BDA

British Dental Association

Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2027-28



Contents

Chapter 1 – Executive Summary 1

Chapter 2 – About the BDA 4

Chapter 3 – BDA response to the 54th report 5

Chapter 4 – Policy update 9

Chapter 5 – Economic conditions and pay trends 15

Chapter 6 – General Dental Practitioners 23

Chapter 7 – Community dental services 28

Chapter 8 – MOD dentists 36

Chapter 9 – Clinical dental academics and hospital dentists 38

Chapter 10 – Our recommendations 42

Chapter 1 - Executive Summary

1.1 NHS dentistry across the UK is suffering the consequences of labour market dysfunction caused by the extraordinary decline in real-terms spending on dentistry that began fifteen years ago. The real-terms value of Government funding for dentistry in the UK is now roughly £760 million lower than in 2009–10. This represents a very significant cut to spending on dentistry even before accounting for the cost pressures driven by clinical complexity arising from unmet demand for dentistry, changing patterns of dentition and disease, and demographic changes within the UK.

1.2 Dental practices have been placed in an increasingly untenable position by the cumulative impact of the pay review process over the last fifteen years. Increases in the essential operating costs of NHS dentistry driven by inflationary pressures on the one hand, and the long-term under remuneration of NHS activity on the other, critically undermine the financial sustainability of NHS dentistry. Our survey data found that laboratory costs, for example, increased by 12% in the 2024-25 financial year, compared to a 9% increase in the previous financial year. More widely, increases in the non-pay essential costs of delivering NHS dentistry including materials and utilities continue to limit the financial viability and resilience of practices across the UK, leaving many with little choice but to reduce or cease their NHS activity altogether.

1.3 Dentists' real earnings for the 2024-25 financial year increased across the UK for both practice owners and associates. The long-term trend, however, is of a very significant decline in real earnings. For example, an index of CPIH deflated earnings based on the Dental Earnings and Expenses dataset published by NHS England demonstrates that the real earnings of practice owners in Northern Ireland in the 2024-25 financial year were just 66.7% of their earnings in the 2008-9 financial year. Similarly, the real earnings of associates in England in the 2024-25 financial year was only 67.3% of their real earnings in the 2008-9 financial year. There is a direct relationship between the very significant reduction in the real terms' earnings of dentists across the UK and the difficulties the public face in accessing NHS dentistry.

1.4 Our survey this year found that 59% of practice owners and 46% of associates across the UK disagreed or strongly disagreed that they were fairly remunerated for their work. Where practice owners or associates worked at a practice with a high NHS commitment, those figures increased to 83% and 60% respectively. Unsurprisingly given dentists' limited belief in the fairness of their remuneration, 44% of both practice owners and associates intended to reduce their NHS commitment in the next five years. This represents a worsening of this indicator relative to the position shown in our survey last year. Alongside those reporting their intention to reduce their NHS commitment, 19% of practice owners and 11% of associates told us this year that they intended to leave NHS dentistry altogether.

1.5 59% of practice owners and 48% of associates with high NHS commitments reported their morale as low or extremely low, compared to 43% and 28% respectively for those with a lower NHS commitment. Other key workforce indicators in our survey this year both reflected the association between poorer workforce outcomes and high NHS commitment and remained profoundly concerning in absolute terms. For example, 63% of practice owners and 40% of associates described their job as very or extremely stressful. 92% of practice owners across the UK said that increased costs were one of the main factors contributing to their stress, and 53% of

associates reported that the financial unviability of NHS dentistry was one of the main factors contributing to their stress.

1.6 The recruitment and retention of dentists and the wider dental team continues to be extremely challenging. 89% of practice owners across the UK reported difficulty recruiting associates in the 2024-25 financial year, up from 85% in our survey of GDPs last year. Of those practice owners having difficulty recruiting associates, 74% reported that this difficulty was caused by the reluctance of associates to deliver NHS dentistry. 46% of practice owners who had at least one vacancy for an associate in the 2024-25 financial year had not been able to fill the position at the time of completing our survey. Where a practice held a high NHS commitment, that figure increased very substantially to 73%. 77% of practice owners reported difficulties recruiting dental nurses, 70% of practice owners reported difficulties in recruiting dental therapists, and 67% of practice owners reported difficulties recruiting dental hygienists.

1.7 In the Community and Public Dental Services (CDS/PDS) increases in demand for services, longer waiting lists, and higher workloads continue to undermine recruitment and retention and put downward pressure on workforce indicators. Across the UK, 74% of respondents to our survey described the morale of the CDS/PDS as low or very low, and 45% of respondents reported a decrease in their morale since our previous evidence submission. We reiterate our support for your prior recommendation that Government undertake a review of pay and progression including starting salaries for CDS dentists. This group are the only salaried dentists who have not had a pay review in recent years, and a widening pay differential undermines recruitment and retention into the service. Government appears unable to offer a rationale for its inertia in this area beyond asserting that data is limited.

1.8 Regrettably, our survey this year also made plain that the long-term mismatch between demand and workforce capacity in the CDS/PDS has serious consequences for dentists' working lives beyond measures of their morale: 70% of our survey respondents told us that they had been subject to physical violence from their patients. 10% of respondents that had been subject to physical violence said this had occurred more than ten times. The failure of the governments to even enable the conditions to deliver meaningful workforce planning in the CDS/PDS can only be understood as the wilful neglect of a service working directly with some of the most complex and challenging patients. This abrogation of responsibility forces dentists to carry the burden of a political failure. We set out these issues through our primary research in paragraphs 7.10 - 7.48 / Chapter 7.

1.9 The causes of the recruitment and retention crisis in dentistry across the UK are multifactorial, mediated by increasingly divergent contractual arrangements in the four nations no less than the particularities of a given local health and social care economy. This does not, however, obscure the critical role of dentists' pay. Our member survey shows that whether a dentist is an associate delivering NHS dentistry in Weston-super-Mare, a practice owner with a highly Health Service committed practice in Belfast, or a CDS dentist working across multiple communities, they are disappointingly likely to feel underpaid, have low morale, and be considering how to reduce their NHS commitment or leave the service. It is the responsibility of the DDRB to recognise the cumulative impact of fifteen years of pay review process outcomes that have left NHS dentistry across the UK ever less viable, and the dental profession ever more demoralised, and act accordingly.

1.10 The British Dental Association (BDA) continues to believe that pay and operating costs are indivisible in any equitable total funding package. It is therefore profoundly disappointing to note that, in summary, little to no progress has been made since our previous evidence submission toward the parties agreeing an evidence-based account of the essential operating costs of NHS dentistry. We reiterate our support for the DDRB's prior recommendation in this area and are frustrated by the ongoing disinterest of Government in making progress toward the fair remuneration of NHS dentistry. Additionally, despite engaging extensively with the Department of Health and Social care, little to no progress has been made toward fundamental contract reform in England since our previous evidence submission. There is, therefore, no reason to believe that fundamental changes to the NHS contract for dentistry or the basis on which the operating costs of NHS dentistry are funded are likely in the short to medium term. As a result, the DDRB's recommendations must account not only for the scale and persistence of the recruitment and retention crisis facing dentistry, but also the absence of meaningful progress toward structural change that could mitigate the impact on the dental workforce of the long term, planned underfunding of NHS dentistry.

1.11 We therefore call on the DDRB to recommend an overall uplift of 6.83% for all NHS general dental contracts, fees and allowances. This figure includes a pay uplift of 6.4%, and operating costs uplifts, as outlined in paragraphs 5.15-5.23 / Chapter 5. In line with this, we ask the DDRB to recommend a pay uplift of 6.4% for employed dentists. Alongside these pay uplifts, we also call for:

1.11.1 Timely implementation of pay awards
1.11.2 Reinstatement of commitment payments for England, Wales, and Northern Ireland
1.11.3 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
1.11.4 Clarity from the DDRB that to accept an uplift recommendation necessarily entails not imposing additional contractual conditions
1.11.5 Clarity from the DDRB that its uplift recommendations are, if accepted, to be applied across all parts of the contract, not only to elements arbitrarily deemed core
1.11.6 Clarity from the DDRB that its non-pay recommendations are integral to its considerations and therefore indivisible from its recommendations on pay
1.11.7 The overall annual expenses uplift to be applied to service costs for Dental Foundation Training (DFT) Practices
1.11.8 The DDRB to reiterate the historical recommendation of pay parity of clinical academics

Chapter 2 – About the BDA

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

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

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.

4. Fieldwork for the quantitative survey that informs this submission was conducted between 16th April – 14th June 2026. 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 54th report

Uplifts

3.1 It was welcome that the DDRB's recommendation for GDPs and CDS/PDS dentists for 2026-27 was higher than any other NHS staff group's pay review body recommendation. This was an appropriate recognition of the unique challenges facing NHS dentistry, and of how processes outside the pay review body have impacted on relative pay levels across the remit group.

3.2 The DDRB needs to build on the recommendation for 2026-27, amounting to a modest real-terms pay rise, by ensuring that its future recommendations are above inflation and act to counteract the more than 15 years of real-term pay cuts. As we set out in detail later in this evidence, these cuts have led directly to the crisis in recruitment, retention, morale and motivation plaguing NHS dentists.

3.3. The scale of this crisis requires decisive and sustained action on pay. Regrettably, there has been no amelioration of the structural, compounding factors set out in detail later in this report impacting the labour market in dentistry.

3.4 It remains the case that dentists lose money for providing many NHS treatments. The DDRB has a responsibility to uplift pay so that dentists' labour is remunerated fairly. Without this, NHS dentistry will continue to become ever less attractive, and dentists will continue to be compelled to take on more private work at the expense of NHS dentistry to ensure that they can pay rising costs.

England

3.5 In England, the Government has accepted the DDRB's recommendation on pay. It has moved more promptly than for many years in implementing the CDS pay uplift and in applying the contract value uplift to GDS contracts.

3.6 In relation to GDPs, the DHSC has again applied the GDP deflator to non-pay expenses and has applied 3.75% to non-dentist pay costs. This has resulted in an overall uplift of 3.31%. As in previous years, we responded to the consultation on this proposal setting out why this approach is unacceptable and outlining our evidence-based proposals on practice operating costs, but the DHSC has nonetheless implemented its proposal. This has been applied from July, earlier than in previous years.

3.7 The real-world effect of the DHSC's approach is that, while it claims to accept the DDRB's recommendation on pay, it is not implementing a 3.75% increase to GDPs' pay net of expenses.

3.8 Regrettably, the DHSC has also recently taken several decisions in relation to new payments arising from changes to the contract for NHS dentistry that undermine both the spirit of the DDRB's recommendation and the DHSC's wider objective to improve the contract.

3.9 New payments for quality improvement and appraisals have not been uplifted at all. The DHSC has also taken an approach to uplifting new payments for unscheduled care that does, overall, implement a 3.31% increase, but does so by uplifting the activity payment by 4.15% and freezing the fixed payment.

3.10 In the first few months of these dental contract changes being introduced, these decisions

communicate entirely the wrong message to the dental profession. We hope that the DDRB will be clear that its recommendations for 2027-28 apply to all payments under the contract for NHS dentistry. In the absence of an explicit recommendation, the BDA is concerned that the integrity of the pay review process will continue to be eroded in this fashion.

3.11 The DHSC has continued to freeze the service costs payments for Dental Foundation Training (DFT). This payment has only been uplifted once, by 1.68%, since 2013, and as a result, the value of these payments has been very significantly eroded. It has become increasingly difficult to recruit and retain Educational Supervisors to deliver DFT. As a result, a number of ICBs are introducing local top-up payments to secure sufficient training provision.

3.12 It is irresponsible of the DHSC to absolve itself of the responsibility for this vital part of safeguarding future dental workforce supply. The result of this failure to take responsibility is to force these costs to be dealt with locally, with the predictable consequence that some DFT practices are left without the resources needed to deliver training that is essential to securing an NHS dental workforce.

Scotland

3.13 The Scottish Parliamentary election took place in May 2026. Unfortunately, due to the special pre-election arrangements which apply to the handling of Scottish Government business, between 26 March and polling day on 7 May, an announcement on their response to the DDRB's 54th report was not forthcoming.

3.14 As soon as the parliamentary session commenced in May, we wrote to the newly appointed Cabinet Secretary for Health and Care to press for a response to the DDRB's recommendations as a matter of urgency. We urged her to clarify the Government's position, asking for confirmation on whether the Scottish Government has accepted the recommendations in full.

3.15 In August 2026, the Scottish Government announced that it had accepted the DDRB's recommendation on pay for NHS employed dentists. At the time of writing, there has been no acceptance of the DDRB's recommendation on pay for General Dental Practitioners for 2026-27.

3.16 In relation to the operating costs facing dental practices, the Scottish Government has said they are committed to continuing the wider dialogue with BDA Scotland on remuneration and expenses. The Chief Dental Officer (CDO) wrote to the chair of Scottish Dental Practice Committee (SDPC), in relation to establishing a working group to discuss how dental expenses could be considered as part of the annual pay uplift process. We have welcomed the opportunity to address this recommendation with the Scottish Government, along with their commitment to establish an exploratory working group, to jointly consider the matter of reflecting dental expenses within the annual pay uplift process.

3.17 We shared written proposals with the Scottish Government on the development of an index of dental costs in January and March. This index would be used to determine the expenses element of the dental contract uplift in Scotland.

3.18 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 commence for future pay rounds.

3.19 We remain extremely concerned regarding the impact of measures to increase the national minimum wage and employer National Insurance contributions (eNICs) and have continued to call on the Scottish Government to fully mitigate the increased cost associated with the eNICs increase. No mitigation or amelioration has been forthcoming.

3.20 For this pay round, the Scottish Government has again failed to discuss the costs of delivering care with SDPC, despite our calls highlighting the need for support to meet rising costs and soaring general and dental inflation.

Wales

3.21 The Welsh Parliamentary election took place in May 2026, resulting in a new Government. We had hoped that the change of Government would lead to a more appropriate approach to the implementation of the uplift in Wales. However, to date, this does not appear to have been the case. We are concerned that, once again, the DDRB's uplift recommendation may be used as part of the annual contract negotiations, which risks diluting the role of the DDRB and further undermining the confidence of the dental profession in the pay review process. We have also found it challenging to secure meaningful engagement with the relevant political stakeholders on the pay review process, including the implementation of the uplift.

Northern Ireland

3.22 Due to the NI Executive's continued failure to agree a budget for 2026/27, the pay uplift recommendations from the DDRB's 54th report have not yet been implemented in Northern Ireland, despite being agreed by the Minister. Departments have been operating on contingency budgets since April 26.

3.23 Delays in payment of the 4.04% increase to GDS fees for 2025/26, the outcome of the 53rd report, have once again been wholly unacceptable. Salaried dentists only received their 4% uplift backdated to April in February 2026, while arrears were paid to Northern Ireland GDPs in June, and the remainder following in July. On top of the considerable delay in having pay uplifts funded, we have highlighted further concerns directly to the Minister over an additional delay in the processing of payments by DoH/SPPG and BSO to GDPs, compared with salaried colleagues.

3.24 On 26th March 2026, BDA NI wrote to the First and Deputy First Ministers following publication of the 54th DDRB Report, regarding the impact the lack of an agreed NI Executive Budget would have on timely implementation of pay uplifts, but also highlighting once again that 'substantial reform to the contract is needed to make NHS dentistry attractive.'

3.25 The deregistration of just under half a million patients since 2023 (almost 485,000 in a population of 1.93 million) simply cannot be ignored. The latest annual GDS Statistics for 2025/26 published on 18th June 2026 show that just under half (49%) of the population is now registered with a Health Service dentist, a decrease of 9% (95,000 patients de-registered) since 2024/25.

3.26 In April 2026, BDA NI urged the NI Executive to secure a future for HS dentistry, responding to measures announced 'to help stabilise and safeguard' access to HS dentistry in NI. The BDA warned this must be followed by fundamental and urgent reform of the dental payment system. Regrettably, there is no clear indication yet as to when GDPs can expect their 2026/27 uplift of 3.75%, never mind more substantive payment reform.

Delays

3.27 As in all recent years, the process for applying uplifts to dentists' contracts and salaries is unacceptably delayed. 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.

3.28 The DDRB's efforts to move the pay review process timetable forward are very welcome. However, Governments continue to fail to respond to the DDRB's recommendations and implement them with extraordinary delays. These extraordinary delays are devoid of a credible rationale, reduce the financial sustainability of dental practices, and send a consistent message to the profession that it cannot rely on Governments to act as good faith partners in the delivery of dentistry. All parties must redouble their efforts to reach a situation where the uplift is implemented on 1 April each year.

Non-pay recommendations

3.29 Despite the DDRB's welcome recommendation for an index of dental costs to be established and for a review of CDS pay and progression in both its 53rd and 54th reports, little progress has been made in taking them forward.

3.30 In Scotland, as noted earlier, Government has committed to establishing a joint working group to consider how the operating costs facing dentistry can be appropriately funded through the pay review process.

3.31 In England, ministers formally rejected the 53rd report's recommendations. In correspondence, the BDA set out the problems, inaccuracies, and inconsistencies in how the DHSC sought to justify its decision.

3.32 Following the 54th report, the DHSC agreed to meet with the BDA to discuss these recommendations, and a meeting was held on 18th August 2026. The DHSC agreed to hold internal discussions and consideration of a Dental Index of Costs, but drew our attention to the constrained fiscal environment in which decisions are made and continued to insist on the value of consistency in application of the GDP deflator.

3.33 With regard to the CDS, there was agreement between the BDA and the DHSC that there is not a comprehensive and coherent dataset on the workforce, and that the parties would look to work to establish a mutually agreed dataset on which to then base decisions about the need for a review of CDS pay and progression.

3.34 While this meeting was useful, it was only a start, and we remain very far away from this leading to action that will address the fundamental issues about GDS operating costs and CDS pay and progression. We will be pressing for further dialogue to move these issues forward in the months ahead.

3.35 In Wales and Northern Ireland, little to no action has been taken. In the latter, it is understood that the DoH is awaiting progress in England before starting its own work further to the Cost of Service Review.

3.36 Given the extremely disappointing lack of progress in these critical areas, we hope that the DDRB will once more emphasise its recommendations on practice costs and CDS pay and progression.

Chapter 4 – Policy update

4.1 The policy divergence we have reported in previous years continues, with approaches to NHS dentistry by each of the governments across the UK becoming increasingly distinct. Regrettably, the common theme remains that pay, working conditions, and contracts are not sufficiently attractive to dentists. This under-remuneration of health service dentistry is the source of the recruitment, retention, morale and motivation crisis set out in detail later in this report.

England

UDA contract changes

4.2 NHS England and the DHSC have continued to pursue an approach of implementing changes within the framework of the existing UDA contract. The BDA has worked with NHS England on a package of changes since late 2022 and these have now been belatedly introduced, with a first tranche implemented in April 2026 and a further set of changes from June 2026. In broad terms, these changes were intended to address urgent and unscheduled care, prevention, high needs patients, and quality. In some areas, payments are now made in national tariffs rather than UDAs. It is important to highlight that all the changes are being delivered within the existing financial envelope.

4.3 From April 2026, contracts are required to deliver 11 unscheduled courses of treatment per £10,000 of contract value. Alongside this, the payments for unscheduled courses of treatment were amended so that rather than being worth 1.2 UDAs, they are worth £77.49. Contracts receive £15 of this as a fixed payment for each course of treatment they are required to deliver, which is topped up by £62.49 when it is delivered.

4.4 Fissure sealants have been rebanded to band two, rather than one. Dental nurses are now able to submit separate claims for applying fluoride varnish, worth 0.5 UDAs. The UDAs allocated to denture modifications and repairs have been changed.

4.5 For high needs patients, new Complex Care Pathways (CCPs) have been introduced. These are a distinct means of paying for care from the pre-existing banded courses of treatment. Care is delivered over a period of either six or 12 months, and payments are credited over the length of the pathway. These are paid as national tariffs, rather than in UDAs. While the clinical approach and attempt to better recognise the costs of high needs patients are welcome, there are a number of problems with the final design of the pathways.

4.6 Dentists can now claim a financial contribution towards the costs of completing appraisal as a measure to support quality and career development. Practices can also opt-in to a funded quality improvement project.

4.7 While these mark the most significant change to the UDA contract since its introduction, these changes are insufficient to resolve the fundamental problems with NHS dentistry brought about by the contract.

CDS waiting lists

4.8 The BDA has long been concerned about waiting times for patients accessing the CDS, particularly treatment under general anaesthetic for children and vulnerable adults. Anecdotal reports suggest that it is typical for patients to wait far longer than the 18 weeks that is standard for the rest of the NHS, and there are examples of patients waiting years.

4.9 There has been a lack of consistent and comprehensive data collection on waiting lists in the CDS. From August 2025, NHS England has asked CDS providers to submit waiting list data. Despite commitments to do so, this data has not been published.

4.10 As we set out in chapter seven, these delays in accessing care for patients reflect a workforce that is stretched far too thin. DHSC and NHS England must develop plans to expand the CDS workforce and CDS commissioning to meet patient need. This must be underpinned by improvements to the pay of CDS dentists, including through pay progression reform, so that a career in the CDS is attractive and rewarding.

Workforce planning

4.11 There remains uncertainty over the Government's workforce plans for dentistry. The revised plan is yet to be published, but it is anticipated that previous plans to significantly expand undergraduate dental education have been abandoned.

4.12 The Government has announced a small increase of 50 undergraduate places at two new dental schools. There has also been an expansion in the opportunities for overseas dentists to gain registration with the GDC. The latter will see international dental graduates become the majority of new registrants, by three to one, in the coming years.

4.13 The Government remains committed to tying graduates in England to working in the NHS. The intention is for this to apply to those starting dental school in autumn 2027. While the BDA is wholeheartedly opposed to this policy, we have engaged extensively with the DHSC about the design of the policy's detail to seek to mitigate its impact on the dental profession. We expect a consultation shortly but have concerns that it is unreasonable for school pupils to be expected to apply to dental school in autumn 2026 and then have a compulsory tie-in applied to them, when the Government will not have confirmed its policy on the tie-in at the point when they make their dental school applications. We are also profoundly concerned that, if the Government fails to deliver fundamental reform, this policy could lead to graduates being compelled to work under the flawed UDA contract.

Scotland

4.14 As noted in our previous evidence submission, we continue to work with the 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.

4.15 We wrote to Ivan McKee MSP in Autumn 2024 and Jenny Gilruth, Cabinet Secretary for Finance and Local Government in July this year, outlining concerns with the performance of SPPA in delivering pension information to members of the NHS Pension Scheme (Scotland). We have urged the Scottish Government to invest in member communications and scheme administration, with a focus on increasing resources for SPPA. Strengthening these areas would not only improve member experience but also support better outcomes in recruitment, retention and workforce productivity.

4.16 The NHS Pension Scheme is a highly valuable component of the overall reward package for staff across all services and roles. The benefits it provides represent a significant investment by members, employers, and taxpayers alike. It is therefore essential that the Scheme's value is

maintained and that it remains sustainable in the long term. The Scheme also plays a critical role in supporting the NHS to recruit and retain the skilled and motivated workforce that the public relies upon.

4.17 However, we remain concerned that the NHS and the public it serves are not currently deriving the full benefit from the Scheme. Awareness and understanding among members remain too low. In addition, members are not consistently receiving timely, or in some cases accurate, information to support effective retirement planning. It is not unreasonable to expect a service that enables all members to model their pension benefits directly, using user-defined assumptions.

4.18 We recognise that a significant proportion of SPPA resources has been devoted to implementing the McCloud remedy and associated provisions in recent years. While we appreciate the scale and complexity of this work, it is disappointing that this has continued to have a consequential impact on the timeliness of core services, including the provision of Annual Benefit Statements and retirement quotations. Delays in these areas have a direct and negative impact on members of the NHS workforce.

Wales

4.19 The new NHS General Dental Services (GDS) contract was implemented in April 2026 following the Welsh Government's decision to conclude negotiations before agreement had been reached with the profession. BDA Cymru has continued to engage with the Welsh Government on the implementation of the new arrangements, while maintaining that the contract does not provide a sustainable basis for NHS dentistry in Wales.

4.20 Since implementation, practices have encountered significant operational challenges. Ongoing software issues have affected the administration of the contract, including activity recording, performance monitoring, and financial reconciliation. These problems have increased the administrative burden on contractors and decreased confidence in the accuracy of contractual performance data. Several software problems are ongoing.

4.21 The Dental Access Portal (DAP) has now been rolled out nationally as the principal mechanism for managing access to NHS dental care. While intended to improve access, concerns remain that the system does not adequately reflect local levels of patient demand or workforce capacity. The continued emphasis on accepting new patients also risks reducing the ability of practices to provide timely recall intervals and maintain continuity of care for existing patients.

Northern Ireland

4.22 In January 2025 the Health Minister announced a GDS Cost of Service review. A Health Economist at Queen's University was commissioned to undertake the research into a complex payment system in response to BDA's request for an informed GDS fee rebasing exercise that addressed the true cost of providing care at practice level.

4.23 In an attempt to stabilise services, Minister Nesbitt wrote to the BDA in April recognising the significant pressures facing the dental profession and advising of approved measures for 2026/27, which included the continuing of the Activity Support payment (increasing from £1.6m to £2m), recurrent continuation of the 30% enhancement for fillings, extractions, and root canals, recurrent continuation of the enhanced child examination scheme, commissioning of a new Emergency Dental Clinic in the Western Trust area, and an additional six Dental Foundation training places.

4.24 The fact that there were two NI Assembly debates on dental access within a matter of weeks indicates dentistry's priority on the political agenda but time is running out and sticking plaster approaches won't fix the damage.

4.25 Given that the current mandate of the NI Assembly ends with elections in May 2027, we are calling on the Minister to take forward dental payment reform urgently in what is left of this mandate, fully informed by the Cost of Service review findings. Addressing the very significant gap – between the essential operating costs of providing HS care and fees paid to nominally cover those costs – is vital if we are to safeguard what is left of this rapidly disappearing essential health service.

4.26 It is profoundly concerning that the annual GDS Statistics for 2025-26 published on 18th June 2026 showed that HS registrations continue to plummet; they are down by 95,000 on the previous year, a decrease of 9% for 2025-26. Under half of the Northern Ireland population is now registered with a HS dentist (49%), including 44% of adults. Figures for some parts of Northern Ireland like Fermanagh & Omagh are as low as 30% of adults registered. Treatment claims were also down by 4% on year, and 37% since COVID.

Contract reform

England

4.27 The DHSC and BDA have engaged in detailed talks over the last year regarding fundamentally reforming the contract. This has led to high-level contractual models being developed. Despite this work, the DHSC has insisted that reform must be delivered within the existing funding envelope. The BDA's view is that it is simply not possible to deliver a contract that is better for the profession and patients without investment.

4.28 The then-Minister for Care, Stephen Kinnock MP, stated that a consultation on reform would take place before the summer recess. This was delayed and its status is currently uncertain following the change in government.

4.29 Previous political instability has seen delay and the deprioritisation of dental contract reform, and there is a significant risk that history will repeat itself. The Government had committed to delivering a reformed contract this Parliament. To enable that commitment, progress must be made far more rapidly than has been the case to date. Crucially, it must also ensure that reform is supported by investment.

Scotland

4.30 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.

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

4.32 Several dental policy announcements were made by the Scottish Government during 2026.

4.33 Firstly, Scottish Government confirmed that from November 2026, prior approval will move from a financial threshold to a clinical based system. We have long argued that the current prior approval system created unnecessary delays for dentists and patients, as well as creating a clinical and administrative burden. A clinically focused model has the potential to be more efficient, more transparent, and more aligned with patient need. We have worked constructively with the Scottish Government to ensure the detail of this policy is reasonable, and we will continue to seek assurances during the implementation of this policy that the new system remains workable, fair, and genuinely reduces clinical burden and bureaucracy.

4.34 From January 2026, the mandatory training requirements for dentists joining a health board list have been updated and a process known as provisional listing has been brought forward. Changes have been made to the National Health Service (General Dental Services) (Scotland) Regulations 2010 to enable GDC-registered dentists to list on a provisional basis, pending the successful completion of mandatory training.

4.35 Previously, dentists who wanted to provide NHS dental services in Scotland for the first time, or after a break of 12 months or more (subject to some exceptions), had to complete a course of mandatory training and undertake a test of knowledge before they could join a health board's dental list. The mandatory training courses are offered four times per year, meaning a dentist may have to wait for several months before they can attend the training. The Scottish Government have said this can result in dentists opting not to work in Scotland at all, or choosing to only provide private dental services, in some cases exacerbating recruitment issues for dental practices. We support the principle of ensuring that all clinicians are appropriately trained and supported but we have been clear that the new requirements must be fair and proportionate.

4.36 By joining a dental list to provide NHS services on behalf of the NHS Board dentists and dental bodies corporate agree to comply with the terms set out by the National Health Service (General Dental Services) (Scotland) Regulations 2010. That includes the terms of service set out in schedule 1 of the regulations. We understand that the Scottish Government plans to develop a process around compliance whereby new applicants to the dental list and existing entrants will be required to complete a Declaration of Compliance every three years. We understand the intention is to ensure clarity and consistency across the system in relation to compliance with the terms of service. But we have emphasised that this must not become another administrative burden. It must be simple, fair, and aligned with existing processes.

4.37 The detail of this process is yet to be brought forward. We will continue to engage with the Scottish Government to ensure the new arrangements are transparent and proportionate. They have stated that they will be working closely with us throughout the development of these new arrangements.

4.38 Finally, it is important to stress that workforce challenges are still being felt acutely across the dental sector and must be addressed. We have therefore continued to call for the Scottish Government to develop and implement a fully costed and fully-funded NHS dentistry workforce plan as a matter of urgency.

Wales

4.39 The contract continues to place considerable emphasis on volumetric delivery and access measures, with insufficient recognition of prevention, case complexity and the time required to deliver high-quality patient care. Combined with ongoing workforce pressures, rising practice costs and wider financial challenges, these factors continue to place significant strain on NHS providers.

4.40 There is, therefore, increasing concern within the profession regarding the sustainability of the new contractual arrangements. Without changes to both the contractual framework and the operational systems supporting it, there is a significant risk of further reductions in NHS dental capacity in Wales.

Northern Ireland

4.41 In January 2026 following a meeting with the Minister, a short-life GDS Reform Advisory Group was established. The BDA was invited to nominate two representatives. The aim of the group was to 'translate practical and workable reform options that DoH and ultimately the Minister can consider', with a view to producing a GDS Action Plan by April 2027. The combination of the Cost of Service review and the GDS Reform Advisory Group was intended to enable evidence and expert advice to determine what elements of GDS reform are deliverable.

4.42 On the 14th April 2026 the BDA urged the NI Executive 'to go further and faster' to secure a future for HS dentistry, responding to measures announced to help stabilise and safeguard access to HS dentistry in NI. The BDA warned these measures must be followed by fundamental and urgent reform of the dental payment system.

4.43 On 28th April 2026 the NI Assembly was unanimous in passing a motion on the need for urgency to deal with the dental crisis. All parties were united in expressing alarm at the widespread access issues arising from the most rapid disappearance of HS dentistry anywhere in the UK. All parties acknowledge the crisis manifesting in GDS is entirely the result of a dental payment model which bears no resemblance to the true cost of providing care, making it unviable for practices to deliver. The Minister said 'let's get onto the same page as the BDA' in relation to putting in place a viable and sustainable dental payment model.

4.44 In summary, BDA NI has urged the Minister to prioritise dental payment reform informed by the Cost of Service review, taking a 'twin-track' approach of prioritising financial sustainability of practices alongside maximising patient outcomes in shaping GDS reform. We have briefed MLAs and ensured the root cause of this crisis is a matter of public record. Moreover, we have raised the dental access crisis directly to the First and Deputy First Ministers, as this will require a whole-Executive response, most notably a budget to take forward dental payment reform. Regrettably, despite our advocacy for a future for this vital component of the Health Service, we continue to wait for a reply from the NI Executive.

Chapter 5 – Economic conditions and pay trends

5.1 Following notable price growth through mid-2025 the UK economy has transitioned into a steadier phase as CPI inflation moderates. July 2026 data showed inflation easing to 2.9%[1]. Despite falling from its 2025 peak, the rate has yet to hit the Bank of England's 2% target. Broader measures of inflation reflect a similar trend, with the Consumer Price Index including owner occupiers' housing costs (CPIH[2]) tracking at 3.1%[3] during the same timeframe. This cooling environment, paired with more measured economic expansion, forms the backdrop for evaluating multi-year wage trajectories.

Private and Public Sector Pay Growth

5.2 According to the latest ONS data[4], in the year to June 2026, average weekly earnings excluding bonuses and arrears of pay, a clearer measure of underlying pay growth, rose by 3.6% across the whole economy. Within this, pay in the private sector grew by 2.9%, while the public sector recorded higher growth of 6.4%. Since the turn of the year, regular public sector earnings growth has averaged 5.5%. Sustaining this upward momentum is critical to reversing long-standing real terms pay erosion, addressing worsening recruitment crises, and helping to stabilise essential public services.

Spend on NHS dentistry

5.3 Gross expenditure on NHS dentistry across the four nations rose steadily over the past decade, reaching £4.717 billion in 2024-25 in cash terms[5]. This represents a full 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 has been in aggregate one of stubborn decline.

5.5 Turning to the current year, NHS dental funding in 2024-25 increased slightly, rising to £2.186 billion.

5.6 It is important to note that, across the UK, the real-terms value of Government funding is now roughly £760 million lower than in 2009–10. This prolonged shortfall leaves NHS dentistry critically underfunded in the face of rising demand and operating costs.

[1] CPI Annual Rate – ONS
[2] CPIH includes housing costs and is the Office for National Statistics' preferred measure of inflation.
[3] CPIH Annual Rate – ONS
[4] Average weekly earnings – ONS
[5] UK Dental Market: 2024-25 GDS Spend and PCR

5.7 The chart below 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, which remains substantial despite a recent uptick in real spending in 2024–25.

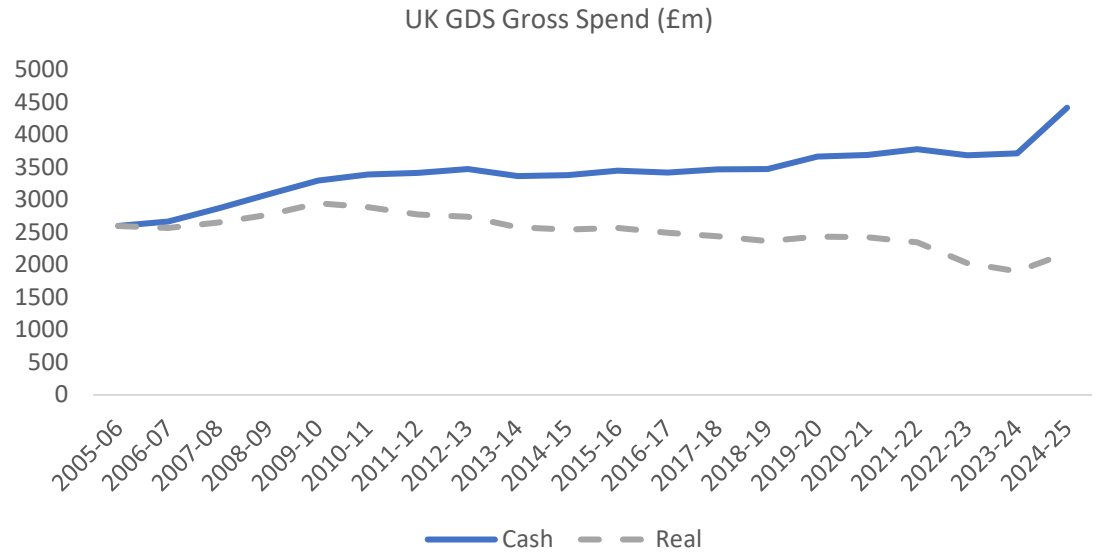


Fig 1: UK gross spend on GDS in millions. Sources: Health departments.

5.8 Patient charge revenue in England reached £863 million in 2025-26[6], up from £806 million the previous year, marking a continued recovery from the sharp drop during the pandemic. In the 24 months leading to 31 March 2026, the number of adult patients seen rose to 18.8 million, up from 18.5 million previously, but still below the pre-Covid level of nearly 22 million recorded in 2019. As a result, financial contributions from patients have outpaced the recovery in access, meaning fewer patients are generating higher overall revenue.

[6] Dental statistics – England 2025/26 – NHS BSA

Practice owner incomes

5.9 Between 2023-24 and 2024-25, practice owner taxable income increased across each of the four UK nations. Scotland reported the highest average taxable income (£149,900), while Wales recorded the strongest year-on-year growth (+17.4%), albeit from a lower base. These figures, of course, do not reflect the long-term and very substantial increases in the essential operating costs of dentistry that have accrued over many years. The latest taxable income figures are shown in the table below.

Nation	Year	Income Before Tax
England	2023-24	£134,400
	2024-25	£146,300
	Change	+8.9%
Scotland	2023-24	£135,500
	2024-25	£149,900
	Change	+10.6%
Northern Ireland	2023-24	£121,200
	2024-25	£133,500
	Change	+10.1%
Wales	2023-24	£114,100
	2024-25	£134,000
	Change	+17.4%

Fig 2: Practice owner earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[7]

5.10 Operating costs, such as staffing, premises, and clinical materials, account for just over two-thirds of gross earnings. As a result, the income left after expenses continues to fall well short of the real cost of providing NHS dentistry.

5.11 Given that essential outgoings absorb such a large share of gross earnings, practice owners are left with minimal operational flexibility. Across all four nations, although earnings have increased, to remain financially viable, many are reducing their NHS commitments and shifting toward private care. In fact, as is set out in detail in the following chapter, our latest survey data reveals that just over a third of practice owners intend to expand the proportion of private work they undertake over the next five years.

5.12 Since 2008–09, a continuous erosion of real earnings across all nations has left practice owners with incomes far below historic levels[8]. This prolonged financial decline underscores the intensifying pressure on NHS practices, an issue that will be explored in greater detail later in this chapter.

[7] Dental Earnings and Expenses Estimates – NHS England Digital
[8] UK Dental Market 2023-2024 time series earnings

Associate pay

5.13 Associate earnings increased across all four UK nations in 2024-25, marking a stronger year for taxable income than the previous reporting period. Again, despite these gains, increases in cash earnings must be understood alongside continuing pressures from inflation and operating costs, which are likely to have constrained improvements in real income. The latest figures are shown in the table below.

Nation	Year	Income Before Tax
England	2023-24	£66,700
	2024-25	£70,500
	Change	+5.7%
Scotland	2023-24	£80,700
	2024-25	£87,400
	Change	+8.3%
Northern Ireland	2023-24	£65,500
	2024-25	£76,500
	Change	+16.8%
Wales	2023-24	£74,500
	2024-25	£79,800
	Change	+7.1%

Fig 3: Associate earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[9]

5.14 Recent pay uplifts have failed to offset soaring costs, creating a real-income squeeze for associates that is masked by steady nominal cash figures. This tracks an over decade-long downward trend where associates, mirroring practice owners, face compounding real-earnings losses across all four nations. This persistent trend highlights the ongoing structural flaws in the current NHS contractual framework.

[9] Dental Earnings and Expenses Estimates – NHS England Digital

Real Net Earnings in NHS Dentistry

5.15 The long-term trend in dentistry across the UK is of a very substantial decline in real earnings. As shown in Figure 4, an index of CPIH-deflated earnings (2008-09 = 100) shows that real earnings of providing performers (practice-owners) in England have fallen by 27.9% since the base year (reaching 72.1 in 2024-25), while providing performers in Wales have faced a steeper decline of 29.1% (falling to 70.9 in 2024/25). Associates in England saw an overall fall of 32.7% over the same period (dropping to 67.3). Across all four nations, Northern Ireland providing-performers faced the most severe contraction, with real earnings plummeting by 33.3% to an index level of 66.7 by 2024-25, an extraordinary reduction given their role in bearing wider operating costs.

5.16 On an RPI basis, the cumulative fall for Northern Ireland providing performers exceeds 43%, having fallen to 56.7 by 2024-25. This extraordinary reduction underlines the scale of the challenge when a higher inflation benchmark is applied, particularly when compared to the CPIH-deflated trends. Both associates and practice owners across all four nations failed to see any real-terms increase over this period, with associates in England and providing performers suffering massive RPI-adjusted declines of 42.8% and 38.8% respectively.

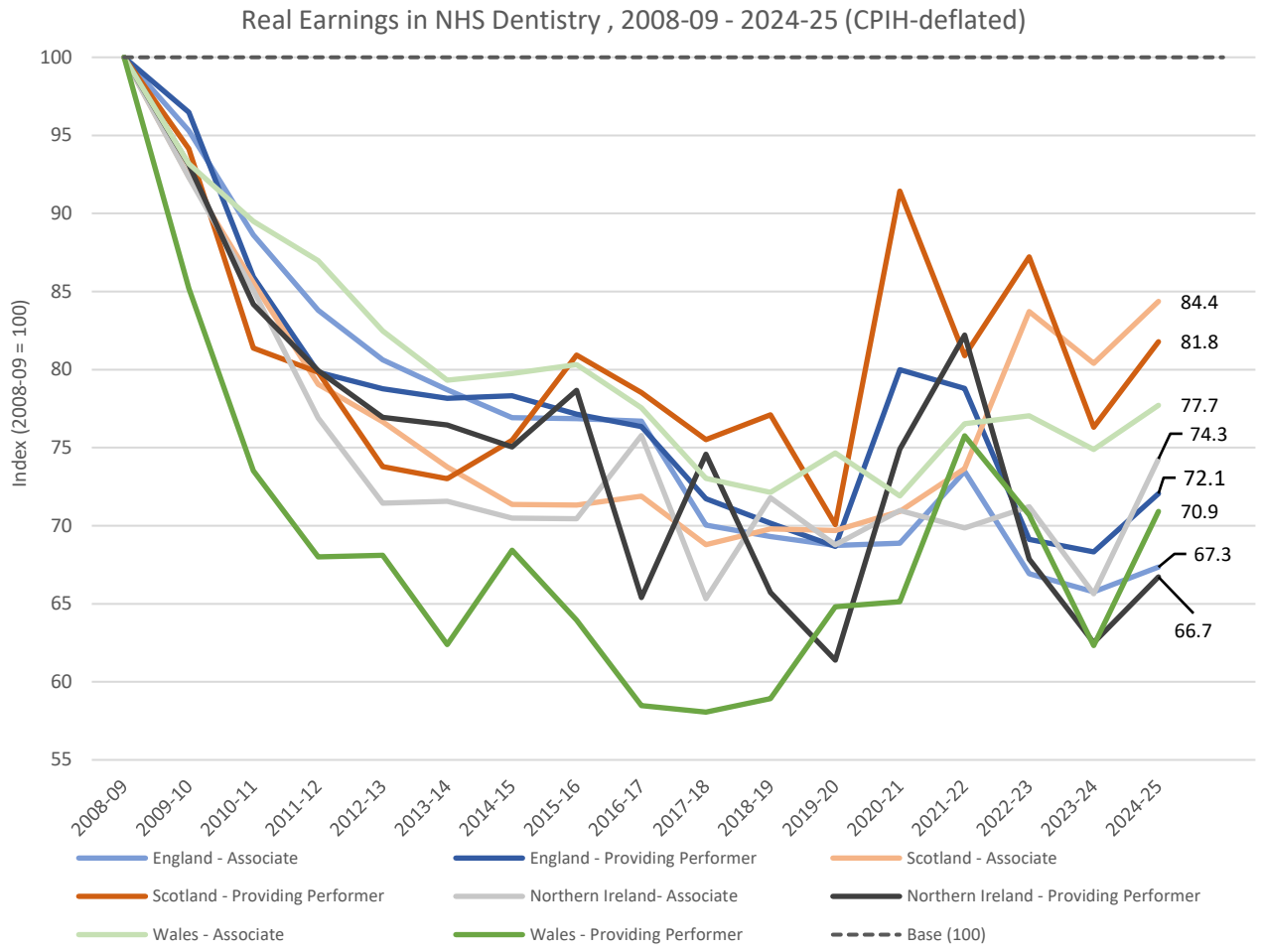


Fig 4: BDA derived CPIH-deflated real earnings index for NHS Dentists, 2008/09-2024/25. Source: Dental Earnings and Expenses Estimates – NHS England Digital[10]

5.17 This widespread contraction highlights how both associates and practice owners across the UK are particularly exposed to inflationary pressures. With most operating as self-employed contractors, their incomes are uniquely impacted by rising costs and changes to contractual

[10] Dental Earnings and Expenses Estimates – NHS England Digital

arrangements, leaving them more vulnerable to sustained real-terms erosion compared to many other health and social care professionals. Every dentist across all four nations has suffered deep real-terms income losses under both CPIH and RPI metrics.

Practice operating costs

5.18 The BDA continues to believe that practice operating costs must be fully accounted for in all pay review deliberations by the DDRB or Government. We continue to urge the DDRB and policymakers to reflect these pressures in their 2027–28 recommendations. It is important to recognise that cost inflation does not just affect practice owners directly; it also impacts associates, whose earnings depend entirely on overall practice viability.

5.19 To monitor sector-specific pressures, the BDA tracks changes across key inputs, including staff, laboratory, and material costs, as well as energy, insurance, and professional services. Combining original BDA research with official statistics allows for a more precise, practice-focused measure of inflation than using standard consumer-based indices alone.

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 in hourly pay across staff groups weighted by workforce size, as reported in our survey of GDPs. In addition, an adjustment has been incorporated for the April 2026 increase in the National Minimum Wage, announced in the 2025 Autumn Budget.

5.21 Laboratory costs are drawn directly from survey data, while material costs are benchmarked against ONS CPI (06.1: Medical Products), which directly reflects retail price changes in medical and dental products. Remaining expenses (Other costs), such as housing, utilities, fuel, insurance, and professional services, are linked to ONS CPIH. This approach ensures a transparent blend of official consumer price measures and sector-specific data.

	Weighting	Index	Weighted value
Dentists' pay	0.466	6.40%	2.98%
Staff costs	0.22	7.86%	1.73%
Laboratory costs	0.06	23.28%	1.40%
Materials costs	0.066	2.20%	0.15%
Other costs	0.188	3.10%	0.58%
Total	1		**6.83%**

Fig 5: Formula for overall GDP uplift. Sources: BDA Survey of GDPs 2026 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 6.40% for dentists' pay, 7.86% for staff costs, 23.28% for laboratory costs, 2.20%[11] for materials (CPI 06.1: Medical Products, year to July 2026), and 3.10% for other costs (CPIH, year to July 2026), the model points to an overall uplift of

[11] CPI Annual Rate 06.1 – ONS

6.83% to offset rising practice costs in 2025-26. This compares with average earnings growth across the whole economy of 5.0% in the private sector and 4.7% in the public sector since the pandemic, emphasising the unique financial pressures facing NHS dentistry relative to the wider economy.

5.23 On this basis, we ask that the DDRB recommends an overall uplift of 6.83% to be applied across all NHS dental contracts, fees, and allowances.

Pensions as part of a total reward package

5.24 BDA notes that IDR produced a review of pay comparability for the DDRB in March 2026[12]. We agree that it is important to consider the value of the pension package. IDR chose to value the NHS Pension Scheme purely by reference to the current value of the employer pension contribution of 23.7%. While this is an acceptable metric, we would urge caution as the contribution rate can be influenced by a variety of factors not explicitly linked to the quantity of pension benefits accruing. Specifically, in assessing the contribution rate, the Government Actuary makes a number of financial assumptions about the future, and applies these to the expected quantum of pension benefits that will be paid. The primary assumption is the discount rate, which has a very significant bearing on the employer contribution rate, but has direct impact on the amount of pension benefits accrued by any dentist or the long-term cost to the public purse.

5.25 The DDRB may be aware that the actuarial valuation for the NHS Pension Scheme in England and Wales was published in July 2026[13]. The results of this valuation indicate that the employer contribution is expected to decrease from 23.7% to 15.5% from April 2027. Based on the above IDR methodology, we would conclude that the reward package is due to reduce by more than 8% next year, and we would urge the DDRB to take this into account.

5.26 Whilst actuarial valuation reports for equivalent pension schemes in Scotland and Northern Ireland have not yet been published, we understand that equivalent levels of reduction in employer contribution will arise from these.

Pension Scheme Opt Outs

5.27 The BDA believes that the NHS Pension Scheme is a highly valuable benefit of NHS employment and engagement. We remain concerned at the levels of dentists who are opting out and foregoing the protections and financial security offered by the Scheme. In England and Wales, NHS Business Services Authority publishes periodic updates of opt outs[14]. The most recent data (for March 2026) shows that 11% of Medical and Dental grades of NHS staff are opting out. Further data obtained by BDA from NHS BSA Dental Services in March 2026 shows that for dental practitioners in England and Wales 5,888 (20.71% of eligible dentists) are not in the pension scheme. Reasons for opting out are generally given as affordability or other financial priorities. We are mindful that the Annual Allowance, despite some welcome reforms, remains a significant concern for dentists.

NHS Pension Schemes' members contributions

5.28 Further to our previous evidence submissions it remains the case that the issue of NHSPS member contributions are of concern to the BDA. Across the UK we believe that the case for tiered

[12] A Review of Pay Comparability for the DDRB, March 2026
[13] 2024 Valuation - NHS Pension Scheme (England and Wales) - GOV.UK, July 2026
[14] NHS Pensions Opt-out data | NHSBSA

pension contributions is seriously diminished. This is because the Annual Allowance serves to mitigate against high levels of income tax relief. Furthermore, the administrative burden being generated by tiered contributions, especially linked to aggregating employments, has caused significant errors in Scotland, and remains an area for policy reform which is proving difficult to resolve. The BDA would prefer a longer term move towards a flat rate of member pension contribution and would urge the DDRB to support such a move.

NHSPS Administration

5.29 The BDA recognises that this is outside the scope of DDRB's remit, but it is relevant to dentists' confidence in their NHS pensions, and ultimately on the NHS as an employer. It has been the case for some years that Administration agencies across the UK have experienced large scale failures in delivering on their statutory requirements. Whilst they are making slow progress towards delivering the McCloud Remedy, the continued delays are causing distress, concern, and a lack of confidence in the service. The BDA believes that administration agencies need a significant level of one-off investment so that their data recording, calculations and communications processes can be fully automated and modernised. With such development, we would hope members would be able to directly access their own pension records and data; and model their own retirement scenarios. This would remove the need for burdensome and timely interventions to employers and agency staff.

Chapter 6 – General dental practice

6.1 The results of the BDA's annual survey of General Dental Practitioners (GDPs) in England, Scotland, Wales and Northern Ireland continue to reflect the profound recruitment and retention challenges facing NHS general dental practice. Unless explicitly stated otherwise, the data presented in this chapter relate to the whole of the UK.

6.2 As has been highlighted by our evidence for many years, already poor workforce indicators among dental practices are unfortunately significantly weaker among those practices with a high NHS commitment. In fact, this relationship is reflected almost without exception across the dozens of workforce indicators assessed by the BDA's annual survey of GDPs, including recruitment and retention, morale, and stress. The breadth, persistence, and size of this correlation is stark evidence of the dysfunction of the labour market for dentistry that is driven by the under remuneration of NHS dentistry.

"The best decision I ever made for my own quality of life was to hand back most of our UDA commitment and focus on providing private care. Moving to private dentistry has allowed me to provide better care to patients, reinvest the extra income back into the practice and staff, and no longer feel burnt out." Practice owner

Workforce

6.3 Recruitment and retention difficulties remain widespread across the dental workforce. 89% of practice owners who sought to recruit at least one associate reported difficulties doing so, rising to 94% among those with a high NHS commitment. Recruitment of Dental Care Professionals (DCPs) also remains challenging, with 77% of practice owners reporting difficulties recruiting dental nurses, 70% reporting difficulties recruiting dental therapists, and 63% reporting difficulties recruiting hygienists. Of those practice owners experiencing difficulties recruiting associates, 74% identified a reluctance among associates to undertake NHS work as a key reason for these recruitment challenges.

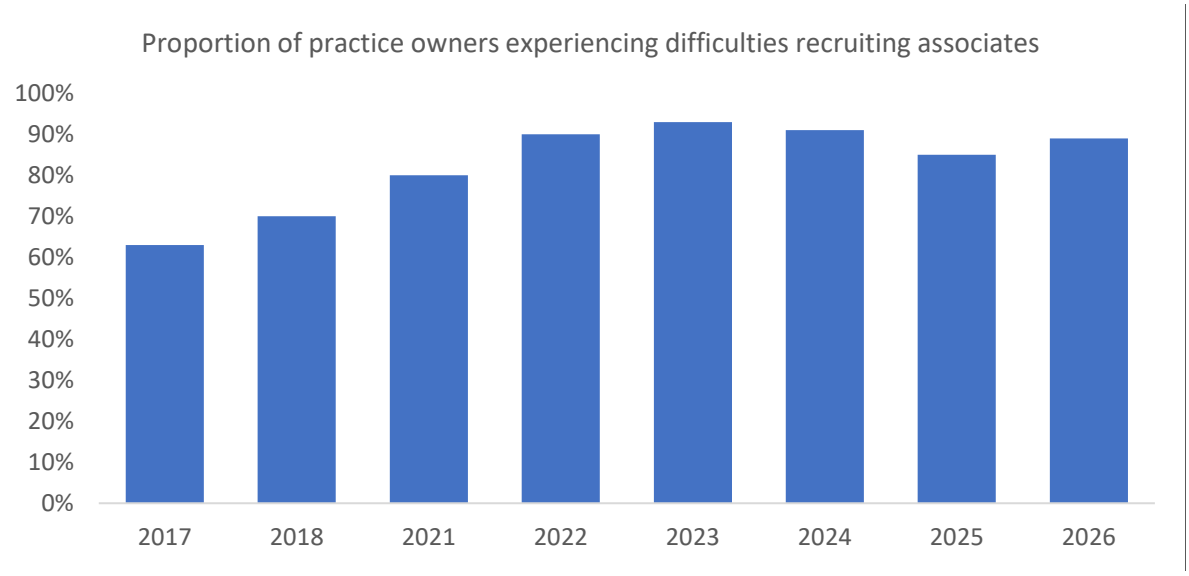


Fig 6: Proportion of practice owners experiencing difficulties recruiting associates. Sources: BDA Survey of General Dental Practitioners 2026

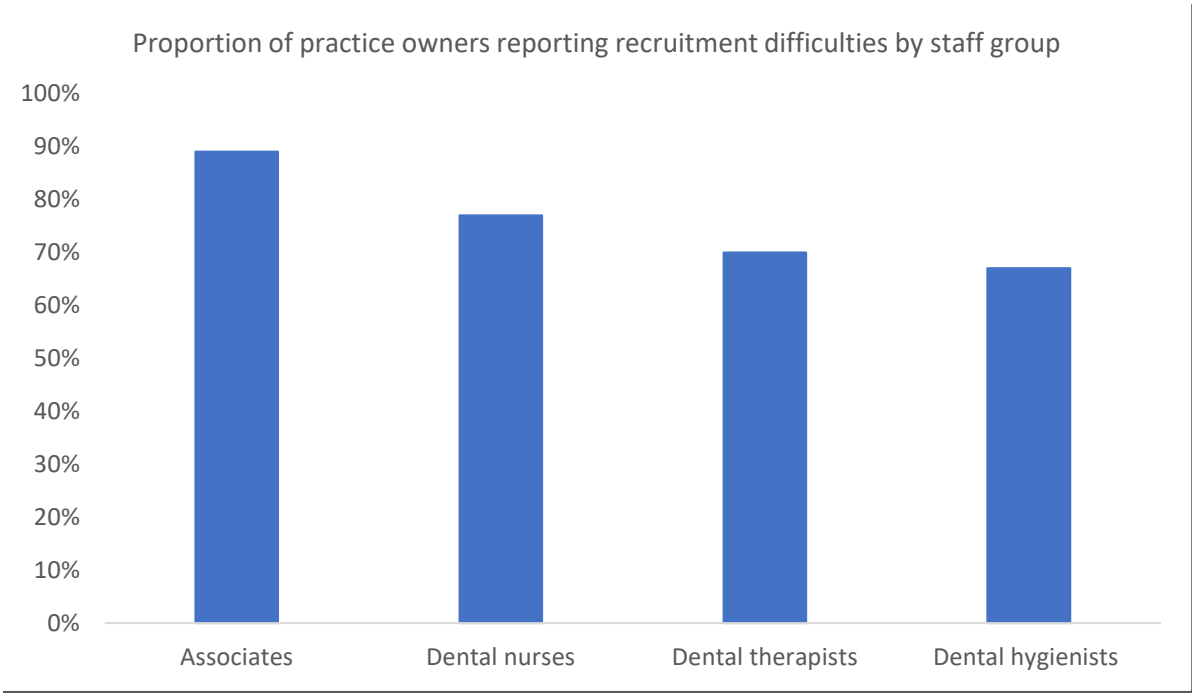


Fig 7: Proportion of practice owners reporting recruitment difficulties by staff group, 2025-26 financial year. Source: BDA Survey of General Dental Practitioners 2026

6.4 We noted in our previous evidence submissions that increasing workforce numbers alone will not resolve the workforce challenges facing NHS dentistry without a sustained improvement in participation in the NHS labour market. The continued difficulty practices experience recruiting associates willing to undertake NHS work suggests there has been little progress towards reversing the established trend of declining participation in NHS dentistry. This reinforces the importance of improving the attractiveness and financial sustainability of NHS dentistry if long term workforce shortages are to be addressed.

6.5 The number of dentists registered with the General Dental Council and the headcount number of active NHS dentists provide only a limited indication of overall workforce capacity in dentistry. Headcount data do not account for working patterns nor 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 from the NHS Dental Workforce Survey. At the end of 2025, there were 47,916 dentists registered with the General Dental Council, representing an increase of 3.4% compared with the previous year.

6.6 The NHS Dental Workforce Survey demonstrates the disparity between workforce headcount and NHS workforce capacity. As of December 2025, there were 9,824 full time equivalent (FTE) NHS general dentists in England – down on the previous year. This figure remains significantly below the headcount number of dentists delivering NHS care in England which exceeded 24,000.

6.7 The NHS Dental Workforce Survey agrees with the evidence from the BDA's own survey data regarding the dysfunction of the labour market for NHS dentistry.

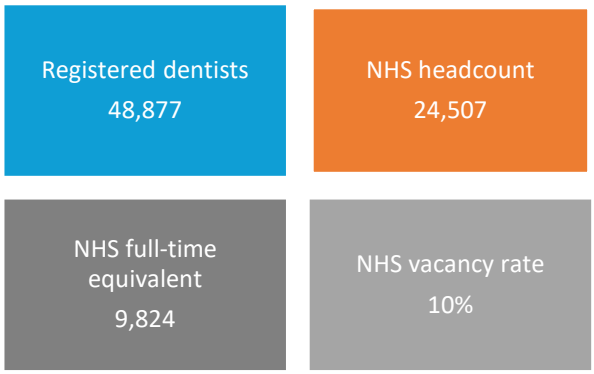


Fig 8: NHS dental workforce indicators in England. Sources: General Dental Council registration data & NHS Dental Workforce Survey.

Recruitment and retention

6.8 Recruitment and retention challenges continue to impact the sustainability of NHS dentistry. 20% of associates sought a new role in the 2025-26 financial year, and our survey found that they did so because they sought a better work-life balance (61%), higher remuneration (45%), and had a desire to work in a practice with a higher private commitment (47%). The substantial labour mobility in the associate labour market is driven by under remuneration, and at the practice level, this labour mobility places additional demands on practice owners. At the system level labour market friction of this kind makes it harder for patients to access NHS dentistry.

"After many years, giving up on working under the NHS contract was a major game changer. I feel like I've got my life back, as a professional!" Associate

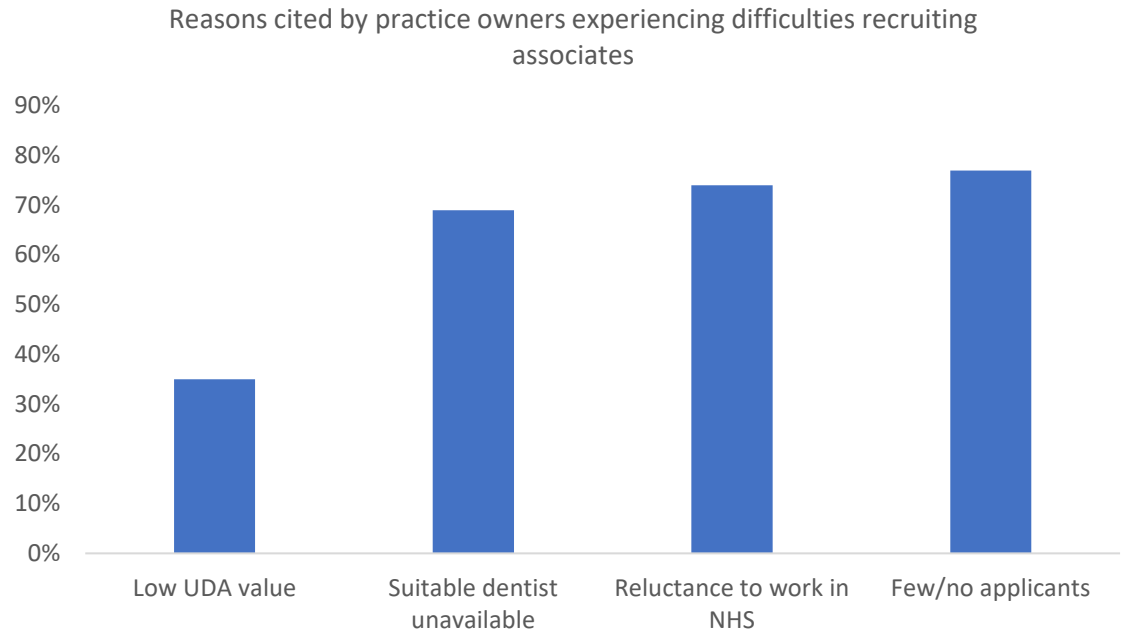


Fig 9: Reasons cited by practice owners experiencing difficulties recruiting associates during the 2025-26 financial year. Source: BDA Survey of General Dental Practitioners 2026

6.9 In our survey this year 77% of practice owners delivering NHS dentistry and 75% of associates delivering NHS activity told us that they intended either to reduce their overall hours or increase

their private activity. The participation rate of dentists within the market for their labour continues to face downward pressure stemming from the under remuneration of NHS dentistry, with predictable effects on access to dentistry.

6.10 Mobility within the market for the labour of associate dentists and downward pressure on the participation rate of both practice owners and associates are long-term, compounding factors driving the recruitment and retention crisis in dentistry. The under remuneration of NHS activity is the source of both of these predictable factors and continues to distort the effective functioning of the market for NHS dentistry.

Dental nurses

6.11 As noted in our previous evidence submission, 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.

6.12 During the 2025-26 financial year, 77% of practice owners sought to recruit dental nurses and, of those doing so, 77% reported experiencing difficulties. Of those practice owners who reported difficulties, 61% reported having to hire trainees and apprentices due to no interest from experienced nurses. Where a practice had a high NHS commitment, that figure increased to 67%, highlighting the impact of the under remuneration of NHS dentistry across the entire dental team.

"Pressure on nursing staff wages meant we can't recruit and retain good staff." Associate

Dental therapists and dental hygienists

6.13 During the 2025-26 financial year, 70% of practice owners seeking to recruit dental therapists and 67% of those seeking to recruit hygienists reported difficulties. The challenge facing practices recruiting dental therapists and hygienists is particularly concerning given the critical contribution these professionals can make to improving access and supporting prevention. Greater utilisation of the wider dental team has long been recognised as an important means of improving the efficiency and capacity of NHS dentistry. The reality at the practice level is clear: to unlock the benefits of skill mix – such as freeing up dentist capacity – practices must first have the financial means to offer dental therapists and hygienists competitive pay,

Morale and motivation

6.14 47% of practice owners and 39% of associates rated their morale as low or very low. Dentists with a high NHS commitment continued to report substantially poorer morale than those doing less NHS work; among practices with a high NHS commitment, 59% of practice owners and 48% of associates reported low or very low morale. Only 38% of associates with a high NHS commitment would recommend a career as a dentist, with that figure increasing to 46% for those without a high NHS commitment. Similarly, just 37% of practice owners 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.

"I feel that providing NHS dentistry is very over scrutinised, the administration and way we have to work is over complicated making the job much more stressful. I can understand why many of my colleagues have moved to the private sector." Associate

6.15 Many dentists continue to feel undervalued and inadequately rewarded for their work. Our survey this year revealed that almost three in five (59%) practice owners did not believe that they

were fairly remunerated, while almost two-thirds (63%) did not believe that they achieved a good work-life balance.

"Since dropping NHS dentistry my job satisfaction has increased hugely. I can do work I am proud of, better help my patients and maintain the viability of my dental practice. NHS work was starting to feel restrictive, and I could not properly utilise the skills I was developing as I grew as a clinician." Practice owner

Stress

6.16 Stress levels remain exceptionally high across the profession. Almost two-thirds (63%) of practice owners and 40% of associates described their present job as extremely or very stressful. Practice owners and associates working in practices with a high NHS commitment continued to report higher levels of stress, with 71% of practice owners and 43% of associates describing their work as extremely or very stressful, compared with 59% and 35% respectively among those with a lower NHS commitment.

6.17 Concerningly, an already exceptionally high level of stress among dentists appears to be accelerating. 70% practice owners and 50% of associates reported that their level of stress had increased over the previous 12 months. Once again, this was more pronounced among those with a high NHS commitment, with 76% of practice owners and 55% of associates reporting increasing stress, compared with 66% and 42% respectively among those with a lower NHS commitment.

6.18 Our survey also provides insight into the factors driving these high levels of stress. For practice owners, increased practice costs, regulatory compliance, financial concerns, the increasing unviability of NHS dentistry, and workforce recruitment and retention were among the most frequently reported causes of stress. For associates, patient complaints and fear of litigation were more frequently identified factors. Dentists are being placed in the invidious position: they must sacrifice their own wellbeing to deliver the level of NHS care demanded by both their professional ethics and the regulatory system. Exceptionally high levels of stress will continue to put downward pressure on the participation rate of dentists, in the market for their labour, in the absence of fair funding for NHS dentistry.

"We are paid so little to care for people's teeth. Some of the patients have such extensive treatment plans that if I am caring for them properly (which I do because I'm that generation of dentist) I make a loss. The job is stressful enough without having to worry about how I'm going to get paid for doing my job properly." Associate

6.19 Taken together, these findings once again demonstrate that the central workforce challenge facing NHS dentistry is not simply the number of dentists available, but the ability of the NHS to attract and retain their clinical time. Recruitment difficulties, declining NHS participation, poor morale, and exceptionally high stress are consistently worse where NHS commitment is highest. A DDRB recommendation that fails to restore the competitiveness of NHS remuneration risks further reductions in NHS participation, undermining the Government's ambitions to improve access irrespective of increases in overall dentist headcount.

Chapter 7 – Community dental services

7.1 The crisis facing the CDS/PDS dental service across the four nations continues, with nearly half of the respondents to our annual member survey reporting an erosion of their service since our previous evidence submission. The BDA's call to the DDRB and Governments therefore remains as it has for many years; urgent and meaningful intervention must take place, to reverse the deterioration of the CDS workforce's size, capacity, and morale. The Government's long-term failure to address these challenges represents a failure to fulfil its duty of care to CDS dentists and the vulnerable patients they often serve.

7.2 The gulf between patient need and the capacity of the CDS workforce places extraordinary pressure on individuals no less than services. Despite CDS dentists' commitment to delivering the highest standards of care for their patients, headcount decline, systemic underinvestment, and under-commissioning have meant that patient demand simply cannot be met. Vulnerable adults and children continue to experience pain for far longer than they should. This has predictably translated into a concerning number of CDS dentists reporting worsening morale and high levels of stress in our survey this year, exacerbating recruitment and retention issues within the service.

7.3 The reality of unmet need within the CDS right across the UK must motivate decision makers to tackle the existential threat facing the service. The BDA is therefore calling for the immediate release of national CDS waiting list data for England so the full extent of CDS patients' need can be understood and addressed. In the absence of transparency of this kind, those often least able to advocate for their own healthcare needs will continue to be punished.

7.4 We welcome the DDRB's recognition in its 54th report of the long-term and multifactorial challenges facing the CDS/PDS workforce. We particularly welcome its recommendation that salaried dentists working in the CDS/PDS receive a differential pay uplift.

7.5 Despite this, other key stakeholders do not accept that the CDS is in crisis. The joint DHSC and NHS England evidence submission to last year's pay round dedicated less than a page to the CDS. The data it provided made no attempt to contextualise the size of the workforce or vacancy rates against the needs or size of its patient population, nor did it account for the headcount decline that has occurred over the course of a decade. Wilful neglect of strategic workforce planning will not improve the situation vulnerable patients and the dentists who treat them find themselves in, nor will it improve the morale, recruitment and retention of this critical workforce.

7.6 We also welcome the DDRB's decision to once again recommend that the four national Governments undertake a review of pay and pay progression within the CDS, recognising the extraordinary challenges facing the service, including recruitment and retention. These recommendations mirrored the recommendations of a BDA roundtable report on the CDS in Northern Ireland, held in September 2025. We were deeply disappointed to note DHSC's rejection of this recommendation from the 53rd report. It is the BDA's view that the reasoning used by DHSC to justify this rejection was unsound and based on flawed evidence. This view was conveyed in our correspondence to the DDRB earlier this year.

7.7 As noted earlier in this evidence submission, once again, salaried dentists in Northern Ireland experienced a considerable delay in receiving their 4% uplift for 25/26, backdated to April 2025, as this was not paid until February 2026. Regrettably, the continued absence of an agreed budget by the NI Executive will mean further delay in uplifts being applied for 2026/27.

7.8 Again, as noted earlier in this evidence submission, the BDA wrote to the Scottish Government in May highlighting that the 54th DDRB report had been published on 25 March 2026 and urged them to clarify the Government's position on the recommendations of the report urgently. We said we would welcome confirmation on whether the Scottish Government has accepted the recommendations in full and would like to discuss how these can be taken forward at the earliest opportunity. The Cabinet Secretary for Health and Care responded to our letter in June stating that she was considering the implications of the DDRB recommendations. On 12 August a pay circular was published by the Scottish Government confirming a 3.5 per cent uplift to basic pay across NHS medical and dental staff and a 3.75 per cent uplift to Public Dental Service dentists, which would be back dated to 1 April 2026.

Workforce

7.9 As highlighted in prior evidence submissions to the DDRB over recent years, the BDA holds significant concerns regarding the CDS/PDS workforce's size and capacity. Inadequate staffing levels require significant investment and workforce planning over the long term to increase capacity to a level which enables dentists to meet the needs of their patient population.

England

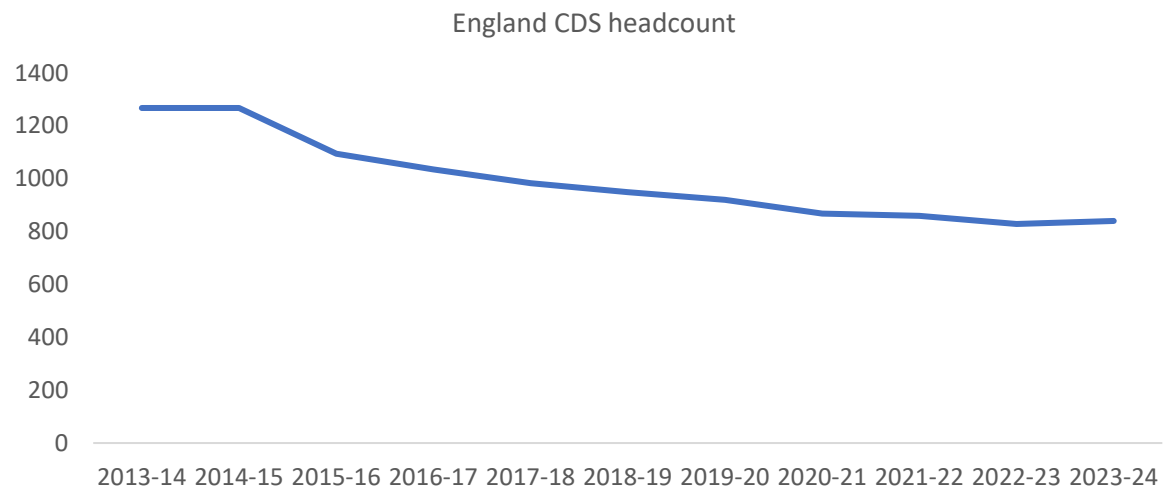


Fig 10: England CDS headcount. Sources: Health Departments and NHS Digital

7.10 Workforce statistics published last year by NHS England revealed a stark picture of deterioration, which was even worse than previous data from other sources had suggested. These figures, also highlighted in last years' submission, confirm the warnings issued by the BDA over many years.

7.11 Previously available data had shown a sustained decrease in the CDS workforce (see Fig 10). As of December 2024, new data published by NHS England[1] had the CDS headcount in England at 640, amounting to an FTE workforce of only 367.[2] When compared to pre-existing data from alternative sources available at the time, the England CDS dentist headcount has precipitously declined over the course of a decade. It is astonishing, then, to notice both the scale of this

[1] Dental Workforce – NHS England
[2] 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.

decline and the lackadaisical efforts of the Government to recruit and retain a resilient CDS workforce. Data published in relation to 2025, reports that there were only 277 general dentists working in the CDS. Regrettably, this does not appear to be a sufficiently robust dataset from which to draw conclusions.

7.12 Nonetheless, qualitative data from the BDA's network of CDS members, coupled with quantitative data from our 2026 survey of employed dentists, suggest that capacity challenges have not eased. More than half of survey respondents in England reported having to cover for their colleagues once a month or more, with 20% of respondents covering once a week, or more often. Nearly half reported resource availability having a somewhat or very negative influence on their decision to remain in the service. This clearly points to staffing shortages, which is corroborated by qualitative survey responses.

'Recruitment and retention is a huge issue, with major impacts of patient wait lists, continuity of care, and pressures on remaining staff.' England, Band B Senior Dental Officer, 11-15 years of service

7.13 A significant proportion of the community dental workforce is in the latter stages of their careers, with many considering reducing their commitment to their service or leaving it entirely. The BDA therefore anticipates that, without meaningful interventions to improve recruitment and retention, numbers will fall further in the immediate future. The BDA's 2026 survey of CDS members in England indicated that nearly 20% of respondents were aged 55 or above. When asked about their career intentions in the next five years, 22% reported an intention to retire, 28% planned to reduce their working hours, and 11% intended to leave dentistry entirely.

7.14 The impact of retirement and workforce shortages is reflected in the following survey response:

'I work extremely hard and many extra unpaid hours. My work load is intense and I have been expected to take on additional work when colleagues retired, on top of my existing workload. I average 10-12 hours a day of work.' England, Band C Clinical Manager, 21 – 25 years of service

Scotland

7.15 The Public Dental Service (PDS) combines the Community Dental Service (CDS) and the Salaried General Dental Services in Scotland. The PDS plays a vital, unique role in treating patients who need specialised and specialist dental care, and acts as a 'safety net' for patients who cannot access care within general dental practice. The PDS is managed and delivered directly by NHS boards, which employ the service's staff and ensure full compliance with all relevant GDS legislation and regulations. It continues to provide a complementary service to the independent contractor GDS.

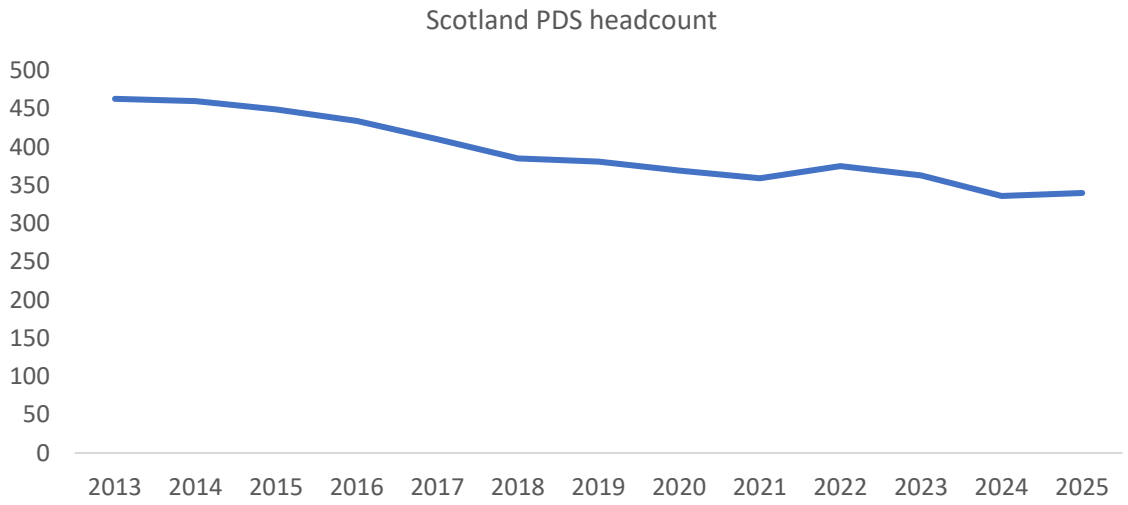


Fig 11: NHS Scotland workforce PDS Dentists Headcount. Source: NHS Scotland workforce | Turas Data Intelligence

7.16 As in England, there has been a trend of PDS headcount decline over the course of the last decade; from March 2015 to March 2025, the workforce has reduced by 24%. There is an indisputable recruitment crisis affecting the PDS, and evidence of the negative impact this has had on existing staff was clear throughout the qualitative responses to our survey.

"More staff are leaving the profession and the jobs are not being replaced quick enough. Struggling to recruit for these jobs." Scotland, 0-5 years of service, Dental Officer

"Less resources and chronic understaffing is getting worse. It is very difficult to recruit and retain younger staff." Scotland, 16-20 years of service, Senior Dental Officer

"Reduced staffing, increased workload. Many people feeling stressed." Scotland, 11-15 years of service, Senior Dental Officer

7.17 The PDS must be sufficiently resourced, with fair remuneration and appropriate career opportunities, to attract and retain dentists to the service, and ensure that it has sufficient capacity to meet the future oral health needs of the population in Scotland. There should be appropriate health board funding to ensure the PDS can meet the local population needs, as identified as part of strategic planning. The Scottish Government must develop and implement a fully-costed and fully funded dental workforce plan for the PDS.

Northern Ireland

7.18 There were 86 dentists employed in the CDS in Northern Ireland as of March 2026, equivalent to 64.59 FTE. This included a headcount of 81 Community Dental Officers/Senior Dental Officers (59.28 WTE) and 5 Director/Assistant Directors (5.31 WTE). Qualitative and quantitative survey responses indicate the understaffing is still a widely held concern for CDS dentists in Northern Ireland, with 65% reporting that staffing levels had a somewhat or very negative influence on their decision to remain in the service. One clinical director succinctly summarised the workforce challenges facing their service:

'More work with less staff. Trying to cover sickness, maternity which are impossible to recruit to.' Northern Ireland, 21 – 25 years of service, Clinical Director

7.19 The absence of workforce planning at strategic and operational levels, and a lack of clear lines of responsibility and accountability for the salaried dentist workforce in Northern Ireland, has been a particular cause for concern. The BDA NI CDS workforce roundtable on 16th September 2025 was intended to be a strategic reset, bringing together all key stakeholders to adopt a pan-Northern Ireland approach to addressing CDS Workforce needs.

7.20 Urgent action must be taken by the Department of Health to make tangible improvements on CDS pay, on career progression within the CDS, and on CDS staffing levels and workload.

Wales

7.21 BDA Cymru remains concerned by the continued lack of comprehensive workforce and activity data relating to the Community Dental Service (CDS) in Wales. Access to accurate information, including Full Time Equivalent (FTE) staffing levels, vacancy rates, clinic capacity and service activity, remains limited and inconsistent across Health Boards. This lack of transparency makes it difficult to assess workforce pressures, understand available capacity or evaluate the effectiveness of measures intended to improve recruitment, retention and patient access.

7.22 Despite these data limitations, evidence from members indicates that the recruitment and retention challenges facing the Welsh CDS persist. Vacancies remain difficult to fill across a number of specialties and geographical areas, increasing workload pressures for existing staff and these are impacting the resilience of services. Difficulties in recruiting dentists and other members of the dental team continue to impact service delivery and limit the ability of services to make full use of available infrastructure.

7.23 The BDA is also concerned that some CDS clinical capacity is being under-utilised due to workforce shortages and operational constraints. In some areas, clinics and facilities are available but cannot operate at full capacity because there are insufficient staff to provide the necessary level of service. This represents an inefficient use of existing resources at a time when demand for CDS care remains high and waiting lists continue to grow.

Patient demand and capacity in the CDS/PDS

7.24 The depth of our concern regarding the long-term decline of the CDS/PDS workforce must be understood in the context of the needs of its specific patient population. The UK's population continues to experience increased demand arising from an ageing population with increasingly complex healthcare needs.

7.25 The expansion of those being treated by the CDS is also, in part, a consequence of the wider access crisis facing the GDS. The increased financial unviability of the GDS across the UK and withdrawal from NHS provision has increased pressures on the CDS, particularly where patients have nowhere else to turn for dental care. This has resulted in a significant spillover of patients from NHS general dental practice to the CDS.

7.26 The strain caused by changes to the size and complexity of the CDS workforce is emphasised by a Senior Dental Officer in England:

'Case complexity continues to increase for many reasons, including declining mental health in many age groups, insufficient support in many social structures including underfunded schools and health care services, loss of oral hygiene promotion services, huge waiting lists in many areas of healthcare including simply being able to register with an NHS dentist.' England, Band B Senior

Dental Officer, 11 – 15 years of service.

7.27 CDS/PDS dentists are dedicated and passionate professionals who are highly motivated to provide the best care to their patients. Disappointingly, 27% of respondents to our survey this year did not agree that they were able to provide a standard of patient care that they were satisfied with, and qualitative data suggest that the gap between the desire to help patients and a lack of capacity to do so is a source of distress for many.

"I have found that demand from patients is ever increasing, but a lack of staffing/unreliable staff put additional pressure on the service. The service can't be provided to the same level or standard patients expect, resulting in dissatisfaction." **Scotland, 6-10 years, Dental Officer**

7.28 Over a number of years the BDA has called for the collection and publication of accurate data regarding waiting times in the CDS to ensure all parties at national and local level grasp the scale of the problem. NHS England launched a new data collection process in August 2025 to address this gap.

7.29 It is deeply disappointing that, nearly one year on, the waiting list data collated through this process is still yet to be released in the public domain.

7.30 The impact of delays to treatment in the CDS/PDS across the UK will see health inequalities widen further. For example, children with tooth decay miss on average five more half-days during their first primary school year than those with healthy teeth. Living with consistent pain and infection also impacts on children's engagement in the education setting during some of their most formative years.

7.31 As well as exacerbating health inequalities and leaving frequently vulnerable patients in unnecessary pain and discomfort, delays to treatment increase the risk of clinical deterioration, and increase demand on unplanned and urgent dental services.

7.32 The prevention of poor oral health is preferable to costly urgent dental treatment for patients, dentists, and the wider health and social care system. It is frustrating, then, that the governments show little appetite to accurately quantify the scale of the problem, much less fund services appropriately.

Morale and Wellbeing

7.33 Our survey responses this year demonstrate that CDS and PDS dentists' morale and wellbeing remain unacceptably low. Across the UK, 74% of respondents described the morale of the CDS/PDS as low or very low. 45% of respondents reported a decrease in their morale, whilst only 6% reported an increase. 42% of respondents described their wellbeing as low or very low, and 39% percent felt their wellbeing had decreased in the last year. Quantitative and qualitative responses indicated that volume and complexity of workload were key contributing factors to this decline.

'Morale has eroded and more demands on staff' Scotland, Dental Officer, 21-25 years of service

'We feel more under pressure. We are constantly bombarded with things like "service provision" and "increasing our targets" etc with little to no focus on improving working conditions and morale. The patients are increasingly difficult and increasingly dissatisfied with the NHS and the "broken system" and we are the ones who have to face them.' Northern Ireland, Community Dental Officer, 11 – 15 years of service

7.34 CDS dentists are under overwhelming pressure to scale down patient backlogs and keep up with the pace of demand. This pressure is 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 CDS dentists are routinely working well over their contracted hours to tackle their workload. When asked how often they had felt obliged to work outside of their contracted hours in the last year, 45% of respondents said this occurred once a week or more often. Moreover, 74% described their workload as high or very high.

'I had an enforced 7 week break recently but up until that point I was heading towards complete burn out' Wales, Band B Senior Dental Officer 21-25 years of service

7.35 This extraordinary, long-term pressure is having a predictable impact on the stress levels of CDS and PDS dentists across the four nations. Only 2% of respondents did not find their job stressful. 47% found their job moderately stressful, and another 38% found their job very or extremely stressful. Almost 15% felt unable to cope with the levels of stress they were experiencing at work, while nearly a quarter were seeking or had already sought help. For some, the working environment has impacted their mental and physical health:

'*My health both physically and mentally has become worse. I am struggling with stress/burnout/hypertension and unable to take adequate leave due to diaries being booked up months ahead*' England, Band C Clinical Manger, 21 – 25 years of service

7.36 We are deeply concerned by 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, regrettably, endemic. Across all four nations, 94% of respondents had experienced aggressive or demanding behaviour at work over the last 12 months from patients, their relatives, or other members of the public. When asked about whether they had been subject to physical violence from the same group over this period, a shocking 70% said they had, with 10% of those being the victim of physical violence more than ten times.

7.37 CDS and PDS dentists continue to report extreme levels of stress, abuse, and violence in their roles. Immediate action needs to be taken to protect their mental and physical wellbeing. Improved recruitment and retention into the service is an obvious and essential step towards alleviating the harm currently done to those working with some of the most vulnerable members of society. While the BDA has begun discussions with NHS Employers in England to seek to improve violence and abuse prevention measures in the CDS setting, urgent work from health and social stakeholders across the UK is needed to increase the capacity of the service and address the causes of violence and abuse at their root.

Career progression, job satisfaction and pay

7.38 CDS/PDS dentists are not receiving the recognition, career development opportunities, or pay that would fairly reward them for the work they provide in an increasingly challenging environment. CDS/PDS dentists' commitment to their patients must not stand in for Governments' continued failure to support and remunerate them appropriately.

'Personally, I find myself working many additional unpaid hours to try to keep things running smoothly. In real terms, this means my actual hourly wage is probably about a third less than it appears on paper...our collective years of effort and servitude to the NHS are considered worthless by a Government who should be considering the importance of integrity and the clinician-patient relationship, and ideally should be supporting healthcare workers by being absolutely clear about

the years of frozen pay, the increase in workload, and the heroic efforts many continue to go through daily.' England, Band B Senior Dental Officer, 11 – 15 years of service.

7.39 Many CDS and PDS dentists understandably reported in our survey this year that they were dissatisfied with their remuneration and with their careers more generally. Staffing issues, workload, working conditions, lack of recognition, and low pay were some of the key themes identified as contributing to decreased job satisfaction. Almost half of respondents across all four nations reported decreased job satisfaction since the previous year, and more than a third reported being completely, mostly, or somewhat dissatisfied with their job.

7.40 A lack of career progression opportunities was also highlighted by survey respondents, with more than half disagreeing that there were opportunities to progress in their career and over a third of respondents considering career progression as a 'very or somewhat negative influence' in their decision to remain in the CDS. The lack of career progression opportunities in the CDS in Northern Ireland was also a central theme to emerge from the CDS Workforce Roundtable event. One Northern Ireland respondent reported the following:

'Our jobs have become increasingly difficult with less time to spend on more difficult patients. We have little to no time to focus on learning skills and CPD, no time to learn management skills, very poor career progression. Zero recognition for how difficult our jobs can be and the pay doesn't reflect how hard we work. We feel very much like the underdogs of the dental world often forgotten about by the Government and the health board funding.' Northern Ireland, Community Dental Officer, 11-15 years of service

7.41 63% CDS respondents to our survey this year disagreed that their pay was fair. Qualitative survey responses also included frequent reference to low pay that has failed to keep up with inflation and appropriately remunerate CDS dentists for their work. Additionally, 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. Across the four nations, the majority of respondents reported that parity between the sectors very or somewhat negatively influenced their decision to remain in the service.

7.42 Unsurprisingly, the results of our survey of CDS/PDS dentists this year indicate strong support for uplifting band A or equivalent starting salaries. Three quarters of respondents agreed or strongly agreed that Band A or equivalent starting salaries must be uplifted to improve recruitment into the service. Recent successive pay deals for resident dentists in England have meant that starting salaries for dentists taking up a DCT post in the hospital setting are far higher than those of the CDS, further reducing the attractiveness of the CDS career pathway for new dentists. DCT1 pay for resident dentists now stands at £55,355, but the CDS pay scale starts at £54,502. Government must urgently reconsider its decision to reject the DDRB's recommendation for a review of CDS pay and progression, including starting salaries.

7.43 More widely, as set out earlier in this evidence submission, a meaningful uplift to pay, improved career progression, and recognition across the board are vital to safeguarding the current and future CDS/PDS workforce. It is imperative that CDS/PDS dentists feel valued through progress in all these areas, if the worsening of key workforce indicators as revealed through our survey is to be halted. CDS/PDS dentists and their vulnerable patients must not be made to carry the burden of inadequate workforce planning and systemic underfunding of these highly specialised services.

Chapter 8 - MOD Dentists

8.1 The British Dental Association (BDA) continues to represent Ministry of Defence (MOD) dentists, a small and often overlooked cadre of salaried civilian dentists employed within Defence Medical Command (DMedC). These dentists operate alongside military colleagues, delivering a broad range of clinical care to UK Armed Forces personnel both in the UK and overseas. Despite their essential role, MOD dentists face persistent challenges that impact their effectiveness and wellbeing.

8.2 As of July 2026, there were 104 MOD dentists in patient-facing roles, but the service is staffed at only 84% of its full establishment. Although recruitment has improved somewhat over the past year, retention remains a significant issue. The perceived recruitment gains largely reflect efforts to address existing shortfalls rather than a sustainable solution. Persistent recruitment and retention difficulties have resulted in chronic staff shortages, increased welfare concerns related to burnout, and loss of valuable institutional knowledge. While similar challenges exist across the NHS, this does not justify inaction.

8.3 MOD dentists are salaried civilian employees classified as Departmental Grades within the Civil Service, with pay negotiations conducted separately from other civil servants. Historically, the MOD selected the PROSPECT Trade Union to represent all civil service dental healthcare professions, including MOD dentists, who fall outside the remit of the Armed Forces Pay Review Body (AFPRB). Under a 2003 agreement between MOD and PROSPECT, MOD dentists' pay awards align with the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations for salaried dentists. However, PROSPECT does not engage directly with the DDRB evidence process, so the BDA collaborates with PROSPECT to advocate for pay levels competitive with NHS colleagues.

8.4 A significant challenge is the absence of an accessible, reproducible record of the 2003 MOD–PROSPECT Agreement clarifying which salaried dental roles MOD dentists align with, though Community Dental Services (CDS)/Public Dental Services (PDS) appear to be the closest comparators. Like their CDS/PDS counterparts, MOD dentists have not undergone a pay reform review since 2003. Current pay spines and bands are outdated and lack a clear basis. For transparency and to avoid confusion interpreting DDRB findings, especially following recent pay award differentials, the reference document should be sourced to support a future pay review and reform.

8.5 MOD dentists represent a distinct and specialised group within the dental profession, the Civil Service, and the MOD. Their small cadre size and unique role often leave them overlooked and vulnerable to disadvantage. The BDA's annual surveys and direct feedback consistently highlight significant concerns: inadequate successive pay awards, limited career development opportunities, lack of empowerment and representation within Defence Primary Healthcare (DPHC), unreasonable delays in implementing allowance and expenses packages, and increasing workload driven by recruitment and retention challenges. This ongoing dissatisfaction contributes to the loss of essential dental professionals, undermining the MOD's ability to provide critical care to the Armed Forces amid a turbulent geopolitical situation.

8.6 There is considerable unease among MOD dentists regarding the widening pay gap between themselves and their uniformed colleagues, even when accounting for military X-Factor Pay. This disparity is compounded by growing expectations for MOD dentists to cover duties of Armed Forces colleagues without corresponding reward, recognition, or career progression opportunities. For example, a MOD dentist at the top pay band and spine, equivalent to a Master's-level postgraduate qualification with over 10 years' experience, managing a single-chair practice, earns approximately 22% less than a military counterpart with similar service length. Overall, the MOD dentist pay package no longer reflects the scope of their role, has failed to keep pace with

inflation and the rising cost of living, and is adversely affecting recruitment and retention. The prevailing view within the MOD dentist cadre is that their pay is no longer competitive, having fallen significantly behind national employment market rates across most age groups.

8.7 The 2026 DDRB Report introduced a pay differential for salaried dentists, bringing the issue of the MOD dentist pay comparator into sharp focus. Despite a 3.5% pay uplift this year, this increase was lower than the 3.75% awarded to CDS/PDS, due to the absence of the 2003 MOD–PROSPECT Agreement needed to confirm the appropriate pay award level. This lack of a clear, reproducible comparator has perpetuated successive pay awards below inflation, resulting in real term pay erosion for MOD dentists. Compared to NHS doctors and dentists, military dentists, and private practice, MOD dentists' salaries are increasingly uncompetitive and fail to reflect their value, skills, or the unique demands of their role. This growing pay disparity is a significant barrier to recruiting new MOD dentists and retaining experienced professionals.

8.8 MOD dentists, though a small but vital group within DMedC, continue to face understaffing, retention difficulties, and widening pay disparities compared to their military and NHS counterparts. While recruitment has improved recently, ongoing pay erosion and non-competitive remuneration have contributed to low morale and risk the loss of essential expertise. To address these issues, the BDA emphasises the urgent need for the MOD to conduct a comprehensive review of MOD dentist pay structures, to establish a clear and transparent comparator framework, and to consider structured career pathways to support and retain this vital workforce. It is disappointing that the challenges faced by MOD dentists were again not recognised in last year's DDRB Report, despite a workforce size comparable to the Community Dental Services of Northern Ireland or salaried services of Wales, and the integral role they play in supporting the health needs of the Armed Forces.

8.9 MOD dentists are increasingly being asked to undertake critical and demanding roles within Defence, yet continue to operate within an outdated and uncompetitive pay structure, with limited career progression opportunities, and insufficient recognition of their contributions. Without urgent action to address these issues, recruitment, retention and workforce sustainability challenges will continue to erode workforce resilience and threaten an essential Defence capability at a time when it is needed most.

8.10 The BDA, therefore, strongly recommends the following actions:

- Conduct an urgent, comprehensive review into MOD dentist pay structures, establishing a clear, transparent comparator framework to ensure fair and competitive remuneration aligned with comparable roles.
- Review career progression pathways, the recognition of additional responsibilities, professional representation and empowerment within DMedC, and the processes for payment of allowances and expenses, to ensure these are fair, transparent, and aligned with the responsibilities of Defence dentists.
- Acknowledge the MOD dentist cadre in future DDRB evidence and recommendations.

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.

Workforce

9.2 The latest annual census released this year by the Dental Schools Council (DSC) revealed concerning trends of decline in the UK's dental clinical academic workforce, leading to calls for decisive action from the government, universities and the NHS to reverse this trajectory. From 2024 to 2025, the number of FTE dental academics fell to 550, amounting to a loss of 40 FTE roles in only one year. The number of clinical teachers has reduced by 25%, professors by 17%, and lecturers by 13%. Moreover, more than a quarter of clinical academics are now aged over 55, indicating a growing risk of sudden gaps in senior expertise. At the same time, the dental student population is set to grow further. This year, the government announced the first sustained increase in UK-trained dentist numbers in a generation, a total of fifty extra students per year, expected to be delivered at new schools in the South and East from 2027. There are anticipated increases in numbers of private dental schools providing opportunities to international graduate students to complete an abridged dental course for registration with the GDC. These increases in dental student numbers in addition to increased offerings of dental hygiene and therapy schools will place strain on a shrinking dental academic workforce.

Increased demand and workload

9.3 If this downward trajectory continues, dental academics will simply not have the capacity to meet the demands placed upon them. Dental academics have key roles in areas including clinical service delivery, teaching, direct clinical supervision, and research responsibilities. The dental courses are reliant on clinical delivery of care via student clinics which place significant clinical and administrative demand on clinical academics.

9.4 Appropriate staff to student ratios are key to patient safety when clinical care is delivered by students, who need close clinical supervision. This burden of safe clinical care delivery through student clinics often compromises clinical academic research outputs which is critical for career progression. The government's decision to increase the student population without proportionate investment into the growth of this critical workforce demonstrates its failure to understand the reality of dental education on the ground.

9.5 Concerningly, the BDA's 2026 survey results illustrate that many dental academics are struggling to fulfil the demands of their role, in part because of unsustainable student to staff ratios. Many respondents reported high or very high workloads, working more than their contracted hours at least once a week, and more generally struggling to meet the varied demands of their role with the capacity available to them.

Morale

9.6 The imbalance between workforce supply and demand illustrated above has translated to low morale and poor wellbeing at work for many dental academics, with 32% believing their morale had decreased in the last year. One respondent described the personal impact of this extremely challenging working environment:

'The demands of working long hours for effectively lower renumeration are beginning to impact my health.' Reader/Associate Professor, 21 – 25 years of service.

Pay and job satisfaction

9.7 Pay and rewards for dental academics has not improved at a rate commensurate with the mounting burden of their roles, impacting their pay satisfaction and, crucially, their job satisfaction. Unsurprisingly, 42% of respondents to our survey disagreed or strongly disagreed that their pay was fair, and 36% were not satisfied with their terms and conditions of employment.

'*Lack of promotion coupled with increased workload and effectively lower pay when considering inflation adjustment over the last decade or more.'* Reader/Associate professor, 21-25 years of service.

Career progression

9.8 Wider funding pressures within the university sector have put the academic career pathway under pressure and a number of universities have implemented redundancies in recent years.

9.9 Concerningly, in July 2026 guidance from the Secretary of State for Education imposed targeted cuts to the Strategic Priorities Grant, advising that the longstanding funding for clinical consultants' pay, senior academic general practitioners' pay, and NHS pension scheme compensation be revoked. The extent of cuts in the dental academic sector that will result from this decision is yet to be revealed.

9.10 A sustainable and appropriately remunerated dental academic workforce is fundamental to the delivery of high-quality education for dental students and, in turn, the future of an NHS dental workforce which must expand if it is to meet the future needs of the UK's growing patient population. In our evidence last year, we highlighted that incentivising more dentists to join academia is urgently needed to ensure there is sufficient capacity to support undergraduates studying dentistry. We once again call for stable investment into dental education, the maintenance of pay parity between academia and other sectors of dentistry, and a meaningful pay uplift as set out earlier in this evidence submission.

Hospital dentists

9.11 The BMA provides evidence for doctors and dentists based in hospital services. This includes consultants, SAS and resident dentists. 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.

9.12 The BDA has continued its campaign for fair pay for hospital dentists, working in solidarity with the BMA. We re-entered dispute with Government regarding resident, consultant and SAS dentists' pay in England, and for consultant dentists in Northern Ireland. We also entered 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 is addressed.

9.13 The BDA wishes to note the BMA and BDA's acceptance of a pay deal in June this year for resident doctors and dentists in England. We welcome the pay uplift, pay restructure and other contractual improvements secured, thus ending our current dispute for this cohort.

9.14 We are 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.

9.15 The BDA's 2026 survey responses from hospital dentists are reflective of the wider picture across NHS dental services; they are overstretched, understaffed, and underfunded. We urge the DDRB to deliver a recommendation on pay that ensures the attractiveness of this vital part of the dental workforce.

Workload and waiting lists

9.16 Increased workload and growing waiting lists were a prominent theme throughout our survey responses from hospital dentists. 83% per cent of respondents described their current workload as high or very high, with 59% feeling obligated to work outside of their contracted hours once a week or more. More than half of respondents reported that the backlog of patients to be seen had deteriorated in the last year:

'My job satisfaction has declined compared with last year. The role has become increasingly demanding, with growing service pressures and rising patient demand that are not matched by adequate staffing or resources. This makes it difficult to develop and improve services and can affect the quality and efficiency of care delivery.' Consultant, England 21-25 years of service

Morale, wellbeing and job satisfaction

9.17 As highlighted above, unmanageable demand is having a direct effect on job satisfaction and wellbeing for those in the hospital dental service:

'While I remain committed to delivering safe and compassionate patient care, the sustained intensity of workload and ongoing pressures associated with work, alongside difficulties achieving a healthy work-life balance, have at times led to emotional and physical fatigue, a reduced capacity for recovery, and concerns regarding the long-term sustainability of current working patterns. Compared to earlier in my career, I have noticed a reduction in my emotional and psychological resilience, with periods of leave or time away from work taking longer to adequately restore energy levels and regulate stress.'. Consultant, Scotland, 11-15 years of service

9.18 Hospital dentists' commitment to patient care despite extremely challenging circumstances is evident from our survey results, with 76% identifying 'helping patients' as the motivation for their work as a dentist. Regrettably, given the capacity constraints and systemic workforce issues already discussed, this commitment to patient care risks leaving hospital dentists to carry an unsustainable burden:

'There is an increasing expectation to deliver more with fewer resources, including managing larger new patient clinic volumes, manage waiting lists, additional roles including teaching and leadership while having to 'fight' for additional SPA and without corresponding administrative or workforce support…cumulative pressures have altered the nature of work considerably. What was previously experienced as a strongly vocation-driven career can at times feel increasingly operationally focused, which has affected my sense of professional fulfilment. In addition, these can cause moral injury as clinicians striving to maintain safe and compassionate practice often have to balance this with personal care and outcome driven departmental needs.' Scotland, Consultant, 11 – 15 years of service.

9.19 Perhaps unsurprisingly, less than half of respondents to our survey reported satisfaction with their working environment. Morale followed a similar trend, with 44% rating the morale within hospital dentistry as low or very low, and 43% feeling their morale had decreased since last year.

Training pathways and the future of hospital dentistry

9.20 Our resident dentist members continue to report worrying disparities in their training. Many employers are using service provision as justification to place restrictions on training, including reductions to study leave and entitlements for attending learning events. Training opportunities were described as steadily reducing, with resident dentists unable to focus on the important aspects of skill development and left without enough time to secure the vital training needed to progress within their specialty. Recruitment planning has also been described as very poor, with multiple cases reported in which individuals had to move hundreds of miles across the country for a training role, only to leave as soon as possible to be located nearer their home.

9.21 Strengthening and protecting opportunities for career progression is essential to recruitment and retention in hospital dentistry. It is inappropriate to allow the admittedly challenging levels of demand on services to crowd out the development of an expert, sustainable workforce.

Pay and recognition

9.22 The demands placed on hospital dentists have risen but pay has declined in real terms.

'Less members of staff which has led to higher workloads and stress. The pay does not take this into consideration.' England, Specialty Doctor, 6-10 years of service

9.23 The failure to appropriately remunerate and recognise the value of hospital dentists is reflected in the attitudes of our survey respondents, with less than half of respondents believing their pay is fair. Moreover, many hospital dentists reported feeling undervalued and unrecognised for the work they delivered whilst under increasing pressure.

'Not valued in current role. I suspect if I left tomorrow no one would thank me for my hard work.' Scotland, Consultant, 21 – 25 years of service

9.24 It is essential that all parties recognise and reward hospital dentists for work they deliver in an increasingly pressured environment. We call on the DDRB to make a recommendation on pay that acknowledges the deteriorating service environment and its impact on staff wellbeing and morale; in the absence of fairer remuneration, workforce indicators will continue to deteriorate, and dentists will continue to carry the burden of systemic failure.

Chapter 10 - Our recommendations

10.1 We ask that the DDRB recommends an overall uplift to all NHS GDS contracts, fees and allowances of 6.83% to ensure that a real-terms increase in take-home pay is delivered for GDPs. This includes a 6.4% uplift in GDP pay. We highlight that the cumulative impact of fifteen years of pay review process outcomes has been to leave NHS dentistry across the UK ever less viable and has critically undermined the financial sustainability of the sector. Once again, 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. The absence of meaningful progress toward fundamental contract reform that could mitigate the impact of the long term, planned underfunding of NHS dentistry only increases the urgency of this recommendation.

10.2 We ask that the DDRB recommends a pay uplift of 6.4% for employed dentists to attract and retain a sustainable NHS workforce. As revealed in our survey this year, increases in demand for services, longer waiting lists, and poor morale continue to impact employed dentists. The profound impact on the employed dental workforce of political inertia is also laid bare by the results of our survey demonstrating the extraordinary levels of physical abuse endured by some of this group. 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 and complex patients to make a choice between their own well-being and physical safety, and the clinical outcomes 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 recent efforts of the DDRB to bring forward the pay round timetable. We regret, however, that these measures have had little 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 2027-28 pay award should be implemented on 1 April 2027 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. Similarly, we call for the DDRB to be clear that its uplift recommendations are, if accepted, to be applied across all parts of the contract – not only to elements arbitrarily deemed “core” by governments, as happened in England this year with regards to the non-application of the uplift to the quality improvement and appraisal activities agreed as part of the contractual reforms implemented. This dilution of the role of the DDRB and devaluing of the wider pay review process sends a regrettably clear message to the dental profession alongside the obvious impact on pay.

10.5 We do not recommend targeting awards.

10.6 We again call for clarity from the DDRB that its non-pay recommendations are made as part of a complete, considered 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. Disappointingly, governments continue to engage little if at all with the substance of the DDRBs non-pay recommendations. We again 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, and it is concerning that in England Government has chosen to not apply the uplift to all parts of the recent contractual reforms, as mentioned earlier. The DDRB must state plainly 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.