BDA

British Dental Association

Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2023-24

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Chapter 1 – Executive summary

1.1. Long-term and unfunded cost increases in the delivery of NHS activity continue to profoundly undermine the financial sustainability of dental practices and the sector.

1.2. Real-term government spend on NHS dentistry across the UK remains well-below 2010-11 levels, representing a 38 per cent cut since 2010. Alongside managing the inevitable consequences of this long-term reduction in government spending on NHS dentistry, practices are now facing extraordinary inflationary pressures that are increasing the costs of essential materials and services. We set out these pressures in detail as captured by our primary research in paragraphs 5.17-5.23/Chapter 5.

1.3. Despite an increase in pay for practice owners in 2020/21 attributable to the temporary financial support given to dental practices during the pandemic, the long-term trend since 2006/2007 for both practice owners and associates is of a very significant decline in take-home pay.

1.4. Reflecting the ongoing challenge of delivering NHS activity, in the British Dental Association's (BDA) annual survey almost half of associates reported their intention to increase the amount of private work they undertake, up from 39 per cent in 2021. The proportion of practice owners reporting their intention to increase the amount of private work they undertake also increased considerably from 22 per cent in 2021 to 39 per cent this year. Almost two-thirds of practice owners and associates told us their morale was low or very low, representing the poorest results ever recorded in our survey. 75 per cent of practice owners and 56 per cent of associates working in practices with a high NHS commitment told us they were very or extremely stressed.

1.5. The recruitment and retention crisis in dentistry has deepened since last year, with more vacancies going unfilled for longer periods. 95 per cent of practices with a high NHS commitment who had tried to recruit associates reported difficulties in doing so, with more than half of all practices with vacancies reporting that they had posts that had been vacant for more than six months. 90 per cent of practices reported difficulty recruiting dental nurses.

1.6. There is unequivocally a crisis in recruitment, retention, morale and motivation, and, critically for patients, in the availability and delivery of NHS dental services. The DDRB must act in this pay round to address the long-term real-terms decline of dentists' pay, as well as ensuring that the current very high levels of inflation do not erode this further. We therefore ask the DDRB to recommend an uplift of RPI plus five per cent for GDPs and employed dentists' pay. We also call for:

1.6.1. Timely implementation of pay awards
1.6.2. Separate recommendations on expenses
1.6.3. Reinstatement of commitment payments for England, Wales, and Northern Ireland
1.6.4. The overall annual expenses uplift to be applied to service costs for Dental Foundation Training Practices
1.6.5. That the DDRB reiterates the historical recommendation of pay parity of clinical academics

Chapter 2 – About the BDA

2.1 The BDA is the professional association and trade union for dentists practising in the UK. Our membership includes general practice, community dental services, the armed forces, hospitals, academia and research, dental public health and includes dental students.

2.2 Our evidence to DDRB covers General Dental Practitioners, the Community Dental Service (Public Dental Service in Scotland) and Dental Academics. We have also included a short section on Civilian Dental Practitioners and a short section on Hospital Dentists (Consultants, SAS dentists and dentists in training), which should be read as complementary to the relevant section in the British Medical Association's submission.

2.3 Fieldwork for the quantitative survey that informs this submission was conducted between 6th June and 15th August 2022. Where we refer to practice owners with a 'high NHS commitment' we are referring to respondents who have indicated that their practice as a whole delivers 70 per cent NHS activity. Where we refer to associates with a 'high NHS commitment' we are referring to respondents who have indicated that 75 per cent of their time is spent on NHS activity.

Chapter 3 – BDA response to the 50th report

3.1 As we have repeatedly shared in our evidence to the DDRB, delays to the uplift process have a material impact on the financial sustainability of dental practices. Delays also cause practical problems for GDPs where backdated payments must be made, particularly where individuals have retired or left the NHS, and also for Foundation Dentists who completed their training in August. We welcome the DDRB's comments in the 50th report again reiterating the importance of timeliness in the contract uplift process, and similarly again emphasise the critical importance of a return to the former timetable to ensure uplifts occur in April each year.

3.2 As we stated publicly in response to the 2022-23 pay round, the DDRB's recommendation regrettably fell well below the levels of inflation that have subsequently occurred, and therefore amounted to a real-terms pay cut. We therefore sought a recommendation that accounted for inflation and do so again this year.

Year	NI		England		Scotland		Wales	
2022-23	*Still not known*	-	Feb 2023 anticipated	10 mths	Dec 2022	8 mths	Dec 2022	8 mths
2021-22	May 2022	13 mths	Dec 2021	8 mths	Dec 2021	8 mths	Oct 2021	6 mths
2020-21	Aug 2021	16 mths	Dec 2020	8 mths	Nov 2020	7 mths	Nov 2020	7 mths
2019-20	Aug 2020	16 mths	Nov 2019	7 mths	Aug 2019	4 mths	Aug 2019	4 mths
2018-19	Aug 2019	16 mths	Dec 2018	8 mths	Nov 2018	7 mths	Sept 2018	5 mths
2017-18	July 2018	15 mths	Aug 2017	4 mths	April 2017	0 mths	May 2017	1 mth
2016-17	April 2017	12 mths	June 2016	2 mths	April 2016	0 mths	June 2016	2 mths
2015-16	No uplift*	10 mths	Aug 2015	4 mths	April 2015	0 mths	Aug 2015	4 mths

Fig 1: Implementation date of GDP uplift and the delay across the UK (**2015/16 decision to provide no uplift made 10 months late)*

Response to expenses uplifts

3.3 In our previous evidence, we set out the impact inadequate expenses uplifts have had on dentists' (in particular, associates') take-home pay, and we provide further evidence on this in paragraphs 5.18-5.24/Chapter 5. The BDA's long-standing position has been that the DDRB should return to its previous practice of making recommendations on uplifts to expenses. It was very welcome that the DDRB set out in its 50th report its clear expectations that the expenses uplift should form part of negotiations between the BDA and the governments, and that these uplifts should reflect the increases experienced in practices' operating costs.

3.4 It is worth underlining that 'expenses' refer to practices' operating costs and, in the main, not to the regulatory and indemnity professional costs incurred by individual dentists. Essentially, this represents the funding made available to dental practices to deliver NHS dental services, and as such covers everything from clinical materials and laboratory fees to non-dentist staff costs, clinical waste disposal and mortgages or rent. It is more accurate to describe these as the 'costs of care'. These costs of providing NHS care account for the majority of the funding provided, and therefore fluctuations in these costs have a direct bearing on the remaining funding that is left to be allocated among dentists as their take-home pay.

3.5 In line with the DDRB's 50th report, the BDA wrote to each government in July 2022, setting out the evidence that we had gathered from dentists on increasing costs of care and offered to discuss these with the view to agreeing an appropriate expenses uplift. This outlined that overall 'dental inflation' sat at 11.15 per cent and that inflation in staff costs was 15 per cent. In Northern Ireland, we supplemented this with further, detailed data on locally specific costs facing practices.

3.6 It is extremely frustrating that, despite the DDRB's clear view that expenses uplifts should be agreed by negotiation and on the basis of reflecting increases experienced in the cost of care, none of the four governments approached the process in this way.

3.7 In Northern Ireland, Scotland and Wales, no explanation has been provided of how the figure for an expenses uplift relates to increases in practice expenses, nor do we have any indication that any effort was made to quantify these increases. The governments simply imposed 4.5 per cent as the overall uplift. No effort was made to negotiate, nor consult, with the BDA on this figure.

3.8 In England, the DHSC has opted to apply a modified GDP deflator (5.3 per cent) to the expenses elements of the uplift and 4.5 per cent for staff costs; leading to an overall uplift of 4.75 per cent. This was subject to consultation, and not negotiation, with the BDA in November and December 2022, respectively. The BDA requested, but did not receive, evidence that the GDP deflator was an appropriate proxy for practice expense inflation.

3.9 All four governments indicated that 'affordability' was the principal criterion in their decision-making, rather than ensuring that the uplift reflected the inflationary pressures facing practices. Instead, they have decided that the burden of unaffordable costs should be borne by dentists.

3.10 The breakdown of the expenses uplift process, both procedurally and in the outcomes it delivers, is a matter of profound concern. It means that even where governments 'accept' the recommendation of the DDRB on pay, there is a mechanism by which this can be effectively bypassed and governments can ensure that this is not reflected in dentists' take-home pay by restraining the uplifts given on expenses. Therefore, even if the DDRB does not make

recommendations on expenses, it has a direct interest in ensuring that the expenses process works effectively and does not undermine the recommendations it makes on pay.

3.11 Given the complete failure of the current approach, there is a need for a fundamental review of how uplifts to the costs incurred in providing dental care are determined. Our strong and repeatedly expressed view is that the DDRB make recommendations on expenses uplifts. This would have the benefit of ensuring that pay and expenses are considered in tandem, in line with how funding is delivered to practices and dentists. Nonetheless, we are open-minded and willing to seriously consider other proposals and approaches, and to discuss this with the DDRB and governments urgently. The current mechanism is broken, and we must find a solution to end the continued real-terms cuts to dentists' take-home pay.

England

3.12 As occurred in the previous pay round, the DHSC's consultation rather than negotiation on the contract uplift for GDPs was significantly delayed, this year not taking place until the middle of November. While the BDA responded promptly to the consultation, the current pay round nonetheless represents the latest this process will have concluded. We anticipate that the uplift will be paid from February 2023.

3.13 Further to our comments in our submission to the DDRB last year, we are extremely disappointed to note that the DHSC intends that, for the 2022/23 period, service cost remuneration for Dental Foundation Training Practices will remain at the current level.

3.14 The monthly payment made in support of dental foundation training which is expressly intended to '*represent the service cost to the contractor of employing the Foundation Trainee'* has been fixed at £5,347 per month since the update to the *Statement of Financial Entitlements* in 2013.[1] If the monthly payment to Dental Foundation Training Practices had been adjusted in accordance with annual inflation since 2013, in 2022 it would be £7,482.00 by RPI.

3.15 The refusal to acknowledge cost inflation for Dental Foundation Training Practices represents another mechanism through which the DDRB's recommendations can be notionally accepted while take-home pay for dentists is eroded, and is clearly unacceptable. Anecdotally, members have told us that this long-unfunded cost could have a material impact on their ability, and willingness, to act as Training Practices in the future because of the financial position many practices find themselves in.

3.16 The BDA calls for the *Statement of Financial Entitlements* to be updated each year to align service costs for Dental Foundation Training Practices with the overall annual expenses uplift determined by the DHSC as part of its response to the recommendations of the DDRB. The expenses element of the uplift and the service cost payments are both intended to cover the same category of costs (i.e. costs associated with the provision of dental services) and therefore the uplift applied in respect of the former should be applied to the latter.

3.17 In relation to the expenses uplift, as discussed the Government has opted to apply the GDP deflator. There is evidence to suggest that the Government's use of the GDP deflator as their

[1] General Dental Service Statement of Financial Entitlements 2013 – NHSBSA (Chapter 7.5 d)

measure of inflation will lead to a misunderstanding of the pressures on practices now and in future rounds of funding. The deflator is not calculated at the same rate as other widely used inflation indexes and has in-built biases which over-value decreases and suppress increases. Given the energy-price related shock which has driven headline inflation since 2021, using the deflator is flawed as it does not include imports, but is closely related to economic growth – evidenced by its value being near 0 for 2021[2] even though food and oil prices were rising. Lastly, the value of the GDP deflator to judge price rises in the current climate is skewed due to its reliance on government spending, which has changed shape drastically since the Covid-19 pandemic.

Scotland

3.18 The Scottish Government made an announcement in October, confirming the 2022/23 pay uplift for GDPs which would be applied from 1 November and backdated to 1 April. The Scottish Government accepted the DDRB's recommended pay increase of 4.5 per cent and applied the increase to gross Item of Service fees, and to capitation and continuing care payments. However, we are again disappointed that the uplift will not be applied to the full GDP renumeration package. We made it clear that the uplift should be applied to all allowances otherwise it is not a true 4.5 per cent pay rise.

3.19 As NHS dental contractors have been in receipt of both multiplier payments and bridging payments during the 2022/23 financial year, the 4.5 per cent pay award will also be applied to both of these payments. The pay award will have been included in the November 2022 paid December 2022 schedule and backdated payments will be made in the December 2022 paid January 2023 schedule.

3.20 The salary payable for vocational trainees under Determination IV will increase to £2,937.17 per month (£35,246 per annum) with effect from 1 April 2022. Members have also highlighted that the Vocational Training (VT) Trainer Allowance has not been increased since 2014. This could impact on the sustainability of training practices and risks destabilising the VT scheme.

3.21 In relation to expenses, the Scottish Government applied the 4.5 per cent pay uplift to GDP expenses too. This was despite our calls highlighting the need for additional support from all four UK administrations to meet rising costs and soaring dental inflation. In his letter, the Cabinet Secretary cited the pressure on public finances and the 'unprecedented challenging fiscal environment'. This inadequate increase in expenses represents a further real-terms pay cut for GDPs. There is a real concern that some Items of Service are now being delivered at a financial loss. Treatment items involving laboratory fees are a particular area of concern, since significant increases in laboratory fee costs are impacting on practice expenses.

Wales

3.22 Delays in the GDS contract uplift have continued. The response to DDRB on pay awards was published by the Welsh Government in July. GDS contracts were to be uplifted by 4.5 per cent in full (not net of expenses) backdated to April 2022. This was confirmed by the Health Minister Baroness Morgan in correspondence on 15 August 2022 and was implemented from 1 December.

[2] GDP Deflator: Year on Year growth: SA % - Office for National Statistics (ons.gov.uk)

Northern Ireland

3.23 Once again, dentists in Northern Ireland are facing considerable delay and uncertainty regarding when they will receive their 2022/23 pay uplift. This year, we are also deeply concerned over the lack of due process in determining expenses, i.e. the costs incurred when providing dental care.

3.24 On 26 October 22, Minister Swann confirmed that while DoH has agreed to a 4.5 per cent net increase to fees and allowances for GDPs, the absence of a Northern Ireland Budget meant that this could not be paid. On 8 December, DoH announced it was in a position to implement DDRB recommendations for 22/23, with the expectation 'that staff will receive their pay increase before the end of the financial year'. As a result of political dysfunction, the pay review process continues to apply a full year behind in Northern Ireland, a situation that is completely intolerable.

3.25 We very much welcomed the clarity provided by the DDRB in its 50th Report in relation to expenses, specifically:

> 10.56 *'…instead expect that expenses uplifts will be agreed between the BDA and the governments as part of annual contract negotiations. Expenses uplifts must address issues such as increased operating and practice staff costs, which fall under practice expenses'*;
>
> 10.57 '*Ensuring that dental practices' financial sustainability and dental earnings are not affected by such fluctuations is an important responsibility that lies with the governments in agreeing expenses uplifts'.*

3.26 In response BDA NI wrote to DoH[3] to request a fit-for-purpose approach towards calculating expenses during a time when wider inflation is in double-digits. We supplied DoH with BDA calculations showing dental inflation requiring an 11.15 per cent uplift to the expenses element in order to provide the recommended 4.5 per cent uplift in pay. We also furnished DoH with extensive evidence of increased lab costs/examples of fees which generate losses e.g., dentures; dental treatments which generate hourly earnings considerably less than what is viable to meet surgery operating costs.

3.27 Despite clarity from DDRB on the correct process which ought to be followed, the profession has been left feeling badly let down by the decision by DoH to simply apply a blanket 4.5 per cent uplift to expenses, in common with the 4.5 per cent pay uplift element due to 'the financial pressures currently facing the department'.

Chapter 4 – Policy update

4.1 Dentists throughout the UK continue to deliver care to their patients in the face of unfunded cost increases in NHS dentistry and the resulting long-term reductions in take home pay. Alongside the deepening recruitment and retention crisis, practices are struggling to manage extraordinary inflationary cost pressures with a knock-on impact on the financial sustainability of the dental sector as a whole.

[3] BDA NI correspondence to Northern Ireland Health Minister of 21st July 22

England

4.2 As noted in our previous submission, in quarter four of the 2021/2022 financial year, dentists in England were expected to deliver 85 per cent of their contractual Unit of Dental Activity (UDA) targets, with that figure being effectively treated as '100 per cent delivery' for the purposes of income protection.

4.3 The need to maintain enhanced Infection, Prevention and Control (IPC) protocols for patients with respiratory symptoms, the emergence of the Omicron variant in quarter four of 2021/2022 and the resulting staff absence and patient cancellations presented a significant challenge to practices seeking to increase their activity. We understand that many practices struggled to reach 85 per cent delivery and, through our regular dialogue with NHS England, were able to secure further income protection, so that practices achieving between 75 and 85 per cent of their UDA target were subject to partial clawback. An exceptional circumstances scheme was also put in place to allow for those affected by patient cancellation and staff absence to have this specifically recognised.

4.4 Nonetheless, we understand that there are a large number of practices facing clawback from this period at a level that could pose a material threat to their financial sustainability. We have requested information from NHS England on the level of clawback for 2021/22 but have been told that data is currently unavailable as local contractual disputes are ongoing.

4.5 In quarter one of the 2022/2023 financial year, dentists in England were expected to deliver 95 per cent of their contractual UDA targets to have their income protected. This rapid increase from the 85 per cent threshold of the previous quarter occurred in the face of the ongoing recruitment and retention crisis and patient care backlogs, representing a steep cliff edge for many practices. The BDA therefore opposed the increase to a 95 per cent UDA threshold for the quarter, noting that both the previously achieved activity levels and reports from our members suggested this was unrealistic.

4.6 With the introduction of the 'next steps' for IPC in dental practices set out by NHS England and the Chief Dental Officer (CDO) for England in June 2021, patients seen in dental practices were no longer required to wear facemasks except when attending on an emergency basis and exhibiting respiratory symptoms. The routine pre-attendance screening of all patients was no longer expected, while practices continued to ask patients to contact them if feeling unwell so appropriate clinical decisions could be made considering any risks to both patients and staff. Importantly, the BDA continued to support dentists to develop risk assessments appropriate to their own specific practice environment to ensure effective controls and risk mitigation processes were in place.

4.7 From quarter two of the 2022/2023 financial year, dentists in England were expected to return to 100 per cent delivery of their contractual UDA targets. The long-term underlying factors acting as a brake on activity – unfunded cost increases in NHS dentistry, the resulting falls in take-home pay, and the recruitment and retention crisis – alongside the continued prevalence of covid-19, suggest the return to a 100 per cent delivery target is ill-judged. This is particularly the case given more dentists than ever are reporting difficulties recruiting vital members of the dental team including nurses, as set out in detail in paragraphs 6.15-6.16 / Chapter 6.

4.8 The BDA has repeatedly, and in several forums, communicated to NHS England that, in the absence of steps to resolve the long-term underlying factors imperilling NHS dentistry, setting unrealistic UDA delivery targets will only further destabilise the dental sector. We remain extremely

concerned that unrealistic delivery targets will increase clawback and lead to the further deterioration of the financial sustainability of many dental practices.

Scotland

4.9 In April, the Scottish Government ended the emergency covid support payments for NHS dental practices and introduced a 1.7 multiplier for all dental fees to incentivise practices to increase their activity and help reduce the significant backlog of unmet dental treatment need that accumulated during the pandemic. We continued to urge the Scottish Government to retain the multiplier at this level following the initial three-month review at the end of June, and to keep it in place until a long-term replacement for the current contractual framework is agreed.

4.10 Despite our calls to retain the multiplier at 1.7, on 28 June the Cabinet Secretary informed the profession that, having considered a range of factors including the remaining infection prevention control constraints, overall levels of activity, and affordability, the Scottish Government had decided to reduce the multiplier to 1.3 from July. The profession was informed about this change at short notice and without consultation. We again expressed concerns that reducing the multiplier would compel dentists to deliver some treatments at a financial loss. This could result in an exodus of dentists from the NHS and adversely affect patient access, further widening oral health inequalities.

4.11 On 23 September a new 'bridging payment' uplifting NHS fees at a rate of 1.2 for the next three months, falling to 1.1 for the remaining period up to April 2023 was announced. It would replace the 'multiplier' when it expired on 1 October.

4.12 Scottish Government has asked practices to take part in an ‘open books’ exercise in Spring 2023, to allow them to better understand the impact of business costs on NHS practice and to allow them to better understand the financial pressures which practices are under.

4.13 In light of the Scottish Government’s policy commitment to the provision of free NHS dental care for all, a new, sustainable model for delivering dental care must be developed. In the interim, a workable funding model is needed to replace the current bridging payment arrangements, which will ensure the viability and sustainability of NHS dental practices.

Wales

4.14 There had been indications a year ago that Welsh Government would be anticipating around 70 per cent of pre-pandemic GDS activity in 2022-23. However, current data on most metrics[4] suggest activity is sitting at circa 55 per cent of pre-pandemic levels.

4.15 One exception to this general trend appears to be extractions5 which were nearly back to pre-pandemic levels by March 22. Another exception is that urgent treatments[5] were maintained year on year throughout the pandemic. One notable difference is in the level of fluoride varnish application[5] which had almost doubled by March 2022 compared with March 2020 given it was the main metric during the second recovery year. More analysis can be found in the latest review of dental services[6].

4.16 Having undertaken surveys of dentists in March and July it is apparent that many practices are

[4] Current contract data – StatsWales
[5] Dental Activity data by charge band, patient type, treatment type and year - StatsWales
[6] Statistics: NHS dental services: April 2021 to March 2022 – Welsh Government (gov.Wales)

fearful of clawback as they are not reaching their new targets, despite considerable investment of time and staff.

4.17 We made the arguments to Welsh Government that these are new and untested targets that should not put practices in jeopardy of clawback where a full staff complement has provided a comprehensive service. However, most Health Boards seem reluctant to offer such assurances, creating a downhill spiral of morale in the dental teams.

4.18 When the DDRB recommends a pay increase for dentists and the Welsh Government lifts the value of the GDS contract there is no guarantee that associates will see a pay increase. This is largely because of dental inflation which isn't properly captured in the uplift and the fact that the value of the GDS contract doesn't cover infrastructure spending (capex) – often cross-subsidised by private income in a mixed practice.

4.19 The latest figures, 2020/21, from NHS Digital[7] show in Wales those associates with any NHS activity in the GDS took an average real pay cut of almost £2,000 (nearly -3 per cent) and practice owners saw a very small pay increase of 1.5 per cent. These average figures included private income. However, associates do the bulk of NHS work, and the majority of their work is provided through the NHS. It is our view that these factors have led to associates not seeing their incomes rise by the DDRB recommendation and that associate pay in Wales has instead fallen over the last decade.

4.20 However Welsh dentistry has several issues aside from the financial pressures impacting services, especially when it comes to access. In the year up to July 2022, 16 practices closed in Wales exacerbating the mounting issue of patient's not being able to find appointments.[8]

Northern Ireland

4.21 Interim support funding to help mitigate the ongoing impact of covid-19 has continued, albeit at a reduced rate. The Financial Support Scheme (FSS) was replaced with the Rebuilding Support Scheme (RSS) with effect from quarter one, which provided a 25 per cent 'top-up' to SDR fees for quarter one and two in the current financial year.

4.22 While appreciative of additional support that has been forthcoming to help offset the continued impacts associated with covid-19, the decision by DoH to reduce their original offer of 35 per cent funding under RSS to 25 per cent - at a time when equivalent funding was 70 per cent in Scotland - was very negatively received in March 22.

4.23 Moreover, RSS support has been reduced to 10 per cent for quarters three and four, the reason given by DoH that covid-19 impacts have reduced.

4.24 Looking at the financial situation within General Dental Services, we have made a robust case that DoH should look at all costs being experienced by practitioners at this time, including soaring dental inflation. The harsh reality is that 94 per cent of practice owners have witnessed an increase in costs since last year. With 17 per cent stating that costs have increased by over 50 per cent, this is a clear indicator that a blanket rise of 4.5 per cent to cover both the pay and expenses elements for

[7] Dental Earnings and Expenses Estimates, 2020/21 – NHS Digital
[8] Dentistry Part 1 – Can you access dental care when you need it? (senedd.wales)

dental practitioners simply will prove totally insufficient.

4.25 However, while the DoH has insisted that RSS is only to compensate for the continued impacts of the pandemic, such as staff absences and patients not attending appointments, they admit that they have no established mechanism for mitigating the soaring costs of delivering care. This is despite BDA NI furnishing DoH with extensive evidence confirming the unviable nature of many of the fees contained within the SDR - not least dentures - where lab bills often exceed the rate practitioners receive for providing the service, thus providing NHS dentistry at a loss. (Ninety-three per cent of practice owners in NI witnessed an increase in lab/material costs – 44 per cent decreased the amount of laboratory work in the past year).

4.26 In addition to the significant impact of covid-19, the profession has had to contend with rising costs, with significant recruitment issues such as finding associates who want to work to provide NHS care, and the shortage of dental nurses which are essential to deliver services. The key factor driving the shortage of dental nurses is that, despite their desire to do otherwise, practice owners are unable to offer higher rates of pay because of the underfunding of NHS activity. Practices with a high NHS commitment are most susceptible to retention and recruitment difficulties, and vacancies for both associate dentists and support staff.

4.27 In addition to RSS at 10 per cent, DoH has announced its intention to uplift all denture fees by 25 per cent from quarter four. Worryingly, this modest uplift is insufficient as many laboratories have taken the decision to withdraw completely from manufacturing NHS dentures, while for those still providing NHS work, laboratory bills have soared. A £5 million Revenue Grant Scheme was launched in the previous financial year to utilise underspend monies, with support based on patient registrations and conditions attached to maintaining patient registrations within a five per cent threshold, for a period of 24 months.

Contract reform

England

4.28 The BDA has called for radical reform of the GDS contract since 2007 on the fundamental basis that reform will improve the working lives of dentists and improve the care offered to patients. The UDA contract put in place from 2006 is widely acknowledged to be unfit for purpose.

4.29 As noted in our previous submission to the DDRB, in March 2021 responsibility for reform of the GDS contract was transferred from the DHSC to NHS England. The BDA participated in an Advisory Group and Technical Group formed by NHS England, before beginning a series of meetings with NHS England in Autumn 2021 that were framed by NHS England as an opportunity to agree 'rapid, modest and marginal changes' to the GDS contract that could be implemented rapidly, and would therefore not seek to address the long-term, underlying factors threatening the future of NHS dentistry.

4.30 While the BDA would have preferred to immediately begin substantive discussion on fundamental reform to the GDS contract, we considered that incremental improvement for patients and dentists was better than no improvement. We again communicated clearly to NHS England and other stakeholders that tweaks to a broken contract could not replace the fundamental reform required.

4.31 In July 2022, NHS England set out the 'marginal changes' to the GDS contract it would introduce, with an anticipated implementation date of 1 October 2022. The BDA adopted a neutral stance on the final package introduced by NHS England, reflecting our belief it would offer *some* improvement in the financial sustainability of *some* dental practices, without addressing the long-term, underlying factors threatening the future of NHS dentistry.

4.32 The 'marginal changes' package introduced additional UDAs for Band 2 Courses of Treatment involving the filling or extraction of three or more teeth, and non-molar endodontic care to permanent teeth. Disappointingly, despite the anticipated implementation date of 1 October – an implementation date which had followed a protracted period of negotiations – legislation implementing the additional UDAs for Band 2 Courses of Treatment were only laid in Parliament in early November, coming into effect from 25 November. The BDA asked NHS England to backdate payment to the promised implementation date but was informed this was not legally possible.

4.33 The package also introduced a minimum UDA value of £23, which will be uprated by the DDRB uplift from the previous round. This was implemented from 1 October 2022 through a reduction to the agreed UDA targets of impacted practices and an associated contract variation. The BDA believes the £23 figure is too low to have more than a small impact on approximately 200 practices.

4.34 The changes also included additional powers for commissioners to rebase contracts. Where a contractor delivers less than 96 per cent of their contracted activity for three consecutive years commissioners will be able to reduce the size of a contract to the highest level of delivery in the preceding three years. Similarly, where offered by commissioners, contractors will be allowed to deliver up to 110 per cent of their actual contract value on a non-recurrent basis. This additional activity will be funded at the existing indicative UDA value and will not count as over-delivery.

4.35 The 'marginal changes' package also introduced amendments to the FP17 form which NHS England intended to remove administrative barriers which might prevent therapists and others from opening courses of treatment. The BDA believes there will be limitations as to what DCPs can realistically do under a UDA contract that makes sense for practices financially, and that there will also still be scope of practice limitations. In addition, given the significant challenges many practices are facing in recruiting and retaining dental therapists and other members of the wider dental team, it seems unlikely this amendment will have a material effect on activity levels.

4.36 Following the conclusion of discussions relating to the changes, the BDA and NHS England have now resumed contract reform discussions. The slow pace of this process has been profoundly disappointing given the scale of the challenges facing dentistry, as set out throughout this submission. Similarly, the apparent lack of ambition from NHS England for radical reform that includes equitable remuneration for activity is deeply concerning. However, the BDA remains committed to the rapid negotiation and implementation of a contract that brings about an end to the UDA. We do not believe that change of a lesser scale within the UDA framework will be able to address the issues that NHS England has identified.

Scotland

4.37 There is widespread recognition that the current fee-per-item model is not sustainable for NHS dentistry. Before the pandemic, the Scottish Government established working groups (including BDA representation) to develop a "new model of care" for NHS dentistry, including a replacement for the current Statement of Dental Remuneration. This work was paused during the pandemic, but the past

two years have emphasised the need for a payment model that prioritises prevention, is patient-centred and reflects modern dentistry. The Cabinet Secretary's letter to dental teams in October 2021 indicated that the Scottish Government would develop proposals for long-term contract reform, during 2022/23. This would involve consultation with the profession, and possibly regulatory changes.

4.38 On the 23 September 2022 the Scottish Government announced that they were working at pace on appropriate payment reform. This followed a survey to which 500 people responded. They set out an ambition to have a new set of Determination 1 payments finalised for April 2023. The intention is to implement the new Determination 1 during 2023/24 across the whole sector.

4.39 An Advisory Group has been established to provide short life consultative comments and advice to the CDO about the development and shape of a revised Determination I, this will form part of an iterative engagement with the sector. Disappointingly, BDA representatives were not given the opportunity to contribute to this consultative process. The overarching approach outlined is to consider and develop the full range of treatment options that are necessary to ensure that NHS dental contractors are able to provide care to patients that secures and maintains the oral health of NHS patients.

4.40 The remit for the short life Advisory Group function is to develop and revise Determination I items, consider the report of the recent sectoral survey and to provide general clinical insight into some aspects of item fees. The remit does not include consideration of financial matters relating to specific fee items in new Determination I, nor consideration of the overall financial package required to deliver NHS dental service provision. Formal negotiation of fees and prices is a matter for discussion between government and the BDA.

4.41 We have had initial fee reform discussions with Scottish Government and the CDO. It is expected that regular meetings will commence in January with the ambition to have an agreement on the fees for the new Determination I finalised by April 2023 and implemented across the sector in 2023/24.

Wales

4.42 We (BDA Wales and Wales General Dental Practice Committee) are part of the dental programme reform stakeholder workstream group. In Wales the approach is one of co-production and collaboration with various stakeholders including the community health councils. In the last six months the CDO has held several engagement events of different types with various stakeholders, as well as travelling to speak with LDCs, which was appreciated.

4.43 The definitive volumetrics for the financial year 2023/24 were published just before Christmas. This followed our extensive feedback to the CDO on the draft proposed volumetrics. As a result, the new patient target has been changed to include urgent patients. The temporal separation of NHS and private practice has been dropped. Whether these targets are workable remains to be seen

4.44 The BDA has significant concerns regarding the methodology for end-of-year reconciliation for practices adhering to this current year's contract reform volumetrics. Shortly before Christmas we gave our feedback on the draft guidance for Health Boards regarding end-of-year reconciliation. We consider this guidance, as drafted, carries the risk of considerable clawback to practices trialling the

reformed contract. We have emphasised the need for equitable outcomes.

Northern Ireland

4.45 In October 2021, BDA NI secured a commitment from the Health Minister Robin Swann to expedite work on GDS Contract Reform. The reduction in interim support funding, combined with rising costs has left the existing contract model unviable to deliver.

4.46 While this work is in early stages, the BDA have called on DoH to commission an independent Cost of Service Investigation to help inform the level at which fees should be appropriately set at, reflecting the actual cost to deliver care. Our primary concern with the current system is that SDR fees bear no correlation with the costs incurred; there is no mechanism to address any fluctuations in expenses on a regular/annual basis, and therefore they need to be calibrated to rates which are realistic. A Cost of Service Investigation would approach this important work in an objective way, to bring transparency to these issues, and is a vital precursor to being able to fix the systemic issues of the current discredited contract model: practice owners state that increased practice costs (97 per cent), staffing recruitment and retention issues (76 per cent), and lack of financial certainty and other pay related issues (75 per cent) are the top three factors for causing stress.

4.47 While DoH has stated that a Cost of Service Investigation will be an important part of the contract reform process, so far no indication has been given as to when this will be carried out.

4.48 The BDA fully appreciates the difficult environment in which DoH officials are attempting to take forward contract reform, particularly in Northern Ireland. Political dysfunction in the absence of a functioning Northern Ireland Executive and significant delays around the Budget have not been helpful in addressing the challenges we face. These have been compounded by wider economic challenges at a UK-wide level, especially inflation.

4.49 It is clear that we are now witnessing the 'looming crisis' which the BDA warned would happen in previous DDRB responses, with many practitioners in Northern Ireland concluding that they simply cannot afford to continue to be so wedded to a flawed and loss-inducing NHS contract model. We are deeply concerned that the pace of contract reform will not be enough to retain many of our practitioners for NHS dentistry, HS activity continuing to be significantly down compared with pre-pandemic levels: 60 per cent intend to increase the amount of private work (compared to 48 per cent across the UK). Of practice owners, 41 per cent suggested that they will increase their private work, 26 per cent intend to retire; and 46 per cent plan to sell.

4.50 Covid-19 has been a wake-up call for many that the unreasonable pace at which they had to work to generate a living under a high volume/low margin contract was simply not sustainable. While interim support during the height of the pandemic was appreciated, the response from DoH this year to reduce funding and not to adequately address rising expenses has damaged NHS dentistry further, potentially irreversibly.

4.51 Trends in GDS activity confirm the shift that is already underway in Northern Ireland as a result of the major disincentives to deliver NHS care: 30.2 per cent of practice owners in NI reported a reduction in HS turnover last year (compared to the UK average of 11.4 per cent). This is further illustrated by the 20.3 per cent of associates reporting a reduction in NHS patients over the last year.

4.52 These figures point to more than the continued impact of the pandemic. They reveal that we are seeing a definite transition away from the Health Service towards more Private earnings. Eighty-six per cent of associates and 75 per cent of practice owners said they have had enough with the deep financial uncertainty that has surrounded NHS dentistry and the inability to run a business on that basis.

4.53 Certainty, and planning for success, as well as the ability to take control of their own financial destinies and not be beholden upon the inadequacies that characterise NHS dentistry are key. Government has failed to rebuild confidence among the profession that the future of HS dentistry will be much better than what has gone before: 82 per cent of associates in NI would not recommend dentistry as a career choice, compared to 68 per cent UK average. Ninety-five per cent of associates in Northern Ireland find their job extremely, very or moderately stressful, (compared to a UK average of 86 per cent).

4.54 The widespread access to NHS dentistry issues we now see in Northern Ireland for the first time in many years - with 90 per cent of practices in Northern Ireland not taking on any new NHS adult patients[9] - confirms just how serious the situation we find ourselves in is.

4.55 In conclusion, BDA NI recognises the steps that the DDRB took in being explicit about governments' obligations to address expenses and fluctuations in operating costs within the 50th Report. In response, in Northern Ireland we have sought to do everything possible to engage constructively to inform the process that the DDRB had envisaged. It is with deep concern that this year again, the application of the process by government has been wholly deficient. It has added to the sense that this process can never work for the profession, and is at the heart of the crises within GDS across the UK that we see today. We would therefore urge the DDRB to once again deliver robust recommendations regarding the timeliness of the pay review process itself, and the key role of expenses in meeting the real costs to provide NHS dental care. Fundamentally, we believe our shared aim should be to have GDS remuneration models in place that can ensure NHS dentistry is financially viable and sufficiently attractive to deliver in its own right.

Chapter 5 – Financial backdrop across the UK

5.1 The current inflationary environment presents significant challenges for the profession as practices face sharply increased costs. Since the time of the last BDA submission, the rate of RPI inflation has risen from 7.8 per cent to 14.2 per cent.[10] Practices are coping with high demand as the impacts of the pandemic are still felt, yet the costs of energy, laboratory support, materials and staff rise. The UK's dental services face a combination of high inflation and a recession which could be the longest lasting since the 1950s.

5.2 The significant economic disruption at the height of the pandemic led to dramatic changes in public spending. This means that much of the currently available data, largely relating to the period during the height of the pandemic and lockdown, are not reflective of the current situation. However, for dentistry the challenges remain remarkably similar to previous years and the principal impact of the pandemic has simply been to exacerbate previous issues concerning practices'

[9] Full extent of NHS dentistry shortage revealed by far-reaching BBC research - BBC News
[10] Inflation and price indices - Office for National Statistics (ons.gov.uk)

financial viability. ONS data on gross pay indicates that relative to inflation, the fall in real-terms earnings for associates in the UK is one of the sharpest amongst similar public sector employees.

5.3 Despite a modest pandemic-specific increase in the cash-terms gross UK spend on the GDS/PDS in 2020/21, the overall cash-terms trend has remained flat for a decade. Real-terms spend remains well-below 2010-11 levels, representing a 38 per cent cut since 2010. This means that dentists are required to do more with less and that there are inevitable pressures on dentists' pay, as practices face sharply rising expenses, a tight labour market and static budgets.

Gross spend

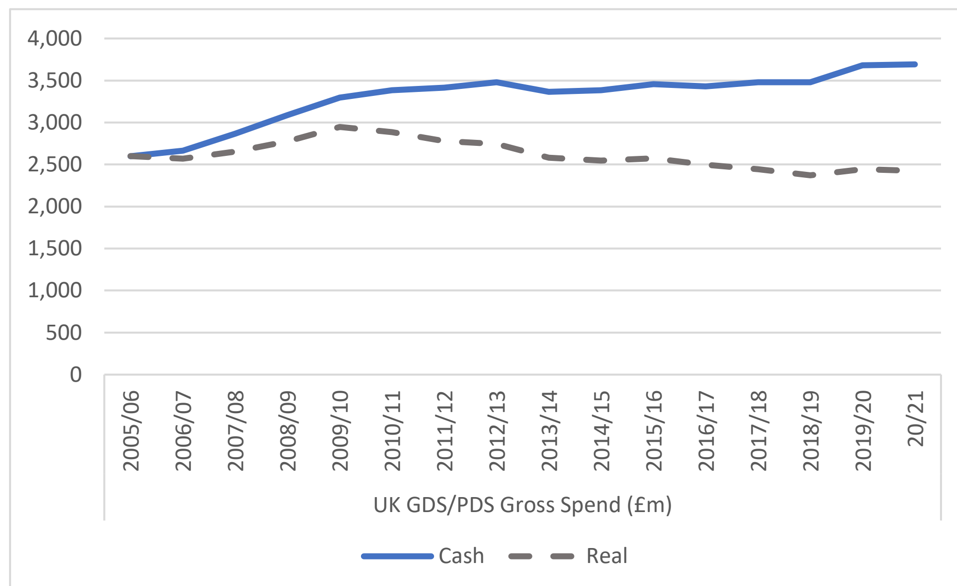

Fig 2: UK gross spend on GDS/PDS. Sources: Accounts from Departments of Health

5.4 In aggregate, data from the four nations on the trends in taxable incomes for performer-providers show an uncharacteristic and undoubtedly temporary improvement in earnings for 2020-21. However, as set out below, there is considerable variation in this temporary improvement across the four nations. Critically, the figures are distorted by the financial support given to dental practices during the pandemic's most difficult period. There were also deferred costs from that financial year, such as from loan repayment holidays, that will then be incurred in subsequent years. Therefore, a full picture of the financial health of practices will only be known after the fact.

5.5 However, looking at the longer-term Performer-Provider taxable income has fallen considerably from the levels seen in the late 2000s across all parts of the UK. More recent years show greater volatility in the data, particularly in Northern Ireland and Wales. These falls in cash terms come despite the recommendations that the DDRB has made for pay uplifts and mean that against inflation the real-term reductions in pay have been even more substantial.

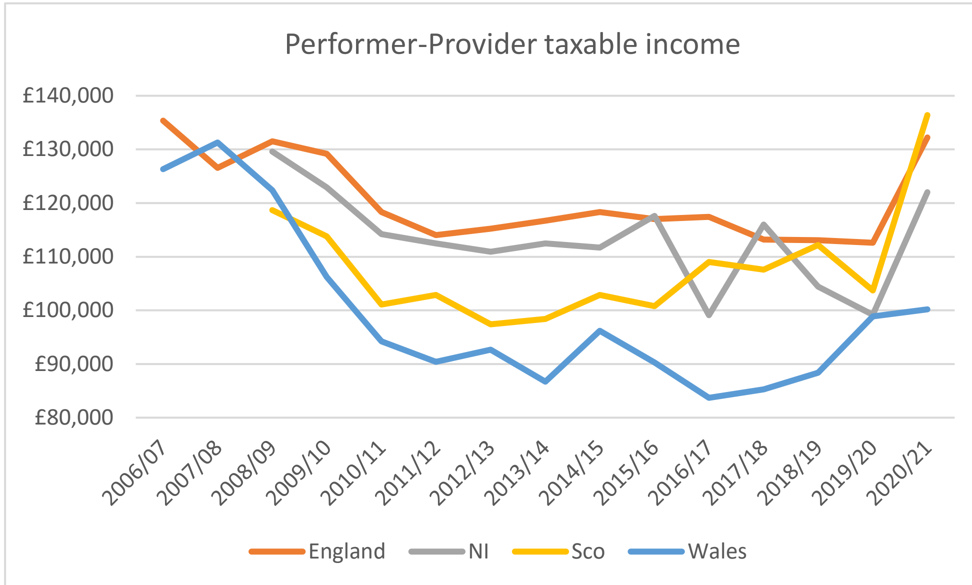

Fig 3: Data on practice owner taxable income. Sources: NHS Digital

5.6 Among performer-providers, there have been substantial falls in taxable income in the longer term. Performer-providers in Wales experienced a slightly different trend to the other three nations, their taxable earnings rising by £10,500 the year before the pandemic. Between 2020 and 2021,they only saw a minor increase in taxable earnings of £300.

5.7 Whereas taxable incomes in the other three nations saw an uncharacteristic increase, experiencing an average rise of 23 per cent, bolstered by extra financial support given the pandemic and associated lockdown's impact on earnings.

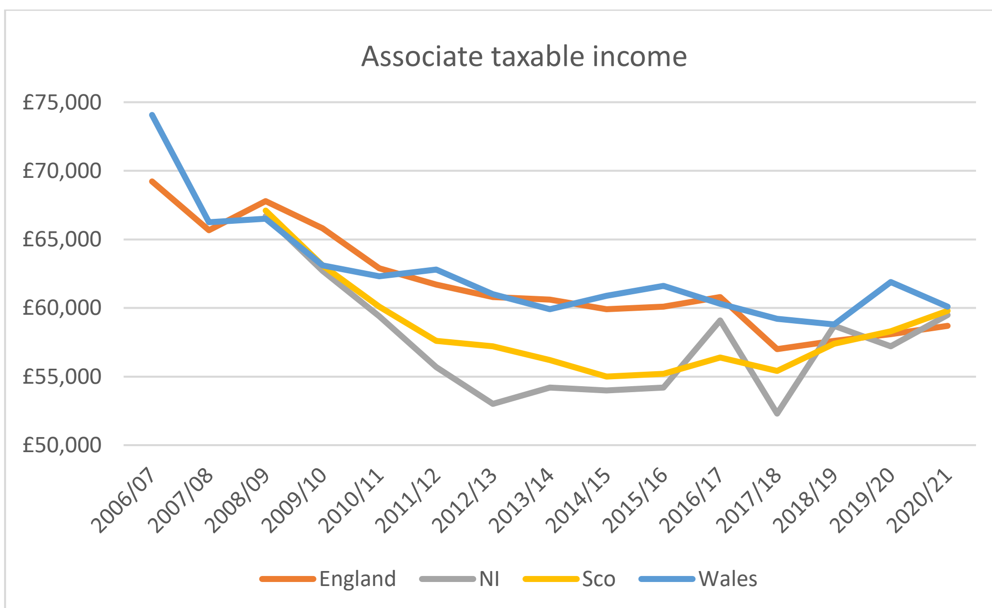

Fig 4: Taxable income of associates. Sources: NHS Digital

5.8 The taxable incomes of associate dentists follow a similar trend in the long run, however without the distortion of Covid-19 support funding in 2020. Earnings collapsed in cash terms at the beginning of the 2010s. In Scotland, this was followed by a minor recovery from 2017, which still puts associates £7,100 behind their earnings in 2008/9.

5.9 Associate earnings in Northern Ireland were consistently the lowest in the UK during this period, also experiencing the most volatility. However, English UDA values skew higher in London and the Southeast meaning that there are pockets throughout the UK where earnings are much lower than the average.

5.10 By 2020/21 the average earnings of associates had converged at just below £60,000 per year. When compared to previous peaks in earnings adjusted to take into account inflation, real-terms earnings are more than £50,000 below what they were in 2006[11].

5.11 It is impossible to separate the pay element from expenses. In many cases (especially as price pressure mounts on materials, energy and other component costs of providing treatment rise), this means that the uplift that the DDRB has intended to increase dentists' take-home pay is used entirely to meet rising expenses, for which the departments have allocated insufficient uplifts to cover. We cover the pressure of increasing expenses in more detail from paragraphs 5.17-5.23 / Chapter 5.

5.12 A similar dynamic exists in Northern Ireland and Scotland, where associates hold individual NHS contracts, but will agree with the practice a proportion of the NHS fee to be paid in respect of expenses. Therefore, even though the uplift is applied directly to the SDR fee that the associate receives from the NHS, the practice may seek to negotiate an increased proportion to cover increased costs that negates the impact of the uplift on the associate's take-home pay.

5.13 A further issue in Scotland is that the uplift is not applied to all allowances and payments, meaning that the increase to dentists' overall remuneration package falls below the headline percentage.

5.14 There is also the issue of the ever-increasing, but unremunerated, regulatory burden on practitioners that detracts from their ability to undertake remunerated clinical activity. This has been exacerbated in recent years as the pressures on associates dealing with firstly the provision of PPE and ventilation, and then the backlog of patients which lengthen treatment time and expand administrative costs.

5.15 The implementation period of uplifts has also regressed, particularly in Northern Ireland, in recent years. This constrains practices, making it much harder to keep up with rising costs month to month nor help them plan ahead, potentially hampering investment and recruitment decisions.

"We do try to pass any fee increase, any UDA increase onto the staff, associates, and nurses alike but costs are equally well going up, lab fees regardless of what the UDA contract goes up by, lab fees go up a few percent each year, our rent is index linked and that goes up 3% or 4% each year. All the costs continue to rise, whereas your actual money from the NHS stays stagnant really, or even in real terms, reduces." **Practice owner, England**

5.16 It is our view that these factors have led to associates not seeing their incomes rise by the DDRB recommendation and that associate pay has instead fallen considerably over the last decade. This downward trajectory in take-home pay has persisted despite the countervailing labour market pressures caused by the difficulty recruiting associates to NHS roles that would be expected to lead to higher pay. Further, it points to the fundamental lack of NHS resources made available to provide dental services on a sustainable basis. The Review Body does not engage on discussions of expenses,

[11] £ average annual earnings in 2021 of £59,525 vs £71,648 in cash terms. When adjusted using RPI, the 2006 figure equals £109,787, meaning that the current cash figure for taxable earnings in 2021 are £50,263 below earnings in 2006 if adjusted

but for self-employed dentists it is our continuing recommendation that the DDRB returns to making a separate recommendation on expenses for GDPs.

Expenses and inflation

5.17 Since our last submission, the global and national economy has entered a protracted inflationary period after a decade of historically low price increases, predicted to last until 2024.[12] Thus, an increasing proportion of the NHS fee is used to cover expenses. The uplifts that have been applied to expenses for many years have fallen far short of the necessary provision to maintain adequate financial support to practices. Practice owners have had to make difficult decisions about how to distribute the contract uplift to ensure the financial sustainability of their practice.

5.18 This year, given the pressure on practices we have commissioned two rounds of evidence gathering to illustrate how rising costs are pushing practice balance sheets to breaking point. The former, looking at a basic level how costs were rising for laboratory work, staff and utilities suggested that there had been an 11.15 per cent annual increase in the price of delivering dentistry.[13]

5.19 The second piece of work covered a multitude of specific cost pressures affecting practices, but focused specifically on energy and utilities, staff renumeration and capacity, laboratory prices and materials, and the supply chain. More information on specific costs is available in the appendix. Pay awards for non-clinical staff in particular have clearly risen year on year in order to maintain competitiveness as energy, travel costs and food[14] prices have risen since 2020. Average pay for dental nurses (£12.49) and office staff (£12.38) however, remains only £2 above the living wage,[15] making recruitment and retention harder. Fundamentally, practice owners want to pay staff at levels that support sustainable recruitment and retention, as well as rewarding valued members of the team for their contribution and skill but are impeded from doing so as a result of the underfunding of NHS activity and ongoing cost pressures.

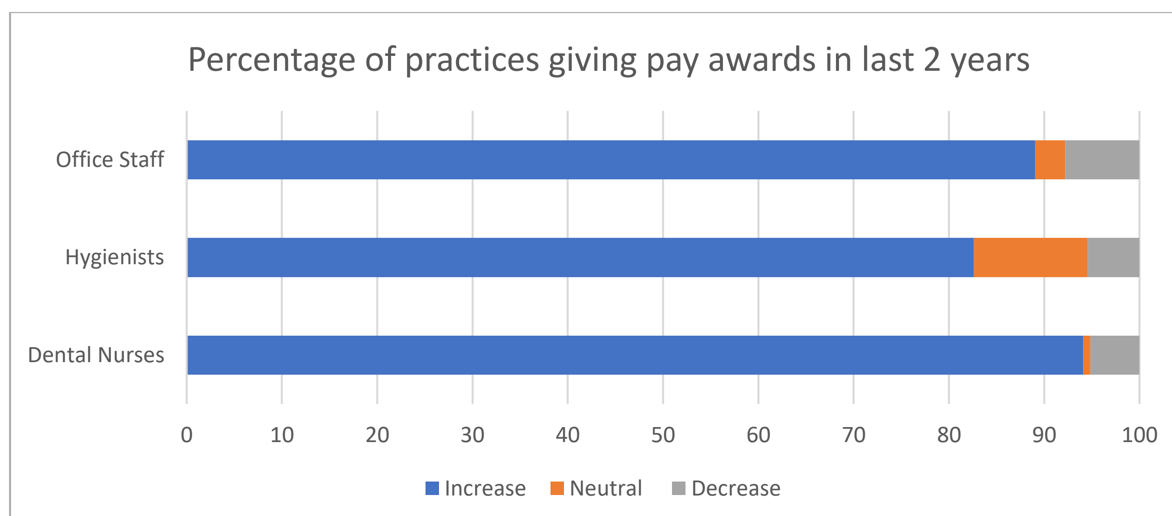

Fig 5: Pay awards in the last 2 years. Sources: BDA expenses survey October 2022

[12] Monetary Policy Report - November 2022 - Bank of England
[13] Action needed to combat dental inflation (bda.org)
[14] Consumer price inflation, UK - Office for National Statistics
[15] The Calculation - Living Wage Foundation

5.20 Evidence has also been gathered in detail as to the specific itemised costs of performing work and the problems faced when sourcing it. Most practices have experienced an increase in the cost of dentures (95 per cent of practices) and crowns (93 per cent).[16] The biggest issues, as of October were in sourcing basic materials and replacement parts, particularly for dentist chairs.

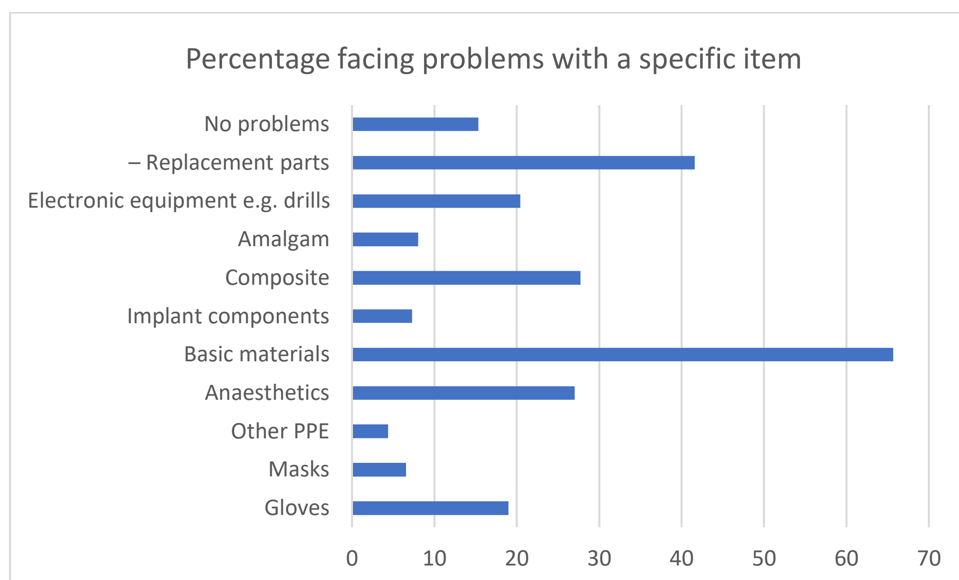

Fig 6: Supply chain problems. Sources: BDA expenses survey October 2022

5.21 Of the practices surveyed, varying in size and level of contracted NHS activity, the average annual spend on laboratory work was £32,000. Basic materials and replacement parts were considered the hardest items to source. When referring to replacement parts, we understand this is primarily an issue with dentist chairs, many of which are produced in the EU. When asked what the main reasons for the delays were, 72 per cent of respondents experienced problems with rising costs of materials, whilst 71 per cent cited a lack of stock.

5.22 Most practices also experienced an increase in energy costs. Last year 77 per cent of members were paying below £1000 a month for their energy supply, only 18 per cent were paying between that and £3000. Looking at the same group, from October only 14 per cent were paying below £1k and 46 per cent were paying the higher rate.

5.23 We do not agree with the position that has been taken that information on practice expenses drawn from HMRC data is unreliable, and would urge the DDRB to revert to using this data and make a recommendation on expenses. These costs necessarily impact on dentists' take-home pay and therefore it is only correct that the DDRB considers them when making its recommendations.

Financial sustainability across the UK

England

5.24 For more than a decade, there has been severe funding restraint on the GDS, to such an extent that an additional £879 million investment would be required to return funding to 2010 levels.

5.25 Repeated above-inflation increases in patient charges have come to substitute for meaningful investment in NHS dentistry from the Treasury. Perceived and actual costs are a well-known deterrent to attendance, particularly for those from low-income backgrounds, acting as a breaker on

[16] BDA expenses survey October 2022

patient demand on what is essentially a limited service. Though tweaks have been made to the banding system and a minimum UDA rate of £23 has been introduced, helping approximately 200 practices previously on lower rates, given the sharp rise in expenses this increase will be cancelled out by other costs.

5.26 Clawback, in respect of under-delivery of NHS targets, from practices in England has risen significantly each year, placing significant and growing strain on practice finances. In 2015-16, the total clawback stood at £54,505,326, by 2021 it had risen to over £169 million. The current data is skewed by the events of the pandemic, bringing levels of clawback temporarily down to £10,364,213. However, we have every reason to believe that the same factors driving clawback persist, and have in all likelihood worsened, so would expect clawback for 2022/23 to return to the levels experienced before the pandemic.

5.27 Previous figures indicated that nearly a third (30 per cent) of contracts have some amount clawed back from them and 5.7 per cent of NHS GDS funds are clawed back. Significant clawback took place in 2020-21 despite protections on NHS contracts in place. Anecdotally, some practices facing this plethora of financial pressures are considering handing back a proportion of their contract early rather than face a difficult level of clawback at the end of the financial year. We will have to wait until next year's data publication for confirmation.

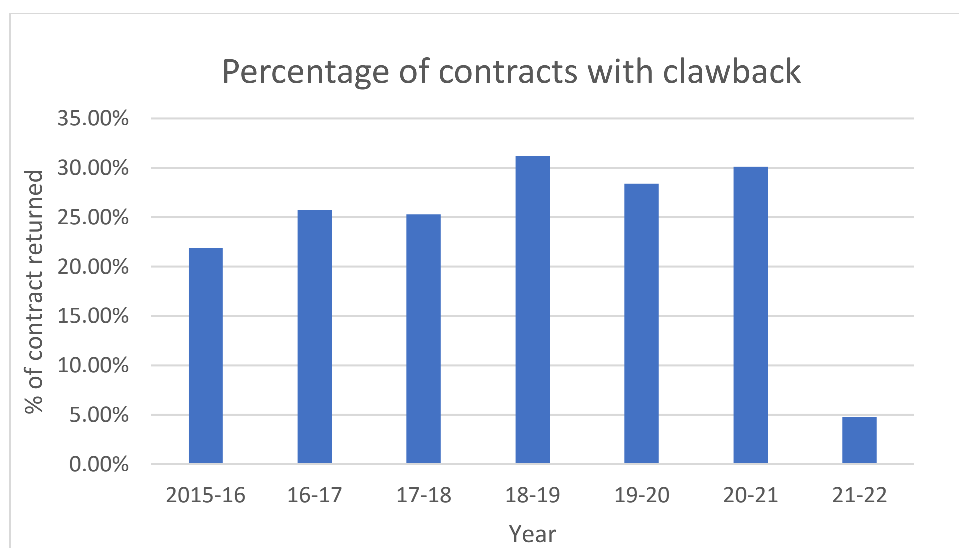

Fig 7: Data on Clawback in England. Sources: NHS BSA

Wales

5.28 The *percentage* of the primary care budget spent on dentistry has declined each year from 2016-17 to 2019-20. It is therefore not surprising that the figure of expenditure per head remained almost unchanged and thus devalued by inflation year on year. The slight increase in 2020-21 to 10.43 per cent reflects the covid funding arrangements that offset loss of PCR and it remains to be seen what the longer terms trend shows.

Year	Percent of primary care budget spent on dentistry (%)	Expenditure on primary care dentistry (£000)	Per head (£) Primary LHB
2016-17	10.8	152,005	48.83
2017-18	10.6	153,960	49.26
2018-19	10.4	153,085	48.77
2019-20	10.36	159,865	50.70
2020-21	10.43	172,489	54.42

Fig 8: Expenditure on dental primary care in Wales. Sources: StatsWales[17]

5.29 If the percent of primary care budget expenditure on dentistry had remained at 10.8 per cent of total primary care budget in 2020-21, then expenditure on primary care dentistry would have been at £178,539m, thus representing *a* real terms loss of £6 million. per annum. The "extra" £2m per annum for 2021-22 and 2022-23 therefore falls significantly short.

5.30 Although clawback was suspended for the two financial years 2020-21 and 2021-22 due to covid support measures, there was nevertheless significant abatement of individual contract values (to 80 per cent in the red alert phase and 90 per cent in the amber phase) due to loss of patient charge revenue.

Scotland

5.31 Dentistry in Scotland is experiencing the same strains regarding financial sustainability and cost pressures. In the Scottish Budget 2022/23[18], published in December 2021, the total Health and Sport budget increased by 4.7 per cent from £17.235 billion in 2021-22 to £18.040 billion in 2022-23.

5.32 The 2023/24 GDS budget was released in December 2022, this saw a further increase to the budget of £7.2 million (Fig 9).[19] However, it must be understood in the context of high inflation, representing a miniscule 1.5 per cent increase in the GDS budget.

5.33 Scottish Government officials have previously stated that these figures represent a "nominal" budget, as NHS dentistry is a demand-led service. Whilst these increases in funding are an improvement, and track closer to inflation, the subsequent expenses uplift of 4.5 per cent announced in August did not.

5.34 The Scottish Government introduced free NHS dentistry for all 18–25-year-olds in August 2021 and plans to extend this to all adults in Scotland during the current 5-year Parliament. To maintain the GDS budget at its current level, the Scottish Government will have to allocate additional funds to cover patient charges as these will no longer be collected.

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[17] NHS programme budget – StatsWales
[18] Publication - Corporate report: Scottish Budget 2022 to 2023 (www.gov.scot)
[19] Scottish Budget: 2023-24 (www.gov.scot)

	2019/20	2020/21	2021/22	2022/23	2023/24
GDS budget (£m)	416.6	428.6	431.0	469.0	**476.2**
Change from previous year (£m)	1.8	12.0	2.4	38.0	**7.2**
% Change from previous year	0.43%	2.88%	0.60%	8.82%	**1.53%**

Fig 9: Spend on the GDS in Scotland [Note: Actual spend on GDS and PDS was previously included in the annual *Primary Care Dentistry in Scotland* reports but the last one was published in November 2019. We have requested the latest figures from Public Health Scotland]. Sources: Scottish Budget[19]

Northern Ireland

5.35 The gross General Dental Services Budget in the 2021/22 year equated to £143.8 million.[20] However, this includes both £43 million in Covid-19 support funding and patient charges of £13 million. The primary budget figure for NHS dentistry stood at only £87 million, or £700,000 pounds less in cash terms than in 2010/11. If the budget had kept pace with RPI it would be close to £121 million annually in 2021. If the service were to be run at 2019 levels (£99.5 million) with an RPI-adjusted budget today, it would require a cash-injection of £11 million just to keep up with inflation in the period.[21]

5.36 Though investment has fluctuated and there was an extra £43 million of investment to aid with the Covid-19 backlog, it is not guaranteed to continue at that level. There is a clear problem of underfunding in Northern Ireland. In order to restore the budget to 2011 levels there would need to be an extra £33 million of extra funding guaranteed per year.[22]

5.37 Patient charges meanwhile have steadily risen during that period from just below £17.4 million to £26 million in the year before the pandemic, therefore historically making up a higher proportion of funding. However, during the pandemic there occurred a steep drop off in patient charges.

Pensions

5.38 The BDA continues to engage with Scheme Advisory Boards for the NHS Pension Schemes across the UK. However, many of the pensions issues arising are linked to the pensions tax regime, which falls under the jurisdiction of HM Treasury, rather than with Health Departments or the NHS.

5.39 The BDA recognises that it is prudent Government policy to restrict the level of tax relief given to pension savings, and that it is a matter for HM Treasury to set the limits that should apply. However, the Lifetime Allowance (LTA) and Annual Allowance (AA) were introduced as measures to influence the behaviours of pension savers rather than to explicitly raise revenue through AA/LTA charges.

5.40 The NHS Pension Scheme in its current form remains a generous vehicle for retirement saving, but it does not afford members the flexibility to control their levels of pension saving. As a result, members who find themselves in breach of these limits are changing behaviours by:

a. Opting out of the pension scheme and foregoing the generous contribution by the NHS. This also results in members losing enhanced death in service and ill health retirement benefits.

[20] General Dental Statistics for Northern Ireland - General Dental Statistics Publication 2021-22.pdf (hscni.net)
[21] ONS RPI Index
[22] ONS RPI Index

b. Reducing levels of NHS activity. By lowering pensionable NHS earnings, and earnings generally, members reduce their exposure to both Annual Allowance and Lifetime Allowance charges.
c. Seeking early retirement. Taking a pension early can reduce exposure to Lifetime Allowance charges.

5.41 Some mitigations have been introduced. One of these, announced by DHSC in their policy paper "Our Plan for Patients" (Sept 2022), was that the NHS Pension Scheme would be reformed by "encouraging NHS trusts to explore local solutions for senior clinicians affected by pension tax charges, such as pension recycling". At the time of writing, we are trying to engage with NHS England (who are leading on the implementation of this policy) to ensure that this mitigation is extended to General Dental Practitioners. It is currently unclear if GDPs will be able to access recycling of the pension contributions made on their behalf by the NHS. It is imperative that GDPs are included in this policy, otherwise continued breaches of Annual Allowance are likely to be followed by even lower levels of NHS engagement from this group.

5.42 The mitigations announced to date include a change to the revaluation of NHS pensions and proposals to allow a more flexible approach to retirement. These are welcome, but unfortunately do not go far enough and, crucially, they still do not give members any facility to control their level of pension accrual. As a result, many dentists will still be subject to high tax charges linked to AA and LTA breaches. Therefore, we still envisage dentists feeling forced to reduce their levels of NHS work.

5.43 We are advocating a system of flexible accrual in the NHS Pension Schemes that will allow members to determine how much pension they build up. Any such election would be coupled with a lower member contribution (and consequently lower levels of income tax relief) and, crucially, a payment of the unused NHS/employer contribution as taxable pay. The introduction of flexible accrual will give members the opportunity to better control the extent to which their pension savings are in breach of Annual and Lifetime Allowances. It would also offer a cheaper alternative form of pension saving to NHSPS members who opt out of their pension schemes on the grounds of affordability.

5.44 BDA would invite the DDRB to support our call for flexible accrual, with enhanced pay in lieu of full pension contributions, to be implemented for dentists, and across the wider NHS family.

5.45 The issue of NHSPS member contributions remains of concern to us and is intrinsically linked to the take home remuneration of dentists. Whilst changes have been made in October 2022, with further changes proposed for 2023, we believe that the career average nature of NHS pension provision, coupled with the fact that Annual and Lifetime Allowance serve to mitigate against high levels of income tax relief, means that the case for tiered pension contributions are diminished. BDA would prefer a longer term move towards a flat rate of member pension contribution. We would urge the DDRB to support such a move.

Gender pay gaps

5.46 There is a clear and discernible gap in pay between male and female dentists. The self-employed nature of much of the dentist workforce means that determining the extent and causes of the gender pay gap is made more complex. Nonetheless, it is clear from the available data, as with most other sectors, that in dentistry men are paid more than women. The latest release of the NHS business services data[23] acknowledged that it is possibly (at least in part) due to the higher likelihood

[23] Microsoft Power BI

of men being principal dentists, and therefore likely to earn more. This is despite the year-on year increase of women becoming dentists.[24] The disparity may be skewed further this year as practice owners would have received Covid-19-related support (Fig 10).

5.47 Data from NHS Digital's Earning and Expenses report shows that there is a gendered difference in the taxable income of self-employed primary care dentists, with female dentists earning less than male dentists across both associates and practice owners in all parts of the UK. Men on average are earning more than £27,000 per year than women. On average male dentists in the GDS have an earnings to expenses ratio of 51.9 per cent whereas their female counterparts have a much lower ratio of 41.8 per cent. These differences exist regardless of contract system between the four nations.

	Male	Female	Percentage difference
England	£87,800	£59,100	39%
Wales	£93,600	£56,800	48%
Northern Ireland	£88,500	£63,000	33%
Scotland	£78,300	£57,500	30%

Fig 10: Average taxable income from NHS and private dentistry for associates by gender, 2021/22 Sources: NHS Digital Dental Earnings and Expenses Estimates

5.48 The BDA have previously looked at the underlying trends which may influence this gap. For instance, there has been found a small difference in pay per UDA value between men and women, however these were not found to be statistically significant. Gender intersects with age, for example, in that older dentists tend to be paid more (Fig 11) and, in our research, male dentists tended to be older. As lower-earning younger female associates enter the workforce in higher numbers, yet older and higher-earning male associates and provider-performers leave or reduce their NHS work with older age, there may be further reduction in the average cash and real-terms pay of dentists. Not only would this underline the gendered nature of pay in NHS dentistry, but it also illustrates further the complex problems relating to renumeration in the wider system which continue to reduce the service's ability to serve patients adequately.

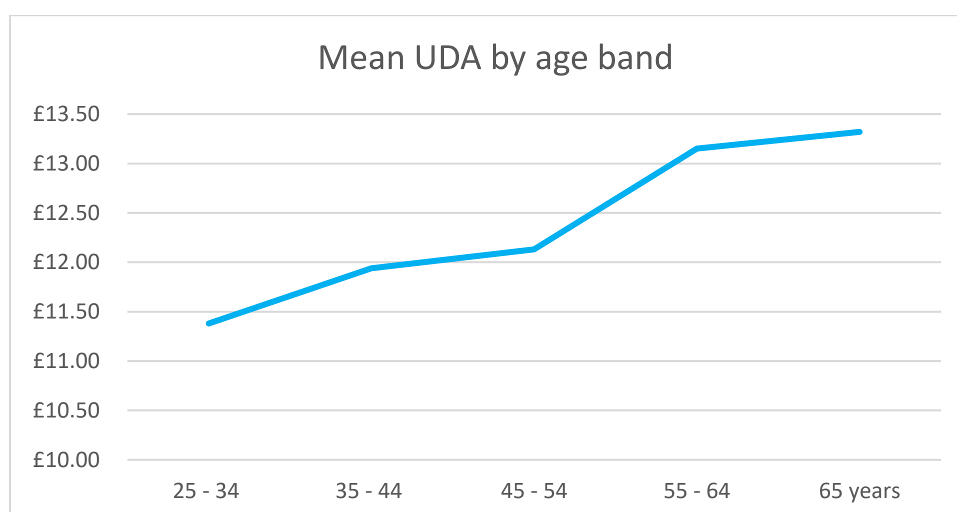

Fig 11: Mean UDA value by age band, weighted sample of 2645. Sources: BDA survey data August 2022

[24] Microsoft Power BI

Chapter 6 – General dental practice

6.1 The BDA once again notes that there is not enough capacity among General Dental Practitioners to deliver enough NHS activity to meet existing patient demand. NHS dentistry in England is unsustainable without radical reform including a substantive pay rise. Further, we note that the inability to meet existing patient demand is a result of unfunded cost increases in the delivery of NHS activity, which have led directly to the long-term fall in take home pay for GDPs. Dental practices already struggling to deliver NHS activity in a financially sustainable way are now also experiencing historic levels of cost inflation in the essential materials and services they require.

6.2 The combination of inflationary pressure and the long-term underfunding of NHS activity is making the recruitment and retention crisis ever more acute. This increases the risk of under-delivery of contracted activity, threatening the financial sustainability of practices, having a knock-on effect on the local health and social care economy, and making it harder for patients to access the care they need.

'I really miss talking to my patients, I really like knowing them really well and having that bond and I feel like that makes the whole experience so much better, but you get to the stage where it's just a numbers game, its quantity over quality, and I just don't like that and I feel like that's where mistakes happen, that's where your patients don't trust you, that's where you get burnt out, and so I just want to take that little step back and realign with my own values and remember why I wanted to do this.'
Associate, England

Workforce

6.3 While we include headcount data here in the absence of more granular information, the number of dentists registered with the General Dental Council and the headcount number of active NHS dentists is at best a very rough proxy for overall workforce capacity in dentistry. Headcount data does not account for working patterns - or indeed the quantity of NHS care - delivered by new or existing dentists. As such, while the overall headcount of GDPs across the UK has increased somewhat since last year, it would be wrong to infer from that increase that labour supply in dentistry is operating effectively.

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Change 20/21 vs 21/22
England	24,007	24,308	24,545	24,684	23,733	24,272	+539
Wales	1,475	1,479	1,506	1,472	1,389	1,420	+31
Northern Ireland	1,108	1,081	1,139	1,147	1,142	1,146	+4
Scotland	2,933	2,978	3,029	3,038	3,039	2,883	-156
Total	29,523	29,846	30,219	30,341	29,303	29,721	+418

Fig 12: Number of primary care dentists in England, Wales, Northern Ireland and Scotland. Sources: NHS Digital, NHS Education for Scotland, Northern Ireland Statistics and Research Agency and StatsWales, respectively

6.4 Fundamentally, the long-term underfunding of NHS activity is the single biggest factor inhibiting effective workforce supply in dentistry and is ever more threatening to the financial sustainability of dental practices.

6.5 More salient than headcount data is our survey result demonstrating that the proportion of practice owners reporting an intention to increase the private work they intend to deliver increased significantly from 22 per cent in 2021 to 39 per cent this year. For associates, this figure increased from 39 per cent in 2021 to 48 per cent in 2022. In the absence of a substantive pay rise that addresses this root cause of the recruitment and retention crisis, many dentists will continue to be forced to subsidise their NHS activity with private income where they are able to do so.

'… I'm not going to lie here; you can't earn a living [delivering NHS activity]. It's nothing to do with making a fortune, it's to do with earning a living. So, my private work was having to creep up and up to subsidise my NHS income.' **Associate, England**

6.6 To enable more strategic workforce planning at a national and local level, the BDA again calls for the publication of the modelling undertaken by Health Education England as part of its dental education and training reform package Advancing Dental Care. Similarly, the BDA would welcome NHS Digital resuming the collection and publication of its Dentists' Working Patterns Motivation and Morale dataset. The BDA believes that the absence of publicly available, high-quality data remains an impediment to strategic workforce planning, and further that Government is the only actor able to collect such data.

Recruitment and retention

6.7 The BDA's annual quantitative and qualitative survey of GDPs found that 90 per cent of practice owners seeking to recruit an associate in the 2020-2021 financial year had difficulty doing so. This is a substantial increase on what members told us in 2021. The figures in our GDP surveys in 2021, 2018 and 2017 were, respectively, 80 per cent, 70 per cent and 63 per cent.

'I was an NHS dentist for 26 years of my career, all pretty much bulk NHS, but I'm not going to go back to doing that, not unless there's something hugely dramatic that changes.' **Associate, England**

6.8 As was found in our survey in 2021, practices with a high NHS commitment found it significantly harder to recruit associates. When practice owners were asked why they had struggled to recruit associates, 71 per cent told us that this was due to reluctance among applicants to deliver NHS care. 82 per cent of practice owners reported that they had had few or no applicants to advertised positions, while 39 per cent reported that a low UDA value had caused difficulties in recruitment.

'We haven't been at full capacity for nearly four years now, even pre-Covid. Covid just compounded it. What tends to happen is associates will come and work for us, but then they'll find themselves a private job.' **Practice owner, England**

6.9 As well as assessing the overall difficulty of recruiting associates, our survey asked practice owners about the number of associate vacancies. 41 per cent of practices reported two or more associate vacancies compared to 28 per cent last year. 54 per cent of those reporting vacancies told us that they had posts that had been empty for more than six months. These results represent a significant worsening of the position since our survey last year, with both the number of vacancies

and the time taken to fill posts increasing.

6.10 The most recent available data from NHS Digital demonstrated that, in 2019/20 across the four nations, between half and three quarters of practice owners often thought about leaving general dental practice, and between half and two-thirds of associates often thought about leaving general dental practice.

6.11 This year we found that roughly one in three practice owners and one in five associates intend to leave dentistry as soon as possible or in the next 12 months. Among both practice owners and associates, the likelihood of wanting to leave dentistry was heavily correlated with a high NHS commitment. Thirty-six per cent of practice owners delivering more than 70 per cent NHS activity wanted to leave dentistry, compared to 29 per cent of those with more private work. Twenty per cent of associates delivering more than 75 per cent NHS work wanted to leave dentistry, compared to 13 per cent of those with more private work.

'NHS dentistry is not going to be attractive for people coming out of dental school and we're seeing that already with maybe 20 per cent of graduates not taking up [Foundation Dentist] places. So, are they leaving the profession altogether and not even joining the profession or they go straight to private practice?' **Practice owner, England**

6.12 Our survey found that over the next five years, 50 per cent of practice owners were intending to sell their practice, with just 27 per cent intending to continue working in their current main role. For context, in our 2018 survey only 32 per cent of practice owners intended to sell their practice over the next five years, with 46 per cent intending to continue working in their current main role. This year 45 per cent of practice owners reported an intention to reduce their hours worked, compared to 42 per cent in 2021. Perhaps most strikingly, as noted earlier, the proportion of practice owners reporting an intention to increase the amount of private work they do has almost doubled to 39 per cent since our survey last year, at which point the figure was 22 per cent.

6.13 Turning to associates, our survey found the same trend of an intention to both reduce overall hours worked and increase the proportion of private work, a trend that has accelerated since our survey last year. Forty-two per cent of associates reported their intention to reduce the number of hours they worked, compared to 36 per cent in 2021. Forty-eight per cent of associates reported their intention to increase the amount of private work they undertook, compared to 39 per cent last year.

6.14 The data on recruitment and retention from our survey demonstrates that the crisis in dentistry set out in the BDA's submission to the DDRB last year has become even more profound. More practices are struggling to recruit, more dentists are seeking to reduce their overall hours worked, and more dentists are seeking to increase their private work. The correlation between a high volume of NHS work and even greater recruitment and retention challenges underlines that the underfunding of NHS activity is having a direct impact on workforce capacity and stability. Any meaningful attempt to address the workforce challenges facing dentistry must therefore include a substantive pay rise.

Dental nurses

6.15 The challenges facing practices seeking to recruit and retain dental nurses have worsened dramatically since last year. Our survey found that 90 per cent of practice owners reported difficulty in recruitment, compared to 80 per cent in 2021. Eighty-two per cent of practice owners were seeking to recruit dental nurses, compared to 63 per cent in 2021. When asked what the reason for the challenge of recruiting a dental nurse was, 92 per cent of practices told us that they had received too few or no applicants to the position to run a recruitment process, while 61 per cent reported that applicants wanted higher salaries than could be offered.

'Two months, we've had three nurses hand in their notice… one to work in another practice, it's a private practice… and one nurse is leaving because she's going to go into a school, so holidays are better, the pay is better… we've been trying to recruit for 18 months… they don't want to sign up!'
Practice owner, England

6.16 Dentists are required by the GDC to always be appropriately supported when treating patients. With rare exceptions, dentists will work in tandem with a dental nurse, and the availability or absence of a nurse is therefore critical to delivering clinical work. As a result of the long-term underfunding of NHS activity and the long-term erosion of real-terms take home pay for dentists, practices are unable to fund pay for dental nurses at a level that supports effective recruitment and retention. In many practices, the lack of dental nurse capacity is acting as a limiting factor on activity that could otherwise be delivered by dentists.

Morale and motivation

6.17 As noted in the BDA's previous submission to the DDRB, the most recent NHS Digital data available from 2019/20 found that morale among GDPs was extremely low; in some parts of the UK, barely one in ten reported high or very high morale. This, of course, was prior to the pandemic & its aftermath, and the extraordinary circumstance of the current rapid deepening in a decade-long real-terms take home pay cut as a result of inflationary pressures.

6.18 This year, the BDA's qualitative and quantitative survey found that 62 per cent of practice owners and 61 per cent of associates reported low or very low morale, representing a slight increase on last year's aggregate figure. In 2018, the number of practice owners and associates reporting low or very low morale was 39 per cent and 44 per cent respectively. The morale of GDPs has significantly declined in the medium term, and given the absence of a post-pandemic recovery in levels of morale, it appears unreasonable to attribute recent continuing low morale simply to the challenges of recovery from Covid-19.

	Practice owners	Associates
All	62	61
≥75% NHS commitment*	82	69
<75% NHS commitment*	45	48

Fig 13: Percentage of GDPs saying their morale was low or very low. Sources: BDA survey data August 2022
*≥70% and <70% NHS commitment for Practice Owners

6.19 Seventy-two per cent of practice owners and 68 per cent of associates would not recommend a career in dentistry. Alongside a slight aggregate increase in reported low or very low morale, this year's survey also found that more practice owners and more associates were dissatisfied overall in their job.

6.20 Perhaps unsurprisingly given the similar patterns in recruitment and retention data from our survey discussed earlier, the proportion of practice owners and associates who would not recommend a career in dentistry was highly correlated with working in practices with a high-level of NHS commitment.

	Practice owners	Associates
All	72	66
≥75% NHS commitment*	80	75
<75% NHS commitment*	64	57

Fig 14: Percentage of GDPs answering 'no' to whether they would recommend a career as a dentist. Sources: BDA survey data August 2022
*≥70% and <70% NHS commitment for Practice Owners

6.21 The most recent available NHS Digital data found that in England, Scotland and Northern Ireland, 'increasing expenses and/or declining income' was the leading cause of low morale for GDPs, while in Wales this cause came third, closely behind admin/paperwork and regulations.

6.22 The BDA's survey of GDPs this year found that that 57 per cent of both practice owners and associates would disagree or strongly disagree that they were fairly remunerated for their work, a substantial increase from 40 per cent for both groups in 2021.

'The NHS side of things, some months it doesn't even cover the costs of running the practice and you'll find that the private side of things keeps it going. So, we actually run the two practices with two separate bank accounts so that we can keep an eye.. some months it will be a case of going to transfer, you know, £10,000 over to the NHS account just to sort of keep it in credit and pay the bills, to be honest and that's not right really.' **Practice owner, England**

6.23 Seventy-four per cent of practice owners and 76 per cent of associates agreed or strongly agreed with the statements that they receive support from their colleagues at work, while 80 per cent of practice owners and 80 per cent of associates agreed or strongly agreed with the statement that they were treated with respect by the people they work with. More widely, a majority of practice owners and associates also agreed that they had opportunities to do interesting work, were able to provide patient care to a standard they were satisfied with, were secure in their work, had opportunities to develop, and were treated with respect by patients. These results are particularly noteworthy given the position of NHS England in ongoing contract reform discussions with the BDA that a lack of integration between dentistry and the wider NHS and within the dental team is imperilling better outcomes for patients.

6.24 In stark contrast to these positive motivational indicators, only 20 per cent of practice owners and 42 per cent of associates agreed or strongly agreed with the statement that they achieved a good balance between their work life and private life, representing a slight deterioration to a historic

low.

6.25 As in our previous submission to the DDRB, a majority of GDPs reported supportive work environments, opportunities for development, and the opportunity to provide a high level of patient care. Broadly, indicators of satisfaction and morale not relating to pay or the closely related issue of work/life balance are positive. Given the overall poor levels of morale reported by GDPs, we can once more reasonably infer that pay issues are highly salient and act as a critical drag on overall morale.

'That's the major reason for going down the conversion, they've repeated restrictions on increases in contract value, and that has restricted the income into the practice, yet the expenses increase, and what we pay the associates, what we pay the staff is really restricted and we're really finding it a struggle to retain these staff and retain their morale.**' Practice owner, England**

Stress

6.26 GDPs continue to experience unsustainable levels of stress, with 75 per cent of practice owners and 56 per cent of associates working in practices with a high NHS commitment rating their level of stress in the highest possible category in our survey (very/extremely stressed).

'The pressure is shocking. You are doing so much and there's no incentive, you know you're not getting paid properly for it either. I work in a practice with lots of young people, we all have stress related health issues, and you know, I'm 27! I've got neck problems, back problems, migraines, like to the point where I couldn't work, and it's all stress!' **Associate, England**

6.27 Disappointingly, over the last 12 months, 77 per cent of practice owners and 67 per cent of associates feel that their level of stress has increased. For practice owners and associates working in practices with a high NHS commitment, these figures are 88 per cent and 77 per cent respectively.

6.28 When asked to pick which factors were causing stress in their current role, 91 per cent of practice owners chose increased practice costs, and 79 per cent chose staffing, recruitment, and retention issues. For associates, the two factors most frequently identified as causing stress in their current role were staff shortages/staff turnover and hitting NHS targets, at 71 per cent and 67 per cent respectively. Given the critical role NHS activity plays in the financial sustainability of many practices, it seems reasonable to infer that the wider cost pressures facing practices are part of the explanation for associates identifying NHS targets as the second most salient factor contributing to stress in their role.

'I know quite a few people who are making plans to leave or have left. I don't know anyone who works in a practice who's four years qualified, who works full-time anymore. I am about to go to four days.' **Associate, England**

Chapter 7 – Community/Public Dental Services

7.1 The Community Dental Service/Public Dental Service (CDS/PDS) is an NHS primary care dental service which treats patients (children and adults) not usually seen in conventional high street services. They take time to see, manage and treat appropriately. In the GIRFT report, the CDS is defined as a service provided in community settings offering dental care to children and

adults with special care needs who are unable to access care from high street dentists.[25] Depending on what services are commissioned this will include paediatric and special care dentistry. Paediatric dentistry provides specialist oral healthcare for children from birth to adolescence. This includes children and young people up to 16 and in some cases 18, who have extensive oral disease or developmental disorders of the teeth and mouth. Special care dentistry focuses on improving the oral health of people over 16 who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or a combination of these issues. It includes the important period of transition as the adolescent moves into adulthood.

7.2 Across the UK there has been a sustained and long-term decline in the numbers of dentists working in this setting for more than a decade. This has been experienced during a period of significantly increased demand, a pandemic and more widely damaging under investment in the sectors that employed dentists work.

7.3 In this chapter we describe in detail the individual circumstances in each UK country affecting the workforce across CDS and PDS (in Scotland).

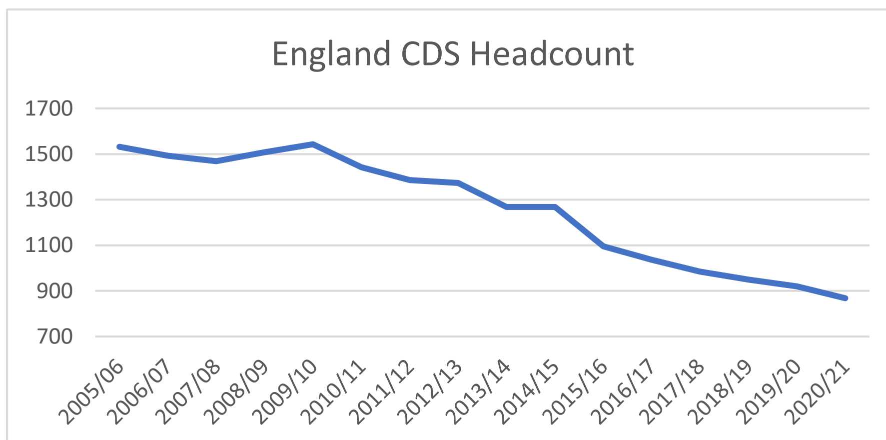

Fig 15: CDS headcount in England from 2005. Sources: Health Departments and NHS Digital.

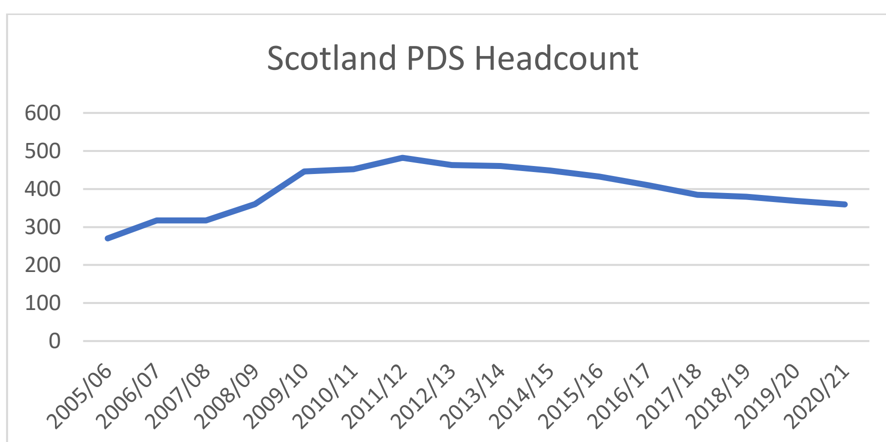

Fig 16: PDS headcount in Scotland from 2005. Sources: Health Departments and NHS Digital.

[25] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

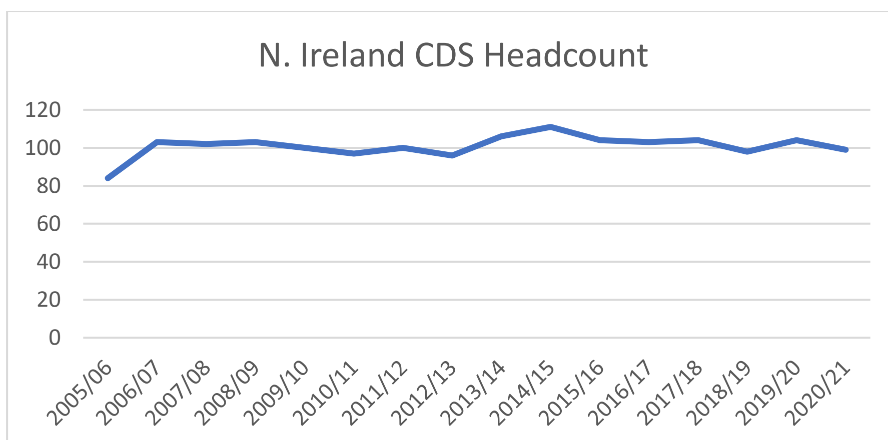

Fig 17: CDS headcount in Northern Ireland from 2005. Sources: Health Departments and NHS Digital

7.4 In England, the workforce continues to decline, and the service has many experienced and senior dentists in the latter stages of their careers. This is also highlighted in the 2021 GIRFT (Getting It Right First Time) report, which notes that there is a significant shortage of suitably trained specialists to deliver Level 2 commissioned services covering special care dentistry, and that many specialists currently on the specialist list were due to retire in the near future.[26] The BDA's own survey highlighted that nearly 25 per cent of respondents were aged 55 and over and therefore supporting reports that a significant proportion of the workforce are approaching retirement in the near future.

7.5 Between 2014 and 2021, in Scotland there was a 20 per cent reduction in Public Dental Service (PDS) dentists. This decrease in capacity, together with reports of PDS dentists continuing to treat large numbers of unregistered patients and referrals from GDPs, means that the PDS in some services has to balance the salaried GDS aspect of its service and the community dental patients which include some of the most vulnerable groups in society including care home residents, adults and children with learning difficulties and complex medical conditions. NHS Scotland Workforce statistics note that similar to other UK countries, the workforce is predominantly female. In 2022 there were 371 dentists working in the PDS in Scotland but with a WTE of only 281. Fifty-six posts were advertised between April 2021 and April 2022 and only 38 posts were filled.

7.6 In Northern Ireland as of 30 September 22, there were 83 individuals on community dental pay scales in HRPTS, with a total whole time equivalent of 66.54. Some have more than one post, not always at the same pay scale, and sometimes with another Trust. Fourteen point six per cent of these dentists were aged 55 years and over and a further 18.3 per cent were aged 50-54 years old. Eighty-nine per cent of this workforce were female.

Grade	**Headcount**	**WTE**
Community Dental Officer/Senior CDO	77	61.14
Director /Assistant Director of Community Dental	6	5.40
TOTAL	83	66.54

Fig 18: Headcount and WTE data. Sources: HRPTS as at 30th September 2022.

7.7 In Wales dentists in the CDS are directly employed by Local Health Boards (LHBs). The tasks

[26] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

undertaken by the CDS are ever growing, yet the service itself is stable at best, and in some cases shrinking. Currently, dentists' posts are being lost at retirement or advertised but remain unfilled. Recruitment and retention issues are felt particularly in more rural areas, which are known to be difficult to staff. Once again, we have not been able to produce a set of data for Wales headcount because the data used by *Stats Wales* has proved unreliable.

7.8 Looking at the UK wide situation the significant challenges for the CDS/PDS workforce that were highlighted in our evidence last year have not improved and have instead deteriorated even further. Across the whole of the UK there are now significantly longer waiting lists for child and adult general anaesthetic treatment and sedation which were over one-year pre-pandemic but now have grown by a greater amount due to continued restrictions in theatre space right across the NHS. By definition, many of the patients referred to and treated within the CDS/PDS are from vulnerable and disadvantaged groups and a high percentage also have high treatment needs. Those retained by the CDS/PDS for the long term are also the same, meaning that significant treatment backlogs will persist for some time. Despite repeated appeals by the BDA no effort has been made to reveal the scale of these backlogs, given that the data is not captured within wider published NHS waiting list figures. CDS/PDS provide comprehensive care for people of all ages who have special needs and/or who are medically compromised, in effect some of the most vulnerable individuals in the population who can struggle to access services. Visiting patients in their own homes or care homes is often necessary due to their special needs. This can also give the dentist more information on their social history, the circumstances in which they live and the effect this may have on compliance with their dentist's advice. Dentists often work in close liaison with other health care professionals and social services to deliver effective holistic care to their patients.

7.9 The impact of the backlogs across the UK will be the already stark health inequalities for many of these patients widening further, which will be reflected in the CDS/PDS patient cohort waiting for treatment. Without additional staffing, it is difficult to imagine how the most vulnerable patients will get their treatment before their oral health deteriorates and further pain and suffering ensues. These are some of the least well represented patients as they often have no voice and no advocate service, other than their CDS dentists. Data obtained by the BDA from the NHS Business Services Authority under a Freedom of Information request showed that in England, in March 2022, nearly 80,000 vulnerable patients were facing waits of up to 4 years for treatment, with more than year long waits for assessment and again for follow up treatment. The historic and relentless decline in headcount numbers is having a direct impact on the ability of the CDS/PDS to treat the UK's most vulnerable patients, including paediatric and adult special care dental patients with complex needs or disabilities, who are unable to receive routine care on the high street.

7.10 Access to treatment under general anaesthetic (GA) also continues to be one of the key concerns raised by the diminishing CDS/PDS workforce and the patients who clinically require this service. The relentless pressures on staffing in community and hospital settings have continued with lists still being cancelled and the backlogs growing even further. Once again, the situation is not captured within wider NHS data collection. Data obtained by the BDA from the NHS Business Services Authority under Freedom of Information requests showed that, in England, the backlog for treatment is lengthening, with some sites reporting waits of up to 190 weeks for treatment under general anaesthetic in March 2022. The 2021 GIRFT report into Hospital Dental Services[27] highlights the problems facing clinicians across the service who provide treatment under GA. It highlights the shortage of specialists and consultants in many

[27] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

areas of the country available to meet the demand of numbers of children requiring treatment under general anaesthetic. A study on dental decision making for delivering GA for vulnerable patients showed the level of regret and guilt felt in non-COVID times about providing care. With demand increasing and availability decreasing for treatment sessions under GA or sedation, significant levels of stress are ever present as the quote below from the study demonstrates:

"*taking their teeth [out] at times, I do feel guilty. I don't know if everybody else feels like that, but I do*"

7.11 The suffering behind these unacceptable waiting list figures must not be overlooked. As emphasised in the 2021 GIRFT report, many patients awaiting extractions of teeth under GA encounter severe pain on a daily basis. A significant proportion of these patients are young children, and the GIRFT report emphasises the impact that poor oral health can have on a child's ability to eat, speak, play, and socialise, and therefore their development and performance at school.[28] The report recommends that 'waiting lists for children requiring exodontia must be reduced'.[29] It is the BDA's view that this will only be possible if recruitment and retention rates within the CDS are improved, and if steps are taken to improve the GDS access crisis, including through prevention programmes, to reduce the need for invasive treatments like extractions under GA. An above inflation uplift in pay is therefore integral to realising this recommendation.

7.12 The result of the eroding workforce, increased waiting lists and continued demand is that community dentists often feel completely powerless to rectify the situation and a sense of guilt resulting in them taking on even further pressures and therefore taking a personal toll on their own health and wellbeing. This can be understood in the context of motivation as when asked about what motivates their work as a dentist, 89 per cent said helping patients (91 per cent in 2021) and 84 per cent said it was feeling thanked and appreciated by patients that motivated them. However, CDS dentists often experience the stress associated with long waiting lists and frustration from those not able to access services.

7.13 The BDA has once again undertaken its own survey for 2022; 363 dentists completed the survey, which is approximately 23 per cent of the workforce (head count).[30] As well as providing a commentary on the key themes from the survey across the nations we have provided individual quotes from respondents so that the review body can get a sense of the key issues and challenges as described in their own words. A core and repeated theme in all the nations is a decrease in job satisfaction and morale as the impact of the relentless pressure and declining workforce is felt within every workplace. Combined with this trend, the survey has shown dentists feeling even more acutely the need to work outside of their contracted hours with a resultant impact on their own personal health and wellbeing.

7.14 In previous evidence submissions we have highlighted that CDS/PDS dentists (and their teams) provide NHS care to complex patients requiring primary dental care tailored to their specific needs. 'Routine' care in the CDS service is not the same as a routine dental appointment on the high street. However, the points raised in previous years by the BDA within our evidence prompted no new commentary by Department of Health and Social Care in their submission to the 2022/23 DDRB round.

[28] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

[29] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

[30] Head count is based on the most recently available figures which are from 2021.

CDS England

7.15 In 2022 the BDA sent an FOIA to all services that have a community dental service. In England 47 of the 57 providers questioned had a CDS as part of their service. The data showed that between April 2021 and 2022, only 81 posts were filled out of 124 posts which were advertised.

7.16 Satisfaction with pay levels showed a very marked deterioration. Last year 50 per cent of respondents considered their pay as being fair, but this figure has now fallen to just under 30 per cent (a 20 percentage point deterioration compared to 2021).

7.17 Across England 52 per cent of CDS dentists felt satisfied with their present role compared to nearly 60 per cent the previous year (a reduction of nearly 8 per cent). In a separate question 41 percent of respondents said that they felt dissatisfied with their present job overall (a 7 per cent deterioration compared to 2021). Almost 27 per cent never or rarely looked forward to going to work. From the information provided below coupled with what our members are telling us across all parts of England, it is clear that the pressures CDS dentists are working under are still having a significantly detrimental impact on job satisfaction.

		Always/often	Sometimes	Never/rarely
BDA 2020	I look forward to going to work	47.2	30.3	22.6
BDA 2021		37.5	41.8	20.7
BDA 2022		37.4	35.7	26.9
BDA 2020	I am enthusiastic about my job	61.5	28.2	10.2
BDA 2021		50.2	40.1	9.7
BDA 2022		53.5	32.7	13.9
BDA 2020	Time passes quickly when I am working	76.4	19.4	4.2
BDA 2021		77.3	17.4	5.3
BDA 2022		75.4	17.4	7.2

Fig 19: Comparison of BDA survey responses with NHS Staff Survey 2019 showing per cent changes between years.
Sources: BDA survey data August 2022 and NHS Staff Survey 2019

7.18 Combined with the BDA survey data for 2022 on stress it is a continually worrying and deteriorating picture as higher levels of stress for sustained periods have a significant impact on the health and wellbeing of staff. Overall, 34 percent of CDS dentists indicated that they found themselves unable to cope with the levels of stress in their current job. The BDA believes that a significant factor was escalating workloads and the declining number of community dentists in post. If the CDS workforce continues to diminish, it is reasonable to believe that stress levels among this cohort will worsen.

In general, how do you find your job?	2020	2021	2022
Not at all stressful	0.5	1	1
Mildly/moderately stressful	62.8	61.1	57
Very/Extremely stressful	35.2	38	40
I would prefer not to say	1.5	0	0

Fig 20: BDA CDS survey results showing per cent changes between years. Sources: BDA survey data August 2022

7.19 In England four core themes were identified:

a. Workload increases: Respondents reported increased workload and time pressures. Concerns were raised regarding long waiting lists and the backlog of patients needing to be seen in part due to the pandemic, which had exacerbated an existing problem. Increasing from 74 per cent in 2020, 82 per cent in 2021, and now 86 per cent in 2022 respondents said their workload was very high or high. Covering for colleagues is also a fairly regular occurrence, with 27 per cent of staff covering colleagues once a week or more often. Less than 20 per cent of survey respondents felt able to finish on time having completed all essential clinical tasks. An increase in patient complexity and need was mentioned as well as patients not being recalled as the clinician would wish, in order to reduce workload.

"Loss of staff making it even harder to meet patient demand at a time when all waiting lists are increasing" **England, Band A, 35-44, 16-20 years' service**

b. Impact of demand on other sections of dentistry: Respondents reported a shift in workload in relation to other spheres of dentistry, predominantly in comparison to general dental practice but also secondary care due to significantly increased demand within those services. Limited access to urgent care by GDPs, and the impact of contract changes were highlighted as contributing factors for this trend. This shift was also highlighted as impacting on patient discharge from services, with clinicians reluctant to discharge due to difficulty in finding a GDP to discharge to.

"Difficulties accessing GDS has increased workload on CDS - more inappropriate referrals difficulty in discharging patients. Much more disease to manage" **England, Band C Specialist, 0-5 years' service**

"Demand on access emergency slots overwhelming and amount of treatment required to 'Make dentally fit' impacts on appointments slots." **England, Band A Dental Officer, 21-25 years' service**

c. Staffing: Respondents expressed dismay at the impact staffing levels had on both their job satisfaction and morale. Lack of staff and covering for others were highlighted as contributors with difficult/poor recruitment and staff sickness mentioned as well as new staff lacking experience. Too few administrative staff and nurses was also cited. In the BDA CDS survey nearly 70 per cent of respondents said their service was not meeting the needs of patients. 40 per cent indicated that they would not continue practising as a community dentist in the next five years.

"We are critically short staffed being now about ¼ of the size we were when I started 20 years ago" **England, Band C Specialist, 21-25 years' service**

d. Poor leadership: Some respondents felt their service had a poor attitude and approach to patients. Priorities were said to be short-sighted and not patient focused with a general lack of investment in services and driven by politics and statistics. Management was perceived as not supporting their staff, dismissing concerns, having little understanding of roles and making poor decisions with no consideration for those providing the service or the pressures on staff. NHS England was cited as commissioning additional services but not increasing funding and commissioning decisions, in England, also caused feelings of uncertainty. In our survey of CDS dentists, only 41 per cent agreed that they felt supported by management.

"It is very hard to remain professional when you know you are continuously being dumped on, your waiting times to treat patients getting longer and longer, yet managers expect you to do more, collect even more pointless data, in less and less time." **England, more than 26 years' service**

7.20 The results reflect the challenging working lives of those in Trusts and Community providers. A compelling survey figure shows that, in 2021, 74 per cent said that they would recommend a career as a community dentist, but this figure dropped dramatically in 2022 with only 65 per cent feeling that they could make the same recommendation. With headcount numbers declining, posts unfilled and pressures on the workforce growing, the working conditions for NHS staff remains extremely difficult. Feeling valued by the NHS and their employers remains a core priority for CDS dentists, and yet the results described above illustrate that in many areas this is still far from being achieved.

PDS Scotland

7.21 The Public Dental Service combines the Community Dental Services and the Salaried General Dental Services in Scotland.[31] PDS plays a vital and unique role in treating patients who need special care dentistry. They also provide dental services to a range of vulnerable groups – such as homeless people, those in care homes and children – who may have complex needs and difficulty accessing the services within the community. This can also include referrals for paediatric dentistry, anxious adults and bariatric services. PDS are often involved with the delivery of national programmes for example, Caring for Smiles, national epidemiology, oral health promotion, Childsmile and dental outreach. Sedation and dental general anaesthetics are often delivered by the PDS.

In Scotland four core themes were identified:

a. Job Satisfaction: Our survey of PDS dentists in Scotland showed that less than one third were satisfied in their present job overall (27.9 per cent). In common with the other UK countries, half (48.8 per cent) said their job satisfaction had decreased compared to the previous year. Also, the BDA's survey of PDS dentists in Scotland in 2022 raised some significant concerns about morale, conditions, and capacity within the service and highlighted the impact that Covid-19 is still having on this service.

"Having to give more priority to GDS rather than PDS patients. Little say in service provision. Not being given enough time to see patients or do admin. I have to spend evenings after work completing admin (I organise community dental theatre for example) Unable to see PDS patients

[31] Pay, Terms and Conditions of Service for the Community Dental Service and Salaried General Dental Service in Scotland

in favour of GDS patients so vulnerable groups are not being seen as they should. I am doing a lot of extra work for no extra pay. I'm only a DO (dental officer)." **Scotland, 11-15 years' service, Dental Officer**

"General staff unhappiness; the department is not the same as it was. Everyone is disheartened." **Scotland, 21-25 years' service, Senior Dental Officer**

b. Morale: Around half of respondents (46.5 per cent) rated their morale as a dentist as "low" or "very low" – this is similar to the overall UK figure (44.8 per cent). Only half (57.1 per cent) would recommend a career as a community dentist.

"Patients are less understanding of the long waiting times that are now just starting to affect them and the limited staff and services that we have. Patients are also less tolerant of continued Covid 19 restrictions within our service that is there to keep them, vulnerable patients and staff safe in a high-risk environment" **Scotland 11-15 years' service, Senior Dental Officer**

c. Workload and stress: Job strain is a concern with 8 in 10 (81.4 per cent) describing their current workload as high or very high. Almost half (45.2 per cent) had worked over their contracted hours, once a week or more often. 9 out of 10 (86.1 per cent) found their job moderately, very or extremely stressful. The effects of the Covid-19 pandemic, the backlogs of care and the access problem it has created are clearly a concern to PDS dentists. The main areas of concerns are around general anaesthetics for children, special care adults, domiciliary care and their ability to provide care for paediatric and special care patients. Unfortunately, a third (37.2 per cent) of dentists never/rarely look forward to going to work. It is imperative that this group of dentists feels valued. Any further destabilisation of this specialised and specialist workforce could have a significant impact on the already widening health inequalities in Scotland.

d. Career intentions for the next five years: Just 4 in 10 (39.5 per cent) planned to continue practising as a community dentist, lower than the overall UK figure (56.7 per cent) and the lowest in the UK. Over one third (34.9 per cent) are aged over 55.

CDS Northern Ireland

7.22 In Northern Ireland four core themes were identified:

a. Job dissatisfaction and low morale**:** The BDA survey findings show that Job satisfaction and morale have declined for the majority of CDS dentists working in Northern Ireland over the past year. Worryingly, 66.7 per cent of CDS dentists working in Northern Ireland say they are dissatisfied, and 63.6 percent report having, very low or low morale. A wide range of patient care issues are having a negative impact on the morale of dentists working in the CDS. Almost half (47.6 per cent) of respondents disagree that they are able to provide patient care to a standard they are satisfied with; 86.4 per cent of CDS dentists in Northern Ireland disagree that the service meets the needs of patients.

"Lack of leadership in the Trust. Lack of communication. No support with difficult / complex patients from my own trust or elsewhere within NI. Complete disillusionment with community dentistry as we emerge from Covid. Work pressures continuing to mount but staff reaching burnout and no one cares!" **Northern Ireland, Senior Community Dental Officer, 11-15 years' service**

b. Pay and retention: While pay has traditionally not been a particular problem within CDS, it has emerged as an issue this year, with over half (54.5 per cent) disagreeing with the statement 'I feel that my pay is fair'. Only 22.7 per cent agreed that their pay is fair. Overall, a higher percentage of

practitioners are satisfied with the terms and conditions of their employment (40.9 per cent agree; 31.8 per cent disagree). In spite of the many challenges and pressures impacting adversely on the working lives of CDS dentists, 50 per cent reported they are always/often motivated; 31.8 per cent are motivated sometimes; and 18.2 per cent never/rarely motivated. 54.5 per cent would recommend a career as a community dentist. Over a third (36.4 per cent) of CDS dentists in Northern Ireland indicated they plan to retire over the next five years, with 31.8 per cent opting they intend to reduce their hours.

"No continuity in patient care, multiple dentists completing one course of treatment. Appt times being squeezed to see more patients in a day which leads to more admin being generated and no allocation for time to complete this admin which leads to working unpaid overtime. Very little flexibility in taking leave esp if something unforeseen comes up for example with school activities with less than 6 weeks notice. Also being expected to carry out SDO duties without enhanced pay to reflect this." **Northern Ireland, Community Dental Officer, 0-5 years service**

c. Workload and lack of parity: We see the impact the above issues, not least Covid patient backlog are having on individual workloads. 77.3 per cent of respondents described their current workload as high or very high, with a further 22.7 per cent saying it was 'about right'. 54.5 per cent said they have felt obliged to work *more* than their weekly contracted hours once a week or more often; a further 18.2 per cent 2-3 times a month; and 13.6 per cent feeling obliged to work more than their contracted hours 2-3 times over the previous year.

"The dental hospitals in our area often reject referrals and advise to refer to CDS for often patients who could either be seen in general practice or who should be seen in the hospital dental service. Increased demand for domiciliary care as most practices no longer offer this. Generally very little support from our colleagues in orthodontics - generally will refuse to give opinions on extraction patterns involving first permanent molars. As time goes on I feel more and more deskilled in hands on dentistry which is a pity. Many practices in the area referring all children out as they don't want NHS patients and are transitioning to private dentistry. Lots of people in pain contacting our service on a daily basis wanting to register with us as they can't get to see their regular dentist - draining for staff to have to deal with over and over again." **Northern Ireland, role not stated, 0-5 years service**

d. Stress and support from management: It is a particular issue among CDS dentists. 50 per cent find their job as very or extremely stressful, with a further 36.4 per cent opting for mildly/moderately stressful. Extremely concerning is that 45.4 per cent disagree/strongly disagree that they can cope with the level of stress in their current job, such is the personal impact workplace pressures in CDS is having on practitioners. Our survey findings show quite clearly that staff feel let down by the lack of clinical support from management during the pandemic, with only 13.6 per cent agreeing/strongly agreeing they felt clinically supported by management.

"Focused on reducing appointment times to squeeze more patients in. Unable to offer a high quality of care. Pushed in to carrying out services that were traditionally a seniors post without training." **Northern Ireland, Community Dental Officer, 0-5 years service**

Wales/Cymru CDS

7.23 The Community Dental Service's core role is the provision of primary dental care to the most vulnerable groups of people in Wales, including adult and child patients with disabilities, mental health issues or severe anxiety. The CDS also delivers prevention programmes in Wales, such as the national prevention programme for children, Designed 2 Smile[32], and Gwên am Byth[33] which supports oral hygiene and mouth care for people living in care homes. The CDS also undertakes the

[32] Designed to Smile – Public Health Wales
[33] Gwên am Byth – Public Health Wales

yearly epidemiology survey[34], which will be restarting this year following the pandemic. The new Welsh Health Circular[35] on the CDS and Services for Vulnerable People discusses the role of the CDS, including plans to expand its remit.

7.24 In Wales four key themes were identified:

a. **Waiting Lists and backlogs**. Waiting lists in the CDS have increased. The increased demands on the Service and backlogs caused by the lack of access to CDS clinics during the pandemic are mainly responsible. During the red-alert phase of the pandemic, CDS clinics across Wales became Urgent Dentalcare Centres, keeping dentistry going in Wales. Patients normally seen in the GDS were treated by the CDS to minimise the spread of Covid-19. This meant that the vulnerable patients normally seen in the CDS were not seen, and waiting lists, which in some Health Boards were already long, began to grow. In a recent BDA Cymru survey, 85 per cent of CDS dentists were very concerned about levels of patient backlog in the last six months.

> *"Under more pressure. Waiting lists high. Not any thanks for role during the pandemic. Just AWFUL."* **CDS Dentist**

> "*Many experienced staff have retired or left dentistry. Where we have recruited the experience is not at the same level. The result is that we have been dealing with the waiting lists and backlogs with fewer and less experienced staff. We are still tired from being a red centre during Covid too. I worked right through. No time at home at all alongside several colleagues whilst others stayed at home*." **CDS Dentist**

b. **Pressures on the CDS and lack of investment.** The CDS in Wales are affected by chronic under-funding; in particular the estates (lack of equipment) and old IT infrastructure have been directly impeding the rate of patient throughput and adding to a growing backlog of patients. (Investment in air handling installations was very patchy during the pandemic and so fallow times remained long in many surgeries, thus exacerbating the backlog.) Despite this situation, the number of tasks required to be performed by the CDS has been increasing. Currently, every LHB has a CDS with vacancies for Special Care Dentistry Specialists as well as dentist and senior community dentist vacancies.

> *"Each HB should be urged to support the CDS in IT infrastructure and operation as that always appears to be missed out in any major IT planning decisions. If we had robust IT and data support, then the CDS would be able to plan services better to address backlogs.*" **CDS Dentist**

c. **Pressures to treat non-CDS patients***.* E-referrals were introduced in 2018 to streamline the referral process and reduce the number of GAs on children in Wales. This has led to a great deal of extra work in the CDS. While the number of child GAs in hospital has reduced, the CDS is treating double the number of children, and their inhalation sedation services have also increased. Because there has been no additional funding or resources, other CDS groups of patients have been disadvantaged as a result. The access issues in the GDS are having a negative effect on the CDS. In some Health Boards, CDS resources, staff and clinics are being used to relieve the GDS access issues, with CDS staff treating GDS emergency patients.

> *"Along with noting the approach of service management and lack of involvement in any decisions that impact my job. For example, with less than two days' notice we were informed that despite being very busy we were now to take on all the emergency care for the service area as GDPs were no longer doing this as part of their contract. A double whammy leading to greatly increased stress."* **CDS Dentist**

d. **Mental Health of Dentists**. The impact of the reduced workforce and increasing demand is that those working in CDS are feeling the impact on their own health. BDA Wales undertook two surveys

[34] Welsh Oral Health Information Unit – Cardiff University

[35] The role of the Community Dental Service (WHC/2022/022) – Welsh Government

of dentists in 2021 and this showed that over 60 per cent of CDS dentists rated their sleep as very bad or bad. Over half of CDS dentists were having to do admin at their desks during their lunch break. All CDS dentists stated they found the rise in administrative tasks stressful. Nearly 50 per cent CDS dentists went to work while not mentally well enough for more than 10 days in a six-month period.

> *"I cannot be certain when it happened, or what was the trigger, but I have lost almost all enjoyment for the role I currently undertake. It could be the demands of the PPE to be worn at all times, it could be the ever-increasing lists of patients waiting to be seen, it could be an element of deskilling but ultimately in the last year I find that my mental health has been really hit and I would have started feeling retirement cannot come soon enough."* **CDS Dentist**

Conclusion about the state of UK CDS/PDS

7.25 The BDA believe that the repeated themes described above are compelling. It is clear that an above inflation pay award will be crucial if we are to recruit and retain dentists that are trained to meet the dental needs of a vulnerable and growing patient population.

Chapter 8 – Civilian Dental Practitioners – Defence Medical Services

8.1 The BDA is again providing evidence on behalf of Civilian Dental Practitioners (CDP) working within the Defence Medical Services (DMS) as this group of Ministry of Defence (MOD) employed dentists are awarded uplifts linked to the DDRB recommendations. This is in accordance with a 2003 agreement between the MOD and the CDPs' Representative Body within the MOD – PROSPECT. CDPs are not part of the remit of the Armed Forces Pay Review Body (AFPRB) therefore we provide evidence to the DDRB to ensure that pay parity with NHS colleagues is maintained for this group of dentists.

8.2 Currently there are 108 CDPs working within the DMS as part of its primary dental healthcare group termed Defence Primary Healthcare (Dental) (DPHC(Dental)). Currently 65 are Full Time (37hrs per week) and 43 are Part Time (varies between 8 and 32hrs per week). These 43 Part Time CDPs equate to almost 26 WTE. While these figures are remaining stable, they do belie an undercurrent of churn due to CDP turnover.

8.3 DPHC (Dental) CDPs are employed by the MOD to provide occupational, primary dental healthcare to Armed Forces (AF) personnel and entitled civilians, based in the UK and abroad. They are employed as civil servants and are not serving military personnel. They are therefore not deployable on military operations or subject to military discipline. CDPs are termed a Non-Standard Occupational Group (NSOG) by the Civil Service (CS) with unique Statement of Employment Particulars.

8.4 There is an expectation that the DMS People Strategy Plan 2020 – 2025[36] will deliver against work strands aiming to make the DMS more inclusive of all Civil Service Healthcare Workers in line with the Defence Healthcare Delivery Optimisation Study. It is hoped that this will establish a CDP career structure making it possible for CDPs to progress professionally and compete for appropriate clinical and non-clinical roles throughout the DMS. This is required to improve recruitment and retention and reduce workforce turbulence within the cadre.

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[36] Strategic Command (2020) HQ Defence Medical Services Group People Strategy 2020 – 2025: Our People Vision & Objectives accessed 12.1.22 https://dms-leaders.com/storage/app/media/docs/20200924-HQ%20DMS%20Gp%20People%20Strategy%20Launch%20FINAL-O.pdf

8.5 We were pleased that in 2022, PROSPECT and, in turn, the BDA were consulted on a pay rise for CDPs with the view to ensure parity. However, we had very significant concerns regarding the 4.5 per cent uplift awarded by the DDRB for this group; yet again an uplift both below inflation and equating to a real-terms pay cut.

Chapter 9 – Clinical dental academics and hospital dentistry

Clinical dental academics

9.1 The BDA provides evidence to the DDRB on the dental academic cadre to ensure that, across the UK, pay parity is maintained with NHS colleagues. This year we were pleased to see that pay parity has continued to be maintained in England, Wales and Scotland on the UCEA pay scales. We are however dismayed that yet again, there is a significant delay in awarding the uplift to all dentists in Northern Ireland. This continued delay puts dental academia in Northern Ireland in an uncompetitive position in relation to other UK institutions. We also note that there are some aspects of the DDRB award this year that have been applied differently within the nations, leading to unnecessary variations. In Wales, the honorary consultant pay scale ends at a lower level in comparison to England, but the Commitment Award specific to Wales is intended to make up for this shortfall. However, in 2022 the Commitment Award was not subject to the 4.5 per cent uplift, thus leading to disparity in pay.

9.2 While each country of the UK sets its own pay policy and timelines for implementation, the late implementation of pay awards and the different interpretation of how the parity with UCEA pay scales are applied continues to pull the dental academic workforce behind their peers across the rest of the UK. The BDA strongly recommends that robust data be published by the Dental Schools Council to ensure that we have an improved understanding of recruitment and retention of clinical academics. The overall total reward package (including pensions) has been steadily eroded for dental academics, and we have significant concerns about the yearly nature of the implementation delays, because the annual delays simply compound.

9.3 As part of the total package of reward, we once again need to highlight the issue of eligibility for the National Clinical Excellence Awards in England. Consultants are eligible for the National Scheme under the 2003 terms and conditions of service. Within dentistry, we have a pipeline of NIHR funded academic General Dental Practitioners who will become contractually eligible in the next few years. We have made this statement to the Advisory Committee on Clinical Excellence Awards in our 2020 consultation response, and we wish the DDRB to be aware that all those contractually eligible for an award should be able to apply for one.

9.4 We are aware of the workforce challenges created by the absence of an award scheme and the lack of a nationally agreed process for discretionary points in Scotland. This situation makes it more difficult to attract and recruit excellent candidates from England.

9.5 Members of the clinical academic workforce are either a member of the NHS Pension Scheme or the University Superannuation Scheme pension (USS) depending on their contract of employment. We share the UCU's concern at the detrimental proposals for members of the USS and have highlighted those concerns to the Scheme. The changes look increasingly less attractive than the NHS Pension Scheme.

9.6 More widely we would like to bring to the attention of the review body the need to encourage and incentivise qualified dentists to consider academia as a potential career to deliver high quality education for the dentists of the future. This is a key aspect to ensuring that suitable and up to date

education and training are delivered under a sustainable system of workforce supply of dentists, in order to meet the future demands of the population. If the dental educator workforce does not increase to match this demand, it is likely that the existing workforce will be overburdened.

Hospital dentists

9.7 The British Medical Association (BMA) provides evidence for doctors and dentists based in hospital services. Our evidence on hospital dental services merely seeks to provide some additional dental context to the overall picture. Our evidence is complementary to the BMA evidence submission and should be read as such.

9.8 As with the wider dental profession, our members in the Hospital Dental Services across the UK have been affected by the many pressures within the system. In many cases, patients are experiencing challenges to access an NHS dentist. This is the situation for both children and adults across the UK. Hospital dentists in some specialties are seeing patients with more acute problems who are presenting later due to a number of factors including: waiting lists, the impact of late referrals as a result of the pandemic and the difficulties being experienced in accessing care through the general dental services. This is highlighted in the 2021 GIRFT report, which states that 'in many cases children are only going to the dentist once they are in pain or have a dental infection, by which time it would be inappropriate to give a local anaesthetic and they may be too anxious and not acclimatised to sit in the dental chair'.[37] If conservative treatment was provided in a timely manner by a GDP, then many patients could avoid the need to be seen in secondary care.

9.9 In terms of dentists at consultant grades, the absence of new Clinical Excellence Awards and pensions allowance mitigations compounds the difficulty of recruiting to Northern Ireland.

Trainees

9.10. Due to the continued lack of parity in terms and conditions for hospital dental trainees in Northern Ireland, and also centralised National Recruitment to trainee positions, we are now finding it increasingly difficult to recruit candidates to training in Northern Ireland. The trainees we already have in post also may not feel valued. This has resulted in vacant posts, which impacts on service delivery and the need to appoint locums.

9.11 In England, dental trainees share the same frustrations as their medical colleagues regarding the recent pay award for 2022/23. We recognise that the 2016 Junior Doctors and Dentists terms and conditions of service tied trainee hospital doctors and dentists into a multi-year pay deal. However, hospital trainee doctors and dentists only received a two per cent pay uplift in 2022/2023, despite the Doctors' and Dentists' pay review body advising a 4.5 per cent uplift for this cohort. This below inflation uplift was coupled with years of real terms pay cuts for an overstretched and underfunded workforce. Many of the staff experiencing dramatic pay erosion over many years have worked tirelessly to provide care while under increased pressure as a result of the pandemic. We note that the pay review body allowed scope for more flexibility on agreeing pay awards. Our dental trainees, together with their medical colleagues, felt profound disappointment that this opportunity was not taken by Government. The BDA asks the review body to address the many years of pay erosion experienced by trainees.

9.12 We are also still working alongside the BMA and NHS Employers looking at the trainee pay scale and the need for dental trainees at levels ST4-6 to be paid at the nodal point 5 pay point. This has

[37] Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

been an ongoing issue for hospital dentists and there has been disappointment that further progress has not been made since the last pay review in 2021.

Chapter 10 – Our recommendations

10.1 **We ask the DDRB to recommend a pay uplift of RPI plus five per cent for GDPs and employed dentists** to ensure that a real-terms rise in take-home pay is delivered, and to attract and retain dentists to work in the NHS.

10.2 **We again call for a timelier implementation of the pay award.** We welcomed the DDRB's acknowledgement in the Fiftieth Report 2022 that a pay review process that is taken seriously by Government is vital, and we note the impact of delays on the overall morale of those delivering care. In addition, given the material impact delays to the implementation of the pay award has on the financial sustainability of dental practices, we ask the DDRB to strongly recommend that the 2023/24 pay award should be implemented on 1 April 2023 to avoid erosion of its value.

10.3 **We ask the DDRB to revert to its prior practice of providing a separate uplift recommendation on expenses for GDPs**. The fundamental issue of successive expenses uplifts being insufficient to both deliver dental services and protect dental incomes continues to critically undermine the financial sustainability of dental practices. Given the complete failure of the current approach, we believe that pay and expenses being considered alongside one another would deliver better outcomes for dentists and patients alike.

10.4 **We call for the overall annual expenses uplift to be applied to service costs for Dental Foundation Training Practices.** As previously noted, the expenses element of the uplift and the service cost payments are both intended to cover the same category of costs and therefore the uplift applied in respect of the former should be applied to the latter.

10.5 **We do not recommend targeting awards**

10.6 **We again call for the reinstatement of commitment payments for Northern Ireland, Wales and England.** This has been our ask since 2017 and we ask the DDRB to consider this call and encourage the Health Departments to explore the options with the BDA.

10.7 **We again call for Dental Schools to maintain pay parity for clinical academics with their substantive NHS colleagues.** As in other specialties, pay awards must be implemented in a timelier way. The annual delays across the nations have a significant impact on the pay erosion of dental academics.