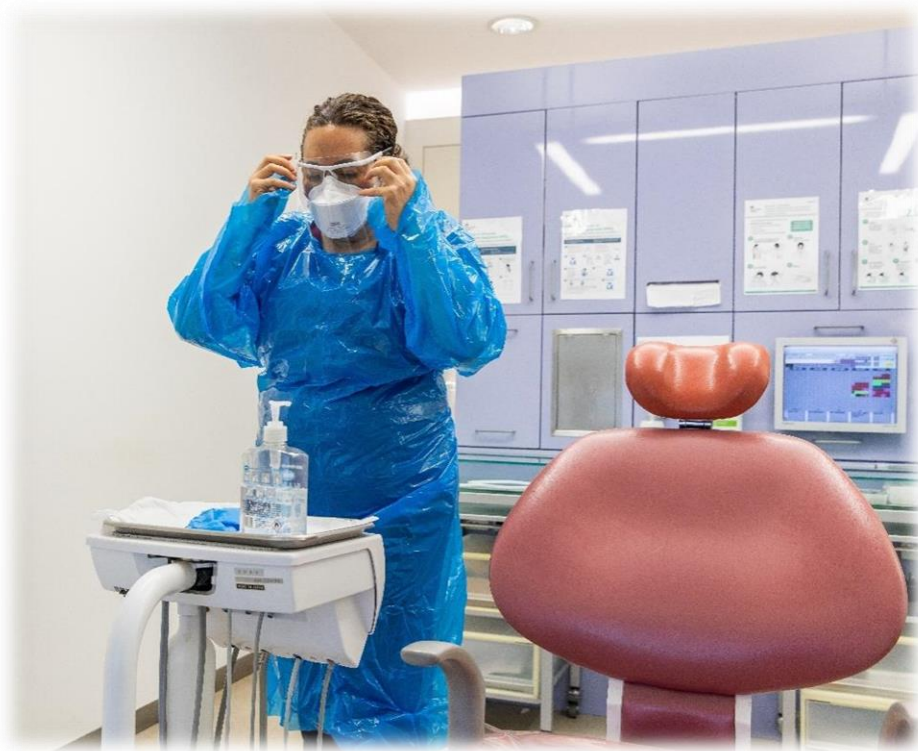




Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2022-23

24 January 2022



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Chapter 1 – Executive summary

- 1.1. The pandemic has amplified long-standing problems in dentistry. Across the UK, the system is in crisis.
- 1.2. Our evidence shows that morale is at rock bottom among dentists. In some parts of the UK, fewer than one in ten respondents to our survey rated their morale as high or very high. Among associates with a high NHS commitment, 76 per cent would not recommend a career as a dentist.
- 1.3. The problems that we have described to the Review Body with recruiting and retaining dentists have only become more profound. Ninety-three per cent of these heavily-committed NHS practice owners who had sought to recruit an associate said that they'd experienced difficulties doing so. There are also severe challenges recruiting and retaining dental nurses. Nearly two-thirds (63 per cent) of practice owners had needed to recruit a dental nurse between April-September 2021, and of those 80 per cent had experienced difficulties doing so.
- 1.4. The NHS is unable to attract dentists and dental nurses, and as a result the NHS workforce is shrinking. Across the UK, there were 1,038 fewer dentists working in NHS primary care in 2020/21 than there were in 2019/20. This will inevitably have a direct impact on the amount of NHS care that can be delivered.
- 1.5. As we have reported year on year, pay for both associates and practice owners continues to fall. but take-home pay remains significantly below the levels seen a decade ago. Compared to 2008-09 levels, performer-provider taxable income in 2019-20 has fallen by 23.5 per cent in Northern Ireland, 19.2 per cent in Wales, 14.4 per cent in England and 12.6 per cent in Scotland. For performers, compared to 2008-09, taxable incomes have fallen in cash terms by 14.3 per cent in England, 14.2 per cent in Northern Ireland, 13.1 per cent in Scotland, and 6.9 per cent in Wales. These are falls in cash terms that 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.
- 1.6. The past decade of rising costs and low uplifts has created a situation in which the financial sustainability of many practices is in question and where many dentists are now actively leaving the NHS. In its 50th report, the Review Body must set out action that addresses this and that delivers a real-terms pay rise for dentists.
- 1.7. We ask the Review Body for to recommend an uplift of dental inflation plus three per cent for GDPs and RPI plus three per cent for employed dentists. We also ask for:
 - 1.7.1. Timely implementation of pay awards
 - 1.7.2. Separate recommendations on expenses
 - 1.7.3. Reinstatement of commitment payments for England, Wales and Northern Ireland
 - 1.7.4. An increase in the prior approval limit in Northern Ireland
 - 1.7.5. That the Review Body reiterates the historical recommendation of pay parity of clinical academics which is impacting on recruitment and retention.

Chapter 2 – About the BDA

- 2.1 The British Dental Association (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. Hospital Dentists (Consultants, SAS dentists and dentists in training) are included in the BMA's evidence submission as these dentists work on nationally negotiated contracts for doctors and dentists.

Chapter 3 – BDA response to the 49th report

- 3.1 It is welcome that the 49th report sets out in paragraphs 1.38 and 1.48 the DDRB's disappointment at the unhelpful delays throughout the pay round. Delays in implementing uplifts are now commonplace from the four departments of health and are completely unacceptable. It is now routine that the implementation of any uplift takes place in in the second half of the financial year to which it applies and in Northern Ireland delays are at times more than one year (Fig 1). It is appreciated that the DDRB has specifically raised concerns in paragraph 1.48 about the extreme delays to implementation in Northern Ireland.

Year	NI	England	Scotland	Wales				
2021-22	<i>Still not known</i>	Dec 2021	8 mths	Dec 2021	8 mths	Oct 2021	6 mths	
2020-21	August 2021	16 mths	Dec 2020	8 mths	Nov 2020	7 mths	Nov 2020	7 mths
2019-20	August 2020	16 mths	Nov 2019	7 mths	August 2019	4 mths	August 2019	4 mths
2018/19	August 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)

England

- 3.2 In England, despite accepting the DDRB's pay recommendation in June, the DHSC's consultation as to the percentage contract uplift for GDPs was significantly delayed and did not take place until late October 2021. The BDA responded promptly to this consultation and the backdated uplift was implemented in December 2021. The DHSC opted to hold a separate consultation on uplifts to various SFE payments related to Dental Foundation Training (DFT) and this has yet to occur. This is particularly notable given that the grant that DFT practices receive in respect of service costs has been frozen since 2013, when it should have been uplifted in line with other expenses.

Scotland

- 3.3 In October 2021, the Scottish Government confirmed the 2021/22 pay uplift for GDPs which would be applied from 1 December and backdated to 1 April. The Scottish Government accepted the DDRB's recommended pay increase of three per cent, and applied the increase to gross Item of Service fees, and to capitation and continuing care payments. However, we again expressed our disappointment to the Government that the uplift will not be applied to the full GDP remuneration package. We made it clear that the uplift should be applied to all allowances otherwise it is not a true three per cent pay rise – we estimate the overall increase will only be around 2.2% to 2.3%. Members have also highlighted that the Vocational Training (VT) Trainer Allowance has not been

increased since 2014. As a result, VT Trainers are apparently valued less than their VDPs year on year.

Wales

- 3.4 In Wales, the uplift was applied to all contracts (backdated to 1 April) in time for the September payment on 1 October 2021. The Welsh Government chose to apply three per cent to all aspects of the formula, and so GDS contractor holders received a three per cent uplift.

Northern Ireland

- 3.5 Northern Ireland has continued to be impacted by unacceptable delay in how the DDRB process is implemented. Despite the Minister accepting in January the recommended pay uplift for 2020-21, it took until August 2021 before this was fully applied by way of uplifted SDR fees.
- 3.6 At the time of writing, while the Minister in his remit letter to Mr Pilgrim has advised that he has accepted the recommendations of the Review Body in full for 2021-22, we have yet to receive confirmation of the percentage uplift that will apply, or crucially, when practitioners will actually see the uplift being applied to the SDR. As per our letter to Minister Swann of 2 December on this issue, any benefit contained within a three per cent uplift will have been wiped out by inflation due to the extensive delay in having this implemented.
- 3.7 The systemic delay is as a result of a dysfunctional approach by the NI Executive towards annual pay reviews and operating to annual budgets. Despite the Health Minister's best intentions, the Department of Finance also has a key responsibility in providing the necessary consents and budget required to implement pay uplifts in Northern Ireland.

Chapter 4 – Policy Update

- 4.1 Dentists across the UK continue to deal with the ongoing impact of the pandemic, which has only amplified and exacerbated the long-term, underlying problems facing NHS dentistry. Not only must dentists contend with enhanced infection prevention controls, stretching activity targets and patient backlogs, but they do so in an NHS system with failing contracts and falling take-home pay.

COVID 19 financial support and interim contractual frameworks

- 4.2 Across all four countries the approach to financial support for dentistry has varied during the second financial year of the pandemic.

England

- 4.3 From 1st April 2021, dental practices were working under new contractual arrangements which held through quarters one and two of the financial year, all while the Infection Prevention and Control (IPC) guidance continued to govern the way in which treatments, especially aerosol generating procedures, could be carried out. Practices continued to be paid their normal monthly payments. The contractual arrangements stipulated that clawback would not be applied to practices that were delivering, or going beyond, 60 per cent of their contracted UDAs, and 80 per cent of their contracted UOAs; with those levels of activity effectively being treated as '100 per cent delivery'. NHS England also established a lower threshold of 36 per cent of contracted UDAs and 56 per cent of contracted UOAs. Clawback would be applied linearly to those practices who delivered activity at a rate between the upper and lower thresholds, and those delivering under the lower threshold would be subject to the full rate of clawback.

- 4.4 As in the previous quarter, the payment for any undelivered activity continued to be subject to an abatement of 16.75 per cent; an arbitrary figure which the BDA repeatedly contested and asked for NHS England to justify. The requirement to ensure universal availability of urgent dental care, and to prioritise those patients with the highest clinical risk, also remained.
- 4.5 The decision to increase the upper UDA threshold to 60 per cent was opposed by the BDA, as we believed it to be too high to be reasonable and achievable considering the activity levels that had been achieved in quarter four of 2020-21 and the ongoing IPC requirements. NHS England and the BDA monitored practice delivery against this 60 per cent target and we felt that a concerning number of practices were struggling to meet it. We felt that, on the basis of these outcomes, any further increase to expected UDA activity would be unwise at the end of the second quarter.
- 4.6 On 19th July 2021, dental practices were informed that the ‘transition to recovery’ Standard Operating Procedure (SOP) would remain in place, despite announcements that England would move out of step four of the Covid-19 response, and this SOP remained when the contractual arrangements for quarter three of 2021-22 were announced on 30 September. This announcement was made only one day before the proposed contractual arrangements were to be implemented, giving practices less than 24 hours’ notice of the target to which they would be working. Such late announcements have become routine, but are completely unacceptable. This was further exacerbated by the fact that the BDA had regularly engaged with NHS England throughout the first half of the financial year in an attempt to determine the quarter three arrangements in a timely manner, but to no avail.
- 4.7 For quarter three, NHS England imposed a new upper threshold of 65 per cent of contracted UDAs and 85 per cent of UOAs, while the lower threshold was increased to 52 per cent of UDAs and 60 per cent of UOAs. The abatement was decreased to 12.75 per cent. These arrangements were proposed to last for only one quarter of the financial year in anticipation of changes to the Covid-19 SOP.
- 4.8 In late November 2021, new IPC guidance and an updated SOP were introduced that provided for distinct pathways based on whether a patient had respiratory symptoms or not. While this in theory could increase patient throughput, the interaction of the need to maintain enhanced IPC for patients with respiratory symptoms during cold and flu season and the emergence of the Omicron variant has constrained the impact of the change in guidance.
- 4.9 For quarter four, NHS England has imposed a target of 85 per cent and removed any lower threshold, meaning that practices are exposed to far greater financial risk if they are unable to reach this stretching level of activity. Omicron has led to widespread issues with staff absence and patient cancellations that severely hamper the ability to increase activity limits.

Scotland

- 4.10 Following the letter from the Cabinet Secretary to dental teams in October 2021 about the Scottish Government’s plans to reintroduce an (amended) Statement of Dental Remuneration and end Covid support payments in early 2022, we issued a [press release](#) warning the Government that its plans to return NHS practices to pre-Covid models of work could devastate dental services across the country. We issued a survey in late October to gather GDCPs’ views on the Scottish Government’s plans. We received the highest response rate to any BDA survey, with results showing:
- 80 per cent of respondents said they are likely to reduce their NHS commitment
 - Over a third (38 per cent) indicated they would consider changing career or seek early retirement in the next 12 months
 - 15 per cent said they would look to practise outside of Scotland

- One in 10 estimated their practice would probably cease operations if emergency support was removed.

- 4.11 Latest figures from Public Health Scotland show the scale of the backlog of unmet patient care facing dental practices due to restricted capacity during the pandemic. The number of treatments delivered in the year to March 2021 was less than 25 per cent of those delivered in the previous 12-month period, corresponding to over 3.5 million appointments lost as a result of the pandemic. Patients are now presenting with higher levels of need, requiring additional time. BDA Scotland has warned that the return to a 'business as usual model' – low margin and high volume – will put practices under unsustainable financial pressure and will likely lead to closures or movement to the private sector.
- 4.12 In light of the Scottish Government's centrepiece policy of providing free NHS dental care for all, a new, sustainable model for delivering care must be developed. In the interim, a workable funding model is needed to replace the current "emergency" arrangements to support dentists and their teams to care for their patients.

Northern Ireland

- 4.13 Over the past 20 months, BDA has sought to work constructively with the Health Minister and officials to provide collective leadership to try to avoid a complete collapse of Health Service dentistry in the GDS. While we put on record the short-term supports that have been provided, including Financial Support Scheme (FSS) funding and ventilation funding under the Patient Throughput Scheme, without a fundamental shift of trajectory away from a race to the bottom, Health Service dentistry will not survive. We have reached a point where the majority of NHS committed dental professionals are feeling utterly demoralised, burned-out, and concerned for the future.
- 4.14 Those same practitioners who volunteered to work in Urgent Dental Care Centres at the start of the pandemic have been working harder than ever under incredibly challenging conditions due to more stringent Infection Prevention Control (IPC) measures, hamstrung in the number of patients they can see in a day. And, in addition to trying to address their own patient backlog, as a condition of FSS support they continue to be compelled to treat unregistered patients, and to be on-call to provide emergency cover at weekends and holiday periods.
- 4.15 In the absence of emergency out of hours cover being reinstated (despite input from LDCs about how these services should be reinstated) our dental teams are now also being subjected to new levels of abuse from a frustrated section of the public. They have to perform complex dentistry with the constraints and exhaustion of wearing enhanced PPE and all the while knowing how far Health Service pay has been eroded and continues to be eroded. It is no surprise that GDP morale has dropped to just 4% 'high' or 'very high' according to the latest BDA survey.
- 4.16 Our grim assessment is that the conditions pertaining to the provision of Health Service dentistry in Northern Ireland have reached a point where many dentists feel like they are being pushed out of being able to continue to offer care under the NHS. As small businesses and self-employed practitioners, goodwill, the bond with their patients and cross-subsidisation of NHS by private dentistry is no longer enough to make up for years of government inaction to heed the warnings. Enough is enough.
- 4.17 There is a very real sense that the scale of the challenge is such that the DDRB process on its own is not nearly enough to make the impact required. Nothing short of extensive reform of the GDS remuneration model to make Health Service dentistry financially viable in the 'here and now', plus simultaneously getting on with the work to develop a new GDS contract, will suffice.

- 4.18 Certainly, tinkering around the SDR with an uplift of a few small percentage points, while delayed implementation wipes out said 'uplift' is nowhere near sufficient to cover the reality of what Health Service dentistry actually costs small dental practice businesses to deliver, not least as inflation reaches new highs. Any business must be able to cover costs and have enough left over to re-invest in the business to be sustainable, and dentistry is no different. There simply must be a mechanism embedded within the GDS remuneration system that automatically adjusts for increased dental inflation so that a pay uplift is just that - a real terms increase to pay. A 40 per cent- reduction in dental earnings over the past decade is clear evidence that the current model is not fit for purpose.
- 4.19 Our members and the general dental profession at large have struggled to shoulder what was hitherto HSCB responsibilities towards unregistered patients and providing emergency out of hours cover as conditions attached to FSS support, as well as trying to get through large backlogs of their own patient care. The removal of emergency provision at weekends has combined to significantly worsen conditions for practitioners, a situation that has continued 20 months on from the start of the pandemic. The system has failed to reward their hard work, skill and dedication.
- 4.20 Recent surveys of BDA NI members show just how far morale and job satisfaction has plummeted, and how high stress levels have soared. A staggering 87 per cent describe their morale as low or very low. It is clear that the current financial arrangements are a major factor in this; 84 per cent state the lack of financial certainty as a primary cause of stress. Meeting the conditions of the FSS specifically providing emergency cover at weekends and over holiday periods is a significant stress factor for 90 per cent of associates in Northern Ireland. Working in high levels of PPE and abuse also rated highly as stressors. It should be a matter of concern that 92 per cent of associates in Northern Ireland would not recommend dentistry as a career choice. This does not bode well for both the short and long-term outlook for the profession.
- 4.21 In addition to the GDS Rebuilding Stakeholder Group, a GDS Contract Reform group has been established. This group met for the first time on 15 December 2021. We welcome the resumption of discussions on a new GDS contract, but note the delay of over six years since these discussions were last had in earnest.
- 4.22 Only by addressing how financially unviable Health Service dentistry in its own right has become, and by seeking to provide additional financial support in the short-medium term, while seeking to put in place a new contract that is attractive to practitioners, we fear there will be a significant exodus of practitioners away from NHS dentistry. The crisis of confidence among practitioners in being able to provide HS dentistry under the GDS in a financially viable way simply has to be urgently addressed. In addition, work to devise a new contract must demonstrate that government recognises that the sustainability of the GDS depends on retaining practitioners, and delivery for the general public.

Wales

- 4.23 The BDA has been in close consultation with dental branch and dental public health during the progress of the pandemic regarding the second year of NHS recovery measures. We continue to fully support the suspension of the UDA measure and have continued to communicate extensively with the profession about the pandemic recovery measures of service in the GDS and NHS contract remuneration. Rather than being measured against UDA targets, practices have instead been asked to meet a [set of expectations](#), which include conducting annual ACORN oral health assessment, being open to new patients, undertaking aerosol generating procedures, applying fluoride varnish to children and higher risk adults, and reporting workforce data. These expectations have been phased in over the course of the financial year.
- 4.24 The BDA has several times communicated to the Welsh Government's dental branch that the local health boards are in some cases not following the legal guidance set out for fluoride varnish targets

inasmuch they have been threatening practices with clawback if they are failing to reach 80 per cent which is an advisory measure. The subordinate legislation clearly stipulates 75 per cent as the threshold for clawback.

- 4.25 In one case, after quarter one of this financial year, Swansea Bay University Health Board (SBUHB) actually clawed back monies from over twenty practices that hadn't reached 80 per cent for fluoride varnish. This was also against a backdrop of issues with the accuracy of eDen, the BSA's reporting platform. The BDA complained vociferously; pointing out that in-year clawback is illicit. Fortunately, the monies were eventually repaid by SBUHB, but this was an unfortunate move during a time when practices were still finding their feet with the new measures in a very difficult financial environment.
- 4.26 The Welsh Government's dental branch is currently working with their legal advisors regarding the GDS volumetric measures for next financial year to ensure they are compliant with existing primary legislation. These measures have not been shared with the BDA as yet, but are expected early in the new year. There have been indications that the Welsh Government will be looking for around 70 per cent of pre-pandemic GDS activity, assuming the new IPC guidance and use of the new pathways. However, with the Omicron situation currently developing it seems premature to speak about the likelihood of being able to fulfil those measures, or even whether those measures can be enforced with the current levels of uncertainty.
- 4.27 Given the measured activity as courses of treatment in quarter one this financial year were at circa 41 per cent pre-pandemic levels; a proposal to increase activity to 70 per cent in the next financial year would appear to be challenging.
- 4.28 BDA Wales has always supported the principle that the prudent use of public money must be demonstrated. However, we have advised government that any new target must be designed and applied carefully to avoid unintended consequences that disincentivise the treatment of high-needs patients, as was the case with UDAs. It is with that mindset that we have advised on developments of parameters within contract reform and will continue to do so.

Contract reform

Wales

- 4.29 We are part of the new dental programme reform stakeholder workstream group which has met twice and will continue to meet regularly now the GDS reform program is recommencing. Programme reform formally re-starts in April 2022. The Welsh Government considers this process to be part of the wider program of primary healthcare reform.
- 4.30 We shall be consulting extensively with the profession on how the changes to GDS delivery during the pandemic can be made to work in the longer term as a financially viable proposition, once those provisional parameters for the new contract have been proposed. In Wales the approach is one of co-production and collaboration with various stakeholders including the community health councils.
- 4.31 The Welsh Government's approach to reform is based on a recognition of the inappropriateness of the UDA and the Programme intends to move away from UDA targets as the contractual measure. Reform is aimed at improving delivery of evidence-based prevention, the implementation of needed dental recall intervals, and an increase in the use of skill mix.

Northern Ireland

- 4.32 Such is the depth of concern among grassroots dentists, in late August a BDA Northern Ireland letter co-signed by 500 GPs was sent to the Health Minister appealing for urgent reform of the GDS, acknowledging the financial challenges in general practice and the need for immediate

support to move us forward. In addition, we urged that work should resume in earnest on a new GDS contract to safeguard the sustainability of the GDS.

- 4.33 We have since met with the Minister, and are heartened that commitments have been given to carry out the reform of the GDS, and taking Health Service dentistry forward under a rebuilding phase and not reverting to a broken and discredited model. That work is being taken forward within the recently established GDS Rebuilding Stakeholder Group in which BDA plays a key role.
- 4.34 As dentistry continues to be so heavily impacted by stringent Infection Prevention Control measures, additional PPE costs (level two not provided in Northern Ireland) and reduced patient throughput on top of Item of Service fees that bear little resemblance to the actual cost of delivering NHS dentistry, and while inflation continues to push up costs, it is essential that we see continued additional support to the IoS contract to help make Health Service dentistry viable in its own right. And in combination with incremental supports to help make it financially viable for practices to treat patient backlogs, we also need to move towards a new contract model that is sustainable for both practitioners and patients.
- 4.35 We recognise the significant efforts made by the Minister of Health and officials to keep the lights on in dental practices. However, we now need to move beyond a 'holding pattern' and to ensure the Health Service officer is cognisant of real world costs, and is far more competitive with the private market not least when capacity is so constrained. Practice owners can no longer afford to have one part of their business subsidise another.
- 4.36 Ultimately, it will be for individual practitioners to make the tough decisions that they need to at this time. For our part, BDA NI remains committed to working with departmental colleagues to come up with innovative solutions to help pave a viable way forward during the GDS rebuilding phase, and to work diligently towards a new GDS contract. It remains to be seen if the GDS will be transformed to be sufficiently attractive to enable business planning to be undertaken, and talented professionals retained to provide NHS dental care.
- 4.37 We welcome the recent appointment of a Chief Dental Officer in Northern Ireland, and the Minister's firm commitments as contained in a joint statement issued with BDA NI to drive forward the significant reform of the GDS. Putting dentistry on a sustainable footing in this immediate rebuilding phase is paramount while working forward to a new GDS contract. Building in a mechanism that can adequately account for inflationary cost pressures while also factoring in an additional annual uplift to earnings is essential if the DDRB process is to be workable.

Scotland

- 4.38 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 adult 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 will involve consultation with the profession, and possibly regulatory changes.

England

- 4.39 Since 2007, the BDA has sought a reformed contract for GDS services in England that improves the working lives of dentists and the care they are able to provide for their patients. At the outset of the pandemic, the already protracted reform process stalled. In March 2021, the DHSC, NHS England and the Office of the Chief Dental Officer recommitted to a reformed dental contract and transferred responsibility for delivering this from the DHSC to NHS England.

Over the summer, NHS England formed an Advisory Group and Technical Group to discuss ideas for contract reform. These concluded in autumn 2021 and from 19 November the BDA and NHS England began scoping meetings on modest contractual changes that can be made from April 2022. It is intended that this scoping process will be followed by a negotiation phase in early 2022. Parallel to this, discussions have begun on a long-term alternative contractual system.

4.40 In October 2021, NHS England notified prototype practices that these arrangements would be terminated at the end of March 2022 and from 1 April 2022 these practices would revert to the underlying GDS contract. NHS England has stated that this decision was a result of the prototypes not providing a model that could be rolled out more widely. It is a matter of profound regret that a model that was well liked by dentists and patients, was developed on the basis of advice from leading figures in the field, and in which practices had invested significant time and resource has now been abandoned.

Chapter 5 – Financial backdrop across the UK

5.1 The pandemic has obviously caused significant economic disruption and has led to dramatic changes in public spending. This means that much of the currently available data, largely relating to the period prior to the pandemic, 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 with practices' financial viability.

5.2 Despite a modest increase in the cash-terms gross UK spend on the GDS/PDS in 2019/20, the overall cash-terms trend is of flatling for the last decade, while the real-term spend remains well-below 2010-11 levels. This means that dentists are required to do more with less and that there are inevitable pressures on dentists' pay, as practices face rising expenses and static budgets.

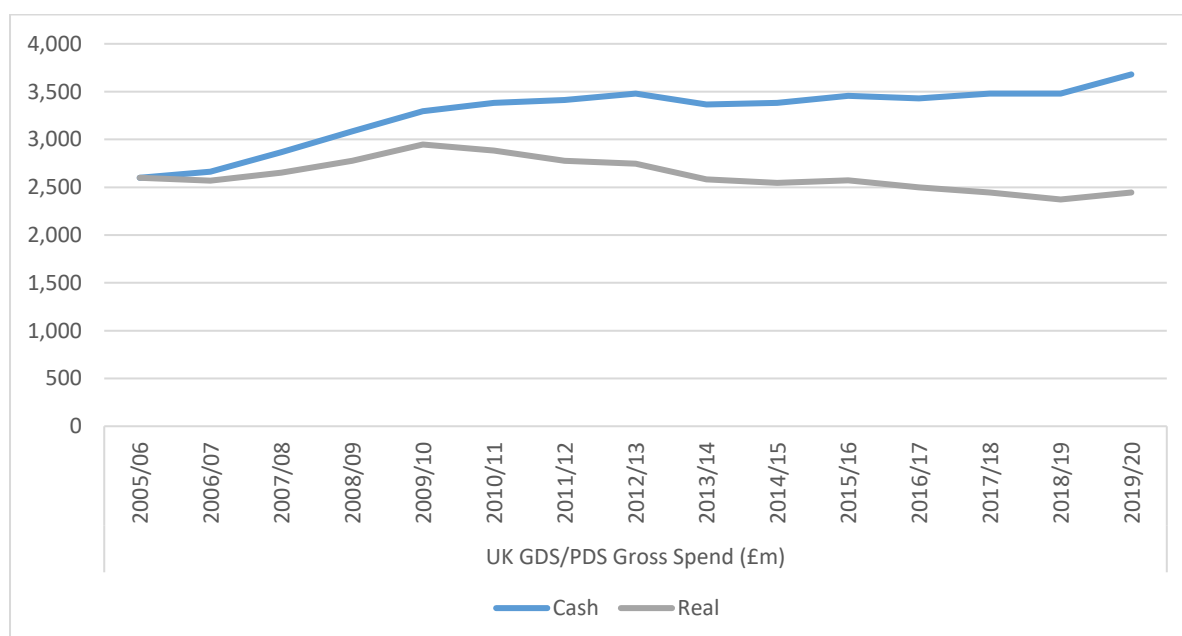


Fig 2: UK gross spend on GDS/PDS Accounts from Departments of Health

5.3 Data on the trends in taxable incomes for both performer-providers and associates show that it 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, but take-home pay remains significantly below the levels seen a decade ago. 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.

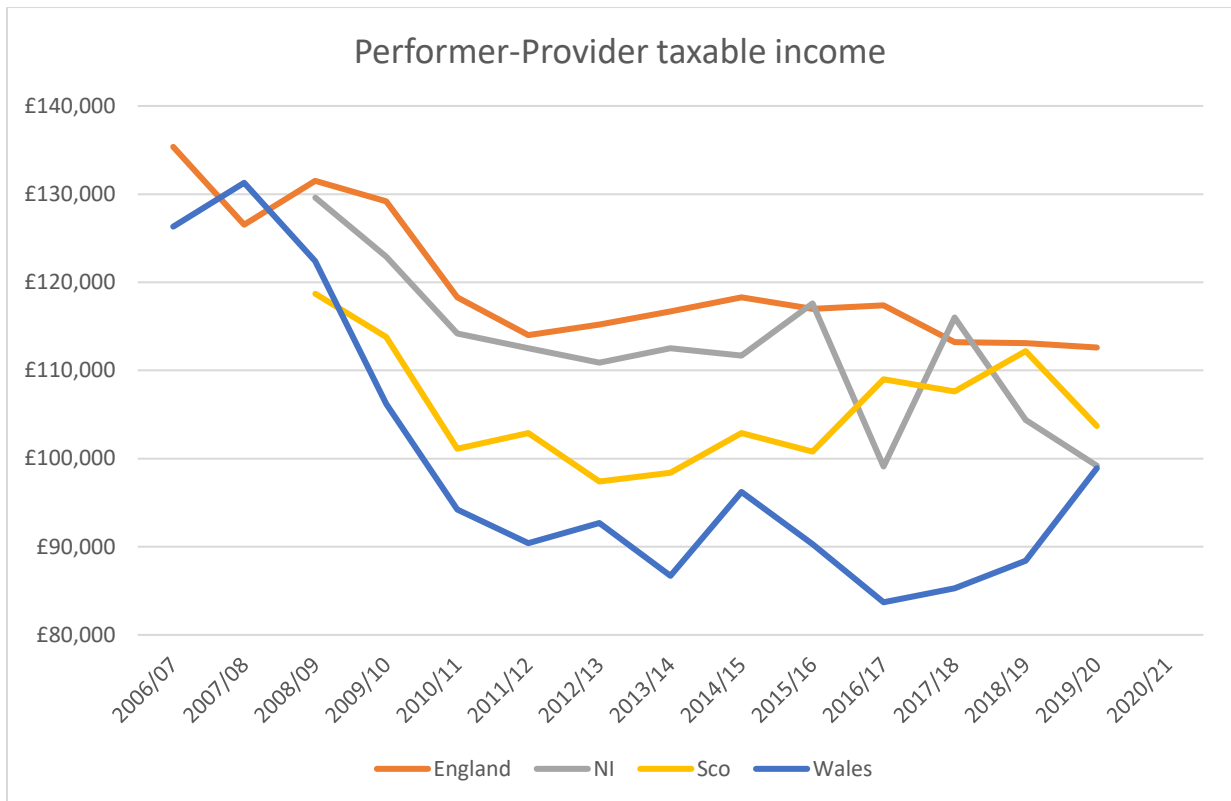


Fig 3: Data on practice owner taxable income

5.4 Among performer-providers, there have been substantial falls in taxable incomes. For example, provider-performers In Wales have seen their pay fall from a peak of £131,287 in 2007-08 to £98,900 in 2019-20. Compared to 2008-09 levels, performer-provider taxable income in 2019-20 has fallen by 23.5 per cent in Northern Ireland, 19.2 per cent in Wales, 14.4 per cent in England and 12.6 per cent in Scotland. These falls are in cash terms and take no account of inflation.

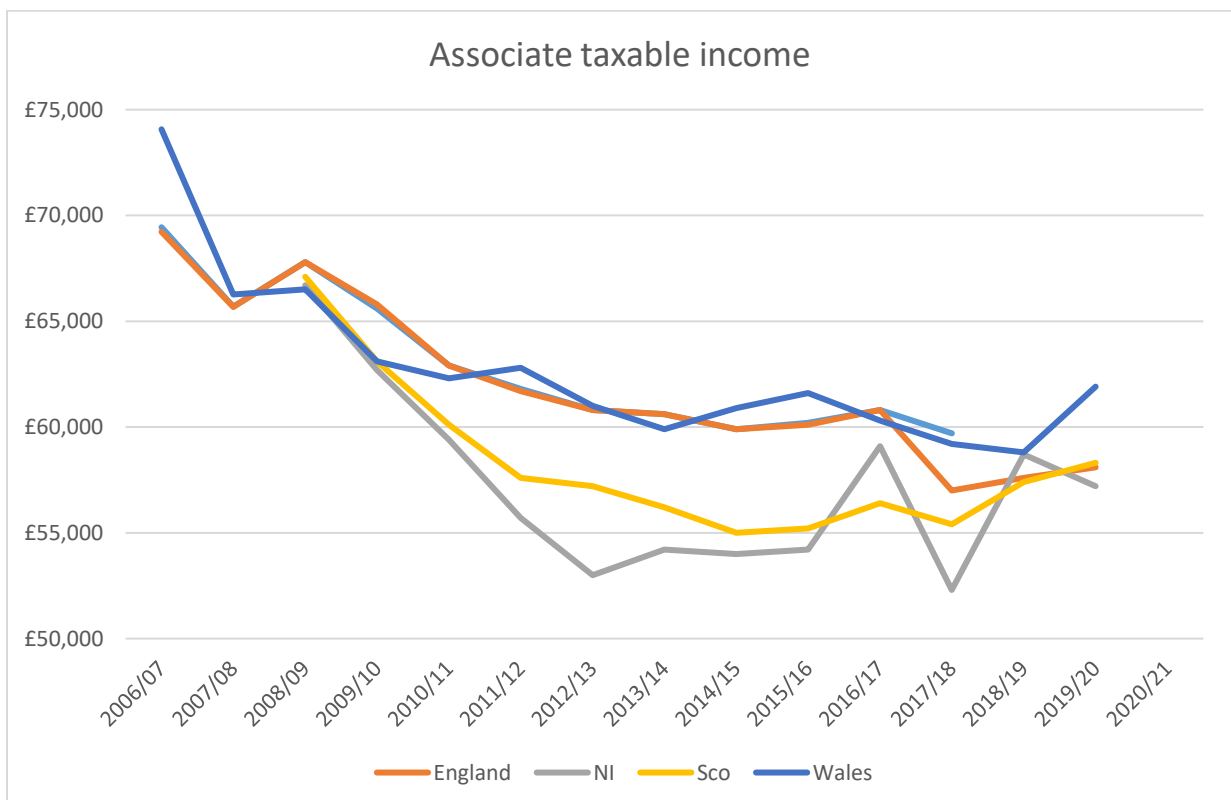


Fig 4: Taxable income of associates

- 5.5 Performers have also seen steep falls in their take-home pay. As self-employed individuals – they too are subject to the impact of expenses and dental inflation. Compared to 2008-09, performers' taxable incomes have fallen in cash terms by 14.3 per cent in England, 14.2 per cent in Northern Ireland, 13.1 per cent in Scotland, and 6.9 per cent in Wales.
- 5.6 Associate earnings in Northern Ireland were the lowest in the UK in 2019/20 and overall GDP earnings fell by 4.2 per cent compared to the previous year. The Dental Earnings and Expenses Estimates clearly shows how financially unviable Health Service dentistry has become. Quoting directly from the report, in Northern Ireland “the lowest combined taxable income from Health Service and Private dentistry for all dentists, of £51,500, was reported for those dentists whose Health Service earnings accounted for at least 75% of their total gross earnings”. This translates into a new low average £49,700 annual taxable income for Associate dentists, compared with an average £94,500 for those Associates with just 25% or less earnings from Health Service dentistry.
- 5.7 These 2019/20 figures follow a steep downward trajectory in dentists' pay recorded over the past 11 years across the UK and, in Northern Ireland, this equates to a considerable real-terms pay cut of 36 per cent for associates since 2008/09, and by 43 per cent for practice owners over the same period. While dentists across the UK have experienced sustained cuts to their incomes, practitioners in Northern Ireland have seen their pay eroded by the largest proportion. In addition, these latest published figures largely pre-date the further impact that COVID-19 has had on general dental services and practice finances. Combined, they underline the extremely precarious state of the NHS GDS and that without significant reform is no longer financially sustainable.

Associate pay uplifts

- 5.8 The DDRB's 49th report expressed a desire to better understand the mechanism by which associate dentists see the Review Body's recommendations passed on to them and the factors that influence their take-home pay. Associates are in almost all cases self-employed contractors. In England and Wales, where practice owners hold the NHS contract, associates have contractual rights to a limited set of NHS-funded parental leave and sickness payments, but there is no provision within the NHS contract that entitles associates to a particular level of pay or to a pay uplift. Associates agree with a practice owner to deliver a certain amount of NHS activity, the proportion of the UDA fee which they are paid, and the proportion that the practice retains in respect of the expenses incurred by the associate's work. Given that a significant proportion of the NHS fee is needed to cover practice expenses, the derisory uplifts that have been applied to expenses for many years and the inflationary pressures on dental expenses, practice owners have had to make difficult decisions about how to distribute the contract uplift to ensure the financial sustainability of their practice. In many cases, 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.

“It's the fact that we've had not real time or real world raise in money at least for a decade. I'm on exactly the same per UDA as I was 10, 11, 12 years ago. But the cost of living has gone up. We're definitely not well remunerated.” Associate, England

- 5.9 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.

5.10 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. We also have concerns that the commissioning of new services in England is being done on the basis of low UDA values, and time-limited contracts, and that this is another downward pressure on dentists' pay. 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.

“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

5.11 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, and points to the fundamental lack of NHS resources made available to provide dentistry on a sustainable basis. The Review Body does not engage on discussions of expenses, but for self-employed dentists it is impossible to separate the pay element from the expenses. It is our continuing recommendation that the DDRB starts to make a separate recommendation on expenses for GPs again.

Expenses and inflation

5.12 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 Review Body 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 Review Body considers them when making its recommendations.

5.13 To supplement the HMRC data, our research has sought to understand the extent of dental inflation and its sources. 91 per cent of practice owners reported that there had been a significant or some increase in their overall practice running costs compared to before the pandemic. The leading causes of this were costs associated with fallow time/down time (95 per cent¹), consumables (90 per cent), wages and staff costs (90 per cent), utility expenses (90 per cent), and clinical waste (88 per cent).

Expense	% stating there had been a significant or some increase in costs
Costs associated with fallow time / down time	95%
Consumables including dental materials	90%
Wages and staff costs	90%

¹ Percentage saying there had been a significant or some increase in this expense

Utility expenses (energy, electricity, heating, telephone and internet etc.)	90%
Clinical waste (collection and disposal)	88%
Cleaning and laundry	86%
Ventilation costs	85%
PPE	84%
Equipment maintenance and repair charges	79%
Administration / reception costs	76%
Laboratory costs	74%
IT costs	66%
Business rates and rent	37%

Fig 5: Percentage of practice owners saying there had been a significant or some increase in practice expenses.

5.14 There are clearly particular cost pressures facing dental practices, but inflation more generally is considerably higher than it has been for several decades. The Bank of England forecasts that inflation will rise to six per cent later this year. The Review Body must ensure that its recommended uplift is such that all dentists receive a real-terms pay rise, and it is for this reason that we are calling for an above-inflation recommendation.

Financial sustainability across the UK

England

- 5.15 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. Taken alongside the growing population, this meant that Government contributions per head (excluding spend from patient charges) fell from £41.79 to £34.53 from 2010 to 2020. It is no wonder that dentistry has risen to be the number one patient issue raised with Healthwatch over the pandemic, and the volume of feedback continues to grow. From April to June 2021, feedback about dentistry was up 55 per cent on the previous three months, and 794 per cent higher when compared with the same period in 2020. Nearly four-in-five patients (79 per cent) sharing their stories with Healthwatch said they had found it difficult to access timely care.
- 5.16 Patient charges in England are now significantly higher than in other parts of the UK and constitute a far greater proportion of the overall NHS dental spend. Repeated above-inflation increases in patient charges have come to substitute for meaningful investment in NHS dentistry from the Treasury. Given that perceived and actual costs are a well-known deterrent to attendance, particularly for those from low-income backgrounds, practices are seeing the impact of this on patient behaviour and attendance. It is also notable that, as a result of the low contract uplifts and high patient charge increases, in 2019-20 there were 356 contracts that were paid less for a band one course of treatment than the patient charge (£22.70). Not only does this mean that the NHS is effectively drawing a surplus from these courses of treatment, but it raises troubling questions as to how these practices can sustainably provide care for such low payments.
- 5.17 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 and by 2020-21 this had risen by 310 per cent to

£169,136,077. This means 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. It should be noted that this clawback took place in 2020-21, despite the significant protections that had been put on NHS contracts, and this figure does not include the further £29,761,954 deducted from contracts as an 'adjustment' imposed by NHS England as part of the pandemic financial arrangements. When practices are facing increased expenses, the loss of NHS income, despite best efforts to meet contractual targets, is a considerable threat to practices' financial viability. The BDA understands that the leading factor in under-delivery is the inability to recruit associates to deliver NHS activity.

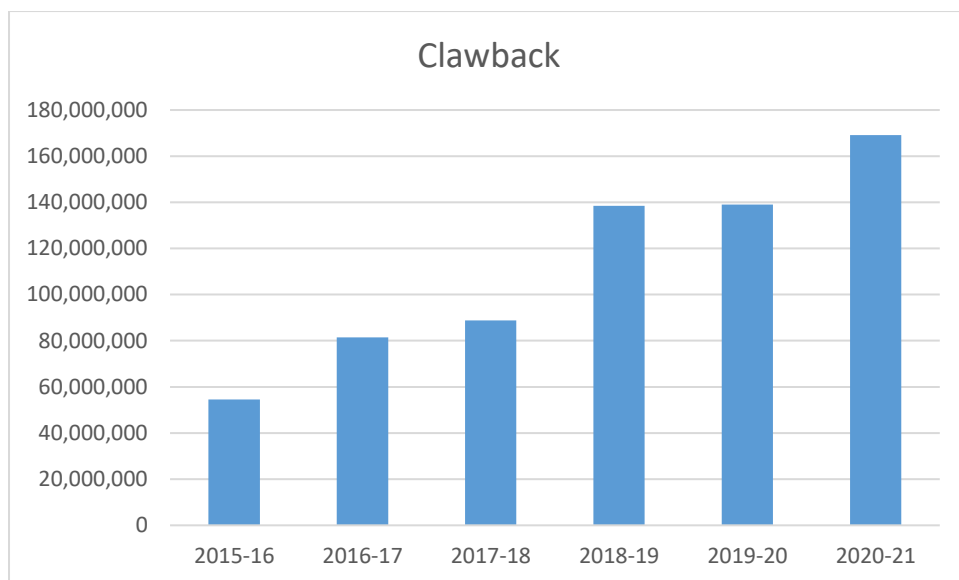


Fig 6: Data on Clawback in England (BSA)

Wales

- 5.18 The percentage of the primary care budget spent on dentistry has declined each year since 2016-17. It is therefore not surprising that the figure of expenditure per head has remained almost unchanged and thus devalued by inflation year on year.
- 5.19 If the percent of primary care budget expenditure on dentistry had remained at 10.8 per cent of total primary care budget in 2019-20 (£1,542,925,000) expenditure on primary care dentistry would be at £166,635,900, thus representing a real terms loss of £6.771 million from the primary dental care budget in 2019-20. 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 (80 per cent in the red alert phase and now 90% in the amber phase) due to loss of patient charge revenue – reduced from £35M to £9m in approximate terms in the last reported year². Different LHBs have stipulated different criteria for practices to redress this 10 per cent shortfall in low amber phase, which we remain within. Unfortunately, there are many practices still on 90 per cent of their contract values as they have found the criteria too challenging for various reasons. This has inevitably had a negative impact on the income of dentists – both providers-performers and associates.

²

<https://www.bda.org/advice/Coronavirus/Documents/Wales%20CDO%20Letter%20Restoration%20of%20dental%20services%2020520.pdf> and <https://gov.wales/nhs-dental-services-april-2020-march-2021-html>

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

Fig 7: Expenditure on dental primary care in Wales <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget>

- 5.20 The Health Minister Baroness Morgan pledged additional funding of £3 million in the current year and also recurrent funding of £2m in future years. While this news is welcome it doesn't make up all the losses described in the previous section. Furthermore, health boards are going to find it difficult to spend it in the GDS presently, given we are three quarters way through the financial year and also practices are struggling to take on more patients in the current pandemic conditions. In fact, with Omicron guidance suggesting many healthcare professionals could be isolating at some stage over the winter, patient throughput is likely to fall.
- 5.21 We have asked Welsh Government to consider using this funding instead for improving air handling systems in the CDS surgeries. However, this has been met with counter-arguments of not being able to use such funding for capital expenditure. This is hugely frustrating and an example of unwelcome bureaucracy, given that we called for this solution in our manifesto in May and have repeatedly made the case to Welsh Government dental branch of the need to influence the LHBs.

Scotland

- 5.22 In the [Scottish Budget 2021-22](#) published in January 2021, the Scottish Government stated: *From 1 November, dentists have been able to provide a full range of care to their NHS patients, but we recognise that the impact of lockdown has brought financial difficulties. Remobilisation came with additional financial support to NHS dental services, with emergency payments of £12 million per month to support dental incomes and an additional £2.75 million per month as specific sectoral support. In 2021-22, we will provide £431 million for general dental services, helping to support their recovery, accelerate the reform programme for NHS dental services, and take forward a new model of preventive oral health care for NHS patients.*
- 5.23 The overall Health and Sport budget increased by 11 per cent from £15.344 billion in 2020-21 to £17.036 billion in 2021-22. Within this, the GDS budget increased by £2.4 million (0.6 per cent) from £428.6 million to £431 million.
- 5.24 Scottish Government officials have previously stated that these figures represent a “nominal” budget, as NHS dentistry is a demand-led service.
- 5.25 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 an additional £75 million to cover patient charges as these will no longer be collected.
- 5.26 In the [Scottish Budget 2022/23](#), 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. Within this, the GDS budget increased by £38 million from £431 million in 2021-22 to £469 million in 2022/23 – a rise of 8.8 per cent. Presumably this increase covers the patient charge for 18-25 year-olds as they no longer pay for NHS dental treatments.

2018/19 2019/20 2020/21 2021/22 2022/23

GDS budget (£m)	414.8	416.6	428.6	431.0	469.0
Change from previous year (£)		1.8	12.0	2.4	38.0
% change from previous year		0.43%	2.88%	0.60%	8.82%

Fig 8: 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]

Northern Ireland

- 5.27 The gross General Dental Services Budget in the 2020/21 year equated to £131.7 million³. The actual cost of dental services to government minus £7.1 million of patient payments was: £72.7 million plus £51.9 million of COVID-19 Financial Support Scheme (FSS) payments. This compares with £130.9 million spent on general dental services in 2019/20, including £26 million of patient contributions.
- 5.28 While the overall GDS budget has risen by just £0.8 million in the full year after COVID compared with pre-COVID, and government has had to shoulder a significant portion of the shortfall in patient payments, what this has meant to practitioners should be kept in perspective at a time when this budget has also had to compensate for additional costs such as PPE that have been incurred during the pandemic. It would be a misnomer to represent the increased cost of GDS to government as somehow putting GPs in a better off financial position. Increased funding has been essential to avoid financial collapse within the GDS, and to maintain sustainability at a time of considerable vulnerability and constraint.

Pensions

- 5.29 The tapered earnings threshold in relation to the Annual Allowance (AA) was increased in April 2020, this was seen as a remedy in part to the AA crisis which affects many higher earners. By reducing the threshold, it is hoped that there would be a marked decrease in pension scheme members incurring yearly pension tax bills. However, we do not believe that this change has fully solved the impact that the AA tax regime has on dentists.
- 5.30 The BDA has continued to be engaged in the negotiations to reduce the contribution rates for members of the NHS Scheme who are currently paying the higher contribution tiers. Our preferred option, which was shared with many other Unions was that a flat rate for all members should be implemented from April 2022, this rate would be most equitable, when taking into account all relevant pension taxation. The DHSC presented three options for stakeholders to consider, a majority of the stakeholders agreed on the option that featured the removal of the two top tiers from the current contributions structure, with slight changes to the rates for lower to middle earning members. We do not feel that this option is adequate enough to reduce the impact on dentists' total reward. However, we are pleased that the proposal will ensure that the contribution rates will be based on actual annual rates of pay rather than members' notional whole-time equivalent pay, this change will be of benefit to our part-time salaried members who earn a higher rate of pay. We were disappointed with the proposal that thresholds for the member contribution tiers should be increased in line with Agenda for Change pay awards. We pointed out that dentists' clinical pay is not linked to Agenda for Change awards, but to annual DDRB uplifts. We asked that the contribution tiers are subject to periodic review to examine the impact of DDRB uplifts on dentists' pay. The negotiations are continuing.
- 5.31 The BDA has also been discussing how the age discrimination remedy will be implemented, the legislation and relevant systems are currently being prepared. It was agreed that the choice

³ General Dental Statistics for Northern Ireland 2020/21 [General Dental Statistics Publication 2020-21.pdf](https://www.hscni.net/General-Dental-Statistics-Publication-2020-21.pdf) ([hscni.net](https://www.hscni.net))

statements providing information to members about their benefits in both their legacy NHS Scheme and the 2015 Scheme would be sent to retired members and beneficiaries of deceased members first. The system to produce choice statements for those retiring soon after April 2022 may not be live until 2023 but adjustments to members' pensions will be made retrospectively. We are concerned that there is a tranche of members who have retired on the grounds of ill health that may have suffered detriment to their benefits in the light of the age discrimination issue. An investigation has been launched and is in the very early stages, any member affected by this issue will be contacted once the investigation is complete.

Gender pay gaps

- 5.32 The DDRB has asked for further evidence on gender pay gaps in dentistry. 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.
- 5.33 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. The difference is at its greatest among associates in Northern Ireland, where male associates earn 37 per cent more than female associates. A gender pay gap is present regardless of the NHS contract system used. By comparison, the Independent Review into Gender Pay Gaps in Medicine in England found that the gender pay gap among GPs was 33.5 per cent, and the ONS figures for the gender pay gap for median gross hourly earnings for all employees is 15.4 per cent and for part-time employees is 7.9 per cent.
- 5.34 This data is not based on an FTE or other basis that would control for factors that may influence pay such as hours worked or clinical activity delivered. Therefore, there are limits to how much the data can tell us about the nature of the pay inequality.

	Male	Female	Percentage difference
England	£119,300	£96,100	21.5%
Wales	£99,600*	£96,700*	3%
Northern Ireland	£108,300*	£80,600*	29.3%
Scotland	£110,300	£91,500*	18.6%

Fig 9: Average taxable income from NHS and private dentistry for practice owners by gender, 2019/20, NHS Digital Dental Earnings and Expenses Estimates

*Sample size is <150

	Male	Female	Percentage difference
England	£69,100	£50,300	31.5%
Wales	£71,300	£54,900	25.9%
Northern Ireland	£71,100	£48,900	37%
Scotland	£67,600	£52,000	26.1%

Fig 10: Average taxable income from NHS and private dentistry for associates by gender, 2019/20, NHS Digital Dental Earnings and Expenses Estimates

- 5.35 Given these difficulties in drawing conclusions from taxable income, the BDA gathered data as to how much associates in England are paid per UDA. This gives us a standard contractual currency that allows for comparison in a similar way to 'pay per hour' would in other settings. This found that female associates were paid on average £12.54 per UDA and that male dentists were paid on average £13.01; meaning that there is a 3.7 per cent gender UDA rate gap. However, the difference between average UDA values was not found to be statistically significant.
- 5.36 A factor in the overall difference in taxable income is that there is an inequality in the payment of female and male associates for the same unit of contract currency; women associates are paid less

on average than men for the same work. However, the gap in UDA rates is considerably lower than the difference in take-home pay and can therefore only account for a small proportion of it. Furthermore, our analysis also indicates that the distribution of other factors that influence pay within each gender may impact on the average pay for male and female dentists. Gender intersects with age, for example, in that older dentists tend to be paid more and in our research male dentists tended to be older.

Chapter 6 – General dental practice

- 6.1 The BDA has long made the point in our evidence to the DDRB, and elsewhere, that despite the number of dentists registered with the GDC increasing, there are not enough dentists who are willing to work on the NHS as a result of the working conditions, contractual system and the long-term fall in take-home pay. The consequences of this are that practices are finding it increasingly difficult to recruit associates and subsequently to deliver NHS activity. In England and Wales, this leads to clawback for under-delivery, further threatening practices' financial liability, and across the UK it means a reduction in the NHS dentistry that patients can access. This situation has clearly been exacerbated by the impact of the pandemic, but most of the issues – including falling take-home pay – that are driving the recruitment and retention crisis are long-standing.

Workforce

- 6.2 Data on the headcount of GDPs from across the UK shows that the trend for a rising number over the last decade has ended. In 2020/21, the headcount in England fell by 951 (-3.9 per cent), in Wales by 83 (-3.6 per cent), and in Northern Ireland by five (-0.4 per cent). In Scotland, the number increased by one. In England, this means that the workforce has been reduced to levels last seen in 2013/14 and in Wales there has been a 7.8 per cent reduction in the headcount over the last two years. Further to this, more recent quarterly figures on the workforce in Scotland show a fall to 2,945 GDPs in September 2021.

	2016/17	2017/18	2018/19	2019/20	2020/21	Change 19/20 vs 20/21
England	24,007	24,308	24,545	24,684	23,733	-951
Wales	1,475	1,479	1,506	1,472	1,389	-83
Northern Ireland	1,108	1,081	1,139	1,147	1,142	-5
Scotland	2,933	2,978	3,029	3,038	3,039	+1
Total	29,523	29,846	30,219	30,341	29,303	-1,038

Fig 11: Number of primary care dentists in England, Wales, Northern Ireland and Scotland, NHS Digital, NHS Education for Scotland, Northern Ireland Statistics and Research Agency and StatsWales

- 6.3 However, there are limits to these data as they only provide the headcount numbers, and do not provide the real workforce capacity. In England, we have explored joint working with HEE around understanding FTE. HEE has undertaken some workforce modelling to underpin its dental education and training reform package Advancing Dental Care, but this has not been made publicly available.

Recruitment and Retention

- 6.4 Given this workforce contraction, it is not surprising that the difficulties practice owners have reported recruiting associates have only become more widespread. Our survey of practice owners found that, of those who had sought to recruit an associate from April-September 2021, 80 per cent said that they had experienced difficulties in doing so. This is a substantial increase in the

proportion experiencing difficulties from when we last conducted the survey in 2019, when 68 per cent of practice owners reported it had been challenging.



Fig 12: Percentage of practice owners, who had sought to recruit an associate between April-September 2021, and who responded 'yes' to whether they had experienced difficulties when recruiting, BDA GDP Survey 2021. Note: The survey was not conducted in 2020.

- 6.5 Among practice owners with an NHS commitment of greater than 75 per cent, the problems recruiting were even worse. Ninety-three per cent of these heavily-committed NHS practice owners who had sought to do so said that recruiting an associate had been difficult.
- 6.6 The leading reasons for these difficulties were reported as few or no applicants, difficulty finding a suitable dentist, and associates' reluctance to work on the NHS.

“We’ve had vacancies now for two and a half years more or less, in part due to a young associate going to work in private practice and two associates who are seven or eight years post qualified deciding to go and buy a private practice locally and we’ve been unable to fill those vacancies since then.” Practice owner, England

- 6.7 We also asked practice owners about the vacancies for associate positions that they had had in the period from April-September 2021. Over a third (36 per cent) had at least one vacancy in the first half of the financial year and, of these, 61 per cent said that they had not been able to fill all of these vacancies. This difficulty filling vacancies was worse among heavily-committed NHS practice owners, where 74 per cent had not been able to fill all of their vacancies, and were more likely to have had a vacancy in the first place (46 per cent compared with 31 per cent among those with an NHS commitment below 75 per cent). Where practices had vacancies, these were long term, with 71 per cent having vacancies for more than two months and 41 per cent had vacancies for more than six months. While most practices (71 per cent) had only one vacancy, a substantial minority (28 per cent) had multiple vacancies.
- 6.8 These findings from our GDP survey are supported by evidence gathered from a qualitative interview-based study with practice owners and associates that we conducted in autumn 2021. This found that practice owners were struggling to fill vacant associate positions and that some had had vacancies for more than two years. Practice owner participants said that they received fewer applications to positions and that a high number of their associates were looking to leave NHS-

focused posts for ones with greater opportunity for private work. They said that the NHS had become an unattractive place to work and associates were looking for positions which will be better remunerated. This was mirrored by our findings from associates who said that the NHS, including the pay it is able to offer, was not a desirable working environment and that associates were looking to leave the NHS; “I think it’s easy to get an NHS associate’s job. I don’t think it’s necessarily easy to get a private associate’s job, because people are leaving the NHS.”

- 6.9 In addition to these existing issues, data from NHS Digital’s Dentists’ Working Patterns, Motivation and Morale report and the BDA’s GDP survey indicate that there is a deep retention challenge also facing dentistry. NHS Digital’s figures for 2019/20 show that the majority of GDPs often think about leaving general dental practice, with levels as high as 74.9 per cent among practice owners in Wales.

	Practice owners	Associate
England	61.3	55
Northern Ireland	70.4	65.2
Scotland	61.9	51.1
Wales	74.9	53.7

Fig 13: Percentage of dentists that answered ‘strongly agree’ or ‘agree’ to the leaving question, 2019/20

- 6.10 These findings are supported by the outcomes of the BDA’s GDP survey conducted this year. This found that 38 per cent of practice owners and 27 per cent of associates were thinking of leaving dentistry as soon as possible or within the next 12 months and this proportion is higher among those who are heavily committed to the NHS, at 45 per cent for practice owners and 33 per cent for associates.
- 6.11 In the medium-term, our GDP survey also found that 47 per cent of practice owners and 28 per cent of associates were planning to retire in the next five years. Over the same period, 42 per cent of practice owners and 36 per cent of associates were intending to reduce their working hours; and 22 per cent of practice owners and 39 per cent of associates were planning to increase the proportion of the time they spend on private work. It is also notable that nearly half (49 per cent) of practice owners were looking to sell their practice in the next five years, while conversely only eight per cent of associates were planning to buy, or buy into, a practice.
- 6.12 Again, this quantitative data is supported by the qualitative evidence we gathered. Associates were currently or actively planning to transition to greater private work, or were looking for other roles in dentistry outside general dental practice. The relative level of remuneration for NHS and private dentistry was repeatedly cited as a factor motivating this decision. For example, one associate said “I think compared to the amount of work that we do, especially now, we don’t get paid enough for it. I’d be tempted to come back, but I’m looking at going down the private route rather than the NHS route because it remunerates you a lot better.”
- 6.13 **All of this evidence points to a profound recruitment and retention crisis within dentistry, in which the workforce headcount is contracting, NHS practices are struggling to fill associate vacancies, and many GDPs are planning their exit from the NHS, if not dentistry altogether. More than a decade of cash and real term pay cuts has pushed dentistry to the brink, and there is now a real challenge to sustaining an NHS workforce at viable levels.**

Dental nurses

- 6.14 Practices have also experienced challenges in recruiting and retaining dental nurses during the pandemic. Practice owners have told us that they are unable to compete on pay with other employers outside dentistry, where dental nurses could work, sometimes for higher pay, without having to wear uncomfortable, high-level PPE or comply with the various requirements of being part of a regulated profession.

6.15 The recruitment and retention issues are reflected in the findings from our GDP survey, which found that nearly two-thirds (63 per cent) of practice owners had needed to recruit a dental nurse between April-September 2021, and of those 80 per cent had experienced difficulties doing so. Our qualitative study found that practice owners felt that they were not able to compete with other employers on pay within the funding available to them for NHS work.

“These guys [dental nurses] are deemed professionals yet they get more at Aldi or Morrisons stacking shelves than they do helping in a surgical procedure.” Practice owner, England

“A couple of my nurses have had to have something like 17-18% pay rises just to put them back into a position where I feel it’s competitive against something else. I’m lucky because I can alter my [private] fees, accordingly, put my prices up 10% in order to do that, but NHS practitioners can’t do that.” Practice owner, England

6.16 Given that dentists require a dental nurse in order to be able to carry out clinical work, these recruitment and retention difficulties present fundamental challenges to practices’ ability to deliver patient care.

Morale and motivation

6.17 Even prior to the pandemic, morale among GDPs was very low. NHS Digital data from 2019/20 found that, in some parts of the UK, barely one in ten would say their morale was high or very high, and the highest level of morale – among associates in Scotland – sees less than a third saying they have high or very high morale. Morale has fallen sharply in recent years; with the proportion of associates in England, for example, saying that they have high or very high morale falling from 42.8 per cent in 2013/14 to 25.6 per cent in 2019/20.

	Practice owners	Associates
England	20.7	25.6
Northern Ireland	12.8	15.9
Scotland	21.1	30.9
Wales	17.3	26.4

Fig 14: Percentage of dentists saying their morale was high or very high, 2019/20, NHS Digital Dental Earnings and Expenses Estimates

	Practice owners	Associates
All	62	60
>75% NHS commitment	80	70
<75% NHS commitment	34	50

Fig 15: Percentage of GDPs saying their morale was low or very low, 2021, BDA GDP survey

6.18 The BDA’s GDP survey shows that morale has sunk further, with 62 per cent of practice owners and 60 per cent of associates saying their morale is low or very low. The difference between those GDPs who have the highest NHS commitment and those undertaking more private work is stark; four in five heavily-committed NHS practice owners say they have low or very low morale compared to only 34 per cent of those with a lower NHS commitment. Our qualitative findings echo this, with one associate saying “I think I’ve never seen morale so low in all my years of practising, I’ve never seen it get to this point where everyone’s just like, ‘We actually don’t like it anymore’.”

6.19 Relatedly, we also found that the majority of GDPs would not recommend a career as a dentist and that this is the case for around three-quarters of the most heavily-committed NHS GDPs. This is an indicator for how dentists feel about their working lives, but it also presents a potential challenge for recruiting to the profession, particularly given that many applicants to study dentistry do so because they know someone who is a dentist⁴.

	Practice owners	Associates
All	64	64
>75% NHS commitment	72	76
<75% NHS commitment	61	50

Fig 16: Percentage of GDPs answer 'no' to whether they would recommend a career as a dentist, 2021, BDA GDP survey

6.20 From the NHS Digital data, we know that, in England, Northern Ireland and Scotland, 'Increasing expenses and/or declining income' have been identified as the leading cause of low morale for GDPs. In Wales, this came third closely behind admin/paperwork and regulations. Our survey found that a significant proportion of GDPs continue to feel that they are not fairly remunerated and among both practice owners and associates with a high NHS commitment the majority feel this. Our qualitative interviews with GDPs support this dissatisfaction with pay, with one associate, for example saying "I feel I'm working harder now than I was before but I'm getting paid less than I was before".

	Practice owners	Associates
All	37	40
>75% NHS commitment	57	56
<75% NHS commitment	32	21

Fig 17: Percentage of dentists who disagree or strongly disagree with the statement 'I am fairly remunerated for my work', 2021, BDA GDP survey

"It [NHS] needs to be more attractive for people financially, and again I don't mean I want to buy my second house in Barbados. I don't even own my first house in [Location]. It's just being able to earn a living basically." Associate, England

6.21 The extent to which GDPs disagree with this statement about their remuneration contrasts with other indicators of motivation, as evidenced by both our survey and the data from NHS Digital. In our 2021 GDP survey, other than for work-life balance, there is majority agreement with all other motivation statements. From this, it would be reasonable to conclude that dissatisfaction with pay, and the not unrelated issue of work-life balance, are driving the low morale and negative view of dentistry as a career discussed above.

	Practice owners	Associates
I get support from my colleagues at work	73	76
There are opportunities for me to do challenging and interesting work	69	68
I am able to provide patient care to a standard that I am satisfied with	66	67
I feel secure in my job	70	63
There are opportunities for me to develop in my career	56	58

⁴ Review of DDRB Pay Comparability Methodology: Final Report, 2017, Institute for Employment Studies, p.21

There are opportunities for me to develop my skills	64	63
I am fairly remunerated for my work	37	40
I achieve a good balance between my work life and my private life	22	46
I am treated with respect by the people I work with	89	78
I feel valued for the work I do	60	55
I am treated with respect by my patients	75	70

Fig 18: Percentage of dentists who agree or strongly agree with the above statements, 2021, BDA GDP survey

Stress

- 6.22 Our research has found that stress among dentists is incredibly high. For practice owners with an NHS commitment at 75 per cent or above, 76 per cent say that their job is extremely or very stressful. Nearly half (48 per cent) say that they disagree that they can cope with the level of stress that they are under at work. For heavily-committed NHS associates, 59 per cent say that they are extremely or very stressed with their job and 42 per cent feel that they can't cope with the level of stress they're under.
- 6.23 For NHS-focused practice owners, the leading causes of stress are working in high-level PPE, the lack of financial certainty, and hitting NHS targets. For associates there are similar causes; working in high-level PPE, hitting NHS targets, and the inability to provide pre-COVID levels of care. Specifically in Northern Ireland, we found that 90 per cent of associates were stressed because of the FSS conditions of providing emergency cover at weekends and over holiday periods, and 76 per cent were stressed because of the requirement to see unregistered patients. Among practice owners, the same conditions were a main factor causing stress for 66 per cent and 60 per cent respectively.
- 6.24 The pressures placed on dentists by the system that they are working in are taking a personal toll, and for a significant proportion the stress exceeds their ability to cope with it. It is no wonder on this basis that so many are considering whether they can continue to work under these conditions.

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 services⁵. These patients often present with complex medical histories, mental health issues, learning disabilities or other particular needs that cannot be addressed in general dental services. The service sees many of the most vulnerable patients from society. They take time to see, manage and treat appropriately. There will be a mix of continuing care patients that require ongoing care by the service and referred patients who can be discharged back to GDS services once stable.
- 7.2 For 2021/22 financial year, there have been no national lockdowns therefore the CDS/PDS services across the UK have faced the uphill climb to tackle the backlogs of patient care that were in existence long before the pandemic struck and have worsened over the last 2 years. Waves of infection however have affected the services across the UK and clinical care is still significantly disrupted.
- 7.3 Again, this year in autumn 2021 (prior to the emergence of Omicron), the BDA conducted UK wide research into the CDS/PDS:

Freedom of Information Act (FOIA) requests sent to identified potential CDS and PDS service providers looking at recruitment

⁵ Dental treatment for people with special needs NHS.uk (accessed 18.01.2022) <https://www.nhs.uk/using-the-nhs/nhs-services/dentists/dental-treatment-for-people-with-special-needs/>

A census of those working in the CDS and PDS.

- 7.4 The survey was made public and all dentists working in this area were invited to reply (both BDA members and non-members). Surveys were sent electronically, and paper follow-ups sent.
- 7.5 Across the UK the numbers of dentists working in this setting have declined over the last few years. Given the value that this branch of practice has brought during COVID, it comes from an ever-dwindling source. As we raised in our 2021 evidence submission, across the UK almost all CDS/PDS services were among the first providers of services during the first wave. The effort by these dental teams has been immense and many have still not stopped working since March 2020 and yet are still working tirelessly during the winter and yet more waves of infection.
- 7.6 In this chapter we describe in detail the individual circumstances in each UK country affecting the workforce across CDS and PDS (in Scotland).

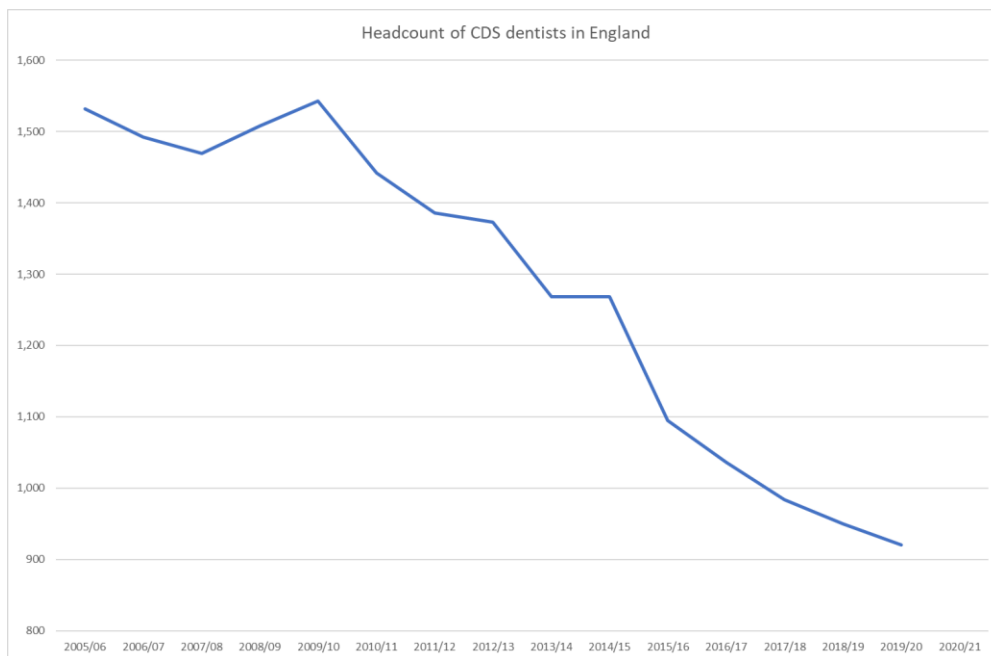


Fig 19: Numbers of CDS in England dentists since 2005. Source Dept Health and Social Care

- 7.7 In England, the workforce continues to decline, and the service has many experienced and senior dentists in the latter stages of their careers.

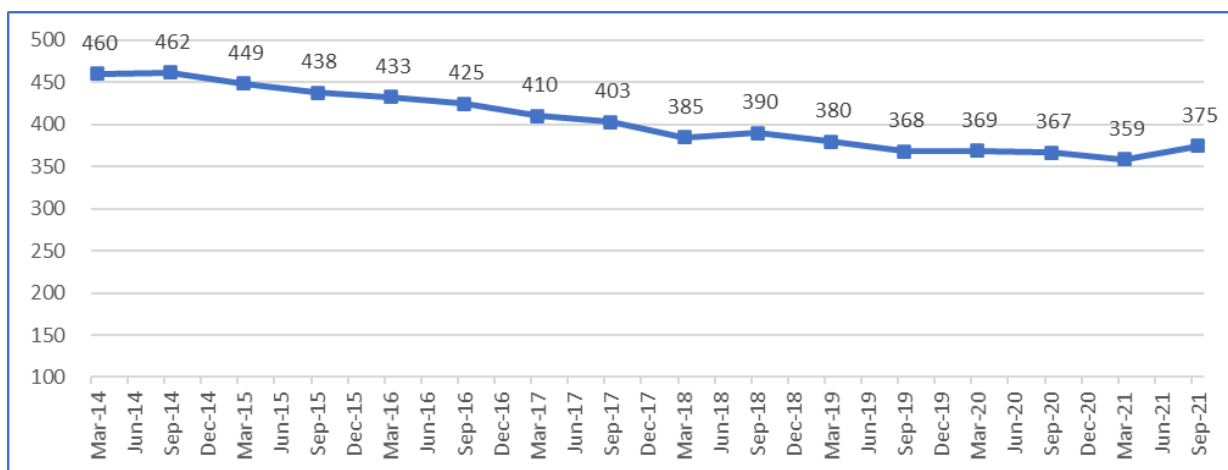


Fig 20: Numbers of PDS dentists in Scotland⁶

⁶ Headcount figure. Source: [Data tables | Turax Data Intelligence \(nhs.scot\)](https://www.nhs.uk/data-and-analytics/turax-data-intelligence/)

- 7.8 Between 2014 and 2020, in Scotland there was an 18 per cent reduction in Public Dental Service (PDS) dentists in Scotland, with a recent increase during 2021 reversing a long-term decrease in numbers. 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 is unable to treat its “usual” patients which include some of the most vulnerable groups in society including care home residents and children with learning difficulties. NHS Scotland Workforce stats note that similar to other UK countries, the workforce is predominantly female.
- 7.9 In Northern Ireland in December 2020, there were 89 individuals on community dental pay scales in HRPTS in 96 posts, with a total WTE of 69.2 across the province. Some have more than one post, not always at the same pay scale, and sometimes with another Trust. The table below only counts an individual once in headcount, but WTE captures the combined posts WTE. What is significant is that 21 per cent of these dentists were aged 55 years and over and a further 16 per cent were aged 50-54 years old. Overall, 85 per cent of this workforce were female.

Grade	Headcount	WTE
Community Dental Officer/Senior CDO	84	64.7
Director /Assistant Director of Community Dental	5	4.5
TOTAL	89	69.2

Fig 21: HRPTS as of 31st March 2021

- 7.10 This year we have not produced a set of data for Wales headcount because the data has proved unreliable. See paragraphs 7.30 to 7.35 for more detail on the issue.
- 7.11 The challenges that face the CDS post pandemic across the whole of the UK include the already long waiting lists for child and adult general anaesthetic treatment and sedation which were over one-year pre-pandemic but now will have grown by a greater amount due to the restriction in theatre space across the NHS. By definition, the patients referred to and treated within the CDS are from vulnerable groups and many have high treatment needs. Those retained by the CDS for the long term are also the same, meaning that significant treatment backlogs will persist for some time. The impact will be the already stark health inequalities widening which will be reflected in the CDS patient cohort.

GA extractions

- 7.12 Access to treatment under General Anaesthetic continues to be a problem for the CDS/PDS and the patients who require it. As levels of community COVID infection grow, it is well documented that the pressures on staffing in community and hospital settings are equally affected meaning lists are still being cancelled and the backlogs grow even more. The 2021 GIRFT (Getting It Right First Time) report into Hospital Dental Services⁷ highlights the problems facing clinicians across the service who provide treatment under GA. It quotes NHS Digital statistics showing that between March 2018 and March 2019, “there were more than 102,000 hospital admissions due to tooth decay among children under the age of ten between 2015-18 (78,000 aged 5-9)”. The research took place prior to 2020 and the final report makes three recommendations (recommendations 10, 11 and 12). The most relevant being around reducing the need to reduce the size of waiting lists. In 2022 as the pandemic continues and the difficulties accessing routine care have been far greater – the impact is being felt acutely by vulnerable patients and the clinicians that see and treat them.
- 7.13 Indeed, community dentists often feel regret and guilt. This can be understood in the context of motivation as when asked about what motivates their work as a dentist, 91 per cent said

⁷ Jones, E (2021) Getting It Right First Time programme National Specialty Report – Hospital Dentistry.

helping patients (97 in 2020) and 88 per cent said it was feeling thanked and appreciated by patients that motivated them however CDS dentists often feel acutely the stress of regret and guilt. A recent study⁸ 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 quotes from the study demonstrate:

“you're gutted when you have a parent ringing you up and saying you know that filling didn't last, such turmoil emotionally”

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

7.14 In England in 2021 we were pleased to see that NHSE/I has created an internal dashboard for commissioners to understand the clinical pressures on CDS services for patients requiring routine care, and treatment under sedation or general anaesthetic. While the data set is slowly being built – they will in time provide a clear understanding of the pressures on the service. This data set will allow NHS England to plan for the restoration and recovery of these services at a local/regional and national level. This will go some way to addressing some of the recommendations in the GIRFT report but also will help to alleviate the pressure on an overstretched and stressed out CDS workforce.

CDS England

7.15 In previous evidence submissions we have highlighted that CDS dentists (and their teams) are often the unsung heroes providing 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, we were very dismayed to see that the evidence from the Department of Health and Social Care on community dentistry was a carbon copy for the last few years which is very dispiriting for our members. It shows a disappointing lack of insight into the service delivered by the CDS and the pressures which they are under.

7.16 In England, the triage and treatment of patients is still subject to the current SOP which continues to ask for children and vulnerable patients to be prioritised which has two impacts. Firstly, that these two historically are the only patient groups seen by the CDS making it very difficult to decide who should and should not be seen within a service struggling for staff and capacity. Secondly, referrals into the CDS have continued because GDPs are continuing to refer children and special care adults in pain as they are prioritising these patients under the SOP.

7.17 In 2021 the BDA sent an FOIA to all services who have a community dental service. In England 48 of the 62 providers questioned had a CDS as part of their service. The data showed that between April 2020 and 2021, only 60 posts were filled out of 78 posts which were advertised.

7.18 For our 2021 BDA survey, 209 dentists completed the survey in England, which is approximately 22 per cent of the workforce (head count) with a split of 82 per cent member/17 per cent non-member.

	Always/often	Sometimes	Never/rarely
BDA 2020	47.2	30.3	22.6
BDA 2021	37.5	41.8	20.7

⁸ McGeown, D., Phadraig, CMG., Whelean, D., Nunn, JH., (2021). Dental decision-making under general anaesthesia for patients with disabilities: A qualitative study. Special Care in Dentistry. 13 July 2021 (accessed 16.1.22 [Dental decision-making under general anesthesia for patients with disabilities: A qualitative study - McGeown - 2022 - Special Care in Dentistry - Wiley Online Library](#))

NHS Staff Survey 2019	I look forward to going to work	56	26	18
NHS Staff Survey 2020		50.8	n/a ⁹	n/a
BDA 2020	I am enthusiastic about my job	61.5	28.2	10.2
BDA 2021		50.2	40.1	9.7
NHS Staff Survey 2019		69	25	7
NHS Staff Survey 2020		65.1		
BDA 2020	Time passes quickly when I am working	76.4	19.4	4.2
BDA 2021		77.3	17.4	5.3
NHS Staff Survey 2019		80	17	3
NHS Staff Survey 2020		77.7		

Fig 21: Comparison of BDA survey responses with NHS Staff Survey 2019

- 7.19 Across England 60 percent of CDS dentists felt satisfied with their present job although 51 per cent reported a decrease in satisfaction compared to the previous year of 58 per cent. 32 per cent of people however felt their job satisfaction had stayed the same as in 2020. The pandemic therefore is still having a significant impact on job satisfaction.
- 7.20 Increasing from 74 per cent in 2020 to 82 per cent in 2021 respondents said their workload was very high or high and like last year covering for colleagues is a fairly regular occurrence. 30 per cent of staff are covering colleagues once a week or more often. This is a picture echoed across the health service and while our data was captured prior to the emergent Omicron variant, the significant staff absences being reported widely demonstrate that this commitment to covering colleagues will remain steady if not increasing during acute periods.
- 7.21 Combined with the BDA data for 2021 on stress it is a worrying picture as higher levels of stress for sustained periods are not good for health and wellbeing of staff.

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

Fig 22: BDA CDS survey

- 7.22 Like last year the results for morale were mixed. For those who reported that their job satisfaction and/or morale had decreased five key themes were identified:

⁹ We have not been able to download the full data set from the NHS Staff Survey 2020, so the only valid comparison is always/often.

- a. The pandemic: Respondents expressed dismay at how the pandemic had influenced their role and/or responsibilities and working environment and impacted on patient care. In some cases, the pandemic was seen as an excuse to enact unpopular changes.

“COVID 19 pandemic still causing multiple issues. Still having problems with patients being able to access care. Frequent staff sickness and isolation leaves the service running on low numbers of staff.” **Female Aged 25-34 years England Band A**

- b. Workload: Respondents reported increased workloads. They were concerns for long waiting lists and the backlog of patients needing to be seen due to, for example, disrupted service or fewer resources. Staff shortages due to lack of recruitment, staff sickness or staff having to shield/isolate were also mentioned as contributors to an increased workload and in some cases this was associated with erosion of service. Aspects such as access to GA or theatres being restricted or unavailable, an increase in patient complexity as well as a shift from the regular patient base to urgent care were mentioned as contributing to loss of job satisfaction.

“I seem to have an ever-increasing workload and less and less time to complete essential tasks, plus dealing with covid-19 measures and staff shortages. I feel I cannot provide the standard of service I would like to.”

Female Aged 35-44 years England Band A

- c. Impact on mental health: Respondents reported feelings of exhaustion and mental fatigue in relation to their work.

“The resilient buckets have run dry”

Female Aged 35-44 years England Band B Senior Dental officer

- d. Feeling undervalued and unappreciated: A perceived lack of recognition or appreciation from management and the government were leading to community dentists feeling undervalued. Patient expectations, behaviour, demands, attitude, and lack of tolerance were noted as being contributors to being undervalued and unappreciated.

“Lack of recognition of the effort staff on the ground are putting in. Micromanagement from those who don't work clinically. No insight into why long-term staff are leaving. Lack of transparency with staff about how the service is being asked to run. Very little actual empathy and compassion. Faux remedies for wellness, but no ability to actually attend sessions or are placed into lunch times/own time.”

Female Aged 35-44 years England Not stated

- e. Poor leadership/management: Some respondents felt they had a lack of autonomy and were not involved in decision making. Management was perceived as being dictatorial, having unrealistic expectations, not listening, nor leading by example and not supporting their staff. Disparity in homeworking was also mentioned as was lack of support from specialists.

“Managers seem to be responding to the covid difficulties and covid backlog by giving clinicians at the coal face less say / responsibility for local decisions but expecting more output”

Female Aged 45-54 years England Band B Senior Dental officer

- 7.23 **The results still reflect the pandemic and the working lives of those in Trusts and Community providers. With headcount numbers declining, with posts unfilled and pressures on the workforces growing, the working conditions for NHS staff is tough. Now more than ever do staff need to feel valued by the NHS and their employers.**

PDS Scotland

PDS survey results

- 7.24 The BDA's survey of PDS dentists in late 2021 raised some significant concerns about morale, conditions, and capacity within the service. Less than one third were satisfied in their present job overall (29.8 per cent) – considerably lower than the overall UK figure (37.2per cent) and the lowest figure of any UK country
- 7.25 In common with the other UK countries, over half (51.1per cent) said their job satisfaction had decreased compared to the previous year
- 7.26 Over half of respondents (52.2 per cent) rated their morale as a dentist as “low” or “very low” – higher than the overall UK figure (43.8per cent)
- 7.27 Like job satisfaction, over half (53.2per cent) said their morale had decreased compared to the previous year
- 7.28 Around 1 in 6 (15.2 per cent) – the highest figure in the UK – disagreed or strongly disagreed that they were able to provide patient care to a standard they were satisfied with
- 7.29 Over two-thirds (71.7 per cent – the highest in the UK) said they were unable to finish on time having completed all essential clinical tasks, including patient administration
- 7.30 Almost half (47.8 per cent) – again, the highest in the UK – disagreed or strongly disagreed that there are opportunities for them to progress in their career
- 7.31 Four in ten (40.4 per cent) disagreed or strongly disagreed that their pay was fair – higher than the overall UK figure (33.0 per cent) and the highest figure of any UK country
- 7.32 Six in ten (59.6 per cent) agreed or strongly agreed that they were satisfied with the terms and conditions of their employment – again, lower than the overall UK figure (69.0 per cent) and the lowest figure of any UK country
- 7.33 Around two-thirds (68.1per cent – the lowest in the UK) would recommend a career as a community dentist.
- 7.34 On their career intentions for the next five years:
- Just over half (51.1 per cent) planned to continue practising as a community dentist, lower than the overall UK figure (59.6per cent) and the lowest in the UK
 - Around 1 in 25 (4.3 per cent) planned to leave the UK to work abroad/overseas – the highest figure in the UK
 - Over one third (36.2 per cent) intended to retire from working as a dentist – the highest in the UK
 - Fewer than 1 in 5 (19.1per cent) planned to develop professionally (for example, enter a specialist list, obtain promotion, or undertake formal study) – lower than the overall UK figure (24.7per cent) and the lowest figure of any UK country.

CDS Northern Ireland - Workforce review and planning in Northern Ireland

- 7.35 The CDS provides a service to some of the most vulnerable and disadvantaged members of our society. COVID has impacted on treatment waiting lists for this cohort.
- 7.36 CDS dentist numbers and DCP staff with regard to Oral Health promotion is a key consideration within CDS. The 2018 Health and Social Care Workforce Strategy 2026 indicated that significant numbers of the most experienced community dentists are approaching retirement,

with up to 40 per cent reported to be potentially retiring by 2025.¹⁰ In previous evidence, we welcomed that a long awaited CDS Workforce Review was to be carried out by DoH. Whilst Terms of Reference were agreed and representatives selected, the review did not go ahead as planned in early 2020 and has still not been completed.

- 7.37 The Skills for Health Dental Workforce Review Report, which was finalised in Summer 2018, has also not yet been published.
- 7.38 It is BDA's view that a policy vehicle aimed at meaningfully addressing the full range of workforce issues that have built up within dentistry over successive years is imperative at this time. Not least, owing to the unprecedented scale of the further impact on dentistry resulting from the COVID pandemic.
- 7.39 Regrettably, the story of low morale is replicated among salaried dentists also. Qualitative survey data from this year's DDRB survey of CDS dentists in Northern Ireland revealed a lack of recognition or appreciation from management and the government, leading to community dentists feeling particularly disillusioned. Patient expectations, behaviour, demands, attitude, and lack of tolerance were noted as being contributors to feeling undervalued and unappreciated.
- 7.40 There were concerns regarding long waiting lists and the backlog of patients needing to be seen. Staff shortages due to lack of recruitment, staff sickness or isolation were also mentioned as contributors to an increased workload and in some cases, this was associated with erosion of service. Access to GA restricted or unavailable was a predominant aspect contributing to loss of job satisfaction. Vacancies for community dental officers and senior community dental officers remain unfilled.
- 7.41 The unacceptable delays in implementing the pay award for 2021-22 once more have further exacerbated dissatisfaction, along with a dispute that has arisen regarding overtime and pay in the CDS for additional hours worked. The above reinforces the urgency of a community dental services workforce review in Northern Ireland to be undertaken before the service collapses.
- 7.42 We also ask for the re-establishment of the CDS placement for Dental Foundation Trainees, which ceased in 2017. Early engagement with Foundation Dentists could demystify the service, revitalise it and contribute towards its long-term sustainability.
- 7.43 Management of waiting lists at a time of high backlogs is compounded by not having access to suitable IT software. Going forward, Encompass would help. In practice, this means CDS services continuing to collect data manually without access to suitable IT software. This is both frustrating and time consuming for CDS in Northern Ireland and needs to be addressed.

Wales: Delivery of Patient Care in the CDS

- 7.44 The BDA is concerned about the lack of contemporary data regarding the CDS. No government reports have been produced for 2019/20 or 2020/21. It is therefore difficult to present formal evidence here of the impact of the pandemic on the CDS and their patients. However, we have on good authority from representatives of the CDS that the impact of the pandemic is still being acutely felt, with a growing feeling of being overlooked in some parts of Wales with any meaningful intervention; for example, the lack of investment by some local health boards in air handling equipment to reduce fallow times. (See comment under Wales: Financial Update.) All parts of the CDS were under pressure to deliver the Urgent Dental Care Centres for many months from the start of the pandemic and some continued to operate well into the low amber phase. This focus on UDCs, together with continuing long fallow times for many CDS practices

¹⁰ [Health and Social Care Workforce Strategy 2026](#), Department of Health, May 2018

due to poor ventilation systems, means that the waiting lists of their vulnerable patients are growing, which is having a profound impact on motivation and morale of the dental teams.

- 7.45 All data relating to CDS, including workforce data, have been moved to different sections in StatsWales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care>. These reports remain as the most accessible information: <https://gov.wales/community-dental-services>, but note patient care data have not been made available since 2018/19. See also: [Patient contacts by community dental service and age \(gov.wales\)](#)
- 7.46 Workforce data for CDS became highly unreliable around 2017 when the 970 code for community dentists was closed down [NHS Occupation Codes - NHS Digital](#). Other codes had to be used instead, and the numbers became split across two or more codes. In the last two reported years there is a suggestion that numbers of dentists working for the CDS nearly doubled in Wales due to the pandemic going from 119 in June 2019 to 189 in June 2021. However, these are headcounts and the additional staff recorded are likely to add up to minor increases in FTEs at best. The experience of CDS dentists was that they had to contend with staffing the UDCs from their existing numbers.
- 7.47 The CDS Directors Group gave [written evidence](#) to the Senedd Health Committee Inquiry into Dentistry (2018/2019) which encapsulates frustrations in lack of investment in the CDS pre-pandemic. However, the [final recommendation](#) didn't provide sufficient focus to the CDS "We recommend that the Welsh Government ensures and monitors the consistent reinvestment of clawback money recovered by health boards back into dentistry services until a new system for monitoring outcomes is in place"

Conclusion about the state of UK CDS/PDS

- 7.48 There is a mixed picture across the UK with different challenges being faced in each country with some similarities and differences. However, one thing is clear, the dentists that remain in the system across the CDS and PDS deserve an above inflation pay award.

Chapter 8 – Civilian Dental Practitioners - Defence Primary Healthcare (Dental)

Civilian Dental Practitioners

- 8.1 The BDA is again providing evidence on behalf of Defence Primary Healthcare (DPHC) Civilian Dental Practitioners (CDP) as this group of dentists are awarded uplifts linked to the DDRB recommendations. This is in accordance with a 2003 agreement between the Ministry of Defence (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 107 CDPs within DPHC (Dental). 57 are Full Time (37hrs per week), 50 are Part Time (varies between 8 and 32hrs per week). These 50 Part Time CDPs equate to almost 31 WTE.
- 8.3 CDPs are employed by the MOD to provide occupational, primary dental care to Armed Forces (AF) personnel and entitled civilians, based in the UK and abroad. They work in what is known as DPHC (Dental). 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 by the Civil Service (CS) with unique statement of employment particulars. Traditionally many CDPs are ex-AF dentists, but in recent years there has been an increasing number of dentists joining from General Dental Practice and other employed dental backgrounds, such as community dentistry.

- 8.4 Last year we reported that the COVID pandemic had enabled overtime and on-call payments to be introduced and we hope that the continuation of these payments will remain following the end of the pandemic.
- 8.5 There is an expectation that the Defence Medical Services Group (DMS Gp) People Strategy Plan 2020 – 2025¹¹ will deliver against work strands aiming to be more inclusive of all CS 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 career progression with CDPs able to compete for appropriate clinical and non-clinical roles throughout the DMS Gp.
- 8.6 We were pleased that in 2021 PROSPECT and in turn, the BDA were consulted on a 3 per cent pay rise for CDPs in line with the DDRB recommendation.

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 been 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.
- 9.2 We were pleased to note that the DDRB highlighted the workforce shortages in dental academia which as of 2018 were being filled by clinical teachers. We agree with the Review Body's statement that *"A robust and sufficiently large clinical academic workforce is essential to maintain the quality of new doctors and dentists, and we would expect those that are responsible for medical and dental training to ensure that this workforce is maintained. This is pivotal to both teaching and clinical research"*. However, unless there is more robust data supplied by the Dental Schools Council, the 2018 data fails to offer analysis over time of the dental academic workforce. Without contemporary data, the vacancy and fill rates of clinical academia is hidden, which makes for poor workforce planning.
- 9.3 The delays we have highlighted in on page 4, figure 1 on the implementation of awards in Northern Ireland have a significant impact upon dental clinical academics in Northern Ireland. While each country of the UK sets its own pay policy and timelines for implementation, the late implementation in Northern Ireland continues to pull the dental academic workforce behind their peers across the rest of the UK. Without robust data being published by the Dental Schools Council – we cannot contend the impact that this is having on recruitment and retention of clinical academics but based on the 2018 data the picture is unlikely to have improved. The overall total reward package (including pensions) is therefore eroded for dental academics, and we have significant concerns about the yearly nature of the implementation delays, because the annual delays simply compound.
- 9.4 As part of the total package of reward, we would also like to bring to the attention of the Review Body 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.

¹¹ 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>

- 9.5 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.
- 9.6 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.

Hospital dentists

- 9.7 The British Medical Association provides evidence for doctors and dentists based in hospital services within their remit group. 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 significantly affected by the pandemic. Hospital dentists are seeing patients with more acute problems who are presenting later, due to the various closures of primary care services since the start of the pandemic.
- 9.9 Across the UK, the hospital workforce provides specialised services to patients as well as carrying out leadership roles within Trusts. This workforce in Northern Ireland is undervalued compared to their counterparts in other parts of the UK due to the continued lack of Clinical Excellence Awards. This workforce is also financially disincentivised from taking on additional duties due to the tax penalties on pension pots, something which has been mitigated for in the rest of the UK but still not in Northern Ireland.

Trainees

- 9.10 Due to the continued lack of parity across the UK in terms and conditions for hospital dental trainees in Northern Ireland, and with the continued centralised UK recruitment to trainee positions, we are now finding it difficult to recruit the brightest and best to training in Northern Ireland and to value and retain the excellent trainees we already have in post. This has resulted in vacant posts, impact on service delivery and the need to fill rotas with locums.
- 9.11 In England we are still working alongside the BMA and NHS Employers looking at the trainee pay scale and the ability for dental trainees at levels ST4-6 to be paid at the nodal point 5 pay point.

Chapter 10 – Our recommendations

- 10.1 We ask the Review Body to recommend a **pay uplift** of dental inflation plus three per cent for GDPs and RPI plus three per cent for 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 ask for timely implementation of pay award.** To address the unsustainable impact of continued lengthy delays to annual regional pay uplifts, the BDA requests that the DDRB again states clearly that these delays are unacceptable. Furthermore, we ask that the DDRB strongly recommend that the 2022/23 pay award should be implemented within three months of the DDRB report publication, to avoid erosion of its value.
- 10.3 **We do not recommend targeting awards.**

General dental practice

- 10.4 We recommend for all General Dental Practitioners a pay increase of dental inflation plus three per cent.
- 10.5 **We urge that the DDRB starts again to make a separate recommendation on expenses for GDPs.** With the four countries treating expenses differently there is a widening disparity between remuneration levels and the approach taken by departments has failed to keep pace with dental inflation, leading to falling pay in real- and cash-terms. We have never agreed that information on practice expenses gained from HMRC data is unreliable and would urge the Review Body to revert to its former practice.
- 10.6 For Northern Ireland, Wales and England, we again recommend the reinstatement of commitment payments. This has been our ask since 2017 and we ask the Review Body to consider this suggestion and encourage the Health Departments to explore the options with the BDA.
- 10.7 For Northern Ireland we ask for an increase in the Prior Approval limit. Under Northern Ireland's Statement of Dental Remuneration, a GDP must request prior approval before undertaking a course of treatment with a cost greater than £280. This limit is not automatically uplifted following pay uplifts and has not been increased for decades. In 2019/20, 21,284 – 78 per cent of the total – prior approval submissions were for a course of treatment with a value of less than £410 – the then Scottish prior approval limit.¹² The impact has been to result in more and more procedures requiring prior approval every year. This has contributed to the trend for GDPs to avoid higher cost treatments and focus on lower cost treatments – requiring them to work harder for same level of payment.

Community dental services

- 10.8 We recommend for Community Dental Services a pay increase of RPI plus three per cent.

Clinical academia

- 10.9 It is imperative the Dental Schools maintain pay parity for clinical academics with their substantive NHS colleagues and that timely pay awards are given. The annual delays in Northern Ireland have a significant impact on the pay erosion of dental academics.

¹² Derived from unpublished statistics - BSO Internal Management Information obtained upon request

Annex – Glossary of dental terms

BSA: NHS Business Services Authority in England
BSO: HS Business Services Organisation in Northern Ireland
CDS: Community Dental Services
CDS dentist: primary care dentist (employed) in the CDS
CDP: Civilian Dental Practitioner employed by MOD not military personnel
Dentist in training: hospital dentist on a dental core training or speciality training pathway
DFT: Dental Foundation Training
DHSC: Department of Health and Social Care (England)
DoH: Department of Health (Northern Ireland)
FD: Dentist on a DFT programme. Fully qualified dentist, one-year post graduation.
GDP: General Dental Practitioner: self-employed primary care dentist
GDS: General Dental Services
GDS contract: contract to deliver mandatory dental services with no end date
HDS: Hospital Dental Service (Consultant, SAS, dentists in training)
IoS: Item of Service
NHS/HS: National Health Service or Health Service in Northern Ireland
PDS: Public Dental Service (CDS equivalent in Scotland)
PDS agreement: Personal Dental Services agreement, contract to deliver mandatory services with time limit or referral services with time limit.
UCU: University and Colleges Union
UDA: Unit of Dental Activity (England and Wales)
UOA: Unit of Orthodontic Activity (England and Wales)

British Dental Association
64 Wimpole Street
London
W1G 8YS

BDA Northern Ireland
The Mount
2 Woodstock Link
Belfast
BT6 8DD

BDA Scotland
Forsyth House
Lomond Court
Castle Business Park
Stirling
FK9 4TU

BDA Wales
2 Caspian Point
Cardiff
Wales
CF10 4DQ