BDA

British Dental Association

# Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2025-26

Friday 29th November

# Contents

## Chapter 1 – Executive summary

1.1 The long-term and unfunded increases in the operating costs borne by dental practices continue to compound, undermining the financial sustainability of the sector. This under-remuneration distorts the effective functioning of the labour market for dentistry, with obvious consequences for access to dental services. Real-terms Government spend on health service dentistry across the UK in 2023 was £2.025 billion. In 2006 the real-terms Government spend on health service dentistry across the UK was £2.6 billion.

1.2 The long-term trend since the 2006-07 financial year for both practice owners and associates remains a very significant erosion of take-home pay. In summary terms, in the 2023-24 financial year take-home pay for practice owners remained essentially flat or reduced, while take-home pay for associates remained essentially flat or increased, though there is inevitably variation by country. These issues are discussed in greater detail in paragraphs 5.5-5.10 / Chapter 5.

1.3 While headline inflation stabilised in the 2023-24 financial year, the British Dental Association's (BDA's) annual survey revealed that dental practices faced very significant increases to their non-pay costs in 2023-24 including a 16.5% increase to laboratory costs, and a 4.7% increase to the cost of materials. Recently announced amendments to the contributions and thresholds of Class 1 National Insurance Contributions will place additional financial pressure on many dental practices. Given that the Government has indicated that the impact of these changes on primary care providers including dentists will be dealt with through existing contract mechanisms, these costs must be recognised through the 2025-26 contract uplift.

1.4 Dentists continue to respond to the long-term, planned under-remuneration of NHS activity by shifting toward private dentistry. Our survey this year found that just 29% of practice owners and 39% of associates agreed or strongly agreed that they were fairly remunerated for their work. Where practice owners and associates worked at practices with a high NHS commitment, this figure dropped to just 12% and 23% respectively. Across all practices, 32% of practice owners and 37% of associates intended to increase the amount of private work they delivered.

1.5 A high NHS commitment remains strongly positively correlated with poor motivation, morale and job satisfaction. For example, this year, our survey found that 50% of practice owners across the UK and 38% of associates reported low or very low morale. Where the relevant dentists held a high NHS commitment, that figure increased to 65% and 49% respectively. We set out these issues in detail as captured by our primary research in paragraphs 6.24 - 6.27 / Chapter 6.

1.6 The profound challenges of recruiting and retaining staff across the dental team identified in our previous evidence submission continue to impact practices. 91% of practice owners across the UK reported that they had difficulty recruiting an associate. While this extraordinary figure is a marginal improvement on the historic high of 93% last year, in 2021 this figure was 80%, itself reflecting the long-term dysfunction of the labour market in dentistry. 60% of practice owners reporting vacancies told us that they had vacancies across the dental team that had been open for more than six months, with that figure increasing to 73% for those with a high NHS commitment. 78% of practice owners reported difficulties recruiting dental hygienists, 77% of practice owners reported difficulties recruiting dental nurses, and 71% of practice owners reported difficulties in recruiting dental therapists. Just 33% of practice owners who had vacancies in the 2023-24 financial year were able to fill all posts they sought to recruit for.

1.7 In the Community Dental Services (CDS) dentists continue to experience increases in demand for services, longer waiting lists, and higher workloads, with 82% of respondents to our survey once again reporting a high or very high workload, with obvious implications for the sustainability

of services. Our survey of CDS dentists in England this year found that 25% of respondents were aged 55 and over, and 27% of respondents reported their intention to retire from dentistry within the next five years; similar demographic trends exist across the UK, and in combination with a patient cohort anticipated to expand substantially in coming years, it is clear that urgent action is required to ensure the most vulnerable patients are able to access dental services. One critical part of that action is addressing the under-remuneration that is acting as a brake on the effective recruitment and retention of the CDS workforce. We set out these issues in detail as captured by our primary research in paragraphs 7.27 - 7.39 / Chapter 7.

1.8 The ongoing recruitment and retention crisis in dentistry is one symptom of the distortion in the labour market that is caused by unfunded increases in the operating costs faced by dental practices. This distortion of the labour market leads directly to the under-remuneration of dentists, which leads directly to the access challenges the public and political decision-makers are already keenly aware of and wish to resolve. Perhaps less widely understood is the central dynamic of successive uplifts being insufficient to both cover the operating costs borne by practice owners and protect pay. This dynamic critically undermines the financial sustainability of dental practices. Given the complete failure of the current approach, the BDA continues to believe that pay and operating costs are indivisible in any equitable total funding package.

1.9 We therefore call on the DDRB to recommend an overall uplift of 11.5% for all NHS general dental contracts, fees and allowances. This figure includes a pay uplift of 9.2% and operating costs uplifts as outlined in paragraphs 5.11 - 5.15 / Chapter 5. In line with this, we ask the DDRB to recommend a pay uplift of 9.2% for employed dentists. Alongside these pay uplifts, we also call for:

1.9.1 Timely implementation of pay awards
1.9.2 Reinstatement of commitment payments for England, Wales, and Northern Ireland
1.9.3 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
1.9.4 The overall annual expenses uplift to be applied to service costs for Dental Foundation Training (DFT) Practices
1.9.5 The DDRB to reiterate the historical recommendation of pay parity of clinical academics

## Chapter 2 – About the BDA

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

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

2.3 Where we refer to 'operating costs' in this submission, we are referring to the costs of delivering NHS care that must be borne by practices beyond dentists' pay. Our experience tells us that non-specialist audiences including political stakeholders and the public understand 'expenses' as discretionary. As such, the term 'operating costs' more accurately communicates the essential nature of this component of the total funding package received by dentists.

2.4 Fieldwork for the quantitative survey that informs this submission was conducted between 14 June and 10 September 2024. 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 52nd report

### Uplifts

3.1 As we stated publicly in our response, the DDRB's recommendation for a 6% pay uplift was progress when compared to previous real-terms pay cuts. However, one above-inflation pay rise will not undo more than a decade of pay erosion. We now need to see DDRB continue to deliver real-terms increases to allow for the pay of NHS dentists to recover.

3.2 As in previous years, we continue to see unacceptable delays to the implementation of uplifts, particularly for GDPs. For this year, we submit evidence without conclusion to the 2024-25 round in England, Wales and Northern Ireland.

3.3 The pay uplifts for employed dentists have been implemented.

### England

3.4 In England, the DDRB recommendations have been applied to pay, but to date has made no public announcement on the contract uplift. Given this, we feel obligated to provide evidence based on the proposals on which we have been consulted on in confidence. As discussed further below, the DHSC continues to pursue an arbitrary approach to practice operating costs. The proposal on which the BDA has been consulted is for a contract uplift of only 4.64%, with only 1.68% applied to practice operating costs. This figure clearly bears no relation to inflation in these costs, or common measures of inflation such as CPI or RPI. In our limited engagement with the DHSC about this proposal on the costs of delivering NHS care, it has not offered a compelling rationale for this figure. It reflects a forecast of the GDP deflator for the financial year, which is an inflation measure that bears no relation to the particular costs dental practices face, a fact that is tacitly accepted by the DHSC.

3.5 The DHSC has also opted not to apply an uplift to the DFT service costs payments, as it considers there to be no evidence that these costs have increased since 2014. This is entirely illogical as these payments are to cover the same costs as the practice operating cost element of the overall contractual payments, which it has uplifted by 1.68% and by other figures in the period since 2014. Given the decade-long freeze, the funding provided is significantly below what it reasonably should be, with a consequent impact on the pay of those dentists providing this training, and on the ability of NHS England to recruit and retain DFT practices.

### Scotland

3.6 The Scottish Government made an announcement to the dental sector in November 2024, confirming the 2024-25 pay uplift for GDPs and Dental Bodies Corporate. The Scottish Government accepted the DDRB's recommended pay uplift of 6% and applied this to gross item of service fees (including orthodontic fees), and to capitation payments. This will be applied from 1 December and backdated to 1 April. The qualification thresholds for Determination IX of the Statement of Remuneration (Commitment Payments) will also increase by 6%, with these increases applied from 1 January 2025. The value of the commitment payments have not been not uplifted, so this is effectively a reduction in the value of each Commitment Payment level. While Scottish Government state they have accepted the DDRB recommendation their application of the uplift does not deliver a 6% uplift on take home pay.

3.7 As in previous years our position remains that any uplift should be applied to the full remuneration package within the Statement of Dental Remuneration. We are again disappointed that the uplift was not applied to the full General Dental Service (GDS) renumeration package. In particular, we note that not raising the cap on the General Dental Practice Allowance in line with the recommendation increases the inequity for the most committed NHS dental practices. The uplift should be applied to all allowances otherwise it is not a true 6% pay increase.

3.8 The salary payable for vocational trainees is currently £3,113.42 per month (£37,361 per annum) since 1 April 2023. The Scottish Government is yet to announce any pay uplift on the vocational trainee salary for 2024-25.

**Wales**

3.9 As part of 'whole system primary care reform' the Welsh Government requires all four primary care contractor groups to be subject to annual negotiations around contractual arrangements in return for the uplift award.

3.10 For the 2024-25 award, the Welsh GDS uplift negotiation is ongoing. The Government remains entrenched in its policy position with all four contractor groups that annual uplift awards must be tied to a set of conditions that promote contract reform. This year several options of conditions have offered to the BDA group in exchange for the uplift. We have yet to find common agreement on what those conditions should be.

3.11 It is of note that the BMA Wales GPC announced a breakdown of negotiations this autumn and are subsequently running a referendum with their members[1].They have stated on their website that: "*We have urged the Welsh Government to separate annual GP and staff pay awards from wider contractual changes, as is the case in other nations. However, they have chosen to disregard this request, coupling financial investment to negotiation outcomes thus delaying practices receiving a much-needed uplift to their finances for the new financial year. This has unnecessarily prolonged financial uncertainty, given that we were ready to negotiate before April, but the Welsh Government delayed negotiations until September.*"

3.12 In a similar manner we have raised to Government officials our objections about the reform conditions and the onerous negotiation process, but the official reply has been the same – that it is ministerial policy. Given that this process is effectively imposed on the BDA, we have no option but to engage with it to seek the best deal for the profession.

3.13 The Welsh Government appears to intend to continue to participate in the DDRB process, but to use the DDRB's recommendation as an input into collective bargaining on pay. Our view is that this fundamentally alters the DDRB's role in NHS GDPs pay, in a way that undermines and sidelines its role. This change to the pay-setting process has been enacted without a full and proper consultation with either the BDA or the DDRB. We would urge the DDRB to consider whether Welsh GDPs (and indeed Welsh GPs) are being subject to a process which is discriminatory.

**Northern Ireland**

3.14 Once again, dentists in Northern Ireland face an unacceptably long delay regarding implementation of the 2024-25 DDRB recommendations. While Health Minister Mike Nesbitt has expressed his preliminary support for the recommendations contained in the 52nd Report of the DDRB, he warned, "*the severe budgetary pressures on health and social care in NI mean I am unable to make an immediate decision on the recommendations…*".

[1] Welsh GMS contract referendum 24/25- BMA

3.15 In response to BDA correspondence, as of 20 September 2024, the stated position of the Department of Health (DoH) regarding the 2024-25 recommendations remains that "*Whilst the Minister has welcomed the recommendations of the DDRB, the Department is currently not funded to implement such an uplift. The Minister is committed to continuing to engage with his NI Executive colleagues to make the case for additional funding*".

3.16 In Northern Ireland practitioners have experienced multiple issues regarding implementation of the 2023-24 pay uplift. The DoH response to 2023-24 recommendation was only made/communicated on 5 March 2024, significantly behind other nations. Further, the DoH unilaterally chose to apply a 6.47% uplift for just the 2023-24 financial year, applying a much lower 4.92% for future years on a recurrent basis by imposing an arbitrary 3% to expenses on DoH 'affordability' grounds.

3.17 The decision to opt for a divergence between an uplift figure for 2023-24 and future years has created considerable confusion amongst those operating the payment system resulting in errors, corrections and delays for practitioners. As of the end of September 2024, DoH/BSO still had not identified a suitable mechanism to process the 1.55% element of uplift for 2023-24 (i.e. the difference between 6.47% and 4.92%) to ensure the full (one-year only) 6.47% uplift is paid and seen to be paid to practitioners. This process has been further complicated by the length of time which has passed between uplift recommendation, approval and payment.

3.18 The cumulative impact is yet further detachment between practitioners and their pay awards, namely that uplifts are paid correctly and on a timely basis, and in a manner which can be understood by practitioners. Not knowing when the various components of 2023-24 backpay would be received, meant that practitioners had insufficient information to confidently reconcile backpay and ultimately had to raise concerns via the BDA highlighting errors in calculation of much overdue backpay. All of this was occurring at a time when the 2024-25 payments should be issued. The Northern Ireland government is operating a year behind the recognised schedule using a novel formula of their own making which, at best, complies in name only with the DDRB's recommendations.

**Delays**

3.19 As in all recent years, the process for applying uplifts to dentists' contracts and salaries has been unacceptably and unnecessarily delayed. It is particularly frustrating that, once again, while calling in the remit letters for an earlier report from the DDRB, governments continue to issue remit letters so late in the year as to preclude the uplift being applied for 1 April. The failure of this process is compounded by the UK Government submitting extremely late evidence again.

3.20 It is disrespectful to parties that submit timely evidence for some parties to ignore the deadlines set by the DDRB, but most importantly these delays have a tangible impact on the dental profession. Not only is there a negative effect on morale, in a period of high inflation, delayed uplifts also bring with them challenges to practices' financial sustainability and dentists' personal finances. There are also practical problems for GDPs where backdated payments must be made, particularly where individuals have retired or left the NHS.

3.21 We are grateful to the DDRB for acknowledging these issues in its 52nd report, and for the Chair raising this matter with the Prime Minister. We also welcome the DDRB's particular comments about the extreme delays in Northern Ireland and the intervention of the Chair.

3.22 We again emphasise the critical importance of a return to the former timetable to ensure uplifts occur in April each year. It has been seven years since this happened anywhere in the UK.

| Year | NI | | England | | Scotland | | Wales | |
|---|---|---|---|---|---|---|---|---|
| 2024-25 | | | TBC | TBC | Dec 2024 | 8 mths | TBC | TBC |
| 2023-24 | March 2024* | 12 months | October 2023 | 6 mths | Nov 2023 | 7 mths | January 2024 | 9 mths |
| 2022-23 | March 2023 | 11 mths | Feb 2023 | 10 mths | Dec 2022 | 8 mths | Dec 2022 | 8 mths |
| 2021-22 | May 2022 | 13 mths | Dec 2021 | 8 mths | Dec 2021 | 8 mths | Oct 2021 | 6 mths |
| 2020-21 | Aug 2021 | 16 mths | Dec 2020 | 8 mths | Nov 2020 | 7 mths | Nov 2020 | 7 mths |
| 2019-20 | Aug 2020 | 16 mths | Nov 2019 | 7 mths | Aug 2019 | 4 mths | Aug 2019 | 4 mths |
| 2018-19 | Aug 2019 | 16 mths | Dec 2018 | 8 mths | Nov 2018 | 7 mths | Sept 2018 | 5 mths |
| 2017-18 | July 2018 | 15 mths | Aug 2017 | 4 mths | April 2017 | 0 mths | May 2017 | 1 mth |
| 2016-17 | April 2017 | 12 mths | June 2016 | 2 mths | April 2016 | 0 mths | June 2016 | 2 mths |
| 2015-16 | No uplift** | 10 mths | Aug 2015 | 4 mths | April 2015 | 0 mths | Aug 2015 | 4 mths |

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

**Response to practice operating cost uplifts**

3.23 As we have set out in previous evidence, inadequate practice operating costs uplifts have had a significant impact on dentists' (in particular, associates') take-home pay, and we provide further evidence on this in Chapter 5. For 2024-25, both the processes and their outcomes have once again been unacceptable.

3.24 All four governments continue to indicate that 'affordability' is the main criterion in their decision-making on operating costs, rather than ensuring that the uplift reflected the inflationary pressures facing practices. Instead, they have decided that the burden of unaffordable costs should be borne by dentists.

3.25 It is worth considering the implications of this approach. By failing to implement a practice operating costs uplift that reflects the increases in the real costs of delivering NHS treatment, dentists must either accept lower pay, decrease their NHS work, or increase their private work. This would appear to run contrary to the stated policy of all four governments, but is the practical effect of their actions.

3.26 Our evidence-based assessment of the increase in practice operating costs, in relation to 2024-25, is that material and laboratory costs increased by 18.04%, other non-staff costs by 20.39% and staff costs have increased by 17.74%. Had this evidence-based approach been taken, the uplift applied to contracts would have been 12.82%.

| | Weighting | Index | Weighted value |
|---|---|---|---|
| Dentists' pay | 0.47 | 6% | 2.82% |
| Staff costs | 0.22 | 17.74% | 3.90% |
| Laboratory costs | 0.06 | 18.04% | 1.08% |
| Materials costs | 0.07 | 18.04% | 1.19% |
| Other costs | 0.19 | 20.39% | 3.83% |
| Total | 1.00 | | **12.82%** |

Fig 2: The GDS contract uplift formula using the DDRB recommendation on pay and the BDA's evidence on practice operating costs. Sources: Estimated average practice operating cost increases derived from BDA Practice Owners survey 2023, along with data from the ONS. Pay uplift based on BDA pay ask.

3.27 In England, the DHSC has stated that it instead intends to apply the GDP deflator at only 1.68% in respect of all non-staff costs and 6% in respect of non-dentist staff costs. This leads to an uplift of 4.64%. The BDA was consulted via an exchange of letters and a meeting with civil servants to discuss the proposal. It was clear that this was not a 'negotiation' in which there was any scope to move from the DHSC's position of applying the GDP deflator. This process concluded in September 2024. No confirmation of the uplift has yet taken place.

3.28 In addition to the GDP deflator having no relation to increases in dental-specific costs, the DDRB is correct to note in its 52nd report that the DHSC applies a forecast of the deflator. There is no mechanism to address a variation in actual outturn against the forecast. This has been the case in both years to which the GDP deflator has been used. In 2022-23, the GDP deflator forecast applied was 5.3%, but the outturn was 7.13%. In 2023-24, 3.23% was applied, but the outturn was 6.14%. These discrepancies have denied practices, and dentists, significant sums of funding.

3.29 In Scotland, the Government failed to discuss operating costs with Scottish Dental Practice Committee (SDPC), despite our calls highlighting the need for support to meet rising costs and soaring general and dental inflation. This failure to address the operating costs element represents a further real terms pay cut for GDPs. Once again, we asked for discussions with Scottish Government regarding the operating cost element of the pay uplift this year, but they failed to engage with us, and therefore no discussion took place. In a letter from the Minister for Public Health and Women's Health, to David McColl, Chair of SDPC, from 31 October 2023, she advised that she had asked for *"an exploratory discussion around principles and rules of engagement happens to support a shared understanding of the issues and to develop an expenses engagement framework".* The Scottish Government has committed to these discussions with SDPC but unfortunately, these have not taken place, despite our calls for these discussions to commence.

3.30 In Wales, as noted earlier, the Government appears to intend to continue to participate in the DDRB process, but to use the DDRB's recommendation as merely one input into collective bargaining on pay. No meaningful attempt was made by Welsh Government to engage with the BDA regarding what constitutes appropriate remuneration for the costs of delivering care.

3.31 In Northern Ireland, the BDA remains concerned at the absence of any robust methodology applied by DoH for the 2023-24 round, as expressed in our letter to Chris Pilgrim of 17 June 2024. We have no reason to believe the process will be any more robust for the 2024-25 round.

3.32 It is worth reiterating that what is often described as the 'expenses uplift' refer to practices' operating costs and, in the main, not to the professional costs incurred by individual dentists.

Essentially, this represents the funding made available to dental practices to deliver NHS dental services, and as such covers everything from clinical materials and laboratory fees to non-dentist staff costs, clinical waste disposal and mortgages or rent. It is more accurate to describe these as the 'costs of care'. These costs of providing NHS care account for the majority of the funding provided, and therefore fluctuations in these costs have a direct bearing on the remaining funding that is left to be allocated among dentists as their take-home pay.

**The practice operating costs process**

3.33 We agree with the DDRB's comments in paragraphs 1.12 and 1.22 in relation to the practice operating costs process. As in our previous evidence and reflecting the discussions above, we must restate that there are no agreed processes for agreeing uplifts in relation to practice operating costs. In effect, there is a process of imposition by the governments. In England, there is a form of highly-limited consultation, but we must stress that this does not reflect an agreed process between DHSC and the BDA. As set out in our previous evidence, we have made proposals to the DHSC on a revised process and these have not been taken up.

3.34 The effect of this absence of an agreed and fair process is that, even where governments 'accept' the recommendation of the DDRB on pay, there is a mechanism by which this can be effectively bypassed, and governments can ensure that this is not reflected in dentists' take-home pay by restraining the uplifts given on practice operating costs. Therefore, even if the DDRB does not make recommendations on practice operating costs, it has a direct interest in ensuring that the practice operating costs process works effectively and does not undermine the recommendations it makes on pay.

3.35 As we have set out above, this has real impacts on the future sustainability of NHS dentistry. It leaves dentists with a choice of whether to accept lower pay, to do less NHS work, and/or do more private work.

3.36 The BDA's long-standing position has been that the DDRB should return to its previous practice of making recommendations on uplifts to practice operating costs. This would provide a trusted process for all parties to submit evidence on practice operating costs and to have a recommendation made. As a result, we again submit evidence on practice operating costs to the DDRB, in Chapter 6, and request that the DDRB makes a recommendation on the uplift to be applied.

3.37 Nonetheless, we are open to alternative means of resolving this matter, and we are willing to work constructively with the DDRB and government parties to reach a mutually-acceptable solution.

**The Amended Terms of Reference for the DDRB**

3.38 There is profound scepticism of the pay review process amongst many dentists. In summary terms, this is the inevitable result of the failure of governments to deliver a total remuneration package that accounts for very substantial increases in the operating costs facing practices, and the failure to implement uplifts on time.

3.39 It is welcome that the DDRB's revised terms of reference make clear that the component parts of the same are evaluated independently, in parallel, and non-contingently. Given the mobility of the dental workforce it is likewise welcome that the DDRB will have reference to comparator professions, including international comparators, when making its recommendations. Regrettably, while these are helpful developments in one component of the pay review process,

the wider process remains fundamentally broken when governments fail to act as good faith partners and undermine the process through obfuscation, delay, and wilful negligence.

### Gender pay disparity

3.40 We welcome the DDRB's ongoing engagement with the gender pay gap in dentistry. Given the likely multifactorial nature of the gender pay gap, in the absence of workforce data weighted for working hours, it is difficult to identify the primary causal factors involved.

## Chapter 4 – Policy update

4.1 The Nuffield Trust has said that NHS dentistry is in 'near-terminal decline' and 'at its most perilous point in its 75-year history'[2]. Its report is about England, but the same is true across all parts of the UK. As we have set out repeatedly, at the core of these issues are the contractual models used for NHS dentistry and the substantial real-terms cuts to funding that have taken place over the last 15 years.

### England

#### Delivery

4.2 The recovery of delivery of NHS contracted activity has been a persistent issue since the pandemic. There were high levels of under-delivery prior to the pandemic, but the problem is now magnitudes worse. NHS dental activity has still not recovered. Well over 50 million NHS dental appointments have been lost since lockdown, the equivalent of well over a year's worth of dentistry in normal times. As a consequence, unmet need for NHS dentistry is at record levels[3].

4.3 The collapse of activity in NHS dentistry was more significant than other services, and it lags well behind the recovery seen elsewhere in the NHS.

[2] Bold action or slow decay? The state of NHS dentistry and future policy actions – Nuffield Trust
[3] 13 million: Unmet need for NHS dentistry breaks records – British Dental Association

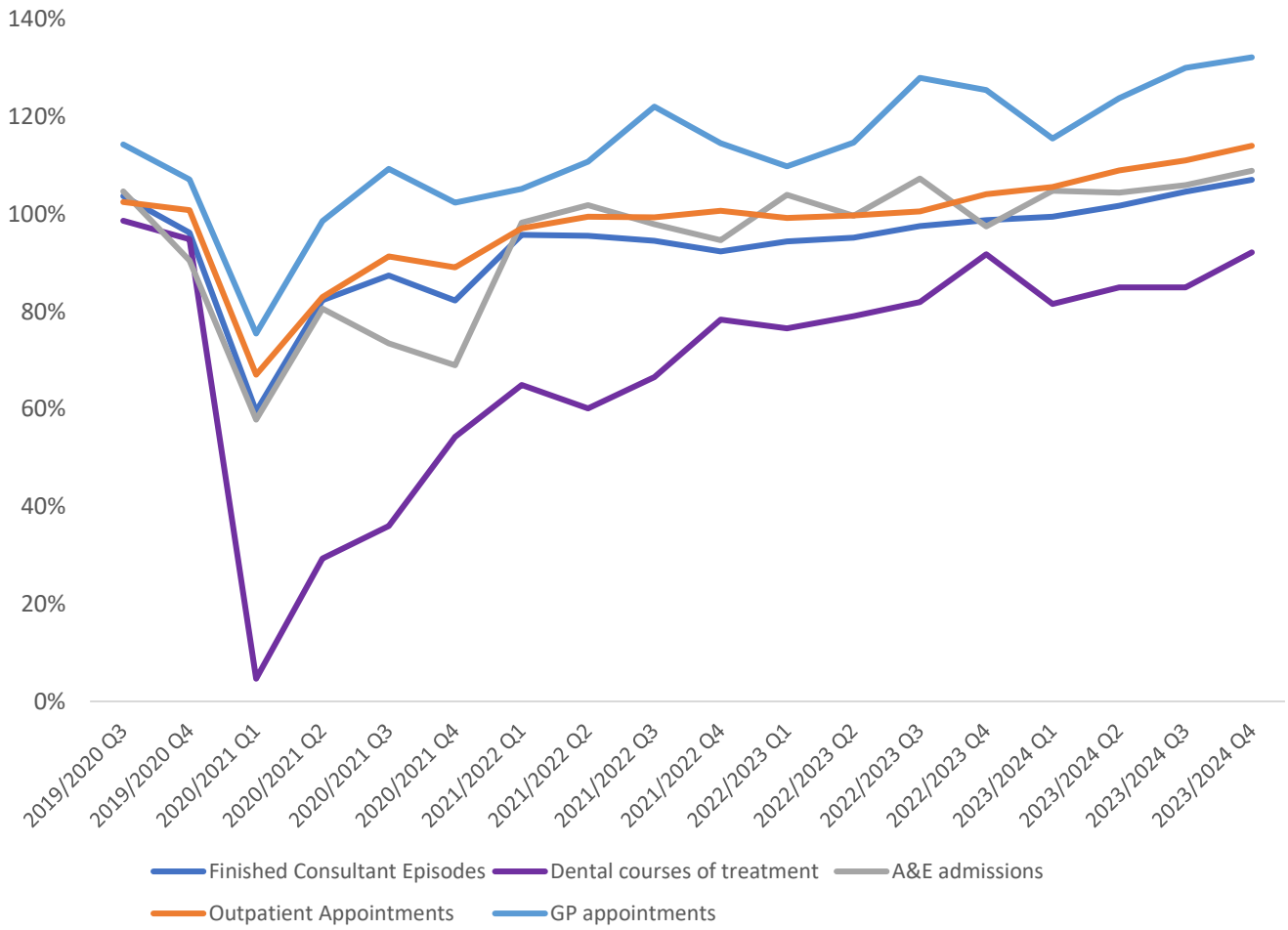


Fig 3: Activity delivered by quarter as a proportion of pre-COVID averages from 2018-19. Sources: Data is from NHS Dental statistics, Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data, Hospital Admitted Patient Care Activity, and Appointments in General Practice.

4.4 In respect of UDA delivery in 2022-23, NHS BSA data reports that £480 million was clawed back from contractors, amounting to 14% of the total of contract financial values[4]. Of the 8,900 contracts, 40% were subject to clawback in this year.

4.5 Contract delivery expectations have returned to the pre-pandemic norms from 2023-24 onwards, meaning that contractors must deliver at least 96% of their contracted activity to avoid facing clawback. The figure for clawback has not yet been confirmed, but, while it is likely to be lower than the 2022-23 figure, it will still be several hundreds of millions of pounds.

4.6 Comparing delivery in the most recent month for which data is available – July 2024 – to the same month in previous years shows that there has been some recovery in NHS activity, but it remains well below the overall contracted level of activity, and the 96% threshold. That month contracts delivered 89.3% of their notional monthly contracted activity[5], whereas in July 2023 it was 79.9% and then in 2022 it was 70%. Underlying this inability of NHS dentistry to fully recover activity levels is dentists turning away from NHS work. Practices simply cannot recruit and retain associates to deliver NHS activity.

[4] 'Financial adjustment' (i.e. clawback) data taken from NHS Payments to Dentists 2023-24 - NHS BSA

[5] Calculated by dividing the total contracted activity by 12.

**Dental Recovery Plan**

4.7 The UK Government published its Dental Recovery Plan (DRP) in February 2024, having committed to do so the previous year. The main measures set out in the DRP were to introduce a New Patient Premium, to increase the minimum UDA value to £28, to offer golden hellos to recruit dentists to hard-to-recruit areas, and to provide care in dental vans in 'dental deserts'.

4.8 Our view is that the measures set out in the DRP did not amount to a 'recovery plan', and this is evidenced by the figures discussed above. Only 3% of dentists felt that the DRP would improve access to NHS care. The most common open text response from members was '*too little too late*'.

4.9 Ministers initially stated that the DRP was supported by £200 million in additional funding, but later corrected the record, as the funding involved came from recycling under-spend within the existing budget.

4.10 The New Patient Premium is intended to incentivise seeing patients who hadn't attended for two years. Where these patients need a band one course of treatment, the Premium is worth £15, and where they need a band two or three course of treatment then the Premium is worth £50. However, it is important to recognise that this is not additional funding, but is simply earned against the existing contract. The £15 and £50 have been converted into UDAs and are claimed against the contract's UDA target. The Premium will operate from March 2024 to March 2025. The BDA's view is that the Premium has been set too low, but we would support extending and enhancing the scheme.

4.11 The minimum UDA value increased from £25.33 to £28, which, while positive, fell below the £35 that the BDA believes is necessary. The increase in UDA values in the DRP impacted on fewer than 900 contracts. A number of ICBs have recognised that the national UDA value is too low and have implemented local, higher rates. For example, Dorset ICB has introduced a UDA value of £35.

4.12 There will also be 240 golden hello payments to dentists to attract them to work on the NHS in specific areas. These will be worth £20,000 spread over three years, with the related requirement to work in the area for three years. We are sceptical about this approach, as there is a clear risk that this simply moves the workforce around, rather than meaningfully addresses it.

4.13 The DRP also instigated a number of consultations on workforce policies that are discussed below.

**Workforce**

4.14 We remain concerned that the proposals in the NHS Long Term Workforce Plan are not realistic, and in particular that the expansion in dental school places is not adequately funded. The Government is yet to confirm capital funding to expand estates in preparation for the first increased cohort in 2026. Given the likely timelines for any estates projects, this is concerning. Moreover, because the Government has confirmed[6] that there will not be additional funding to dental schools to support an expansion in the dental academic workforce, we are concerned that this will lead to increased student to staff ratios, which risk lower levels of clinical experience for graduates.

4.15 Following the DRP, the Government consulted on the principle of an NHS tie-in, which would involve dental graduates repaying up to £200,000 if they did not work on the NHS post-graduation. Our view is that this is an entirely disproportionate means of addressing the current workforce issues in NHS dentistry. We fear that it would be counter-productive. 40% of the more than eight hundred of our student and graduate members responding to our survey on this

[6] Dentistry: Training Question for Department of Health and Social Care – UK Parliament

consultation proposal said they would not have chosen to study dentistry had such an arrangement been in place. Instead, we suggest that, in addition to contract reform, the Government should look at how to make NHS dentistry an attractive environment in which to work throughout dentists' careers. The Government is yet to respond to the consultation.

4.16 The DRP also instigated a consultation on proposals on provisional registration, which would allow overseas-qualified dentists to be able to work as a dentist under the supervision of a fully registered individual, while working to demonstrate that they are of the required standard for full registration. The BDA has a number of concerns about this proposal, which we submitted in our response to the consultation. Fundamentally, we believe that the main solution to the NHS workforce challenge is contract reform. The Government is yet to reply to the consultation.

## Scotland

### Schedule payment recovery

4.17 Following the BDA's engagement with Scottish Government the bridging payment which uplifted NHS fees at a rate of 1.1 was extended until 31 October 2023, in order that payment reform could be implemented before this support for dental practices was removed. The last bridging payment was included in the October 2023 paid November 2023 schedule. A manual payment was made in February and May 2024 to reconcile any courses of treatment where an additional 10% should have been applied to item of service fees for existing courses of treatment submitted after the October paid November schedule.

4.18 National Services Scotland (NSS) via the dental payments team of practitioner services division (PSD), made payment errors on the item of service multiplier during the reconciliation process. This meant that a number of dentists received overpayments in their May payment schedules which were then recovered by PSD in June. We were disappointed that this was not brought to the attention of SDPC prior to the recovery communications being sent to the dentists. We raised our concerns about their lack of communication and the handling of this process directly with NSS.

### Workforce Census

4.19 As part of the Quality Improvement Activity 2022-25 cycle which is part of the Statement of Dental Remuneration, a practice-level workforce census was sent to all dental practices by the Scottish Government on 1 May 2024 for completion by 12 June 2024. The census was to be completed once per practice, or PDS location, and was intended to provide details of all staff within the practice as at week commencing 25 March 2024.

4.20 All staff within the practice at that date were to be included in the census return. Any absences due to sickness or leave were to be ignored and those staff were to be included within the return as if they were working their normal hours. The purpose of the workforce census is to enable the Scottish Government to better understand the current dental workforce and they will use the results to inform workforce planning going forward. Currently the only workforce information available for primary care dentists in Scotland is via the Turas NHS Scotland workforce data which only provides a headcount of dentists, so fails to reveal information on whole time equivalents or NHS activity levels and does not include the wider dental team.

4.21 Recruitment of dentists into NHS dental practice remains very challenging. Dentists choosing to work less than full time (FT) and the delivery of private treatment options, is impacting on the availability of the workforce. The workforce census should be used to inform an evidenced based dental workforce plan, and the Scottish Government should consider developing a costed NHS dental workforce plan, as a matter of urgency.

### Scottish Public Pensions Agency (SPPA)

4.22 We continue to work with 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.

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

## Wales

4.24 GDS contractual arrangements have for several years come under the umbrella of whole system primary care reform in Wales. Ahead of a new negotiated GDS contract to be brought into legislation for 2026, there has been a series of annual contract variations, since 2021, operating under the 2006 legislation. Although the Welsh Government has indicated its support for a prevention-focussed contract, its actions have demonstrated its focus is access.

4.25 Each year the Welsh Government has formulated an offer to contract holders based on a series of volumetrics targets which the contract holder must meet. In particular, the volumetrics have shifted towards greater provision for new patients including new urgent patients. This has resulted in seeing fewer historic patients (those already seen by practices and on the practice registers). These patients have in many cases had their recall intervals shifted to 12 months. The only element of the contract offer that relates to prevention is the indiscriminate application of fluoride varnish which many practitioners regard as being the very definition of a clinical 'sticking plaster'.

4.26 Of note, contract variation operates a crude unweighted capitation system with no remuneration based on levels of treatment. Practices are expected to operate a 'swings and roundabouts' financial model which is not dissimilar to the UDA system, in that it discourages the treatment of very high needs patients and makes no provision for the more expensive interventions such as dentures which are becoming difficult to afford and to procure. It also makes no weighting allowances for areas of deprivation and high needs. As a result, each year there is a retrospective mitigation process at year-end based on profiling numbers of interventions, which from a business planning perspective is high risk.

4.27 Contract variation has created business instability for practices due to insufficient risk mitigation and difficulties in business planning from one year to the next. Widespread clawback of monies against arbitrary untested targets has undermined trust in the reform programme. The number of NHS contracts handed back in the last 18 months has escalated several-fold and the trend is continuing. Perceptions expressed by associates and practice owners are predominantly critical of the NHS landscape.

4.28 These BDA findings chime very closely with an independent report by Bangor University[7] on the outcomes from primary care system reform and annual GDS contract variations. We strongly recommend that the Bangor report is read in its entirety.

[7] Evaluation of the NHS General Dental Services Contract Reform Programme in Wales - Bangor University

### Northern Ireland

4.29 In January 2024, over 700 or two-thirds of GDPs signed an open letter to the Permanent Secretary at the DoH, in the absence of a Health Minister, to ask: 'What's the plan for Health Service dentistry?' The letter called for urgent action. With a well-documented reduction in patients seen and patients treated it was regarded by the profession as a last chance appeal to stem the downward trajectory of the service and to slow the move away from health service dentistry.

4.30 The EU Parliament voted in favour of a complete ban of dental amalgam by January 2025. Northern Ireland would have been subject to direct implementation of the NI Protocol arrangements, with disastrous consequences for Health Service dentistry. Following lobbying from the BDA and others, a 10-year derogation for Northern Ireland was secured (until 2034 or earlier, depending on the Minamata Convention). Nonetheless, this should serve as a wake-up call for how fragile Health Service dentistry in Northern Ireland is; too reliant on a cheap, old-fashioned material, and based on wholly inadequate fees. The Government has failed the profession and the public in not enabling the three core conditions to achieve an amalgam phase out; that is, prevention and improved oral health, dental system reform, including a new prevention based GDS contract, and alternative materials and techniques.

4.31 In March 2024, a '£9.2 million investment' package was announced by the DoH. Disappointingly, the BDA did not have advance sight of the package which included a Dental Access Scheme (DAS), Enhanced Children's Examination Scheme (ECE) and 30% uplift on fees on select SDR treatments for one year only. This measure was a 'sticking plaster' approach in the absence of any meaningful contract reform. Indeed, to describe this money as an investment was misleading. It was not new money, but a scheme that we would argue was created in anticipation of further shrinkage in NHS care provision. It has provided dental A+E services which will have no effect on the provision of routine care, and will secure no improvement in the oral health of our population. It has provided a time-limited uplift to certain fees which nonetheless fail to support a viable business model for GDPs, and has to date had limited effects on delivery of care. The new patient premium (NPP) has attracted child registrations, but as yet has done nothing to enable child dental treatment.

4.32 At a time when Health Service dentistry is rapidly shrinking, and on a worrying downward trajectory, the DoH has not followed through on previous commitments made to re-invest the 2023-24 underspend in GDS. Real and substantive action towards a new, fit-for-purpose GDS contract has not happened. Failure to act has driven dentists away; GDS dentists do not strike, they leave, and when they leave HS dentistry, they do not come back. We are alarmed and disappointed that despite all evidence pointing to decline, Government in Northern Ireland by its own admission, continues to apply an 'iterative approach' including short-term measures such as the Dental Access Scheme without addressing the long-term under-remuneration that makes practices financially unsustainable. There is currently no timeline for contract reform including reform of the payment system for HS dentistry.

## Contract reform

### England

4.33 The BDA has called for fundamental reform of the GDS contract since 2007. The UDA contract put in place from 2006 is widely acknowledged to be unfit for purpose. It has led to a situation where dentists are increasingly unwilling to work on the NHS, leaving 13 million adult patients without access to an NHS dentist.

4.34 It has been welcome to see a growing consensus about the need for reform, with the Health and Social Care Committee and the Nuffield Trust both calling for significant contractual change. In the election, Labour, the Liberal Democrats and the Greens all made manifesto commitments to reforming the dental contract.

4.35 Following the election, we have held a number of conversations with ministers and officials about NHS dentistry, and we have held a specific meeting with NHS England and the DHSC on contract reform. We have made clear our view that NHS dentistry needs change that does away with the UDA and introduces a prevention-focused, patient-centred contract. We need a clear timetable and process to negotiate and deliver that contract. The initial discussions have been positive, but we now need public commitments and action to demonstrate that progress is being made.

4.36 In our previous evidence, we referred to a further package of marginal changes to the contract that had been discussed with the BDA from autumn 2022 to autumn 2023. Since then no substantive discussions have taken place about these proposals. The BDA understands that the development of the DRP hindered making progress towards implementation. We have encouraged NHS England and the DHSC to proceed and understand that they intend to. While interim measures to support NHS dentistry are undoubtedly necessary, only fundamental reform will put the Service on a sustainable, long-term footing.

## Scotland

4.37 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 and deliver an administratively simpler and more clinically focused system.

4.38 Payment reform was implemented on 1 November 2023 and has seen a change to the remuneration of NHS dental practices and services in Scotland. Careful analysis of the impact of these payment reforms and their impact on the sustainability of NHS dentistry will need to be undertaken by the Scottish Government. The Minister for Public Health and Woman's Health has stated, '*I recognise there remains further work to do to ensure the long-term sustainability of dental businesses, and I look forward to working with you as we test and refine the system post launch. As always, we will be looking to ensure value for money, that clinical care is delivering for patients, and that the sector is supported*.' The BDA is concerned that the item of service fees listed in Determination I and delivered by Payment reform were based on the amount of funding Scottish Government wanted to commit to delivery of the Determination I, rather than basing the fees on clinical rationale.

4.39 We conducted a survey of dentists on the impact of payment reform earlier this year. It found that while two thirds of respondents considered the new system an improvement, only 26% said the change made their practices more financially sustainable, 31% disagreed that the new system was an improvement, and nearly half were unsure. The sustainability of NHS dental practice in Scotland remains a profound concern for our members. Almost 9 in 10 (88%) agreed this should not be the end of the road for reform. Only 22% of respondents believed the new system enabled a move to a preventive model of dentistry.

4.40 The model of care enacted by the payment reforms is, disappointingly, still predicated on a high volume and low margin approach. We remain concerned that it is not focused enough on preventive care or the utilisation of skill mix.

4.41 As part of the Quality Improvement Activity 2022-25 Cycle, Scottish Government included team-based reflective reports for dental practices "*to reflect on the ways in which the introduction*

*of the new Determination I has enabled the practice to further improve the quality of care provided to patients.*" Scottish Government said the exercise would provide practices with a reflective framework which would guide the development of a practice action plan. We are unsure what Scottish Government mean by this statement as the current Statement of Dental Remuneration does not fund action plans or facilitate effective use of skill mix within dental practices.

4.42 In July an announcement was made on the NSS Dental Services webpages; 'Continuation of the November 2023 Dental Reform Implementation' stating that following the introduction of Dental Reform in November 2023, that there were several changes that were proposed to be delivered but were deferred due to the tight timescales. These changes were categorised as; annotation / material information to support clinical governance, oral health metrics, provision of reason for item 1-(c) Unscheduled care assessment and treatment and eDental validation rules. We were disappointed that these changes were implemented without consultation or discussion with SDPC.

4.43 BDA Scotland and SDPC representatives continue to engage with the Scottish Government regularly, along with the PSD, to discuss and highlight any emerging issues or concerns associated with payment reform.

4.44 We believe Scotland needs a 21st century NHS dental service, one in which dentists choose to build a career. The NHS must be an attractive place to work and somewhere that enables recruitment and retention of dentists throughout their careers.

## Wales

4.45 We have been in intense negotiations with the Welsh Government over the last 18 months, working to secure a new NHS GDS contract to be ready for April 2026. Our aim has been to reshape how dental care is delivered in Wales, ensuring a sustainable and accessible model that better serves both dental professionals and patients. We made it clear in negotiation meetings that a new model of service is our vision and that merely tweaking the existing contract variations with the volumetric targets could not provide the changes needed. We were eventually successful in bringing our counterparts around to our way of thinking.

4.46 Regrettably, Government officials prematurely closed the negotiation process in September 2024, arguing that the timeline to completion demands cessation of this important phase of the reform process. This means that many elements of the contract remain indeterminate. The Government's solution is to take the draft model to public consultation; however, it remains to be seen how much of the areas of accord will translate into that model. We anticipate the Government public consultation will be launched before Christmas. We have yet to decide whether BDA Wales will conduct a separate exercise to gauge the views of the profession. Most of the negotiated elements (and unresolved aspects) remain confidential currently.

4.47 One of the Welsh Government's primary goals for the new contract is to enhance patient access to dental care across Wales, especially for those who have struggled to find NHS dental appointments. To meet this objective the Government is introducing a nationwide system of patient access called the Dental Access Portal or DAP. It will go live in November 2024 across Wales, having been piloted in Powys. This will be a soft launch where practices are encouraged to signpost new patients to the DAP. In future, however, the Government may choose to use the DAP exclusively to funnel all new patients to practices.

## Northern Ireland

4.48 On 3 October 2024 DoH officials gave evidence to the Northern Ireland Assembly Health Committee on GDS issues. As referred to earlier, given the extraordinary scale of the challenges

facing the profession we were profoundly concerned to hear DoH officials characterise their current approach as 'incremental' and 'iterative'.

4.49 It is important to note here that the last substantive meeting of the joint DoH and BDA Contract Reform Group established by Government in 2021 took place in June 2022. Indeed, only three meetings have taken place since the establishment of the Contract Reform Group. DoH has done nothing to move forward with urgently needed contract reform despite our repeated warnings that dental practices delivering HS dentistry are ever less financially sustainable. In the absence of any indication from Government that it will take urgent, substantive action, practices will continue to make the difficult choice to reduce their exposure to HS dentistry.

## Chapter 5 – Economic conditions and pay trends

5.1 While the UK economy has experienced a more stable rate of headline inflation over 2023-24 than in previous years, growth has been limited. In this chapter we set out the current macroeconomic conditions and long term pay trends that are necessary factors to account for when determining an appropriate recommendation on pay for dentists.

**Private and Public Sector Pay Growth**

5.2 According to the latest ONS data from September, excluding bonuses the annual growth in average pay was 5.1% for the year to August 2024. For the public sector as a whole, the average was 5.7%, reflecting the pay awards in July. Private sector pay has typically been stronger than public sector pay since the 2008 financial crisis. Average private sector pay growth in the year to July was 4.9%.

**Spend on NHS dentistry**

5.3 Gross spend across the four nations only rose over the last decade to £3.683 billion in cash terms, before falling by £100 million between 2022 and 2023, as expressed in the chart below. This figure includes patient charges. In real terms, this means that Government spending on NHS dentistry fell very rapidly between 2022 and 2023 as a result of the combined effect of the removal of Covid support payments and higher inflation. In 2023, real terms spend on dentistry fell to £2.025 billion, compared to £2.6 billion in 2006. In England in particular Government real cash terms spending on NHS dentistry has remained flat, meaning that it is over £1.5 billion behind since 2010 when inflation is considered.

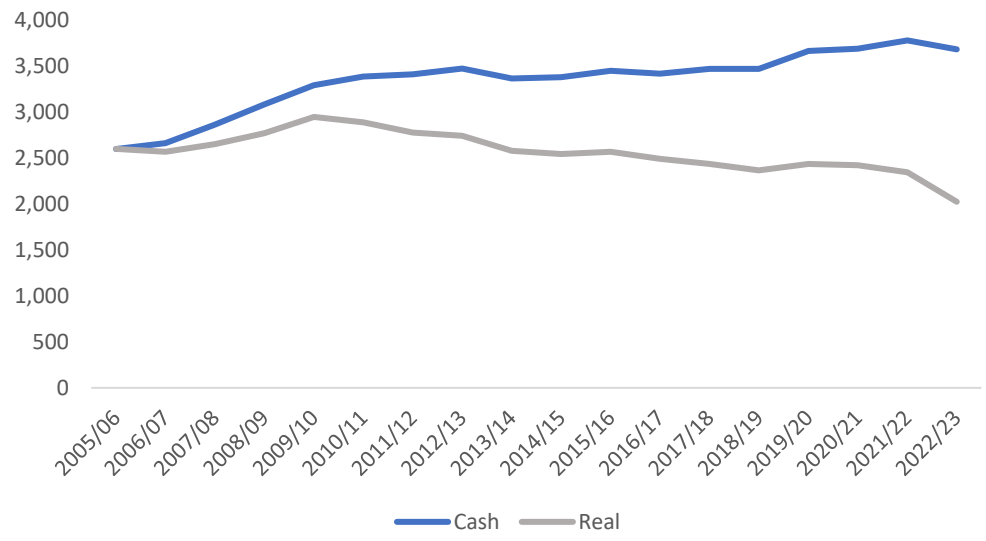


Fig 4: UK gross spend on GDS in millions. Sources: Health departments.

**Patient charge revenue**

5.4 Patient charge revenue was £775,994,804 for the financial year 2023-24[8]. Patient fees have risen year on year, in this case by 4%. However this represents a cash loss since the pandemic as the number of patients seen is still below the level seen on average up to 2019: just above 50% of the English population.

**Practice owner incomes**

5.5 In summary terms, GDPs have seen more than a decade of falling or flatlining take-home pay. For practice owners, taxable income is nearly flat or going backwards year on year. This is most significant in Northern Ireland. Scotland remains an outlier. The increase in earnings represented in figure five for Scotland are a consequence of covid-related support payments. A quarterly multiplier was applied to each month's gross item of service fees. The extensive alteration to the determination 1 outline of dental fee items may also affect earnings going forward.

| Nation | Year | Income Before Tax |
|---|---|---|
| **England** | 2021-22 | £135,000 |
| | 2022-23 | £128,800 |
| | Change | -4.6% |
| **Scotland** | 2021-22 | £125,100 |
| | 2022-23 | £146,700 |
| | Change | 17.3% |
| **Northern Ireland** | 2021-22 | £138,800 |
| | 2022-23 | £124,600 |
| | Change | -10.2% |
| **Wales** | 2021-22 | £120,800 |
| | 2022-23 | £122,600 |
| | Change | 1.5% |

Fig 5: Practice owner earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[8]

5.6 It is important to emphasise that around two thirds of the earnings of practice owners are spent on operating costs, and that the remuneration received by dentists is far below the true cost of NHS treatment borne by practice owners once those costs of delivering care are accounted for.

5.7 In England and Northern Ireland, the drop in taxable income is likely a direct result of practice owners having no choice but to adjust their practice profile to pay essential operating costs. Indeed, modelling conducted by the BDA has concluded that the cross subsidy of private income supporting NHS treatment could be as high as £300 million.

**Associate pay**

5.8 Associate pay remains at comparable levels to the late 2000s in cash terms and has therefore been eroded significantly in real terms. Data that we have on the fees associates are paid per UDA in England shows that they have remained largely static over the past three years. It is likely

[8] Dental Earnings and Expenses Estimates - NHS England Digital

that this is replicated elsewhere in the UK in relation to NHS fees, and therefore, it is reasonable to conclude that the growth in associate earnings cannot be attributed to a growth in their incomes from NHS sources.

| Nation | Year | Income Before Tax |
|---|---|---|
| **England** | 2021-22 | £66,300 |
| | 2022-23 | £64,300 |
| | Change | -0.9% |
| **Scotland** | 2021-22 | £64,400 |
| | 2022-23 | £79,600 |
| | Change | 23.6% |
| **Northern Ireland** | 2021-22 | £60,700 |
| | 2022-23 | £67,300 |
| | Change | 10.9% |
| **Wales** | 2021-22 | £66,300 |
| | 2022-23 | £72,600 |
| | Change | 9.5% |

Fig 6: Associate earnings and taxable income. Source: Dental Earnings and Expenses Estimates - NHS England Digital[8]

5.9 Associate earnings in England have fallen in cash terms, and we believe they are also being driven down as expenses rise substantially. As a result of the DHSC's approach to operating costs in particular, the contract uplifts in England have tended to be lower than those in the rest of the UK, with the consequent impact on associate income that we have described in repeated evidence to the DDRB.

5.10 This evidence reinforces what we have said about the long-term erosion of associate pay, which has resulted from inadequate pay and practice operating cost uplifts for NHS activity. It is only now that associates have shifted the balance of their practice towards private dentistry that they have been able to see increases in their income.

**Practice operating costs**

5.11 As expressed in our previous written evidence submissions to the DDRB and more widely, the BDA believes that the DDRB should consider practice operating costs in any uplift recommendation, and we are keen to work with the DDRB and other bodies to bring this about for future pay rounds. In the meantime, we ask that the DDRB makes a recommendation on practice operating costs for 2025-26 based on the currently available data.

5.12 In recent years the BDA has tracked 'dental inflation' across a number of key inputs and costs for dental practices. Data comes from a mixture of public sources and original BDA research. We incorporate the ONS annual Retail Price Index, as well as their data on fuel price fluctuations. The ONS' medical products, appliances and equipment annual rate in CPI has also been incorporated into our analysis for the first time, forming the basis for our assessment of the increase in dental materials costs. The Ofgem energy price cap increase by 10% in October was latterly picked up in our survey results. Our survey of practice owners found that most have experienced increases in costs across each category. The most frequent responses were that costs

had increased by 11-20% or increased by 21-30%.

5.13 Weights for each cost input category are derived from the formula and weightings used by the DHSC for contract uplift calculations in England. The estimated rise in costs year on year, based on a mixture of survey and ONS data has then been applied to each.

5.14 Following from the announcements contained in the October 2024 budget that the minimum wage would rise, and that there would be changes to National Insurance employer contributions, we have calculated the impact on practices based on average pay of the employees affected and annual contract data. We have concluded that the changes will add as much as 9.5% to the non-dentist staffing costs for practices.

| | Weighting | Index | Weighted value |
|---|---|---|---|
| Dentists' pay | 0.47 | 9.20% | 4.29% |
| Staff costs | 0.22 | 24.58% | 5.41% |
| Laboratory costs | 0.06 | 16.46% | 0.99% |
| Materials costs | 0.07 | 4.70% | 0.31% |
| Other costs | 0.19 | 2.70% | 0.51% |
| Total | 1 | | **11.50%** |

Fig 7: Formula for overall GDP uplift. Sources: Estimated average practice operating cost increases derived from BDA Practice Owners survey 2024, along with data from the ONS. Pay uplift based on BDA pay ask.

5.15 As noted earlier, the BDA therefore asks that the DDRB make a recommendation in line with the above, so that staff costs are uplifted by 24.58%, laboratory costs by 16.46% and materials costs are uplifted by 4.7%, and other costs are uplifted by RPI for the year to September at 2.7%. On this basis, we ask that the DDRB recommends an overall uplift to be applied to all NHS contracts, fees and allowances of 11.50%

**Impact of the October 2024 budget**

5.16 In October, the Chancellor announced changes to the Class 1 National Insurance Contributions paid by employers and changes to the threshold at which they are paid, from £9,500 to £5,000, for the financial year beginning in April 2025. The threshold for employment allowance has risen and the overall qualifying cap lifted, and the percentage paid on earnings above the payment threshold is currently 13% but set to rise to 15%.

5.17 Dental practices which generate more than 50% of their revenue from NHS activity will be subject to the rise in full, while private, or mostly private practices will be able to claim the employment allowance. Input costs may also be affected as manufacturers, distributors and other related services which practices rely on for materials are likely to see changes to their employment costs.

5.18 Understandably, these changes have generated considerable concern from BDA members. Combined with the rise in the minimum wage, the changes arising from the budget place additional pressure on already stretched practice finances. There have been indications from

Government that the impact of these changes on primary care providers including dentists will be dealt with through normal annual contract mechanisms. Should that be the case, we fully expect these costs to be recognised in their entirety through the 2025-26 contract uplift.

**Pensions**

5.19 The BDA engages with NHS Scheme Advisory Boards across the UK. These are the relevant fora for discussing changes to the NHS Pension Schemes. However, pensions are identified as a key element of the reward package for NHS employees and practitioners.

5.20 Since our last DDRB submission there have been some developments regarding pension saving for dentists. Employer contributions to the NHS Pension Scheme have been changed from April 2024 to 23.7% in England and Wales, 22.5% in Scotland, and 23.3% in Northern Ireland.

5.21 Implementation of Partial Retirement; the DDRB is familiar with the new retirement flexibilities allowing pension access for members who reduce their NHS pensionable earnings (or commitment for practitioners) by at least 10%. This requirement remains arbitrary, unnecessary, and unjustified and does not maximise the service potential of senior clinicians.

5.22 Changes to NHS Pension contributions for members have been implemented. Different structures apply in Scotland compared with Schemes in the rest of the UK. Some example rates at different earnings levels are summarised in fig 8.

| Actual Pensionable Earnings | Member Contribution rate | | |
|---|---|---|---|
| | **England** and Wales From Apr 24 | **Scotland** From Oct 24 | **Northern Ireland*** From April 24 |
| **£25,000** | 6.5% | 6.4% | 6.5% |
| **£30,000** | 8.3% | 7.0% | 8.3% |
| **£40,000** | 9.8% | 10.5% | 9.8% |
| **£50,000** | 10.7% | 11.2% | 10.7% |
| **£70,000** | 12.5% | 11.6% | 12.5% |
| **£100,000** | 12.5% | 12.7% | 12.5% |

*DoH in Northern Ireland are currently consulting on increasing all member contributions by 0.2% from April 2025.
Fig 8: Member contribution rate per actual pensionable earnings across UK nations. Sources: England & Wales – NHS BSA Pensions[9], Scotland – Scottish Public Pensions Agency[10] and Northern Ireland – HSC BSO Pension Service[11].

5.23 The issue of NHSPS member contributions remains of concern to BDA and is intrinsically linked to the take home remuneration of dentists. We believe that the case for tiered pension contributions is seriously diminished. This is due to the fact that the Annual Allowance serves to mitigate against high levels of income tax relief and the litany of administrative problems and revenue collection uncertainty which tiered contributions cause. The BDA would prefer a longer term move towards a flat rate of member pension contribution. We would urge the DDRB to support such a move.

5.24 The BDA continues to advocate a system of flexible accrual in the NHS Pension Schemes that will allow members to determine how much pension they build up. Any such election would

[9] Cost of being in the Scheme – NHS BSA
[10] How your NHS pension works – Scottish Public Pensions Agency
[11] Membership, Contributions & Pay – HSC BSO Pension Service

be coupled with a lower member contribution (and consequently lower levels of income tax relief) and, crucially, a payment of the unused employer/government contribution as taxable pay. The introduction of flexible accrual will give members the opportunity to better control the extent to which their pension savings are in breach of the Annual Allowance. It would also offer a cheaper alternative form of pension saving to NHSPS members who opt out of their pension schemes on the grounds of affordability. The BDA would invite the DDRB to support our call for flexible accrual, with enhanced pay in lieu of full pension contributions, to be implemented for dentists, and across the wider NHS family.

5.25 The DDRB is familiar with the McCloud remedy, and the requirements to provide members with updated information related to pension benefits and Annual Allowance taxation. It is disappointing to note that, at the time of writing the provision of this information is subject to continual delay. Members are worried about the impact this will have on retirement planning and, more importantly, on the provision of information to HMRC. These delays come against a backdrop of members reporting delays and errors in processing retirement applications, compounded by frustration at the inability for members to independently model their own retirement plans. It is clear to BDA that the administrative functions for the health service pension schemes are in need of a substantial refresh with a focus on providing correct and timely information to members who are able to link this information into personal modelling tools.

## Chapter 6 – General dental practice

6.1 The BDA's annual survey of GDPs in England, Scotland, Wales and Northern Ireland reveals a beleaguered dental workforce with poor motivation, morale and job satisfaction. Unless explicitly mentioned otherwise, the data in this chapter pertains to the whole of the UK.

6.2 Dentists with a high NHS commitment continue to report worse motivation, morale, and satisfaction indicators, report greater recruitment and retention challenges for the entire dental team, and are significantly less likely to report that they are able to deliver patient care to a standard they are satisfied with. The ongoing dysfunction of the labour market for dentistry arising from the long-term, planned under-remuneration of NHS dentistry inevitably increases the risk of the under-delivery of contracted NHS activity, puts additional pressure on local health and social care economies, and makes dentistry harder for patients to access.

**Workforce**

6.3 The recruitment and retention crisis in dentistry continues to be reflected in our annual survey of GDPs. While there has been some slight improvement in some quantitative measures of motivation, morale and job satisfaction compared to the findings of our survey last year, the aggregate position remains very challenging for practice owners and associates alike.

6.4 91% of practice owners across the UK who had sought to recruit at least one associate reported difficulty in doing so, essentially maintaining the historic high reached last year. This year's survey found that a new historic high of 65% of associate vacancies remained unfilled for at least six months, up from 55% last year. Practice owners told us that recruitment of DCPs remains difficult, with the recruitment and retention of dental hygienists and dental therapists in particular proving very challenging.

*"We will be recruiting next year, and I know it's going to be a struggle because people just don't want to work in an NHS practice."* **Practice Owner, Wales**

6.5 Alongside data underlining that the recruitment and retention crisis continues to impede the effective functioning of the labour market in dentistry, the participation rate of dentists in the market for their labour continues to be low. The proportion of dentists reporting an intention to increase the amount of private work they undertake remains too high to meet the rapid growth in the delivery of NHS dentistry the NHS Long Term Workforce Plan is predicated on.

6.6 As noted in our submission last year, the NHS Long Term Workforce Plan intends for nearly two-thirds of the projected increase in capacity of the dental workforce to come from GDPs delivering more, rather than less, NHS activity.

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | Change 22-23 vs 23-24* |
|---|---|---|---|---|---|---|---|
| **England*** | | 24,706 | 24,621 | 23,759 | 24,227 | 24,335 | +108 |
| **Wales** | 1,506 | 1,472 | 1,389 | 1,420 | 1,434 | 1,398 | -36 |
| **Northern Ireland** | 1,139 | 1,147 | 1,142 | 1,146 | 1,163 | 1,195 | +32 |
| **Scotland** | 3,029 | 3,038 | 3,039 | 2,883 | 2,681 | 2,798 | +117 |
| **Total** | | 30,341 | 29,303 | 29,721 | 29,429 | 29,726 | + 297 |

Fig 9: Number of primary care dentists in England, Wales, Northern Ireland and Scotland. Sources: NHS Digital, NHS Education for Scotland, Northern Ireland Statistics and Research Agency and StatsWales, respectively. *Responsibility for producing the NHS Dental Statistics in England dataset has transferred to the NHSBSA from 2023-24. We have amended the historic data for England in this table in line with the new figures produced by the amended methodology adopted by the NHSBSA to allow comparison over time. Data for 2018-19 has not been made available.

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

6.8 The survey of the dental workforce as of March 2024[12] found that there were just 10,539 full-time equivalent (FTE) NHS dentists in England, with 70% of the time recorded for a given dental chair being used for NHS activity. This FTE figure is less than half the headcount figure in England of 24,335 GDPs who delivered primary care services in 2023-24. It is also important to note that considerable regional variation in the degree of chair utilisation for NHS activity exists, ranging from 77% in London to just 59% in the Southwest.

6.9 The finding from the survey of the dental workforce of an NHS vacancy rate of 21% against a non-NHS vacancy rate of 17% accords with the consistent evidence from the BDA's own annual survey of the ongoing dysfunction of the labour market for NHS dentistry. Similarly, the finding of a total of 495,774 days in which a GDP role that delivered NHS activity were vacant strongly agrees with the evidence from our survey of the ongoing recruitment and retention crisis in dentistry.

6.10 As previously noted, the proportion of practice owners and associates reporting an intention to increase the amount of private work they deliver remains high. In our annual quantitative and

[12] Dental Workforce – NHS England

qualitative survey of GDPs from across the UK, this year 32% of practice owners reported their intention to increase the amount of private work they delivered, compared to 38% last year, 39% in 2022, and 22% in 2021. Similarly for associates, the proportion of respondents to our survey reporting an intention to increase the proportion of private work they deliver remained high at 37%. The figure was 48% last year, 48% in 2022, and 39% in 2021.

*"Many 50-year-olds are leaving the profession, because they just don't feel valued anymore, and they go into private because they want to be paid a similar amount of money to do less work, under less pressure."* **Associate, England**

**Recruitment and retention**

6.11 Our survey of GDPs found that 91% of practice owners across the UK seeking to recruit an associate in the 2023-24 financial year had difficulty doing so. These figures in our GDP surveys in 2023, 2022 and 2021 were, respectively, 93%, 90% and 80%.

6.12 As has been a consistent result in our surveys for several years, practices with a high NHS commitment found it harder to recruit and retain associates. 95% of practice owners with a high NHS commitment seeking to recruit an associate in the 2023-24 financial year reported difficulty, compared to 91% of all practice owners. 60% of practice owners reporting vacancies told us that they had posts that had been empty for more than six months, with that figure increasing to 73% for those with a high NHS commitment.

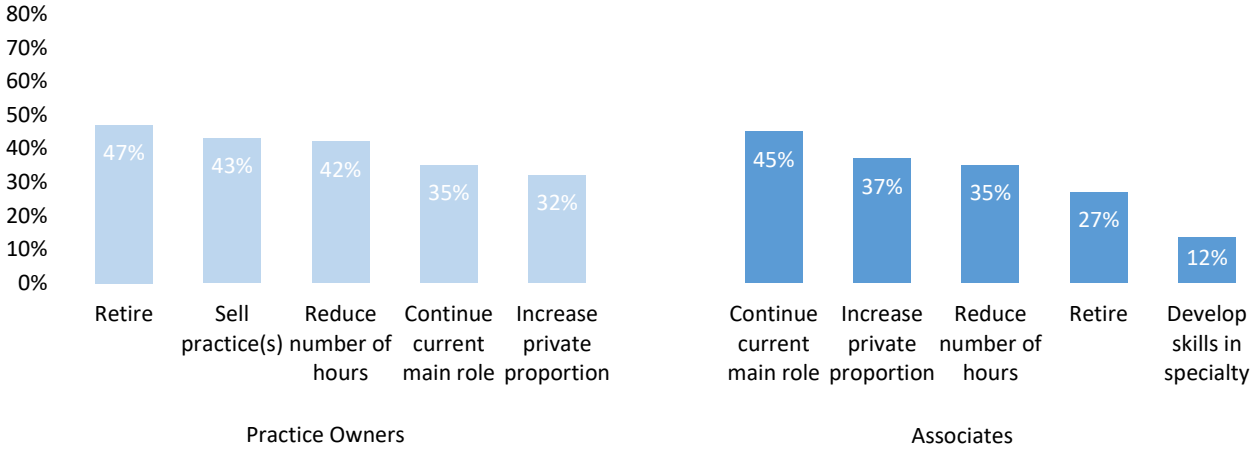


Fig 10: Percentage of GDPs selecting option as a future career intention for the next 5 years (Top 5 shown). Sources: BDA survey data 2024

6.13 As well as assessing the overall difficulty of recruiting associates, our survey asked practice owners about the number of associate vacancies they held. 38% of practices reported two or more vacancies in the 2023-24 financial year. Just 33% of practice owners who had vacancies in the 2023-24 financial year were able to fill all posts they sought to recruit for. As noted earlier, NHS data for England from the survey of the dental workforce stated that 21% of NHS general dentist posts were vacant, and that, of all GDP vacancies, 87% were for NHS posts.

6.14 While all dental practices are impacted by the ongoing dysfunction of the labour market in dentistry, our survey data once again demonstrated that a high NHS commitment was strongly positively correlated with vacancies remaining unfilled for longer. For example, of practice owners with a high NHS commitment, 73% reported an associate vacancy that had remained unfilled for at least six months, compared to 60% for those without a high NHS commitment. Reluctance to

deliver NHS dentistry was overwhelmingly the most likely reason practice owners reported when asked to quantify the factors involved in a post being difficult to fill, with a low UDA value and a reluctance to work in a rural area being the next most likely reason.

6.15 This year we found that 45% of practice owners and 30% of associates intend to leave NHS dentistry as soon as possible or in the next 12 months. Poor morale indicators continue to be positively correlated with a high NHS commitment for both associates and practice owners; for example, only 36% of associates with a high NHS commitment would recommend a career as a dentist, with that figure increasing to 52% for those without a high NHS commitment. Similarly, 43% of practice owners with a high NHS commitment would recommend a career as a dentist, with that figure increasing to 50% for those without a high NHS commitment.

6.16 More broadly, our survey found that over the next three years, 43% of practice owners were intending to sell their practice, with just 35% intending to continue working in their current main role. For context, in our 2018 survey only 32% of practice owners intended to sell their practice over the next five years, with 46% intending to continue working in their current main role.

*"I can't see me having the energy to keep going. I'm finding it more and more tiring. It's not as rewarding as it used to be. My husband would say I used to be probably one of the most passionate people about dentistry, that there was, but I don't have the love for it that I used to have. Although I do still love treating patients, there's just too many other stresses, whether it be trying to balance books, trying to work within the NHS remit or trying not to get sued... so I think I'm probably going to end up selling the practice."* **Practice Owner, Scotland**

6.17 This year 42% of practice owners reported an intention to reduce their overall hours worked in the next five years, with 47% of practice owners reporting an intention to retire from dentistry completely within the next five years. 35% of associates reported an intention to reduce their overall hours worked this year, with 27% of associates reporting an intention to retire from dentistry completely within the next five year.

*"You cannot get an associate to do a five-day week; now, that would not be seen as full time. That would be seen as you're working ridiculous hours! They're all working 30-to-33-hour weeks"* **Practice Owner, Scotland**

6.18 The likelihood of whether both practice owners and associates indicated an intention to remain in their current role in the next five years was, once again, mediated by their NHS commitment. 43% of associates with a high NHS commitment intended to continue working in their current main role, compared to 47% of those without a high NHS commitment. 32% of practice owners with a high NHS commitment intended to continue working in their current main role, compared to 37% of those without a high NHS commitment.

6.19 This correlation between a high volume of NHS work and even greater recruitment and retention challenges underlines that the underfunding of NHS activity is having a direct impact on workforce capacity and stability, with obvious consequences for patients.

**Dental nurses**

6.20 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.

6.21 77% of practice owners responding to our survey had sought to recruit dental nurses, compared to 80% in 2023. Of practice owners who had sought to recruit dental nurses, 83% reported difficulty in doing so, compared to 85% in 2023. Practices with a high NHS commitment were significantly more likely to report that applicants had withdrawn from application processes at short notice, as well as being significantly more likely to report that they had received no applications from experienced nurses. 39% of practices with a high NHS commitment reported that either the current occupant of the dental nurse position no longer wanted to work in the profession, or applicants were reluctant to work in dentistry, compared to 36% of practices without a high NHS commitment.

*"It's always difficult to recruit dental nurses. We've managed to recruit a qualified dental nurse recently, but usually we've given up trying to recruit and we just get trainees because most of them will come do the training and then go off to a private practice, as they don't want to work at an NHS practice. We're having to try and match the private practices with pay to retain nurses. We don't have the budgets they've got."* **Practice Owner, Wales**

**Dental therapists and dental hygienists**

6.22 Of those practice owners who sought to recruit dental therapists in the 2023-24 financial year, 71% reported difficulties in doing so, compared to 62% in 2022-23. Of those practice owners who sought to recruit dental hygienists, 78% reported difficulties in doing so, compared to 75% in 2022-23. Clearly, the recruitment and retention crisis in dentistry continues to extend to the entire dental team. This is particularly concerning given that the NHS Long Term Workforce Plan anticipates that DCPs will increase the quantity of NHS activity they deliver by a factor of five by 2036-37.

6.23 Underscoring the profound recruitment and retention challenges facing practices, and indeed the highly competitive nature of the recruitment market for dental care professionals, our survey this year found that 92% of dental nurses, 76% of receptionists, 63% of practice managers, and 53% of dental hygienists received a pay rise in the last financial year. However, irrespective of these pay rises, as a result of the long-term underfunding of NHS activity, practices are frequently unable to pay for dental care professionals at a level that supports effective recruitment and retention, as evidenced by both the very high number of practice owners reporting that they sought to recruit dental nurses in the 2023-24 financial year, and the difficulty they reported in doing so.

**Morale and motivation**

6.24 50% of all practice owners across the UK and 38% of all associates reported low or very low morale in our survey this year. While these headline figures represent a slight improvement from last year's position of 60% and 49% respectively, the labour market in dentistry across the UK will continue to function poorly while half of practice owners and more than a third of associates remain demoralised. The likelihood of respondents to our annual survey reporting low or very low morale remains strongly positively correlated with their NHS commitment, with 65% of practice owners and 49% of associates with a high NHS commitment reporting low or very low morale.

6.25 The morale of GDPs has significantly declined in the medium term. While the pandemic undoubtedly accelerated and catalysed declining morale, given the absence of a full post-pandemic recovery, the most coherent explanation for declining morale is the one that dentists themselves continue to report; the long-term, systemic under remuneration of NHS dentistry.

*"As I get older, you've got a lot more personal commitments and a lot more financial commitments and if you can't support that, then whether you want to or you don't want to, you have to think about the financial side of things. And the NHS doesn't support that at all. It's a shame, because if the NHS did support that, I wouldn't have to consider leaving the NHS."* **Associate, England**

| | Practice owners | Associates |
|---|---|---|
| All | 50 | 38 |
| ≥75% NHS commitment | 65 | 49 |
| <75% NHS commitment | 41 | 29 |

Fig 11: Percentage of GDPs saying their morale was low or very low. Sources: BDA survey data August 2024

6.26 Perhaps unsurprisingly given poor morale across the profession as highlighted above, 52% of practice owners and 56% of associates would not recommend a career in dentistry. The proportion of practice owners and associates who would not recommend a career in dentistry was highly correlated with working in practices with a high-level of NHS commitment.

| | Practice owners | Associates |
|---|---|---|
| All | 52 | 56 |
| ≥75% NHS commitment | 57 | 64 |
| <75% NHS commitment | 50 | 48 |

Fig 12: Percentage of GDPs answering 'no' to whether they would recommend a career as a dentist. Sources: BDA survey data August 2024

6.27 Just 29% of practice owners and 39% of associates agreed or strongly agreed that they were fairly remunerated for their work. Where practice owners and associates had a high NHS commitment, this figure dropped to just 12% and 23% respectively. Just as the most serious challenges of recruitment and retention are correlated with a high degree of NHS commitment, so too the level of NHS commitment of practitioners is a key mediator of whether a practitioner feels they are fairly remunerated for their work.

*"Even the changes that have been introduced in the last few years do not pay for that extra bit of time. You know, we've always been told it's swings and roundabouts and that you'll make up on the swings when you lose on the roundabouts. But it always seems to feel that you're losing out and you're doing this course of treatment because of your professional ethics. That's why you're doing this for five UDAs, and it might take 10 visits."* **Associate, England**

**Stress**

6.28 Our survey this year found that 66% of practice owners and 45% of associates felt that their level of stress had increased over the last twelve months. For practice owners and associates working in practices with a high NHS commitment, these figures were 74% and 54% respectively. When asked to pick which factors were causing stress in their current role, 87% of practice owners chose increased practice costs, and 78% chose staffing, recruitment, and retention issues. For associates, the two factors most frequently identified as causing stress in their current role were patient complaints and legal issues, and staff shortages or high staff turnover, at 67% and 54%

respectively. 62% of practice owners and 45% of associates also reported that financial pressures specifically arising from the increasing lack of viability of NHS dentistry were a factor in causing stress.

*"To fund this last pay rise that I've had to give to the nurses, I've had to take a pay cut because there's just no more money in the pot and its meaning my job satisfaction, my happiness has gone down. I think that's probably rubbed off on the team as well. I do think it's a kind of vicious circle that if I'm struggling mentally, I'm not coming in as happy and full of joy because I'm stressed."*
**Practice Owner, Scotland**

## Chapter 7 – Community/Public Dental Services

7.1 The crisis facing the Community and Public Dental Services (CDS/PDS) across the four nations has, year on year, been a consistent feature of the BDA's submission to the pay review body. This crisis has now reached a critical level, and is the product of the long-term decline in the headcount of community dentists, coupled with relentless increases in demand from patients. The CDS/PDS patient cohort, comprised of some of the most vulnerable members of our society, is projected to grow in coming years. The decline in workforce and growth in need has occurred at the same time as wider underinvestment in the NHS dental sector to varying degrees across the United Kingdom. The combination of these factors has exacerbated the demands placed on a severely overstretched and underfunded service.

7.2 Inevitably, we have heard from our CDS and PDS members of worsening morale and motivation in their roles because of unmanageable and unsustainable demand. Community dentists are passionate and dedicated to delivering excellent care for their patients, and their lack of capacity to deliver the standard of care they would wish to is itself harming morale. Our latest research has revealed further deeply concerning results regarding high levels of stress, and a subsequent inability to cope with workplace induced stress.

7.3 Failing to reverse the decline in the community dental workforce and address the systemic underfunding of NHS dentistry will see an unacceptable number of vulnerable patients unable to access the treatment they need to live well and free from pain; for too many, this is already a reality. Urgent action is therefore needed from decision makers to prevent the crisis from reaching the point of no return.

7.4 We welcome the DDRB's recognition of the challenges the CDS and PDS are facing in its 52nd annual report, as well as its reference to our CDS vision paper, which outlines the expansion of the CDS patient population, decline in NHS spend, the spillover of demand from the GDS, and the negative impact of short-term approaches to the commissioning of CDS services. At the same time, we maintain our significant disappointment regarding the lack of substantial evidence covering this crucial sector of the dental workforce within NHS England's, DHSC's and the Scottish Government's evidence submissions. It is completely unacceptable for health departments to simply refer to the existence of the service and provide no significant evidence on workforce trends, recruitment and retention. Sadly, this system wide lack of understanding, appreciation and recognition for the work of community dentists is one of the many contributing factors to their worsening morale and motivation. We have engaged with officials from NHS England and DHSC regarding our vision for the future of the CDS and have had early indications that there is some improved understanding of the workforce. However, it is critical that this year's evidence submissions from all health departments and NHS England fully informs the review bodies understanding of the workforce. This is particularly the case given the DDRB's stated intention to explore the workforce issues for this important service in more detail for 2025-26.

7.5 In this chapter we describe in detail UK wide trends and individual case studies in each of the four nations affecting the workforce across the CDS and PDS. This is informed by both quantitative data from the BDA's annual survey and qualitative data from throughout our representative structures.

**Workforce**

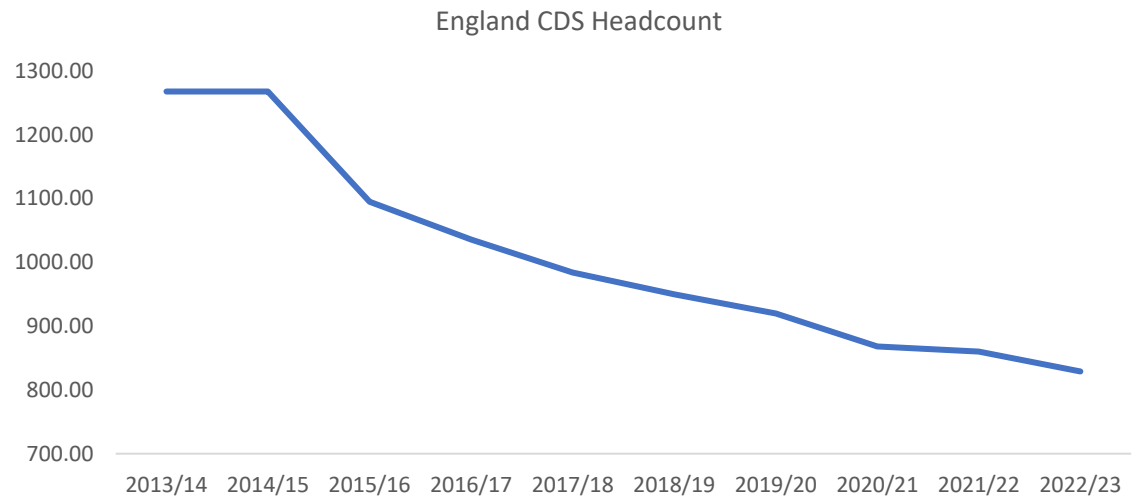


Fig 13: England CDS headcount. Sources: Health Departments and NHS Digital.

7.6 As illustrated in fig 13, the workforce in England has continued its decade long trajectory of decline. Given that a significant proportion of the workforce is comprised of dentists in the latter stages of their career it is likely that, without immediate, meaningful action to improve recruitment and retention, numbers will continue to fall. The BDA's 2024 survey of CDS/PDS members revealed that 25% of respondents were aged 55 and over. Further, 27% of respondents reported their intention to retire from dentistry within the next five years. As these senior, experienced dentists leave the service, the capacity of the workforce to train the future generation of CDS dentists will reduce significantly.

7.7 The sustained decline in headcount in England is coupled with high levels of vacancies across the service. In 2024, an FOIA request was submitted by the BDA to all organisations in England with a community dental service. Of the 43 organisations that responded, it was revealed that a total of 137 positions were vacant. The breakdown of vacancies by grade and role are shown in fig 14.

| Grade | Vacancy headcount |
|---|---|
| Band A | 76 |
| Band B | 28 |
| Band C Clinical | 22 |
| Band C Managerial | 1 |
| Band C Clinical/managerial | 5 |
| Other | 5 |

Fig 14: Headcount in England. Sources: FOIA received by the BDA

7.8 Based on data from those organisations which did respond, this total vacancy headcount amounts to 18% of the workforce. Given this significant vacancy rate, it is unsurprising that approximately 61% of survey respondents in England reported extreme concern over recruitment of staff.

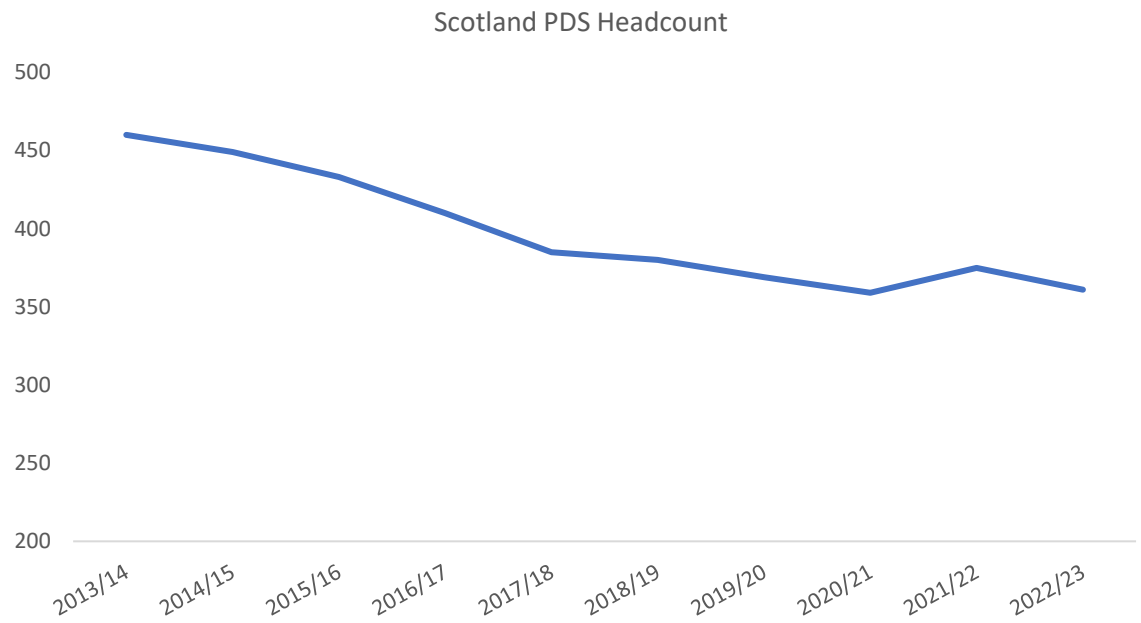


Fig 15: Scotland PDS headcount. Sources: Health Departments and NHS Digital.

7.9 The Scotland PDS combines the CDS and the Salaried General Dental Services in Scotland, playing a vital and unique role in treating patients who need specialised dental care and acting as a 'safety net' for patients who cannot access care within general dental practice. As in England, there has been a trend of PDS headcount decline over the course of the last decade; from 2013-2014 to 2022-23, the workforce has reduced by 21%.

7.10 Issues with recruitment to vacant posts were also mirrored in Scotland. Of the 14 organisations that responded to our FOIA request, 40 vacancies were reported, amounting to 11% of the total workforce. Furthermore, of all the vacant posts advertised between 6 April 2023 and 5 April 2024, only 49% of posts were filled. There is an indisputable recruitment crisis affecting the PDS, and evidence of the negative impact this has had on existing staff was evident throughout the written responses to our survey. An example of a response is provided below:

*"We are understaffed and under constant pressure to see as many patients as possible despite this. I feel that managers have forgotten what it is like to treat some very difficult uncooperative patients and think that we should be able to treat them as quickly as GDP's treat routine patients. I am only staying because of my pension"*, **Dental Officer, 16-20 years service, Scotland**

7.11 We continue to hold longstanding concerns regarding the persistent lack of data for the Wales CDS workforce. Even basic data, such as FTE staff numbers, are either unavailable or often inaccurate when provided. Without clear workforce data, and transparency of service delivery metrics from the health boards, the problems facing CDS cannot be effectively addressed. It is therefore vital that we establish a clear understanding of the current state of the CDS and monitor workforce trends moving forwards.

7.12 Despite the lack of official metric data, the BDA is aware, both from first-hand accounts and from its FOIA data, that the CDS in Wales is facing a recruitment and retention crisis. The service is experiencing widespread vacancies and increasing difficulties filling these roles. Of the seven organisations that responded to our FOIA request, 21 vacancies were reported, amounting to 16% of the total workforce. Of the 21 vacant posts advertised between 6 April 2023 and 5 April 2024, less than half were filled.

7.13 In Northern Ireland, the impact of poor staffing levels and its impact on morale was evident in responses to our survey of CDS dentists. 81% of respondents considered staffing to be a 'very negative'/'somewhat negative' influence on morale. Moreover, 50% of CDS dentists in Northern Ireland reported being 'extremely concerned' about staff availability and 63% of respondents were 'extremely concerned' about staff recruitment. Our FOIA request revealed that, in Northern Ireland, of the five vacant posts for CDS dentists advertised between 6 April 2023 – 5 April 2024, only one was filled. Current whole time equivalent numbers in relation to CDS dentist headcount can be found in fig 16.

| Grade | Headcount | Whole Time Equivalent |
|---|---|---|
| Community Dental Officer/Senior CDO | 79 | 61.43 |
| Director /Assistant Director of Community Dental | 5 | 4.40 |
| TOTAL | **83*** | **65.83** |

**nb. x1 individual is counted in both CDO/SCDO & Director/Assistant Director grades, so total does not total 84*
Fig 16: HRPTS as at 30 June 2024

7.14 It should also be noted that the lack of access to a pool of short-term locum cover for the CDS in NI adds to the impact on staff at a time of long delays in recruiting and backfilling posts.

7.15 The 52nd DDRB report stressed the need for workforce planning and other actions to be taken to improve working conditions. One year on, there is little evidence of any progress having been made to address staffing shortages and associated pressures in a Northern Ireland context. A *Skills for Health Workforce Review* for Dental Services in Northern Ireland[13], completed in 2018 but only published in 2023 stated that many of the then 92 CDS dentists were approaching retirement, with up to 40% approaching retirement by 2025. As a result, an additional 36 community dentists could be required by 2025, meaning a total number of 61 additional dentists to meet future demand.

7.16 The BDA find it unacceptable that no progress has been made on dental workforce planning for the Northern Ireland CDS so far as the Department of Health (Northern Ireland) taking strategic action to grow the overall headcount within the service. At a time when pressures on the service and its staff have never been greater, we find the continuation of this situation deeply unfair to the CDS and the patients they support. We have highlighted workforce issues over many years, including a lack of workforce planning, little to no career development/progression, and in particular, the lack of regional access to special care consultant services. We expect to see significantly improved levels of action from key decision makers in Northern Ireland to address these issues at the very time when pressures on the service are becoming intolerable and impacting on worsening staff morale and wellbeing.

[13] Skills for Health Workforce Review for Dental Services in Northern Ireland, August 2018 - Skills for Health

7.17 We note acknowledgment of recruitment difficulties by other stakeholders in their evidence submission for the 2023-24 DDRB round. NHS Employers highlighted that several employers had faced difficulties when trying to recruit to band A salaried dentists, with adverts active for long periods without any applicants, and the Association of Dental Groups said that there had been a noticeable drop in the number of applicants applying for CDS roles in recent years.

**Expanding patient population**

7.18 As highlighted at the start of this chapter, the overall trajectory of decline in the CDS/PDS workforce and difficulties with recruitment and retention is deeply concerning in the context of the expansion of the CDS/PDS patient cohort, especially considering the unique needs and vulnerabilities of those who fall into this demographic. This includes categories of patients who need dental services such as general anaesthetic (GA) or sedation, adults and children with physical or learning disabilities, severe anxiety, medical conditions, people who are housebound or live in care homes and people experiencing homelessness.

7.19 The UK's population continues to experience fundamental shifts in relation to its healthcare needs and, in the context of this chapter, its dental needs. The BMJ reported that one in five adults in England will be living with a major disease by 2040. In total there are over 11 million people aged 65 and above with multiple long-term conditions and in ten years' time this will have increased to 13 million people, 22% of the population. The Health Foundation has reported that the number of people living with major illness is projected to increase by 37%, over a third, by 2040, nine times the rate at which the working age population (20 to 69-year-olds) is expected to grow (4%). One million people in the UK have dementia and, according to a report by the Alzheimer's society[14], this figure is projected to rise to 1.4 million by 2040. The number of children with learning disabilities in the UK is already significant, with Mencap reporting that there are approximately 349,000 children aged 0-17 with a learning disability in the UK[15]. At present, there are also 700,000 autistic adults and children in the UK[16]. We therefore anticipate further, dramatic increases in demand from patients whose conditions will necessitate them needing treatment within the CDS/PDS.

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

7.21 In Scotland, payment reform of NHS dentistry from 1 November 2023 has had an impact across the whole dental system, including on the PDS. This impact must be evaluated by the Scottish Government and appropriate action taken to manage any adverse effects this may have on the PDS and its workforce. There is a fine balance to strike between the PDS providing a "*safety net dental service*" often for unregistered or emergency patients and its ability to have adequate capacity to provide dental care for core patient groups. Many dentists are concerned about the impact this is having on their ability to deliver timely care to patients from priority and vulnerable

[14] Facts for the media about dementia - Alzheimer's Society
[15] Children - research and statistics - Mencap
[16] Our vision, mission and values – National Autistic Society

groups.

**Waiting lists, unmet demand, and health inequalities**

7.22 The simultaneous trends of decreasing capacity and increasing demand for care have culminated in an access crisis within the CDS/PDS, both for primary care appointments and for treatment under GA.

7.23 Across the UK, we have consistently highlighted the shocking length of waiting lists for child and adult GA treatment and sedation, with reports of some patients having to wait over a year for treatment. Despite the BDA raising this issue over many years, very limited effort has been made by health departments to even disclose the scale of these backlogs, and the data is not captured within wider published NHS waiting list figures.

7.24 The reality of the suffering of patients that is underneath waiting list figures remains shockingly unaddressed. Many patients awaiting dental treatment under GA encounter severe pain and dental infections daily. A significant proportion of these patients are young children, with poor oral health impacting their ability to eat, speak, play, and socialise, and therefore impacting their development and performance at school.

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

7.26 We are aware that CDS/PDS dentists are struggling to balance the demand from patients requiring emergency treatment versus that of their core patients who should be recalled on a regular basis. CDS/PDS dentists are often being forced to prioritise one category of patient over another, especially in Scotland and Wales, where seeing unregistered, emergency patients is often a requirement There are consequent concerns that the CDS/PDS is not able to properly serve the vulnerable cohort that it was built for. The difficulty associated with striking this balance was described by a survey respondent working in Scotland:

*"We are not providing adequate care for the priority groups that we should be focusing on. The most vulnerable and voiceless in our society are not getting their needs met. We are struggling to fulfil the needs of the general population- getting routine treatment completed is near impossible and this is causing the amount of unscheduled care to dramatically increase. There is no extra capacity for NHS care, and only limited capacity for private care. The number of complaints entering the service is huge- mostly because patients can't access the service."* **Dental Officer, over 26 years of service, Scotland**

7.27 Our survey results indicate high levels of concern among the CDS/PDS workforce regarding their service's ability to provide care:

- 67% were slightly or extremely concerned about caring for paediatric patients.
- 75% were slightly or extremely concerned about caring for special care patients.
- 92% were slightly or extremely concerned about access to General Anaesthetic treatment for special care patients.

- 78% were slightly or extremely concerned about access to General Anaesthetic treatment for paediatric patients.

*"Intense pressure to reduce waiting lists. Insufficient staff and insufficient government investment to fulfil the needs of the population we serve/look after".* **Senior Dental Officer, 11 – 15 years of service, England**

**"***Increased demand (time, Patient complexity, etc.) feel we're providing a worse/more stretched service, cannot provide standard of care".* **Community Dental Officer, 6 – 10 years of service, Northern Ireland**

**Morale, motivation and wellbeing**

7.28 The impact of long waiting lists and overwhelming demand is having a predictable impact on the wellbeing of CDS/PDS dentists, as well as those they care for. Again, it is paramount to stress that this lack of capacity is a consequence of systemic underfunding in the NHS, and a failure to increase the CDS/PDS workforce at a rate that meets demand. In fact, our survey results show that many CDS/PDS dentist consistently work over and above their contracted hours. Over the past year, 54% felt obliged to work more than their weekly contracted hours 'once a week or more often'.

7.29 Responses to the BDA's 2024 survey show poor morale, motivation and wellbeing among CDS/PDS dentists. Factors that impacted on their wellbeing included increasing workload, increasing pressure, long waiting times, and insufficient staff numbers. This negatively impacted personal relationships, mental health, self-care and sleep, as well as leading to more serious consequences including suicide attempts. Many respondents described the working environment as toxic and relentless. Some had trouble switching off and felt run into the ground, tired, drained, overwhelmed, constantly worried, mentally exhausted, burnt out and unable to cope. NHS Employers highlighted in their own evidence to DDRB that burnout was a key theme in how employers described their salaried dentists in this service. Outlined below is a collection of results and written responses from our survey which convey the gravity of the situation:

- 82% described their workload as very high.
- 39% of respondents found their job either 'very stressful' or 'extremely stressful', with a further 42 % reporting moderate levels of stress.
- 32% of respondents disagreed or strongly disagreed that they could cope with the level of stress in their current job.
- In response to workplace stress, 44% of respondents reported blaming themselves for things that happened, 63% were 'learning to live with it' and 18.6% were 'giving up trying to deal with it'.

*"So much pressure from assessments like a conveyor belt, excessive notes to write up and paperwork to complete. Demanding patients and parents. Aggressive parents. Appointment to a fixed time limit which aren't long enough. Inhalation sedation patients booked one after another all day. Bureaucracy and demands from non clinical managers, with unrealistic expectations"* ***Senior Dental Officer, 6 – 10 years of service, England***

7.30 We are also deeply saddened to learn of CDS/PDS dentists facing incidences of abuse from patients and their relatives/carers within the workplace, which we understand in many cases to be the result of frustrations that have built due to difficulty accessing treatment in an appropriate timeframe.

- In the last 12 months, 34% of respondents had experienced physical violence from patients, their relatives, or other members of the public while at their workplace or conducting their work.
- 91% had experienced aggressive or demanding behaviour over the same period.
- 64% had experienced verbal abuse over the same period.

7.31 We have highlighted these alarming issues in previous submissions. It is unacceptable that CDS/PDS dentists are required to work in an environment that has such a detrimental impact on their mental and physical wellbeing. Action is needed without delay for the health of CDS/PDS dentists and their patients alike.

**Job satisfaction and remuneration**

7.32 Although only part of the solution to the crisis facing the CDS and PDS, it is essential that CDS/PDS dentists are well remunerated for their critical work if we are to reverse the tide of workforce decline and safeguard the future of the service. Dissatisfaction with pay, and job dissatisfaction more broadly, was a key theme identified in our survey responses. Furthermore, at our 2023 CDS Accredited Representative Conference, grass roots members voted in favour of considering industrial action as a means of securing improved pay for CDS dentists. Although the BDA's community dental service committees representing CDS opted to explore other means of improving pay before proceeding to an industrial action ballot, that this motion was passed illustrates the strength of feeling on the frontline that fairer remuneration is desperately needed. There is no certainty that our members working in this service will not return to this option if the many years of pay erosion is not urgently addressed.

7.33 In England, satisfaction with pay levels are concerningly low, with the majority of respondents disagreeing or strongly disagreeing that their pay was fair. Job satisfaction was also low, with more than half of respondents disagreeing or strongly disagreeing that they were satisfied with their working environments. When asked about the motivating factors behind their decrease in job satisfaction, one CDS member reported the following:

*"Working conditions not improving, lack of decent pay increases in line with inflation, opportunities for flexible working nil, lack of support for carers in NHS despite women making up majority of workforce"*. **Senior Dental Officer, 16 – 20 years of service, England**

7.34 In Scotland, poor rates of job and pay satisfaction were also evident in the qualitative and quantitative findings of our survey of PDS dentists. Almost two thirds of respondents (65%) did not believe that their pay was fair and nearly half (43.9%) were not satisfied with their terms and conditions.

*"No clear career progression, pay is poor, management expecting us to do more including working in an out of hours service, which hasn't increased pay in over 10 years. Poor communication from higher management in NHS."* **Dental Officer, 16-20 years service, Scotland**

7.35 It is imperative that this group of dentists feels valued. Any further destabilisation of this specialised and specialist workforce could have a significant impact on the already widening health inequalities in Scotland.

*"Overwhelmed by the quantity of work. Feeling vastly underappreciated by the politicians and blamed for their failings. There are too few of us and the salary is so low that it seems unlikely there will be any change in staffing levels unless there is some change to recognise us and the important work we do!"* **Dental Officer, 0-5 years service, Scotland**

7.36 In Northern Ireland, more than half of survey respondents strongly disagreed or disagreed that their pay was fair. While there are clearly other considerable underlying issues, pay dissatisfaction and a growing sense of pay inequity has emerged as a particular issue within the CDS in Northern Ireland. CDS dentists are increasingly dissatisfied with their pay, not least as they make comparisons with higher awards made to dental colleagues working in other parts of the dental sector, and at a time when private earnings in Northern Ireland have been growing, CDS pay has failed to keep pace at a time of cost-of-living increases.

7.37 The considerable delay in pay uplifts being applied in Northern Ireland continues to impact negatively on staff morale. Indeed, the 2023-24 DDRB pay recommendations were not paid until June 2024; moreover, at time of writing there is still no clear indication of what the pay uplift will be in Northern Ireland, or when it will be paid in relation to the 2024-25 uplift. This is simply not fair, and perpetuates the damaging impact on morale, recruitment, and retention.

7.38 It should also be noted that pay for CDS dentists working in in Northern Ireland is lower than in the other nations. For instance, a Community Dental Officer starting salary of £47,655 in Northern Ireland compares unfavourably with £50,512 in England. We welcome the acknowledgement of pay disparity in the DDRB 52nd Report, which stated that '*Differences in pay and conditions between the nations of the UK had grown wider and CDS posts in NI needed to have parity with rest of the UK to attract new staff and to encourage retention of existing staff by enhancing career progression, increasing the number of senior posts, training pathways and specialist grades.*'

7.39 In Wales, overall job dissatisfaction and dissatisfaction with pay was, again, evident in the responses to our survey this year. 47% of respondents disagreed or strongly disagreed that their pay was fair, and the same percentage disagreed or strongly disagreed that they were satisfied with their working environment.

**Conclusion**

7.40 We welcomed the DDRB's recognition in its last report of the critical issues of rising workloads, falling staff numbers, and worsening morale in the Community and Public Dental Services. Our evidence demonstrates clearly that the situation continues to deteriorate. The root cause of the crisis facing the CDS and PDS is multifactorial, and further work is needed from Government to better understand the extraordinary pressure faced by these vital services as well as action to address those pressures. Our survey data makes clear, however, that an above inflation pay award for all NHS dentists including the CDS is one crucial aspect of a wider package of measures that must be taken to ensure access to dental services for the most vulnerable patients. Action is now desperately needed to safeguard the future of the service.

## Chapter 8 – Ministry of Defence Dentists

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

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

8.3 Data from October 2024 suggests that there are 103 MOD Dentists working within the DMS, all in patient facing roles. This headcount is slightly reduced from 2023 due to a recent moratorium on CS recruitment. Total headcount for MOD Dentists would be expected to be in the region of 110 while there are approximately 140 regular, uniformed, AF dentists[17]. Uniformed dentists are more often tasked with the administrative/managerial/strategic roles due to a defined career structure. This can divert them away from clinical delivery with some employed outside of clinical dentistry either on a FT or Part Time (PT) basis.

8.4 Currently 62 MOD Dentists are FT (37hrs per week) and 41 are PT (varies between 8 and 36hrs per week). These latter 41 dentists equate to almost 25 FTE. 52% of MOD Dentists identify as she/her/hers while 48% identify as he/him/his. Around 30% of MOD Dentists previously served in the AF and can enhance pay with an AF Pension. For this group the pension supplement significantly helps competitiveness to work within the DMS, but this resource cannot be relied on to continue in the future.

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

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

8.7 Despite benefitting from DDRB pay awards, MOD Dentist salaries continue to significantly lag behind those of their military colleagues even after adjustment for X-Factor (An addition to military pay that recognises the special conditions of the AF compared with civilian peers). After decades of pay restraint, available salaries for both groups are now falling considerably behind the national employment market rates in most age-matched cohorts. However, this difference is greater for the MOD Dentist cadre who are often expected to cover for their uniformed colleagues despite fewer opportunities for either reward or recognition and with much reduced career prospects in comparison.

8.8 The recruitment landscape is changing with the overall dental workforce diminishing due to several factors including national workforce shortages and movement into the private sector. This has been amplified by the moratorium on recruitment in the MOD which has deleteriously impacted on the available workforce to deliver oral healthcare. Both the Civil Service People Survey and the Armed Forces Continued Attitude Survey confirm the experiences of the MOD Dentist with increasing workload, decreasing morale and reduced well-being. The CS must ensure that recruitment and retention remain competitive to enable operational preparedness of military personnel in the current political world climate.

8.9 It was concerning that in 2024 neither PROSPECT nor the BDA were consulted by the MOD on the proposed pay award for MOD Dentists and the delay in both notification and implementing the 2024 pay award until November 24 was unsatisfactory. It was also disappointing that no

[17] Armed Forces and Ministry of Defence: Dental Services: Question for Ministry of Defence - UK Parliament

mention was made of MOD Dentists within the DDRB 52nd Report 2024.

8.10 As for all other cohorts, last year's pay award in isolation is insufficient to deal with the consequences of pay erosion and must be followed by further above-inflation uplifts. MOD Dentists are experiencing increasing workload with resultant decreasing morale. This is due to recruitment and retention challenges and inadequate reward and recognition. The MOD Dentist Pay Scales need to be reviewed and updated with more transparency regarding their origin and associated comparators. MOD Dentists should have an established career structure making it possible for career progression and competition for appropriate clinical and non-clinical roles throughout the DMS akin to their uniformed colleagues.

## 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. While each country of the UK sets its own pay policy and timelines for implementation, the late implementation of pay awards and the different interpretation of how the parity with UCEA pay scales are applied continues to impact adversely on the dental academic workforce who see their remuneration falling further behind their peers across the rest of the UK.

On the clinical dental academic workforce four key themes have been identified as follows:
9.2 **Staffing, workload and retention of workforce:** Reductions in staff being employed for teaching undergraduate dentistry has been widely reported by respondents to this year's survey of BDA members. Losing colleagues across academic departments in universities has led to increased workload, impacting both on the quality of teaching and having an adverse impact on colleagues' mental health. In the last year 80% (last year 72%) of respondents indicated that they were concerned with their current workload and from this group 40% (last year 37%) were extremely concerned. Further frustrations were expressed on the renumeration applied relative to years of training and seniority which then impacted negatively on levels of retention. Respondents to our survey highlighted that clinical academia was becoming ever less attractive as a career option for dentists, and the increased workload pressures due to the reductions in staffing were only exacerbating this trend. With the new Government in Westminster placing an emphasis on improving access to NHS dental care for people who need it, it is vital that there is sufficient capacity in place to cater for an increase in the supply of undergraduate dentists. In our survey this year 73% of respondents said they were concerned regarding their capacity to take on more undergraduate students. A significant proportion of the workforce were potentially approaching retirement with 55% of respondents being aged 55 or over. Recruitment to senior positions was widely reported as being difficult, and funding was reducing whilst demand had increased substantially.

9.3 **Workplace culture:** Respondents noted the increasing lack of recognition of their professional qualifications, and engagement from their employers. Many described the impact of limited communications with dental academics, with a perception they were not valued within the wider university. There was also a gradual loss of autonomy, and steady erosion of previous opportunities for career progression. Some respondents felt this was an important factor in making their working environment increasingly stressful. These challenges were reflected in our survey which showed more than 27% of dental academics found their job very or extremely stressful.

9.4 The overall total reward package (including pensions) has been steadily eroded for dental academics and this is impacting directly on the workforce. The BDA once again needs to highlight the critical issue of equivalence of remuneration levels to NHS Consultants terms and conditions

of service. It is vital that the review body understand the need to encourage and incentivise qualified dentists to consider academia as a potential career to deliver high quality education for the dentists of the future. If the dental educator workforce does not increase in capacity to match this demand, it is likely that the existing workforce will simply become even more overstretched. This is particularly important considering the projections of the NHS Long-term Workforce Plan, including the planned expansion of dental training places. Incentivising more dentists to join academia is needed urgently to ensure there is sufficient capacity to support undergraduates studying dentistry.

## Hospital dentists

9.5 The British Medical Association provides evidence for doctors and dentists based in hospital services. The BDA's evidence on hospital dental services is informed by our annual survey of dentists working in hospital settings and is complementary to the BMA evidence submission, and should be read as such.

### Pay and the recent disputes with Governments in each of the nations

9.6 The frustration of hospital dentists experiencing many years of below inflation uplifts in pay led many to join their medical colleagues in taking organised industrial action at NHS trusts. Although we acknowledge that addressing industrial action is not within the remit of the DDRB, it is essential that the learning is taken from the various disputes so doctors and dentists based in hospitals across all four nations can regain confidence in the wider pay setting process. For far too long, pay has been eroded, with unacceptable impacts on the workforce, and ultimately service delivery. Although the disputes in England and Wales have been resolved for the immediate future, some remain within the devolved nations, for example in Northern Ireland for trainee dentists, and SAS dentists. In Northern Ireland, Hospital dentists have endured over 10 years of pay erosion, also contending with unfair pay scales versus awards in other nations and pay uplifts being implemented much later than in the other nations. In our survey approximately 55% reported vacancies in their teams. The BDA calls for a pay uplift that addresses the scale of the challenge, and the urgent need to incentivise dentists to join or be retained within hospital dentistry teams.

9.7 **Culture and morale:** Our survey of hospital dentists found evidence of poor morale and culture, combined with high workloads and concerns about staffing. Less than half of respondents in our survey were satisfied with their working environment. Many employers did not listen or engage with staff and that had led to demotivation. Respondents reported a sense of apathy, and they were often presented with a choice to "*put up or shut up*". This made the workplace unnecessarily stressful and impaired the quality of care. Factors such as wondering if study leave would or would not be paid for was stressful. Working conditions were not seen to be improving and innovation was described as being difficult and complex. 40% of hospital dentist survey respondents said their job satisfaction had deteriorated compared to this time last year. A quarter described their morale as low, and almost 40% said their morale had decreased in the last year.

9.8 **Workload and staffing:** As with the wider dental profession, our members in the hospital dental services across the UK report significant workload strain. Overall, in our survey hospital dentists said they felt their workload was unmanagable. Less than 20% felt that their workload was at the right level. Resignations and staff changes saw low staffing levels and reduced clinical capacity. Recruitment difficulties were reported, with high staff turnover. Hospital dentists in some specialties are seeing patients with more acute problems who are presenting later due to the difficulties accessing general dental services. One respondent in our survey described this as like *"fighting a rising tide of need with no additional support*". Over 45% of respondents said their service was not meeting the needs of patients. Service pressure had increased over the last year with targets being seen as meaningless. Waiting lists and referrals were increasing, and theatre time had been lost over the year with poor IT infrastructure also having an effect. Hospital

dentists reported an assumption by many employers that overtime would be worked for free until the task was done. This had knock on effects such as affecting the provision of critical training for hospital dental trainees. There was a perception that many employers did not listen to suggestions as to how services could be improved. Less than half of respondents to our survey felt they could recommend a career in hospital dentistry.

**Lack of parity between the four nations for hospital dentists**

9.9 The BDA wishes to raise the issue of pay scales for hospital dentists in post within Northern Ireland compared to their colleagues in England. The pay differentials that exist between hospital dentists in Northern Ireland and their counterparts means that vacancy rates remain unjustifiably high, making Northern Ireland an unattractive place to be located and therefore work is still required to address pay erosion and the contractual issue of pay protection. The BDA are also concerned at the significant variations in levels of dental workforce planning across the nations which is in turn directly impacting on services to patients. Although nation specific reviews are taking place, there appears to be no dedicated wider planning process covering the provision of hospital dentistry.

## Chapter 10 – Our recommendations

10.1 **We ask that the DDRB recommends an overall uplift to all NHS GDS contracts, fees and allowances of 11.5% to ensure that a real-terms increase in take-home pay is delivered for GDPs. This includes a 9.2% uplift in GDP pay.** Given the failure of previous approaches to deliver real-terms pay increases, we continue to believe a recommendation from the DDRB that reflects operating costs in dentistry is essential to tackling the ongoing crisis in the recruitment, retention, morale and motivation of dentists, and the resulting crisis in the availability and delivery of NHS dental services.

10.2 **We ask that the DDRB recommends a pay uplift of 9.2% for employed dentists to attract and retain a sustainable NHS workforce.** Employed dentists have faced more than a decade of ever-increasing workloads and continue to experience increases in demand for services, longer waiting lists, and poor morale. It is wholly inappropriate to ask dentists working with some of the most vulnerable patients to make a de facto choice between their own well-being, and the well-being of their patients. Similarly, 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.

10.3 **We call for a timetable for the pay review process that will restore its credibility.** We welcomed the DDRB's repeated acknowledgement in recent reports that a pay review process that is respected by Government is vital. We also welcome the DDRB's request for earlier written evidence in the process this year. However, we again stress the impact of delays on the overall morale of those delivering care. In addition, given the material impact delays to the implementation of the pay award has on the financial sustainability of dental practices, we ask the DDRB to strongly recommend that the 2025-26 pay award should be implemented on 1 April 2025 to avoid erosion of its value.

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

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

10.6 **We 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.

10.7 **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.**

10.8 **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.