BDA

British Dental Association

Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2026-27

Tuesday 30th September

Contents

Chapter 1 – Executive summary

1.1 The underfunding of NHS dentistry continues to be the root cause of the profound dysfunction of the labour market for NHS dentistry. Real terms spending on dentistry across the United Kingdom fell to £1.901 billion in the 2023-24 financial year, compared to £2.6 billion in 2006. This underfunding has predictable consequences for dentists and the public alike.

1.2 In the absence of appropriate remuneration dentists are forced to bear the burden of substantial increases to the non-pay costs of NHS dentistry. Laboratory costs, for example, increased by 9% in the 2023-24 financial year. In addition to substantial increases to the routine operating costs of NHS dentistry, dentists have also been forced to bear the burden of structural changes to the labour market for dentistry including amendments to Class 1 National Insurance contributions and thresholds impacting on the costs of employing practice staff. Any costs arising from similar structural changes to the labour market for dentistry must be reflected in the 2026-27 uplift.

1.3 Take home pay for associates and practice owners across the United Kingdom fluctuated somewhat in the 2023-24 financial year compared to the position last year, with significant reductions in take home pay for practice owners in Scotland and Wales. As noted in our submission last year, the long-term trend is of an extraordinary reduction in take home pay for both associates and practice owners across England, Scotland, Wales and Northern Ireland. While there is variation by nation it is difficult to overstate the impact of this trend on the sustainability and resilience of NHS dentistry across the United Kingdom. These trends are explored in detail in paragraphs 5.8 – 5.14 / Chapter 5.

1.4 Our survey this year found that just 20% of practice owners and 40% of associates agreed or strongly agreed that they were remunerated fairly for their work. Where practice owners and associates worked at practices with a high NHS commitment, this figure dropped to just 7% and 29% respectively. The extraordinarily limited belief in the fairness of remuneration for NHS dentistry is an indictment of a broken system which punishes those most responsible for preventing a total collapse in the supply of NHS dentistry. Predictably, many dentists continue to respond to the long-term, planned under-remuneration of NHS activity by delivering more private activity; this year's survey found that 44% of practice owners reported an intention to reduce their NHS commitment in the next five years, while 41% of associates reported an intention to do the same.

1.5 As noted in our evidence submission last year, a high NHS commitment remains strongly positively correlated with poor motivation, morale and job satisfaction. 56% of all practice owners across the United Kingdom and 42% of all associates reported low or very low morale in our survey this year, representing a worsening of the already deeply concerning position recorded in our previous survey. This year, where the relevant dentists held a high NHS commitment, 71% of practice owners and 49% of associates reported low or very low morale. 92% of practice owners reported increased practice costs as a major contributor to stress. We set out these issues in detail as captured by our primary research in paragraphs 6.19 – 6.22 / Chapter 6.

1.6 Disappointingly, the recruitment and retention crisis identified in our previous evidence submissions shows no sign of abating. 63% of practice owners reporting vacancies told us that they had vacancies across the dental team that had been open for more than six months, with that figure increasing to 76% for those with a high NHS commitment. 63% of practice owners reported difficulties recruiting dental hygienists, 77% of practice owners reported difficulties recruiting dental nurses, and 70% of practice owners reported difficulties in recruiting dental

therapists. Just 34% of practice owners who had vacancies in the 2024-25 financial year were able to fill all posts they sought to recruit for.

1.7 In the Community and Public Dental Services (CDS/PDS) increases in demand for services, longer waiting lists, and higher workloads continue to negatively impact those working with some of the most vulnerable and complex patients. 52% of all respondents across the UK reported low or very low morale, with 58% indicating that their morale had decreased since our previous survey. Our survey this year found that 19% of respondents were aged 55 and over, and 42% of respondents reported their intention to either retire from dentistry within the next five years, leave the UK, or leave dentistry. The ongoing mismatch between demand for vital services and workforce capacity places an unsustainable and wholly unfair burden on those delivering Community and Public Dental Services, and under-remuneration compounds this burden by impeding effective recruitment and retention. We set out these issues through our primary research in paragraphs 7.11 – 7.40 / Chapter 7.

1.8 There are multiple causes of these crises facing the provision of NHS dental services in the UK, with the pay for NHS work critical to why there are workforce supply shortages and why, where there is a workforce, they experience very low morale and motivation. The Review Body on Doctors and Dentists Remuneration (DDRB), therefore, has a central role in ensuring its recommendations on pay are commensurate with the scale of these crises.

1.9 The British Dental Association (BDA) continues to believe that pay and operating costs are indivisible in any equitable total funding package. Successive uplifts have been insufficient to both cover the increased operating costs borne by practice owners and protect pay. Further, the urgent reversal of this decade long erosion of take-home pay can only be secured by a pay award process in which all parties act in good faith and commit to an evidence-based approach that recognises the failure of the current system. We therefore welcome the DDRB's recommendation that an index of dental costs be devised and agreed by the parties, and regret that to date no Government has accepted this proposal. Unfunded increases in the operating costs facing dental practices continue to distort the functioning of the labour market for dentistry and cripple the supply of NHS dentistry. In the absence of bold action from the DDRB this long-term, planned underfunding will continue to degrade capacity and resilience in the supply of NHS dentistry.

1.10 We therefore call on the DDRB to recommend an overall uplift of 8.99% for all NHS general dental contracts, fees and allowances. This figure includes a pay uplift of 9.5% and operating costs uplifts as outlined in paragraphs 5.18 – 5.23 / Chapter 5. In line with this, we ask the DDRB to recommend a pay uplift of 9.5% for employed dentists. Alongside these pay uplifts, we also call for:

1.10.1 Timely implementation of pay awards
1.10.2 Reinstatement of commitment payments for England, Wales, and Northern Ireland
1.10.3 Clarity from the DDRB that any uplift recommendation it makes to the Northern Ireland Executive is in addition to the uplift recommendation in the previous pay round
1.10.4 Clarity from the DDRB that to accept an uplift recommendation necessarily entails not imposing additional contractual conditions
1.10.5 Clarity from the DDRB that its non-pay recommendations are integral to its considerations and therefore indivisible from its recommendations on pay
1.10.6 The overall annual expenses uplift to be applied to service costs for Dental Foundation Training (DFT) Practices
1.10.7 The DDRB to reiterate the historical recommendation of pay parity of clinical academics

Chapter 2 – About the BDA

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

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

2.3 Where we refer to 'operating costs' in this submission, we are referring to all costs facing dental practices beyond those of dentists' pay. This includes, for example, the pay of the wider dental team, or the costs of materials. Our experience tells us that non-specialist audiences including political stakeholders and the public understand 'expenses' as discretionary. As such, the term 'operating costs' more accurately communicates the essential nature of this component of the total funding package received by dentists.

2.4 Fieldwork for the quantitative survey that informs this submission was conducted between 27 May and 29 July 2025. Where we refer to practice owners or associates with a 'high NHS commitment' we are referring to respondents who have indicated that their practice as a whole or they as individual associates deliver 75% or more NHS activity.

Chapter 3 – BDA response to the 53rd report

Uplifts

3.1 As we stated publicly in our response, the DDRB's recommendation of a 4% pay rise was insufficient to have a substantial impact on the recruitment, retention, morale and motivation of dentists working for the NHS. The scale of the crisis facing NHS dentistry requires decisive action, including on pay.

3.2 This uplift, which looks set to be almost entirely eroded by inflation, comes after more than a decade of real-term pay cuts. We need to see the DDRB deliver sustained real-terms increases to allow for the pay of NHS dentists to recover its value, and for dentists to feel properly remunerated for their NHS work.

England

3.3 In England, the Government has accepted the DDRB's recommendation on pay. In relation to GDPs, shortly after the publication of the DDRB report, the BDA submitted a paper to the Department of Health and Social Care (DHSC) outlining the approach we thought should be taken to the contract uplift. However, the DHSC then wrote to the BDA in late July proposing to take the same approach of applying the GDP deflator to the practice operating costs elements. We responded setting out why this approach is unacceptable, outlining our evidence-based proposals on practice operating costs, and highlighting the need to apply uplifts to all elements of the Statement of Financial Entitlement payments, including the DFT service costs.

3.4 The DHSC confirmed to the BDA on 16 September that it would implement a 3.55% uplift, with 2.39% applied to the non-pay practice operating costs. 4% would be applied to non-dentist staff pay. There has been no confirmation as to whether this will apply to the DFT service costs payments. The uplift will be applied from October – 6 months late – and backdated to April.

3.5 The effect of the DHSC's proposed approach is that, while it claims to accept the DDRB's recommendation on pay, it is not implementing a 4% increase to GDPs' pay net of expenses.

3.6 For salaried dentists, NHS Employers have issued a pay circular to implement the 4% uplift. The Government is yet to confirm whether it accepts the DDRB's recommendation in relation to the need to review pay and progession in the CDS.

Scotland

3.7 The Scottish Government made an announcement to the dental sector in August, confirming the 2025-26 pay uplift for GDPs and Dental Bodies Corporate. The Scottish Government accepted the DDRB's recommended pay uplift of 4% and applied this to gross item of service fees (including orthodontic fees), and to capitation payments. This will be applied from 1 November and backdated to 1 April.

3.8 Our position remains as in previous years that any uplift should be applied to the full remuneration package within the Statement of Dental Remuneration (SDR). We are again disappointed that the uplift was not applied to the full remuneration package. Our view is that the uplift must be applied to all allowances otherwise it is not a true 4% pay increase. While Scottish Government state they have accepted the DDRB recommendation on pay, we would dispute this, as in reality their application of the uplift does not deliver a 4% uplift on take home pay.

3.9 The prior approval limit in Determination I of the SDR will increase by 10% which means a change from £600 to £660. This reflects the 6% pay award in 2024-25 and the 4% pay award in 2025-26. The new limit will apply to courses of treatment with an acceptance date on or after 1 November. We would like the prior approval limit to be increased on an annual basis in line with the pay award.

3.10 The qualification thresholds for Determination IX of the SDR (Commitment Payments) will also increase by 4%, with these increases applied from 1 January 2026. However, the value of the Commitment Payments has not been uplifted, so this is effectively a reduction in the value of each Commitment Payment level. We have again called for the Scottish Government to uplift the value of the Commitment Payments by the pay award to maintain parity.

3.11 The amount of General Dental Practice Allowance (GDPA) Determination XIV of the SDR which can be applied to dental practices has been increased by 4% to a maximum of £22,880 per quarter. This change will be effective from 1 January 2026. Whilst this increase is welcome, the previously static and capped GDPA along with associated pay uplifts over a number of years, has placed many dental practices at the capped GDPA level, leaving them with inflationary cost which they must absorb and this must be addressed in future pay awards.

3.12 Within this financial year, a particular concern is the impact of measures in the UK Autumn Budget to increase the national minimum wage and employer National Insurance contributions (eNICs). We have called on the Scottish Government to fully mitigate the increased cost, associated with the eNICs increase. No mitigation or amelioration has been forthcoming.

3.13 In relation to operating costs, the Scottish Government has said they are committed to continuing the wider dialogue with us on remuneration and expenses. An initial exploratory meeting, to consider future costs of delivering care uplift methodologies, took place earlier this year. However, we are seeking further discussion on establishing a jointly agreed methodology for assessing changes in practice operating costs and have told Scottish Government that we would like these conversations to restart for future pay rounds.

3.14 For this pay round, the Scottish Government again failed to discuss the costs of delivering care with Scottish Dental Practice Committee (SDPC), despite our calls highlighting the need for support to meet rising costs and soaring general and dental inflation. This failure to address the operating costs element of pay represents a further real terms pay cut for GDPs.

Wales

3.15 The process in Wales regarding the implementation of DDRB uplifts continues to diverge significantly from that of England, Scotland and Northern Ireland. The Welsh Government insists on linking any annual uplift to contractual reform conditions. This means practices do not receive certainty on pay awards until protracted negotiations are concluded. For this financial year, this issue remains unresolved, leaving practices facing ongoing financial instability and threatening the wider financial sustainability of the sector.

3.16 BDA Cymru has consistently raised concerns about this approach, highlighting that it undermines the independent role of the DDRB and can ultimately reduce the uplift amount should the conditions imposed incur a cost to the practice. Welsh Government ministers have, however, continued to enforce this policy position across all four contractor groups. This has placed NHS dentistry in Wales in an especially precarious position compared with the other nations, where uplifts are applied more straightforwardly and without further conditions.

3.17 The consequences are clear: workforce morale and retention are under increasing strain. Associates in Wales are less likely to receive annual uplifts than their counterparts in England, for example, and many report that they have not seen any pay rise for several years. Practice owners, meanwhile, face growing business risks, with contract instability and clawback compounding this problem.

3.18 BDA Cymru has continued to press for a separation of annual uplifts from both reform negotiation and further conditions, aligning with similar calls from colleagues in general medical practice. We have urged the DDRB to recognise that the Welsh approach not only delays award announcements but fundamentally changes the pay-setting process in ways that may disadvantage Welsh GDPs. We will continue to challenge this process on behalf of the profession.

Northern Ireland

3.19 Implementation of the 2024-25 DDRB pay uplift in Northern Ireland proved an extremely drawn-out process. In a context of a significant Department of Health (DoH) funding shortfall, it took until 11 February 2025 for the Health Minister to confirm that funding was in place to approve payment of the full 12 months backdated to 1 April 2024. The 6% recommendation translated to an uplift of 4.85% to fees and allowances, comprising 2.8% CPIH applied to expenses.

3.20 While salaried dentists received backpay arrears in their March 2025 pay, first payments to GDPs was not received until May 2025, or 13 months after this should have applied. We highlighted our dissatisfaction in the strongest terms at this additional delay caused by, 'operational issues' which had a further detrimental impact to GDPs over their salaried colleagues at a time of intense financial pressure in Health Service (HS) dentistry. The Minister advised us in writing on 9 July that he has accepted the recommendation of a '4% increase to SDR fees for 25/26'. However, once again the inadequate DoH budget position is causing delay to practitioners from receiving this increase.

3.21 The Minister advised us in writing on 9 July that he has accepted the recommendation of a '4% increase to SDR fees for 25/26'. However, once again the inadequate DoH budget position is causing delay to practitioners receiving this increase.

3.22 While the Minister has taken the unprecedented step of issuing a Ministerial Direction on health service pay because of the significant budget deficit, at time of writing we have no clarity on when or even if this uplift will be applied, including backpay. We understand the matter currently sits with the Northern Ireland Executive.

3.23 On 24 June we wrote formally to request that the DoH accept the specific recommendation outlined at 1.119 in the 53rd DDRB Report[1] regarding developing an index of dental costs, and further that it engages in this important piece of work in collaboration with governments in England, Scotland and Wales. Regarding the 2025-26 uplift, we have shared BDA analysis which recommends an overall 9.08% uplift to be applied, incorporating appropriate remuneration for the costs of delivering care. To date, we have not received a definitive response from DoH on how they will approach these issues.

Delays

3.24 As in all recent years, the process for applying uplifts to dentists' contracts and salaries is delayed to an extraordinary extent. Again, we are in the position of submitting evidence for the subsequent year, before this year's uplift has been determined and implemented for all parts of the remit group.

3.25 While the current round marks a welcome move to a timelier pay review process, remit letters for the last round were issued at a date that effectively precluded the uplift being applied for 1 April.

3.26 In a period of higher inflation delayed uplifts exacerbate challenges to practices' financial sustainability and dentists' personal finances and erode already poor morale. There are also practical problems for GDPs where backdated payments must be made, particularly where individuals have retired or left the NHS.

3.27 We are grateful to the DDRB for acknowledging these issues in its 52nd report, and for the Chair raising this matter with the Prime Minister. We also welcome the DDRB's particular comments about the extreme delays in Northern Ireland and the intervention of the Chair. However, we again emphasise the critical importance of a return to the former timetable to ensure uplifts occur in April each year.

Year	NI		England		Scotland		Wales	
2025-26	TBC	TBC	Oct 2025	6 mths	Nov 2025	7 mths	TBC	TBC
2024-25	Mar 2025	11 mths	Jan 2025	9 mths	Dec 2024	8 mths	Feb 2025	10 mths
2023-24	Mar 2024*	12 mths	Oct 2023	6 mths	Nov 2023	7 mths	Jan 2024	9 mths
2022-23	Mar 2023	11 mths	Feb 2023	10 mths	Dec 2022	8 mths	Dec 2022	8 mths
2021-22	May 2022	13 mths	Dec 2021	8 mths	Dec 2021	8 mths	Oct 2021	6 mths
2020-21	Aug 2021	16 mths	Dec 2020	8 mths	Nov 2020	7 mths	Nov 2020	7 mths
2019-20	Aug 2020	16 mths	Nov 2019	7 mths	Aug 2019	4 mths	Aug 2019	4 mths

[1] Review Body on Doctors' and Dentists' Remuneration Fifty Third Report: 2025 - UK Government

2018-19	Aug 2019	16 mths	Dec 2018	8 mths	Nov 2018	7 mths	Sep 2018	5 mths
2017-18	Jul 2018	15 mths	Aug 2017	4 mths	Apr 2017	0 mths	May 2017	1 mth
2016-17	Apr 2017	12 mths	Jun 2016	2 mths	Apr 2016	0 mths	Jun 2016	2 mths
2015-16	No uplift**	10 mths	Aug 2015	4 mths	Apr 2015	0 mths	Aug 2015	4 mths

Fig 1: Implementation date of GDP uplift and the delay across the UK (*Note that implementation is not yet complete. **2015/16 decision to provide no uplift made 10 months late)*

Response to practice operating cost uplifts

3.28 As we have set out in previous evidence, inadequate practice operating costs uplifts have had a significant impact on dentists' (in particular, associates') take-home pay, and we provide further evidence on this in Chapter 5. The process for practice operating costs for this year fails to address the criticism of it that is set out in the 53rd report. Neither the approach of applying the GDP deflator nor the approach of substituting the DDRB's recommendation on pay for the practice operating costs element is appropriate. Nonetheless, the governments persist in taking these approaches.

3.29 This is particularly damaging in a context in which dental inflation remains high. There have also been specific costs imposed by the Autumn Budget 2024 in relation to Employer National Insurance Contributions and the National Minimum Wage.

3.30 It is important to once again underscore that, while the governments formally accept the DDRB's recommendation on pay, they do not implement it net of expenses. This means that the value of the uplift intended to apply to pay is eroded before it reaches dentists' pay packets. This acts to undermine the DDRB and its recommendations on pay.

3.31 We welcome, therefore, the DDRB's recommendation that an index of dental costs be devised and agreed by the parties. It is regrettable that, to date, no government has accepted this recommendation.

3.32 Such an index is technically feasible. There is existing data from official sources, such as NHS Dental Earnings and Expenses, ASHE and the ONS; other data sources, such as the NASDAL reports; and the DHSC and NI DoH are undertaking economic reviews of general dental practice that can inform the baseline of this index. There may be a need for some bespoke data gathering to meet gaps. We are open to working collaboratively with the governments to develop this index. We have previously submitted papers to the DHSC proposing a mechanism of this nature, which have not been taken forward by the DHSC.

3.33 To be frank, we perceive the barrier to the development of an index of dental costs to be one of political will and public finance. At present, governments are effectively free to impose an 'affordable' uplift on practice operating costs. They do not appear willing to be tied to a mutually-agreed mechanism for determining this uplift. Instead, they would rather continue to erode the resourcing of NHS dental treatment in a way that perpetuates the crisis facing the service, with predictable implications for patients' access to dental care.

Chapter 4 – Policy update

4.1 There is increasing policy divergence in approaches to NHS dentistry by each of the governments across the UK. Regrettably, there remains common ground in that the pay, working conditions and contracts available to dentists across the UK are not sufficiently attractive to deal with profound recruitment, retention, morale and motivation challenges.

England

Dental Recovery Plan

4.2 Since our last evidence submission, it is now widely accepted that the Dental Recovery Plan failed to achieve its objectives, and most of its policy measures have been abandoned. Plans to roll-out dental vans were shelved before implementation had even begun, and the New Patient Premium (NPP) was terminated on 31 March 2025. The 'golden hellos' scheme remains in place, but to the best of our knowledge only 35 posts have been filled.[2]

4.3 We have concerns about how decisions were made to terminate the NPP. The qualitative feedback that we received, and which we know was shared with NHS England in focus groups, was that dentists and practices were using the Premium to take on new patients. However, the data available to NHS England at a national level painted the opposite picture. While considered inadequate to fully meet the costs of new patients, the NPP was a step towards better matching payments to the costs of delivering treatment. Removing it has been viewed negatively by the profession.

4.4 Fundamentally, the impact of the Dental Recovery Plan and other contractual changes are hamstrung by their not being supported by additional funding and by the UDA system forming the basis for the contractual framework.

Further changes to the UDA contract

4.5 This same approach of pursuing policy changes within the existing budget has been applied to the current package of changes to the UDA contract that are under consideration. These changes will retain the fundamental framework of the current contract, but act to ameliorate its worst failings. We have sought to negotiate a package that is attractive to dentists, moves as far away from the UDA as possible, and better matches payments to the cost of care.

4.6 The BDA is supportive of many aspects of what is proposed, and, through our work with NHS England, we have shaped the proposals. There are meaningful improvements, but this cannot be the final destination.

4.7 The proposals will see the introduction of care packages for high needs patients, each worth an amount in pounds. There are improved remuneration arrangements for fluoride varnish, fissure sealant, and denture repairs. Quality improvement measures to conduct clinical audits and peer reviews will be funded while dentists and other members of the clinical dental team will be paid to undertake annual appraisals. There will also be measures to require contractors to deliver a certain level of urgent care and this will be paid at a higher rate than the 1.2 UDAs currently associated with these treatments. There are improvements to eligibility for NHS benefits, such as maternity pay.

4.8 There are areas where we think that the package must be improved. For example, we think that the proposal to pay 0.5 UDAs for a separate course of treatment to provide fluoride varnish will be insufficient to incentivise this care and to move to a model of delivering it through

[2] Dental Patient Charges Uplift 2025/26 – UK Parliament

Extended Duties Dental Nurses. The costs are not well matched to the payments proposed.

4.9 The development of these changes first began in Autumn 2022 and the glacial pace of progress is therefore profoundly frustrating. The package has been subject to public consultation over the summer, and it is anticipated that the changes will be implemented from 1 April 2026.

NHS 10 Year Plan

4.10 This summer, the Government published its 10 Year Plan for the NHS. Unlike previous similar documents, the Plan contained a relatively extensive section on dentistry and oral health. The vision articulated for 2035 is ambitious relative to the current parlous state of NHS dentistry. To meet the aspirations set out, the Government will need to deliver on its commitment to reform the contract, and this reform will need to be underpinned by investment.

4.11 It is regrettable that the Plan includes pursuing plans for a tie-in to the NHS for new dental graduates. Our view is that this is both in principle unfair and in practical terms likely to backfire as a means to secure a long-term workforce.

4.12 We anticipate that the Plan will be followed by a refreshed workforce plan. This needs to contend with how we retain existing dentists, not just train new ones. There also needs to be planning about where within the NHS capacity is needed so that, for example, there is a flow of dentists into the CDS. This will be as much about pay, conditions and contract, as it will be about education, training and registration.

Scotland

4.13 We continue to work with Scottish Public Pensions Agency (SPPA) to ensure improvements are made to the running of the NHS Pension Scheme. Whilst we believe that the benefits of this pension scheme present a high-value, good-quality retirement savings vehicle, we believe that much more needs to be done to improve scheme communications, processes and the tools available to members.

4.14 We have continued to call for the Scottish Government to make additional funding available to improve the administration of the NHS Pension Scheme. We do not think it is unreasonable to ask for a service that all members can expect to provide timely and error-free information; or that all members can have access to online tools to model their own retirement plans. Sadly, for too many people this level of service has been lacking. We will continue to ask for these much-needed improvements.

4.15 We joined our GP, pharmacy and optometry colleagues to warn the Scottish Government that failure to protect primary care from the increased costs in the UK Government's budget would have 'real consequences for the communities we serve' and called for their support to protect these services from significant increases in overheads.

4.16 In a joint open letter to the Cabinet Secretary for Finance and Local Government, we stressed that the increase in employers National Insurance contributions would have a major impact on all NHS primary care providers, that largely operate as small businesses and would present a wholly unacceptable financial burden. We continued to make the case for the Scottish Government to bring forward mitigation for these costs by making representations at a roundtable event arranged by the Scottish Government where they explored the potential wider system impacts across primary care.

Wales

4.17 Contractual arrangements in Wales remain tied into the wider primary care reform

programme, but with dental services disproportionately affected by the policy of annual contract variation. Since 2021, practices have been operating under year-on-year changes to the 2006 framework, with adjustments framed around volumetric targets. These prioritise new and urgent patient access at the expense of continuity of care, leaving long-standing patients often shifted to 12-month recall intervals. The only prevention element formally included is a blanket requirement for fluoride varnish, which many clinicians see as an inadequate proxy for meaningful preventive care.

4.18 The model currently in operation is a crude, unweighted form of capitation, with no recognition of case complexity, deprivation, or high-needs patients. Practices are left to absorb the cost of high-need cases and expensive treatments such as dentures, which are increasingly unaffordable. Annual retrospective mitigation based on intervention profiles creates high levels of financial risk and makes forward business planning near impossible. For the year 2024-25, multiple practices received targets for historic patients that were mathematically impossible to achieve. Despite this, they faced significant difficulty in getting these targets amended.

4.19 This instability has been reflected in workforce and morale data in recent years, such as the Quality Assurance Self-Assessment which saw that almost a third of NHS practices had vacancies for dentists. Recruitment and retention of associates is more challenging in Wales than elsewhere in the UK, with 189 NHS dentists (13% of the workforce) leaving the service in Wales since 2022.[3] The repeated application of short-term contract variations has eroded trust in the reform process, driven contract hand backs, and fuelled the shift towards private provision.

4.20 Clawback against arbitrary targets remains a major source of frustration, compounding the challenges facing already fragile practice finances. The lack of risk-sharing in contract design has left practice owners exposed, and Welsh practices report the lowest morale and job security across the UK. The system now mirrors the worst features of the discredited UDA model, while also failing to deliver meaningful improvements in access or prevention.

Northern Ireland

4.21 The widening gap in Northern Ireland between costs associated with providing modern dental care at practice level, versus a discredited contract/remuneration model lacking any objective underpinning has destabilised the entire dental system. In November 2024, we warned Minister Nesbitt an objective General Dental Service (GDS) fee rebasing exercise plus establishing a mechanism to fairly mitigate costs annually is urgently needed if the GDS has any hope of being put on a sustainable footing. We also pointed to the prospect of thousands of pounds being added to payroll costs via increased National Insurance employer contributions and National Living Wage increases announced in the Budget.

4.22 Dentistry did feature in the Minister's set of priorities to the end of this Assembly mandate, launched on 10 December 2024. Commitments included in Health and Social Care NI: A three year plan to Stabilise, Reform, Deliver stated: 'by April 2027 we will have developed an action plan and programme of work for the reform of General Dental Services'.

4.23 In January 2025, Minister Nesbitt advised that he had approved the commissioning of a GDS Cost of Service review, to be carried out in 2025/26 which he said, 'will provide the information necessary to inform the future of GDS in Northern Ireland'.

[3] Y Cyfarfod Llawn Plenary – Senedd Cymru Welsh Parliament

Contract reform

England

4.24 The DDRB is undoubtedly aware of the BDA's views of the current NHS GDS contract in England and we appreciate the DDRB's repeated calls for it to be reformed.

4.25 Our position remains that the reformed contract needs to be based on a prevention-focused and capitation-centred model. We have submitted detailed proposals of the system we envisage to the DHSC.

4.26 The current UK Government was elected on a manifesto that committed to reforming the contract, but in its first year there was little sign of this being pursued. More recently, the Minister has given public signals that he wishes for progress to be made rapidly; stating to the Health and Social Care Committee that "fundamental contract reform to put us on the pathway to change has to happen within this Parliament." Over this summer talks have begun, and we anticipate that there will be a consultation on reform in coming months.

Scotland

4.27 Contract reform has taken the form of payment reform in Scotland. The foundation of this payment reform builds on commitments made in the Oral Health Improvement Plan 2018, with the Scottish Government noting the concerns expressed by the sector during the pandemic which highlighted the need to prioritise payment reform, delivering an administratively simpler and more clinically focused system.

4.28 Payment reform was implemented on 1 November 2023 and has seen a change to the remuneration of NHS dental practices/services in Scotland. We surveyed NHS dentists to seek their feedback on these changes. 69% of respondents agreed that Payment Reform represents an improvement over the system that proceeded it. However, respondents also said it has not met the Scottish Government's stated policy objectives. Only 1 in 5 agreed that the reformed system reduced bureaucracy, while just over 1 in 4 said it increased clinical freedom. Only 7% believed it enhanced access for NHS patients and only 3% said it supported a reduction in oral health inequality.

4.29 With practices facing higher costs as a result of the most recent UK Budget, 45% estimated their practices would struggle to remain financially sustainable. Over half warned it would accelerate the move to the private sector. 65% stressed these costs must be covered by either the UK or Scottish Government.

4.30 Only 10% could describe the NHS as an attractive place to build and maintain a career. 91% felt their job was stressful, with 71% saying they felt burnt out by it. 86% identified higher needs patients requiring more clinical time as a challenge affecting their practice. 83% cited not being able to accommodate all the patients who contact them. Recruitment and retention of dentists was flagged as an issue by 72%, for dental nurses by 78%.

4.31 BDA Scotland and SDPC representatives continue to constructively engage with the Scottish Government regularly along the Practitioner Services Division and other key organisations/stakeholders, to discuss and highlight any emerging issues or concerns associated with the delivery and remuneration of GDPs.

4.32 Workforce challenges are now being felt acutely across the sector and must be addressed as a matter of urgency. The NHS must be an attractive place to work and somewhere that enables recruitment and retention of dentists throughout their career. We are calling for the Scottish Government to develop and implement a fully-costed and fully-funded NHS dentistry workforce

plan as a matter of urgency.

Wales

4.33 BDA Wales had been engaged in intensive negotiations with the Welsh Government on a new NHS GDS contract, planned for introduction in April 2026. From the outset we made clear that small adjustments to the existing volumetric model would not meet the needs of patients or practitioners. Our objective has been to secure a contract that balances access, prevention, and financial sustainability.

4.34 Despite this progress, negotiations were brought to a premature close by the Welsh Government, who cited the need to meet tight legislative deadlines. As a result, the new model is not a negotiated agreement. The draft model was taken to public consultation, with questions that were incredibly leading. The Welsh Government outlined their response to the consultation on 23 September 2025, however, there remains a lack of detail for dental practices.

4.35 A central government priority in the new model is improved access, including through the roll-out of the Dental Access Portal (DAP). This system creates a centralized waiting list, despite the lack of data on demand and the impact this will have on areas with high waiting lists and fewer NHS practices. While the stance on healthy or green patients has softened, the DAP still poses a risk for the flow of patients. With a consistent need to see new patients, recalls will likely become greater than 24 months. The contract still fails to be prevention focused, with access as a number, rather than the population's oral health, being the goal.

4.36 BDA Cymru has consistently warned that the proposed contract reform is fundamentally flawed: it is unnegotiated and imposes unrealistic volumetric targets that threaten continuity of care, destabilize practice finances and financial planning and undermine clinical autonomy. While some elements of negotiation were superficially included in the model, the substance had been stripped away to focus on access without prevention or continuity of care, leaving dentists faced with uncertainty and stress, during a time when recruitment and retention are already strained. While concessions have been made, detail is still lacking. Practices and patients are facing a lack of clarity on a final model which will be implemented in April 2026.

4.37 Crucially, this contract is entirely untested. Patients and dentists will both be left to suffer the consequences unless targets are subject to a moratorium. Without any pilot, it is impossible to assess the contract's practical impact or sustainability, resulting in the risk of losing NHS dentistry in Wales.

Northern Ireland

4.38 The situation facing HS dentistry in Northern Ireland is beyond dire and unmanaged. The mass fall-off of patient registrations comes as no surprise when our survey findings show virtually all dentists have lost faith in the current system, and as financial pressures intrinsic with providing HS care go unaddressed.

4.39 Regrettably, while the core financial challenges are not new, they have become compounded to become more acute, while governments response has failed to stabilise the situation compared with responses taken in neighbouring jurisdictions, most notably and comparably, Scotland. For many, the logical step is to disentangle themselves from a failing contract model, and all the additional stress/recruitment issues/financial burden that comes with it.

4.40 Recent trends demonstrate that the very survival of HS dentistry in Northern Ireland is at risk, a service which has already shrunk in terms of registered patients at an unprecedented rate - by 24% over the past year, with all future projections pointing to this decline exacerbating. While a Cost of Service review has been promised, there is deep concern for what a future service will

look like in a year, or a few years' time, not to mention what the impact will be on those practitioners continued to be shackled to it, and patients who rely on HS care.

4.41 We welcome that the Minister has approved the commissioning of a General Dental Services Cost of Service review, to be completed in 2025/26. This is a signal that there is recognition of the perilous position Health Service dentistry is in. Our grave concern however is what the pace, scope, and practical impact of the results of this important exercise will be. The Cost of Service Review must be the precursor to a 'rebasing exercise' which sets the remuneration for dentistry at level that reflects market realities. This should mean that a practice that is 100% HS committed can make a reasonable return, and be able to reinvest in providing a modern service without any cross-subsidy from private earnings. This must be commissioned urgently.

4.42 We urge the review body to sound the alarm as loudly as possible regarding the critical situation in Northern Ireland; moreover, at a time when even granting a modest 4% pay uplift for 2025-26 seems a nigh impossible task, government must urgently get a grip of the crisis unfolding before us.

Chapter 5 – Economic conditions and pay trends

5.1 After a period of sharply rising prices throughout 2021 and 2022, CPI inflation has eased, though still well above its long-term target. By August 2025, headline inflation stood at 3.8%.[4] This level of inflation is above the norm for recent decades and, alongside further modest economic growth, provides the macroeconomic context for considering long-term pay trends and the appropriate real-terms pay uplift for dentists.

Private and Public Sector Pay Growth

5.2 According to the latest ONS data,[5] in the year to July 2025 average weekly earnings excluding bonuses and arrears of pay – a clearer measure of underlying pay growth – rose by 4.7% across the whole economy. Within this, pay in the private sector grew by 4.5%, while the public sector recorded growth of 5.3%. Since the pandemic, average regular pay growth has been stronger in the private sector at 5.3%, compared with 4.4% in the public sector, reflecting sustained differences in wage pressures. Dentists should not see their pay eroded relative to those in other occupations, nor more than it should in relation to inflation.

Spend on NHS dentistry

5.3 Gross expenditure on NHS dentistry across the four nations rose steadily over the past decade, reaching £3.717 billion in 2023-24 in cash terms.[6] This represents a partial recovery from the dip seen in 2022-23, and includes both direct Government contributions and patient charge revenue.

5.4 Critically, in real terms, however, the trend is markedly different. Adjusted for inflation, NHS dental funding has continued to decline, falling to £1.901 billion in 2023-24 – its lowest level since the mid-2000s. As noted in previous evidence submissions, the impact of high inflation has accelerated this fall in recent years.

5.5 Across the UK, while cash spending has remained broadly flat, the real-terms value of Government support is now around £1 billion lower than in 2009-10. This long-term, panned underfunding leaves NHS dentistry beleaguered in the face of rising demand and operating costs.

[4] CPI Annual Rate 00: All items 2015=100 – ONS
[5] Average weekly earnings in Great Britain: September 2025 – ONS
[6] Health Departments

5.6 Figure 2 illustrates these trends, comparing gross spend in cash terms with the equivalent in real terms, and highlights the widening gap that has developed over time.

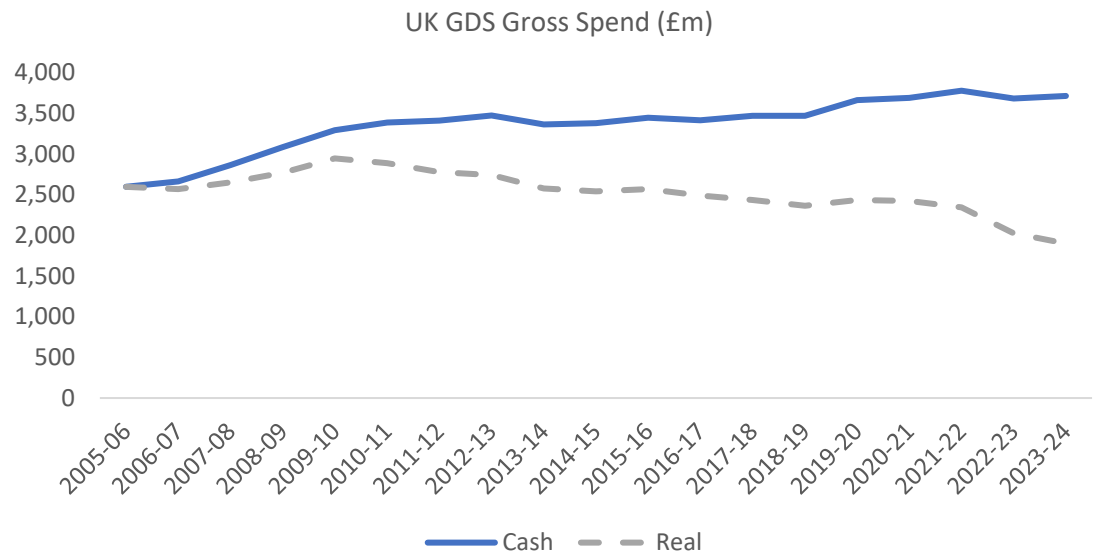

Fig 2: UK gross spend on GDS in millions. Sources: Health departments.

5.7 Patient charge revenue in England reached £807 million in 2024-25,[7] up from £774 million the previous year and continuing the recovery from the sharp drop during the pandemic. Over the same period, the number of adult patients seen rose to 18.5 million by mid-2025, still below the pre-Covid level of nearly 22 million recorded in 2019. This divergence highlights how rising patient contributions have outpaced the recovery in access, with fewer patients supporting a higher overall revenue.

Practice owner incomes

5.8 Over recent years, GDPs have continued to see little to no improvement in take-home pay, with incomes either stagnating or declining. For practice owners, taxable income remains under strain, with only England seeing a modest year-on-year increase, while Scotland, Northern Ireland and Wales all reported reductions. Scotland's fall partly reflects the withdrawal of Covid-related support, but overall, the trend highlights continuing fragility in earnings across the nations. The latest figures are shown in Figure 3.

Nation	Year	Income Before Tax
England	2022-23	£128,800
	2023-24	£134,400
	Change	+4.30%
Scotland	2022-23	£146,700
	2023-24	£135,500
	Change	-7.60%
Northern Ireland	2022-23	£124,600
	2023-24	£121,200

[7] Dental statistics – England 2024/25 – NHSBSA

	Change	-2.70%
Wales	2022-23	£122,600
	2023-24	£114,100
	Change	-6.90%

Fig 3: Practice owner earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[8]

5.9 Roughly two-thirds of practice owners' gross earnings are taken up by operating costs, including staffing, premises, and clinical materials. As a result, their take-home pay is significantly influenced by increases in operating costs and, where these are unfunded, dentists' pay is cut as a result.

5.10 With such a large share of income tied to essential outgoings, practice owners have limited flexibility and are often compelled to adjust their services simply to remain viable. As noted elsewhere in this evidence submission, many practices are left with no option but to alter their service mix, scale back NHS commitments, or increase private provision to stay afloat.

5.11 Critically, since 2008-09, real earnings for practice owners have eroded year after year across all nations.[9] These sustained declines underline the growing strain facing NHS practices.

Associate pay

5.12 Associate earnings have shown limited movement across the nations. In the most recent financial year, incomes increased slightly in England, Scotland, and Wales, while Northern Ireland recorded a decrease. However, these cash-term changes provide little indication of the real pressures faced by associates, as inflation has steadily eroded the value of their earnings. The latest figures are shown in Figure 4.

Nation	Year	Income Before Tax
England	2022-23	£64,300
	2023-24	£66,700
	Change	+3.60%
Scotland	2022-23	£79,600
	2023-24	£80,700
	Change	+1.40%
Northern Ireland	2022-23	£67,300
	2023-24	£65,500
	Change	-2.60%
Wales	2022-23	£72,600
	2023-24	£74,500
	Change	+2.60%

[8] Dental Earnings and Expenses Estimates 2023/24 – NHS England Digital
[9] NHS Digital

Fig 4: Associate earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[10]

5.13 Again, recent uplifts in pay have not been sufficient to keep pace with rising costs. As a result, associates have continued to experience a squeeze on their real incomes, with apparent stability in cash figures masking profound financial pressures. Associates are also impacted by unfunded increases in practice costs, as explored further in Chapter 6, paragraph 6.10.

5.14 The longer-term trend shows that associates, like practice owners, have faced sustained reductions in their real earnings across all nations. While the extent of decline differs, incomes everywhere are now significantly lower than they were a decade ago, leaving many with constrained flexibility and limited room to adapt.

Real Earnings in NHS Dentistry relative to GPs

5.15 Recent years have seen sharp declines in the real earnings of NHS dentists, contrasting with relative stability among GPs. As shown in Figure 5, an index of CPIH-deflated earnings (2017-18 = 100) shows that the real earnings of associates in England have fallen by around 7% since the base year, while principals (practice-owners) in Northern Ireland have faced a much steeper decline of more than 16%. England providing-performers (practice owners) saw a fall of 2.9%, a notable drop given their role in bearing wider operating costs, and one that mirrors the decline experienced by Northern Ireland's salaried GPs over the same period. On an RPI basis, the fall for Northern Ireland principals exceeds 20%, underlining the extraordinary scale of the challenge when a higher inflation benchmark is applied. By contrast, salaried GPs in England saw a marginal real-terms increase, highlighting the divergence with dentists.

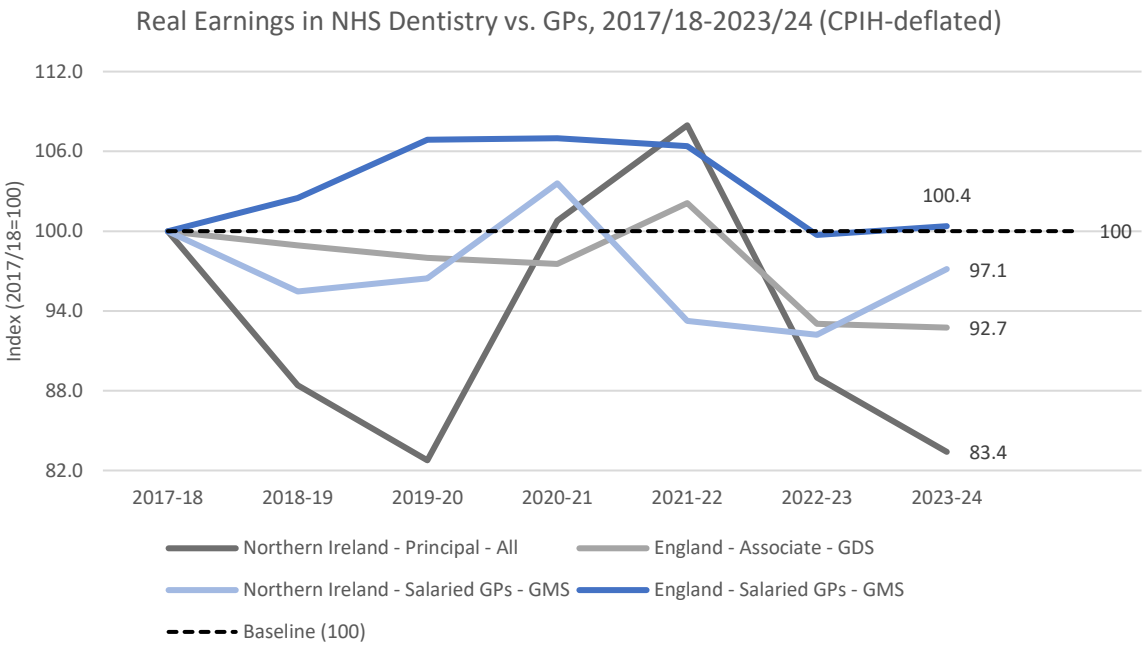

Fig 5: BDA derived CPIH-deflated real earnings index for NHS Dentists and GPs, 2017/18-2023/24. Source: GP Earnings and Expenses Estimates & Dental Earnings and Expenses Estimates – NHS England Digital[11,12]

5.16 This divergence highlights how both associates and practice owners across the UK are particularly exposed to inflationary pressures. With most operating as self-employed contractors,

[10] Dental Earnings and Expenses Estimates 2023/24 – NHS England Digital
[11] Dental Earnings and Expenses Estimates 2023/24 – NHS England Digital
[12] GP Earnings and Expenses Estimates - NHS England Digital

their incomes are directly impacted by rising costs and contractual shifts, leaving them more vulnerable to sustained real-terms erosion than staff in other parts of the NHS workforce.

5.17 The evidence demonstrates a widening gap between dentistry and the rest of the NHS clinical workforce. Fundamentally, sustained real-terms erosion of pay continues to impact recruitment and retention and directly undermines attempts to improve access to NHS dentistry. This underscores the necessity for the DDRB to intervene on practice operating costs, if it is to secure the full implementation of its recommendations on pay.

Practice operating costs

5.18 As highlighted in previous evidence submissions, the BDA has consistently argued that practice operating costs must be appropriately funded in any total remuneration package for NHS dentistry. Cost increases do not just affect practice owners directly; they also inevitably impact associates, whose earnings depend on the overall financial viability of practices.

5.19 To monitor 'dental inflation', the BDA tracks cost changes across all key inputs into practice delivery. This draws on both original BDA research and official statistics, capturing shifts in staff, laboratory, material costs, as well as wider operating expenses such as energy, insurance, and professional services. Energy remains a significant factor, with Ofgem confirming that the domestic price cap will rise by 2% in October 2025, signalling inevitable increases for commercial premises.[13] Together, these sources provide a more practice-focused measure of inflation than consumer-based indices alone, ensuring that real cost pressures are not overlooked. Evidence from our survey of GDPs in 2024 reinforced these findings, with most respondents reporting increases in costs, most commonly in the range of 11-20% or 21-30%.

5.20 Each cost category is weighted in line with its share of overall practice expenditure, following the formula used by the DHSC for NHS contract uplifts. Staff costs, the largest element of practice expenditure, are derived from a year-on-year change of +5.8%, calculated from changes in average hourly pay across staff groups weighted by workforce size, as reported in our survey of GDPs. In addition, adjustments have been incorporated for the April 2025 increases in the National Minimum Wage and employer National Insurance contribution, both announced in the October 2024 Budget.

5.21 Laboratory costs are drawn from our survey of GDPs; materials costs are benchmarked using ONS CPI (06.1: Medical Products), which directly reflects retail price changes in medical and dental products; and other costs are linked to ONS CPIH, which captures housing costs, utilities, fuel, insurance, and professional services. This approach ensures transparency by relying on official consumer price measures alongside sector-specific survey data, providing benchmarks that are both robust and relevant.

	Weighting	Index	Weighted value
Dentists' pay	0.47	9.50%	4.43%
Staff costs	0.22	13.61%	2.99%
Laboratory costs	0.06	8.99%	0.54%
Materials costs	0.07	3.90%	0.26%
Other costs	0.19	4.10%	0.77%
Total	1		**8.99%**

[13] Changes to energy price cap between 1 October and 31 December 2025 – Ofgem

Fig 6: Formula for overall GDP uplift. Sources: BDA Survey of GDPs 2025 and ONS indices (CPI ANNUAL RATE 06.1, CPIH for other costs). Pay uplift reflects the BDA's recommended adjustment.

5.22 Applying this approach, and after applying uplifts of 9.50% for dentists' pay, 13.61% for staff costs, 8.99% for laboratory costs, 3.90% for materials (CPI 06.1: Medical Products, year to August 2025, and 4.10% for other costs (CPIH, year to August 2025)), the model points to an overall uplift of 8.99% to offset rising practice costs in 2024-25. This compares with average earnings growth of 5.3% in the private sector and 4.4% in the public sector since the pandemic, underscoring the scale of the pressures facing NHS dentistry relative to the wider economy.

5.23 On this basis, we ask that the DDRB recommends an overall uplift of 8.99% to be applied across all NHS dental contracts, fees, and allowances.

Pensions

5.24 The DDRB will be aware that the NHS Pension schemes are a highly valuable feature of dentists' remuneration package, with government contributions exceeding 20% of members' pensionable earnings. The DDRB will also be aware that the relevant fora for discussions about pension scheme benefits are the Scheme Advisory Boards. However, we believe that it is important for the DDRB to be aware of ongoing issues and concerns related to this aspect of the remuneration package.

5.25 Further to our submission last year, it is disappointing to report that no tangible progress has been made in delivering the McCloud age discrimination remedy. As noted last year we have serious concerns about the ability of scheme administrators to deliver a service that matches either the quality of pension benefit provision or members' expectations. This year, many members have been left in a position where they cannot disclose information to HMRC as the provision of statutory tax information from scheme administrators has been beset by errors and delays.

5.26 Discussions have progressed on implementing a system of flexible pension accrual that would allow members to reduce their NHS Pension and receive increased pay in lieu of this. This would be of particular value to those who opt out of the pension scheme due to an inability to afford pension contributions or because of high Annual Allowance tax charges. We continue to advocate for such flexibility in the context of a total reward package and would encourage DDRB to support this.

5.27 Whilst the introduction of Partial Retirement provided a means to access pension benefits without the need to end a contract, the requirement to reduce pensionable earnings by at least 10% is presenting some difficulties at a local level. Some dentists are reporting that employers are presenting barriers to the contractual variations required. We continue to believe that this requirement is arbitrary and unnecessary and should be scrapped.

5.28 The issue of pension scheme contributions remains high on BDA's agenda. Unlike the pension scheme benefit structures, these contributions have a direct impact on each dentist's take home pay. The current tiering structure is underpinned by Government principles to include protections for the lower paid, minimise the risk of opt-outs from the scheme across the whole membership, and ensure that the scheme remains sustainable and a valuable part of the reward package and affordable to all members. The BDA believes that each of these could be better met with a more generous pay structure, and with member options for increased flexibility of pension accrual (and consequently reduced contributions).

5.29 The current tiered structure is presenting problems on a number of fronts, including; difficulties for employers in calculating member contributions on a regular basis, under-delivery of the total 9.8% yield required by HM Treasury, cliff-edges whereby members receiving a pay increase could end up with lower take home pay, legislating for, and locally calculating, the impact of backdated pay awards, and the fact that the current tiered system would seem to favour part time members of staff over full-time comparators.

5.30 We believe that a flat rate pension contribution, applicable to all, would eradicate these problems and provide the simplest approach for members and would reduce burdensome calculations for employers. Given the intrinsic link between pension contributions and take-home pay, we would urge DDRB to support this.

Chapter 6 – General dental practice

6.1 The results of the BDA's annual survey of GDPs in England, Scotland, Wales and Northern Ireland reflect the extraordinary recruitment and retention challenges facing GDPs because of the sustained dysfunction of the labour market for dentistry. Unless explicitly mentioned otherwise, the data in this chapter pertains to the whole of the UK.

6.2 56% of practice owners and 42% of associates reported their morale as very low or low in this year's survey, compared to 50% and 38% respectively last year. Of those dentists who did not indicate their intention to leave the dental workforce entirely in the next five years, 44% of practice owners and 41% of associates reported an intention to reduce their NHS commitment.

6.3 Dentists with a high NHS commitment continue to report worse motivation, morale, and satisfaction indicators, report greater recruitment and retention challenges for the entire dental team, and are significantly less likely to report that they are able to deliver patient care to a standard they are satisfied with.

'The lack of funding is not sustainable. I am only able to afford to continue providing NHS care to a decreasing number of patients by increasing the proportion of private work I do.' Associate

Workforce

6.4 85% of practice owners who sought to recruit at least one associate reported that they had had difficulty filling the role, with that figure increasing to 94% for those with a high NHS commitment. Similarly, practice owners told us that recruitment of Dental Care Professionals (DCPs) remains very difficult, with 77% of practice owners reporting they had had difficulty recruiting dental nurses, 70% reporting they had had difficulty recruiting dental therapists, and 63% reporting they had had difficulty recruiting hygienists.

6.5 We noted in our previous evidence submission that to secure the increases in dental activity implied by the then Government's NHS Long Term Workforce Plan a very substantial expansion of training places would be required, as well as a sustained reversal of the now established trend of declining participation by dentists in the market for their labour. Regrettably, our survey suggests that the participation rate of dentists in the NHS market for their labour continues to be low with no indication of a return to pre-pandemic norms. Indeed, this year's survey found that 67% of practice owners intend to either cease delivering NHS or Health Service dentistry entirely or reduce their commitment in the next twelve months.

6.6 The number of dentists registered with the General Dental Council and the headcount number of active NHS dentists is at best a very rough proxy for overall workforce capacity in dentistry. Headcount data does not account for working patterns, or indeed the quantity of NHS care, delivered by new or existing dentists, but we include the information here in the absence of long-term trend data being available for the survey of the dental workforce introduced by NHS England.

6.7 The survey of the dental workforce as of December 2024[14] found that there were just 10,727 full-time equivalent (FTE) NHS dentists in England, with 70% of the time recorded for a given dental chair being used for NHS activity. The figure has remained essentially static from the position in the previous survey released in March 2024 of 10,539. As noted in our evidence submission last year, this FTE figure is less than half the headcount figure in England of 24,543 GDPs who delivered primary care services in 2024-25. Considerable regional variation in the degree of chair utilisation for NHS activity also exists, ranging from 77% in the Northeast and Yorkshire to just 62% in the Southeast.

6.8 The finding from the survey of the dental workforce in England of an NHS vacancy rate of 19% against a non-NHS vacancy rate of 15% accords with the consistent evidence from the BDA's own survey data of the ongoing dysfunction of the labour market for NHS dentistry. This NHS vacancy rate contrasts with a 6.9% rate reported for the NHS as a whole.[15] Between April 2024 and December 2024, the dental workforce survey found that there was a total of 1,823 unsuccessful recruitment processes for positions that would deliver NHS dentistry in England.

'*Valuable to patients, but not always valued by patients. Not valued by government - constant erosion of morale, changing goalposts at short notice, lack of financial support in the face of increasing costs.*' Practice Owner

Recruitment and retention

6.9 Our survey of GDPs found that 22% of associates sought a new role in the 2024-25 financial year. Alongside this indicator of high turnover, 28% of associates seeking a new position experienced difficulties in their search.

6.10 The largest factors in associates seeking a new role were better remuneration, better work life balance, and a desire to deliver more private activity. 46% of associates reported that they were seeking a new role to deliver more private activity compared to 29% of respondents who were seeking a new role for reasons of geography, and 6% who were seeking a new role with greater flexibility over hours. 59% of associates who did not feel able to ask their practice owner for a pay rise indicated that this was because of increases to the costs of delivering dentistry including laboratory bills and materials. This compared to just 34% who did not feel able to ask for a pay rise because of a concern that it would lead to a difficult relationship with their practice owner. The effective functioning of the labour market in dentistry is impeded by unfunded increases to the operating costs of NHS dentistry and their predictable impact on the financial sustainability of practices. As is clear from these survey results, associates are aware of the precarious financial sustainability of many practices, and this naturally impacts how they value their labour and the extent to which they can secure pay increases.

6.11 60% of practice owners had a vacancy for an associate in the 2024-25 financial year. As

[14] Dental Workforce – NHS England

[15] NHS Vacancy Statistics England, April 2015 - June 2025, Experimental Statistics - NHS England Digital

noted earlier, 85% of practice owners with a vacancy reported that they had had difficulty filling the role, with that figure increasing to 94% for those with a high NHS commitment. Indeed, as has been consistent in our survey findings for several years practice owners with a high NHS commitment found it significantly harder to recruit associates and experienced longer periods of unfilled vacancies.

6.12 76% of practice owners with a high NHS commitment had not been able to fill the vacancy they reported in the 2024-25 financial year at the time of our survey compared to 57% of those without a high NHS commitment. 63% of practice owners reported that they had experienced a vacancy open for more than six months. Where a practice owner held a high NHS commitment, this figure increased to 76%. 39% of practice owners reported two or more vacancies, and just 34% of practice owners responding to our survey were able to fill all their vacancies. 70% of practice owners who had difficulty recruiting an associate for the 2024-25 financial year reported that the cause of the difficulty was that candidates were reluctant to deliver NHS or HS dentistry. This compares to, for example, just 8% of respondents reporting a lack of agreement on working patterns or hours.
6.13 This year we found that 20% of practice owners intend to leave NHS dentistry as soon as possible or in the next 12 months, while 32% of associates intend to retire or leave dentistry in the next five years. Further compounding the medium-term pressure on supply in the dental workforce, this year's survey found that 44% of practice owners reported an intention to reduce their NHS commitment in the next five years, while 41% of associates reported an intention to do the same.

'The current climate has made me accelerate my retirement plans, I'm looking to get out much sooner than I had originally planned. I can't take this much longer, my health and well-being is more important than a job that doesn't value me.' Practice Owner

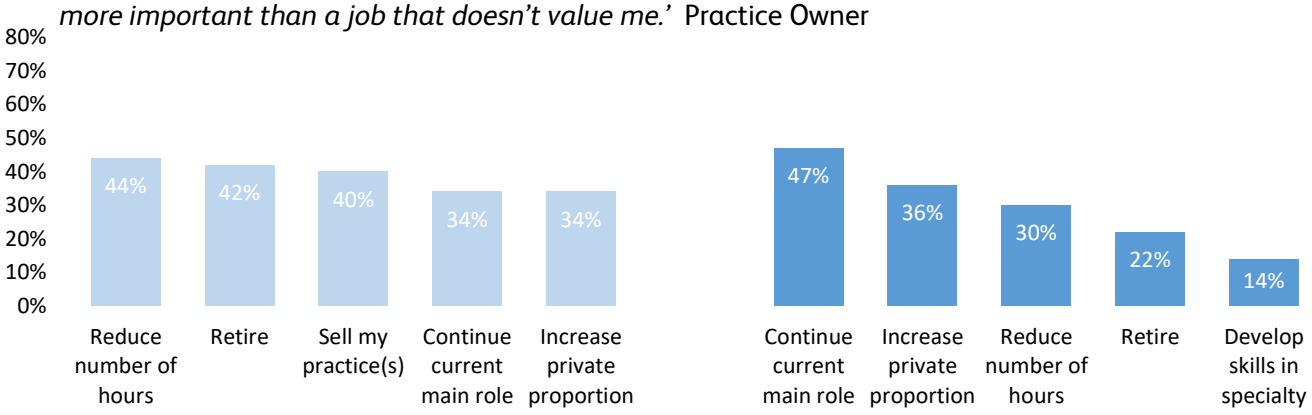

Fig 7: Percentage of GDPs selecting option as a future career intention for the next 5 years (Top 5 shown; pale blue are practice owners, dark blue are associates). Sources: BDA survey data August 2025

Dental nurses

6.14 Dentists are required by the GDC to always be appropriately supported when treating patients. For example, with rare exceptions, dentists will work in tandem with a dental nurse, and the availability or absence of a nurse is therefore critical to delivering clinical work. In many practices, the lack of dental nurse capacity will be acting as a limiting factor on NHS activity that could otherwise be delivered.

'I'm a great believer in NHS dentistry and would like to stay as an NHS dentist, however the remuneration is not high enough to cover practice costs, attract new dentists to the health service, and it limits how much DCPs can be paid which leads to high staff turnover and job

dissatisfaction.' Associate

6.15 73% of practice owners responding to our survey had sought to recruit dental nurses, with 77% reporting difficulty in doing so. Of those who had difficulty recruiting nurses, 40% reported that candidates were reluctant to work in NHS or Health Service dentistry. 35% of practice owners with a high NHS commitment reported that the nurse vacancy arose because of staff unwillingness to continue to work in dentistry, while for practice owners without a high NHS commitment this figure reduced to 27%.

6.16 34% of practice owners with a high NHS commitment reported that they had been unable to appoint a candidate because they lacked the capacity to train a candidate with less experience who might otherwise be suitable, compared to just 18% of practice owners without a high NHS commitment who reported the same. This result highlights the invidious position practice owners frequently find themselves in. As noted earlier, insufficient nurse capacity can act as a brake on the delivery of dentistry that would otherwise take place. It is therefore profoundly revealing that such a high proportion of practice owners with high NHS commitments are both in need of additional dental nurse capacity and yet unable to devote sufficient capacity to train inexperienced but otherwise suitable candidates.

Dental therapists and dental hygienists

6.17 Of those practice owners who sought to recruit dental therapists in the 2024-25 financial year, 70% reported difficulties in doing so, compared to 71% in 2023-24 and 62% in 2022-23. Of those practice owners who sought to recruit dental hygienists, 63% reported difficulties in doing so. Once again, the degree of NHS activity delivered by a given practice owner was the key mediating factor across several metrics relating to recruitment and retention. Where a practice owner held a high NHS commitment, they were significantly more likely to report that an inability to offer an acceptable salary to candidates had led to difficulty in filling the position. For example, 76% of practice owners with a high NHS commitment reported that the salary demands of dental therapists had led to difficulty recruiting, compared to 37% of those without a high NHS commitment.

6.18 The recruitment market for experienced dental care professionals remains highly competitive. Our survey this year found that 94% of dental nurses, 80% of receptionists, 67% of practice managers, and 48% of dental hygienists received a pay rise in the last financial year. Irrespective of these pay rises, it is clear from the frequency with which practice owners reported an inability to pay candidates salaries supportive of long-term recruitment and retention, that the long-term underfunding of NHS dentistry continues to weaken the labour market across the entire dental team.

Morale and motivation

6.19 Like recruitment and retention challenges, poor morale indicators remain robustly positively correlated with a high NHS commitment for both associates and practice owners; for example, only 35% of associates with a high NHS commitment would recommend a career as a dentist, with that figure increasing to 47% for those without a high NHS commitment. Similarly, just 26% of practice owners with a high NHS commitment would recommend a career as a dentist, with that figure increasing to 41% for those without a high NHS commitment. Regrettably the professions' views in this area have remained consistently negative since as far back as 2018. Indeed, in the period 2018-2025 more than three in five respondents to our annual survey did not

recommend a career as a dentist.

	Practice owners	Associates
All	65	60
≥75% NHS commitment	74	65
<75% NHS commitment	59	53

Fig 8: Percentage of GDPs answering 'no' to whether they would recommend a career as a dentist. Sources: BDA survey data August 2025

6.20 56% of all practice owners across the UK and 42% of all associates reported low or very low morale in our survey this year compared to 50% and 38% respectively in our survey last year. As has been the case for several years, low or very low morale remains strongly positively correlated in our surveys with a high NHS commitment, with 71% of practice owners and 49% of associates with a high NHS commitment reporting low or very low morale.

	Practice owners	Associates
All	56	42
≥75% NHS commitment	71	49
<75% NHS commitment	45	32

Fig 9: Percentage of GDPs saying their morale was low or very low. Sources: BDA survey data August 2025

6.21 Just 20% of practice owners and 40% of associates agreed or strongly agreed that they were fairly remunerated for their work. While the figure for associates has remained essentially static compared to our survey last year, the figure for practice owners reduced from the very low position of 29% last year to 20% in a single year. Where practice owners and associates had a high NHS commitment, this figure dropped to just 7% and 29% respectively.

'Not many professions would find themselves effectively paying out of their own pocket for a client's items whether that be a denture, crown etc. You wouldn't expect your local garage to pay towards new tyres.' Associate

Stress

6.22 Our survey this year found that 72% of practice owners and 47% of associates felt that their level of stress had increased over the last twelve months. When asked to pick which factors were causing stress in their current role, 92% of practice owners chose increased practice costs, and 70% chose staffing, recruitment, and retention issues. For associates, the two factors most frequently identified as causing stress in their current role were patient complaints and legal issues, and financial pressures specifically arising from the underfunding of NHS dentistry, at 62% and 50% respectively.

'I started a career as a dentist from a caring perspective and did not worry about income generation. Due to low UDA values, I constantly need to think of targets to meet my modest financial needs and do more private work to supplement my NHS income. The constant battle between dentistry/money adds to the stress of work.' Practice Owner

Chapter 7 – Community/Public Dental Services

7.1 The BDA is calling on the DDRB to support it in recognising and reversing the multifaceted crisis facing the CDS/PDS across the four nations. Each year, the BDA has spotlighted the decline in CDS (and PDS in Scotland) headcount, capacity and wellbeing in its submission to the pay review body. This year, sadly, is no exception. Deterioration is a theme that has emerged clearly throughout the survey data gathered by the BDA of CDS dentists in 2025. This deterioration has extended across numerous categories including recruitment, access to treatment and staff morale.

7.2 The vulnerable population treated by the Community Dental Services continues to grow and so too does the gulf between patient need and the capacity of the workforce. CDS dentists are acutely aware of this lack of capacity. Despite their strong commitment to delivering an excellent standard of care for CDS patients, headcount decline and systemic underinvestment in NHS dentistry has meant that patient demand is unsustainable in the current climate. It is inevitable, then, that this has translated into the deeply concerning number of CDS dentists who have reported worsening morale and high levels of stress, which many report being unable to cope with.

7.3 All relevant stakeholders including health department and employers have a duty of care to CDS dentists and their patients. Regarding patients, the duty of care is to ensure the CDS is fit for purpose, well-resourced and able to alleviate their pain in an acceptable timeframe. To CDS dentists, the duty of care is to protect them from the emotional and physical toll that unmanageable workplace demand creates.

7.4. We appreciate the DDRB's recognition in its 53rd report of the importance of the CDS workforce, particularly in light of the specific needs and vulnerabilities of the patient groups they care for. We concur that further work is needed to provide accurate data regarding workforce and waiting times within the CDS so that we can better understand the scale of the problem facing the service and drive forward change. Recent collaboration between NHS England and the BDA has meant that steps are gradually being taken towards this shared goal. Nonetheless, we note that evidence submitted over many years by the DHSC has remained wholly inadequate; it is profoundly limited in scope and lacking in any meaningful understanding of the importance of the CDS workforce and the plethora of challenges it faces. This system wide lack of understanding, appreciation and recognition for the work of community dentists is one of the many contributing factors to their worsening morale and motivation.

7.5 We were reassured to note the shared messaging across many other stakeholders in their 2025-26 evidence submissions regarding difficulty recruiting to vacant posts and the mutual understanding that uncompetitive starting salaries were a leading factor behind this. The strength of our collective evidence gave rise to the DDRB's timely recommendation that the Government conduct a review of CDS and PDS pay and pay progression in order to assess whether the reward structure is appropriate to support recruitment, retention and service delivery. As in last years' submission, we maintain that current pay levels remain far below the level needed to support these critical categories. We therefore urge the four governments to accept this recommendation as soon as possible so that discussion and collaboration with stakeholders can begin. The BDA will provide regular reminders to the government health departments that a failure to address the DDRB's recommendations will only exacerbate the current difficulties we have described repeatedly within our evidence submissions.

7.6 As noted earlier in this evidence submission, implementation of the 2024-25 DDRB pay uplift

in Northern Ireland proved a drawn-out process, resulting in CDS dentists only receiving back pay arrears in their March 2025 pay packets. In relation to the 2025-26 pay uplift, while the Health Minister has taken the unusual step of issuing a Ministerial Direction on health service pay in light of the significant budget deficit, at the time of writing we have no clarity on when, or even if, this uplift will be applied as the matter appears to be stalled at NI Executive level.

7.7 In the DDRB's assessment of CDS pay within its 53rd report, we note the reference to job levelling and market data from Willis Towers Watson indicating that base pay for CDS dentists in England is above the market median, especially for Band B dentists. The market median should not be used as a basis to assess the appropriateness of CDS and PDS pay; CDS dentists fulfil a vital and specialised role. This, alongside the significant recruitment, retention and service needs, should be the predominant factors used to inform appropriate rates of pay.

7.8 This chapter of our evidence submission is based on Government workforce data, BDA membership survey results, and anecdotal evidence from frontline CDS dentists. All sources agree that an above inflation pay uplift is an essential step towards turning the tide of the workforce decline, and a necessary precursor to restore the workforce to safe and sustainable levels.

Workforce

7.9 The trajectory of decline in the capacity of the CDS/PDS workforce remains a real concern across the four nations. In England, new data provided by NHS England illustrates an even starker picture of deterioration, indicating the situation is far worse than previous iterations of workforce data had suggested. We have lobbied NHS England to publish data on this area and it is with regret that their new figures confirm the concerns expressed by the BDA for many years.

England

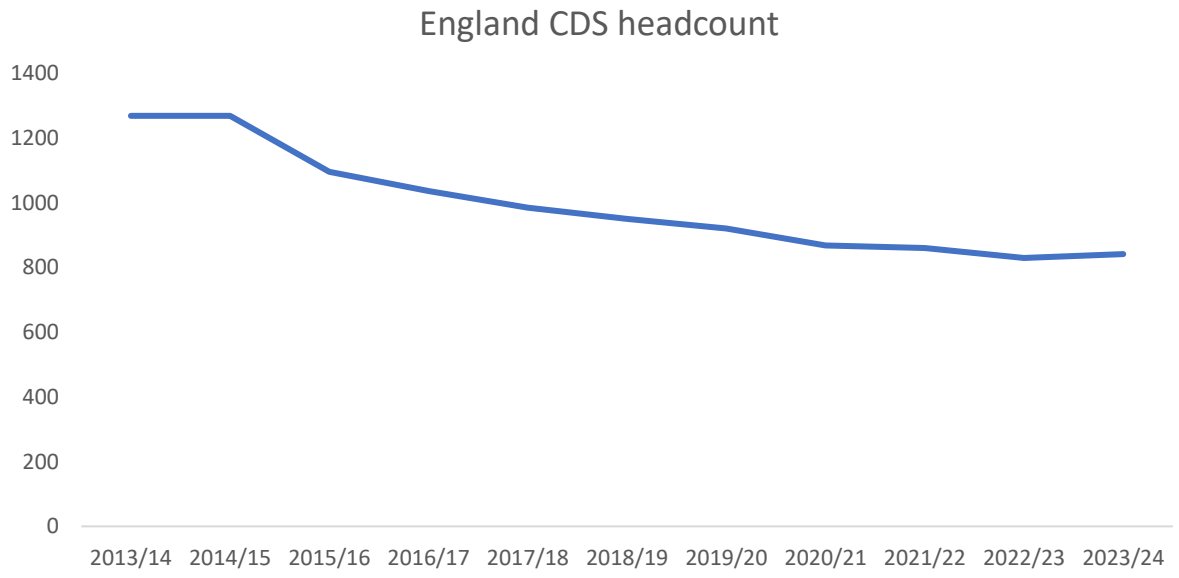

Fig 10: England CDS headcount. Sources: Health Departments and NHS Digital

7.10 Previously available data had already shown a sharp and sustained decrease in the CDS workforce (see Fig 10). As of December 2024, new data published by NHS England[16] had the CDS

[16] Dental Workforce – NHS England

headcount in England at 640, amounting to a FTE workforce of only 367.[17] When compared to pre-existing data from alternative sources available at the time, the England CDS dentist headcount appears to have almost halved over the course of a decade. This intense decline is a cause for great concern for the future of the service and urgent action is needed from health departments and all key stakeholders to prevent this rate of deterioration from continuing into the next decade.

7.11 Given that a significant proportion of the workforce is comprised of dentists in the latter stages of their career it is likely that, without meaningful interventions to improve recruitment and retention, numbers will fall further in the immediate future. The BDA's 2025 survey of CDS members in England indicated that nearly 19% of respondents were aged 55 or above. Moreover, when asked about their career intentions in the next five years, approximately 20% reported an intention to retire, 9% planned to leave the UK, and 13% intended to leave dentistry entirely.

Evidence of a retiring workforce and its impact was reflected in the following survey response:

'We lost members of the community team to retirement and these have not been replaced as according to management our service is not commissioned to have more of us working in the field.' England, Band C Specialist, 21 – 25 years of service

Scotland

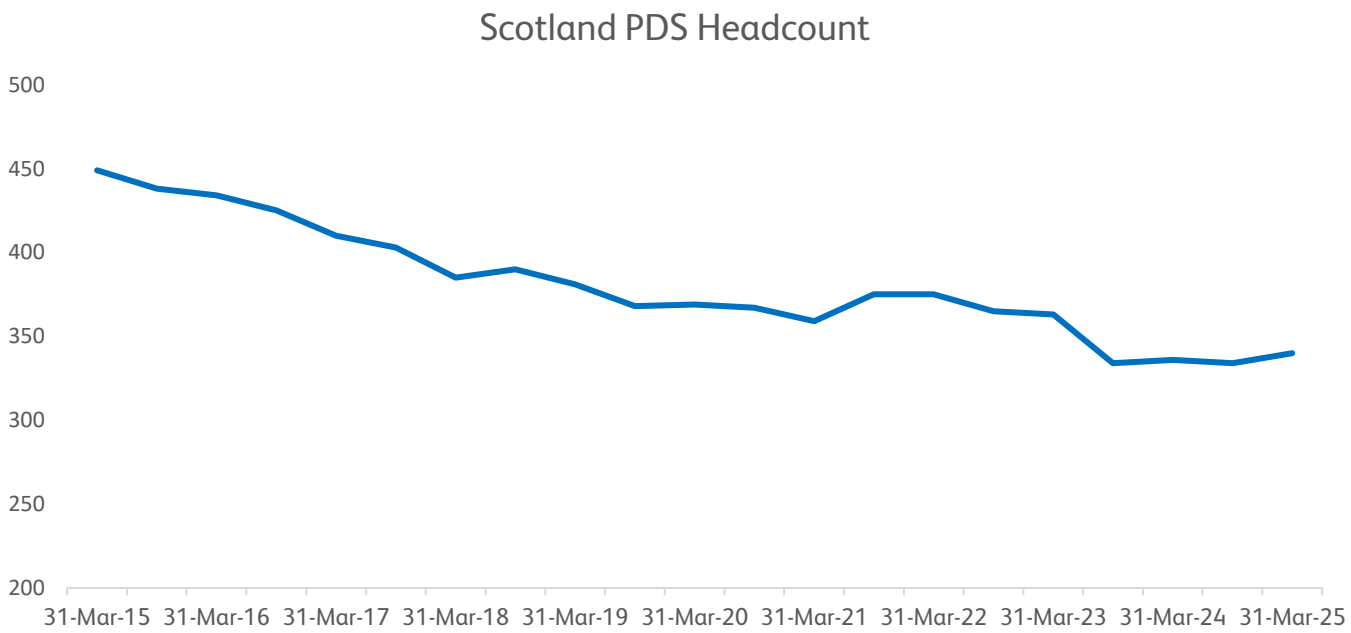

Fig 11: Scotland PDS Headcount. Sources: NHS Scotland workforce[18]

7.12 The PDS combines the CDS and the Salaried General Dental Services in Scotland, playing a vital and unique role in treating patients who need specialised dental care and acting as a 'safety net' for patients who cannot access care within general dental practice. As in England, there has been a trend of PDS headcount decline over the course of the last decade; from March 2015 to

[17] NHS England notes some data quality concerns about this data publication, and we would reiterate our deep concern about the lack of consistent and reliable data about a critical workforce where there has long been evidence of significant challenges.

[18] NHS Scotland workforce – TURAS Data Intelligence

March 2025, the workforce has reduced by 24%.

7.13 There is an indisputable recruitment crisis affecting the PDS, and evidence of the negative impact this has had on existing staff was evident throughout the written responses to our survey:

'Patients are more angry at the lack of dentists so take it out on public dental service dentists.'
Scotland, 16-20 years service, Senior Dental Officer

'Staffing shortages have led to a reduction in what can be offered to referred patients.'
Scotland, 11-15 years service, Senior Dental Officer

Northern Ireland

7.14 A key priority of the Northern Ireland Community Dentists Committee remains seeing growth of the CDS dentist workforce. Workforce data[19] confirms the whole-time equivalent (WTE) of HSC employed community dentists has remained largely static between June 2018-June 2024 (WTE of 63.36 in 2018 compared with 65.83 in 2024), in stark contrast to the 16.4% growth across HSC as a whole in the same time period.

Grade	Headcount	WTE
Community Dental Officer/Senior CDO	79	60.0
Director /Assistant Director of Community Dental	6	5.4

Fig 12: HRPTS as of 31 March 2025 [20]

7.15 According to official data, as of 31 March 2025 there were 84 individuals on community dental pay scales in HRPTS, with a total WTE of 65. Nine people have more than one post, not always at the same pay scale, and sometimes with another Trust. Five of the staff as of 31 March 2025 were on maternity leave. Fifteen (18%) of these dentists were aged 55 years and over and a further thirteen (15%) were aged 50-54 years old. In comparison with March 24 figures, DO/SDO headcount has contracted by 1.43 WTE, while Director/Assistant Director WTE has increased by 1. This does not constitute in any way a growth of the service.

7.16 The case for growing the CDS dental workforce to meet rising demand for services is not new. A Skills for Health Workforce Review for Dental Services in NI[21] completed in 2018 stated that many of the then 92 CDS dentists were approaching retirement, with up to 40% approaching retirement by 2025. As a result, an additional 36 community dentists could be required by 2025, meaning a total number of 61 additional dentists to meet future demand. Despite this, growth has failed to materialise, and as noted earlier we have actually witnessed a further reduction of the service to a headcount of 84 as of 31 March 2025.

Wales

7.17 There remains a disappointing absence of comprehensive data from the Welsh Government regarding the CDS in Wales. Crucial data such as WTE for the CDS workforce remains impossible to attain. Anecdotal evidence provided by our BDA Accredited Representatives consistently points to significant challenges in both recruitment and retention within the CDS. Recruitment is

[19] AQW 20238/22-27 Table 1 HSC Community Dentists Employed (whole-time equivalent) on 30 June 2018-24 by HSC Trust
[20] Note that 1 individual is counted once in the first category and once in the second category, hence the table totals to 85
[21] Skills for Health Workforce Review for Dental Services in Northern Ireland, August 2018 – Skills for Health

hindered by factors such as limited training and career development pathways, uncompetitive remuneration when compared with other dental sectors, and difficulties in attracting candidates to posts in certain geographical areas. Retention is similarly affected by challenges in maintaining workforce morale, and insufficient opportunities for professional development and progression. Without transparent data and meaningful intervention, the sustainability of the CDS in Wales remains in question.

7.18 Preventing the exodus of dentists from the CDS across all four nations is one key step towards reversing the loss of the workforce, but so too is improving recruitment into the service. Disappointingly, responses to the BDA's annual survey show that recruitment difficulties have endured across the four nations. In England, nearly three quarters of respondents felt staff recruitment had deteriorated over the last year. In Northern Ireland, 66% of respondents reported the same. In Scotland, this figure stood at 84% and, in Wales, at 92%.

CDS/PDS patient demand

7.19 As referenced in earlier evidence submissions, and highlighted in the beginning of this chapter, the declining capacity of the CDS/PDS workforce is deeply concerning precisely because it is taking place against a wider backdrop of unmet need and increasing demand from the patient population the service was established to care for. This includes patients who need dental services such as general anaesthetic (GA) or sedation, adults and children with physical or learning disabilities, severe anxiety, Alzheimer's, medical conditions, people who are housebound or live in care homes and people experiencing homelessness.

7.20 The UK's population continues to experience fundamental shifts in relation to its healthcare needs and, in the context of this chapter, its dental needs. The BMJ reported that one in five adults in England will be living with a major disease by 2040. Age UK estimates that there are 2 million people aged 65 and above who have unmet needs for care and support.[22] The Health Foundation has reported that the number of people living with major illness is projected to increase by 37%, over a third, by 2040, nine times the rate at which the working age population (20 to 69-year-olds) is expected to grow (4%). One million people in the UK have dementia and, according to a report by the Alzheimer's society,[23] this figure is projected to rise to 1.4 million by 2040. The number of children with learning disabilities in the UK is already significant, with Mencap reporting that there are approximately 349,000 children aged 0-17 with a learning disability in the UK.[24] At present, there are also 700,000 autistic adults and children in the UK.[25] We therefore anticipate further, dramatic increases in demand from patients whose conditions will necessitate them needing treatment within the CDS/PDS.

7.21 Public Health Scotland has reported that Scotland has several longstanding and connected public health challenges. People in Scotland die younger than in any other Western European country. After decades of improvement Scotland's health is worsening, people are spending more of their life in ill health and the gap in life expectancy between the poorest and the wealthiest is growing. According to the 2022 Census,[26] Scotland now has more than a million people aged 65 and over, while there are fewer than 750,000 people aged under 15. The data also reveals that the number of people who have reported having a mental health condition in Scotland has more than doubled between 2011 and 2022. During this time period there has been a 15.7% increase in

[22] State of Health and Care of Older People in England 2024 - Age UK
[23] Facts for the media about dementia - Alzheimer's Society
[24] Children - research and statistics - Mencap
[25] Our vision, mission and values – National Autistic Society
[26] 2022 reports – Scotland's Census

the number of people with a health problem or disability that limited their daily activities considerably. The percentage of people reporting a learning disability, learning difficulty or developmental disorder increased from 2.8% in 2011 to 5.2% in 2022.

7.22 The expansion of the CDS/PDS patient population is also, in part, a consequence of the wider access crisis facing the GDS. There remains simply not enough capacity among GDPs to deliver sufficient NHS activity to meet existing overall patient demand. This has resulted in a very significant spillover of patients from NHS general dental practice across to the CDS due to the overwhelming pressure within the wider system, the impact of flawed contractual changes, and wider underinvestment. In Scotland and Wales, if no GDPs are available, CDS/PDS dentists are often required to 'bear the brunt' of seeing urgent care patients who could otherwise be seen in the GDS setting, instead of treating core CDS patients who require specialist care. Across the UK, there are often regular difficulties discharging patients back to the GDS once courses of treatment are complete, as there are no GDPs to take on new patients in some areas, with nowhere for them to go in this scenario.

7.23 Public Health Scotland states that the main role of the Public Dental Service is to provide dental services for people who cannot access care from an independent dentist. However, there is a fine balance to strike between the PDS providing a "safety net dental service" often for unregistered or urgent care patients, and its ability to have adequate capacity to provide dental care for core patient groups. Many dentists are concerned about the impact this is having on their ability to deliver timely care to patients from priority and vulnerable groups.

Unmet need and waiting lists

7.24 The access crisis facing the CDS and PDS is the inevitable consequence of the growing gap between capacity and demand. This chasm has resulted in some of the most vulnerable members of our society being left in pain and unable to access dental care for unacceptable lengths of time.

'Longer waiting list due to reduced staffing levels and more patients being referred to the service.'
England, Senior Dental Officer, 11 – 15 years of service

7.25 Across the four nations, a significant percentage of survey respondents either disagreed or strongly disagreed that the service was meeting the needs of their patients:

- England – 41%
- Northern Ireland – 44%
- Scotland – 59%
- Wales – 61%

Moreover, 78% of Scotland respondents, 69% of Wales respondents, 65% of England respondents, and 63% of Northern Ireland respondents, felt that the backlog of patients needing to be seen had deteriorated over the course of the last year.

7.26 In our campaigning work, the BDA have consistently highlighted the shocking and unacceptable length of waiting lists for child and adult GA treatment and sedation, with regular reports of some patients having to wait over a year for treatment. Over many years we have pushed for the implementation of accurate, publicly available data collection on CDS and PDS waiting times to ensure stakeholders have a grasp on the scale of the problem. In response to lobbying by the BDA NHS England launched a new data collection process in August 2025 to address this gap. We hope that, in our next evidence submission, we will have an even stronger

evidence source to convey the severity of the crisis in this area.

7.27 Behind the waiting list statistics lies individual stories of patient suffering. Many patients awaiting dental treatment under GA encounter severe pain and dental infections daily. A significant proportion of these patients are young children, with poor oral health impacting their ability to eat, speak, play, and socialise, and therefore impacting their development and performance at school.

7.28 The impact of treatment backlogs across the UK will see the already poor health outcomes for many of these patients widen even further, exacerbating health inequality. Without additional staffing, it is difficult to imagine that the most vulnerable patients will receive treatment before their oral health deteriorates and further unnecessary suffering ensues. The BDA is concerned that the impact of extraordinary waiting times on those using community dentistry services will be much poorer health outcomes, and much greater need for interventions such as tooth extractions. Worryingly, more of those waiting will present as emergency cases, in effect compounding the existing challenges within the system, and resulting in much higher costs to the NHS over the long term.

7.29 CDS dentists, who are passionate professionals, dedicated to providing their patients with exceptional levels of care, also suffer as a result of the access crisis; finding themselves unable to address the scale of the problem is emotionally difficult for many who cannot comprehend why the situation has been allowed to continue to the detriment of their patients. It is important to note that 92% of Northern Ireland, 91% of England, 84% of Wales, and 78% of Scotland respondents, said that helping patients motivated their work as dentists. It is unsurprising, then, that when asked about the leading factors behind their decreased morale, respondents reported the following:

'We continue to be under extreme long-standing pressure and at risk of burnout. The only thing that keeps me going is that I genuinely want to help others more than myself, and I have a strong sense of duty to my patients...Patients who are non-verbal are inevitably unable to express the severity of their problems or advocate for themselves and are waiting unacceptably long times for treatment.' England, Senior Dental Officer, 11 – 15 years of service

'Against the collapse of GDS services we are expected to absorb an increasing patient load and untreated dental disease, while budgets whether for capital improvements, or staffing have shrunk as health boards are asked to provide more savings. The range and quality of the service we can provide to special care groups has decreased.' Wales, Band C Specialist, ≥ 26 years of service

Morale and Wellbeing

7.30 CDS and PDS dentists' morale and wellbeing remains unacceptably low. The majority of respondents across all four nations reported that their morale had decreased from the previous year; 75% of respondents in Scotland, 51% of respondents in Northern Ireland, 47% of respondents in England, and 46% of respondents in Wales described their morale as low or very low. Increase in workload and stress was repeatedly referenced in qualitative responses regarding declining morale.

'It is impossible to run to time most days due to pressures so every day is stressful. I don't get any admin time, so I am using breaks/lunches to do admin and never get caught up. We have very little time as a team to even socialise in the staff room so generally morale is poor.' Scotland, Dental Officer, 11 – 15 years of service

'Resources are reduced. Demand has increased. Patients are more ready to complain. Politicians are putting increased pressure on the system without addressing the resource needs. Staff morale is low…this is not the service I want to deliver.' Northern Ireland, Clinical Director, ≥ 26 years of service

7.31 Their deteriorating morale is, in large part, due to the overwhelming pressure placed on them as they attempt to scale down patient backlogs and keep up with the pace of demand. This is not for their want of trying, but a direct consequence of the systemic underfunding of NHS dentistry over many years and a failure to increase the workforce in line with patient need. In fact, many are working well over their contracted hours in an attempt to tackle their relentless workload. When asked how often they had felt obliged to work outside of their contracted hours in the last year, 61% of Wales, 53% of England, 50% of Scotland, and 44% of Northern Ireland respondents said this occurred once a week or more often. Moreover, 100% of Wales respondents, 81% of England respondents, 77% of Northern Ireland respondents and 71% of Scotland respondents described their workload as high or very high.

7.32 Undoubtedly, this extreme pressure is having a sustained and detrimental impact on the stress levels of CDS and PDS dentists across the four nations:

- In Wales, 53% of respondents found their job very or extremely stressful. 38% did not feel that they could cope with the level of stress present in their job, and 61% had sought or were seeking help for workplace stress.
- In Scotland, 31% found their job very or extremely stressful; a further 56% reported moderate stress levels. 31% did not feel able to cope with that stress, and 34% had or were seeking help for workplace stress.
- In Northern Ireland, approximately 30% found their job extremely or very stressful, and 60% found it moderately stressful. Over 20% did not feel able to cope with that stress.
- In England, approximately 40% found their job very or extremely stressful, and a further 51% found it moderately stressful. Nearly 30% were unable to cope with that stress, and over 30% had or were seeking help for it.

7.33 We remain shocked and saddened at the scale of violence and abuse that CDS and PDS dentists are subject to from patients, their relatives and their carers. Our survey has illustrated that this problem is endemic. Across all four nations, a significant majority of respondents had experienced aggressive or demanding behaviour and verbal abuse in the last 12 months from patients, their relatives, or other members of the public whilst at work. When asked about whether they had been subject to physical violence from the same group over this period, nearly 45% of England respondents, 59% of Northern Ireland respondents, 18% of Scotland respondents, and 30% of Wales respondents said they had experienced this at least once.

7.34 It is simply wrong that CDS and PDS dentists should continue to be subjected to such extreme levels of stress, abuse and violence in their roles, and immediate action needs to be taken to protect their mental and physical wellbeing. Undoubtedly, improved recruitment and retention into the service is an essential step towards alleviating this harm. Although we have initiated collaboration with NHS Employers within England to seek to improve violence and abuse prevention measures in the CDS setting, simultaneous work is needed to increase the capacity of the service and address the causes of violence and abuse at their root.

Job and Pay Satisfaction

7.35 Although helping patients is one of CDS dentists' main motivators, their commitment to their patients cannot compensate for the Governments' continued failure to remunerate them fairly and appropriately for the level of skill and resilience their job requires of them, nor can it compensate for delivering care in working environments that severely impact on their wellbeing.

7.36 Despite their passion for their vocation, a considerable number of CDS and PDS dentists report dissatisfaction with remuneration, and with their careers more generally. Staffing, workload, resources, and poor working conditions were the key themes identified to explain decreasing job satisfaction. A majority of respondents across all four nations reported decreased job satisfaction since the previous year and the following percentage of respondents across the four nations reported being completely, mostly or somewhat dissatisfied with their job:

- England – 42%
- Northern Ireland – 53%
- Scotland – 59%
- Wales – 46%

7.37 The BDA's survey data also revealed that, when respondents were asked to consider what factors were important when comparing their career to other professions, base pay and pay progression ranked highly across the four nations. In England, 27% felt base pay was important, and 23% believed pay progression was important. In Northern Ireland, 40% believed base pay was important, and 33% felt pay progression was important. In Scotland, these percentages stood at 28% and 25% respectively, and in Wales, at 38% and 30% respectively.

7.38 A significant majority of respondents in England, Northern Ireland and Scotland disagreed or strongly disagreed that their pay was fair; 67%, 74%, and 69% respectively.

7.39 As noted in our previous evidence submissions, a lack of pay parity between the GDS and CDS/PDS is making the service an unattractive prospect for new dentists and is a barrier to recruitment and retention of staff. In England, Northern Ireland and Scotland, the majority of respondents reported that parity between the sectors very or somewhat negatively influenced their decision to remain in the service.

'Lack of dentists- we cannot employ any as the pay is derisory compared to general practice.'
Northern Ireland, Senior Dental Officer, 11 – 15 years of service

7.40 These responses illustrate that a meaningful uplift to CDS/PDS pay scales and improvements to pay progression are both vital to securing the future CDS workforce. It is imperative that this group of dentists feels valued. Any further destabilisation of this specialised and specialist workforce could have a significant impact on the already widening health inequalities.

Administrative Dentists in Northern Ireland

7.41 This cohort of dentists (currently 8 WTE) employed by Business Service Organisation (BSO) are contracted under the *1988 Terms and Conditions for Administrative Dental officers and Community Dental Officers employed by Health and Social Services Boards.*

7.42 Since the implementation of a new set of terms and conditions for clinical community dentists in Northern Ireland in 2019, this group is the last tranche of employees who remain on these outdated terms and the last cohort of healthcare workers in the UK who have not had a

modernisation of their conditions in decades.

7.43 Since the 1988 terms and conditions were enacted, the role of these dentists has expanded substantially beyond their original remit due to a number of factors:

- statutory duties flowing from changes to legislation and regulatory frameworks
- new departmental policies including changes in commissioning
- modern standards and guidance
- reforms to the roles and functions of HSC bodies including the transfer of employment to BSO to undertake the work of the DOH following closure of the regional Health Board in 2021
- Impact of technology on workload, communication and deadlines.

7.44 This unique position has created a number of issues for this cohort of dentists, including low morale and feeling undervalued compared to other professions within their organisation. They also report a lack of engagement by BSO with their requests for job evaluations, matching, and regrading to reflect the reality of their current roles, as their colleagues are entitled to. Indeed, there are no extant job evaluations to act as the justification for the pay grades of this cohort. An interim BDA and staff proposal paper produced in 2023 to address some of these issues was rejected by the DoH workforce policy directorate.

7.45 It is plainly indefensible for an employer to have failed to undertake job matching and evaluation processes for an entire cohort of dentists, irrespective of their absolute numbers. This is particularly the case given this cohort has been left languishing on outdated terms and conditions. The BDA calls on the DDRB to take all necessary steps to make an appropriate recommendation in this area to support urgently needed negotiations for modernisation.

Conclusion

7.46 The evidence outlined in this chapter demonstrates that the CDS and PDS remains in a state of crisis, which will only accelerate without meaningful and rapid intervention from Government and other stakeholders. The situation within CDS and PDS services has deteriorated even further in the last year and can no longer await prioritisation by wider Government actors. We strongly urge the DDRB to use all available means to persuade Government to take immediate action toward restoration of this critical sector. An above inflation pay uplift is an essential part of a package of measures which are necessary to stem the exodus of the CDS workforce and build a service that can address the scale of demand placed upon it. The health of CDS dentists and their patients will be materially affected by Government's decisions in this and forthcoming pay rounds, and we implore the DDRB to make its pay recommendation in light of this responsibility.

Chapter 8 – Ministry of Defence Dentists

8.1 The BDA is again providing evidence on behalf of Ministry of Defence (MOD) Dentists who work as MOD civil servants within the Defence Medical Services (DMS). There has been an important nomenclature change for this employment group from Civilian Dental Practitioner (CDP) to MOD Dentist. This is to better reflect their professional roles and identities while reducing confusion regarding their unique function within the MOD and DMS in supporting delivery of dental healthcare to the nation.

8.2 MOD Dentists are salaried, civilian dentists who work alongside their uniformed, Armed Forces (AF) dental colleagues delivering occupational, primary dental healthcare to AF personnel and entitled civilians, based in the UK and abroad. They are termed a Non-Standard Occupational Group (NSOG) by the Civil Service (CS) with attendant Statement of Employment Particulars.

8.3 The BDA provides evidence on behalf of MOD Dentists to the DDRB as MOD Dentists are civilians and therefore not part of the remit of the Armed Forces Pay Review Body (AFPRB).

8.4 The MOD historically assigned the trade union, PROSPECT, to represent MOD Dentists rather than the BDA. It is in accordance with a 2003 agreement between the MOD and PROSPECT that MOD Dentists are given a pay award in line with the DDRB recommendations for salaried dentists. As PROSPECT is not engaged with the provision of evidence to the DDRB, the BDA works with PROSPECT to ensure that the MOD Dentists have appropriate representation in pay considerations. Thus, the BDA provides evidence to ensure that MOD Dentist pay remains competitive with their NHS colleagues.

8.5 Data from August 2025 suggests that there are 97 MOD Dentists working within the DMS, all in patient facing roles which is a 10% reduction when compared to the same time in 2024. 56 MOD Dentists are full-time (37 hours per week) with the 41 part-time dentists equivalent to 25 FTE. The DMS are established for 103 FTE MOD Dentists and is currently 80% manned against that metric. 58% of MOD Dentists identify as she/her/hers while 42% identify as he/him/his. Around 30% of MOD Dentists have previously served in the AF.

8.6 The BDA annual survey and direct feedback from MOD Dentists have identified persistent and significant concerns regarding successive pay awards at an inadequate level, poor career development opportunities, lack of empowerment within the Defence Primary Healthcare (Dental) (DPHC(D)) community, and creeping increases in workload and responsibility resulting from recruitment and retention issues for dental healthcare workers in DPHC(D). With this ongoing undercurrent of dissatisfaction, the MOD is continuing to experience losing the professionals it relies upon to provide essential care to our AF in turbulent geopolitical times.

8.7 There is considerable disquiet from MOD Dentists about the increasing differentials between their current pay rates and those of their uniformed colleagues. This is becoming more marked with the increasing requirement to cover AF colleagues' responsibilities despite fewer opportunities for either reward or recognition and with much reduced career prospects in comparison. Similarly, pay has not increased in line with either inflation or the cost of living and this is impacting negatively on recruitment and retention. The perception amongst the MOD Dentist cadre is that pay rates are no longer competitive as they have fallen considerably behind the national employment market rates in most age-matched cohorts.

8.8 Despite the 4% uplift this year, year on year pay awards below inflation rates have seen real-terms MOD Dentist pay erosion. When compared with the NHS, the wider civil service, AF military dentists pay, and especially private practice, MOD dentists are left with salaries that do not reflect their value, skills, or the unique demands of their role. This growing pay disparity makes it harder each year to attract new MOD Dentists and even harder to retain the dedicated professionals already in post.

8.9 MOD Dentists, unlike both their AF and salaried colleagues do not have a clear pathway for career progression. There is no structured way to recognise experience, no professional development framework and no senior roles to aspire to. This stagnation is demoralising for highly skilled clinicians, and this is reflected in various surveys. There must be an aspiration that MOD Dentists should have opportunity to engage with a professional career pathway making it possible for career progression and competition for appropriate clinical and non-clinical roles throughout the DMS, akin to their uniformed colleagues.

8.10 In summary terms, it was again disappointing that no mention was made of MOD Dentists within the DDRB's 53rd Report despite being of comparable size to the Community Dental Service of Northern Ireland or the salaried services of Wales. MOD Dentists are experiencing decreasing morale due to recruitment and retention challenges and inadequate reward and recognition. The

pay scale structures for MOD Dentists need to be urgently reviewed especially with the banding being based on outdated postgraduate qualification requirements and the pay spines being seen to reach a ceiling too early. If MOD dentists are to be encouraged to stay in the DMS and continue providing the high-quality care expected by the nation for our military personnel, then salaries must be made competitive and career progression routes must be introduced.

Chapter 9 – Clinical dental academics and hospital dentistry

Clinical dental academics

9.1 The BDA provides evidence to the DDRB on the dental academic cadre to ensure that, across the UK, pay parity is maintained with NHS colleagues. In the last year, pay parity has broadly been maintained in England, Wales and Scotland on the UCEA pay scales. Each country of the UK sets its own pay policy and timelines for implementation. On the clinical dental academic workforce 4 key themes have been identified as follows:

9.2 **Workload and deteriorating student to tutor ratios:** This year, dentists working in academia have described poorer working conditions, not having enough time for their work and being under unrealistic and increased pressure from management to do more with fewer staff. They have reported in many cases that staff are leaving academia due to these deteriorating working conditions, and that these roles then remain unfilled. This trend is placing unacceptable pressure on those who have remained in dental academia and are therefore required to take on extra responsibilities without additional support or pay. One survey respondent said that the "amount of work only increases as more people leave" and this very much reflects the feedback from wider BDA survey work. Staff are increasingly reporting feeling compelled to attend meetings during lunch breaks, struggling to find time for proper breaks and facing overwhelming pressure to agree to poorer student-to-tutor ratios within clinical teaching settings. This trend will impact not only the wellbeing of dental academic staff but will also impact on the quality and safety of undergraduate dentistry education that is so important for the future of dentistry within the UK. In the last year 40% of respondents indicated that they were concerned with their current workload and 50% were extremely concerned.

9.3 **Management:** Respondents have reported that management overseeing academic dental education had limited understanding of the requirements, and contemporary trends, in clinical practice and the wider patient population. This was once again associated with many universities not fully understanding the uniqueness of training dental professionals and lacking awareness of the need to retain senior dental academics over the long term. Central government departments and agencies overseeing dental education were cited as a key factor in why there was poor support for progression within their profession. Greater engagement from management and where needed prompt action was identified as part of the solution for ensuring an effective supply of qualified dentists. Many dentists working in academia felt this year that they were faced with risks to their jobs, as well as more general challenges such as the cost of living and pay keeping up with neither inflation nor other cohorts of dentists. A number have taken voluntary redundancies where offered by their university.

9.4. **Wellbeing and morale**: A worrying and significant theme in our survey responses this year was that the mental health of dentists working in the academia was deteriorating. A major factor was that dental schools were understaffed, and dentists being faced with increased workloads following staff reductions. Our survey showed that 45% considered that their morale was low or very low. There was a strong presumption that remaining staff would be willing to or be forced to take on additional responsibilities without time or support provided to do so. Development opportunities for career progression were limited as a result and many felt there was a lack of

genuine appreciation by the university they worked in. Key decision makers were often considered disengaged from the impacts these trends were having on staff morale, prioritising numbers over staff wellbeing or the quality of education. There was an absence of meaningful support, and an absence of appropriate time being provided to protect wellbeing.

9.5 **Pay and retention:** For a number of years our survey has revealed profound frustration regarding the renumeration of dental academics relative to their years of training and seniority. This has a predictable impact on retention. Just 20% of survey respondents felt that their pay levels were fair or commensurate to the volume of work they were required to undertake. 75% of respondents said they were concerned regarding their capacity to take on more undergraduate students. A significant proportion of the workforce were potentially approaching retirement with 20% of respondents being aged 55 or over, with 80% saying that they were concerned about succession planning.

We have seen increasing qualitative feedback from our surveys that clinical academia is now overwhelmingly viewed as a substantially less attractive career option for dentists. There is a clear need to do more to encourage early career dentists into this field as well as considering steps to retain clinical academics mid-career. With the Westminster Government discussing the recovery of NHS dental care for people who need it, it is critical not to lose sight of the importance of this essential enabler of the next generation of dentists. The overall total reward package (including pensions) has been steadily eroded for dental academics. As part of the total package of reward, we once again need to highlight the critical issue of equivalence of remuneration levels to NHS Consultants terms and conditions of service. It is vital that the DDRB understands the need to encourage and incentivise qualified dentists to consider academia as a potential career to deliver high quality education for the dentists of the future. Last year we highlighted that incentivising more dentists to join academia is needed urgently to ensure there is sufficient capacity to support undergraduates studying dentistry. We once again urge that this message is heard and addressed, including ensuring that universities can implement any settlements with appropriate funding and not need to make funding cuts elsewhere.

Hospital dentists

9.6 The BMA provides evidence for doctors and dentists based in hospital services. Our evidence on hospital dental services seeks to provide some additional dental context to the overall picture, is complementary to the BMA evidence submission, and should be read as such. 146 dentists working in hospital settings completed our survey this year. These dentists are an important part of the healthcare system and have a significant impact on their patient's quality of life. We have provided a commentary on 5 key themes from the survey as follows:

9.7 **Pay and the recent disputes with Governments:** The BDA has continued its campaign for fair pay for hospital dentists, working in solidarity with the BMA. Although the pay settlements agreed by our members in 2024 made important progress, the DDRB recommended pay uplift for all hospital dentists did not fully redress the pay erosion that has been experienced since 2008-09. We therefore re-entered into dispute with Government regarding resident, consultant and SAS dentists' pay in England and for consultant dentists in Northern Ireland. We also entered into discussions with Governments in the devolved nations regarding pay for hospital dentists and have continued to work in partnership with the BMA to ensure that pay erosion continues to be addressed. It is critical that the learning is taken from the various disputes so doctors and dentists based in hospitals across all 4 countries can regain confidence in the wider independent pay setting process. In our survey only a quarter of respondents thought their pay was fair. Approximately 50% of respondents reported vacancies in their teams. The BDA calls for a pay uplift that addresses the scale of these challenges and responds to the urgent need to appropriately incentivise dentists to join or remain within hospital dentistry teams.

9.8 **Career development and training pathways:** A significant trend this year is that many of our

members are reporting to us significant and worrying disparities in their training. Many employers are using the need to ensure service provision as justification to place restrictions on training, including, for example, reduced study leave and reduced entitlements for attending learning events. For resident dentists there was significant uncertainty about being able to meet the specialty training curriculum, pass exams, and complete programmes arising from the imposition of these additional barriers. Training opportunities were described as steadily reducing with there being so much 'noise' it prevented resident dentists focusing on the important aspects of skill development and with not enough time to secure the vital training needed to progress within each specialty. Recruitment planning was described as very poor, with multiple cases where individuals had to move hundreds of miles across the country for a training role, only to then leave as soon as possible to be located nearer their home. Departments lacked scope for further training and dentists found themselves unable to find permanent jobs. Although this area is not within the direct remit of the DDRB this increasing trend will ultimately impact on the workforce numbers at various grades right across hospitals. One respondent described how they were in the process of resigning from hospital dentistry and going into private practice due to lack of career progression for associate specialists, combined with bullying and lack of support. Greater support from employers and clinical stakeholders is urgently needed to enable hospital dentists to progress along specialty pathways and use their clinical skills to deliver high quality care to patients, as they uniformly wish to do.

9.9 **Workload, workforce numbers and morale:** Hospital dentists have highlighted that demand on services across the UK are what one respondent to our survey described as 'ever increasing whilst funding for posts is reducing'. Approximately 70% of hospital dentists who responded to our survey said they did not feel able to complete all essential clinical tasks in the time available to them. The dramatically increasing workloads have been accompanied by NHS financial pressures affecting capacity and the inevitable impacts on the delivery of patient services. Another respondent described how they 'regularly see patients with dental abscesses with spreading infection which require drainage and tooth removal under general anaesthetic'. Nearly 40% of hospital dentists have told us that morale has deteriorated compared to 2024, and over 40% now considered their morale to be low or very low. High patient demand with often complex needs and long, unmanageable waiting lists resulted in pressure to meet unrealistic targets, leading to compromised safety protocols and diminished patient care. This trend has been accompanied by reductions in staff, with recruitment freezes being introduced in many areas and increasingly no cover provided when staff were off. This had an inevitable adverse effect on stress and wellbeing. There remained a fear of 'speaking up' amongst hospital dentists who felt they could be easily targeted for using any mechanisms for raising concerns.

Regrettably, our survey found that there was a persistent expectation among employers that hospital dentists would work unpaid overtime with little recognition or support provided. The lack of administrative staff had shifted more non-clinical tasks onto clinicians, exacerbating the situation. As a result, working culture was experienced as dehumanising and unsustainable, with a sense that unsafe waiting lists remained the responsibility of individual clinicians rather than their employer. Long serving staff were leaving as a result of stress and understaffing, and there was a predictable compounding effect on poor retention arising from reductions in leave by employers attempting to plug gaps in the workforce.

9.10 **Management and working conditions:** There was concern expressed that the level of understanding and appreciation from management on the role, experience and skills of hospital dentists had deteriorated further. Only a quarter of survey respondents said they felt supported by management within their hospital. There was a growing sense of being undervalued by hospital management along with clinicians having a decreasing input into roles, with top-down decisions being imposed at short notice and associated with crisis management approaches. Management appeared disconnected from clinical realities with cost-cutting measures impacting service quality and patient care. There was an increasing emphasis on productivity and income generation but often at the expense of the quality of patients care. Management was perceived

as prioritising short-term savings over safety and care quality and staff facing pressure to deliver more with fewer resources. Decisions were increasingly top-down, with growing micromanagement, poor communication and diminishing levels of staff input. Outreach services were also being cut, equipment not upgraded, IT system challenges not addressed, and staff felt unsupported to explain the impacts to patients and blamed issues arose. Patient dissatisfaction and complaints were increasing with some patients becoming abusive due to wider frustrations of navigating access to care. There was an unwillingness by managers to accept the obvious and profound impact of dramatic increases in clinical activity and patient complexity over recent years.

9.11 **Wellbeing:** The result of the factors described above are that hospital dentists felt overworked and burnt out, with our survey showing that over 30% of respondents felt that their wellbeing was low. Decreased wellbeing was because of stress and tiredness, and in some cases bullying. Patient backlogs and an increase in referrals were contributing to a sense of alarm that vital treatment was being delayed and risking severe consequences for patients in this situation. Hospital dentists did not receive recognition for the extra hours they were expected to put in, and questioned how long their current work life balance could continue, with stresses overspilling into their personal and social lives. Some respondents were feeling disengaged with their local employer and for resident dentists the uncertainty about meeting the specialty training curriculum, exams and completing programmes contributed to the decrease in wellbeing and sense that career progression was possible in the current environment. Many feared repercussions for their careers if they raised any concerns formally as they could be identified relatively easily. Respondents were often presented with a choice to, in effect, 'put up or shut up', and were frequently left wondering if, for example, their study leave would be paid for, leading to unnecessary stress.

Impacts of variations in pay across the four nations for hospital dentists

9.12 The BDA feels compelled to highlight once again the issue of the pay differentials that exist between hospital dentists across the UK. This issue is compounded by the significant variations in levels of dental workforce planning across the nations for hospital dentistry. Industrial action concluded in 2024 following approval of the new pay offers. However, the significant variation in approaches by the respective governments, and indeed timelines for the implementation of any uplifts, continues to distort the recruitment and retention of hospital dentists.

Chapter 10 – Our recommendations

10.1 **We ask that the DDRB recommends an overall uplift to all NHS GDS contracts, fees and allowances of 8.99% to ensure that a real-terms increase in take-home pay is delivered for GDPs. This includes a 9.5% uplift in GDP pay.** We highlight that a decade of real terms pay cuts for GDPs has critically undermined the financial sustainability of the sector and continues to drive the recruitment and retention crisis across the UK. A recommendation from the DDRB that reflects the genuine operating costs of dentistry is an essential component of tackling the recruitment and retention crisis, and the resulting brake on the delivery of NHS dental services.

10.2 **We ask that the DDRB recommends a pay uplift of 9.5% for employed dentists to attract and retain a sustainable NHS workforce.** Increases in demand for services, longer waiting lists, and poor morale continue to bedevil employed dentists. It is wholly inappropriate to allow the capacity of essential health service dentistry to degrade while the patient cohort treated by those services is projected to increase. It is similarly wholly inappropriate to ask dentists working with some of the most vulnerable patients to make a de facto choice between their own well-being, and the well-being of their patients.

10.3 **We redouble our call for a timetable for the pay review process that will restore its credibility.** We note and welcome the bringing forward of the evidence submission deadline and timetable for oral evidence this year. We regret, however, that these measures have had no impact on governments regarding the timeliness of the implementation of the uplift for the previous pay round. There is no credible justification for this delay, and the practical impact of the delay is to materially erode both pay and the morale of those delivering care. We ask the DDRB to strongly recommend that the 2026-27 pay award should be implemented on 1 April 2026 to avoid erosion of its value.

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

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

10.6 **We call for clarity from the DDRB that its non-pay recommendations are made as part of a considered and complete package, and are therefore indivisible from its pay recommendations.** The independence and fairness of the DDRB's role in the pay review process is predicated on governments giving appropriate weight and consideration to the totality of the DDRB's recommendations. Regrettably, governments have frequently adopted wilful ignorance toward many of the DDRBs non-pay recommendations. Similarly, any meaningful acceptance of the DDRB's recommendations precludes the imposition by governments of contractual conditions which are beyond the DDRB's oversight. In both these areas we call on the DDRB to take seriously its responsibility to deliver independent advice to the governments, and to have regard to the NHS strategy to place the patient at the heart of all it does.

10.7 **We call for clarity from the DDRB that to accept an uplift recommendation necessarily entails not imposing additional contractual conditions**. The Welsh Government's approach of seeking to use the DDRB's recommendation as a starting point for negotiations about contractual requirements or amendments undermines the process. The DDRB must be clear that its recommendations on pay should not be used in this way.

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

10.9 **We ask that the DDRB is explicit that any uplift recommendation it makes to the Northern Ireland Executive is in addition to the uplift recommendation in the previous pay round.**

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