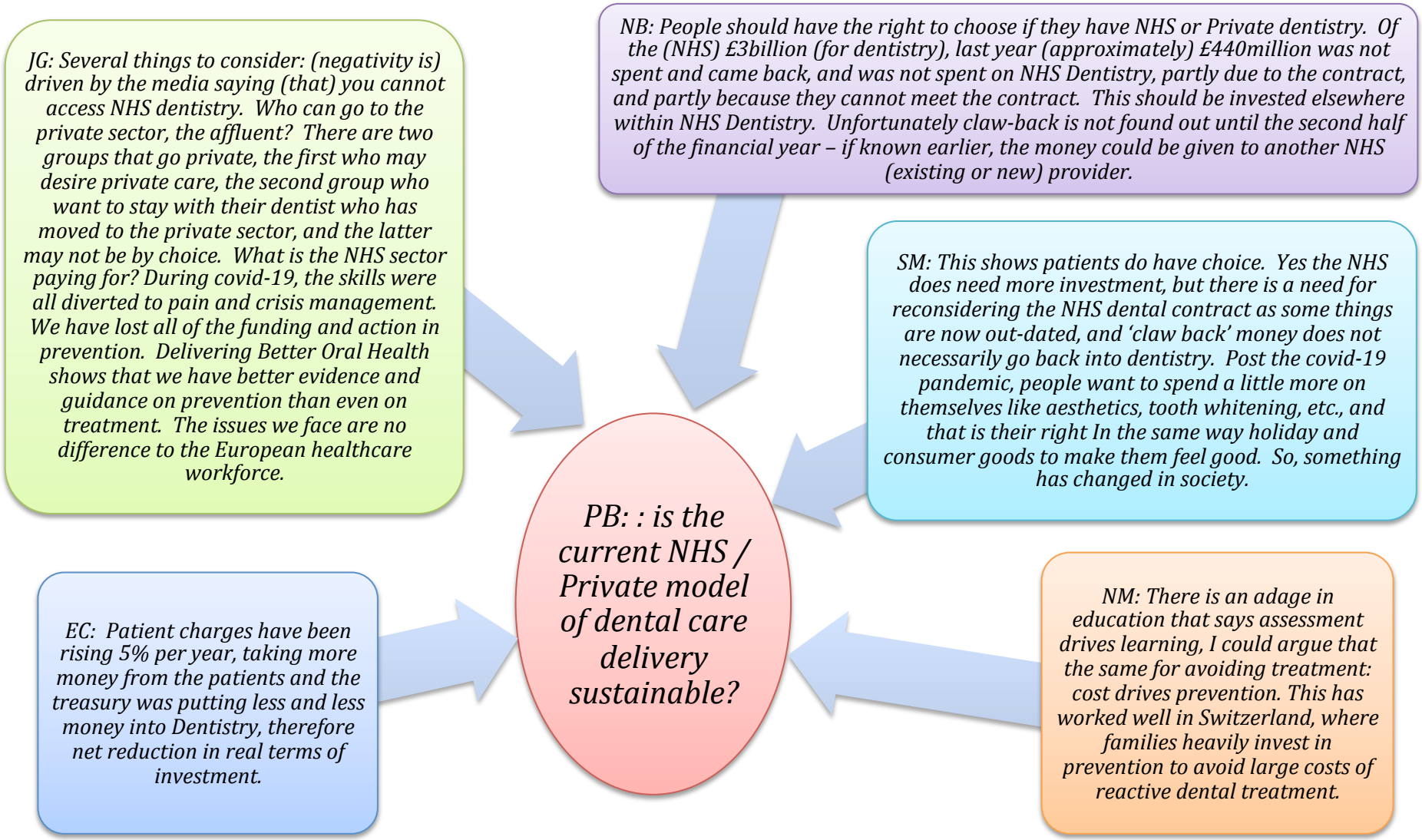
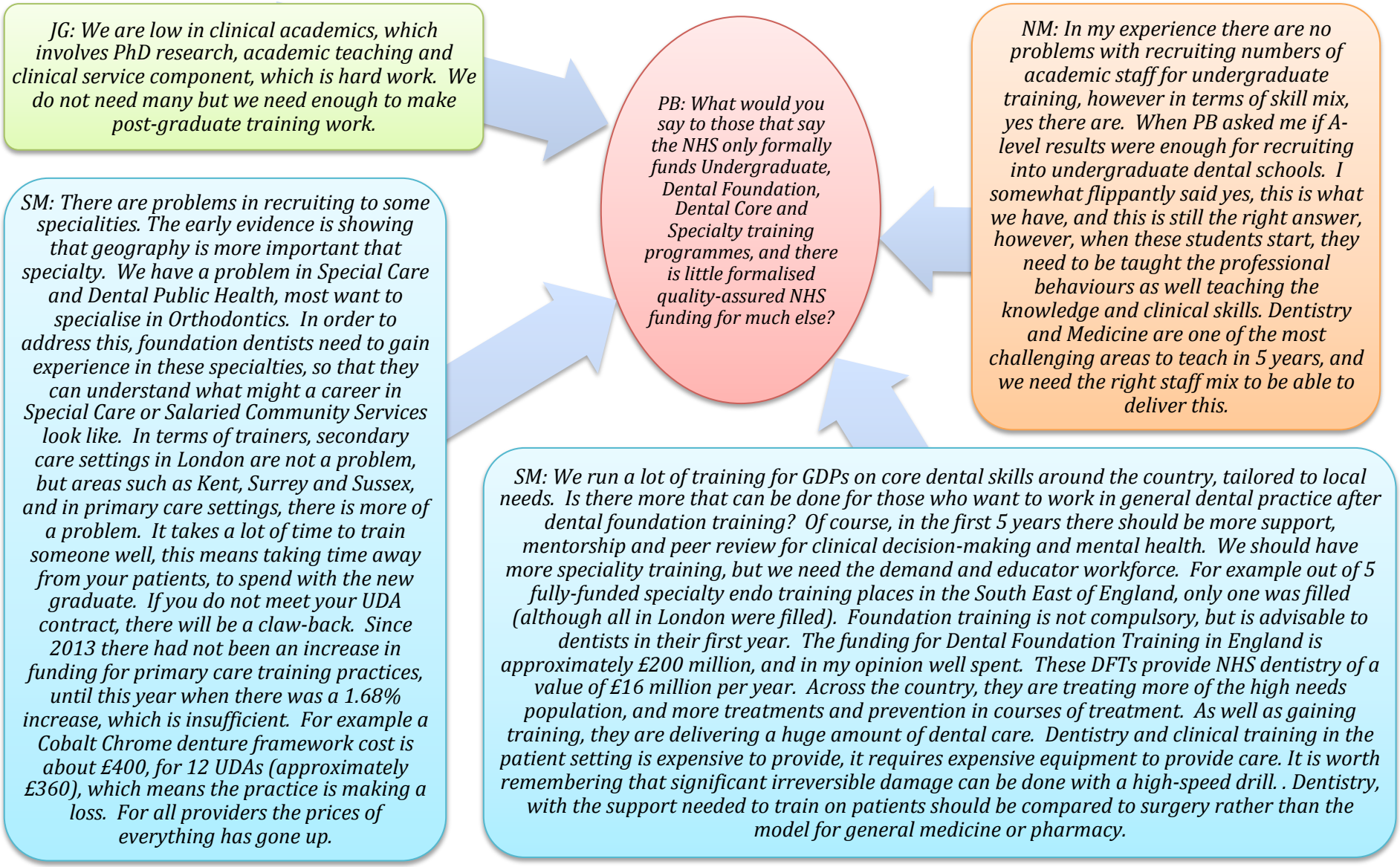
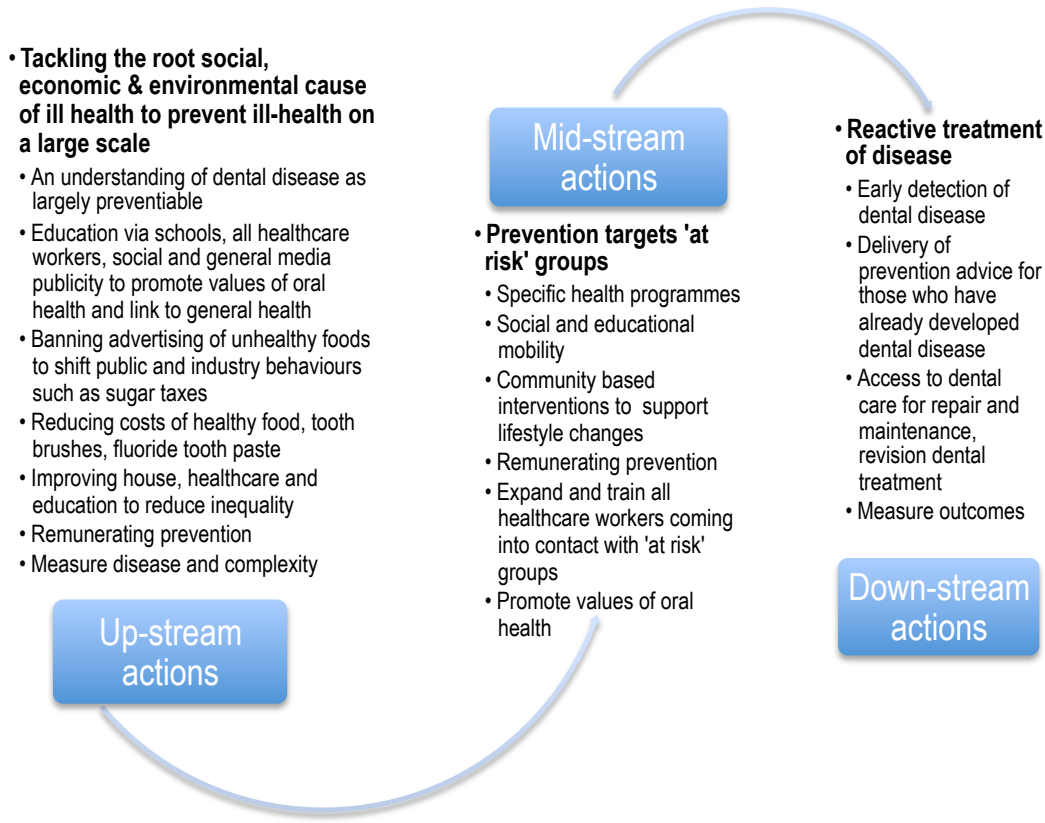

JG: We need to be advocates for patients and support our leaders to affect change. As with all things people can't have, people have realised the value of NHS dentistry, as they have not been able to access it. How can we make ourselves as accessible as possible? In terms of sustainability, is this a tipping point for us to promote the fact that self-care is a really important part of oral health? This will be easier for the affluent than for those in challenging circumstances. Let us not waste a good crisis, when we can use this opportunity to find innovative new ways of promoting self-care, including supporting the sugar tax and such like.
NB: Yes, the current NHS contract does not work and reform has taken place and will continue to do so given the available evidence. Clinical input has been provided that has led to plans to diagnose and treatment plan patients with moderate to high risk factors in a more evidence-based approach. This is the first time we have focussed on prevention as opposed to treatment.
SM: Yes this is an emergency and the problems are more severe in some regions, not only at primary care level, but also at secondary care and community care where the waiting lists are long. Patients at all levels are being affected. The contract is out-dated and not evidence based, and needs to be clinically led with input from those with experience in working in the different environments and understand the context.
EC: Yes, 13 million people are looking for access to an NHS dentist, the Labour Government's Dentistry Recovery plan considered the 'Rescue Plan' (NHS England 2025) has promised 700,000 extra urgent and emergency appointments but the government data itself suggests 2.1million people are in need of these appointments, so only a third are being provided. £150 million will need to be invested in NHS dentistry but this is not new money, this is from 'claw back' or underspent money in Dentistry. Although there is an issue of money, the bigger issue is the contract, which has been cited as an issue by two health select committees, Health Watch and The Nuffield Trust. Contract reform is needed.
PB: Is this an emergency for dentistry?
NM: Primary care NHS is not serving patients in a reasonable manner. I presented yesterday, the mean oral health of a 50year old as 'high oral disease rate'. Why is this the case? We are an affluent country, we have a good education system and we have huge access to health services. There is something that we are not doing well. The way that society views oral health is a product of the system. The system does not encourage preventive self-care; the system encourages reactive, reparative treatment. The society and culture expects that the dentist will fix dental disease. There is no or very little culture of preventing this dental disease instead of fixing it once it has occurred. The system cannot continue to keep delivering this reactionary reparative dentistry.


JG: People do not get into Dentistry if they do not apply. The volume of applications from Greater London and London were larger than any other area. Dentists will gravitate to metropolitan areas. Dentists are also human beings with wider lives, families, care needs for example, and these will impact where they want to live, more than the population needs. If they are embedded in the community they are more likely to stay. We do need recruit people from the dental deserts, who might have an affinity to return to that area. But expecting people to move to an area where they have no friends or family, and expect they to set up a new business, and take that risk is unrealistic. We need to think about this more humanly.
NB: Numbers on the GDC register are increasing, with more overseas dentists on the register than ever before. But what is the skill-mix that is correct for us? How many therapists and dental nurses with extended skills are needed? This is better assessed in other areas like medicine.
EC: We have record numbers of registrants, there is always a churn, but there are a lot of under 40year of age leaving the register. Are they moving abroad? We need to consider the whole time equivalent number rather than the number of dentists per population or a proper work force assessment. Other countries are also facing similar problems and having a dental school in an area may serve that population better, as long as they recruit locally. Skill mix is essential but this is not part of the current contract.
PB: Are more people leaving the GDC register that joining it? Are oversees dentists the solution to our NHS dentist sustainability issues?
SM: What do new graduates want? What would make them want to stay in the NHS and what do they desire from their future careers? Over fifty percent of UK dental students come from within the M25, and of course naturally, most will want to return. UCAS (Universities and Colleges Admissions Service) announced in September 2024, that Dentistry was the most popular course. We know there is a demand, we know that there are not enough dental schools, but do people know what dentistry is about, and that 90% of dentistry is working in primary care? It can be very isolating, working by yourself, you and your nurse in a surgery all day, very little mentorship, very little support. And past their dental foundation programmes, what is the support and mentorship available? There are huge ethical and sustainability issues of plugging our gaps with overseas dentists, including the effect on the country they emigrated from, but also the support, mentorship and training given to integrate to our society and better serve our population. Skill-mix is important but all groups dentists, therapists, trained nurses; they all need to have had the experience to feel confident. If they have the confidence, if they feel they have the support and they see the merits, most will continue to contribute to the NHS. Human nature is that people will stick to doing the things they are confident in, and may not necessarily work the whole breadth of their scope of practice.


JG: Several things to consider: (negativity is) driven by the media saying (that) you cannot access NHS dentistry. Who can go to the private sector, the affluent? There are two groups that go private, the first who may desire private care, the second group who want to stay with their dentist who has moved to the private sector, and the latter may not be by choice. What is the NHS sector paying for? During covid-19, the skills were all diverted to pain and crisis management. We have lost all of the funding and action in prevention. Delivering Better Oral Health shows that we have better evidence and guidance on prevention than even on treatment. The issues we face are no difference to the European healthcare workforce.
NB: People should have the right to choose if they have NHS or Private dentistry. Of the (NHS) £3billion (for dentistry), last year (approximately) £440million was not spent and came back, and was not spent on NHS Dentistry, partly due to the contract, and partly because they cannot meet the contract. This should be invested elsewhere within NHS Dentistry. Unfortunately claw-back is not found out until the second half of the financial year – if known earlier, the money could be given to another NHS (existing or new) provider.
SM: This shows patients do have choice. Yes the NHS does need more investment, but there is a need for reconsidering the NHS dental contract as some things are now out-dated, and 'claw back' money does not necessarily go back into dentistry. Post the covid-19 pandemic, people want to spend a little more on themselves like aesthetics, tooth whitening, etc., and that is their right In the same way holiday and consumer goods to make them feel good. So, something has changed in society.
PB: : is the current NHS / Private model of dental care delivery sustainable?
EC: Patient charges have been rising 5% per year, taking more money from the patients and the treasury was putting less and less money into Dentistry, therefore net reduction in real terms of investment.
NM: There is an adage in education that says assessment drives learning, I could argue that the same for avoiding treatment: cost drives prevention. This has worked well in Switzerland, where families heavily invest in prevention to avoid large costs of reactive dental treatment.

Audience Q1: Is dentistry absent from almost all debates at a government levels and what are you doing about it?	• *EC: The mention of dentistry in parliament has never been as important as it is now. I have in my BDA role met nearly 200 MPs in the past 4 years. This means that people are telling their MPs about dentistry, many in dental deserts. The time for talking about this is over, what we need now is action. If there is no more money, then we need to ask what an NHS dental service can and cannot provide. Does it mean the money is focussed on making our children the healthiest in terms of oral health? We need bold ideas on how to use the money we have effectively.*
Audience Q2: What is a realistic time frame for reform of the primary dental care contract (the dreaded UDAs)?	• *NB: The timeframe was 2 years ago. The changes were not considered that effective, as we need to get all of the part of the puzzle right to deliver this. To be controversial, have we got evidence to show that the care we receive privately is better than the care we receive on the NHS? Does private dentistry earn well from prevention? If we start to turn the NHS to a prevention style contract, then all of a sudden the contract mirrors good practice, very good practice. Contract reforms next steps are by April 2026.*
Audience Q3: In my area, there are no NHS Tier 2 providers with the skills to manage a simple toothwear case. Why are Tier 2 roles in prosthodontics/restorative dentistry not recognised as an agenda item for commissioners?	• *SM: This is a question for the commissioners. We have tried to train performers in this area, but the NHS primary care contracts are not there for them. There is no point us training anyone, if the jobs are not there for them at the end of the training. The bureaucracy has to reduce and change, because the governance for spending public money is there.*


JG: We are low in clinical academics, which involves PhD research, academic teaching and clinical service component, which is hard work. We do not need many but we need enough to make post-graduate training work.
PB: What would you say to those that say the NHS only formally funds Undergraduate, Dental Foundation, Dental Core and Specialty training programmes, and there is little formalised quality-assured NHS funding for much else?
NM: In my experience there are no problems with recruiting numbers of academic staff for undergraduate training, however in terms of skill mix, yes there are. When PB asked me if A-level results were enough for recruiting into undergraduate dental schools. I somewhat flippantly said yes, this is what we have, and this is still the right answer, however, when these students start, they need to be taught the professional behaviours as well teaching the knowledge and clinical skills. Dentistry and Medicine are one of the most challenging areas to teach in 5 years, and we need the right staff mix to be able to deliver this.
SM: There are problems in recruiting to some specialities. The early evidence is showing that geography is more important that specialty. We have a problem in Special Care and Dental Public Health, most want to specialise in Orthodontics. In order to address this, foundation dentists need to gain experience in these specialties, so that they can understand what might a career in Special Care or Salaried Community Services look like. In terms of trainers, secondary care settings in London are not a problem, but areas such as Kent, Surrey and Sussex, and in primary care settings, there is more of a problem. It takes a lot of time to train someone well, this means taking time away from your patients, to spend with the new graduate. If you do not meet your UDA contract, there will be a claw-back. Since 2013 there had not been an increase in funding for primary care training practices, until this year when there was a 1.68% increase, which is insufficient. For example a Cobalt Chrome denture framework cost is about £400, for 12 UDAs (approximately £360), which means the practice is making a loss. For all providers the prices of everything has gone up.
SM: We run a lot of training for GDPs on core dental skills around the country, tailored to local needs. Is there more that can be done for those who want to work in general dental practice after dental foundation training? Of course, in the first 5 years there should be more support, mentorship and peer review for clinical decision-making and mental health. We should have more speciality training, but we need the demand and educator workforce. For example out of 5 fully-funded specialty endo training places in the South East of England, only one was filled (although all in London were filled). Foundation training is not compulsory, but is advisable to dentists in their first year. The funding for Dental Foundation Training in England is approximately £200 million, and in my opinion well spent. These DFTs provide NHS dentistry of a value of £16 million per year. Across the country, they are treating more of the high needs population, and more treatments and prevention in courses of treatment. As well as gaining training, they are delivering a huge amount of dental care. Dentistry and clinical training in the patient setting is expensive to provide, it requires expensive equipment to provide care. It is worth remembering that significant irreversible damage can be done with a high-speed drill. . Dentistry, with the support needed to train on patients should be compared to surgery rather than the model for general medicine or pharmacy.


• Tackling the root social, economic & environmental cause of ill health to prevent ill-health on a large scale
• An understanding of dental disease as largely preventiable
• Education via schools, all healthcare workers, social and general media publicity to promote values of oral health and link to general health
• Banning advertising of unhealthy foods to shift public and industry behaviours such as sugar taxes
• Reducing costs of healthy food, tooth brushes, fluoride tooth paste
• Improving house, healthcare and education to reduce inequality
• Remunerating prevention
• Measure disease and complexity
Up-stream actions
Mid-stream actions
• Prevention targets 'at risk' groups
• Specific health programmes
• Social and educational mobility
• Community based interventions to support lifestyle changes
• Remunerating prevention
• Expand and train all healthcare workers coming into contact with 'at risk' groups
• Promote values of oral health
• Reactive treatment of disease
• Early detection of dental disease
• Delivery of prevention advice for those who have already developed dental disease
• Access to dental care for repair and maintenance, revision dental treatment
• Measure outcomes
Down-stream actions