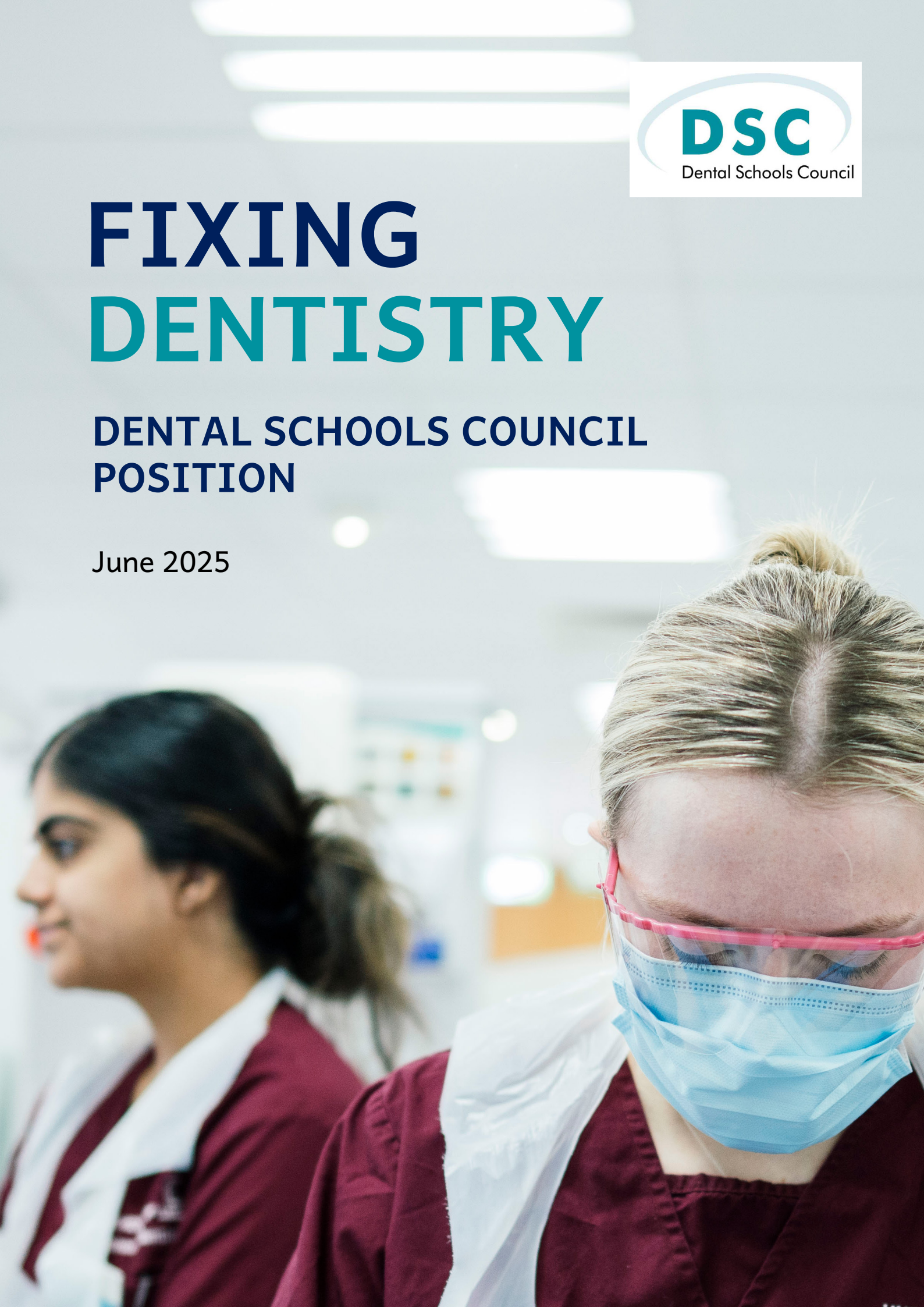
FIXING DENTISTRY

DENTAL SCHOOLS COUNCIL POSITION

June 2025



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Summary

What are the problems?

- There are insufficient dentists, dental hygienists, dental therapists and dental nurses to meet patient demand for NHS oral healthcare.
- Some regions, like the East and South East, have fewer applicants to dentistry and dental therapy, meaning there is a smaller pool of potential NHS oral healthcare workers wishing to work in those regions. However, recruiting students from under-served areas does not guarantee they stay in or return to that region, as there are no structured career pathways nor incentives to support long-term retention.
- Dental Hygiene and Dental Therapy clinical placements receive 10 times less funding support than Dentistry, making these programmes financially non-viable for universities to expand training, with Dental Therapy programmes closing across the UK. On these placements, students treat real patients for free.
- More clinical academics are retiring than being replaced, risking the viability of training future generations of oral healthcare practitioners and researchers.
- Poor access to NHS dentistry leads to preventable health issues which have economic impacts. It is estimated there are 1.2 million lost workdays per year, and £millions in extra NHS treatment costs.
- Ineffective use of the diverse and cost-effective skill sets of dental professionals including dental nurses, dental hygienists and dental therapists.
- Few incentives for dental hygienists and dental therapists to join and stay within the NHS workforce, primarily due to limited job opportunities, inequitable payment structures, and restricted access to pension benefits.

What needs to happen?

- Better incentivise new and existing dentists to work in NHS oral healthcare. This can only be solved by the Government.
- Government must define and commit to new training numbers in all four nations.
- Expand Dentistry and Dental Hygiene and Dental Therapy places in England.
- Fix clinical placement funding to make training viable for Dental Hygiene and Dental Therapy.
- Establish regional training hubs in dental deserts.
- Invest in clinical academic careers to sustain expert-led cutting-edge treatments.
- Invest in capital funding to support uplift in training rather than increase in current establishments where the only option leads to diluting quality of training.

Background

Existing and proposed dental schools recognise the urgency of NHS access issues and are keen to take more dentistry, and dental hygiene and therapy students. Meanwhile, applicant numbers increase yearly and potential oral healthcare workers are turned away, for example in 2023 there were over 10,000 UCAS applications for 940 dentistry places at UK schools [This figure is based on UCAS data provided under a Standard Licence, subject to UCAS publication limits of 100 datapoints total.]

Internationally trained members of the dental team are crucial and valued in the UK, and they bring unique skills and perspectives to research, clinical work, and education. Indeed, the UK remains heavily reliant on professionals trained overseas, for example, in 2024, 47% of new dentists registered qualified abroad. However, given the high cost of training dental staff, (DHSC estimates that it costs £292,000 to train a UK dentist), the UK's overreliance on other countries to provide trained oral healthcare staff is both inappropriate and precarious. Expanding training places for UK applicants would reduce this imbalance and support fairer, more resilient workforce recruitment.

The Dental Schools Council (DSC) has persistently advocated for expanding the dental workforce to address national shortages in patient access. The Public Accounts Committee (PAC) hearing on NHS dentistry (13 February 2025) highlighted the severity of patient access issues especially in 'dental deserts' where there are the fewest NHS dentists. DSC's evidence to the PAC was central to discussions on workforce expansion, clinical training, and regional disparities. With the NHS Long Term Workforce Plan under revision, DSC urges Ministers and NHS officials to implement comprehensive, long-term solutions to improve access to oral healthcare. DSC is pleased to offer its insights and recommendations for a shift to greater provision of NHS oral healthcare.

NHS work

The Dental Schools Council is concerned that there is substantial attrition from the NHS workforce. Evidence by NHS England shows more than 95% of graduates go on to work in the NHS, starting with Dental Foundation Training. By age the youngest staff do the most NHS work. However, the growing number of private-majority and private-only workers highlighted by the GDC is a strong concern for universal patient access. Dental Schools are considering how to continue to promote NHS careers. Dental schools do not advertise private dentistry careers and neither should other public and dental staff facing media.

The NHS may wish to reflect on how it promotes itself to all dental professional groups and ensures their voices are heard. While dental schools embed teamworking across all roles, this is not always mirrored in the workforce plans, career progression routes, or financial incentives for the wider dental team.

Expanding the workforce

Workforce planning should be coordinated across all four nations to ensure consistency in recruitment, training, and retention, including for specialists and clinical academics. In the short term, a combination of international recruitment and increased domestic training will be needed to meet the UK's oral health needs.

In England, dentistry student numbers were cut by 10% in 2013, worsening workforce challenges. DSC called for a reversal, and the previous government announced a 40% increase in BDS and DH&T places through a long-term workforce plan in England. Other UK nations have not had the same cut, nor the same promise of expansion, except for 10 new dentistry places in Scotland.

Workforce expansion must be upheld and embraced across all four UK nations to meet rising patient demand and workforce shortages. The 40% increase in dentistry places previously proposed in the 2023 NHS Long Term Workforce Plan in England was welcomed and seen as essential to ensuring a steady pipeline of trained dentists.

DSC also recommends an increase in Dental Hygiene and Dental Therapy places. The Advancing Dental Care (ADC) Review (2021) underscored the importance

of skill mix, highlighting that better utilisation of dental therapists and Dental Hygienists for preventive care, check-ups, improving efficiency and patient outcomes. Using international comparisons, the ADC showed that systems with a balanced workforce have better patient access, reduced pressure on dentists, and improved oral health outcomes. Expanding DH & DT training is necessary to meet workforce needs, given the very small initial cohort of places (300) to build from in the UK and Ireland. It is worth highlighting the overlapping of legally permitted clinical procedures, between dentists, dental therapists, and dental hygienists, which presents an opportunity to transform service delivery at scale, DSC has prepared a brief introduction on its 'studying healthcare' website.

However, dental hygiene and dental therapy clinical placements, where like dentistry, trainees treat real patients, usually at no charge, receive ten times less funding than Dentistry in England, and there are funding difficulties in other nations. This makes expansion financially non-viable without urgent reform. Uplifting the clinical placement tariff is necessary and will need to be coupled with extended accountability reporting and improved ringfencing by partner trusts so that the funds are spent appropriately and transparently. Due to funding shortfalls, a number of Dental Therapy courses across the UK are closing, leaving future numbers of Therapists in doubt. The overlapping skills abilities (at 87%), academic and clinical training and expectations between dentists and dental therapists are not utilised in reality and not acknowledged financially for training.

Greater awareness of the roles of dental hygienists and dental therapists across the wider dental team, including among reception staff and patients, is essential to ensure appropriate referrals and build patient confidence. Realising the full potential of this skilled workforce will require coordinated collaboration between the British Dental Association, national NHS organisations, and major employers, including through the Association of Dental Groups.

Although training providers are ready to expand provision, significant barriers remain to employing the dental therapy workforce to its full capacity, including limited employment opportunities after graduation, few financial incentives, and restricted access to NHS benefits such as pensions. Without action, there is a real risk that dental therapists will become de-skilled soon after qualification.

The NHS has demonstrated its commitment to equity by integrating other allied

health professionals, such as Physician Associates, into its workforce and offering them financial incentives. However, comparable recognition and support have not yet been extended to dental careers—raising concerns about equity across healthcare professions. Ensuring fair inclusion and investment in the dental workforce is essential if all healthcare professionals are to contribute fully to population health and well-being.

Expanding Dental Nurse training is also vital to ensure fully staffed NHS dental teams. Workforce planning must maintain a balanced pipeline across all Dental Care Professional groups to support team-based care.

A representative workforce – widening access and dental deserts

Widening participation in dental education is essential for a sustainable, diverse workforce that understands the needs of the people it delivers care for. Recruiting talent from a wide range of backgrounds strengthens the profession, improves patient trust, and helps oral healthcare to reach underserved areas. Opportunities to enter dental education are currently skewed by geography, socio-economic background, and ethnicity, unfairly excluding many capable candidates and reducing the pool of talent. Contextual admissions policies that take account of applicant backgrounds such as guaranteed interviews and adjusted entry requirements are necessary to level the playing field.

Individual dental schools improve fairness and representation through contextual admissions, financial support, local recruitment from areas with lower progression to higher education, open days, mentoring schemes and summer schools. Some schools target outreach, especially longitudinal schemes, for applicants from the local region or parts of the region with lower progression to higher education.

DSC Admissions Committee continues to consider best practice in fairness in admissions, which is likely to soon be a regulatory requirement. Actions have included a survey of existing work at schools and a joint fairer work experience policy. DSC, with the Medical Schools Council, runs a programme of work in England funded by NHSE to promote better access to dental and medical careers. Activities are rigorously evaluated and have included online and in person summer

schools for underrepresented students, a national webinar series providing admissions guidance, and market research into applicant motivations and barriers.

Government advocacy and support is essential to scale efforts nationally and align dental workforce expansion with areas of greatest need. No region in the UK has an oversupply of oral healthcare professionals while the most acute shortages persist in underserved areas. Existing efforts to address dental workforce shortages tend to focus on areas within reach of dental schools, rather than the more isolated regional 'dental deserts' such as the East and South East of England. Indeed, relative to their regional 18-year-old populations, DSC analysis of private data supplied by UCAS has found the South West, East of England, and South East of England (excluding London) struggle with far fewer young people applying for dentistry. Policy should encourage a more strategic distribution of places, such as awarding extra points for strong applications from low-progression-to-healthcare regions. Establishing new dental training centres in rural and coastal areas with postgraduate and undergraduate placements could be part of the solution, and the Dental Schools Council will support their development where they are established.

Recruiting from 'dental deserts' is not enough—professionals must be supported to stay or move to them. Attracting local students does not guarantee long-term retention, so further measures are necessary. For graduates to work in dental deserts, there must be structured career pathways that provide clear progression opportunities, expanded local training options, research initiatives to support professional development, and direct incentives such as financial support and enhanced training provisions. The golden hello scheme in England, which has not been substantially impactful yet, should be altered and re-piloted. Stronger regional networks and mentoring schemes should be established to help support professionals and connect them to their communities, increasing the likelihood of long-term. The Welsh Enhanced Recruitment Offer scheme provides strong evidence that this approach can work. In its 2023/24 cohort, 90% of dental trainees chose to remain in Wales after completing their Foundation Training year in rural practices, thanks to structured support including a £7,000 rural living grant, enhanced training, and wellbeing support. Well-designed local incentives and support can help build a sustainable oral healthcare workforce in underserved areas.

Supporting research

The clinical academic workforce is fully responsible for delivering undergraduate dental education. A strong clinical academic workforce is crucial for education, research, and innovation, but retention is challenged. The number of full-time equivalent clinical academics aged 66+ has risen from 10 (1.8%) in 2014 to 25 (4.3%) in 2024, highlighting reliance on an ageing workforce. This creates a 'cliff edge,' with many clinical academics nearing retirement and too few successors to sustain expertise and training. Without urgent action, the loss of experienced academics will harm dental education and research. NHS and university cuts further threaten the pipeline, as these could lead to the prioritisation of teaching and clinical work over research.

DSC's Clinical Academic Working Group will publish its own guidance and engage with the Office for the Strategic Co-ordination of Health Research (OSCHR) commissioned report on improving recruitment and retention to clinical academic roles. Recommendations may include,

- Ongoing funding for INSPIRE, catch.ac.uk, and cross-sector collaborations.
- Support for intercalated degrees and master's/MD Res programmes.
- Career pathways that reduce geographic and financial barriers.
- Greater inclusion of DCPs in clinical academia, aligned with updated Follett principles.
- Promotion of specialist areas with workforce shortages, such as Special Care Dentistry and Dental Public Health.

Economic benefits of dental schools

Dental schools significantly impact the economy by providing direct patient care. Students gain practical experience while delivering treatments to patients in the local community. For instance, Peninsula Dental School has administered treatments to over 50,000 patients including vulnerable groups such as individuals experiencing homelessness and patients with learning disabilities. The integration

of education and service delivery reduces NHS costs and enhances long-term patient outcomes.

Graduates from dental schools contribute to public health and the economy. Poor oral health leads to over 1.2 million lost workdays annually, costing the UK economy approximately £105 million each year. Public Health England has noted that dental problems lead children to miss an average of three school days per year. In 2022-23, 31,165 tooth decay-related extractions were carried out on children in England, an average of 85 per day. This cost NHS England £40.7 million, and disrupted children's education and their parents' work. Better access to preventative oral healthcare would lower these numbers and would bring other wellbeing, health and economic benefits. Illnesses that begin in the mouth do not always stay there, and preventative oral healthcare should be acknowledged for its role in mitigating risks of patients developing morbidities like cardiovascular disease and diabetes. One study estimates treating gum disease earlier for at-risk patients could save the NHS £124 million each year.

Although fatalities are rare within oral health compared to medicine, the economic burden of oral disease disrupts supporting the NHS and overall population health. The current NHS approach in all four UK nations fails to recognise the integral connection between oral health and systemic health, focusing predominantly on treatments rather than preventive care.

Dental schools have a unique and important role in training future generations, improving patient access to care, delivering NHS dental care, and improving the economy.

Next steps

The DSC is ready to collaborate with policymakers, NHS, and the wider dental profession to implement these solutions. Stakeholders to implement these will include the organisations below:

- Government and NHS Workforce Planning Organisations: Department of Health and Social Care, HM Treasury, NHS England, NHS Employers, NHS Workforce Training and Education, Health Education and Improvement Wales, Welsh Government, NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency.
- Education and student representation groups: Dental Schools Council, Medical Schools Council, Vice-Chancellors, Committee of Postgraduate Dental Deans and Directors, British Dental Students' Association.
- Secondary Care and Integrated Care Systems: Association of Dental Hospitals, Integrated Care Systems.
- Workforce groups and Trade Unions: British Dental Association, British Association of Dental Nurses, British Association of Dental Therapists, British Society of Dental Nurses, British Society of Dental Hygiene and Therapy, Dental Technologists Association, Association of Dental Groups, British Dental Industry Association, Dental Laboratories Association.
- Regulatory Bodies: General Dental Council, Office for Students, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, Medr, The Regulation and Quality Improvement Authority.
- Patient Advocacy and Health Policy Groups: Toothless in England, Healthwatch England, Nuffield Trust, King's Fund, Health Foundation.
- Equity, Diversity and Inclusion Organisations: African and Caribbean Dental Association, Diversity in Dentistry Action Group.
- Royal Colleges and specialist representative organisations.

Summary of the recommendations

Recommendation	Lead Stakeholders (not exhaustive)
Better incentivise careers in NHS oral healthcare	Governments NHS Employers Trade unions
UK governments should actively state how many student places should be provided so that dental schools, hospitals, and practices can expand.	Government NHS Regulatory bodies BSHDT BADT BADN
In England, NHSE and DHSC should facilitate an increase in dentistry and DH&T places, ensuring sufficient and ringfenced clinical placement funding.	Government NHSWTE Regulatory bodies Education institutions and student organisations Secondary Care and Integrated Care Systems
Raising awareness of the dental hygiene and therapy scope among DCPs, receptionists, and patients.	Regulatory bodies Patient advocacy and health policy groups Trade Unions BADT BSDHT BADN
Expanding DCPs workforce overall.	Government NHS Regulatory bodies BADT BSDHT BADN

Enabling a fair distribution of awarded dentistry and DCP places. Initiatives could include awarding extra points for strong applications from low-progression-to-healthcare areas.	Government NHS Regulatory bodies
Support retention in dental deserts.	Workforce, employers and trade unions BSDHT BADT BADN
Tackle barriers to starting and continuing research careers.	Education institutions and student organisations Workforce and employer organisations BSDHT BADT BSDHT BADT BADN
Raise awareness of the health and economic contribution of student clinics and preventative oral health care.	Health policy groups

For further discussion, please contact Rosie Pearce: rosie.pearce@medschools.ac.uk.