Evidence to the Review Body on Doctors’ and Dentists’ Remuneration for 2018/19

December 2017
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Executive summary

1.1. The key challenge for NHS dentistry is recruiting and retaining dentists. The impact of morale and motivation is vital to recruitment and retention and in stemming the rates of attrition. Ongoing work is needed to ensure that we attract new members to the profession but we also need to make sure that those currently working in the NHS are valued and want to stay. The NHS is losing valuable dentists as they reduce their NHS commitment and seek to retire or leave the profession and this situation is causing a recruitment issue in general dental practice and the community dental services in many geographic areas.

1.2. We are warning of a looming and fast approaching crisis in recruitment and retention of NHS primary care dentists in the UK. We have similarly significant issues in secondary care and consultant vacancies in Scotland and clinical academic posts across the UK.

1.3. Of real significance is that our members are reporting that the higher the NHS/HS commitment the lower the levels or morale/motivation and enthusiasm about work in the dental profession. This is of grave concern.

1.4. As a result in this 2018/19 submission, our position is that a pay uplift recommendation must at the very least curb any further erosion of pay in real terms and, similar to other NHS professionals we are calling for an inflation (RPI) linked award plus 2 per cent.

1.5. General dental practices are suffering with less than one applicant per post (outside London) for advertised positions and 63 per cent of practices that attempted to recruit associates experienced difficulties in doing so. In England, huge sums of money are clawed back from practices unable to meet their NHS commitment for various reasons including failure to recruit associates.

1.6. In the community dental services morale and motivation have got worse since last year and there are recruitment problems, particularly to specialist posts. For the first time BDA evidence suggests that the majority of CDS dentists are dissatisfied about pay. The role of the service is changing in all four countries to concentrate on complex specialist work with patients who can, in theory, be cared for in general dental practice being discharged back. This increases recruitment problems and does not aid retention.

1.7. In dental academia there is a permanent 10 per cent vacancy level amongst Senior Clinical Lecturers, the backbone of clinical undergraduate teaching.

1.8. GDPs seriously question the effectiveness of the whole DDRB process. Despite engaging constructively with the DDRB over the last four years, it is our view that all that has been delivered is a massive drop in income and no prospect of any meaningful improvements in the pay, morale and motivation of the workforce in the near future.

1.9. Despite the financial challenges facing dental practices and the ongoing cuts in pay, patients’ expectations for high quality care are just about being met. However, the DDRB cannot allow for patient access and care to be severely adversely affected before acting on dentists’ declining incomes.

1.10. Successive below-inflation pay awards, combined with lengthy delays in their implementation, have led to very considerable erosion of dental incomes. In Northern Ireland, the 2017/18 process has still not concluded.
The response to the 45th report

2.1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its membership is engaged in all aspects of dentistry including general practice, community dental services, the armed forces, hospitals, academia and research, and includes dental students.

2.2 Every year the BDA provides evidence to the DDRB covering general dental practitioners, community dentists/salaried practitioners and clinical academic staff. References in this report to the NHS should also be taken to apply to the Health Service in Northern Ireland unless indicated otherwise in the text. NHS England now refers to salaried primary dental care services as ‘community dental services’ or CDS and the latter term is used in this evidence, except for Scotland, where the service is called the ‘Public Dental Service’.

2.3 As in previous years, the BDA has once again undertaken a survey of members who are community dentists, practice owners and associates across the UK. We have also conducted Freedom of Information Act requests to obtain the necessary data to outline the scale of problems facing the dental profession.

Our response to the 45th report

2.4 In 2017/18 the Review Body recommended an increase of 1 per cent to general dental practitioners’ income, net of expenses, and for community dentists, a base increase of 1 per cent to the national salary scales. Such low uplifts continue to force NHS practitioners across the dental profession to question the commitment of the NHS to them as providers of high quality dental services and to question their role as valued members of the NHS family. The NHS cannot run on practitioner goodwill alone and the NHS is running on empty. As in previous years, the BDA and the profession in general were deeply aggrieved by the recommendations made by the Review Body in its 45th Report. We continue to make the point that if GDPs are underpaid on expenses, this means that the 1 per cent pay rise is not actualised. We have commented for at least two years running that acting within public sector pay policies gives the Review Body little room for manoeuvre to fulfil its remit for dentists and, as such, has little opportunity to respond genuinely to the evidence submitted. We were compelled once more to question our participation in a process that we have long believed to be of value. In 2017 the national Conference of Local Dental Committees passed a motion recommending that if the public sector pay cap continues, the BDA should not participate in the DDRB process. This motion was considered by the BDA’s General Dental Practice Committee at its October meeting and after a full debate it voted to continue to submit evidence. This was the first time such a motion was carried by the Conference and shows the depth of disillusionment felt by the profession.

Community dental services

2.5 We are aware that pay restraint remains the primary approach of UK governments in respect of public sector workers. As a result we accept as a matter of fact that there is no willingness to consider amendments to the basic Salaried Primary Dental Care Service (SPDCS) contract of employment. Similarly we recognise that the government considers formally negotiated and locally approved incremental progression to be a form of pay rise and not an appropriate reflection of increased responsibility and skills.

2.6 In previous responses we have highlighted our fundamental disagreement with this governmental approach and those concerns remain apposite.

2.7 It is unfortunate that the well-respected independent process for setting dental salaries has been circumvented for political expediency. For the sake of consistency we continue to
provide information on community dentist/salaried practitioners in the UK. Indeed, we would support the DDRB continuing to offer comment in relation to the position of all community and salaried practitioners across the UK.

**England and Wales response**

2.8 GDPs in England received a 1.14 per cent uplift in contract values and GDPs in Wales received 1.44 per cent. The difference in uplifts was accounted for by the Welsh Assembly government implementing the DDRB formula in full and the Westminster government capping the increase in staff pay to one per cent and inflation to CPI. Our preferred position remains that the DDRB should recommend on an expenses uplift. However, in the absence of DDRB recommendation, we continue to object to the Westminster government’s approach to this issue.

**Scotland response**

2.9 In the 45th Report 2017 *Scotland Supplement*, the DDRB recommended an increase in pay, net of expenses of one per cent for 2017-18. The DDRB also noted that there had been discussions between BDA Scotland and Scottish Government on expenses, but that it was clear it would be very difficult to come to a bilateral agreement. Officials felt that the sample of new evidence on dental practice accounts provided by the Scottish Government, was not statistically representative, but considered that it could usefully serve to give context and further concrete information about expenses.

2.10 Further to negotiations between BDA Scotland and Scottish Government where BDA Scotland provided a breakdown of increased expenses totalling £23.1m, the Scottish Government announced a 2.25 per cent increase in item of service fees and capitation and continuing care payments. The award was made in October 2017 and backdated to 1 April 2017.

**Northern Ireland 2017/18 uplift for GDPs**

2.11 At the time of writing, and at the outset of another DDRB process, GDPs in Northern Ireland have still not received an uplift for 2017/18.

2.12 Northern Ireland has been without a functioning government since January 2017. In the absence of a Northern Ireland Executive, BDA NI wrote to the Permanent Secretary for Health seeking clarification in regards to the government’s response to the DDRB recommendation and subsequent implementation of the 2017/18 pay award.

**Timing and implementation of uplifts in Northern Ireland**

2.13 Unfortunately for GDPs in Northern Ireland, prolonged delays have become commonplace as yet again the pay uplift will not be implemented in the current financial year.

2.14 Northern Ireland is up to twelve months behind the rest of the UK on the implementation and delivery of pay awards to the GDS. It was only in April 2017 that the outturn of the forty-fourth report of DDRB was implemented and backdated to April 2016 - a full 12 months after the DDRB report was published. This follows a zero per cent uplift in the financial year 2015/16, which was formally announced in January 2016 – 10 months after the publication of the DDRB recommendation. For 2014/15, the uplift for GDPs was implemented in April 2015 - again, a full 12 months after the DDRB report was published.
2.15 Dentists operating in the health service cannot continue to tolerate the financial impact of these recurring delays and inadequate uplifts which gives little recognition to the rising costs of providing and maintaining a viable Health Service dental practice, as well as the significant negative impact in the form of personal and professional stress. GDPs are independent contractors, and the significant delays in the application of uplifts makes cash-flow management increasingly difficult, and could force many practices into a position of cash loss, negatively reducing the ability of practices to invest in equipment and premises needed to provide patient care.

2.16 The uncertainty and delay creates anxiety and causes great distress amongst a profession delivering health service patient care in the context of a longer term decline in GDP incomes, rising expenses, the need to undertake additional non clinical work which is not remunerated, the loss of commitment payments, and increasing administrative and regulatory requirements. The net effect is an overall deterioration in the morale and motivation of dentists and financial position of dentists who are striving to maintain quality of care for patients in the health service.

General comments

2.17 Since the announcement of this year’s recommendations, the BDA amongst others has written to the Secretary of State in June strongly condemning the continuation of the public sector pay restraint policy. The situation is untenable and cannot be allowed to continue.

2.18 We recognise that public sector finances are stretched, with the NHS seeking to plug the £22bn gap in finances and we know that Government has planned an increase in investment by 2020. However, the recent NHS staff survey showed that nearly 60 per cent of staff reported working unpaid overtime. With a continuing policy of pay restraint, can this figure rise further without severe consequences on physical and mental health and wellbeing? The Review Body must have regard to the funds available to the Health Departments but also that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. Now is the time to ensure that that ‘mechanism’ is to ensure that the public sector pay restraint cap is removed to enable dentists in the NHS to continue to deliver high quality patient care.

2.19 We note the Review Body’s reflections on the lack of understanding displayed by Departments and employers for the long term sustainability of ongoing pay restraint and we have called strongly and publicly for the pay restraint policy to be reversed for all NHS staff, not just those mentioned in the budget statement of autumn 2017.

2.20 We were interested in the Review Body’s comment that a one per cent increase would allow for more staff to join the service to alleviate workload. As described in detail later in our evidence, primary care dentists have ever increasing workloads and demands placed upon them. With only a one per cent recommendation it is harder to engage/employ more staff to alleviate workload within a practice/service. Persistent below inflation uplifts do not allow providers to attract talent to work in NHS dentistry. We fully support a move toward alleviating workload pressures and fostering job satisfaction among our profession yet this does not seem likely in the near future.

2.21 For general dental practitioners we are concerned that if we are forced to engage solely with the Department of Health for England on discussions about uplifts and expenses (para 24. Page xiii, para 8.46 page 119) then we are not supporting our associate members who rely on an independent body making recommendations on pay for all NHS dentists based on sound evidence from the dental profession. The Departments in
England and Wales can only engage in uplifts for contract holders and associates would be disenfranchised if this were the case.

2.22 Again this year the BDA has seriously considered the independent nature of the Review Body and we call on a forceful demonstration of that independence by the Review Body in this round.
Targeting awards

3.1 We are opposed to targeting as we do not believe that it has any value in this process. We note that the Review Body did not consider it appropriate to implement targeting this year. However, we are concerned that the Review Body has not precluded targeting in future years.

3.2 We strongly believe that the Review Body should recommend a pay uplift for all its remit groups and that targeting would have a detrimental effect on morale, motivation and retention. We do not support the targeting of awards between countries. GDPs in all four countries have experienced similar reductions in taxable income and should receive the same pay uplift. There is no difference in recruitment and retention issues for community dentists and salaried practitioners in each of the countries and we do not wish to create any more differences in pay between the four countries.

3.3 NHS England is already able to target contracts and spending to areas where new dental services are needed, so additional targeting of spending is unnecessary. Targeting rises away from dentists may also affect the numbers of dentists who tender for contracts, given that it will be clear where the priorities are. This issue also affects dentists in Wales.

3.4 If the Review Body were to target resources away from dentists and towards GPs in England, for example, this would ignore the very significant resources put into GP services by NHS England and it would ignore the evidence of recruitment issues for dentists that we provide in our evidence. General dental practitioners have the option to move from NHS to private practice and NHS practice owners themselves are increasingly opting to either sell their practices or terminate NHS contracts and convert to private practice.
General Dental Practice

Numbers of dental practices in England and Wales

4.1 Across England in 2015/16 the CQC estimated that there were approximately 10,300 dental practice locations\(^1\). In 2016/17 they inspected 1116 practices (roughly 10 per cent of registered locations) and these inspections show very high levels of compliance with only a few practices requiring support. Patients too are reporting high levels of satisfaction with dentistry. In May 2017, 4219 organisations submitted Friends and Family Test\(^2\) data from over 2.5 million patients stating that 97 per cent would recommend their dentist.

![Figure 1.13 Outcome of dental care inspections, as at 30 June 2016](image)

*Figure 1: CQC State of care report*

4.2 In Wales, Health Inspectorate Wales (HIW) inspect dental practices.

<table>
<thead>
<tr>
<th>Health board</th>
<th>Number of Practices listed by HIW</th>
<th>Number Inspected by HIW</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABMU</td>
<td>77</td>
<td>44</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>79</td>
<td>50</td>
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<td>Betsi Cadwaladr</td>
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<td>49</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>74</td>
<td>45</td>
</tr>
<tr>
<td>Cwm Taf</td>
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<td>33</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>48</td>
<td>36</td>
</tr>
<tr>
<td>Powys</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>All Wales</td>
<td>434</td>
<td>278</td>
</tr>
</tbody>
</table>

*Figure 2: HIW data on practice numbers*

4.3 These data in figure 1, when compared with figure 2, reveal that there are 80 practices (18 per cent) in Wales that are completely private and do no NHS work.

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4.4  Inspections repeatedly demonstrate that dentists are maintaining high quality patient care despite the reductions in funding and, therefore, at the expense of their own incomes.

Dental contract reform in England and Wales

4.5  The Review Body was interested in receiving further information about contract reform in England and “note that the major change proposed contractually in England is the introduction of a system of capitation payments. For next year’s round, we expect to hear more on the progress of the pilot schemes implemented, and be given greater clarity on the timetable for rollout of the new contracts.” The timeline for the dental contract reform process in England has been extended for another two years to March 2020. The BDA remains fully engaged in the contract reform process but disagrees with the inclusion of Units of Dental Activity (UDAs) as a payment measure, in a dental contract that should be focussing on prevention, outcomes and improving oral health. The current prototypes are also reporting rises in expenses because patients take more time to see and treat. If implemented in its current form we can only see dentists’ income falling even further. A contract that puts prevention first is urgently required.

4.6  Across England and Wales, the 2006 contract UDA system causes problems for patients and dentists alike. Practices are having to go above and beyond to treat patients and hit UDA targets, with many dentists increasing their working hours into the evenings and weekends. There is a misconception that dentists are struggling to achieve their UDA targets because they are not seeing enough patients. However, this simply is not the case. In fact, the UDA system means that a dentist could be with one patient for six hours yet only receive three UDAs.

4.7  This UDA system creates health inequalities and demonstrates inverse care law. Areas with poorer oral health are less likely to have access to dentistry because the dentist must do much more work for no more remuneration. A dentist in an area of good oral health may see six patients for clinical examinations and four patients each having one filling and earn 18 UDAs. A dentist in an area of poor oral health could see three patients, each having root canal treatment and multiple fillings, which take considerable time, and only earn nine UDAs. At the end of the financial year, the dentist in the area of poor oral health may face a claw back of money as they did not achieve their target. This puts the dentist under considerable stress and makes them less likely to remain in NHS practice, or in the area, or indeed in dentistry at all.

4.8  To test alternative systems of payment to dentists and new approaches to the delivery of NHS dental services in Wales, the Welsh Dental Pilot programme was developed. It ran from 2011 to 2015 and focused on widening access; improving quality; and incentivising prevention. Eight practices took part in the scheme. Those taking part in the pilots favoured this new way of working and argued that where the UDA system focused on numbers, the pilot focused on people. Two of the eight pilots moved on to a trial of a more advanced prototype of the new contract in 2016. The two Prototype practices in Swansea are both multi-chair practices which focus on proactive and preventive care, making greater use of dental nurses, hygienists and educators, and encouraging patients to take responsibility for maintaining their own oral health. Payment is based 85 per cent on capitation and 15 per cent on quality as measures by Key Performance Indicators, with overall expenditure and the scope of services available on the NHS unaffected. However, following the announced contract reform by the new CDO the Prototype contract will not be rolled out. Instead, in September 2017, a new pilot scheme has begun with 21 practices taking part in the initial stage. This pilot scheme will work within current regulations, being based on the UDA system, with a small percentage of UDAs given over to preventative work. The Swansea prototype practices will remain on their contract and at this time will not return to using UDAs.
GDS contractual change in Northern Ireland

4.9 Negotiations towards a new contract for General Dental Services have stalled, as we await the findings of an evaluation undertaken by the University of Manchester of the GDS pilots, which ended in August 2016. The report is due in 2018, the findings of which will inform negotiations on a new contract, between the BDA and Department of Health.

4.10 Until new contract arrangements are in place, dentists operate in a fixed fee per item system with payments for patient registration and clinical care, with percentage payments (a proportion of item of service fees) making up a practice allowance. Item of service payments, by their nature must reflect the resources utilised in respect of professional time, materials and overheads in place.

The changing policy landscape in England

4.11 Other areas affecting the dental health landscape is the move by the wider NHS to place based commissioning of services for specific geographical populations (Greater Manchester). The Sustainability Transformation Partnerships (STPs) set the outlines for health services for particular areas, other new models of care are being set up to deliver care locally. As the remit of Accountable Care Organisations do not as yet include the commissioning of dental services, we are maintaining a watching brief on this work. However, we have been warned by NHS England that general dental practices may become part of them at some stage. We are concerned about this and the impact this may have on entitlement to NHS pensions and other NHS benefits. We are not yet seeing any federation of general dental practices, which would have major implications for NHS practice.

4.12 There are ongoing threats to orthodontic practices in 2016/17 with the rushed implementation of the Dynamic Purchasing System approach to orthodontic tendering in the South of England. It is not the DPS system itself which is the greatest concern, but the adverse impact of the process on smaller providers and the absence of appropriate consultation and needs assessment. At the time of writing, the BDA is pursuing Judicial Review against NHS England for the way in which the tendering was approached and the potentially devastating impact on practitioners affected by the rushed implementation. NHS England has proposed that small independent practices might form legal consortia entities in a very short space of time to enable them to contract with fewer providers. This is simply impractical, would have meant loss of NHS benefits to NHS dentists and increasing costs to practices within the consortia. Other areas of the country have paused similar tendering processes while the outcome of the JR is awaited.

4.13 The NHS in England is working rapidly towards a paperless 2020 with a commitment to implementation in 2018. Not all dental practices are computerised and some still submit claims in paper format. With the recent digital threats to the NHS, data and cyber security is increasingly important. Practitioners who own small businesses are all data controllers and we advise our members to have cyber protection in place. The May 2018 implementation of the General Data Protection Regulations and the Data Protection Bill puts more pressure on practice finances to make sure that compliance with the new Information Governance Toolkit (from April 2018) is in place and practices will face stiff penalties for any data breaches, therefore training of all staff will be important. This will increase practice expenses for the cost of implementation and maintenance.

NHS dental spend in the UK

4.14 Spending on NHS general dental practice in all four countries continues to fall in real terms, with spending returning overall to 2005/06 levels. Significant population growth during that
time has also impacted on spending per capita. With no earmarked budget for dentistry, and large sums clawed-back from practices in England and Wales, there is a clear threat to dentists’ incomes and the viability of dental practices in continuing to deliver NHS care.

![UK spend on GDS/PDS](chart1.png)

*Figure 3: Source Health Departments annual reports*

4.15 The chart below outlines the significant drop in taxable income for dentists across all four countries of the UK. For those currently considering studying dentistry, figures like these do nothing to encourage young people into the profession.

![Mean average taxable income for all self-employed dentists (over 75% NHS commitment)](chart2.png)

*Figure 4: NHS Digital Data*

4.16 This continued decline in incomes, in part resulting from successive below inflation uplifts, is clearly unsustainable and is having profound impacts on the ability to recruit and retain dentists, and on morale and motivation within the dental profession.

4.17 Given the difficulties facing general dental practice in the UK the fact that income has reduced significantly across all four countries of the UK shows starkly the problems in delivering not just high quality dental care to patients, but meeting the standards expected
of clinicians in 21st century. It is now beyond doubt that the DDRB can no longer continue to recommend below inflation pay uplifts.

**NHS contracts in general dental practice in England and Wales**

4.18 Where providers in England and Wales fail to deliver at least 96 per cent of their contracted activity, commissioners are able to recover, or ‘clawback’, the payments made for this activity. This can have a considerable impact on practice finances, particularly given that overheads will broadly be fixed even where all contracted UDAs have not been met. These figures do not show the hidden effects of contract value reduction (or rebasing) that may follow after two years of clawback, so the clawback will not be seen in the third year.

4.19 Clawback from English general dental practices in 2015/2016 was already significant, at £54.5 million, but in 2016-17 this increased substantially to £81.5 million, according to the Business Services Authority. The BDA’s research has found that under-delivery and clawback is often caused by practices experiencing difficulties recruiting associates, with 28 per cent stating this was a factor, and/or sickness, parental or other leave. We are also awaiting responses to FOIA requests as to how this money taken back by NHS England commissioners is then spent. This is a long-term detrimental result of the 2006 contract.
<table>
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<th>Area Name</th>
<th>Clawback (£)</th>
<th>No. of contracts in area</th>
<th>No. of contracts with clawback in area</th>
<th>% of contracts with clawback in area</th>
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<td>Cumbria, Northumberland, Tyne and Wear</td>
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<td>South Yorkshire and Bassetlaw</td>
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</tr>
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<td>TOTAL</td>
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<td>8954</td>
<td>2305</td>
<td>25.742685</td>
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</tbody>
</table>

*Figure 5: 2016/17 data from NHS Business Services Authority*

4.20 Clawback is particularly pronounced in some areas, for example affecting nearly half of practices in Cumbria, Northumberland, Tyne and Wear for example, and we have reason to believe that this is related to particular associate recruitment difficulties in those areas.
4.21 We are deeply concerned that this trend of under-delivery is continuing into the current financial year, with the latest NHS Digital data reporting that the number of UDAs carried out in the first quarter in England was down 1.1 million UDAs on the same period last year\(^3\).

4.22 General dental practice in Wales is also subject to clawback from Health Boards (with a 95 per cent threshold), which is increasing at a similarly alarming rate with each financial year, as our FOIA data clearly show. This means that millions of pounds are being clawed, or handed, back from general practice dentistry in Wales. This has doubled in the last year to £6.6m.

4.23 The BDA is dismayed that some Health Boards are not reinvesting this money in general practice dentistry, but rather are using it to balance their books. We have evidence of one Health Board that in the year 2015-16 alone moved a total of £2.5 million from underspend in the dental budget to be “utilised against the overall overspend of the Health Board which was mainly around the areas of pay, drugs, specialised treatments and non-delivery of savings.” The £2.5 million was significantly higher than the amount which was officially declared through the FOI process.

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\(^3\) NHS Digital, 2017, NHS Dental Statistics, England, 2017-18 – Quarter 1
<table>
<thead>
<tr>
<th></th>
<th>Cwm Taf</th>
<th>Aneurin Bevan</th>
<th>Cardiff and Vale</th>
<th>Hywel Dda</th>
<th>Abertawe Bro Morgannwg</th>
<th>Powys Teaching</th>
<th>Betsi Cadwaladr</th>
<th>Wales total</th>
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<td>2014-15</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Funding recovered relating to underperformance of UDAs</td>
<td>£259,000</td>
<td>£520,111</td>
<td>£344,000</td>
<td>£23,000</td>
<td>£739,551</td>
<td>£271,000</td>
<td>£645,000</td>
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<td>Monies handed back from GDS contracts</td>
<td>Nil</td>
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<td>Nil</td>
<td>£80,000</td>
<td>Nil</td>
<td>Nil</td>
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<td>£539,768</td>
<td>£344,000</td>
<td>£103,000</td>
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<tr>
<td>Funding recovered relating to underperformance of UDAs</td>
<td>£614,000</td>
<td>£408,245</td>
<td>£736,000</td>
<td>£279,000</td>
<td>£1,047,064</td>
<td>£718,000</td>
<td>£845,000</td>
<td>£4,647,309</td>
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<td>Monies handed back from GDS contracts</td>
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<td>£47,615</td>
<td>£30,000</td>
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<td>£7,778</td>
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<td>£455,860</td>
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<td>£718,870</td>
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<td>-16%</td>
<td>123%</td>
<td>1502%</td>
<td>43%</td>
<td>165%</td>
<td>58%</td>
<td>115%</td>
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<td>2016-17</td>
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<td></td>
<td></td>
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<tr>
<td>Funding recovered relating to underperformance of UDAs</td>
<td>£459,929</td>
<td>£584,781</td>
<td>£410,000</td>
<td>£1,452,696</td>
<td>£563,209</td>
<td>£412,048.1</td>
<td>£1,045,106</td>
<td>£6,927,769.13</td>
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<tr>
<td>Monies handed back from GDS contracts</td>
<td>Nil</td>
<td>£124,574</td>
<td>Nil</td>
<td>£8,074</td>
<td>£367,301</td>
<td>£416,737.8</td>
<td>£719,435</td>
<td>£1,636,103.87</td>
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<tr>
<td>Total</td>
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<td>£709,355</td>
<td>£410,000</td>
<td>£1,460,773</td>
<td>£930,510</td>
<td>£828,786</td>
<td>£1,764,541</td>
<td>£6,563,873</td>
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<tr>
<td>Percentage change of funding reprieved/returned compared to previous year</td>
<td>-33%</td>
<td>56%</td>
<td>-46%</td>
<td>-11%</td>
<td>-12%</td>
<td>15%</td>
<td>33%</td>
<td>-1%</td>
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</table>

Figure 7: To show increases in Clawback and Handback of GDS monies in Health Boards and Wales overall between 2014-15 and 2015-16 and partial data for 2016-17 showing changes from previous year.

4.24 One Health Board, Abertawe Bro Morgannwg, clawed back £1,047,064.91 in 2015/2016. The number of practices in Hywel Dda having to hand back monies went from one to ten in a single year, increasing from £80,000 to £1,371,000. Across Wales more and more money is being handed and clawed back, with an increase of 236 per cent between 2015 and 2016. The number of practices being affected is also rising but not to the same degree. This means that those practices affected by clawback are experiencing harsher penalties year-on-year. In addition to this, practices in rural Wales are closing, with obvious consequences for the availability of NHS dentistry in rural areas. In West Wales, in particular, there is a lack of NHS dentists and therefore, often, the only option for patients is to pay for private treatment if this can be afforded.

4.25 This evidence is only underscored by Integrated Dental Holdings’ group report to investors setting out their financial position for the 2017-18 financial year-to-date. For quarter one, the biggest corporate in the UK noted continued under-delivery and NHS revenue was down by 3.8 per cent (£3.6 million). It noted continued issues with dentists available for a reduced number of hours. This difficulty in delivering contracted NHS activity has had an impact on the viability of some practices. From 30 September 2016 to 30 September 2017, the number of IDH practices declined from 675 to 661. In the year-to-date, IDH have closed eight practices, four have been sold and a further twenty are currently ‘held for sale’. The NHS contract for one practice has been handed back and the practice has been converted
to solely private practice. IDH reports that it will continue to consider further practice ‘disposals’.

4.26 Overall, this increased clawback is leading to a direct reduction in dentists’ incomes, an increase in stress levels and is resulting in poorer access for patients to NHS dentistry.

Recruitment and retention in general dental practice in the UK

Recruitment

4.27 The highly pressurised NHS environment described, with the decline in dentists’ incomes in recent years, presents a serious threat to sustainable recruitment and retention in general dental practice. How can the NHS encourage young professionals to want to work in a highly stressful job for five or six days a week and ensure older practitioners do not wish to retire early?

4.28 We believe that through successive below inflation pay recommendations, the DDRB is now overseeing a looming crisis in general dental practice recruitment and retention.

4.29 Recruitment problems are now occurring across England and Wales, and must be urgently understood and addressed. Further delay in addressing the declining incomes of dentists will create a situation where it won’t be enough to seek to recruit more dentists, as there will only be the same mechanisms that current dentists are rejecting within the NHS, and the rates of attrition and workforce problems will persist.

4.30 Whilst we would like to see widening participation from underrepresented groups, there has in recent years been adequate numbers of students applying to study dentistry. However, the reduction in the number of dental school places, recruitment problems and uncertainty about the post-Brexit environment will only combine to exacerbate existing workforce issues.

4.31 Recruitment of associates into general dental practice is an increasingly worrying problem for practice-owners. There are regions within England with enormous associate recruitment problems. The number of vacancies are an indicator of strength in labour market demand, but the disparity between London and the South East and other regions has become very destabilising.

4.32 This challenge is set against increasing demand for NHS care in the areas struggling to recruit. NHS Digital reports that in 2016/17, the North East has the highest demand for NHS care (adults and children) and London the lowest. NHS practices in the North East are failing to recruit to associate positions despite 56.8 per cent of the adult population (63.0 per cent of children) seeking NHS care. On the contrary, associates are choosing to apply for positions in London where the uptake of NHS dentistry is the lowest in England (45.0 per cent adults and 49.2 per cent children). Associates are looking to leave the NHS and work in areas with greater capacity for private work.

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### Table 1: Percentage of Practice Owners Who Sought to Recruit Any Dentists March 2016-17 (BDA Practice Owner Survey)

<table>
<thead>
<tr>
<th>Nation</th>
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<td>63</td>
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<tr>
<td>Northern Ireland</td>
<td>25</td>
<td>75</td>
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<tr>
<td>Scotland</td>
<td>38</td>
<td>62</td>
</tr>
<tr>
<td>Wales</td>
<td>42</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>37</td>
<td>63</td>
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</tbody>
</table>

### Table 2: Percentage of Practice Owners Experiencing Difficulties Recruiting Dentists March 2016-17 (BDA Practice Owner Survey)

<table>
<thead>
<tr>
<th>NHS Personal Commitment</th>
<th>Yes</th>
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<tr>
<td>&gt;75%</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>63</td>
<td>37</td>
</tr>
</tbody>
</table>

**Figure 8:** Percentage of practice owners who sought to recruit any dentists March 2016-17 (BDA Practice Owner Survey)

**Figure 9:** Percentage of practice owners experiencing difficulties recruiting dentists March 2016-17 (BDA Practice Owner Survey)

4.33 Across the UK, there are a large number of practices that have sought to recruit new associates and the rates of this are higher in predominately NHS practices. This is indicative of a labour demand in dental practices, but our research indicates that a significant proportion of those who sought to recruit experienced difficulties.

4.34 In our 2017/18 evidence, we noted that nearly half of practices that had sought to recruit an associate in England had experienced difficulties. However, our survey of practice-owners has found the proportion of those who had sought to recruit experiencing problems in England had increased substantially to two-thirds. This trend is clear across the UK, with the overall proportion experiencing difficulties increasing from 45 per cent to 63 per cent. Practices with the highest NHS commitment were more likely to have had problems recruiting and the proportion experiencing these difficulties has increased from last year when 54 per cent experienced problems.

4.35 We also received a number of free text responses to our survey and other qualitative evidence from our members setting out the challenges they are facing in staffing their practices. In general, cities are far more popular as locations for dentists to work, meaning that rural practices are struggling and our members tell us that small villages in rural Wales are particularly hard hit. Practices in areas of high deprivation and low UDA values cannot attract new or experience dentists. Associates are also seeking more part-time working or are less interested in working in practices with high NHS commitments.
One case study that demonstrates these problems is an independently-owned practice in Torrington, Devon with nine dentists (5.5 FTE) offering care to approximately 10,000 NHS patients and a further 2,000 patients privately. It provides additional services under the NHS including sedation orthodontics, domiciliary care for the elderly, and community-based oral health promotion. One of the practice owners told us:

“It has been a nightmare! We have had no contact or leads from the initial advert. We subsequently placed a large coloured advert in October’s BDJ – absolutely nothing! I have tweeted, retweeted, had others tweet it. Nothing. Diddly squat. This is now having massive repercussions on the practice and access to dental care in North Devon. We are currently short of three dentists and I am aware that many other practices in the Southwest are having similar problems. A significant number of our patients will receive a letter next week informing them that we can no longer provide access to NHS dental care. Approximately 5,500 patients will be affected by this.

Earlier this year one of our ex-partners took early retirement and another decided to sell up and move to Scotland (where there is different NHS dental contract). We managed to recruit two young dentists but it was soon clear that they had no intention of staying long term.

The situation as of today is as follows:

- One of our associate dentists went on maternity leave yesterday and we have NO cover for her patients. She has an NHS list of 1,800 patients. We had initially managed to recruit a locum dentist who subsequently withdraw at the last minute as she had been offered a job in Taunton.

- Our two most recent associates (a couple) have resigned and will be leaving in January to work in the West Midlands. They look after a further 3,600 patients in addition to providing four sedation sessions per week for anxious children and adults.

As yet we have been unable to recruit a dentist to provide cover for any of these posts and if this is not addressed by January 2018, some 5,500 patients will be unable to access NHS dentistry in Torrington. Our NHS sedation waiting list is also likely to double. We currently provide seven sedation sessions per week to anxious and vulnerable patients in Devon. This equates to over 1,200 patient contacts per year, and will cause a significant problem across the area. There is limited access to sedation in Devon and this will undoubtedly impact on the number of children being referred to hospital for general anaesthesia.

We have advertised the jobs widely over the last two months in the national dental press, through dental social media, through the postgraduate Deanery and Dental Schools. There has been no interest whatsoever. The handful of dentists I have spoken to are not interested in working in the NHS. We are now using three recruitment agencies in a desperate attempt to recruit dentists.

Recruitment of dentists is a challenge nationally but this appears to be particularly acute in rural areas. I have had various conversations with a number of young graduates and dental students in my capacity as Vice Dean.
of the Faculty of General Dental Practice (UK) and young dentists do not see their future within NHS dentistry. I have had recent discussions with Andrew Harris (NHS England) and he is fully aware of the recruitment situation in Devon.

My staff have spent the day contacting a large number of patients explaining that we will have to cancel their recall visits as we have no cover for their own dentists. Existing treatment will be completed by one of our other dentists and we will try to provide some level of emergency cover for as many of our patients as possible. Our situation is clearly going to impact on access to NHS services in Torridgeside and beyond and will also impact directly on the treatment waiting times for other patients. Healthwatch Devon have been made aware of the situation and they have already been in touch with the practice.

I have campaigned for over 10 years to get the NHS contract changed as it is bad for patients, bad for dentists and bad for oral health. This has been widely acknowledged for many years but political rhetoric has not translated into reality. We are still working under the same NHS contract with reduced funding, increased bureaucracy, burdensome regulation and increasing patient demands / needs. This is one of the main reasons why young dentists do not see a future in the NHS and do not want to work under the current system.

My comments thus far have quite rightly focussed on the impact on patients. It is important to recognise the impact which the situation is having on my staff as they are currently under intolerable stress which I fear may ultimately have consequences.”

4.37 In Wales, the shortage of dentists has been raised with the Cabinet Secretary for Health, Wellbeing and Sport in the Welsh Assembly, however no plans have been announced to make funding available for the newly-formed Health Education Improvement Wales to train more dentists

4.38 In the most recent statistics\(^6\) (August 2017) published by the Welsh Government it is evident there has been little change in the number of dentists per 10,000 of the population for a number of years. However, it is important to note that these are headcount figures and do not provide an indication of the full time equivalents providing NHS treatment.

\(^6\) NHS Dental Statistics in Wales,2016-17: 31August: 2017SFR 98/2017
Statistics Wales: Welsh Government
Recruitment of dental nurses

4.39 The role of dentist as a clinician is dependent on having an adequate supply of dental care professionals, particularly dental nurses. A dentist can only increase the number of patients seen within a practice by increasing the number of practitioners in the practice. Recruitment of dental nurses is an increasingly worrying problem for many dental practices.

4.40 Our survey found that, of those practices seeking to recruit a dental nurse, well over half (55 per cent) had experienced difficulties. In Northern Ireland, nearly two-thirds (65 per cent) of practices that had attempted to recruit a dental nurse had experienced problems doing so.

4.41 It is vital to acknowledge that the only source of funding for dental nurses is dentists themselves. Any higher wages required to attract dental nurses, increases expenses and decreases taxable income.

4.42 It is also important to note the costs to dental nurses of GDC registration and indemnity fees which might make the profession less attractive without an increase in wages.

4.43 This is a critical strategic challenge that must be considered, and could impact on health service provision quite considerably. A fair uplift in dentists’ pay would provide the support practices need to address this pressing skills shortage.

Retention in general dental practice in the UK

4.44 These recruitment problems faced by practices are perhaps in large part explained by the challenges in retaining dentists within the profession and, in particular, within NHS dentistry.

4.45 NHS Digital data reports that those under 35 year old represents 36.2 per cent of the workforce and this age group accounts for the both the largest number of dentists joining the NHS (1,260, 81.4 per cent) and leaving the NHS (639, 39.2 per cent). The effects of this are being felt most clearly in the areas with the highest demand for NHS dentistry, particularly the South West and North East of England. This data is supported by our own survey of associates that found that 28 per cent were looking to increase the amount of...

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time they spend on private work, while only two per cent were intending to increase their NHS commitment. Among 25-34 and 35-44 year old associates, roughly two-fifths were planning to increase the amount of time they spend on private dentistry; 40 per cent and 38 per cent respectively. This clear trend away from the NHS points to a looming skills shortage for the delivery of NHS dentistry and the NHS’s inability to retain younger dentists should be of particular and profound concern.

4.46 In addition to those moving away from NHS dentistry, there are also a considerable number planning to retire. The proportion of associates stating that they intend to retire in the next five years has increased from 13 per cent in our survey last year to 20 per cent this year. Of particular note is that 23 per cent of 45-54 year old associates are planning to retire in the next year. Among practice owners, the proportion stating they intend to retire in the next five years was more than a third, at 36 per cent. This represents an increase from last year when 30 per cent of practice owners said the same. As with associates there was a substantial proportion of practice owners aged 45-54 years old intending to take early retirement, 21 per cent said they planned to retire within five years. With a large and growing proportion of the profession looking to retire in the short to medium term, and a sizable proportion of dentists considering early retirement, there is a real risk that the profession will lose many skilled and experienced dentists; only exacerbating existing skills shortages.

4.47 Moreover, seven per cent of associates stated that they were planning to leave dentistry to work in another sector or industry and the same percentage said they intended to move overseas for work.

4.48 In addition to those intending to give up dentistry altogether, many dentists are intending to reduce the number of hours they work. Around a quarter (26 per cent) of associates and nearly a third (32 per cent) of practice owners plan to reduce their working hours over the next five years. Most strikingly, 30 per cent of 25-34 year old associates intend to reduce the hours they work. This raises fundamental questions about the assumptions that can be made about the workforce capacity based on headcount figures.

4.49 From an FOIA request to the BSA we found that there are a significant number of performers (associates) working performing fewer than 100 UDAs per year in England. In 2016/17 this figure was 7229 and this was a decrease of 1534 performers from 2015/16. We believe that this fall indicates those performers leaving the NHS entirely or retiring.

4.50 It is clear from this evidence that the NHS is struggling to remain an attractive environment for dentists to work in. If established practice owners do not wish to remain in the service and new associates are choosing not to work in NHS then there is a real threat of a skill shortage in NHS dentistry. Without a fundamental change to the system and new incentives to retain committed dentists, bringing new people into a plainly broken system will not stem the rates of attrition.

**Rises in indemnity costs across the UK**

4.51 Just like general medical practitioners, many general dental practitioners have been subject to sharp increases in indemnity costs over the past two years. Typically rises from about £3,000 pounds a year to £5,000. NHS England has in place a scheme to offset average indemnity inflation and we believe a similar scheme should be in place for general dental practice across the UK. We also believe that general practice dentistry should be part of the planned state backed NHS general practice indemnity scheme in England.
Re-introduction of NHS commitment payments

4.52 One of the most effective ways of encouraging retention and commitment within NHS general dental practice would be to re-introduce NHS commitment payments. These payments rewarded dentists financially for their commitment to the NHS and were very successful in solving previous recruitment and retention problems. We believe they should be re-introduced in England and Wales and restored in Scotland and Northern Ireland. In the system in England there is no reason why they could not be either paid directly to performers (using the amount of a performers’ net pensionable earnings as a measure of commitment) or paid to providers with the requirement that the payments are passed on in full to the performer (as is the case for parental leave payments).

4.53 We ask the Review Body to consider this suggestion and encourage the Health Departments to explore the options with the BDA.

Impact of the NHS pension scheme on retention UK

4.54 Recent years have seen significant reforms to the NHS Pension Scheme, not least in respect of the cost of membership to dentists. Ten years ago, the maximum pension contribution rate was 6 per cent. In 2008, this was increased to 8.5 per cent, and from 2014, it has increased further to 14.5 per cent. There has been no recognition of these increased contributions since 2015, in commensurately higher pay. The vast range of member contributions (from 5 per cent to 14.5 per cent) is also of concern to the BDA, particularly as the proportion of members who accrue pension on a final salary basis now represents about one-fifth of the whole scheme population.

4.55 It is notable that between 2012 and 2016, the average annual pensionable earnings of dental practitioners in England and Wales has decreased from £59,603 to £55,348 (males) and from £46,657 to £45,918 (females).

4.56 Outside of the remit of the NHS Pension Scheme, but still a significant factor for dentists who are planning for their retirement is the fact that maximum HMRC allowances for pension savings have been greatly eroded. We agree with the conclusions of the last, March 2017, DDRB report that the NHS Pension Scheme should include greater flexibility, and would suggest that many dentists would appreciate the facility to determine the level of earnings which are pensionable, in order to better manage the degree to which their pension savings remain tax efficient.

Pension provision for practice staff

4.57 Automatic enrolment legislation will see the requirement for rises to statutory minimum contributions in both April 2018 and April 2019. The first increase will see a doubling in employer contributions towards staff pensions, and one year later the current cost will treble. Practice employees will see a greater rise in their own statutory minimum contribution levels, and it is anticipated that, in order to continue participation in pension saving, this will be accompanied by claims for pay rises. These extra practice costs need to be factored in.

4.58 As a significant factor on retention, these additional burdens of reforms to the NHS pension scheme will weigh heavily on associates and practice owners alike, with additional burdens on practice owners for auto-enrolment.
Impact of low morale and motivation in general dental practice in the UK

4.59 Dentistry is a difficult and stressful profession, to which dentists must commit considerable amounts of time and money to join. We asked both associates and practice owners in our 2017 survey whether they would recommend a career in dentistry and a majority among both groups said that they would not. Fifty-nine per cent of associates stated that they would not recommend a career as a dentist and 54 per cent of practice owners said the same. These figures present a stark representation of the dissatisfaction many dentists feel with their professional lives and are particularly striking given the increase on last year, when the proportion who would not recommend a career as a dentist stood at 51 per cent for both associates and practice owners. Those with the greatest NHS commitment (more than 75 per cent of their time spent on NHS work) are even less likely to recommend dentistry as a career; with 63 per cent of these associates and 68 per cent of these practice owners stating that they would not recommend a career as a dentist.

4.60 This reluctance to recommend the profession can, at least in part, be explained by the low levels of morale among dentists. Around a third of associates (31 per cent) and practice owners (33 per cent) reported that there morale was ‘low’ or ‘very low’. While the proportion of practice owners considering themselves to have ‘high’ or ‘very high’ morale was greater than for associates, it still accounted for fewer than two-in-five of all practice owners and for associates was only a third. Notably, half of practice owners with NHS commitment of more than three-quarters of their time reported their morale to be ‘low’ or ‘very low’, compared to only 24 per cent for those working on the NHS less than 75 per cent of the time. Similarly, only 19 per cent of associates with an NHS commitment of less than 75 per cent of their time said their morale was ‘low’ or ‘very low’, whereas the same was true for 38 per cent of those with the greatest NHS commitment. For both practice owners and associates, morale was lowest among those working in Northern Ireland and Wales, with nearly half of practice owners reporting their morale to be ‘low’ or ‘very low’ and two-fifths of associates saying the same.

<table>
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<th>Associates - Would you recommend a career as a dentist?</th>
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<th>No (%)</th>
<th>N</th>
</tr>
</thead>
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<td><strong>Nation</strong></td>
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<td>Scotland</td>
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<td>Wales</td>
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<tr>
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<td>&gt;75%</td>
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<td>63</td>
<td>335</td>
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<tr>
<td>&lt;75%</td>
<td>46</td>
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<tr>
<td><strong>All</strong></td>
<td>40</td>
<td>59</td>
<td>496</td>
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*Figure 11: Data from BDA Associates Survey 2017*
### Practice owners - Would you recommend a career as a dentist?

<table>
<thead>
<tr>
<th>Nation</th>
<th>Yes (%)</th>
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<th>N</th>
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<td>Northern Ireland</td>
<td>42</td>
<td>58</td>
<td>73</td>
</tr>
<tr>
<td>Scotland</td>
<td>38</td>
<td>62</td>
<td>144</td>
</tr>
<tr>
<td>Wales</td>
<td>43</td>
<td>57</td>
<td>88</td>
</tr>
</tbody>
</table>

NHS personal commitment

<table>
<thead>
<tr>
<th></th>
<th>&gt;75%</th>
<th>&lt;75%</th>
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<tbody>
<tr>
<td>England</td>
<td>32</td>
<td>68</td>
<td>275</td>
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<td>Northern Ireland</td>
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<td>45</td>
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</tr>
<tr>
<td>Scotland</td>
<td>46</td>
<td>54</td>
<td>633</td>
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</table>

*Figure 12: Data from BDA Practice Owners Survey 2017*

### Associates - How do you rate your morale in your work as a dentist?

<table>
<thead>
<tr>
<th>Nation</th>
<th>Very high (%)</th>
<th>High (%)</th>
<th>Neither high, nor low (%)</th>
<th>Low (%)</th>
<th>Very low (%)</th>
<th>N</th>
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<tbody>
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<td>England</td>
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<td>36</td>
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<td>32</td>
<td>23</td>
<td>34</td>
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<td>44</td>
</tr>
<tr>
<td>Scotland</td>
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<td>27</td>
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<td>21</td>
<td>10</td>
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<tr>
<td>Wales</td>
<td>7</td>
<td>27</td>
<td>26</td>
<td>33</td>
<td>7</td>
<td>55</td>
</tr>
</tbody>
</table>

NHS personal commitment

<table>
<thead>
<tr>
<th></th>
<th>&gt;75%</th>
<th>&lt;75%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>8</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>10</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Scotland</td>
<td>9</td>
<td>25</td>
<td>35</td>
</tr>
<tr>
<td>Wales</td>
<td>11</td>
<td>26</td>
<td>30</td>
</tr>
</tbody>
</table>

*Figure 13: Data from BDA Associates Survey 2017*

### Practice Owners - How do you rate your morale in your work as a dentist?

<table>
<thead>
<tr>
<th>Nation</th>
<th>Very high (%)</th>
<th>High (%)</th>
<th>Neither high, nor low (%)</th>
<th>Low (%)</th>
<th>Very low (%)</th>
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</thead>
<tbody>
<tr>
<td>England</td>
<td>12</td>
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<td>29</td>
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<tr>
<td>Northern Ireland</td>
<td>6</td>
<td>17</td>
<td>28</td>
<td>35</td>
<td>14</td>
<td>73</td>
</tr>
<tr>
<td>Scotland</td>
<td>8</td>
<td>21</td>
<td>31</td>
<td>28</td>
<td>12</td>
<td>144</td>
</tr>
<tr>
<td>Wales</td>
<td>7</td>
<td>20</td>
<td>26</td>
<td>35</td>
<td>13</td>
<td>88</td>
</tr>
</tbody>
</table>

NHS personal commitment

<table>
<thead>
<tr>
<th></th>
<th>&gt;75%</th>
<th>&lt;75%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>7</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>13</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Scotland</td>
<td>11</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Wales</td>
<td>11</td>
<td>26</td>
<td>30</td>
</tr>
</tbody>
</table>

*Figure 14: Data from BDA Practice Owners Survey 2017*
In addition to around a third of the profession reporting low morale, there is also considerable job dissatisfaction. This is particularly stark among those whose work is overwhelmingly for the NHS. Forty-six per cent of practice owners spending 75 per cent or more of their time on NHS work report that they are somewhat, mostly or completely dissatisfied with their present job and for associates the figure is 38 per cent. By contrast, only 18 per cent of those practice owners with a lesser NHS commitment (below 75 per cent of their time) described their job satisfaction in this way and for associates with the same level of NHS commitment it was 19 per cent.

Analysis from NHS Digital recorded lower morale than that found by the BDA’s own surveys of practice owners and associates. Nearly half (49.1 per cent) of providing-performers reported that their morale was ‘low’ or ‘very low’ and 39.2 per cent of performer-only dentists stated the same. This analysis also observed a relationship between morale levels and the proportion of NHS work. The average NHS commitment for providing-performers reporting very low morale was 71.8 per cent, whereas for those reporting very high morale it was 56 per cent. The relationship was less pronounced for performer-only dentists, but nonetheless those with a higher NHS commitment reported lower morale.

Given the significant falls in net incomes over the last decade, it is unsurprising that we found that less than a third of associates felt that they were fairly remunerated and only 38 per cent of practices owners felt the same. Again, there are striking differences based on NHS commitment (figure 15) with 62 per cent of practice owners with the greatest NHS commitment saying they ‘disagree’ or ‘strongly disagree’ that they are fairly remunerated for their work, whereas for those with a lower NHS commitment 27 per cent ‘disagree’ or ‘strongly disagree’. There is a similar pattern for associates; with 59 per cent of those working predominately on the NHS saying they ‘disagree’ or ‘strongly disagree’ that they are fairly remunerated and only 19 per cent of those with a lesser NHS commitment saying the same. There are also differences by nation; with dentists working in Northern Ireland most likely to disagree that they are fairly remunerated and, to a lesser extent, dentists in Scotland are also less satisfied with their remuneration than those in England and Wales. There may be a number of factors explaining this divergence across nations such as different NHS contracts, the proportion of NHS work, differences in levels of pay and approaches to public sector pay policy. For example, in Northern Ireland, dentists did not receive a pay uplift in 2015/16 and the department is yet to announce the 2017/18 uplift.

I am fairly remunerated- Percentage ‘Strongly agree’ or ‘Agree’

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>England</th>
<th>NI</th>
<th>Scotland</th>
<th>Wales</th>
<th>NHS &gt;75%</th>
<th>NHS &lt;75%</th>
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<tbody>
<tr>
<td>Associates</td>
<td>32</td>
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<td>32</td>
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<tr>
<td>Practice owners</td>
<td>38</td>
<td>41</td>
<td>23</td>
<td>25</td>
<td>33</td>
<td>17</td>
<td>52</td>
</tr>
</tbody>
</table>

Figure 15: Data from BDA Associates Survey and Practice Owners Survey 2017

Dental Working Hours 2014/15 and 2015/16 Motivational analysis, NHS Digital, 2016
I am fairly remunerated- Percentage ‘Disagree’ or ‘Strongly disagree’

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>England</th>
<th>NI</th>
<th>Scotland</th>
<th>Wales</th>
<th>NHS &gt;75%</th>
<th>NHS &lt;75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associates</td>
<td>45</td>
<td>44</td>
<td>64</td>
<td>50</td>
<td>44</td>
<td>59</td>
<td>19</td>
</tr>
<tr>
<td>Practice owners</td>
<td>40</td>
<td>38</td>
<td>59</td>
<td>57</td>
<td>44</td>
<td>62</td>
<td>27</td>
</tr>
</tbody>
</table>

Figure 16: Data from BDA Associates Survey and Practice Owners Survey 2017

4.64 This difference based on the level of NHS commitment is broadly reflected in the NHS Digital Motivation Analysis. Across all of the motivation questions asked by the NHS Digital survey, the overall average of those responding ‘agree’ or ‘strongly agree’ with an NHS commitment of 75 per cent or above was 36.8 per cent, whereas for those with an NHS commitment of 0-25 per cent was 58.5 per cent. Only 16.5 per cent of providing-performers with the highest levels of NHS commitment said they agreed or strongly agreed that their pay was fair and 22.7 per cent of performer-only dentists said the same. For those spending less than 25 per cent of their time on NHS work, 42.2 per cent of providing-performer and 45.4 of performer-only dentists agreed or strongly agreed that their pay was fair.

4.65 The analysis also shows that mostly NHS dentists are less likely to feel there are opportunities to do challenging and interesting work; with only 48.8 per cent of providing-performers and 50.3 per cent of performer-only dentists compared to 74 per cent and 71 per cent for those with the least NHS work. Similarly, dentists with lower NHS commitment were more likely to report that they agreed that they received recognition for the good work they did. Only a third of predominately NHS providing-performer dentists agreed with this statement, whereas among those with lower NHS commit 58.2 per cent were in agreement.

4.66 The NHS Digital analysis also shows, unsurprisingly, that dentists report higher motivation where they work fewer hours, take more annual leave and spend a greater proportion of their time on clinical work.

GDS in Northern Ireland – Health Service commitment

4.67 GDPs in Northern Ireland remain committed to the health service. On average, dentists report spending 72.4 per cent of their time on health service dentistry (26.8 hours). There has however been a gradual decrease in the proportion of time spent on health service dentistry.

4.68 The strain of insufficient health service income is evident, and according to a recent NHS Digital report, over 70 per cent of Principals over 60 per cent of Associate dentists in Northern Ireland disagree or strongly disagree when asked if they feel their pay is fair. In addition, levels of morale are significantly lower in practice owners, which is a cause for concern given the rise in expenses and the fall in income. Less than five per cent of Principals who do mainly Health Service work responded positively when asked if they feel their pay is fair.

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9 Dental Working Hours 2014/15 and 2015/16 Motivational analysis, NHS Digital, 2016
10 NHS Digital Dental Working Hours UK 2014/15 and 2015/16
11 Dental Working Hours 2014/15 and 2015/16 Motivation Analysis Experimental Statistics (Published 8 December 2016)
Over a third of practice owners in Northern Ireland (33.6 per cent) with a HS commitment of 75 per cent or more reported their morale as ‘very low’ and 29.5 per cent as ‘low’ and this is linked to longer working hours and carrying out more health service work. The increased amount of work for diminishing levels of financial return appears to be one of the main causes of dissatisfaction with working in the HS. This situation is untenable, and will leave many in the profession with no option, but to assess whether HS commitment levels can be retained.

Those dentists with the most significant number of health service patients and health service commitment, have the most difficulty in remaining viable in the current environment of rising expenses against a backdrop of fixed fees for dental treatment. This is illustrated by figures from the NHS Digital 2015/16 report on expenses and earnings which shows that for all self-employed GDS dentists whose Health Service earnings accounted for at least 75 per cent of their gross earnings had the lowest taxable income from Health Service and private dentistry at £55,800 (compared to £55,900 in 2014/15 and £57,600 in 2013/14). Those whose Health Service earnings accounted for 25 per cent or less, and between 25 and 75 per cent of their total gross earnings, had taxable incomes of £95,600 and £93,300 respectively (in 2014/15 this was £89,900 and £100,400 respectively).

Dentists are required to spend increased hours on activity which is essential, but not clinical in nature. In Northern Ireland, all dentists report the average proportion of clinical work for the period 2008/09 to 2015/16 as reducing and an increasing amount of time dedicated to non-clinical activity. In 2008/09, GDPs in Northern Ireland spent 32.4 hours per week on clinical work. This has reduced to 28.7 hours per week hours per week in 2015/16. For dentistry, clinical activity is the main method of income generation. Without clinical activity, there can be no turnover. This in turn creates stress for the profession in having to dedicate time which is not remunerated towards essential activities of the practice, which only the dentist can do.

Longer working hours are also more likely to increase the likelihood of practice owners in Northern Ireland thinking about leaving dentistry, whilst health service commitment and age have the strongest influence on Associates. These negative feelings about the future of the profession cannot be understated. The more that the government neglects to invest in GDS dentistry, the more likely it is that dentists will walk away.

In the past, the Commitment Allowance would have gone some way towards remunerating non-clinical activity; the essential elements of dentist activity that are currently not supported through the payment system. Commitment payments ceased in 2016 in Northern Ireland. Commitment payments were put in place as recognition of the commitment of dentists to the NHS, and consequently to encourage retention and improve motivation and allow for an element of career progression.

Night and demand for dental services in Northern Ireland

The current General Dental Services remuneration model is largely demand led and determined by the number of patients seeking health service care and treatment.

At October 2017, there were 1,150 general dental practitioners (GDPs) on the Health Service Dental list. They work across approximately 380 ‘high street’ dental practices and provide care to over 1.18 million people, who are registered as Health Service dental.
patients. Growth in the need for dental services is continuing as the population increases in size and the number of older persons remains dentate. The ageing population is one of the greatest challenges facing the oral health services, and it is vital that there is a sufficiently large, trained and motivated range of professionals available to meet their care demands.

4.76 The change in the number of patients registered with a dentist under health service arrangements shows an increase of 5.6 per cent over the last five years (June 2012 to June 2017 (1,126,484 to 1,189,374). The pace of the population ageing is also increasing dramatically. Of particular note is the 23 per cent increase in patients over 65 (June 2012-June 2017 128,252 to 157,902).

4.77 The context of dental care in Northern Ireland is one of a population with high dental needs. Whist improvements in oral health have been achieved, Northern Ireland still has the worst oral health in the UK – strongly linked to higher rates of deprivation. Risks of decay are higher for children in deprived areas, who are less likely to be registered at a dentist, and large proportions of children continue to be affected by poor oral health. In Northern Ireland, more than double the amount of 15-year-olds had teeth missing due to decay (13 per cent) compared to six per cent in England and 11 per cent in Wales. The prevalence and severity of tooth decay in children are at extremely worrying levels. In Northern Ireland, 72 per cent of 15-year-olds have tooth decay compared to 44 per cent in England, and 63 per cent in Wales.\(^\text{16}\)

4.78 This in turn places stress on the system and the workforce tasked with delivering Health Service dental care for the population where the costs of servicing a high-needs population will be high in respect of materials used and laboratory work generated.

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients registered</th>
<th>Over 65</th>
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</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>1,189,374</td>
<td>157,902</td>
</tr>
<tr>
<td>June 2016</td>
<td>1,187,568</td>
<td>153,136</td>
</tr>
<tr>
<td>June 2015</td>
<td>1,172,427</td>
<td>146,001</td>
</tr>
<tr>
<td>June 2014</td>
<td>1,154,472</td>
<td>142,771</td>
</tr>
<tr>
<td>June 2013</td>
<td>1,150,890</td>
<td>135,998</td>
</tr>
<tr>
<td>June 2012</td>
<td>1,126,484</td>
<td>128,252</td>
</tr>
<tr>
<td>June 2011</td>
<td>1,054,799</td>
<td>123,637</td>
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</table>

Source: Business Services Organisation (BSO)

Figure 17: Patient registrations

4.79 An increase in the number of health service patients registered requires an increase in the amount of resource necessary to care for their needs in respect of the number of dentists and the amount of budget. The costs associated with delivering health service dentistry to patients and the growing costs on maintaining a viable HS dental practice must be recognised through the GDS system.

**NHS commitment across the UK**

4.80 The evidence clearly demonstrates that those who are most highly committed to working within the NHS have lower morale and motivation and there are considerable problems with recruitment and retention in NHS dentistry. Those dentists, have the most difficulty in remaining viable in the current environment of rising expenses against a backdrop of successive below inflation pay uplifts. It is therefore unsurprising that, as stated, we see dentists planning to reduce their NHS commitment.

---

4.81 There has already been a gradual decrease in the proportion of time dentists are spending on NHS dentistry and our research indicates that this is likely to continue. Comparing our research conducted in 2013 with that undertaken this year shows that a trend of practices reducing their level of NHS commitment. For example, in 2013, 15 per cent of practices were exclusively NHS, whereas this year this had fallen to just four per cent.

4.82 For dentistry, clinical activity is the main method of income generation. Without clinical activity, there can be no turnover. This in turn creates stress for the profession in having to dedicate time which is not remunerated towards essential activities of the practice, which only the dentist can do. In the past, the Commitment Allowance would have gone some way towards remunerating non-clinical activity; the essential elements of dentist activity that are currently not supported through the payment system. Commitment payments ceased in 2016 in Northern Ireland. Commitment payments were put in place as recognition of the commitment of dentists to the NHS, and consequently to encourage retention and improve motivation and allow for an element of career progression for all dentists in the UK.

Pay comparability across the UK

4.83 It is clear that amongst the DDRB remit group GMPs make for the most appropriate comparator for GDP pay and we believe that the average pay for GDP and GMP should be broadly similar.

4.84 There is a clear need to ensure that, in comparison to other professions, dentistry remains an attractive vocation for the most able prospective students. However, we are concerned that new analysis of graduate incomes indicates that this position might be threatened. Among those graduates with the highest pre-university attainment (more than 360 UCAS points), Medicine and Dentistry graduates – from a higher starting point - saw a rate of pay increase over the first five years of their career that was much lower than that seen by high-attaining graduates in other professions. While the earnings of Medicine and Dentistry graduates increased by 32.4 per cent over the first five years following graduation, graduates from Economics saw an increase of 123.3 per cent, Business and Administrative
Studies graduates saw a 142.9 per cent increase in their earnings and Law graduates’ earnings increased by 158.6 per cent over this period\textsuperscript{17}.

4.85 This is supported by the findings of our survey of associates, which found that the mode average pay of dentists aged between 25 and 54 years old remained constant at between £50,000 and £74,999. The estimated mean average did increase with age, however associates aged over 65 years old had earnings only 143 per cent higher than the pay of those aged under 25. This is less than the rise Law graduates can expect within the first five years of their career.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Estimated_mean_average_associate_pay_by_age.png}
\caption{Estimated mean average associate pay by age}
\end{figure}

4.86 There is considerable evidence, therefore, that, contrary to expectations, dentists’ pay increases relatively modestly over the course of their careers. It is possible that, by becoming a practice-owner, a GDP could have the opportunity to increase their take-home pay, however, opportunities to do so have reduced and many GDPs can now expect to be career-long associates.

4.87 The DDRB must therefore act to ensure that remuneration is commensurate with the skills, training, personal investment, professional responsibility and financial risk that dentistry requires.

\textsuperscript{17} Analysis of Longitudinal Educational Outcomes data in ‘Review of DDRB Pay Comparability Methodology: Final report’, Brown, Rickard and Bevan, 2017, p.43-44
Community dental services

CDS in England and Wales

5.1 For English community dental services, this year we submitted Freedom of Information requests to 59 providers, nine of which are social enterprises. Of these 59, 54 responded, alongside two further social enterprises. Alongside this we surveyed all BDA members working in the community dental services. As such we are able to present data on not only the structure of the CDS workforce but also the direction of travel of services, the climate in which they are operating and the motivation and morale of the dentists therein.

5.2 In order to provide greater evidence on behalf of CDS dentists we have repeatedly asked that the NHS Staff Survey enable respondents to self-identify as CDS dentists. This request has not been accepted and as such we cannot provide as much evidence on morale, working hours etc as we would wish to do.

5.3 In the tables below, we present figures provided to us from our Freedom of Information Act requests on the demographics of the community dental workforce.

<table>
<thead>
<tr>
<th>Figure 20: FOIA data on CDS workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS Headcount comparison</td>
</tr>
<tr>
<td>Band C Clinical</td>
</tr>
<tr>
<td>Band B</td>
</tr>
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<td>Band A</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Figure 21: FOIA data on CDS workforce WTE comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS WTE comparison</td>
</tr>
<tr>
<td>Band C Clinical</td>
</tr>
<tr>
<td>Band B</td>
</tr>
<tr>
<td>Band A</td>
</tr>
</tbody>
</table>

5.4 Dentists working in the CDS have traditionally considered their roles to be a vocation and as such have displayed loyalty to the services in which they work. As a result, 72 per cent of
CDS dentists have now reached the top of their salary scale with no opportunity for progression unless successfully applying for another post. This loyalty to the service is evidenced by the overall age of the workforce. If we assume an average career of 40 years (ages 25-65) then 61 per cent of the workforce is over the half way point of their careers with over a quarter of the workforce in the likely final stages of their careers.

Figure 22: CDS workforce by age

CDS in Wales

5.5 The domiciliary service in Wales, part of Community Dental Services, is patchy and underfunded compared with a few years ago. Unfortunately, there are also fewer younger dentists involved in this type of work. Maintaining oral hygiene in older people is a concern – for example, it should feature as part of a ‘check list’ when looking at the early stages of dementia.

CDS in Northern Ireland

5.6 New contractual terms and conditions for Community Dental Service Dentists have been agreed but have not yet been signed off and implemented by the Department of Health (DoH). The BDA was informed in January 2016 by the Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI), now DoH, that funding had been secured for a new deal. Progress on this was extremely quick, leading to agreement to ballot on a Summary Agreement on the main changes within the proposed new contract, including revised pay scales and annual leave entitlement. The ballot of all community dentists in Northern Ireland on the proposed new contract closed on 14 March 2016 and an overwhelming majority voted in favour of the new contract as outlined in the Summary Agreement.

5.7 Discussions continued after the ballot result to finalise the Terms and Conditions of service and draw up other associated documentation. However it became clear in September 2016 that the necessary approvals from the Department of Finance (DoF) had not been secured by the Department of Health to allow for the implementation of the contract, much to our grievance. This began a series of meetings between the BDA, DoH and the DoF with the aim of ensuring approval, including the revision and resubmission of the previous business case.

5.8 The Northern Ireland Assembly collapsed in January 2017 before DoF approval could be reached and Ministerial sign off given for the contract. However liaison with the
Departments continued and we have been informed that the DoF now hold no objections to the proposed contract and have been seeking advice on whether the contract can be implemented in the absence of a Minister. Currently we are still without sign off and implementation of the new contract, although we will continue to work with all stakeholders, monitoring the political situation and doing what we can to ensure CDS dentists in Northern Ireland have modernised terms and conditions, which align them with colleagues in the rest of the UK.

5.9 The continued delay in agreement and implementation of the contract has created significant frustration amongst community dentists in Northern Ireland and the wider dental community. There is continued uncertainty about when this will be resolved, perpetuating their concerns and generally lowering morale in the workforce. This inertia has created a perception that their voice, through the indicative ballot, has not been listened to and that the Departments do not share their sense of urgency or concerns. Community dentists are a very valuable part of the dental workforce in Northern Ireland, treating some of the most vulnerable patients and it is imperative that the contract is implemented as soon as possible.

Recruitment in the CDS

5.10 Within the community dental service, last year we highlighted an ongoing trend of a noticeable number of posts being unfilled. We have researched historic and ongoing vacancies in the CDS.

![Advertised vacancies v posts filled](image-url)

*Figure 23: advertised vacancies against posts filled*

5.11 There is clearly an issue in recruitment to the more senior grades within the CDS with only a fraction of Band C and B vacancies filled. This clearly will have an impact on the ability of services to deliver the complex care many CDS patients require. Furthermore, the almost impossibility of filling Band C Specialist posts places services at a clear risk of being unable to meet commissioning requirements for services to be Specialist led. Resultantly staff are now being asked to cover the gaps in service left by these unfilled posts either through general increased working or as direct cover.

Retention in the CDS

5.12 A significant amount of tendering has been reported by our members with 52 per cent of them informing us that their service has undergone a tendering exercise in the past year. In many cases the whole of the CDS was being placed out to tender. Furthermore, 21 per cent
of respondents reported that their services had initiated formal redundancy exercises with dentists identified as being at risk in such exercises.

5.13 Following a decrease, patient numbers have increased well beyond those reported for 2016. Figures highlight a 12 per cent increase in patients treated by the CDS.

![Patient numbers chart](image.png)

*Figure 24: patient numbers for the CDS*

5.14 CDS services in England are subject to the strictures of NHS dental commissioning guides. These guides, when realised in practice are having a twofold negatively stressful impact upon CDS dentists. Firstly, services providing both Paediatric and Special Care dentistry have no guarantees that they will be commissioned to their current level in both specialties hence impacting upon staff numbers. Furthermore, if CDS’ lose less complex patients the workload of the average CDS dentist remaining will inexorably become more complex with them only undertaking Tier two or Specialist treatments. This will then have a multiplying effect on stress and morale levels.

5.15 Whilst we reported earlier that 72 per cent of CDS dentists are at the top of their pay scale and hence require a new post to progress, the vacancies outlined above are not appealing to these dentists as only 8 per cent have relocated for work reasons. Given the absence of any local recruitment premia that can be utilised for SPDCS dentists it seems unlikely that promotional opportunities will remain unappealing to these experienced CDS dentists.

5.16 It is not unsurprising that the factors described above have resulted in pressure being placed on staff.

![Required to work more than contracted hours chart](image.png)

*Figure 25: Requirement to work more than contracted hours*
5.17 The median average of this extra work is approximately 4 hours per week. Given this it is not then surprising that respondents are reporting increased workloads.

5.18 Worryingly the reporting of very high perceptions of workload is mirrored by the reductions in lower perceptions.

5.19 Despite this extra work provided by CDS dentists a significant number of them do not believe they are afforded sufficient time to treat their patients appropriately. Only 61 per cent believe that the default position is that they would generally have enough time to treat their patients.
Given the structural issues identified above it should not be surprising that dentists are now clearly observing a reduction in appointment times. This is particularly problematic given the complex nature of many CDS patients and the attendant time required for their appointments.

Retention in the Public Dental Service in Scotland

Currently, apart from a very small number of practices in Scotland which provide some elements of domiciliary dental care to a small number of nursing homes, specialist care of services for older people in dentistry are provided by the Public Dental Service (PDS). The BDA is concerned how the PDS will meet the growing demands of a frail older population, given the reduction in the number of PDS dentists and clinics across Scotland. This is becoming a growing problem as budgets for PDS services in each NHS Board area are subject to efficiency savings. This, at a time when demand for these services is rising exponentially.

We see this as a critical time for the PDS in Scotland, with changes to the PDS management and recent NHS Board appointments signalling a move away from traditional PDS posts. Many NHS Boards are looking at different management structures and this is a cause for concern.

Many senior dentists who had knowledge and experience of the service are seeking retirement. This is in part due to stress, restructuring of services and the need to be retrained in order to take on new and different roles within the service and to acquire new clinical skills. SPDSC fears that a number of PDS posts are not being ‘replaced on a ‘like for like’ basis. In addition, NHS Boards have been reducing the number of posts in the PDS due to the repatriation of GDS patients to independent GDP clinics with an overall a reduction of 3.6 per cent in posts between 2011/12 to 2015/16\(^\text{18}\).

Forward planning for the future of the PDS is essential to retain a skilled workforce. There is a lack of succession planning and the development of career pathways for Clinical Directors (CDs) with the scope of the posts being diminished. To ensure the standard of the PDS

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service is maintained, it is crucial that future recruitment of CD vacant posts is well planned with proper career pathways in place.

5.25 The complexity of patients treated within the PDS is increasing, 70 per cent of patients suffer from dementia, many of these patients require some form of sedation in order to undergo treatment and therefore a high level of specialisation is required to treat these patients.

5.26 We are concerned that funding continues to be cut, it has not been ring-fenced and there are major impacts on patient care, with fewer dentists, therefore less availability of patient appointments, longer waiting times to see a dentist and fewer service locations due to the rationalisation of the NHS estate. This means more travel time for patients to access PDS services. There is a lack of PDS dentists to meet an unprecedented high demand for unscheduled care at weekends specifically for those looking after frail older patients and those in nursing homes. NHS Boards are using short-term and fixed-term contracts to employ PDS dentists rather than commit resources to any longer term investment in the service. It is essential that salaries for dentists in the PDS are increased.

Impact of morale and motivation on the CDS across the UK

5.27 It should come as no surprise that given the structural pressures of increased patient numbers, reduced staff numbers and unfilled posts that motivation and morale amongst CDS dentists is falling.

5.28 Worryingly our figures show that there appears to be an immediate transfer of respondents from positive to negative categories. Given the constraints that the CDS has operated under for a number of years now it is our contention that for these dentists, there is no desire left to ‘see how things go’ or to express other such neutral views. Rather they are now simply succumbing to the negative.

![Figure 29: Morale levels in CDS](image)

5.29 The impact of this drop in morale and motivation is witnessed by the increasing intent of CDS dentists not to be working in the CDS in the next five years.
According to such projections, the CDS is likely to witness a double whammy of older, experienced clinicians as well as their potential replacements leaving within the foreseeable future.

Last year we reported that a third of CDS respondents were recording negative or very negative responses to questions with a subjective component, arguing that this indicated a fundamental dissatisfaction among many CDS dentists.

However, developments in the past year have resulted in, for the first time in recent submissions, that dissatisfaction regarding pay has not only increased by 9 per cent in the year, but that pay dissatisfaction is now encompassing over half of the CDS workforce.

A key issue in this dissatisfaction is that, as highlighted above, 72 per cent of CDS dentists have reached the top of their pay scale. These dentists have seen their take-home pay eroded as the 2016 award of one per cent consolidated and one per cent for those on the top of their scale concluded in March 2017. For seven months, almost three quarters of the CDS workforce have been earning less than they did in the previous year.

CDS dentists are working more hours than before, they have fewer colleagues with who to liaise or share burdens and patient numbers are increasing. Services are either in stasis or
retreating. CDS dentists no longer wish to be in the CDS. Seventy-five per cent of the workforce do not wish, for whatever reason, to be in the CDS within five years’ time.

5.35 This cannot be an appropriate way to care for the CDS patient group. They deserve a dental service that is attractive to new but talented dentists and rewards existing skilled and conscientious practitioners.

5.36 If the government wishes to invest in a high quality, high skilled dental service for vulnerable patients then it must consider the numbers we have presented. Quite simply, whilst attitudes to work and suchlike remain positive, CDS dentists are not happy. Many are surviving on the goodwill they hold towards their patients. If significant action is taken to address the concerns of CDS dentists the NHS will reap greater rewards from this goodwill. If action is delayed or not forthcoming the goodwill will ultimately evaporate and the CDS will become a forgotten outpost of the NHS.

Local recruitment premia in SPDCS contract

5.37 In the Review Body’s response to last year’s submission mention was made of the utilisation of local recruitment premia. These do not appear within the SPDCS contract and we would welcome the Body initiating some discussion on whether these could be developed to ensure that vulnerable patients in under-resourced (in terms of clinicians) areas receive equally high treatment levels.
Clinical academic staff

6.1 Although clinical academics are outside the formal remit of the Review Body their impact upon dental careers is significant. We discuss in detail below the recruitment and retention challenges of the academic workforce and how this may impact upon the delivery of high quality dental education and research for the two main remit groups.

6.2 For clinical academic staff, staffing levels among this group have a profound influence on the quality of the education received by dental undergraduate students and so impact the recruitment of young people into the profession. Clinical academic staff play an essential role within dental schools and perform high quality teaching and research, with clinical skills which should be rewarded. It is vital to ensure a steady intake and progression of clinical academics to maintain high standards of research and teaching.

<table>
<thead>
<tr>
<th></th>
<th>FTE clinical academic dentists</th>
<th>FTE vacancies</th>
<th>Total available posts</th>
<th>Vacancies as a percentage of total FTE posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor</td>
<td>111.6</td>
<td>5.0</td>
<td>116.6</td>
<td>4.3%</td>
</tr>
<tr>
<td>Reader/Senior Lecturer</td>
<td>130.5</td>
<td>14.6</td>
<td>145.1</td>
<td>10.1%</td>
</tr>
<tr>
<td>Lecturer</td>
<td>108.0</td>
<td>6.5</td>
<td>114.5</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Total (P+SL+L)</strong></td>
<td><strong>350.1</strong></td>
<td><strong>26.1</strong></td>
<td><strong>376.2</strong></td>
<td><strong>6.9%</strong></td>
</tr>
<tr>
<td>Senior Clinical Teacher</td>
<td>68.0</td>
<td>3.4</td>
<td>71.4</td>
<td>4.8%</td>
</tr>
<tr>
<td>Clinical Teacher</td>
<td>156.5</td>
<td>3.7</td>
<td>160.2</td>
<td>2.3%</td>
</tr>
<tr>
<td>Clinical Researcher</td>
<td>20.1</td>
<td>0.0</td>
<td>20.1</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total (SCT+CT+R)</strong></td>
<td><strong>244.6</strong></td>
<td><strong>7.1</strong></td>
<td><strong>251.7</strong></td>
<td><strong>2.8%</strong></td>
</tr>
<tr>
<td><strong>Grand Total (all grades)</strong></td>
<td><strong>594.7</strong></td>
<td><strong>33.2</strong></td>
<td><strong>627.9</strong></td>
<td><strong>5.3%</strong></td>
</tr>
</tbody>
</table>

*Figure 32: Vacant post by Academic grade*¹⁹

Recruitment of Clinical Academic Staff

6.3 The Dental Schools Council’s (DSC) Survey of Dental Clinical Academic Staffing levels 2017 shows there are significant vacancies throughout clinical academia. Figure 32 highlights an overall vacancy level of 5.3%. However, within this there is the much more significant vacancy rate of 10.1% among Senior Clinical Lecturers and Readers. It is this group of staff that provide the link between research, teaching and clinical practice. They are fundamentally necessary to the quality of current undergraduate education.

6.4 Vacancy rates at Senior Clinical lecturer/reader level have been above 10% for the past three years suggesting an ongoing recruitment problem for Higher Education Institutes (HEI).

6.5 Problems in Specialty specific recruitment has also become a problem for a number of HEI’s with 12 HEI’s reporting to the Dental Schools Council that they had experienced difficulty recruiting in specific specialities.

¹⁹ Source Dental Schools Council, Survey of Dental Clinical Academic Staffing Levels 2017, July 2017, pg 15
6.6 The apparent permanence of recruitment issues at Senior Clinical Lecturer/Reader level is clearly likely to have a negative impact upon the working lives of those who remain in post.

6.7 Given the pressure that they are under it is reasonable that clinical academics may seek an alternative career in a substantive NHS post for which, they must, by dint of their honorary status, be eligible. Such substantive NHS posts offer a clarity of purpose from only having clinical work, where as in Dental Schools an academic has to actively manage their clinical career with their academic commitments.

Retention of Clinical Academic Staff

6.8 A recent development that may contribute to retention problems within clinical academia is pension arrangements. The University Superannuation Scheme (USS) pension, the pension offered by Universities, is currently comparable to the NHS pension scheme; however the 2017 USS Actuarial Valuation is proposing changes that will close the Defined Benefit section of the scheme and therefore make the scheme less attractive in relation to the NHS scheme, which continues to be purely Defined Benefit.

6.9 It would therefore not be surprising to witness this adding to the attraction of substantive NHS posts in the eyes of clinical academics and thus exacerbating problems in Clinical Academia.

Clinical Academic Staff in Scotland

6.10 We have raised concerns with Scottish Government about the shortage in some NHS Board areas of Consultant specialists over the last 10 years in all clinical specialties. Academic dentistry lacks a clear route of entry and a transparent career structure, and it is not clear to students who graduate how they might access an academic pathway. Some clinical teaching posts no longer carry a research remit.

6.11 Over the last two years, there has been a high level of vacant posts in the three Scottish dental schools and hospitals and the Edinburgh Dental Institute, which offers postgraduate study opportunities. There has been great difficulty in filling these posts, and a number of the consultant posts were re-advertised at a lower grade because the posts were not being filled on a ‘like for like’ basis and academics were not being attracted to these posts.

6.12 In the last two years, there have been 24 such posts which have been difficult to fill for the reasons noted above. It is recognised that within specialties, the overall small number of posts makes them more vulnerable to staff shortages, and with a fluctuating workforce this makes it difficult to manage and plan for the future.

6.13 We believe these shortages are a major concern for workforce planning, training and recruitment leading to delays in treatment and an increase in waiting list pressures and we urge the Scottish Government to take action. A strong academic presence is important to the continuing high standard of education and development of new technologies and techniques, we are alarmed that some specialties are understaffed and that universities are facing difficulties in recruiting.

6.14 We highlighted to Scottish Government in November 2016 that there was an issue around the recruitment of oral medicine specialists. Subsequently, Scottish Government asked NHS National Services Scotland to undertake a National Review of Oral Medicine Services in Scotland to explore the contextual background for the review, the current situation regarding clinical provision for oral medicine, the various models for service provision across Scotland and the possible impact on education and training (undergraduate and postgraduate) in oral medicine for any changes that the group may identify. The first
meeting of the review group was not held until August 2017. BDA Scotland will be keeping a watching brief on the progress of the review and are keen to highlight this issue to the DDRB this year.

Conclusion

6.15 Parity with substantive NHS colleagues is particularly important for clinical academia because of the specific demands a career in clinical academia requires. Quite simply, whilst clinical academic staff have the qualification and experience to take up full-time substantive NHS posts, the same cannot be said for substantive NHS colleagues. Without a higher degree and a research background, substantive NHS dentists cannot pursue a career in clinical academia. Resultantly therefore, the only workforce available to clinical academia is that which it already has, and that which it is currently training.

6.16 As described above, filling vacant posts remains challenging to HEI’s. Pursuing a career in clinical academia already extracts a financial toll on the individuals concerned, their time spent studying for a PhD will be less well remunerated than if they were in substantive practice. It is therefore imperative, that at the end of academic training clinical academics are able to obtain the same rewards as substantive NHS colleagues. Without this, a career in clinical academic would be financially untenable for most.
Dental Careers

England and Wales

7.1 The Review Body was keen to understand the recruitment and retention changes being undertaken on the horizon “in terms of generalists versus specialists; the meaning of consultant-led/delivered; the role of skill mix; and new roles; the potentially changing nature of the workforce; how they choose to work; and how medical and dental roles will fit within the future models of healthcare delivery. The pay and reward levers available need to be flexible enough to maintain recruitment, retention and motivation in reacting to the changes in both healthcare delivery and the nature of the workforce.” The following paragraphs highlight changes on the short, medium and long-term horizon for England. Some of the discussions on the changing nature of the workforce will be found in chapter 8 on millennials.

7.2 There is some work being undertaken in England which will impact upon recruitment and retention and the specialist skills of dentists. Tier two accreditation, builds on the work of the dental specialty commissioning guides which indicated that primary care dentists would either be working at a treatment complexity level one, two or three. Those working at tier two would be accredited and would provide NHS care on referral. This would be within a managed clinical network led by a Consultant or specialist. Accreditation systems are currently being developed by NHS England and are newly released for Oral Surgery and Endodontics. Work is underway for special care dentistry, paediatrics, orthodontics and periodontics.

7.3 Our survey of associates found that 39 per cent of associates with more than a 75 per cent commitment to the NHS were intending to increase their specialist skills. Given that there will never be enough NHS orthodontic or other specialist agreements available to engage all of these dentists, those who do obtain specialist qualifications or accreditation will have to seek opportunities in private practice or not be able to use their specialist skills, thus leading to lower morale and professional disenchantment.

Career progression

7.4 Moreover, those who are able to buy a practice find a business environment that is increasingly challenging. As the Institute for Employment Studies found, practice-owners report that their time is increasingly consumed by financial management, financing practice mergers, staff recruitment, dealing with employment legislation, IT, purchasing, regulatory compliance and other complex practice management. As one respondent explained: “The practice used to almost manage itself but now you need to look at the costs and the details every week, be more business minded.”

7.5 This presents an obvious risk to the morale and motivation of the profession when dentists enter expecting the opportunity to progress, invest in developing their skills and receive commensurate remuneration, and to have the chance to become business owners, but find the reality of their career in dentistry is very different. It is not surprising then that we have observed a fall in the proportion of associates who ‘agree’ or ‘strongly agree’ that there are opportunities for them to progress in their career compared with the previous year; down from 54 per cent in our 2016 survey to 48 per cent in 2017, and among those with the greatest NHS commitment it has fallen from 50 per cent to 41 per cent. For practice owners, asked the same question, only 37 per cent of those with the highest NHS commitment were in agreement with the statement, down from 55 per cent last year. It is also a cause for concern that among early career associates (aged 25-44), we found the

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proportion agreeing or strongly agreeing that there are opportunities to progress in their career to be only half of respondents.

There are opportunities for me to progress in my career - Percentage ‘Strongly agree’ or ‘Agree’

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>England</th>
<th>NI</th>
<th>Scotland</th>
<th>Wales</th>
<th>NHS &gt;75%</th>
<th>NHS &lt;75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associates</td>
<td>48</td>
<td>46</td>
<td>48</td>
<td>63</td>
<td>51</td>
<td>41</td>
<td>60</td>
</tr>
<tr>
<td>Practice owners</td>
<td>51</td>
<td>54</td>
<td>41</td>
<td>33</td>
<td>41</td>
<td>37</td>
<td>60</td>
</tr>
</tbody>
</table>

Figure 3. BDA Associates Survey and Practice Owners Survey 2017

7.6 For those with the highest NHS commitment to feel they have the fewest opportunities for career progression is a sad reflection on the NHS.
Millennials (or Generation Y) and the developing and changing workforce

8.1 In its 45th report, the DDRB discussed the workforce patterns and trends associated with the cohort of millennials that now account for a substantial proportion of the remit group. It stated that “millennials tend to have a different approach to their careers from their predecessors, valuing, in particular, aspects such as work-life balance, flexibility and variety in the workplace”\(^21\).

8.2 The millennial cohort, now aged between 17 and 37 years old, are reported to be experiencing a particularly difficult time as they enter, and establish themselves in, the labour market and there are factors unique to dentistry that have created particular challenges for this generation of dentists.

8.3 One factor that marks ‘Generation Y’ from its predecessors is the enormous debt with which it has graduated from university, and, with higher tuition fees, this will only be a greater issue for those millennials entering dental school this autumn. The BDA estimates that dental students in England starting their course in 2017/18 could graduate with £76,055 of debt. In this context, we have been deeply concerned by the impact of the removal of the NHS bursary for nursing, midwifery and allied health professionals and continue to watch with concern the situation for the NHS bursary for doctors and dentists. Not only would its removal affect recruitment to dental school, it would also considerably increase the indebtedness of dental students.

8.4 This debt burden, combined with work that is less remunerative, more time-consuming and time-pressured, and with expenses that increase considerably year-on-year, is perceived to pose a threat to the traditional general practice career by making it less attractive to younger dentists\(^22\). It is no wonder that in this context we have seen such a dramatic decline in the proportion of GDPs that have been able to become practice-owners.

8.5 There is a clear need for robust, dental-specific evidence to underpin long-term workforce planning. This must be able to address current issues as well as anticipating future challenges that may arise as dentistry continues to change, oral health needs alter, and ‘Generation Z’ enters the workforce and the demographics of the dental profession are further transformed. The ability of HEE to provide this strategic workforce planning function has been questioned by the House of Lords’ Select Committee on NHS Sustainability\(^23\) and there is a pressing need for this to be addressed.

Millennials in the workforce

8.6 The 45th report references the characteristics of Millennials in the workplace as outlined by a 2012 PWC report; that they seek rapid progression and career variety, have a higher rate of movement between jobs, prioritise work-life balance and flexibility, have a desire to feel valued at work and attach value to learning and development over financial benefit. Notably, Millennials are said to value opportunities for career progression more than pay when seeking employment. The report also states that the work/life balance sought by this generation is not materialising.

\(^{22}\) ‘Review of DDRB Pay Comparability Methodology: Final report’, Brown, Rickard and Bevan, 2017
\(^{23}\) ‘The Long-term Sustainability of the NHS and Adult Social Care’, House of Lords’ Select Committee on the Long-term Sustainability of the NHS, 2017
8.7 Since this research was undertaken, Ipsos Mori has published a comprehensive comparative study into the behaviour, aspirations and experiences of millennials. In contrast to the PWC report, this research is strengthened by providing comparisons between Generation Y and previous generations, and by drawing a distinction between research conducted in the UK and comparable Western countries and that from emerging economies.

8.8 With regards to the workplace, the Ipsos Mori report identifies that common assumptions about Millennials, such as them holding a completely distinct set of expectations as employees, having an increased likelihood to move quickly from job to job or being less motivated to work, are probably overstated. In general, the report finds that “Millennials aren’t so different after all” to other generations of workers.

8.9 In our analysis of our survey of associates and examination of other research, we have sought, where possible, to test whether the assertions made about Millennials are applicable to the dental workforce.

8.10 The dental profession has also seen a significant change in demographics, with considerably more women and ethnic minorities entering dentistry. In particular, the 45th report identifies that women dentists are likely to earn less and are less likely to be provider-performers.

**Practice ownership**

8.11 The 45th report identified the shift towards ‘performer-only’ dentists, who now dominate the dental workforce, as reflective of the increased importance placed on flexibility and work-life balance among generation Y, who do not want the commitment and responsibility associated with becoming a practice-owner. While it may be that changing career aspirations partially explain the trend away from practice-ownership, it is more likely that structural factors within the dental market, not least corporatisation, play a more considerable role. The growing gap between the value of dental practices and the earnings of associates is also a significant factor.

8.12 It is worth noting that dental students remain interested in becoming practice-owners during their careers; with research among University of Bristol dental undergraduates finding that 72 percent aspire to become a partner after gaining experience as an associate and seven per cent hoping to find an opportunity for partnership immediately after graduation. This creates a risk that dental graduates will enter the workforce with unrealistic expectations about the opportunities available to them to buy a practice and that this will have a damaging impact on professional satisfaction and morale. This is particularly acute as NHS Digital data continues to show however that the number of practice owners has dropped 42 per cent since 2008 and the number of associates steadily rises (26 per cent) to 2014/15.

“If I attempt to become a practice owner it’s a sellers’ market, can’t afford a practice.” BDA associate member responding to the BDA Associates survey 2017.

24 ‘Millennial: Myths and realities’, Ipsos Mori, 2017
25 Ibid, p.65
26 DDRB, 2012, Forty-fifth Report
8.13 Our survey of associates found that 13 per cent of associates were planning to purchase a practice in the next five years and among younger associates the percentage was higher; with 18 per cent of 25-34 year olds and 23 per cent of 35-44 year olds intending to buy a practice.

8.14 Of the associate respondents to our survey, 0.3 per cent of those aged 25-34 years old had ever owned a dental practice and for those aged 35-44 it was fewer than one in ten. By contrast, two-thirds (67 per cent) of those aged 55-64 had previously owned a practice. This potentially points to the difficulties younger dentists find in becoming practice-owners, but more importantly demonstrates that associates are not a homogenous group. Those older associates who had previously owned a practice will clearly have different circumstances, motivations and aspirations to younger dentists who have always worked as associates.

8.15 Two-fifths of the respondents to our survey of associates reported that they worked for a multi-site dental provider (dental corporate). Perhaps surprisingly, the age group most likely to work for a corporate were those aged 55-64 years old, with nearly half (49 per cent) stating they currently work for a multi-site provider. For those aged 25-54 years old, the percentage working for corporates is broadly around 40 per cent. This is indicative of the significant role dental corporates now play in the dental workforce.

8.16 It has been noted that there are gender differences among dentists in terms of both pay and the propensity to be practice owners, and it is likely that the former is influenced by the latter. Our research on the career intentions of associates indicates that the gender disparity among practice owners is set to persist. While nine per cent of female associates stated that they planned to buy a practice in the next five years, among male associates 18 per cent had the same career plans to become practice-owners. However, it is not clear from this evidence what the causes of this gender difference are.

8.17 With regards to pay, we believe that an analysis of hourly pay, rather than taxable income, by gender would better allow for a distinction to be made between inequalities resulting from structural workforce factors and those caused by unequal pay for unequal work.

Recruitment and retention

8.18 The risks set out above, combined with other factors, demonstrate that dentistry is not perceived as an attractive profession to join or remain within.

8.19 As part of the view that millennials are more focused on achieving a good work-life balance, it is often asserted that they are more likely to seek to work part-time. Surveys of dental students about their career intentions demonstrate that a significant proportion do envisage working part-time in the future. There is also evidence that a motivating factor for entering the dental profession is, compared with medical careers, the relative flexibility of working hours.

8.20 Our survey of associates found that a significant proportion across all age groups were looking to reduce their hours. While it is perhaps to be expected that nearly a third of those approaching retirement would be looking to reduce the hours they work, it is notable that 30 per cent of 25-34 year olds plan to reduce their working hours in the next five years and a fifth of those aged 35-44 plan to do the same. That dentists would seek to work fewer hours is unsurprising given that NHS Digital analysis has shown that it is correlated with higher reported levels of motivation.

8.21 This has clear consequences for the capacity of the dental workforce, with headcount figures not presenting an accurate picture of this situation. A consideration of the number of FTE dentists is therefore needed to ensure robust workforce planning. The BDA has received anecdotal reports that the desire for part-time work among younger associates has created recruitment problems for practices in finding dentists willing to work full-time. More generally, that dentists feel motivated about their work when working fewer hours, despite the impact on their income, is indicative of a troubled profession and raises questions about the sustainability of the supply of dentists.

**Impact of low morale and motivation**

8.22 One characteristic often attributed to millennials is that, when compared to previous generations, they are less enthusiastic about and committed to their work. Millennials are said to ‘live for the weekend’ and desire a good work-life balance.

8.23 However of real significance is that level of NHS/HS commitment, not the millennial age range is an indicator of levels of morale and motivation. Our survey shows that the higher the NHS/HS commitment the lower the levels of morale and motivation and enthusiasm about work in the dental profession.

8.24 In our survey, we asked practice owners and associates about the extent to which they look forward to going to work, feel enthusiastic about their work and whether time passes quickly while they are at work. The responses to these statements do not indicate a consistent pattern whereby those within the millennial cohort are less enthusiastic about work than older dentists. For example, 54 per cent of those associates aged 25-34 years old said they ‘always’ or ‘often’ felt enthusiastic about their work compared to 43 per cent of those aged 35-44 years old and 51 per cent of those aged 45-54 years old.

8.25 Far more significant than age is the difference based on the level of NHS commitment, with those with the greatest NHS commitment consistently less positive about their work. Less than a third (31 per cent) of associates with an NHS commitment of 75 per cent or above said that they ‘always’ or ‘often’ look forward to going to work compared to nearly half (49 per cent) of those with a lesser NHS commitment. Similarly, only two-fifths of those with the greatest NHS commitment said they were ‘always’ or ‘often’ enthusiastic about their work, while 62 per cent said the same among those who spend less time working on the NHS.

8.26 Similarly, age for practice owners does not show much of significance but NHS commitment does. Those who look forward to going to work and therefore have higher levels of enthusiasm are those who have less than 75 per cent NHS commitment.

8.27 Moreover, a review of relevant research shows that the aspiration for a work-life balance is common across generations of dentists, with individuals originally attracted to the profession because it offers opportunities to work flexibly and to avoid working evenings and weekends.
The future impact of Brexit

9.1 The future after Brexit is of course unknown. In the 45th Report the Review Body asked that “We require more evidence on dentists’ motivation in order to reconcile these differing pictures, including consideration of the impact of Brexit on staff from overseas, when this is available.” Our evidence has already covered motivation of the profession in detail but for this particular chapter we offer more in-depth evidence specifically relating to the movement of dentists to and from the EEA. Depending on the outcomes of negotiations, there is a risk that Brexit will contribute to the existing skills shortages within dentistry and diminish the flexibility to respond to workforce shortages.

9.2 As we discuss in more detail under the Scottish expenses evidence, the devaluation of the pound and the effects of Brexit have seen the cost of materials and equipment in dental practices increasing. Most dental materials are imported to the UK causing this increase and this is directly attributable to the UK’s exit from the European Union.

Northern Ireland

9.3 As the only UK country with a land border with the EU, Brexit poses a unique set of challenges for Northern Ireland, due to potential shifts in migration and trade, funding for research, cross-border health schemes and workers. Already, dentists’ purchasing power in importing essential goods and supplies from outside of the UK has been seriously diminished due to the fall of sterling in the period following the EU referendum result. The impact of Brexit from a monetary point of view should be factored in to the increasingly challenging environment in which dentists are operating.

9.4 As EU citizens, people from Northern Ireland and the Republic of Ireland can move freely across the border, and have the right to live and work on both sides of the border. Anecdotal evidence suggests that there is fluidity between the jurisdictions with regards to the dental workforce and we are aware that there are dentists and dental care professionals who live in the Republic of Ireland and work in Northern Ireland. These dentists work in all spheres of practice and some will own general dental practices.

9.5 Workforce data is urgently required to establish the extent of fluidity and composition of the cross border dental workforce as this has potential implications on workforce supply and patient care. It is also important to establish with accuracy, how reliant Northern Ireland is on dentists and dental care professionals from the Republic of Ireland and other parts of the EU. There will also be dentists and DCPs training in the Republic of Ireland who will want to work in Northern Ireland and the loss of mutual recognition of qualifications could again affect workforce supply. Anecdotal evidence also suggests that there are dental nurses who live and work in both Northern Ireland and Republic of Ireland.

9.6 The BDA is undertaking research into the above workforce issues in Northern Ireland.

Recruitment

9.7 Given that we do not know what protections will be afforded EU nationals coming to work in the UK, possible recruitment of dentists is difficult to predict. However 16 per cent of registered dentists in the UK qualified in an EEA country and these dentists are a significant proportion of the dental workforce. The low value of the pound against the Euro will make it less attractive for these dentists to work in the UK.

9.8 It remains unclear whether the mutual recognition of qualifications will continue in future and this could have a significant influence on the ease with which EEA qualified dentists are able to work in the UK. Additionally, EEA qualified dentists may be required to undertake
‘Performance List Validation by Experience’ in order to work on the NHS, as is currently the case for dentists from outside the EEA. There are naturally limited opportunity for this training and it can be costly to the individual dentist.

**Retention**

9.9 Analysis of the GDC register has demonstrated that those entering the register from the European Economic Area (EEA) remain registered for shorter periods of time than those entering the register via other routes. There is a risk that more onerous migration requirements for EEA citizens seeking to work in the UK would restrict the ability of EEA dentists to contribute to the UK dental workforce for relatively short periods before returning home. This will clearly have consequences for workforce supply, particularly the flexibility to meet short-term workforce shortages.

9.10 It is notable that dentists who qualified in the EEA are far more likely to be considering leaving the UK to work overseas than both UK qualified dentists and those who qualified elsewhere. Nearly a quarter (23 per cent) of EEA qualified associates were thinking of leaving the UK, compared to only four per cent of UK qualified associates and eight per cent of those who qualified in another country. Similarly, among EEA qualified practice owners 10 per cent were considering moving overseas to work, whereas only one per cent of UK qualified practice owners were thinking of doing the same.

9.11 EEA qualified dentists also feel markedly less secure in their jobs. The difference is particularly pronounced among practice owners, where nearly two-thirds of those who qualified in the UK feel secure in their job compared to less than two-fifths of EEA qualified practice owners. A stark, but slightly less marked, difference is also evident among associates. It is also worth noting that, among dentists who obtained their qualification outside the EEA, associates are more likely to feel they have job security than those who are practice owners.

**I feel secure in my job- Percentage ‘Strongly agree’ or ‘Agree’**

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<td>Practice owners</td>
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*Figure 34: BDA Associates Survey and Practice Owners Survey 2017*
Our recommendations

For all dentists we recommend an inflation increase (RPI) plus 2 per cent.

General Practice

10.1. Given the evidence we have already presented, we believe there is a real case for general dental practitioners receiving a pay uplift to stem the tide of repeated reductions in real earnings. This will help to prevent pay falling further behind and help retain general practitioners within the service.

10.2. We would like to see the re-introduction of NHS commitment payments in all four countries which would particularly help NHS associates, who generally have a higher NHS commitment than practice owners and form the vast majority of the workforce.

10.3. Indemnity costs are rising particularly in England and Wales. These costs are paid by dentists personally and increases the disincentive to perform NHS work. Indemnity providers also normally offer part-time rates which can make it worthwhile reducing working hours or partially retiring. As with general medical practitioners we believe there is a case for the NHS paying the cost of rises in indemnity fees to encourage retention.

Community dentistry

10.4. Our evidence demonstrates a recruitment issue with the community dental service. Dentists within the service have felt the effects of pay restraint as have the rest of the NHS workforce. The demands of the job are increasing with the service concentrating on patients with more complex needs. For these reasons we recommend an above inflation pay increase for community dentists.

10.5. We would welcome the Review Body initiating some discussion on whether recruitment premia could be developed to ensure that vulnerable patients in under-resourced (in terms of clinicians) areas receive equally high treatment levels.
ANNEX A – Expenses evidence

The following expenses evidence is specific to Scotland however much of the costs can be applicable to all four UK nations.

Scottish general dental practice expenses evidence

Independent GDPs

1. In the 45th Report 2017 Scotland Supplement, the DDRB recommended an increase in pay, net of expenses of one per cent for 2017-18. The DDRB also noted that there had been discussions between BDA Scotland and Scottish Government on expenses, but that it was clear it would be very difficult to come to a bilateral agreement. Officials felt that the sample of new evidence on dental practice accounts provided by the Scottish Government, was not statistically representative, but considered that it could usefully serve to give context and further concrete information about expenses.

2. Further to negotiations between BDA Scotland and Scottish Government where BDA Scotland provided a breakdown of expenses totalling £23.1 million, Scottish Government announced a 2.25 per cent increase in item of service fees and capitation and continuing care payments. The award was made in October 2017 and backdated to 1 April 2017.

Dental Practitioner Accounts Information

3. BDA Scotland noted that the new evidence/data provided by Scottish Government in 2017-18 on dental practice accounts was not comprehensive and very limited in comparison to, for example, HMRC data on dental earnings.

4. The DDRB commented that their preferred approach was for the parties (BDA Scotland and Scottish Government) to negotiate directly on expenses. To that end, BDA Scotland has held initial discussions with the Scottish Government and will be holding further meetings to negotiate on expenses.

The growing costs for practices of complying with regulatory requirements and guidance in Scotland

5. There are increasing demands on practices to comply with a range of regulatory and guidance changes, some of which are specific to Scotland.

6. Quality of Care provision is essential for GDPs and their staff. The quality of service is not only about providing a product and standard of care, it is essential that Scottish Government provides continued investment for maintenance and upkeep of local decontamination units, maintenance and provision of IT equipment and provision of occupational health services for dentists and their staff including counselling and other forms of mental health support especially in a time of rising stress.

7. The BDA Scottish Dental Practice Committee (SDPC) is concerned that young dentists are leaving Scotland to work abroad, some on a long term basis. This view was confirmed at the Conference of Scottish Local Dental Committees on 21 April 2017 by a young VDP who expressed her concern about the future of the profession.
Brexit

8. The devaluation of the pound and the effects of Brexit have seen the cost of materials and equipment in dental practices increasing. Quality of treatment can be improved by increasing fees and taking account of material and equipment costs. It is estimated that the current cost of materials is £40,000 per annum with the addition of £5,000 per annum (due to the devaluation of the pound), this gives a total of £4.5m per annum.

Emergency drug kits

9. New guidance was issued by The British National Formulary and as a consequence there is a change in how Midazolam oromucosal solution can be used in an emergency situation. The profession is bound by these guidelines. The cost of purchasing emergency drug kits has risen by 300 per cent. It is estimated that the cost of providing emergency drug kits/life support is in the region of £600,000 per annum.

e-Dentistry

10. Changes in the Practitioner Services Division IT systems by 2018 to meet the Scottish Government e-Dentistry timetable mean that all practices in Scotland will require to operate on the e-Dental platform in order to receive their schedules, receive payments and apply for prior approval. This will require additional funding to enable electronic security fobs for home access to the PSD database circa over £100. The cost for software support and cyber security to allow dentists to operate on the e-Dental platform is dependent on the number of surgeries per practice, the cost is estimated to be approximately £3,000 per annum per practice making a total of £2.7m per year.

Minamata Treaty on Mercury

11. The phase down of amalgam will have an effect on the treatment of children under 16 years, pregnant and breastfeeding mothers for amalgam restorations and the alternative use of composite restorations.

12. Based on the number of fillings carried out in 2016/17 on children and pregnant and breastfeeding mothers, the additional cost is the differential between the amalgam filling and the composite filling, the costs would also have to take into account the additional time required per case for a composite filling to be completed. The question is, what are the real costs to a practice of shifting from amalgam fillings to composite fillings / glass ionomer?

- Amalgam one surface IOS fee £9.45
- Composite filling one filling IOS fee £17.85
- Glass ionomer for one filling IOS £16.20

Combined practice inspection

13. The introduction of a revised Combined Practice Inspection Checklist on 1 January 2017 which was approved by the Chief Dental Officer’s Quality Improvement Strategy Group has resulted in an increase in costs for dentists across Scotland as this now includes revalidation of autoclaves. Costs for this have been factored in paragraph 11.25.

14. As part of the quality of care provision, GDPs are at present reimbursed for fifteen Continuing Professional Development sessions and BDA Scotland proposes the number of reimbursed sessions be increased to 20 hours in line with the GDC Guidelines.
15. Many of the initiatives mentioned above consume clinical time, reducing fee earning capacity within a practice, whilst simultaneously generating additional costs.

The Remuneration System in Scotland

16. NHS Scotland continues to operate on the basis of item of service fees (IOS) whereby practitioners are remunerated for treatment provided, through the Statement of Dental remuneration (SDR). Scottish Government has acknowledged in their consultation paper ‘Scotland’s Oral Health Plan’ published September 2016, the need “to review the items of treatment within the SDR to ensure they are up to date and fit for purpose”. Some of the fees paid for these items of services are so low that practices in some cases are required to subsidise NHS treatment, examples include the costs of a patient check-up “clinical examination and report” the gross fee for dentists is £8.90, the gross fee for an extraction of one tooth is £8.75 and the gross fee for the provision of chrome cobalt dentures is £169.35 per denture. For items such as dentures, the laboratory costs to the practice can be in excess of the fee income, leaving the practice in financial deficit. For items such as extractions and check-ups, the gross fee paid under the current SDR, to the dentist does not adequately reflect the dentist’s time, the nurse time, the practice overheads including the lease or purchase of expensive equipment in addition to decontamination costs, consumables costs, other staff costs such as a pension contributions, national insurance contributions and other employer’s costs although, the Scottish Government has reported in their Analysis of Responses to their consultation paper published June 2017, there was a general recognition that the current system of IOS payment needed to be reformed, but not replaced with a completely new system of payment. There is to date, no commitment to increase IOS fees for dentists to properly reflect the rising costs of providing NHS services to patients. The final Oral Health Improvement Plan is due for publication at the end of 2017, therefore it is difficult to gauge what the future proposal and changes will be.

Occupational health costs

17. There is an additional financial burden of occupational health costs in Scotland. Occupational Health Services (OHS) certification is required for practices, including, HEP C for all associates, HIV certification for all associates, TB status for all clinical staff and Mantoux testing for all those clinical staff who had not had their BCG. This includes payment for dental nurses’ testing. A list of costs incurred as at October 2017:

- PVG application per person: £59.00
- HIV blood test: £32.30
- Hep B antibody test: £32.30
- Hep C antibody test: £45.45
- BCG: scar check: £19.15
- Mantoux test: £47.40
- BCG vaccination: £32.10
- Hep B vaccination: £34.20
- Staff counselling sessions for staff suffering from work related stress £50 per hour (private providers cannot be accessed within the NHS).

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18. It is difficult to know how we might cost this, it would be useful to know what frequency these tests have to be carried out and the sort of staff turnover rates especially at the lower grades.

19. Published data acknowledges that GDPs are on the frontline of clinical risk every day of their working lives through the wide range of clinical procedures which they perform on patients, despite that risk, GDPs are denied access to local NHS funded OHS. It is noted that all GMPs, and indeed the wider primary care teams in general practices throughout Scotland have free access to OHS services provided locally by NHS Boards. The Cabinet Secretary for Health and Wellbeing announced at the BMA Scottish Local Medical Conference in March 2016 that a further additional £2m over a two year period would be invested in OHS for primary care practitioners which clearly excluded GDPs.

20. The BDA believes that this is an iniquitous position, and that the whole issue of clinical risk, the safety of patients and the safety and wellbeing of GDPs is not being addressed by current government policy. We asked Scottish Government in July 2017 to formally consider investing in this essential and critically important service for GDPs in Scotland. The Chief Dental Officer confirmed in August 2017 that her team is addressing the request made by SDPC for funding for GDPs for OHS as provided for GMPs.

21. We suggest that since there are approximately the same numbers of GMPs as GDPs in Scotland, around 900, the costs would be roughly comparable. SDPC estimates that £1m should be allocated for OHS for GDPs.

The costs of PVG Clearance in Scotland

22. All clinical staff must have Protecting Vulnerable Groups (PVG) clearance. Previously, all dentists had to have Disclosure but that has been superseded by PVG and all clinical staff now need to have PVG clearance for the purposes of the Combined Practice Inspection. The costs for PVG clearance are currently £82.99 per member of staff which includes £59 for the fee and an additional £23.99 to cover the administration costs.

Replacement costs of local decontamination units (LDUs)

23. A key issue for practitioners is the expensive capital outlays for the replacement and ongoing revenue costs to maintain decontamination equipment, which meet the current standards and ensure all practitioners meet the patient safety guidelines. There is a lack of guidance and advice on cost profile, reliability, repair, breakdown rates and the cost of service contracts.

24. This is a key cost for practices as the equipment installed pre-2009 will in many instances have reached the end of its lifecycle and will require to be replaced. The replacement of decontamination equipment will include washer disinfectors, autoclaves, hand pieces, scalers and instruments and trays. This will require significant capital investment in addition to the manpower and day to day running costs to maintain decontamination standards.

25. In order to maintain the current standards, a BDA SDPC Working Group sought to breakdown the actual costs of replacing and maintaining equipment using real cost data provided by the procurement lead at National Services Scotland. The proposal that Scottish Government should introduce a Decontamination Allowance and the financial basis for that allowance is based on assuming a three-surgery practice and costing provided by NSS at 2016-17 prices:

- Washer disinfector; 5 year lifecycle, purchase cost £12,800 - £14,775 assuming three surgeries then 2 washer disinfectors would be required.
• Autoclave: 5-year lifecycle purchase cost £10,000 - £16,000. A practice would really require two autoclaves with one as a backup and for three or more surgeries a backup autoclave would be essential.

• Kavo handpick leasing; £12 ppm – to include 6 high speed and 6 slow speed hand pieces (fibre optic). Is this the lease cost over 5 year cost £8640

• Scalers: 6 scaler bodies plus tips, approx. cost £1000 per annum or per five year period.

• Instruments and trays: £100 per kit of which you would need 15 per surgery. 3 surgery cost approx. £4500 per annum or per five year period.

26. This does not allow for extraction equipment, straight handpicks for extractions and denture, manufacture of Reverse Osmosis (RO) water or distilled water for autoclave, testing equipment and materials, detergent solution for washer disinfector.

27. Based on this, the 5 year cost for an LDU and for decontamination allowance purposes would be in the region of £47,000 - £50,000 (assuming a 3 surgery practice with two autoclaves), which would equate to an annual allowance to practices of £10,000.

28. This figure would be a starting point for discussion of an annual allowance. The expectation is that these machines last 5 years and are required to be renewed and this is reflected in the £10,000 pa cost (+ VAT). This is based on a three-surgery practice, where it is anticipated that two autoclaves are required since it is unlikely a practice can function with one.

29. The Working Group estimated that the overall figure for decontamination for dentistry is £9 million per annum.

Auto enrolment

30. The cost of auto enrolment in a workplace pension scheme places a further additional burden of cost on Scottish practice owners already struggling with lower turnover and lower profit thresholds. The additional costs will require dental practice owners, with effect from 1st October 2015 or the appropriate staging date, to provide an additional one per cent of the qualifying earnings, rising to two per cent on 1st October 2017 and a further increase to three per cent on 1st October 2018.

31. BDA Scotland suggests that an additional 1.5 per cent is required on wages and based on the calculation of a three surgery practice, working a 35 hour week with approximately five employees, and based on 900 practices in Scotland therefore BDA Scotland estimates an annual cost of £2 million.

Cost of Mandatory Training

32. There was an amendment to the NHS (General Dental Services) (Scotland) Amendment Regulations 2010, which came into effect on 1st April 2016, to introduce a requirement for mandatory training for those applying to join the dental list in Scotland for the first time, those returning to clinical practice within 5 years, and those returning after 5 years or more. A new Regulation 5A (mandatory training) has been inserted into the 2010 Regulations in 2017 to clarify which dentists require to undertake mandatory training which includes those applying to list as assistants.
NHS Education for Scotland has been asked by Scottish Government to set up this training, to assess those who attend, and to issue certification to those who successfully complete it. This certification will be required by each NHS Board before they can issue a list number. The mandatory training involves the attendance at a two-part course, followed by an online assessment, called the “Test of Knowledge” and for assistants.

The costs to practitioners is £300 per day for up to three days training and a further £100 to cover the Test of Knowledge.

**Average GDP Income**

An increase of one per cent would provide a total of £70,700 when multiplied by 3000 (number of Scottish dentists) this equals a revised figure of £2.121 million. It should also be noted that this this figure allows for no capital investment for infrastructure or refurbishment or for other major items such as chairs, radiographic equipment etc.

It is therefore estimated that the average GDP annual income is £70,000, based on 3000 dentists in Scotland, the total cost would be £2.1 million per annum.

**Average dental staff costs**

For other practice based staff, costs are based on a rate of £10/hr + 1% on the salary bill x 35 hours x 52 weeks gives an annual salary of £18,000 x 5 staff x 900 practices gives a total cost of approximately £1 million per annum.

**Record numbers of patient registrations – participation rates go down**

Despite the increase in registration rates due mainly to the introduction of lifelong registration in April 2010, the participation rates i.e. those patients who are registered with a dentist and attend for treatment, have declined. In 2007 when 99 per cent (2.6 million) had contact with an NHS dentist dropped to 73 per cent (3.5 million) in 2015/16. Children are more likely than adults to have seen a dentist within the last two years (85 per cent compared to 70 per cent). Patients from the most deprived areas were less likely to see their dentist within the last two years than those from the least deprived areas; the gap was eight percentage points for children and 10 percentage points for adults.

**Dental care for older people (65 years plus)**

BDA Scotland agrees with the Scottish Government’s current policy for the treatment of patients 65 years plus, but this has to be justified as additional care, which elderly patients could receive and which would improve overall oral health.

The reimbursement for GDPs is complex. There are two aspects to this, one is the issue of caring for elderly patients in the practice and how dentists are reimbursed for that, given it will take longer and that these patients are increasingly likely to be dentate and require more complex treatment.

Secondly, there are those patients those who might need to be seen in their own homes or in care homes either nursing or residential care.

For the first group there are a range of possibilities; enhanced capitation and continuing care for payment for treatment of the elderly age 65 plus and those in their own homes and the increased capitation for elderly patients over 65 years of age, who are on the practice list. The rate of reimbursement could increase in five year age bands 65-70, 70-75 etc. and be paid based on the composition of the practice list. An appropriate capitation fee would
require to be agreed in addition to an Oral Health Risk Assessment (OHRA) and a Preventative Care Plan for elderly patients. Preventative treatment might include for example, fluoride applications via ‘bleaching trays for patient 60 years plus.

43. An alternative approach would be to retain IOS fees per procedure, but to increase these IOS fees by a percentage, based on the age of the patients again in five-year bandings. This would mean the IOS fee for a filling, plus ten per cent additional fee for age 65, 15 per cent additional fee on IOS for age 70 and so on.

44. The OHRA could be planned for 65 years of age with a fee based on 40 minutes of dentists time (reference source: Simplyhealth Professionals, formerly Denplan, based on 20 minutes for younger patients with good oral health, 30 minutes on average for younger patients with poor oral health, 40 minutes for elderly patients and time to explain Preventative Pathway for Older Patient). Fees to be defined for OHRA for 65 plus patient, and fees for starting and maintaining the patient on a separate Preventative Pathway for the Elderly.

**Domiciliary Care**

45. Domiciliary care provision for GDPs has decreased significantly over the last five to ten years with fewer and fewer GDPs providing this level of care. A key issue is the level of remuneration which GDPs receive which is between £39.55 and £71.45 depending on the distance travelled to the patient. In addition, there is a requirement for the dentist and the dental nurse to attend a care home with a specified level of medical equipment including oxygen cylinders.

46. The BDA would like a realistic rate implemented for visiting a single patient in a care home and undertaking an OHRA, providing urgent treatment etc.

47. In order to consider how best to fund this service, either the rate per patient requires to be increased to realistically reward GDPs or NHS Boards require to commission specialist domiciliary care providers on the basis of a contracted service.