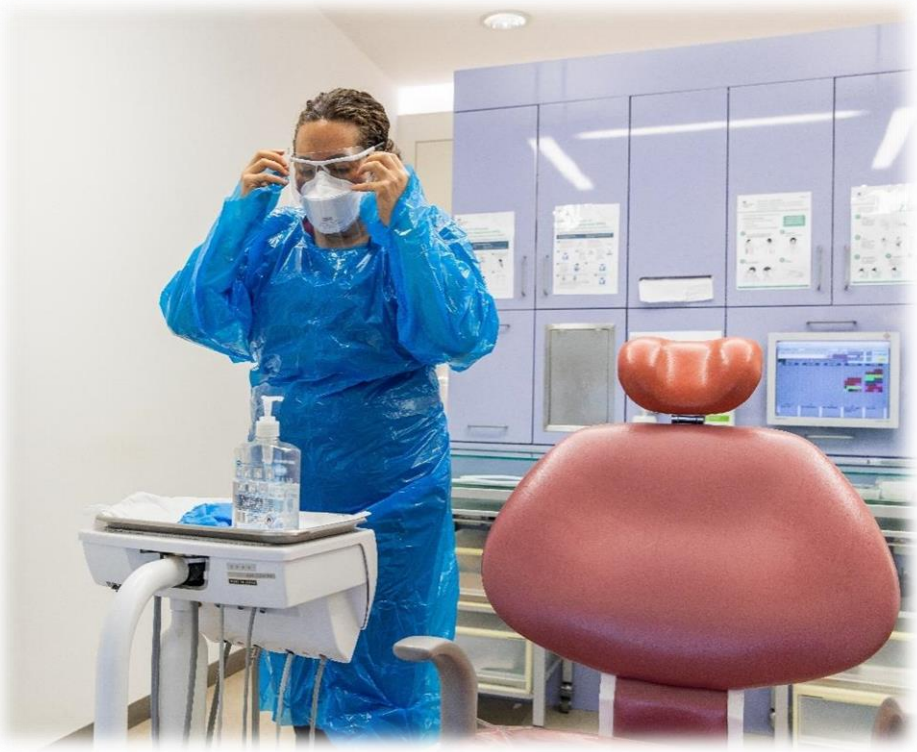
BDA

British Dental Association

# Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2021-22

## January 2021



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## Chapter 1 - Executive summary

1.1. The global pandemic has meant the biggest challenge in a generation for the health service across the UK. The dental profession, as with other health care professions, has lost valued colleagues to this virus and our condolences go to all those who have lost loved ones.

1.2. 2020 has demonstrated a united dental profession, one which has pulled together in the face of the adversity across all branches of practice. This has been a challenging year across the health service and the BDA is proud of the efforts of the dental profession since March 2020. Many individuals and teams have gone to extraordinary lengths to support the COVID effort. In the first wave dental practices donated PPE (totalling millions of pounds) to NHS front line services and also provided vitally needed oxygen to hospitals.

1.3. Dentists across the UK were redeployed to support the wider COVID effort. GDPs and CDS dentists were redeployed to urgent care centres, hospital dentists/academics were redeployed to COVID/ICU wards etc, Foundation Dentists were asked to redeploy to Nightingale hospitals. Dental Public Health teams have been at the forefront of health protection in all parts of the UK. In this current wave, some dentists have become volunteer COVID vaccinators where there is demand.

1.4. Quite simply, dentists have gone above and beyond. As we have reported repeatedly in our evidence, dentistry has been in a fragile state for the last few years. Despite the challenges, the profession has pulled together but only time will tell at what cost.

1.5. Looking to a future beyond COVID, we need an NHS dental service that is an attractive proposition for a young dentist to aspire to and from which they can make a living. Sadly, that vision seems a long way off.

1.6. Therefore, we ask that the Review Body considers a full **5 per cent pay uplift** for all employed and self-employed dentists to aid recruitment and retention. This will go some way to ensuring the future sustainability of a service which is highly valued by patients for the future. It will not address the real terms pay cut over the last decade which has put the service in the position of fragility at the time it needs to be at its strongest, but it will send a message of value to those working in the system.

1.7. We also ask the Review Body for

- 1.7.1. Timely implementation of pay awards
- 1.7.2. Separate recommendations on expenses
- 1.7.3. Reinstatement of commitment payments for England, Wales and Northern Ireland
- 1.7.4. An increase in the prior approval limit in Northern Ireland
- 1.7.5. That the Review Body reiterates the historical recommendation of pay parity of clinical academics which is impacting on recruitment and retention.

## Chapter 2 - About the BDA

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

2.2 Our evidence to DDRB covers General Dental Practitioners, the Community Dental Service (Public Dental Service in Scotland) and Dental Academics. This year we also include a short section on Civilian Dental Practitioners. Hospital Dentists (Consultants, SAS dentists and dentists in training) are included in the BMA's evidence submission as these dentists work on nationally negotiated contracts for doctors and dentists.

**How the DDRB recommendation is implemented for employed and self-employed dentists.**

2.3 Self-employed dentists in England and Wales are unlikely to see their pay uplifted by the recommended amount. The different formula used by the England and Wales governments to include expenses meant that the recommendation (2.8 per cent in 2020) is always translated into a contractual uplift. Contract holders must then decide how to use the contractual uplift to ensure practice sustainability.

2.4 In Northern and Scotland, the SDR is uplifted by the accepted amount with accounting for expenses. However, in Scotland the recommended uplift is not applied to all allowances and payments, therefore the overall award falls short of the DDRB's recommendation. The BDA estimates that the net award for 2020/21 in Scotland was around 2.3 per cent. We recommend that the DDRB extends its recommended uplift to the full GDS remuneration package as contained within the full SDR.

2.5 The Review Body does not engage on discussions of expenses however for self-employed dentists it is impossible to separate the pay element from the expenses. It is our continuing recommendation that the DDRB starts again to make a separate recommendation on expenses for GDPs.

## Chapter 3 - BDA response to the 48th report

3.1 Delays in implementing uplifts are now commonplace from the four Departments of Health and completely unacceptable (Fig 1). It was hoped that this year the process could have begun to return to a more reasonable timetable however the pandemic has prevented that. We acknowledge that the 49th report will again be published after the 1 April 2021 but we urge that the following round is much earlier allowing the Review Body's 50th report to be published in advance of the 2022/2023 financial year.

| Year | NI | | England | | Scotland | | Wales | |
|---|---|---|---|---|---|---|---|---|
| 2020-21 | Jan 2020 | 9 mths | Dec 2020 | 8 mths | Nov 2020 | 7 mths | Nov 2020 | 7 mths |
| 2019-20 | August 2020 | 16 mths | Nov 2019 | 7 mths | August 2019 | 4 mths | August 2019 | 4 mths |
| 2018/19 | August 2019 | 16 mths | Dec 2018 | 8 mths | Nov 2018 | 7 mths | Sept 2018 | 5 mths |
| 2017/18 | July 2018 | 15 mths | Aug 2017 | 4 mths | April 2017 | 0 mths | May 2017 | 1 mth |
| 2016/17 | April 2017 | 12 mths | June 2016 | 2 mths | April 2016 | 0 mths | June 2016 | 2 mths |
| 2015/16 | No uplift* | 10 mths | Aug 2015 | 4 mths | April 2015 | 0 mths | Aug 2015 | 4 mths |

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

**England**

3.2 In England we are particularly concerned about the comments in paragraph 37 of the 48th report. We have approached the Department of Health and Social Care (DHSC) and NHS England in the past about joint working for GDPs but to date this has not been possible. Most of the data that all three parties use is publicly available data, however interpretations differ. Our intention is to present the evidence in the way that affects our members based on the information we hear from those working in the dental profession. We make no secret of the fact we want dental working lives to be satisfying and fulfilling, we want those providing NHS dentistry to be able to provide the best

care to their patients, but this cannot happen while NHS dentistry is under-funded. Practices are robbing Peter to pay Paul constantly and our evidence shows this. Yes, there are many people bidding for contracts each time they are offered – that is because dentists want to continue to provide high quality care to their patients. Yet it does not automatically follow that the contracts are suitable contracts. Often the contracts are paid well below the price needed to provide high quality care. The recent orthodontic contracts were advertised at an average of £54 per UOA as opposed to the national average of approximately £66 when the procurement started. Sadly, dentists had no choice but to bid for contracts they had no hope of financing solely based on the NHS contract value or faced losing their livelihood overnight. People enthusiastically bidding for contracts is not the same as it being the only game in town. We are concerned that paymasters choose not to prioritise the oral health of NHS patients in this process.

**Scotland**

3.3 In October 2020, the Scottish Government formally informed the profession that it had accepted the pay increase recommendation of 2.8per cent for GDPs and, as in previous years, the increase would apply to gross item of service fees and capitation and continuing care payments. We argued that the overall award was around 2.3 per cent as it did not include various allowances and payments.

**Wales**

3.4 Welsh Government announced on 21 July 2020 that the recommendations of the DDRB were accepted in full. This included a base increase of 2.8 per cent to all groups of doctors and dentists. Once the DDRB formula was applied this resulted in an uplift for GDS contracts and PDS contracts of 2.3 per cent. The subordinate legislation didn't come into effect until 25 November 2020.

**Northern Ireland**

3.5 We thank the DDRB for its strong statement condemning the unacceptable delays to the pay award process in Northern Ireland, in its 48th Report. We regret to inform the DDRB that the 2019-20 pay award was not fully implemented until August 2020 – again over a year late - depriving GDPs of much-needed backpay when inflation has totally eroded the pay increase by the time its awarded.

## Chapter 4 – Policy Update

4.1 The pandemic has been all consuming since February when patient footfall in practices reduced. The BDA has been busy trying to support the profession and from March to December 2020 we responded to over 17,000 members who contacted us for information, help and support. We have responded to all four governments on various aspects facing dental services throughout the pandemic to seek financial assistance for dentists, and to raise the mental health and wellbeing concerns of the profession.

4.2 With the second wave and all UK countries in national lockdowns, the approach to dental care differed to the first wave. In March 2020, Wales and Northern Ireland dental practices remained open for certain face-to-face care whereas in Scotland and England dental practices were closed for face-to-face care. All practices provided a remote triage service for patients using the 3A approach (advice, analgesia and antibiotics). In the second UK-wide lockdown dental practices are being asked to stay open. We welcome this, however there are additional challenges to working through a public stay at home order.

4.3 The other priority facing dentists across the UK is (as frontline healthcare workers) receiving at least the first dose of a vaccine. Currently members are reporting high levels of staff isolation

and sickness combined with decreased patient footfall. Running a small business in this situation is difficult. We welcome the rollout of the vaccine for dentists across all four countries.

4.4 One significant UK wide policy issue that affects all CDS / PDS services is the ever-increasing backlog of patients requiring dental treatment under general anaesthetic. This issue has been a problem the last few years however with the cessation of routine care and the backlog of hospital patients, theatre space is at a premium with dental GA sessions often the first to be stopped.

4.5 Meaningful discussion around contract reform in England is currently halted although the prototypes continue to operate. We hope that discussions will re-start and lessons learned during the pandemic can be used to improve the current prototype models which did not seem to be working for many participating practices.

4.6 Northern Ireland continues to be without a modernised oral health strategy, existing in a vacuum of long-term oral health direction and policy. The DoH proposed 2019 Oral Health Options Groups examining children and elderly oral health have not been convened, although there has been a push in December 2020 to reconvene and identify areas for work.

## COVID 19 financial support and interim contractual frameworks

4.7 Across all four countries the approach to financial support for dentistry has varied during the pandemic. (see Annex for timelines).

### England

4.8 Practices were asked to close for face-to-face care in March and only provide remote triage adhering to the 3A. From 8th June practices were asked to begin face to face care by prioritising the most urgent patients first and finish courses of treatment that had been started prior to lockdown. Aerosol generating procedures were permitted from late June if safe to do so in the practice with the correct procedures and PPE. Practices have been operating a new normal service since June with patients being triaged remotely for clinical reasons and COVID reasons before visiting the practice. Capacity has been severely reduced, and dentists have been working under very stressful conditions both physically and mentally. From 1st January, new targets of 45 per cent of former UDA targets were imposed for Q4 of the financial year for general dental practices. Orthodontic practices have a 70 per cent of previous UOA targets to achieve. CDS services and prototype practices are involved in separate discussions around activity measures.

4.9 The BDA has made clear to NHS England and the DHSC that these arrangements are not achievable for practices and run contrary to the wider public health advice. With the virus resurging practices are seeing widespread patient cancellations, with a BDA survey of practice owners in England conducted in early January finding that 79 per cent had seen an increase in cancellations since the start of this year. This finding is supported by polling, which found that 46 per cent of adults in England would be more likely to cancel a dental appointment due to the new lockdown and 45 per cent saying that they would be less likely to seek dental care when due for a check-up than they would have been before the new restrictions[1].

4.10 We are particularly concerned that, where practices fall below 36 per cent of the former UDA targets, there will be a financial cliff-edge, with no protections to their income. Analysis from NASDAL shows that this will pose a severe threat to practices' financial viability; a practice that continues to see patients and to achieve its targets, but is only able to deliver 30 per cent, for example, would suffer greater losses than if it were to simply close and provide no activity.

[1] Figures from YouGov Plc. Total sample size was 2007 adults. Fieldwork was undertaken between 7 -8 January 2021. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+). Figures cited are from 1734 adult respondents in England.

4.11 In England over the summer the BDA was one of a number of stakeholders engaged in a short life working group[2] headed by Deputy Chief Dental Officer Jason Wong looking at the sustainability of dental practices. We support all the recommendations made in this piece of work, many of which still haven't been forthcoming:

- *Extension of the Coronavirus Job Retention Scheme for the dental sector*
- *Extension of the maximum repayment term (currently 6 years) for both the Coronavirus Business Interruption Loan Scheme (CBILS), and the Bounce Back Loan Scheme (BBLS)*
- *Eligibility for business rate relief for all dental practices*
- *Eligibility for Retail, Hospitality and Leisure Grant (RHLGF) for the dental sector 5.*

## Scotland

4.12 Dental practices in Scotland were told to close on 23 March for face-to-face care though they continued to offer advice, analgesia and antibiotics to patients and refer high-priority cases to the Urgent Dental Care Centres which had been set up across Scotland. Practices were open from 9am to 6pm, five days a week, including public holidays, although (unlike General Medical Practitioners) dentists received no additional payment or acknowledgment for their efforts. A number of GDPs were redeployed to the UDCCs and to community assessment centres and to NHS24 (NHS24 was open from 6pm to 9am from Monday to Friday and all weekend). These services were voluntary and unremunerated. GDPs also provided out-of-hours dental treatment at hubs.

4.13 High street practices could reopen from 22 June for only a very limited range of urgent treatments and could offer Aerosol-Generating Procedures (AGPs) only for urgent care from 17 August. The Scottish Government subsequently announced that practices could offer the full range of NHS treatments – including AGPs in routine care – from 1 November.

4.14 Since the start of the pandemic, the Scottish Government has provided support payments to NHS dentists to help practices remain viable. While the Government has secured additional funding to supplement the NHS dental budget, there is still an overall financial shortfall as patient charges (worth around £75 million a year) were not collected between March and November. These charges are now being collected but dentists are operating at vastly reduced capacity so income from patients remains considerably lower than normal. (See Annex A for timeline of financial support)

4.15 Despite several requests from the BDA, the Scottish Government has not provided any direct financial support for the private element of dentists' income. Instead, dentists were advised to apply for various loans and grants to compensate for the loss of private income.

4.16 A financial support package agreed with the Scottish Government in April has seen NHS dentists paid 80per cent of their pre-COVID treatment value (plus all practice allowances), which increased to 85per cent from November 2020, helping to secure the viability of NHS dentistry during the pandemic. These support payments will continue for as long as they are needed. The Scottish Government had planned to introduce minimum activity levels from March 2021, and to link the support payments to these activity levels. However, following tighter restrictions introduced in January 2021, the Scottish Government has delayed the introduction of activity levels and tiered support payments by three months in the first instance.

[2] Investigation into the resilience of mixed NHS/Private dental practices following the first wave of the COVID-19 Pandemic(27 August 2020) https://www.bda.org/advice/Coronavirus/Documents/Investigation-into-the-resilience-of-mixed-dental-practices-following-the-first-wave-of-the-COVID-19-pandemic.pdf#search=jason%20wong

4.17 Dentists in Scotland donated their PPE to the wider NHS (including hospitals, pharmacies and hospices) at the start of the pandemic. Since reopening for face-to-face care, dentists have received a limited amount of PPE free of charge to treat NHS patients. However, there have been issues with local distribution, and some dentists are buying their own PPE so they can continue to treat their patients.

### Northern Ireland

4.18 GDS activity levels dropped dramatically following the outbreak of the COVID pandemic (see Annex A for the timeline of financial support). Between April and September 2020, the number of individual patients seen by GDS dentists fell by 697,675 (-78 per cent) compared to the same period in 2019.[3] According to the October BDA practice survey, 94 per cent of NI practices are operating at below 50 per cent capacity.[4]

4.19 The NI Department of Health (DoH), via the Financial Support Scheme (FSS), has contributed significant financial resources towards maintaining the financial sustainability of the GDS. There have been 8 months of FSS payments made between April and November 2020. The total level of FSS and net IoS payments made over this period is around £43.3 million (£32.7 million FSS) which represents a 32 per cent increase compared with the net IoS payments made over this period in 2019-20[5].

4.20 However, despite this welcome increase in funding, overall Health Service earnings received by GDPs have still fallen significantly. In Q1 and Q2 of 2019/20, the GDS earned a total of £37 million – from both Department of Health contributions and patient charges. In the same period in 2020/21, the GDS earned £33.5 million – a 9 per cent decrease.[6]

4.21 This decrease has been exacerbated by how the Department of Health has approached PPE supply. Northern Ireland is the only region in the UK where GDPs are expected to source and pay for their own PPE. Scottish, Welsh and English GDPs have been able to avail of a free supply of PPE from their respective governments. In Northern Ireland, the DoH took the approach of removing the 20 per cent abatement from the FSS to compensate GDPs for the increased Level 2 PPE costs. When the 20 per cent of total monthly earnings allocated to PPE is removed from GDS earnings, we estimate that the 9 per cent decrease described above increases to circa 15 per cent.

4.22 In theory, lower activity levels should have resulted in reduced expenses due to the corresponding reduction in materials/lab bill costs. Principals however report that costs have increased during the last year due to the need to replace materials that went out-of-date over the lockdown, Level 1 and 2 PPE costs, and the cost of implementing social distancing/infection control measures (screens, increased ventilation etc.), while patient throughput has been considerably reduced. In addition, members report that the well documented issues with GB>NI supply lines following the UK's withdrawal from the EU has resulted in a significant increase in dental material and laboratory costs. However, it is too early to gauge if these issues will result in a long-term increase in dental expenses.

4.23 This financial pressure on dental practices has been exacerbated by the NI Executive's continued refusal to provide financial support to private dentistry – despite the sector being heavily impacted by NI Executive imposed restrictions. This is significant as dental practices have increasingly relied upon private earnings to subsidise Health Service earnings in recent years as Health Service profit margins have got tighter and tighter, and increasingly unsustainable in their own right - circa 100k patients are registered to dentists with less than 50 per cent Health Service commitment.[7]

[3] FPS General Dental Services Statistics: To QE September 2020, BSO, September 2020 – Table 1.6
[4] The BDA UK-wide Practice Survey was carried out between 14-26th October. The survey received 148 valid responses from Northern Ireland - representing 40per cent of the total number of dental practices in Northern Ireland. Data shown relates only to respondents who have a Health Service commitment of over 50%.
[5] Michael O'Neill . Funding Arrangements for the Rebuilding of General Dental Services, 2 December 2020.
[6] BDA calculation derived from unpublished statistics - BSO Internal Management Information obtained upon request
[7] Derived from unpublished statistics - BSO Internal Management Information obtained upon request

4.24 As an example, consider the impact on a 60per cent Health Service, 40 per cent private dental practice. If activity levels are circa 25per cent then private revenue falls from 40per cent to 10 per cent. DoH has covered the 60 per cent but dental practice revenue has still fallen by 30 per cent as overall dental practice salaries/expenses have remained at 100 per cent. It is unsurprising therefore that 82 per cent of NI Practice Owners recently stated that they would be able to maintain the financial sustainability of their practice for less than 12 months – 49 per cent less than six months.[8]

### Wales

4.25 During the initial lockdown dentists in Wales remained open for urgent non AGP face to face treatment in addition to remote consultation and were able to refer patients requiring urgent AGP treatments to 15 urgent dental centres.

4.26 The pandemic has given the opportunity for the GDS contract to be varied in agreement with almost 100 per cent of practices with an NHS contract during the recovery year (2020-21). This meant that UDA targets were suspended and a range of alternative KPI introduced based around patient risk assessment, including the use of the ACORN, in addition to offering urgent access to patients outside of their normal practice base[9].

4.27 This 'reset of service' time is being used to step up a preventive approach in primary dental care in Wales and to widen access wherever possible. This was possible because routine and non-urgent dentistry was on hold for large parts of 2020. Practices have prioritised those with urgent and high dental need.

4.28 This restoration period has offered a contracting environment that allows practices to risk-assess their practice population using the ACORN tool. Practices are expected to offer urgent dental care to any patient as part of the contract variation and to conduct a variation of the ACORN[10] for urgent care.

4.29 The BDA has been in close consultation with Welsh Government and Dental Public Health during the progress of the pandemic regarding the recovery year measures[11]. We have fully supported the suspension of the UDA and have communicated extensively with GDPs about the introduction of the ACORN and the recovery year measures and contract remuneration. Of note however, is that patient charges are still based on the three band system which were increased in September 2020[12]

## UK Contract reform

### Wales contract reform

4.30 Reform of the GDS Contract has been paused due to the pandemic and the BDA was in close consultation with relevant stakeholders regarding the progress of the contract reform as a result[13]. Prior to the pandemic there were approximately 40 per cent of practices with an NHS contract involved in the project. We look forward to working with the government when the contract reform programme recommences and to consulting extensively with the profession on how the changes to GDS delivery in 2020 can be made to work in the longer term.

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[8] The BDA UK-wide Practice Survey was carried out between 14-26th October. The survey received 148 valid responses from Northern Ireland - representing 40per cent of the total number of dental practices in Northern Ireland. Data shown relates only to respondents who have a Health Service commitment of over 50%.
[9] ACORN routine patient care - https://primarycareone.nhs.wales/files/acorn-and-expectations/routine-patient-acorn-pdf/
[10] ACORN urgent patient care - https://primarycareone.nhs.wales/files/acorn-and-expectations/urgent-patient-acorn-pdf/
[11] https://primarycareone.nhs.wales/files/dental-programme-updates/gds-reform-restart-update-report-november-2020-pdf/
[12] https://gov.wales/nhs-dental-charges-and-exemptions
[13] Wales dental contract reform https://primarycareone.nhs.wales/topics1/dental-public-health/dental-reform/

### Northern Ireland contract reform

4.31 Progress on contract reform has been stalled since the pilot schemes ended in August 2016. An evaluation of the pilot schemes' effectiveness was finally published in January 2020 but contract negotiations have not restarted - despite ample evidence that the current activity-based contract model is no longer fit for purpose. Even pre-COVID, we warned that the GDS was facing a sustainability crisis because Health Service dentistry is not a financially viable proposition in its own right.

4.32 GDPs are concerned that – unlike in Scotland – there has been no public statement from the DoH acknowledging that a new contract is required. Even if there was such a desire, the DoH/Health & Social Care Board currently lack the policy resources to swiftly design and implement a new long-term, sustainable, GDS contract. As the DoH has historically assigned very low priority to dental issues, this is unlikely to change.

### Scotland contract reform

4.33 There is widespread acknowledgement that dental practices in Scotland will not be returning to previous ways of working before the pandemic struck. The Scottish Government had an opportunity to pilot a new approach during the pandemic but chose to revert to the current Statement of Dental Remuneration (SDR). A new funding model will be required, and BDA Scotland has established a working group to contribute to discussions with the Scottish Government and other stakeholders. Securing an appropriate replacement for the SDR will be a long-term initiative requiring a national consultation and possibly legislative changes.

### England contract reform

4.34 Since 2007 the BDA has wanted a reformed contract for GDS services in England that enables practices to improve their working lives. The pandemic has placed on hold the discussions this year. Practices are still working in prototype settings but the levels of confusion about how they are to be paid has been worse than those working in purely activity based 'ordinary' GDS contracts. While the discussion about how to pay GDS practices has been long and protracted - the activity element of the prototypes has been even more difficult due to the reduced patient through-put since practices re-opened in June 2020. How contract reform moves forward will depend on the next steps. The recent re-introduction of UDA targets for Q4 2020/21 was a backwards step and an opportunity missed to remove the UDA altogether. No doubt NHS England will argue this was a necessary step to enable their systems to measure activity however this was a golden opportunity to move the profession away from counting activity and move towards a more preventive approach.

## Chapter 5 – Financial backdrop across the UK

5.1 With the pandemic it is difficult to reconcile the financial trends over the last few years with what is happening today however our last few evidence submissions have shown why we think NHS/HS dentistry is not sustainable. Chapter 4 illustrates the difficulties faced by dental practices in 2020 and this pandemic has really shown that the current models are not sustainable. Dentists and dental practices have been often let down in terms of financial support and the data from NHS Digital will show this in two years' time. For now, we give an update of where finances were headed from the latest available data 2018/19.

4.35 Data for all four countries is not yet available for 2019/20 and the situation remains the same as we presented last year. The UK gross spend on dentistry in nominal terms is 'flatlining' but in real terms has fallen dramatically when taking into account the effects of inflation.

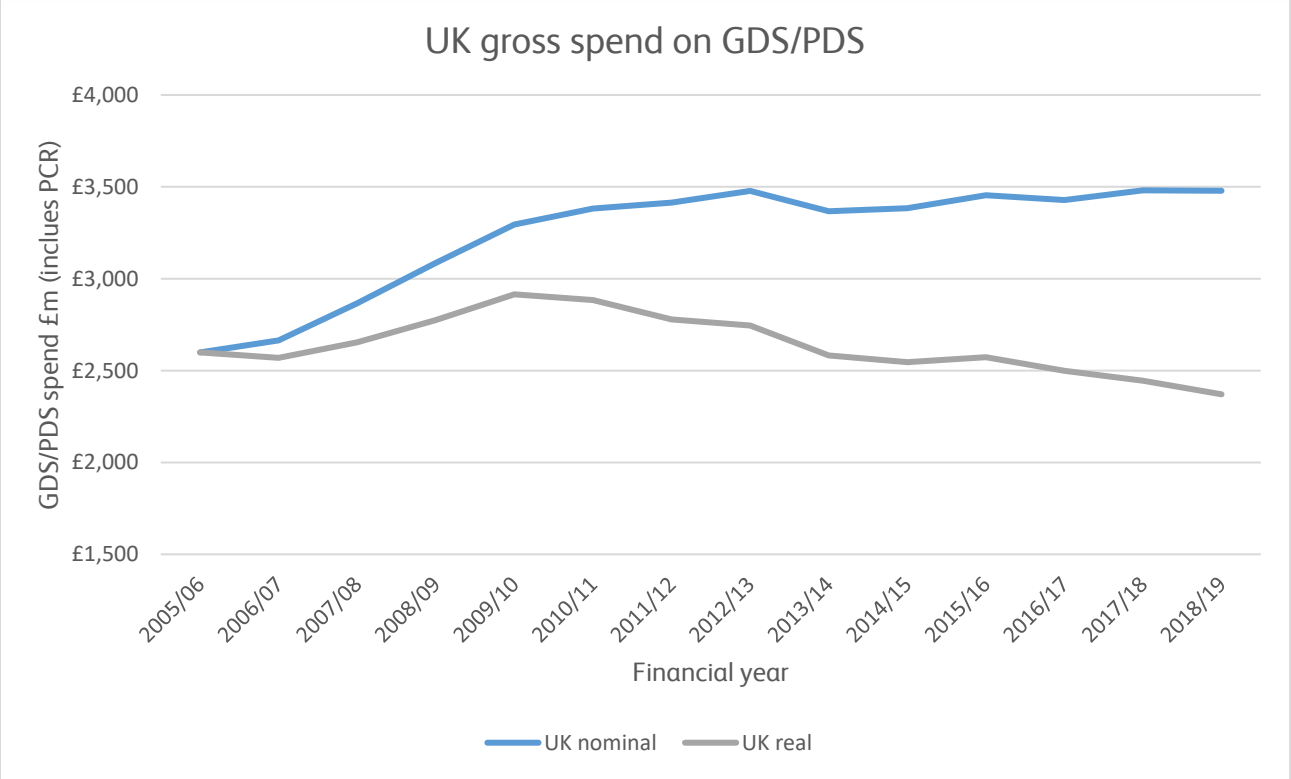


Fig 2: UK gross spend on GDS/PDS Accounts from Departments of Health

5.2 We do have 2019/20 data on taxable income of providers and performers. Fig 3 shows the data for practice owners since 2006/07 (2008/09 for NI and Scotland). This is the first year that NHS Digital has provided separate data for each of the UK countries, but we have kept in the combined England and Wales data until 2017/18 for comparison purposes.

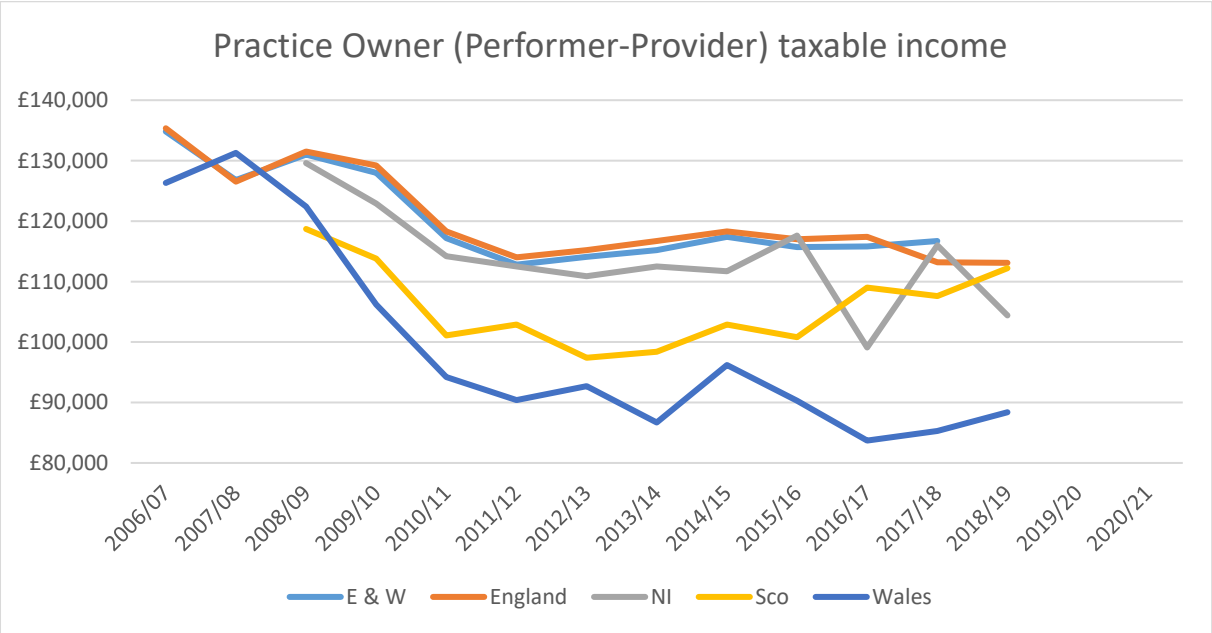


Fig 3: Data on practice owner taxable income

5.3 This shows for Practice Owners the significant drop in income across the UK but particularly for dentists in Wales. This erosion in pay (which is mirrored by associates) needs to be addressed urgently.

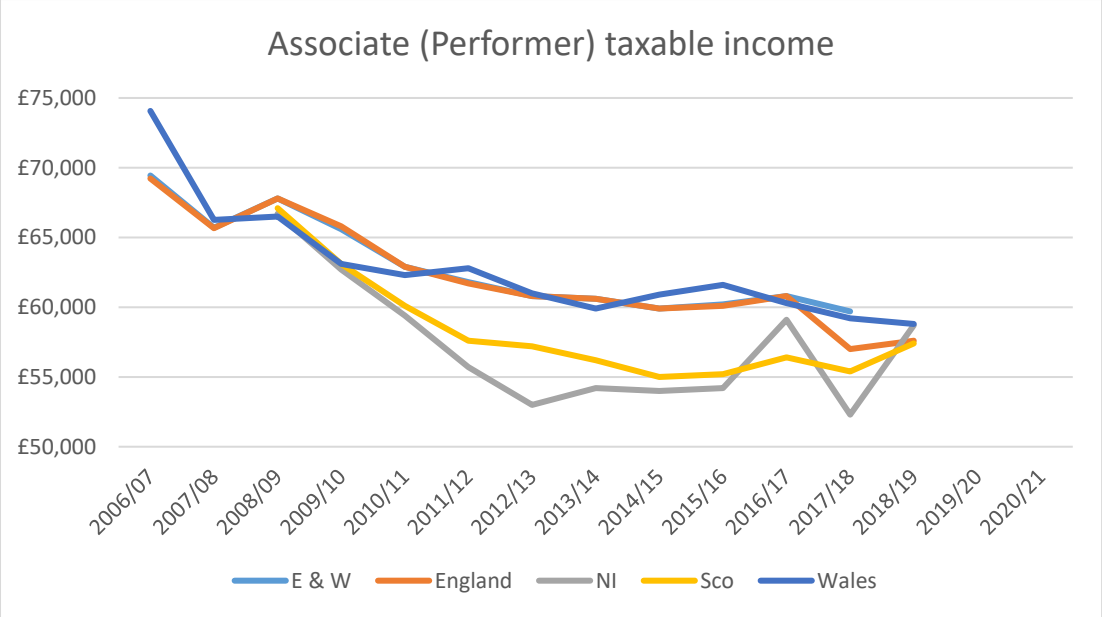

Fig 4: Taxable income of associates

5.4 This graph shows that associates/performers are similarly affected. As self-employed individuals – they too are subject to the impact of expenses and dental inflation. While paragraph 9.6 of the Review Body's 48th report notes that associate income is dependent on the contract uplift in England and Wales, the expenses element facing the self-employed individual has the same impact, whether performer or Provider.

## Financial sustainability across the UK

### England

5.5 The Westminster Government decision in December to increase English dental patient charges has been a real blow to practices already struggling as patients choose not to attend for dental treatment due to the alert 5 threat level restrictions. Increasing patient charges to generate revenue means patients will be further deterred from seeking dental treatment. This is combined with the increased activity targets being imposed from 1 January 2021 whilst most parts of the UK have a stay-at-home order.

5.6 Clawback, in respect of under-delivery of NHS targets, from practices in England has risen significantly each year, placing strain on practice finances. In 2015-16, the total clawback stood at £54,505,326 and by 2019-20 this had risen by 155 per cent to £139,020,395. This means that five per cent of contract values are now clawed back and 28 per cent of contracts have some amount clawed back from them. When practices are facing rising fixed costs, the loss of NHS income, despite best efforts to meet contractual targets, is a considerable threat to practices' financial viability. The BDA understands the factors leading to clawback are the inability to recruit associates to deliver NHS activity, the increased bureaucracy that shifts time away from delivering clinical activity, and a decline in patient attendance including late cancellations. That clawback is now so widespread is a further indictment of the failing NHS contract.

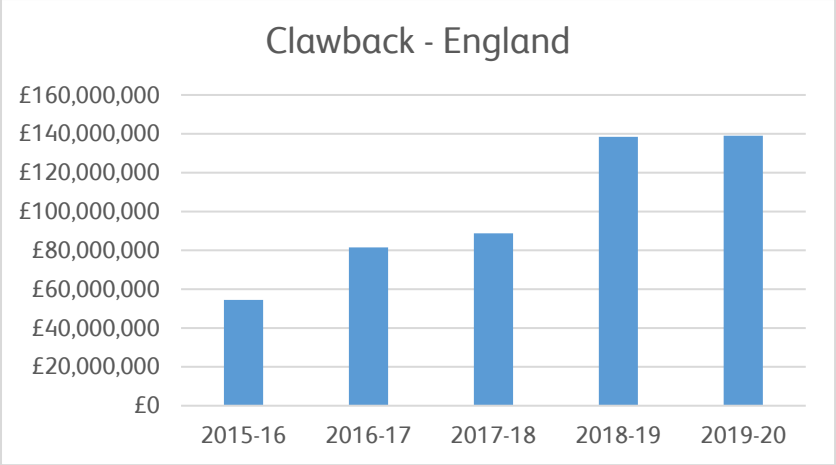

Fig 5: Data on Clawback in England (BSA)

**Wales**

5.7 In the last three years the percentage of primary care budget spent on dentistry has reduced:

| Year | Percent of primary care budget spent on dentistry | Expenditure on primary care dentistry (£000) | Per head (£) |
|---|---|---|---|
| **2016-17** | 10.8 | 152,005 | 63.94 |
| **2017-18** | 10.6 | 153,960 | 63.65 |
| **2018-19** | 10.4 | 153,085 | 64.27 |

*Fig 6: Expenditure on primary care Wales*[14]

5.8 This expenditure has equated to almost no change per head in the last three years and therefore has not kept pace with inflation. Thus, £63.94 in 2016 should equate to £70.20 in 2019 with inflation averaged **3.2per cent** a year[15].

5.9 The backdrop to these figures are:

- 17. Million patients treated in the 24-month period ending March 2020
- 51.4 per cent of adults and 68.6per cent of children were treated.
- In 2019-20 the number of courses of treatment fell by 3.7 per cent from the previous year, in part due to the suspension of dental activity due to the COVID-19 pandemic
- This affected all treatment bands except urgent cases which increased by 2.1 per cent
- In 2019-20, 45.5 per cent of all courses of treatment were for paying adults.
- The total revenue from patient charges in 2019-20 was £34.9 million
- 4.6 million units of dental activity (UDA) were carried out in 2019-20, a decrease of 5.9 per cent from the previous year and the lowest since 2006-07.
- 1472 dentists performed NHS activity during 2019-20, down 34 from 1506 in 2018-19.

5.10 The annual change in treatment activity for the whole population compared to the 24-month period ending March 2019 showed a slight increase of 0.1per cent in the total number of patients treated (1,290 more patients); however, the percentage of the population treated decreased slightly by 0.2 percentage points. The number of children treated increased by 1.3per cent (5,527) and the percentage of the children population treated increased by 0.9 percentage points.

[14] Source: *Source: Stats Wales* https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget
[15] https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

5.11 The annual change in treatment activity for the number of adults treated decreased by 0.3per cent (4,237) and the percentage of the adult population treated decreased by 0.5 percentage points.

5.12 Compared to the 24-month period ending March 2006, the total number of patients treated increased by 4.5per cent (74,806); however, the percentage of the population treated has decreased by 0.9 percentage points.

5.13 *The number of children treated* increased by 2.2per cent (9,235) and the percentage of the children population treated increased by 3.2 percentage points.

5.14 *The number of adults treated* increased by 5.3per cent (65,571) but the percentage of the adult population treated decreased by 1.6 percentage points.

> The BDA welcomes the changes in government reporting to include percentages of the population cohorts treated as this provides a clearer picture for trend analysis and one we have called for previously.

5.15 These data show overall that the percentage of the child population being seen by an NHS dentist has increased slightly in the last four years, but at the expense of the percentage of the adult population which has seen a recent decline. Furthermore, with the percentage of the primary care budget spent on dentistry gradually eroding in recent years, it is not surprising that the number of dentists working in the NHS has declined by 2.3 per cent in the last year.

**Scotland**

5.16 Scottish Government spending on General Dental Services increased by around £11 million (3.8 per cent) between 2017/18 and 2018/19 from £288.2 million to £299.2 million. This follows a £3.5 million (1.2 per cent) increase from 2016/17 to 2017/18.

5.17 The vast majority of dental practices in Scotland provide a mix of NHS and private treatments. The results of a BDA survey of practice owners in July 2020 highlighted the increasing financial pressure facing mixed NHS-private dental practices in Scotland, particularly those with a large percentage of private income for mixed practices:

- 90 per cent largely/exclusively private practices said they were likely to face financial challenges in the next 3 months
- 91 per cent of mixed practices were not confident of maintaining their current staffing levels in the coming year
- Over half (52 per cent) of largely/exclusively NHS practices and 86 per cent of mixed practices predicted a relative reduction in NHS work in the next 12 months.

5.18 The Scottish Government accepted the DDRB recommendation for GDPs in 2020/21 of a 2.8 per cent increase in gross item of service fees and capitation and continuing care payments. These uplifts were backdated to 1 April 2020. However, the Scottish Government did not apply this uplift to practice allowances (which make up around 16 per cent of practice income), therefore the overall increase was less than 2.8 per cent To avoid a repeat of this in future years, we would ask the Review Body to apply its recommendation to the overall remuneration package.

**Northern Ireland**

5.19 Total gross GDS earnings - DoH contributions and patient charges – increased from £117,100,000 to £130,900,000 (+11.8 per cent) between 2012/13 and 2019/20. However, gross funding per registered patient only slightly increased from £104.33 to £107.37 (+2.9 per cent) in the same period while gross funding per GDP fell from £115,369.46 to £114,123.80 (-1.1 per cent). Neither have kept up with inflation resulting in a real-term decrease.

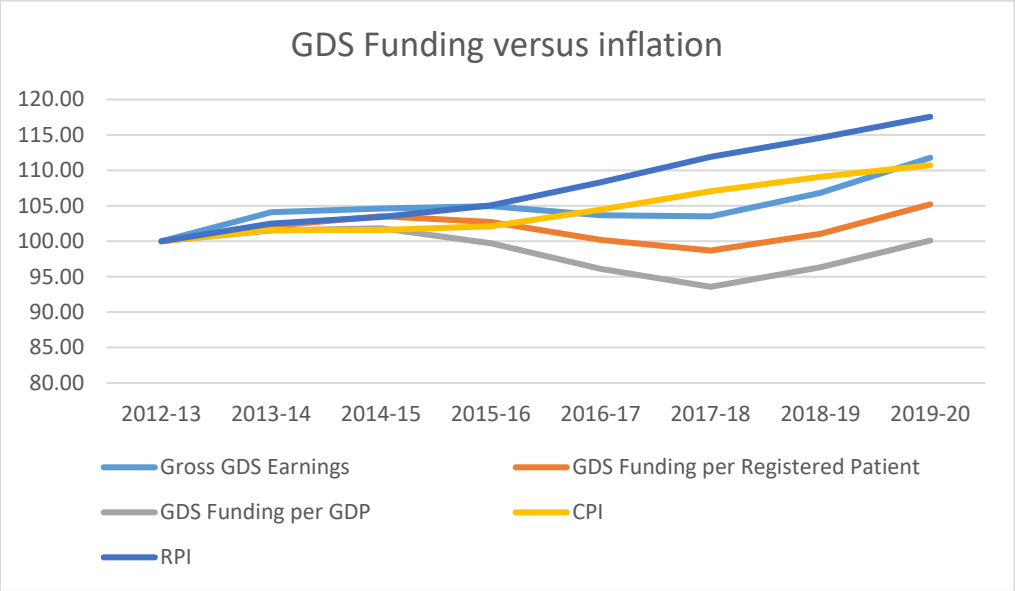


Fig 7: GDS Funding trends in comparison to inflation (Northern Ireland)

5.20 During the same period, GDP pay growth has fallen significantly behind inflation and regional median salary growth due to below inflation increases – including no increase in 2015/16 – and the 12-month plus delays to pay awards. The impact as demonstrated by Figure 2 below is stark. Accounting for delays in implementation, GDP growth has lagged behind the cumulative recommended DDRB pay growth *which is net of expenses.* Statement of Dental Renumeration values increased by 8.92 per cent during this period while cumulative DDRB recommended pay growth increased by 9.88 per cent.

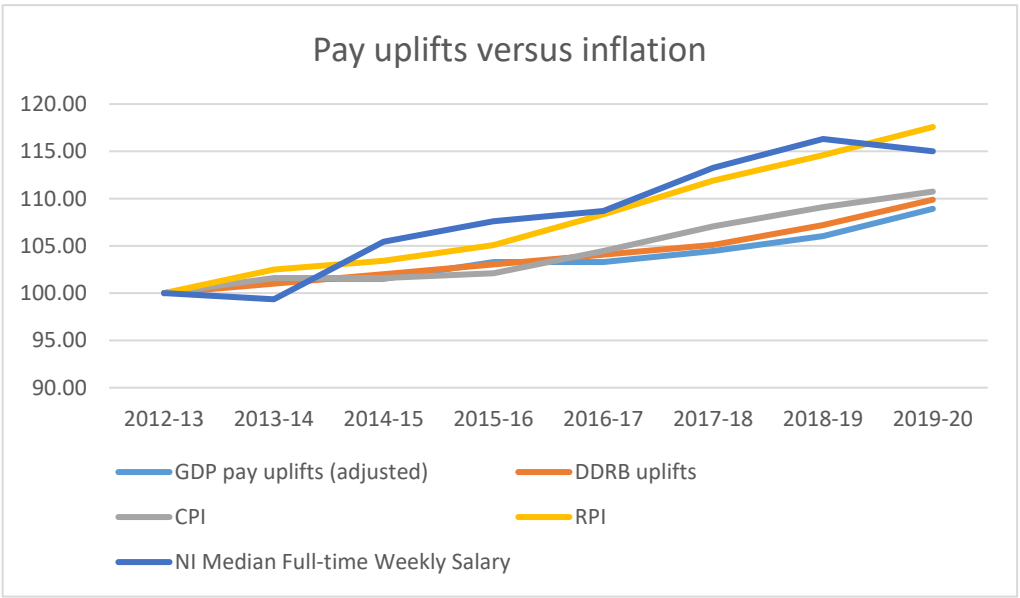


Fig 8: Pay uplifts (adjusted for delays) in comparison to inflation (Northern Ireland)

## Pensions

5.21 The Review Body has expressed an interest in how the pensions taxation issue affects its remit groups. We can only provide commentary on the dentists for which we provide evidence. Hospital dentists are covered by the BMA submission to DDRB. Academic dentists and the USS pension are covered in chapter 9.

5.22 For primary care dentists in the NHS Pension Scheme, we have recently seen the annual allowance problem recognised and 19/20 solution implemented. The process has two stages, and the first stage is to opt for 'scheme pays' to pay the liability. The second stage is the compensation policy. This compensation payment would top the pension back up. For employed dentists, employers will handle the compensation policy element of those who have opted to use this to pay their 19/20 tax bill. For self-employed dentists, the NHS BSA has implemented the solution in England.

5.23 We are concerned about the flattening of contribution tiers in the NHS Pension Scheme. This issue, as with all pension's issues, will be closely linked to total reward and workforce retention. Our belief is that dentists are currently contributing excessively, especially in a CARE scheme, taking into account tiered contribution percentages and all pension taxes (including Annual Allowance and Lifetime Allowance). We believe that it should be a flat rate percentage for all members, but discussions around this are ongoing.

5.24 Since 2019 we have been working with NHS England Health and Justice to ensure that all NHS dental performers who have worked under ultra vires contracts to provide NHS dental care in prisons dating back to 2011 are enabled to pay their NHS pension employee contributions which will be matched with the employer contributions from NHS England. An announcement on this is expected in Spring 2021.

5.25 This year the BDA has replied to UK governments around the age discrimination issue relating to the 2015 NHS pension. Many trade unions including the BDA were consulted on the suggested remedy which may include eligible members choosing which Scheme they would like to be in for a remedy period which is likely to be between 1/4/15 to 31/3/2022. Generally, eligible members will be given a choice as to whether to move back to the 95 or 08 Scheme or stay in the 2015 Scheme for the remedy period. They will get to make that choice either immediately after the remedy period (immediate choice) or decide at retirement (deferred choice). Eligible members will be issued with statements detailing the benefits for both their legacy and 2015 pension schemes which will assist them in making the choice. Further details are expected later this year.

## Chapter 6 – General dental practice

### UK: Recruitment and Retention

6.1 Our data collection this year has focused solely on the pandemic. It is likely that the pandemic meant that normal patterns of recruitment will have been disrupted. We have therefore not undertaken any specific survey work on recruitment and retention this year so there is no data source on recruitment of associates and the difficulties faced by practices. However, the NHS Digital Dentists' Working Patterns, Motivation and Morale - 2018/19 and 2019/20[16] does provide some data on retention. It finds that across the UK among both associates and practice owners well over half agree or strongly agree that they often think about leaving general dental practice. Most strikingly, this is the case for 74.9 per cent of practice owners in Wales.

6.2 Since 2014-15, the proportion strongly agreeing or agreeing that they often thinking of leaving general dental practice has steadily risen in England, Northern Ireland and Scotland[17]. For example, the proportion of associates in this position in Northern Ireland has increased by 16.3 percentage points over this period.

[16] NHS Digital Dentists Working Patterns. Motivation and Morale 2018/19 and 2019/20 https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2018-19-and-2019-20-working-patterns-motivation-and-morale/leaving-general-dental-practice

[17] Data has not been reported over the same period for Wales.

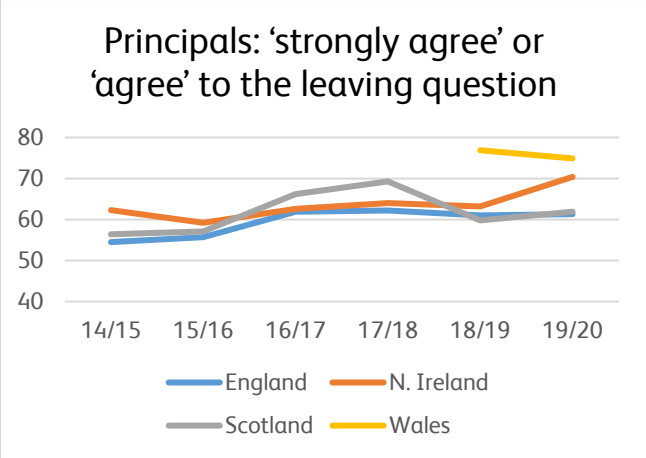


Fig 9: Principals

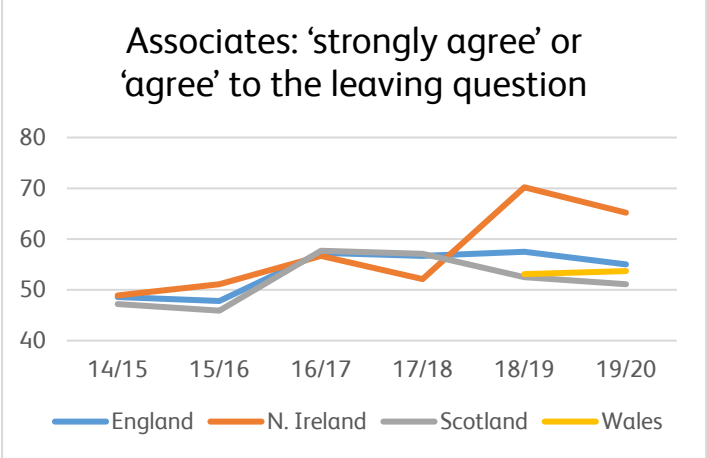


Fig 10: Associates

6.3 Unusually the GDC[18] has undertaken a survey in September/October 2020 which showed the career intentions of all registrants across the UK. Recruitment and retention this year in General Dental Practice will be more about the economic situation than normal. Practice Owners reported that they are likely to change contracts of employment for DCPs but to also change contracts of employment*[19] for dental associates/performers in their practices. When speaking about personal income, all professionals expected a decrease. While the remit of the DDRB is only concerned with dentists, not DCPs or laboratory technicians – this document shows an industry in trouble. It anticipates dental redundancies, reduction in personal and business incomes and patient numbers declining.

## Workforce

6.4 GDP headcount from Health Departments across the UK has shown a steady rise although this does not show us WTE or FTE.

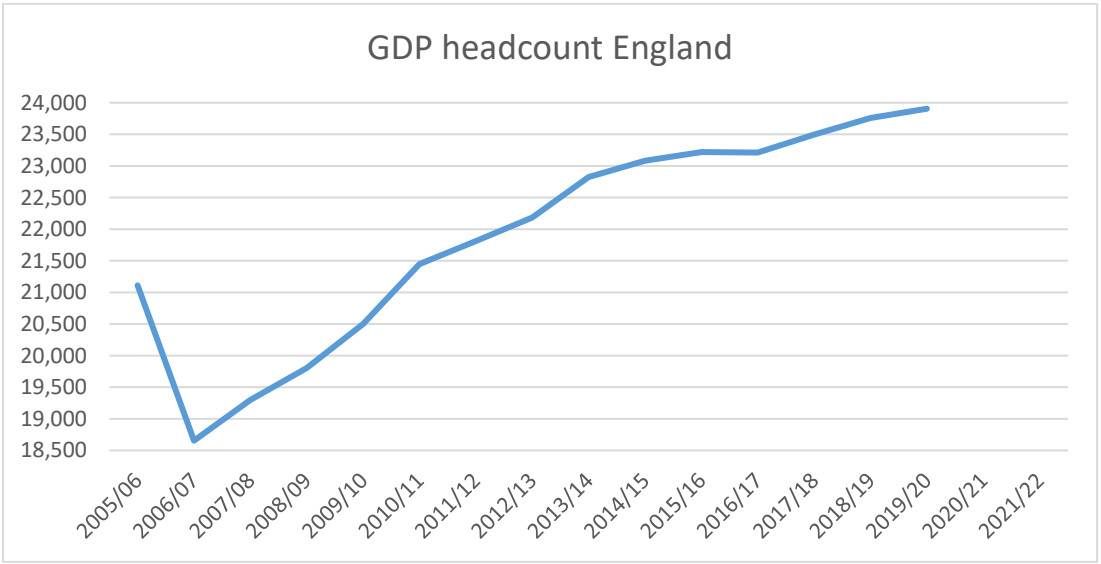


Fig 11: GDP headcount in England

6.5 In England we have explored some joint working with HEE around understanding WTE. We have not been able to provide any data for this year however we will continue to look at this in 2021. The vast majority of these will however be associates. Many associates pre-pandemic were choosing to work part time however the impact of the pandemic on workforces is as yet unknown. Anecdotally

[18] General Dental Council (2020) The impact of COVID 19 on dental professionals https://www.gdc-uk.org/about-us/what-we-do/research/our-research-library/detail/report/the-impact-of-COVID-19-on-dental-professionals

[19] *the wording of the document says contract of employment although most GDP associates will be self-employed.

we hear that many associates have been let go from positions in 2020 as practices struggle to make ends meet and patient footfall decreases.

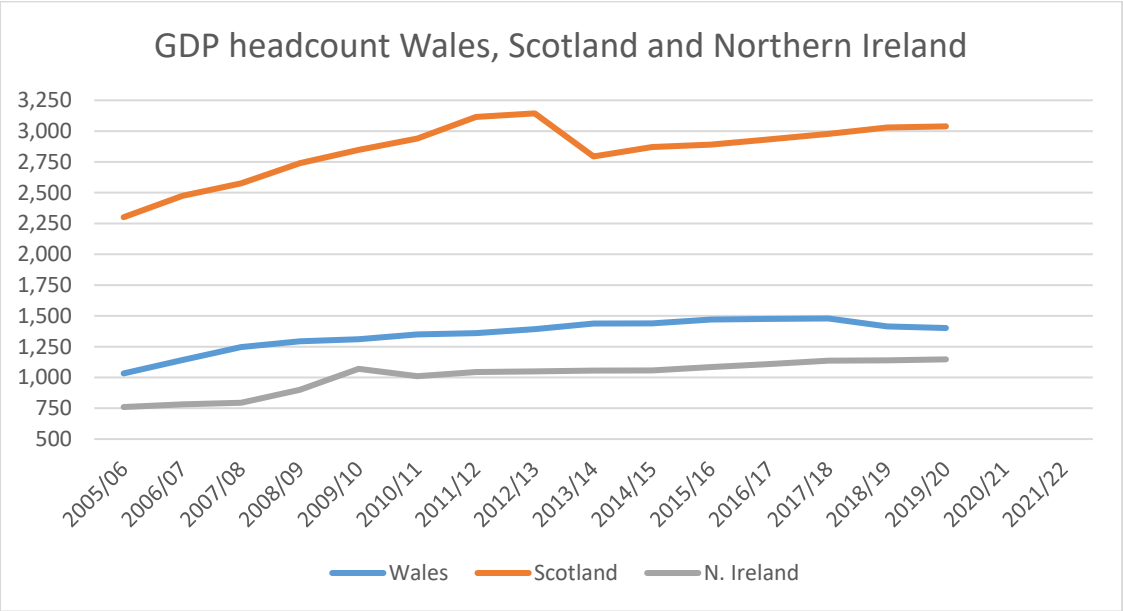

Fig 12: GDP headcount Wales, Scotland and Northern Ireland

6.6 In Wales, the total number of dentists in the GDS in Wales has levelled out in the last few years but a more detailed inspection shows that like England, there has been a significant shift from providers to performers (associates). 1,472 dentists performed NHS activity during 2019/20, down 34 from 1506 in 2018-19. Again, the figures are only a head count however and tell us nothing about WTEs[20].

6.7 Between 2016 and 2020 the number of GDPs registered on the GDS Dental list in Northern Ireland grew from 1,081 to 1147 – a 6.1 per cent increase. However, it is important to note that not all GDP's registered on the dental list routinely carry out Health Service dentistry. For example, between January and March 2020, an average of 1041 GDPs actually submitted IoS claims.

6.8 While dental numbers have been increasing, there is evidence that since the start of the pandemic, more and more dentists are considering leaving Health Service dentistry. Our BDA NI GDS financial support survey findings show the extent of disillusion with HS dentistry and the reasons for it.

**Q 10: Are you considering leaving HS dentistry within the next 12 months?**

YES: 14.91 per cent of Principals and 13.85 per cent of Associates
Considering it: 35.96 per cent Principals and 37.69 of Associates

**Q11. Why are you considering leaving HS dentistry within the next 12 months?**

Insufficient financial return: 75.68 per cent of Principals and 71.25 per cent of Associates
Low morale: 81.08 per cent of Principals and 90 per cent of Associates
Too stressful: 85.14 per cent of Principals and 88.75 per cent of Associates

*n. 116 Principals and 131 Associates completed the survey.*

6.9 NHS Digital research reports that in 2019/20 14.6 per cent of NI GDPs agreed that their pay was fair the worst results in UK. 70.4 per cent of NI Principals reported that they often felt about leaving

[20] Data taken from Welsh Government: NHS Dental Statistics in Wales, 2019–20 (30 September 2020) SFR 156/2020

General Dentistry a 19 per cent increase since 2015/16, while 65.2 per cent of Associates reported that they often felt the same, a 28 per cent increase since 2015/16.

6.10 It is important to remember that dental staff pay uplifts are linked to GDP pay uplifts and so have been affected by the same pay award delays and below inflation uplifts. National minimum wage increased from £6.70 to £7.83 between 2015 - 2018, a 17 per cent increase. However, during the same period GDP Health Service earnings per day increased by barely 1 per cent.[21] The most recent HSCB survey reported that 33 per cent of practitioners had an unfilled nursing position.[22] NI trainee dental nurses command wages 10 per cent higher than the UK average.[23]

### UK: Morale and motivation

6.11 The evidence on GDP's morale and motivation draws on the findings reported by NHS Digital's Dentists' Working Patterns, Motivation and Morale - 2018/19 and 2019/20[24]. As in previous years, this research found that the higher the dentists' level of NHS/HS commitment, the lower their motivation.

| | Practice owner | Associate |
|---|---|---|
| England | 56 | 46.3 |
| Northern Ireland | 64.8 | 56.9 |
| Scotland | 54.3 | 41.4 |
| Wales | 66 | 44.7 |

Fig 13: Percentage of dentists saying their morale was low or very low (2019/20)

6.12 The proportion of those saying their morale is 'very high' or 'high' has declined in recent years, most notably for associates. The trend is starkest for associates in England, where the proportion saying their morale was 'high' or 'very high' has fallen by 17.2 percentage points. Yet, the same pattern is clear for all groups of dentists across the UK.

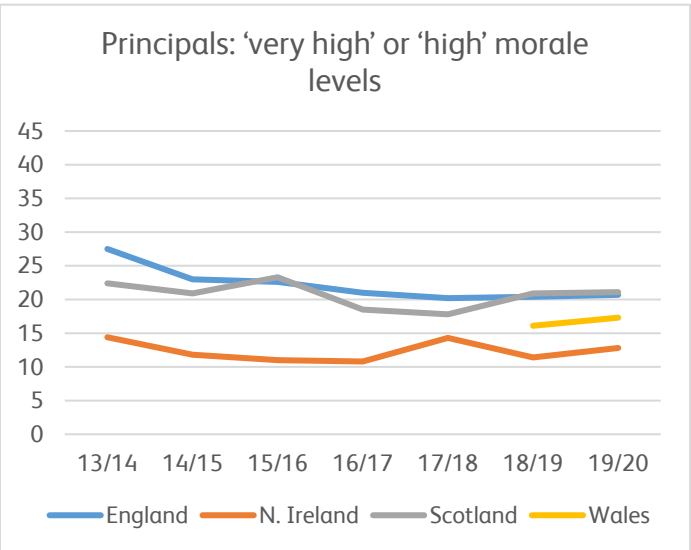


Fig 14: Time series graph for morale in Principals (2019/20)

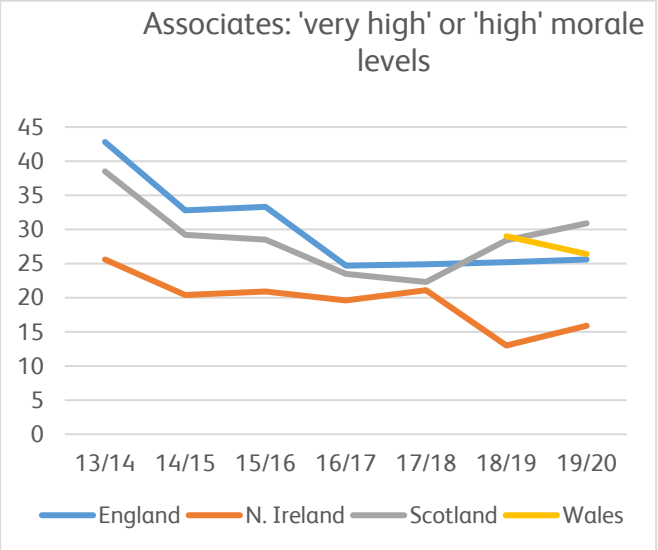


Fig 15: Time series graph for morale in associates

6.13 There is significant dissatisfaction with pay, with a majority of dentists saying they disagree or strongly disagree that their pay is fair (Fig 16). Responses on satisfaction on pay are rated considerably worse than other motivation measures such as career progression, professional autonomy and satisfaction with equipment.

[21] GDS Payment Analysis 2011/12–2018/19 Report & Tables, BSO, January 2021 – Table A10
[22] Health & Social Care Board survey, October 2017
[23] BDA dental care professional employment research, 2019
[24] NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2018-19-and-2019-20-working-patterns-motivation-and-morale/2012-13-to-2019-20-time-series-motivation-and-morale#morale-results

| | Practice owner | Associate |
|---|---|---|
| England | 57.3 | 54.8 |
| Northern Ireland | 73.5 | 68.4 |
| Scotland | 61.9 | 50.5 |
| Wales | 54.9 | 49.3 |

Fig 16: Percentage of dentists who disagree or strongly disagree with the statement 'I feel my pay is fair' (2019/20)

6.14 In England, Northern Ireland and Scotland, 'income and expenses' were the leading cause of low morale identified by dentists. In Wales, this came third closely behind admin/paperwork and regulations.

6.15 In Wales only a quarter of Associates and less than a fifth of Providing-Performers said they were happy with their pay. Not surprisingly analysis of motivation exhibit negative skews towards the lower motivation bands, which is more pronounced for Providing-Performer dentists. Similarly, nearly two-thirds (66 per cent) Providing-Performers rate their morale as 'very low' or 'low' compared to 44.7 per cent of Associates.

### Northern Ireland morale and motivation

6.16 GDP morale in Northern Ireland is the worst in the UK. According to NHS Digital, the percentage of Principals that answered 'very high' or 'high' morale was 12.8 per cent in 2019/20 – the lowest in the UK. The percentage of Associates that answered 'very high' or 'high' morale was 15.9 per cent in 2019/20 – again the lowest in the UK.[25]

6.17 There is evidence that morale has slipped even lower in recent months. Our September NI Activity Survey reported that only 3 per cent of respondents rated their morale as 'high' or 'very high'. In contrast, 88per cent of respondents rated their morale as 'low', including 63 per cent who reported their morale as 'very low'.[26] These historically low levels of morale are of great concern, and reflect the bleak outlook for the future sustainability of Health Service dentistry in Northern Ireland.

6.18 A key driver behind low morale is the widespread perception amongst dental practitioners that the Department of Health does not value dentistry. Our September NI Activity Survey reported that 80per cent of NI GDPs believed that the Department of Health had not valued the service provided by Dental Practitioners since the start of the COVID pandemic.[27]

6.19 This perception has been reinforced by repeated 12-month delays to pay uplifts over the last five years. Dentists question why the rising underspend trends in the GDS Budget, £19.1 million over 5 years (2015/16 – 2019/20) a £6.8 million underspend in 2019/20 alone, was not used to award pay uplifts in year despite the evidence (Fig 8 pay uplifts versus inflation) that GDP pay effectively stagnated between 2012/13 and 2018/19.

## Chapter 7 –Community/Public Dental Services

7.1 The current crisis has shown the essential nature of the CDS/ PDS, not just in an emergency but also in its 'usual' role of treating the most vulnerable in society. These and other groups will need the CDS/PDS more than ever once the pandemic subsides to treat the massive backlog of dental problems that have accumulated in recent months.

[25] Dental Working Hours Motivation and Morale Survey 2018/19 & 2019/20, NHS Digital, August 2020
[26] The BDA NI Activity Survey was caried out between Thursday 27th August and Wednesday 02nd September. The survey received 424 valid individual responses – representing 37per cent of the total number of GDPs in Northern Ireland.
[27] The BDA NI Activity Survey was caried out between Thursday 27th August and Wednesday 02nd September. The survey received 424 valid individual responses – representing 37per cent of the total number of GDPs in Northern Ireland.

7.2 CDS/PDS is a primary care dental service which treats patients (children and adults) not usually seen in conventional high street services[28]. These patients will be children and adults with complex medical history, mental health issues, learning disability or other particular needs that cannot be addressed in general dental services. The service sees the most vulnerable patients and they take time to see, manage and treat appropriately. There will be a mix of continuing care patients that require ongoing care by the service and referred patients who can be discharged back to GDS services once stable.

7.3 For the CDS/PDS across the UK, 2020 has been a tough year. From March in the first wave, many CDS services were designated COVID hot hubs and Urgent Dental Care Centres. In addition to this work, they continued to provide care for their own patient base in a similar way to the rest of primary care dental services in the high street, where they were either asked to run a much-reduced face to face service or only offer remote consultation (3A). In some parts of the UK, without these Urgent Dental Care Centres no face-to-face primary care dental treatment would have been provided at all for approximately 2 months.

7.4 CDS teams have had staff members redeployed to other parts of the health service to support the national effort. Employed dentists across the UK (including hospital dental services) have pulled together to ensure that they treated patients both for dental need and in teams providing direct care to patients with SARS -Cov-2.

7.5 We want to flag to the DDRB that for the past few years our CDS/PDS teams have reported a stretched and undervalued workforce working over and above their contracted hours to provide bespoke and holistic patient care to complex patients. This year, that already overstretched workforce has had to dig even deeper and has faced different and equally challenging circumstances. The sustainability of the dedicated yet small CDS workforce is vital for the patients that are treated and looked after in this service.

7.6 For the first time this year, the BDA has conducted a UK wide survey of CDS/PDS dentists on both issues relating to the DDRB remit areas and also COVID specific issues. The survey was made public and all dentists working in this area were invited to reply (both BDA members and non-members).

7.7 Across the UK the numbers of dentists working in this setting have declined over the last few years. Given the value that this branch of practice has brought during COVID, it comes from an ever-dwindling source. The effort by these dental teams has been immense and many have not stopped working solidly since March 2020.

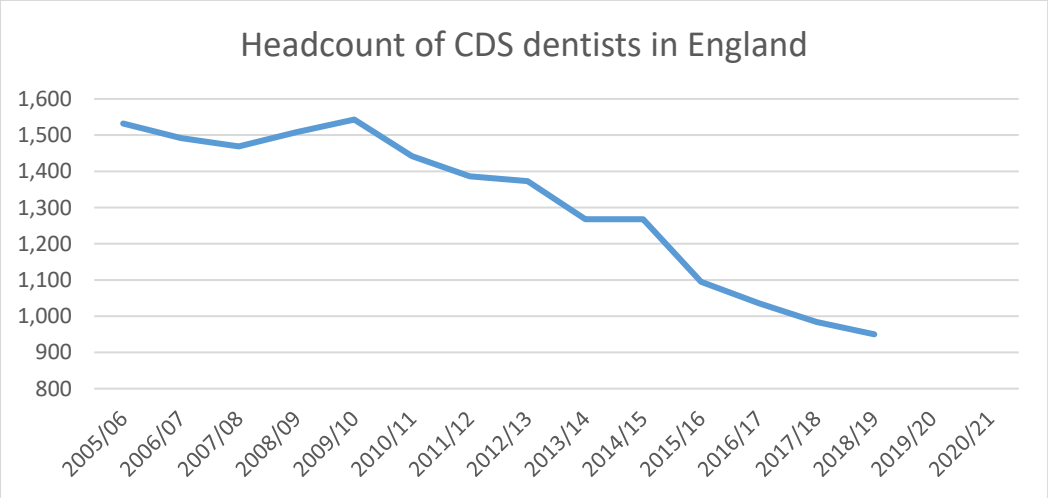

Fig 17: Numbers of CDS/PDS dentists since 2005. Source Health Depts

[28] Dental treatment for people with special needs NHS.uk (accessed 28.12.2020) https://www.nhs.uk/using-the-nhs/nhs-services/dentists/dental-treatment-for-people-with-special-needs/

7.8 In England the workforce is declining and the service has many experienced and senior dentists in the latter stages of their careers.

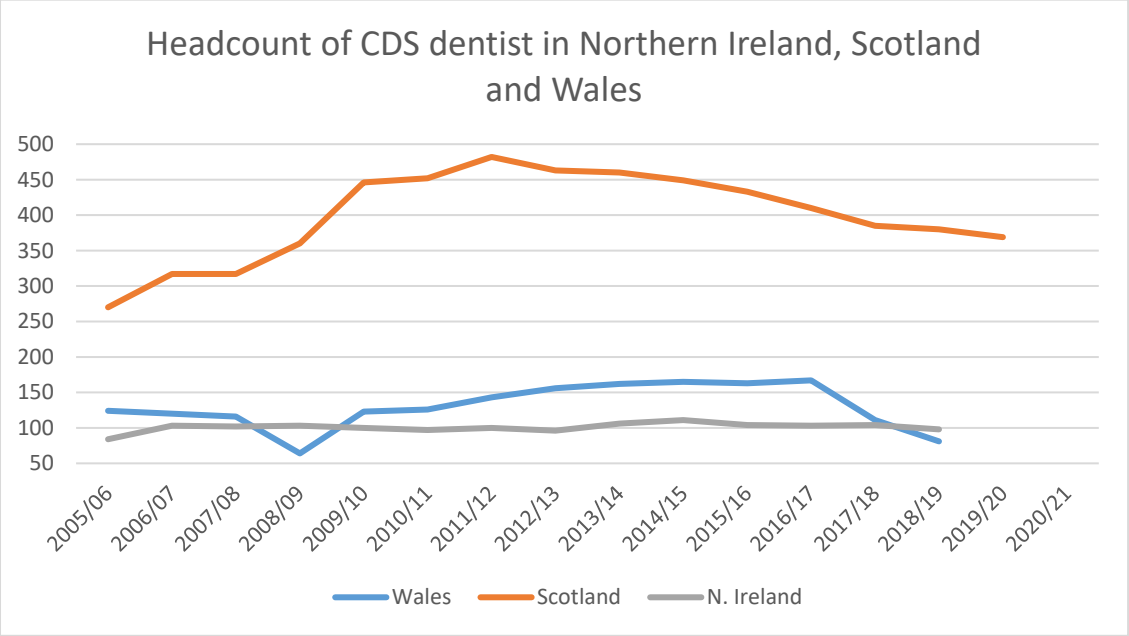


Fig 18: Numbers of CDS/PDS dentists since 2005. Source Health Depts

7.9 England has had the biggest fall, however all countries have seen a decrease since 2017. It is yet to be seen how 2020 will affect the service. While the pandemic is live it is expected that health care professionals will work their hardest to ensure their patients get the care they need. Going forward we cannot tell how many of this cohort will continue to practise as the workload and stressors on an already stressed workforce grows. The challenges facing the profession post pandemic are not insignificant and for those CDS dentists approaching the end of their careers, the numbers may drop further. We might see employed roles becoming more popular than self-employed roles due to job and employment security however a large influx of dentists not skilled in treating special care patients with fewer dentists at the end of their careers is not a good training environment.

7.10 The challenges that face the CDS post pandemic across the whole of the UK include the already long waiting lists for child and adult general anaesthetic treatment which were over one-year pre-pandemic but now will have grown by a greater amount due to the restriction in theatre space across the NHS. By definition the patients referred to and treated within the CDS are from vulnerable groups and many have high treatment needs. Those retained by the CDS for the long term are also the same, meaning that significant treatment backlogs will persist for some time.

### GA extractions

7.11 As highlighted in chapter 4, one of the most pressing issues across the UK for CDS services is the growing waiting lists for general anaesthetic extractions. It is a national crisis, but one which is having a toll on the dentists in the service dealing with the expectations of patients and their carers day in day out. It is a damning indicator of the pressure under which CDS dentistry is operating under.

7.12 A total of 6,582 dental GAs were performed in Wales during 2018-19. This equates to 0.98 per cent of the under 18 population receiving a dental GA in Wales during 2018-19. Or one in every 111 children across Wales receives a GA for dental treatment[29].

[29] Dental Public Health Team CHILD DENTAL GENERAL ANAESTHETICS IN WALES Authors: Maria Morgan Commissioned by: Chief Dental Officer for Wales Date: August 2019 Version: 1

7.13 In 2018-2019 21,940[30] teeth were extracted from young children in Northern Ireland, with 4195 patient cases treated during 736 GA sessions. This equates to 5.2 teeth extracted per patient case. In 2019-2020, 21,720 teeth were extracted from young children, with 3,820 patient cases treated during 746 GA sessions[31]. This equates to an increase of 5.6 teeth extracted per patient case.

7.14 Lengthy waiting lists of over two years in some Northern Ireland Trusts have been exacerbated by COVID-19 and staff are struggling to make a dent in the lengthy backlog. Further, a lack of available anaesthetic and nursing staff and an increasing number of referrals from GDS are contributing to this increase. Although a substantial undertaking, consideration should be given to a regional GA service, working across Trust boundaries to help address patient waiting list pressures and staff resource issues.

7.15 In England we have raised the issue repeatedly with NHS England since 2017 and in September 2020 we wrote to the Secretary of State seeking action. Waiting in pain and discomfort for vulnerable adult and child patients are waiting for over a year in pain and discomfort for dental GA treatment. With the pandemic this has grown.

7.16 In Scotland, for a number of years we have expressed deep concerns about lengthy waiting times for paediatric extractions under general anaesthetic, and the pain and distress this causes for children and their families. Our Freedom of Information request to NHS Boards in November 2019 showed that children in some Boards were waiting up to 40 weeks for this treatment. This dreadful situation will have been made even worse during the pandemic, with access to surgical theatres and staff more difficult than before. We will continue to highlight this issue to the Scottish Government and to NHS Boards.

### Dental appraisal

7.17 Community dentists in England and Wales are subject to an annual appraisal which is linked to pay progression. This year across the community and hospital dental services, appraisals were put on hold from March to October and have only now resumed where it follows a health and wellbeing approach looking at what has been done during the pandemic and how does the individual feel about it.

7.18 DAS[32] is an appraisal system provided by Health Education & Improvement Wales and funded by Welsh government to facilitate appraisal. DAS is an end-to-end system that allows appraisees and appraisers to book meetings and build up information. DAS allows a seamless and simple appraisal process in Wales and is currently available for Community Dentists in Wales. The Welsh Committee for Community Dentists has been in consultation with HEIW to develop the system.

## UK CDS/PDS motivation and morale, recruitment and retention

7.19 In December 2020 we opened a UK wide online survey using Smart Survey to capture data on CDS morale and motivation. Originally BDA CDS/PDS members and non-members on our records were invited to take part via email, and an open link circulated on social media, newsletters and promoted via professional networks. Due to time constraints, we could only promote the survey online with no paper follow-up, so the sample size is smaller than expected but yields some interesting data on which we hope to build some time series data over the next few years. In total

[30] All GA figures provided by HSCB on request by BDA.
[31] All GA figures relate to paediatric extractions only and do not include extractions for special care or dental phobic patients undertaken by the CDS.
[32] Dental Appraisal System https://cds.daswales.org/

284 dentists across the UK completed the survey, approximately 19 per cent of the CDS/PDS population. This data does however reflect the findings of other published statistics.

7.20 Our survey responses mirror the more general demographic picture of the CDS/PDS workforce with predominantly females. Outside of England most CDS/PDS employers are Trusts and Boards. In England there are some other providers of CDS services who are social enterprises/Community Interest Companies.

7.21 Across the board our survey respondents demonstrated a decrease in their job satisfaction from last year ranging from 57.7 per cent in England to 70.3 per cent in Scotland. This pattern is repeated when asked about changes to morale. Dentists are reporting that significant numbers feel their morale now is low and very low and worryingly this has decreased since last year. There will be individual country reasons for the decreases but in general CDS dentists are facing low morale.

| Job satisfaction and morale | | UK (n=284) | England (n=196) | NI (n=22) | Scotland (n=37) | Wales (n=29) |
|---|---|---|---|---|---|---|
| How would you say your job satisfaction has changed compared to this time last year? (2019) | Decreased | 60.9 | 57.7 | 63.6 | 70.3 | 69.0 |
| How do you rate your morale in your work as a dentist? (4 categories) | Very Low/Low | 41.2 | 36.7 | 54.5 | 56.7 | 44.8 |
| How would you say your morale has changed, compared to this time last year? (2019) | Decreased | 61.6 | 56.1 | 72.7 | 70.3 | 79.3 |

Fig 20: Responses to BDA survey 2020

7.22 CDS dentists' value the work life balance and job security that an employed role offers. Factors that adversely affect morale are the areas that impact most on these two areas: constant changes to contracts and working arrangements and insufficient time with patients/workload negatively impact on CDS morale.

7.23 For CDS dentists the total reward package is important. This past year, a heavy burden has fallen on the CDS/PDS and they deserve the recognition that the service values them.

**CDS England**

7.24 In previous evidence submissions we have highlighted that CDS dentists (and their teams) are often the unsung heroes providing NHS care to complex patients requiring primary dental care tailored to their specific needs. 'Routine' care in the CDS service is not the same as a routine dental appointment on the high street.

7.25 For our BDA survey, 196 dentists completed the survey in England, that is approximately 21 per cent of the workforce (head count). However, the results align with the responses given to the 2019 NHS Staff Survey where a total of 451 respondents completed the survey (47 per cent and mainly those based in Trusts). However, the 2019 NHS Staff Survey results were conducted pre-COVID.

| | | Always/often | Sometimes | Never/rarely |
|---|---|---|---|---|
| **BDA 2020** | I look forward to going to work | 47.2 | 30.3 | 22.6 |
| **NHS Staff Survey 2019** | | 56 | 26 | 18 |
| **BDA 2020** | I am enthusiastic about my job | 61.5 | 28.2 | 10.2 |
| **NHS Staff Survey 2019** | | 69 | 25 | 7 |
| **BDA 2020** | Time passes quickly when I am working | 76.4 | 19.4 | 4.2 |
| **NHS Staff Survey 2019** | | 80 | 17 | 3 |

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

7.26 Across England just over half of CDS dentists felt satisfied with their present job however 58 per cent reported decrease in satisfaction compared to the previous year. Three quarters of respondents also said that workload was currently high or very high, with high levels reported of covering for other colleagues. In the last year just under 30 per cent reported working more than their weekly contracted hours 'a great deal'. As the pandemic continues, we expect to see this take its toll.

> *"Working during the COVID-19 pandemic has been more stressful than any other year I have had as a community dentist. I have not been able to provide the usual dental care for my patients and that has been frustrating."*
>
> *""We have lost service (such as access to GA, sedation, joint OMFS operating lists) and have been expected to still accept referrals and not close the waiting lists even though we do not have capacity. We have been told to do more with less money and even less time."*
>
> Free text responses from England CDS dentists

7.27 Similarly, the results for morale were mixed, with a similar amount of respondents reporting high or very high morale compared with low/very low (both 36.7 per cent). Interesting however 56 per cent of respondents felt that their morale had decreased from the previous year. This is reflected in terms of pay as only half of England respondents strongly agree/agree that their pay is fair.

7.28 Despite this CDS dentists seem generally motivated and most would recommend a career in the CDS (78.3 per cent in England) which is comparable to Wales but 14 percentage points higher than Scotland and Northern Ireland.

7.29 Another reflection of the overall UK picture is that 70.4 per cent of England dentists intend to continue in the CDS rather than moving to another branch of practice. When we asked respondents about career intentions the answer allowed multiple selections however 'reduce my hours' and 'retire from working as a dentist' were both marked at 22.9 per cent.

**CDS in Wales**

7.30 The response rate to our survey from Wales was 29 individuals which represents a third of the CDS population in head count terms. Of those who responded, 72 per cent are female and 28 per cent

male. The respondents told us that insufficient time with each patient/workload was a significant negative factor on morale, which differs to the other three countries.

> *"We have less time to deal with the backlog and ever-growing waiting lists."*
>
> *".....None of this has been recognised in a material way, i.e increase in pay, improvement in conditions - just a lot of politicians and managers saying "well done and thank you" but then its carry on dealing with all the stuff no-one else wants to do. I feel significantly undervalued and stressed by the sudden and dramatic changes."*
>
> Free text responses from Wales CDS dentists

7.31 Over two thirds of Welsh respondents told us their job satisfaction had decreased since 2019 and while 45 per cent rated their morale low, just under 80 per cent said morale had decreased from last year. Conditions are deteriorating and Fig 22 shows a downward trend for patient contacts in the CDS over the last five reporting years. There is also a correlation here with the CDS headcount (Fig 17) which shows a steady drop since 2016-17.

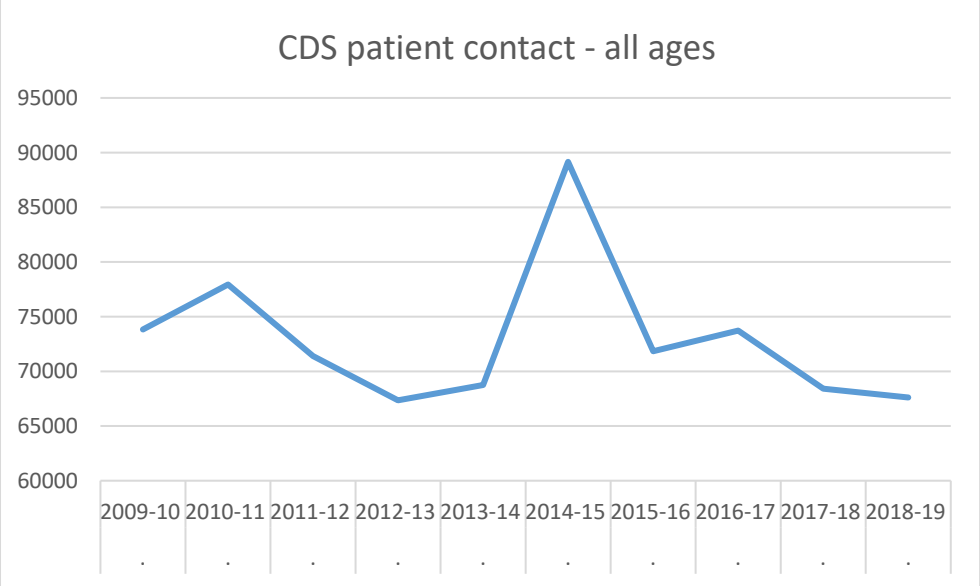


*Fig 22:* Patient contacts in the CDS in the last decade *Stats Wales (no data for 2019-20)*[33]

7.32 Patient contacts have decreased as the service has refocused towards a referral service only for special needs children and adults. This has meant the case load is more complex in both the patient and the complexity of care needed meaning increased surgery time. Wales dentists are working over their contracted hours in many cases, most between 1-5 hours a week. The years of chronic underfunding and decreasing staffing levels are placing an unsustainable pressure on the Wales CDS workforce.

**PDS in Scotland**

7.33 The current crisis has shown in Scotland how essential the PDS is, in an emergency and to its 'usual' role of treating the most vulnerable in society, including the elderly, adults with disabilities and children with special learning needs. These and other groups will need the PDS more than ever once the pandemic subsides to treat the massive backlog of dental problems that have accumulated in recent months.

[33] The official reporting data on salaried dental services in Wales used to be collected via the CDSWR. This system was replaced in April 2019 by the dental data collection system operated by the NHS Business Services Authority - using on-line data collection via the FP17W and FP17OW forms used in the GDS

7.34 The BDA has previously expressed concerns about the future of the PDS in Scotland, including on-going funding cuts. There was a 14.1 per cent reduction in funding (cash terms) between 2014/15 and 2018/19, and a 15.4 per cent drop in the number of PDS posts during this period. Continued reductions in PDS capacity and the departure of experienced staff may jeopardise the long-term viability of the service, and impact negatively on patient care. In July 2020, the BDA sought and secured assurance from the Scottish Government that the 2020/21 PDS budget would match the 2019/20 budget to ensure the PDS has sufficient capacity to meet patient demand. However, there will still be a slight reduction in real terms once inflation is factored in.

7.35 The recent BDA survey highlighted a number of concerns relating to the PDS in Scotland:

- Overall job satisfaction (64.8 per cent) was the highest among UK countries but PDS colleagues also reported the largest reduction in job satisfaction, with 70.3 per cent reporting a decrease compared to last year.
- 56.7 per cent of PDS dentists reported that their morale was either low or very low – the highest percentage for low morale in the UK – and 70.3 per cent said their morale was lower than a year ago.
- While PDS dentists reported the highest job security in the UK (78.4 per cent), only 40.5 per cent (the lowest in the UK) said that their pay was fair.
- Motivation appears to be particularly problematic among PDS dentists, with colleagues in Scotland having the lowest levels in the UK for various measures including never or rarely being enthusiastic about their job (16.2 per cent) or time passing quickly at work (18.9 per cent).
- Over a third of PDS dentists in Scotland (35.1 per cent) would not recommend a career as a community dentist
- Less than two thirds (64.9 per cent) of PDS dentists said they planned to continue practising as a community dentist in the next 5 years – the lowest in the UK – and almost one third (32.4 per cent) intended to retire during this time (the highest in the UK). These figures raise concerns about the future capacity of the PDS.

> *"I am proud of the PDS response which was almost seamless with the ceasing of dental treatment and UDCC work began."*
>
> *"I would like to be doing my normal clinics, these patients are being neglected."*
>
> *"Feeling very stretched with more and more demands piled on us."*
>
> *"Lack of recognition. Using the PDS as a catch-all service without consulting the profession. Being used for political expediency."*
>
> Free text responses from Scotland PDS dentists

**CDS in Northern Ireland**

7.36 Changing societal demographics in Northern Ireland of an increasingly elderly and dentate population, mean CDS practitioners face a growing burden of care provision, particularly within the domiciliary setting. These patients often have multiple co-morbidities and require the specialised services which CDS are best placed to provide. Unfortunately, resources have not followed the service or increased to reflect this. Furthermore regulation, cost and time have all created barriers for GDS in the provision of domiciliary care, increasing the level of CDS referrals and creating an untenable workload.

7.37 Practitioners are working to reset their core services against the backdrop of the ongoing pandemic, provision of care within Urgent Dental Care Centres, an overworked service[34] and a shortage of Special Care consultants to help deliver care for the most complex and vulnerable patients.

7.38 In Northern Ireland 54.5 per cent of respondents have low/very low morale with 63.6 per cent reporting that their job satisfaction has decreased compared to the same period last year. When specifically asked about changes to morale, 72.7 per cent said it had decreased. Whereas the other three UK countries showed clearer results for the issues that made respondents said negatively impacted upon their morale, Northern Ireland dentists showed that a number of issues were having an impact.

> *"I am exhausted and emotionally drained, also trying to manage a family whilst working on frontline."*
>
> *"I feel the impact of COVID on my job has drastically changed my role. Previously I would have been involved in a lot of screening of care homes and due to COVID this can no longer happen."*
>
> Free text responses from Northern Ireland CDS dentists

**Workforce review and planning in Northern Ireland**

7.39 In our 20/21 evidence we welcomed the CDS Workforce Review. Whilst Terms of Reference were agreed and representatives selected, the review did not go ahead. The Skills for Health Dental Workforce Review Report, which was finalised in Summer 2018, has not been published, on the advice from DoH that there was further work to be undertaken before publication. It is unclear if there is available resource to deliver this proposed work and whether a CDS review will form part of this.

7.40 The 2018 Health and Social Care Workforce Strategy 2026 indicated that significant numbers of the most experienced community dentists are approaching retirement, with up to 40 per cent reported to be potentially retiring by 2025.[35] Our BDA survey also reflected this when we asked about career intentions. CDS dentists would not move to another branch of practice but 22.7 per cent consider 'leaving the sector' with the same number selecting 'reduce my hours' and 'retire' (respondents could select more than one option). The service is at a precipice, exacerbated by the COVID-19 pandemic, and we are concerned that practitioners will 'vote with their feet' and opt to take early retirement. With that we will lose expertise, institutional memory, and informal mentoring at a time when the CDS has really shown it is invaluable.

7.41 Whilst applications to Trust employed dental vacancies have recently increased[36] we believe this to be a response to the current pressures faced within GDS. This short-term shift does not address long term sustainability and only displaces the problem of ensuring that the dental profession, and particularly CDS, remains an attractive and accessible option for dental practitioners. One option which could better facilitate graduate students joining the CDS is the re-establishment of CDS placement for Dental Foundation Trainees, which ceased in 2017. Early engagement with Foundation Dentists could demystify the service, revitalise it and contribute towards its long-term sustainability.

[34] BDA survey of community dentists 2020 indicated that 54.% of practitioners are often required to work more than their weekly contracted hours.
[35] Health and Social Care Workforce Strategy 2026, Department of Health, May 2018
[36] DoH published HSC vacancies list September 2020. At the time of publication Dental officer vacancies were at 0, having reached a peak of 8 on the 31 December 2018. It is not known if this is WTE equivalent number spread over several posts, or if Senior Dental Officers and other higher level staff are included in the figures. Vacancy rate does not include those on leave for maternity, sick or other reasons.

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

### Civilian Dental Practitioners

8.1 The BDA is this year providing evidence on behalf of Defence Primary Healthcare Civilian Dental Practitioners[37] (CDP) as this group of practitioners is awarded uplifts from the DDRB. CDPs are a group of 99 dentists (70 WTE), both full time (61) and part time (38), who are employed by the Ministry of Defence (MOD) to provide primary dental care to the Armed Forces (AF) across the UK and abroad. They work in what is known as Defence Primary Healthcare (Dental) (DPHC (Dental)). They are employed as civil servants and not as serving military personnel. They are therefore not deployable or under military discipline. Traditionally many CDPs are ex-AF dentists, but in recent years there has been an increasing number of dentists joining from GDP practices and other employed dental backgrounds, such as community dentistry. As the government seeks to control costs in the MOD, the numbers of CDPs are likely to grow in relation to their military dental colleagues.

8.2 While CDPs are civil servants, their pay increases are determined by the DDRB's recommendations in relation to salaried dentists. The MOD currently recognises *Prospect* as the trade union representing CDPs and the mirroring of the DDRB recommendation is based on an agreement between *Prospect* and the MOD, dating from 2003. While the BDA may not be formally recognised by the MOD, Prospect does understand the role of the BDA for CDPs and communicates with the BDA on matters such as pay before providing its approval to the MOD. We have a number of CDPs as BDA members with CDP representatives on BDA Committees therefore we include this cadre of dentists in our submission for parity.

8.3 In terms of service delivery, the nearest comparator to a CDP is a Community Dental Service dentist (Bands A-C in England). Like a community dentist, a CDP holds a salaried position and treats primary care patients. Both have pay scales and pay progression. The agreement to follow the salaried dentist recommendation is a recognition by the MOD of the relevance of the comparison.

8.4 To enable the MOD to maintain and expand its CDP workforce, it should be able to maintain CDP pay in relation to other dentists, but also provide clear opportunities for career development. It is vital that CDPs are remunerated properly for any overtime and on-call work they are asked to undertake. Prior to the COVID pandemic, with a predominately ex-AF workforce, the MOD have been able to rely on the goodwill of those dentists. In an expanding workforce, with increasing duties and responsibilities, the need for a formalised career structure, with issues such as overtime and on call payments addressed, will become essential going forward. We would like to see the continuation of the overtime and on-call payments after the end of the COVID pandemic.

8.5 To improve the working lives of these dentists we ask that the DDRB be aware of the two areas raised, the need for the pandemic on-call and overtime payments to continue and that a defined career structure is needed going forward. If these issues are not addressed there are likely to be issues in recruiting, which would impact on the DPHC dentists' workload and therefore the oral/dental health of the AF.

# Chapter 9 – Clinical dental academics and hospital dentistry

### Clinical dental academics

9.1 While the DDRB does not make binding recommendations in relation to academic pay, it is the position of the BDA that the DDRB should restate the recommendation for pay parity between academics and their substantive NHS colleagues to ensure there is no long-term loss of dental academics to other areas of the profession.

[37] BDA Blog – Military dentistry and the pandemic (July 2020) https://www.bda.org/news-centre/blog/Pages/Coronavirus-Military-dentistry-and-the-pandemic.aspx

9.2 We share the BMA's recent concerns that universities across the UK are not currently honouring pay increases for clinical academics, in line with that recommended by the Doctors and Dentist Review Body and encouraged by the University and Colleges Employers Association (UCEA)."

9.3 We therefore present evidence of dental clinical academic staff because of the huge impact that this branch of dentistry has now and in the future, in terms of educating new dental undergraduates to enter the profession, to provide an NHS service to patients through the teaching of dental students and the research of new ideas and developments that will keep moving dentistry forwards. Dental school is the foundation stone for anyone entering the dental profession and the recruitment and retention of academics is vital to the whole profession. The recent concerns over the impact of COVID-19 on dental students throughout the dental profession shows how important Clinical Academic Staff are in the future of a functioning dental profession.

9.4 In recent years, even with pay parity, there have been shortages within the Senior Lecturer and Reader positions. While we are awaiting the publication of DSC Surveys for 2019 and 2020, we have been in communication with the DSC and they have indicated from their unpublished results that vacancy rates have not changed substantially since the 2018 Survey[38]. We would however like to see both the outstanding DSC surveys published soon.

9.5 The DSC has confirmed in its raw data for this year's report that for the Reader/Senior Lecturer grades there is a vacancy rate of 10 per cent, which means a vacancy for one in every ten of these posts, Universities have not been able to recruit. In previous surveys there has been a pattern of large numbers of Dental Schools citing difficulties in recruiting to one or more specialties. Of the 16 UK dental schools, there were 13 reporting this difficulty in the 2018 Survey and 12 in the 2017 Survey.

9.6 The consistent level of vacancies in certain posts and the year-on-year overall vacancy levels, combined with sustained recruitment problems in certain specialties, indicate the difficulties Dental Schools have in recruiting clinical academic staff. This is supported by the BDA's 2018 Academic Survey which found just over half of respondents said they were aware of vacant posts that their University was having difficulty filling. In addition, the BDA's own research into clinical academics suggest significant numbers of academics are intending on leaving the profession in the next five years. The BDA's 2018 Academic Survey found 30 per cent of those who replied to the survey intended to leave, with the vast majority intending to retire.

9.7 The issue of the University Superannuation Scheme pension (USS) remains a concern particularly because as previously mentioned pensions have an impact on total reward and workforce retention. The USS is a hybrid defined contribution and benefit model and has been comparable to the NHS pension scheme; however, changes since 2019 have seen increased contributions required and the capping of the Defined Benefit section of the scheme making the scheme less attractive in relation to the NHS scheme, which continues to be purely Defined Benefit. Proposed cuts to the payments expected at retirement prompted industrial action in 2019. Threats to the scheme presents a challenge to dental academic recruitment and retention, when the alternative in most cases is moving to an NHS position with eligibility for the NHS pension scheme, a fully Defined Benefit scheme. Losing dental academics out of the academic pathway would have a significant and detrimental effect on the whole of the undergraduate and postgraduate training pathways and indeed the future of dentistry.

9.8 The overall picture for clinical academic recruitment remains challenging, whether by grade or specialty, and the current uncertainty over the impact of Brexit and COVID-19 on international student numbers only adds to the uncertainty. All these factors indicate that it is imperative the Dental Schools maintain pay parity for clinical academics with their substantive NHS colleagues. If this does not occur and Dental Schools pay policies diverge from the NHS, then the problems of

[38] Dental Schools Council 2018 Survey of Dental Clinical Academic Staffing Levels
https://www.dentalschoolscouncil.ac.uk/?s=Survey+of+Dental+Clinical+Academic+Staffing+Levels+2018

recruitment and retention of clinical academics are likely to worsen significantly. If this was to happen then the adverse impact on the delivery of undergraduate and postgraduate education would be significant.

### Hospital dentists

9.9 Across the UK, as demonstrated by the BMA submission of evidence, Hospital Dental Services are very stretched as they attempt to rebuild services interrupted by the COVID pandemic and are further hampered by the continued redeployment of support staff including nurses. Backlogs of patient care are growing with the outcome of the current wave of the pandemic as yet unknown.

9.10 There are however particular problems in Northern Ireland. Morale is low as poor management communication has left many HDS members feeling underappreciated especially as staff concerns around welfare and protection appear to have been ignored. Staff are concerned about the likely workplace pressures in 2021 as the necessary restructuring of services (given reduced capacity) has not taken place. There are also concerns that extended academic years (teaching through the summer) will negatively impact staff leave and down time.

9.11 In addition, there continues to be several ongoing contentious pay issues as Northern Ireland remains out of step with other UK nations in terms of merit awards for hospital/academic staff. The merit award scheme has not been open to new entrants for a number of years despite existing awardees continuing to receive payments.

9.12 We are also involved in discussions alongside the BMA with the DoH and NIMDTA about the pay scales for Dental Core Training and Dental Specialty Training. There have been a number of factors which have resulted in a significant salary discrepancy between Hospital Dental Trainees in Northern Ireland and those elsewhere in the UK. As Dental Core Training places are nationally recruited, we have argued that the salary scales in Northern Ireland should reflect the skills and competencies of the trainees with their peers.

9.13 Similar to other colleagues across the dental profession, hospital dentists in Northern Ireland feel undervalued due to the DoH's failure to implement pay awards in a timely manner and adequately address long-standing pay issues. This has resulted in unsustainable levels of low morale which threaten to tip over the edge due to the pressures arising from COVID.

## Chapter 10 - Our recommendations

10.1 We ask the Review Body to recommend a **pay uplift** of 5 per cent to attract and retain dentists to work in the NHS.

10.2 **We ask for timely implementation of pay award.** To address the unsustainable impact of continued lengthy delays to annual regional pay uplifts, the BDA requests that the DDRB again states clearly that these delays are unacceptable. Furthermore, we ask that the DDRB strongly recommend that the 2021/22 pay award should be implemented within three months of the DDRB report publication, to avoid erosion of its value.

10.3 **We do not recommend targeting awards**.

### General dental practice

10.4 We recommend for all General Dental Practitioners a pay increase of 5 per cent.

10.5 **We do urge that the DDRB starts again to make a separate recommendation on expenses for GDPs**. With the four countries treating expenses differently there is a widening disparity between

remuneration levels. We have never agreed that information on practice expenses gained from HMRC data is unreliable and would urge the Review Body to revert to its former practice.

10.6 For Northern Ireland, Wales and England, we again recommend the reinstatement of commitment payments. This has been our ask since 2017 and we ask the Review Body to consider this suggestion and encourage the Health Departments to explore the options with the BDA.

10.7 For Northern Ireland we ask for an increase in the Prior Approval limit. Under Northern Ireland's Statement of Dental Renumeration, a GDP must request prior approval before undertaking a course of treatment with a cost greater than £280. This limit is not automatically uplifted following pay uplifts and has not been increased for decades. In 2019/20, 21,284 – 78 per cent of the total – prior approval submissions were for a course of treatment with a value of less than £410 – the then Scottish prior approval limit.[39] The impact has been to result in more and more procedures requiring prior approval every year. This has contributed to the trend for GDPs to avoid higher cost treatments and focus on lower cost treatments – requiring them to work harder for same level of payment.

**Community dental services**

10.8 We recommend for Community Dental Services a pay increase of 5 per cent.

**Clinical academia**

10.9 It is imperative the Dental Schools maintain pay parity for clinical academics with their substantive NHS colleagues.

**Conclusion**

10.10 We welcome the recognition in the 48th DDRB Report of delays in uplifts.

10.11 COVID has exacerbated those significant underlying issues which have cast a shadow over the future sustainability of NHS and HS dentistry across the UK.

10.12 The collapse in morale among General Dental Practitioners is of particular concern.

10.13 Certainty around what financial arrangements will be in place in the medium to longer-term, and a replacement to the outdated contract model is urgently overdue.

10.14 An uncertain future faces us at a national, regional, dental specialty and practice level, not least in the context of the wider economy. However, the challenges of oral health inequalities can be met when young people see a career in National Health Service dentistry as something to aspire to. Both the DDRB and the BDA can make a significant contribution in seeing those aspirations realised.

## Chapter 11 – Glossary of dental terms

BSA: NHS Business Services Authority in England
BSO: HS Business Services Organisation in Northern Ireland
CDS: Community Dental Services
CDS dentist: primary care dentist (employed) in the CDS
CDP: Civilian Dental Practitioner employed by MOD not military personnel
Dentist in training: hospital dentist on a dental core training or speciality training pathway
DFT: Dental Foundation Training
DHSC: Department of Health and Social Care (England)

[39] Derived from unpublished statistics - BSO Internal Management Information obtained upon request

DoH: Department of Health (Northern Ireland)
FD: Dentist on a DFT programme. Fully qualified dentist, one-year post graduation.
GDP: General Dental Practitioner: self-employed primary care dentist
GDS: General Dental Services
GDS contract: contract to deliver mandatory dental services with no end date
HDS: Hospital Dental Service (Consultant, SAS, dentists in training)
IoS: Item of Service
NHS/HS: National Health Service or Health Service in Northern Ireland
PDS: Public Dental Service (CDS equivalent in Scotland)
PDS agreement: Personal Dental Services agreement, contract to deliver mandatory services with time limit or referral services with time limit.
UDA: Unit of Dental Activity (England and Wales)
UOA: Unit of Orthodontic Activity (England and Wales)

## Annex A – timeline of COVID-19 interim contractual arrangements timeline

**Northern Ireland:**

| Date | Description |
|---|---|
| 18 March | Initial restriction on General Dental Services:<br>• Cancellation of all non-urgent domiciliary visits<br>• GDPs to avoid Aerosol Generating Procedures (AGPs) wherever possible<br>*Practices were asked to donate oxygen to hospitals and level 1 PPE to care homes and pharmacies. Later on when reopening, they had to buy their own level 1 PPE but the costs had gone up in some cases by over 1,000 per cent.* |
| 23 March | HSCB advises GDPs to cease all aerosol generating procedures in General Practice. However:<br>• Dental Practices required to remain open and conduct phone triage<br>• Where required dental practices are expected to treat patients who have an urgent dental care need using non-aerosol generating procedures. |
| 08 April | GDS Financial Support Scheme (FSS) introduced:<br>• Applicants provided with a monthly support payment based on 1/12$^{th}$ of their total Gross Item of Service (IoS) payments from April 2019 to March 2020, less the value of any IoS claims submitted that month.<br>• Support payment abated by 20per cent to reflect variable costs which DoH expected would not be incurred such as materials and laboratory costs.<br>• Registration Fees and Allowances continue to be paid as normal. |
| 04 June | HSCB issues Operational Guidance for the Re-establishment of General Dental Services to assist practices in their preparations for a phased return to practice<br>• Focuses on the implementation of social distancing within dental practices, preparation of staff, and the implementation of enhanced cross-infection control procedures. |
| 08 June | Phase 1b of Recovery:<br>• No change to restrictions but all practices must now offer face-to-face urgent dental care |
| 29 June | Phase 2 of Recovery:<br>• GDPs now able to offer non-urgent care but treatments limited to non-aerosol generating only |
| 02 July | HSCB announce that they will provide GDPs with a consignment of Level 1 PPE. However, GDPs will have to source level 2 PPE (required for AGPs) themselves, at their own expense |
| 20 July | Phase 3 of Recovery:<br>• GDPs now able to offer AGPs but must comply with guidance in relation to aerosol settling periods between patients, surgery cleaning and PPE. |
| 31 July | 20per cent abatement disapplied from GDS Financial Support Scheme (FSS) to offset additional PPE costs associated where AGP treatments provided. |
| 21 October | HSCB issues updated Operational Guidance:<br>• Post-AGP fallow time periods are reduced from 60 minutes to 30 minutes<br>• In theory this facilitates a higher activity rate, but PPE costs, social distancing, practice ventilation requirements and the physical/mental demands of wearing PPE present significant barriers to any activity increase. |

**Scotland:**

| Date | Description |
|---|---|
| 23 March | Dental practices were told to close for face-to-face treatment though they continued to offer telephone advice to patients and refer high-priority cases to the Urgent Dental Care Centres which had been set up across Scotland |
| 2 April | Revised financial support announced comprising 80 per cent of pre-COVID Item of Service funding plus various other payments and allowances. Provision of financial support was conditional on patients being able to contact a dental professional during working hours, and on no loss of NHS workforce within practices. |
| 22 June | Phase 2 of remobilisation:<br>• Practices could reopen for urgent treatment not involving aerosol-generating procedures (AGPs). |
| 13 July | Phase 3 of remobilisation:<br>• Practices could reopen for routine treatment not involving AGPs<br>• General Dental Practice Allowance and the GDPA cap both increased by 30 per cent |
| 17 August | Practices could use AGPs for urgent care. Dentists provided with a limited amount of PPE free of charge to dental practices to provide NHS care. |
| 1 November | Phase 4 of remobilisation:<br>• Practices could provide the full range of NHS treatments<br>• Additional enhanced PPE provided<br>• Financial support increased to 85per cent of pre-COVID Item of Service funding plus various other payments and allowances. |

**England:**

| Date | Description |
|---|---|
| 11 March | Chancellor delivers the budget:<br>• Business rates holiday available to retail, leisure and hospitality premises with a rateable value below £51,000<br>Dental Practices in England excluded from this financial support |
| 18 March | Initial restriction on General Dental and Community Dental Services:<br>• Cancellation of all non-urgent domiciliary visits<br>GDPs to avoid Aerosol Generating Procedures (AGPs) wherever possible |
| 20 March | Chancellor announces new financial measures<br>• Business Interruption Loans<br>• Coronavirus Job Retention Scheme 'Furlough' = 80% of salary would be refunded by Govt up to a total amount of £2500. |
| 20 March | NHS England/OCDO second letter of preparedness published.<br>• Reduce routine care and cancel vulnerable patients.<br>• Make arrangements for treatment that cannot be delayed.<br>• Avoid AGPs |
| 25 March | NHS England/OCDO third letter of preparedness published<br>• All primary care dentists advised to provide no face-to-face treatment<br>• Dental Practices required to conduct remote phone/video triage (3AAA)<br>• For patients requiring urgent treatment referral to an Urgent Dental Care Centre<br>NHS practices would be paid 1/12$^{th}$ of contract value<br>Practices were asked to pay staff and associates at previous levels<br>NHS practices could not seek any other sources of funding |
| 26 March | Chancellor announces the SEISS Self Employed Income Support Scheme<br>• Available to those earning under £50,000p/a.<br>Many associates unable to claim any financial support |
| 15 April | NHS England/OCDO fourth letter of preparedness<br>Standard Operating Procedure for Urgent Dental Care v1. |
| 4 June | NHS England SOP Transition to Recovery V2 published |
| 8 June | GDS Practices re-opened for limited face to face treatment where IPC guidelines can be followed and CDS services began the transition out of UDCs. |
| 20 June | Practices able to provide AGP treatments |
| 13 July | NHS England/OCDO fifth letter of preparedness published |
| 28 Aug | NHS England SOP Transition to Recovery V3 published<br>CDO letter published regarding fallow time |
| 6 October | NHS PPE portal opened for NHS dental providers. Order can be made every 7 days. |
| 20 October | 4 nation IPC guidance published with information on post AGP fallow-time |

| | |
|---|---|
| 22 Dec | Q4 arrangements<br>• GDS activity targets of 45%<br>• Orthodontic activity targets of 70% |

**Wales:**

| Date | Description |
|---|---|
| March | We wrote to the CDO, asking for clarification on Business Continuity Measures to support General and Community Dental Services through the pandemic.<br>We sent another Letter to the CDO about Moving from amber alert to red alert<br>We followed up on Business Continuity and Financial support for dental practices in a letter to the CDO.<br>We updated dentists about our efforts to keep dentistry afloat. Funding models for practices with NHS contracts were developed in consultation with the CDO. |
| April | We wrote to the CDO, arguing the inappropriate cuts to the Educational Supervisor Training Grant and Foundation Training Service Fee. As a result, fees were fully reinstated.<br><br>We highlighted the plight of private dentistry in a letter to Rebecca Evans, Minister for Finance and Trefnydd and Ken Skates, Minister for Economy, Transport and North Wales. We made the case for:<br><br>Access by self-employed to the new Economic Resilience Fund in Wales<br><br>Requirement for Banks to offer dental practices loans through the government Coronavirus Business Interruption Loan Scheme<br><br>Asking them to request the Chancellor to significantly elevate the cut-off ceiling for self-employed workers' monthly income to £2,500 for all dentists who provide predominantly private dental care.<br><br>We emailed all 40 MPs in Wales asking for them to request the Chancellor to provide proper support for private contractors. We received a dozen replies including one from Ben Lake who had already written to the Chancellor and he tabled an EDM now with 16 signatures, demonstrating political support for private dentistry. |
| May | We wrote to the CDO, pushing for clarity on how to protect the future of Welsh general dentistry. BDA Reflections on the Pandemic Care Model - with SWOT Analysis and Constraints Analysis<br><br>We met with Colette Bridgman, CDO, to discuss the Welsh Governments plans expanding dentistry in Wales, including the restoration of dental services post-COVID-19, and new SOPs for phased return-to-work.<br><br>We consulted with Welsh Government and ensured practices received at least 90% of their NHS contract value in the recovery phase. |
| June | We wrote to the CDO, pushing for clarity on plans for return-to-work.<br><br>We wrote to the CDO, regarding pandemic de-escalation plans and Contract Reform.<br><br>We lobbied for an expansion of care to include AGPs at a time many patients in dire need of treatment couldn't qualify by the triage system.<br><br>We wrote to the CDO, asking for clarification on Standard Operating Process for Non COVID-19 Dental Centres Providing Aerosol Generating Procedures.<br><br>We developed a survey to hear YOUR thoughts on return to work and areas we needed to focus our energy; concerns were raised about the sustainability of both NHS and private dentistry. |
| July | We wrote to the CDO regarding the 16 July abatement in England compared with the Welsh GDS contract value.<br><br>Our Wales-specific Return-to-work toolkit was released to support dentists. in the transition from red to amber alert using the new SOP. |

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| | We presented oral evidence to the Senedd Cymru Health Committee regarding the impact of COVID-19 on dentistry in Wales. With many practices operating at a limited capacity with high operational costs, they put forward a number of solutions the Welsh Government could act upon. A written report was also submitted. |
| **September** | We wrote to the CDO, seeking clarity on free PPE provision for practices and the nature of the quality control over Government-provided PPE.<br><br>We conducted a telephone survey of 52 dental laboratories across Wales to ascertain their viability during the COVID-19 pandemic. The survey confirmed our fears that dental labs had been hugely affected. We will continue to conduct further analysis of this data to advise the CDO.<br><br>In a meeting with the CDO, Dr Bridgman confirmed that the current financial arrangements with abatement would continue into Oct, Nov and Dec 2020.<br><br>Tom Bysouth, was interviewed by BBC 1 Wales, Wales Today, sharing the predicament of many of Wales' 500 dental surgeries facing the threat of redundancies or even closure. |
| **October** | We wrote to the HIW regarding Dental Practice Inspections<br><br>We wrote to Deputy Chief Dental Officer regarding Recertification of Expired PPE<br><br>We were in regular contact with the CDO regarding the imminent 'firebreak lockdown' announced by the Welsh Government, and were able to provide clarity that dentistry is included as a vital health service, and within the definition of essential travel for healthcare.<br><br>We wrote to the HIW regarding lack of evidence of Recertification of Expired PPE<br><br>We wrote to the CDO about the Annual Conference of Local Dental Committee Motion 2020 regarding the use of the Urgent ACORN forms on busy urgent access or EDS sessions.<br><br>We received an email from Stephen Crabb, MP, voicing concerns about dentists and patients in his caseload who have been impacted adversely by the pandemic. Our reply explained the ongoing challenges that the SOP restrictions placed upon practices have created. |
| **November** | Our Wales-specific Return-to-work toolkit special guidance version 2, was released with updates<br><br>We met with Rhun Ap Iorwerth of Plaid Cymru to inform him of the ongoing impact of the pandemic on GDS NHS, Private and Community dentistry, and to discuss the effectiveness of mitigation measures. We are currently working to influence party manifestos for the May 2021 Senedd elections. |
| **December** | We made the case for Capital investment in air-handling equipment to reduce fallow time between patients, in a letter to Vaughan Gething MS, Minister for Health and Social Services. He responded positively by promising grants in 2021 totalling £450,000. |


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