Evidence to the Review Body on Doctors’ and Dentists’ Remuneration for 2020-21

January 2020
Contents

Chapter 1 - Executive summary ................................................................. 3
Chapter 2 - About the BDA ...................................................................... 3
Chapter 3 - BDA response to the 47th report ....................................... 4
Chapter 4 – Financial and economic landscape for dentistry ............... 7
Chapter 5 – Challenges facing dentistry across the UK ...................... 10
Chapter 6 – Recruitment and retention, morale and motivation in general dental practice .................... 16
Chapter 7 – Sustainability of Community/Public dental services .......... 20
Chapter 8 – Sustainability of clinical academic staff ........................... 26
Chapter 9 - Our recommendations ......................................................... 28
Chapter 1 - Executive summary

1.1. Given the appalling state of recruitment and retention, morale and motivation across the dental profession and all our branches of practice, we ask the Review Body to recommend a pay uplift of at least 5 per cent to attract dentists to work in the NHS and retain those who are currently there. A clear and bold statement of intent must be sent to a battle-weary profession.

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

1.3. A decade of below inflation pay awards, worsening of terms and conditions, increased punitive scrutiny and probity combined with the ever-increasing pension contributions and restrictive annual/lifetime allowance has meant the NHS/HS dental workforce is under profound strain.

1.4. In addition, all dentists have suffered from repeated delays to below inflation uplifts.

1.5. In Northern Ireland particularly, the 12-month plus delays to pay uplifts in recent years has resulted in the lowest levels of morale in the UK. In an effort to address the unsustainable impact of continued lengthy delays to annual regional pay uplifts, the BDA requests that the DDRB states clearly that these delays are unacceptable and places a time constraint on the Northern Ireland Department of Health by recommending that the Department implement the 2020/21 pay award within three months of publication.

1.6. The sustainability of NHS/HS dentistry is on a knife edge. Our evidence this year details where we believe the focus for NHS dentistry should be to ensure that dentists once again believe that NHS dentistry is sustainable. People, pay and patients are at the centre of our evidence. The Health Departments across the UK must understand that people are the mainstay of the NHS/HS. The people who work across the service be they employed or self-employed are the NHS/HS. The pay element is crucial to making the service an attractive place to build a career. Finally, patients deserve better than a service that is crumbling (propped up by thinning goodwill) and in many parts of the UK unable to provide adequate NHS/HS care.

1.7. We continue to oppose targeting as we do not believe that it has any value in this process.

Chapter 2 - About the BDA

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

2.2. Every year the BDA provides evidence to the DDRB covering general dental practitioners, community dentists and clinical academic staff. References in this report to the NHS should also be taken to apply to the Health Service in Northern Ireland unless indicated otherwise in the text. For community dental services across the UK we refer to CDS in this evidence except for Scotland, where the service is called the ‘Public Dental Service’ or PDS.

2.3. The BMA provides evidence to the DDRB on behalf of our hospital members as part of their evidence submission because the NHS terms and conditions are the same for employed hospital dentists as they are for hospital doctors. Where we do supply evidence, this is for supplementary reasons around specific issues.

2.4. This year, we have chosen to streamline our data gathering process and we will be moving towards a biennial data collection exercise on recruitment and retention, morale and motivation. As a result, we will not provide BDA primary research in as much detail in this year’s evidence.
Chapter 3 - BDA response to the 47th report

3.1 Despite the DDRB recommendation of 2.5 per cent on pay which was the biggest recommendation in recent years and exceeded (CPI) inflation, the profession is still struggling. The award offered remained less than what we had asked for. We agree with the Review Body comment that “a long period of real-terms pay decline over the last decade is starting to have a significant negative impact” however we need real change and real pay increases to reverse the institutional decline.

3.2 As in previous years we remain opposed to targeting as we do not believe that it has any value in this process. We still strongly believe that the Review Body should recommend a pay uplift for all its remit groups and that targeting would have a detrimental effect on morale, motivation and retention. We do not support the targeting of awards between countries. GDPs in all four countries have experienced similar reductions in taxable income and should receive the same pay uplift. There is no difference in recruitment and retention issues for community dentists and public dental service dentists in each of the countries and we do not wish to create any more differences in pay between the four countries than have been created by different uplifts and pay increases in the last few years.

3.3 NHS England and Health Boards in Wales are already able to target contracts and spending to areas where new dental services are needed, so additional targeting of spending is unnecessary. Targeting rises away from dentistry will only underline the lack of value placed on dentistry thus further eroding the desire of dentists to work in the NHS system.

3.4 We also repeat that if the Review Body as to target resources away from dentists and towards GPs in England for example, this would ignore the very significant resources put into GP services by NHS England and it would ignore the evidence of increasing recruitment and retention issues for dentists that we continue to provide in our evidence.

Delays in uplift implementation across the UK

3.5 Delays in implementing uplifts is now commonplace from the four Departments of Health and completely unacceptable.

3.6 Normalising late uplifts to SDRs in Scotland and Northern Ireland and SFEs in England and Wales is an unacceptable precedent. We have expressed our concerns to the Review Body directly and to HM Treasury. Unfortunately, it does not seem within any organisation’s gift to ensure the Review Body has enough time to deliberate and assess the evidence and still provide hardworking NHS/HS staff and contractors with a pay uplift in a timely manner. You will find a copy of our correspondence and replies in appendix C.

3.7 For England and Wales, the lateness of awards means that when uplifts on contract values are being paid late into the financial year, practices find it extremely difficult to provide back pay to dentists who may no longer be engaged at the practice or staff who have left. Foundation Dentists who leave practices at the end of August potentially also lose out if the practice is unable to contact them.

3.8 We provide below an outline of the delays across the UK. Whilst we appreciate that many of the Pay Review Bodies are also reporting late into the financial year – a concerted effort must be made to ensure that all the pay review body professions are given timely uplifts. The dental profession must start to see timely uplifts.

3.9 The graph below outlines the length of delay in each of the four UK countries.
<table>
<thead>
<tr>
<th>Year</th>
<th>NI</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
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<tr>
<td></td>
<td>8 months + counting</td>
<td>7 months</td>
<td>4 months</td>
<td>7 months</td>
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<tr>
<td>2018/19</td>
<td>August 2019</td>
<td>December 2018</td>
<td>November 2018</td>
<td>December 2018</td>
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<td></td>
<td>16 months</td>
<td>8 months</td>
<td>7 months</td>
<td>8 months</td>
</tr>
<tr>
<td>2017/18</td>
<td>July 2018</td>
<td>August 2017</td>
<td>April 2017</td>
<td>May 2017</td>
</tr>
<tr>
<td></td>
<td>15 months</td>
<td>4 months</td>
<td>0 months</td>
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<td></td>
<td>12 months</td>
<td>2 months</td>
<td>0 months</td>
<td>2 months</td>
</tr>
<tr>
<td>2015/16*</td>
<td>No uplift</td>
<td>August 2015</td>
<td>April 2015</td>
<td>August 2015</td>
</tr>
<tr>
<td></td>
<td>10 months</td>
<td>4 months</td>
<td>0 months</td>
<td>4 months</td>
</tr>
</tbody>
</table>

Figure 1. Implementation date of the pay uplift and the delay across the UK

**England**

3.10 In England – contractors saw a 2.42 per cent uplift on contract values. The Department of Health and Social Care again used CPI for non-staff expenses uplifts and 2.5 per cent for staff expenses. Employed dentists had the salary scale uplifted by 2.5 per cent, however, for CDS staff working in social enterprises or community interest companies on matched NHS terms and conditions this uplift is not guaranteed to be paid onto staff. This is because like GDP contractors, the uplift is paid to the contract holder to determine how this is distributed. While there is the assumption that the full pay uplift element will be passed on this is by no means guaranteed in these tight financial circumstances. Across England this has been honoured to date in the CDS.

3.11 In response to the Review Body question about the "widely differing picture of dentistry as presented by the parties" we do not understand why NHS England have failed to acknowledge in its evidence the scale of this problem of recruitment and retention. Year on year we present NHS England data in our evidence yet their evidence contradicts their own figures. What we can say is that unless something drastic happens NHS England will have overseen the decline of NHS dentistry as we know it in England. What we want is for them to acknowledge the problem properly and work with us to turn things around. DDRB uplifts have a significant part to play in making the NHS a financially attractive place to work, in England and across the rest of the UK.

**Scotland**
3.12 Following publication of the 47th Report in July, we issued a press release calling on the Scottish Government to: accept the DDRB recommendation; award at least 3 per cent for expenses; introduce the overall pay uplifts as soon as possible; and backdate them to April 2019.

3.13 In late August, the Scottish Government announced that it had accepted the DDRB recommendation for GDPs in 2019/20 of a 2.5 per cent increase in pay, and also awarded 2.5 per cent for expenses. These uplifts were backdated to 1 April 2019. We subsequently issued a further press release expressing our disappointment that the Scottish Government had not awarded at least 3 per cent for expenses.

3.14 We were disappointed that the Scottish Government decided not to increase the General Dental Practice Allowance or raise the prior approval limit this year. The Scottish Government has indicated that it will review these items every three years. This means that GDPs face a real-terms cut in these items this year.

3.15 BDA Scotland and the Scottish Government jointly developed a user-friendly template to gather expenses information from NHS dental practices. The template was issued in May but despite promotion by the BDA and Scottish Government, less than 20 responses were received. BDA Scotland and the Scottish Government have agreed to issue the same template in 2020 but with increased promotion to encourage a higher response rate from dentists.

3.16 In August, the Scottish Government announced that hospital dental staff, Public Dental Service staff and dental training grades would all receive a 2.5 per cent uplift to basic pay for 2019/20 (backdated to 1 April). While this follows the DDRB recommendation, these NHS staff will receive less than the 3 per cent awarded to NHS Agenda for Change staff in Scotland.

Wales

3.17 In Wales, Welsh contractors have recently seen a national uplift of 2.5 per cent to gross contract values for GDPs. CDS dentists will also have seen pay increases of 2.5 per cent.

Spotlight on Northern Ireland

3.18 At the time of writing, Northern Ireland is the only UK country where the 2019/20 pay uplift has not yet been offered. This was expected, though not welcomed, as the NI Department of Health takes on average 13 months to implement dental pay uplift awards. As these delays predate the collapse of the NI Executive between January 2017 and January 2020, they cannot be blamed solely on a lack of Executive ministers and therefore reflect an institutional failure.

3.19 Awards in Northern Ireland now regularly slip into the next financial year. The 2018/19 award was not fully implemented until August 2019 – a 16-month delay – and the 2017/18 award was not implemented until July 2018 – a 15-month delay. Systemic year-long delays devalue the pay uplift in the eyes of practitioners and significantly reduce their positive impact on morale. Delays which recently resulted in NI Community Dental Services receiving their 2018/19 pay award after their Welsh colleagues received their 2019/20 award.

3.20 From next year, the NI Executive intends to set regional Public Sector Pay Policy at the same time as the annual Executive budget – potentially reducing delays by moving the publication date forward six months. However, unless there is a significant effort to address this issue, the Department of Health will continue to struggle to avoid delays due to the impact of the previous years’ delay.

3.21 To address this unsustainable situation, the BDA requests that the DDRB states clearly that these delays are unacceptable and places a time constraint on the Northern Ireland Department of
Health by recommending that the Department implement the 2020/21 pay award within three months of publication.

3.22 Systemic delays and below inflation pay awards have rendered GDP earnings unable to keep pace with the rising cost of staff and materials. Inflation rarely remains flat over the average 13-month period required for a pay uplift to be implemented in Northern Ireland. As such, by the time a pay uplift is implemented, it is largely negated by inflation. For example, RPI increased by 2.6 per cent in the year up to August 2019 – just shy of the value of the final 2018/19 pay uplift (2.73 per cent) when it was implemented in August. Figure 2, below, demonstrates how delays, and a year with no uplift at all, has left pay growth running significantly below inflation and regional median salary growth.

![Pay uplifts versus inflation](image)

**Fig 2: Pay uplifts (adjusted for delays) in comparison to inflation (Northern Ireland)**

Chapter 4 – Financial and economic landscape for dentistry

4.1 The picture has not changed for the better since last year and the situation remains dire. The UK data from NHS Digital shows a frustratingly similar picture from that which we described last year in our evidence. 2018/19 data from the four Departments of Health shows that the UK gross spend on dentistry in nominal terms is ‘flatlining’ but in real terms has fallen dramatically.

![UK gross spend on GDS/PDS](image)

**Fig 3: UK gross spend on GDS/PDS Accounts from Departments of Health**
Spotlight on England

4.2 Of note when discussing the gross spend on NHS dentistry for England is the Government policy of increasing patient charges for treatment year on year. In the cash limited system in England created in 2006, patient charges now account for 30.7 per cent of the overall (declining) spend in England. In 2005/06, patient charge revenue was £410m and in 2018/19 PCR now stands at £856m. The cash limited healthcare system restricts supply against the demand for care. Patient charges, which are billed as a contribution towards the cost of care, have morphed into a substitute for direct state investment as we have previously described. The Government needs to be honest on whether the scale of this shift represents a deliberate and sustained strategy.

4.3 This current spend only enables half\(^1\) of the population in England access to care. Even serving that limited population, there is a lack of clarity for both patients and dentists about what is available from NHS dentistry. Current funding cannot provide a truly ‘comprehensive’ service in either scale or scope. This chronic underinvestment needs to be remedied, but without recourse to higher patient charges given the barriers that costs represent to lower income patients.

Scotland

4.4 The Scottish Government’s Budget for 2019/20 stated that funding for the General Dental Services would increase by 0.4 per cent (from £414.8 million to £416.6 million) between 2018/19 to 2019/20. With inflation currently around 2 per cent, this nominal budget represents a real-terms reduction in funding for NHS dentistry in Scotland. While the overall cost of providing GDS and the PDS increased by £11.8 million (2.9 per cent) in 2018/19 compared with 2017/18, PDS funding decreased by £1.8 million (3.6 per cent) during this period. This continued reduction in PDS funding has led to concerns about the future of the service and the impact on vulnerable patient groups.

Northern Ireland

4.5 The NI Department of Health contribution towards General Dental Services has fallen by £5 million between 2013/14 and 2017/18 – a 4.8 per cent fall. However, during that period, total patient registrations in Northern Ireland rose by 4.8%. This has resulted in a significant £8.28 (9.3 per cent) decline in per patient funding.

Population growth

4.6 The Review Body will be well aware of the overall UK population growth argument we made last year which has not changed, nor has the ageing population or the growing realisation that care of older people is becoming a critical priority for all four UK countries. We discuss this issue in more detail in chapter 5 but to meet the challenges of elderly care, reducing health inequalities the workforce needs investment to deliver this.

Taxable earnings

4.7 Across the UK there is a dramatic fall in net profitability in both nominal and real terms for high street dentists. Across both practice owners and associates in the UK there has been a fall overall since the base year of 2008/09 and since 2006/07 for England and Wales.

\(^1\) NHS Dental Statistics for England 2018-19 Annual Report (Table 4a)
4.8 The table below shows the base years and the most recent data for comparison in nominal and real terms (adjusted for inflation using RPI).

<table>
<thead>
<tr>
<th>Practice owner taxable income (nominal)</th>
<th>Associate taxable income (nominal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England &amp; Wales</td>
<td>£134,827</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>£129,600</td>
</tr>
<tr>
<td>Scotland</td>
<td>£118,700</td>
</tr>
</tbody>
</table>

Fig 4: Taxable income taken from NHS Digital Earnings and Expenses
NB Wales only data is available

4.9 Adjusting for inflation using RPI, practice owners have seen a massive decrease in taxable income in real terms across the UK. Since 2006/07 England and Wales practice owners have seen a 37 per cent decrease (30 per cent since 2008/09). In Scotland the real terms decrease since 2008/09 has been 29 per cent and in Northern Ireland it has been a 30 per cent decrease. In real terms, the pay cut continues.

4.10 Adjusting for inflation using RPI, associates have seen similar levels of decrease of taxable income in real terms. Since 2006/07 England and Wales associates have seen a 37 per cent decrease (31 per cent since 2008/09). In Scotland the real terms decrease since 2008/09 has been 35 per cent and in Northern Ireland has been a 39 per cent decrease. In real terms, the pay cut continues for all dentists.

4.11 Usually the most committed NHS/HS dentists are those which can expect to see the lowest return.

4.12 It should be noted here that the vast majority of dentists delivering NHS/HS dentistry are associates, making up 72 per cent of the dentist workforce across the UK with practice owners declining to only 13 per cent. Net profit/taxable income is dropping year on year. As described in real terms, the earnings of an associate across the UK are slim having significant implications for the workforce and recruitment and retention. Morale and motivation are also severely impacted by this across all four countries.

4.13 It is for reasons of finance that there are very real fears that NHS/HS dentistry is no longer sustainable by the profession.

Northern Ireland

4.14 GDP earnings per day between 2012-13 and 2017-18 have failed to match the expected growth resulting from annual pay uplifts awards.

4.15 Principal GDPS committing more than 75 per cent of the time to NHS dentistry, have seen their earnings per day fall slightly from £746.68 in 2012/13 to £743.84 in 2017/18 - £43.90 below where they should be if earnings per day had matched pay award growth.

4.16 Associate GDPS committing more than 75 per cent of the time to NHS dentistry, have seen their earnings per day fall from £381.66 in 2012/13 to £363.81 in 2017/18 - £38.84 below where they should be if earnings per day had matched pay award growth3.

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2 NHS digital dental earnings and expenses data from all years.
3 Values derived by combining NHS Digital earnings and working hours data sets. A day has been calculated allowing for 37.5 hours per working day and 232 working days per year (4 weeks annual leave & 8 bank holidays)
4.17 Earnings are tracking below annual pay awards due to the delays to pay uplifts and the fact GDPs are being forced to spend a greater proportion of their time on unremunerated administrative tasks (See chapter 5).

Chapter 5 – Challenges facing dentistry across the UK

5.1 With spend going down, patient charges going up, fear of litigation increasing and NHS claiming because of fear declining – the sustainability of the service is not guaranteed.

UK

5.2 The number of dentists on the GDC register have continued to rise steadily since 2013. It is widely understood that there is not a lack of dentists, but there is a lack of dentists willing to work full-time or at all in the NHS, particularly in England. This picture is mirrored in the numbers of dentists with a performer number listed on the national performers list. What these numbers don’t tell us is that fewer and fewer are choosing to work full time in NHS dentistry. While whole time or full-time equivalent data are not available the full picture is masked and the scale of the problem, is potentially under-estimated because of the lack of information on whole time equivalent dentists.

5.3 In our survey to BDA members in 2019 we asked people to rank their concerns on several policy issues across the UK. Whilst individuals could select more than one issue, unsurprisingly a fear of complaints and litigation from patients topped the list with only 2 per cent having no anxiety at all. In fact, 38 per cent reported they were extremely anxious about this. The second highest ranked issue was fear of the regulator. Only 5 per cent reported they were not anxious at all whereas over half of respondents were very or extremely anxious. Dentists are worried about being pursued by patients and the regulator which we believe is driving many younger dentists to work many fewer days in the NHS and face less exposure to patients.

5.4 In 2017 and again in 2018, GDC data shows that 50 per cent of the dental population is now under 40 years old. Younger dentists are embroiled in this climate of fear facing healthcare professionals across the NHS. For younger dentists not used to working in this environment, the writing of copious clinical notes for pre-empting any litigious claim or scrutiny is taking time away from patient care and pushing half of the profession towards excessive stress and burnout. NHS Digital data shows that the weekly clinical hours worked is in decline and given the above it is no surprise. As the profile of the profession is changing so are the working patterns and the desire to work in an undesirable system.

5.5 Whilst oral health remains a ‘Cinderella service’ to the wider NHS and across the UK, younger dentists will choose to spend less time working in it meaning dentistry remains the missing piece in the wider NHS family.

Care of older people

5.6 According to the NI Statistics and Research Agency, Northern Ireland has the fastest-growing ageing population of any UK country. The number of adults aged 65 and over is expected to increase by 63.3 per cent between 2013 and 2033. At the same time, a greater proportion of the over 65 population have retained their natural teeth and require specialised dental care. HSCB estimates that in 1979, 74 per cent of over 75s were edentate, but this has fallen to circa 40 per cent today. There is a growing realisation that oral health provision of the elderly must be prioritised, and that current staffing resources, primarily within CDS are wholly inadequate to meet the growing demand, while inadequate remuneration is an active barrier to enabling GDPs to deliver more domiciliary care to the elderly.

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5.7 In England the recent CQC report into dentistry in care homes highlighted the need for more consistent provision for residents. Official data suggests significant under-commissioning of NHS domiciliary care for those with limited mobility. Levels of commissioning are low and falling, equivalent to providing coverage to under 1.3 per cent of the population whose activity is significantly limited by disability or ill health. Provision of domiciliary care was removed from NHS mandatory services contracts in the 2006 reforms meaning dentist-care home relationships ceased and were only maintained where specific provision had already been commissioned, with very little additional commissioning of new services since. This has led to the deskilling of dentists in the provision of domiciliary care. With an increasing ageing population, current inadequate provision, deskilling and loss of older dentists skilled in this work the outlook is concerning.

5.8 In its Oral Health Improvement Plan (published in January 2018), the Scottish Government recognised that the population of Scotland is ageing, and that more older people have their own teeth. These issues present new challenges which must be addressed. As a first step to ensuring that older people have effective oral care, new arrangements have recently been introduced to train a number of “accredited” GDPs to provide routine oral health care to care home residents. While it is too early to assess the effectiveness of these new arrangements, it is vital that a strong and viable Public Dental Service is maintained to provide more specialised care for older people.

5.9 With dentist recruitment and retention issues it is clear that vulnerable older people will be increasingly disadvantaged given their often-complex care needs. This aspect should be part of the DDRB’s scrutiny given its remit regarding patients.

Reduction in clinical working hours/increase of administrative burdens across the UK

5.10 Dentists across the UK are being forced to spend a greater proportion of their time on administrative tasks due to disproportionate levels of regulation and administrative tasks. However, despite reducing the time GDPs can spend on fee-paying clinical activity, dentists are not remunerated for this growing administrative burden.

5.11 This is an acute problem in Northern Ireland. The proliferation of these unremunerated, and therefore unsustainable, expenses demonstrates that the current NI GDP remuneration model is outdated and needs reform.

Clawback and contract handback in England and Wales

5.12 The crisis seen in NHS dentistry is clear from the significant increase in clawback (and contracts being handed back) resulting from contract under-delivery in recent years across England and Wales.

5.13 In England in 2015/16, £54,505,326 was clawed back from practices, increasing to £81,506,678.00 in 2016/17, £88,774,247.55 in 2017/18 and £138,438,340 in 2018/19. This means that, as of 2019/19, five per cent of the total contract values in England were clawed back and 31 per cent of contracts were affected. The prevalence of clawback provides a clear indication of the difficulties practices are experiencing in delivering their contracts, in no small part due to recruitment problems and low morale. The loss of large sums of funding from practices also causes profound difficulties for small businesses to manage and leaves some practices facing existential financial difficulties.

5.14 Through two Freedom of Information Act requests to NHS England for the details of contracts terminated by the contractor holder, the BDA has established that 231 contracts were terminated by the contract holder from 2015/16 to 2017/18, with a total value £40,109,746.95. In 2018-19, 54 GDS contracts were terminated by the contractor with a combined contract value of £9,022,640 and a total of 378,315 UDAs. This would indicate an average UDA value for this activity of around £24. There were also six PDS agreements terminated by the contractor, with a
combined value of £1,135,603. Calls to the BDA member helpline in the last few months indicate that handbacks are becoming much more common. We will be obtaining 2019/20 figures for our submission next year.

5.15 NHS England also provided information on the reasons for termination in 2018/19. The joint most frequently cited reasons were retirement of the contractor and recruitment and retention problems, with conversion to private practice the second most common. There were also a range of other issues cited from low UDA values to the practice no longer being commercially viable and the death or ill health of the provider. Some reasons provided by NHS England were vague such as ‘provider decision’, ‘business decision’ and ‘personal reasons’.

5.16 BDA Wales conducted the latest annual FOIA requests to each Health Board for information on clawback and contract reduction in the year 2018-19 and the results should have been available by early November. All but one Health Board has complied with our request. Currently, Hywel Dda Health Board is still negotiating their contract reduction figures, though 8 practices are facing contract reduction. Therefore, the all Wales figures for contract reductions, hand-backs and totals for 2018/2019 remain unknown. However, based on figures for all seven health boards, the total for clawback alone stands at £5,673,116, which is £831,804 higher than last year, even though Cwm Taf and Powys have shown reductions. This is disappointing given that the 132 practices now within contract reform should be protected from clawback and suggests that clawback is getting worse and/or affecting a larger number of practices outside of contract reform.

5.17 The clawback data continue to demonstrate that practices are continuing to struggle to deliver against targets and the outcome will inevitably disproportionately affect high-needs patients trying to find an NHS dentist.

Contract reform

5.18 Contract reform continues apace in Wales and continues at a slower pace in England.

5.19 In England, we continue to support the need for NHS contract reform. The clinical pathway being tested is appropriate and has the potential to deliver preventive-based dentistry serving patient need. It is envisaged that if the DHSC and NHS England agree to implement a reformed contract, roll-out may start in April 2021 on a voluntary basis.

5.20 In order to deliver this, the reformed contract must give dentists adequate time to provide preventive care. However official reviews indicate between 20-45 per cent of prototype practices were unable to deliver on their targets. At the time of submission, we are still discussing the financial model to be recommended but we are looking at a national weighted capitulation rate and a national non-capitated activity value. We hope that discussions will conclude and decisions taken during 2020.

5.21 Approximately one third of practices in Wales are currently operating within Contract Reform. Most participating practices are in Phase 1 with a 10 per cent reduction of UDAs to assess patient need and risk status using ACORN without the risk of clawback. The BDA fully supports this clinical model of individual N&R assessment. The few practices in Phase 2 have a 20 per cent reduction of UDAs and are expected to do everything in Phase 1, plus increase patient access by increasing recall times of healthy patients and operate open access sessions for new (high needs) patients. However, to create meaningful capacity the BDA believes an absolute minimum reduction of 30 per cent UDAs is required.

5.22 Furthermore, the BDA considers there should be a weighted target number of high-needs patients to be treated in the place of those extended recall healthy patients. For example, one high needs patient might need the equivalent appointment time of 6 patients with good oral health. The lack of a weighted high-needs patient measure presents a risk to those practices in contract reform. If
they cannot successfully manage this open access activity they may not be able to meet all the Phase 2 KPIs.

5.23 In Northern Ireland we believe that the current NI GDP remuneration model is outdated and needs reform. This has been promised by the Department of Health for quite some time, but progress has been stalled since the pilot schemes ended in August 2016. Should the Department of Health ever move beyond the ‘pilot evaluation’ stage, GDPs would need to be assured that negotiations would concluded more swiftly than the decade-long process experienced by their CDS counterparts. In the meantime, the remuneration model, in particular item of service fees must more adequately reflect the actual resources utilised in respect of professional time, materials and overheads to guarantee the sustainability of Health Service dentistry.

Commissioning

5.24 Commissioning of NHS dental services is of uneven quality. Tendering of all NHS orthodontic services in the last two years has been hugely destructive, with many high-quality practices losing their contracts and many children facing a change of provider mid-treatment, or traveling long distances for care. In late November 2019, one of the batches in the Midlands region was abandoned without notice leaving huge implications on practice viability for those who had bid and on patient care. Two weeks later, the rest of the Midlands and East area procurements were abandoned.

5.25 CDS tendering is similarly damaging as the contracts offered by commissioners often fail to value or recognise their work. Consequently, many services are not being re-tendered, and are left on short-term rolling contracts which severely restricts any investment to enhance patient care. The Yorkshire and Humber tendering exercise was launched then abandoned twice in 2018 as the contracts offered were not considered reasonable by any willing provider.

Sustainability of NHS dentistry in England

5.26 Patient access issues in England have been well documented in the media. The experience of communities from Cornwall and Cumbria suggests a strong correlation between areas of high needs/deprivation, and access problems, demonstrating the inverse care law. Likewise, surveys found parents with children on free school meals find it harder to secure an NHS appointment. Recruiting and retaining dentists in remote, rural or high deprivation areas remains hugely challenging. Over the last year the plight of patients in Portsmouth, as just one example of many, has been extensively covered in the media.

Portsmouth News - Fears grow that some Portsmouth areas could remain without a dentist
Portsmouth joins growing list of communities failed by broken NHS dental system
Crisis mounts as patients offered appointments in August 2020 (Sept 2019)
1 million new patients unable to access NHS dentistry
Portsmouth: the city without NHS dentistry

5.27 The annual GP Survey, collects detailed evidence on patients’ success and failure in securing a dental appointment, and barriers to attendance. The 2017/18 data provided evidence of access problems in many of the ‘hotspots’ acknowledged by government: including rural and coastal communities, areas of high deprivation, West Yorkshire, Lincolnshire among others. Based on the weighted sample, as many as 1.7 million patients who tried to secure appointments, were unable to do so.

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5 Children’s Dental Health Survey 2013
6 GP Patient Survey Dental Statistics, fieldwork by Ipsos Mori
5.28 The latest survey indicates numbers have increased to 1.9 million suggesting access problems are now widespread with the worst performing areas including parts of London and the South East having big implications on the sustainability of the service.

Sustainability of NHS dentistry in Wales

5.29 Across Wales the sustainability of NHS dentistry cannot be taken for granted. BDA Wales provided extensive evidence throughout the year-long Assembly review of NHS Dentistry (2018-19) underlining the importance of this issue.

5.30 According to BDA research in April 2019, access for would-be patients to NHS dentistry did not change overall from the 2017 levels. In fact, the access levels at national level were strikingly similar. (Fig 6.) While some Health Boards had seen some improvement in access, others saw significant decreases in practices accepting NHS patients, so that overall the picture remained depressed.

5.31 On average, only 15.5 per cent of practices in Wales were accepting new adult NHS patients and just 27 per cent were accepting new child NHS patients. Clearly this is inadequate provision of NHS general dentistry services in Wales.

5.32 There was some variation between Health Boards. In Hywel Dda – home to 380,000 people – NHS dentistry amounted to a single practice taking on new child patients. New adult patients had nowhere to go.

![Comparison of 2017 and 2019 Access Data](image)

Fig 6: Comparison of would-be NHS and private patient access Wales-wide 2017 and 2019

5.33 Based on the responses given by practices asked when they last spoke to a would-be patient looking for an NHS dentist, over 40 per cent of practices asked stated that they speak to would-be patients looking for an NHS dentist every day. One practice in Cardiff and Vale reported receiving more than 60 calls a day from would-be patients. Another in Powys said that they get “endless calls daily”. It is clear that NHS dentistry in Wales is in a fragile state, and that the current NHS services are unable to meet the needs of the population.
5.34 Analysis of the data\(^7\) by AM constituency and AM region shows that out of 40 constituencies 12 AMs (30 per cent) have constituencies where no practices are accepting new adult NHS patients and 8 AMs (20 per cent) have constituencies where no practices are accepting new child NHS patients. When looking at the regions, the picture for Mid & West Wales region is dire with the lowest access of just 3.1 per cent (2 practices) for new adults and 7.8 per cent (5 practices) for new children. This constituency and regional picture represents a postcode lottery for many would-be patients unable to access NHS care.

5.35 Government data demonstrates that in a decade the percentage of the whole population seen by a high street dentist over a two-year rolling period has increased by just 1 per cent - or 0.1 per cent per year - from a low of 54 per cent in 2011 to a high of 55 per cent in 2019, due to modest increases in the percent of children being seen. However, the percentage of the adult population being seen has taken a sustained down-turn to well below 52 per cent. Because of the decreasing spend in a cash limited system, where activity levels are going up for children seen this impacts resources for treating adults. This is borne out by the changes to band 1, band 2 and band 3 activity levels, particularly when expressed per capita of the population. The band 2 and band 3 UDAs have dropped significantly.

Sustainability of NHS dentistry in Scotland

5.36 With almost 70 per cent of Principal dentists in Scotland and 60 per cent of Associates thinking about leaving general dentistry, the Scottish Government needs to ensure that NHS dentistry remains sustainable.

5.37 In June 2019, the BDA issued a survey to dentists in Scotland to ask for their views on a range of issues. The survey aimed to ensure the BDA is representing members effectively, and to present the findings to the Scottish Government as evidence of dentists’ concerns. Respondents had concerns about financial implications of implementing aspects of its Oral Health Improvement plan (OHIP):

- Over 90 per cent of respondents had concerns that the Scottish Government will use the NHS dentistry budget to fund aspects of the OHIP. We had previously called on the Scottish Government to ensure that any new initiatives in the OHIP were accompanied by appropriate new investment. To date, we have received no such assurance.

- Three quarters of respondents said they have concerns about the proposed introduction of an Oral Health Risk Assessment (OHRA). While there was some recognition of the benefits of an OHRA, there were major concerns about whether sufficient additional funding would be available that reflect the time taken to carry out an assessment.

- Over three quarters had concerns about the proposed reduction in scale and polish treatments. While there were mixed views about the evidence of the clinical effectiveness of scale and polish treatments, most dentists were in favour of providing regular treatments, as they believe it helps to encourage good oral hygiene. There were also some concerns about the effect of reducing scale and polish treatments on dental practices’ finances.

Sustainability of HS dentistry in Northern Ireland

5.38 Under Northern Ireland’s Statement of Dental Remuneration, a GDP must request prior approval before undertaking a course of treatment with a total cost greater than £280. This figure has not automatically risen in line with fee uplifts, which means a rise in prior approval requests every year. For comparison, the Scottish prior approval limit has risen to £410. This one issue creates an additional, unnecessary, administrative burden for GDPs, which is worsening every year. In

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addition, the limit is having a disproportionately negative impact on the elderly population, with costs associated with domiciliary visits often pushing treatment fees over the limit.

5.39 Due to a past legislative oversight, NI Dental Practices are classified as ‘Independent Hospitals’. This means they are subject to annual inspections by the Regulation and Quality Improvement Authority – a far more frequent inspection schedule than anywhere else in the UK. This creates a significant additional administrative burden, which again is not adequately remunerated.

Brexit

5.40 GDPs have also faced unique challenges in relation to materials costs as all these need to be imported therefore a falling market rate makes them more expensive. Exchange rate volatility has added significant costs in excess of inflation to the cost of dental materials.

Chapter 6 – Recruitment and retention, morale and motivation in general dental practice

6.1 Given that there are enough dentists on the GDC register, the problem is that too few are willing to work on the NHS and, where they are, they don’t want to do so full-time. A decade of below inflation pay awards and worsening of terms and conditions combined with the ever-increasing pension contributions and restrictive annual allowance has forced the NHS dental workforce to reduce its commitment to NHS dentistry across much of the UK.

6.2 The NHS Pension Scheme remains a highly valued part of the remuneration package for dentists, however it is not without challenges and the BDA is concerned about ongoing participation levels amongst dentists. Recent figures from BSA Dental Services suggest that 1 in 6 dentists under the age of 35 have opted out of the pension scheme, in England and Wales. Young dentists have repeatedly told us that the standard cost of participating in the pension scheme is high.

6.3 For higher earners (who contribute 13.5 per cent or 14.5 per cent of their net pensionable earnings to the NHSPS) and those with longer NHS service, pensions tax continues to have a punitive effect. These individuals are experiencing tax charges applied on an annual basis (of up to 45 per cent, through the Annual Allowance) and on retirement (of up to 55 per cent, through the Lifetime Allowance). Instances of such charges are rising and five figure annual charges are becoming more common. Dentists have told us that the Annual Allowance is resulting in pension opt outs and lower levels of NHS activity. The Lifetime Allowance is serving to incentivise early retirements resulting in a loss of experience. Dentists responding to a BDA survey have said that this detrimental activity is likely to increase in the future. We have made strong representation to Government on this issue.

6.4 Flexibility in the NHS Pension Scheme is vital to ensure affordability for dentists who would otherwise opt out, and to help control the exposure to, and consequent impacts of, pensions tax charges. The NHS will make savings from any members electing to use pension flexibilities and it is important that a consistent and equitable solution is developed for directing those savings to scheme members. In the absence of this, the recruitment and retention power of the NHS Pension Scheme will be diminished.

6.5 Against this backdrop, our 2019 research has reinforced this message that things are getting worse not better. As we describe below practice owners told us that associates are reluctant to work on the NHS or in England that their UDA value makes it tricky to attract dentists to their practice. There are also issues filling temporary positions to cover long-term absences like maternity or sickness leave, but still by far the biggest issue was simply not receiving enough, or any, applicants. The consequences of failing to recruit can be dire. In the last financial year, NHS practices in England and Wales have, as described in chapter 5, huge sums clawed back for under-delivering on UDA targets. Although different systems are in place in Northern Ireland and
Scotland, practice there are also feeling the strain. While this will not solely be down to recruitment problems, they certainly don’t help when practices are already facing a whole range of challenges from a sustained lack of government investment and ever higher NHS charges to ever increasing scrutiny on claims and regulatory burdens. All this serves to underscore the need for urgent progress in making the NHS a more attractive working environment. It has long been clear that the current system just isn’t fit for purpose and these long-term issues are now finally coming to a head. We have been saying for a while that the last 10 plus years of decline needs to be reversed. That must start now.

**Shape of the workforce**

6.6 Whilst early work is beginning, official statistics take a headcount, rather than actual NHS commitment. As we reported in our response to the Health Select Committee inquiry into dental services in England, addressing the lack of reliable data on Whole Time Equivalent (WTE) numbers of dentists in both NHS and private general practice would be valuable in understanding capacity and workforce changes across the UK.

6.7 Across the GDS/PDS dental workforce, women now constitute more than half (50 per cent) of the NHS general dental practice workforce in England and represent about 65 per cent of new dental graduates. Dental student intake stands at 63 per cent women. This significant change in the demographics of the profession must be factored into proper workforce planning.

6.8 Professionals working in NHS general dental practice are in a unique position to identify those who are likely to be vulnerable to various non-communicable diseases in the future, as many conditions share common risk factors with dental diseases. The mouth can therefore act as a “window on to the body”, particularly with children. Those suffering from high levels of dental disease are likely to be at greater risk of a number of chronic conditions and so dental professionals could play a highly important role in signposting where targeted preventive services and action are most required and would accrue most benefit. Rather than celebrating this vital piece of the NHS, instead it is underfunded, undervalued and unsustainable.

6.9 Simply put there is no NHS/HS dentistry without dentists. There also cannot be any NHS dentistry without dental nurses and problems with recruiting them are reported across the UK.

**Dental nurse shortages**

6.10 In 2019 the BDA ran a (yet unpublished) survey on employment of DCPs across the UK. Of the 674 valid responses received back, 65 per cent of all respondents sought to recruit any dental nurses in their main practice in the financial year 2018/19. Of these (basis = 435), 73 per cent said they experienced difficulties doing so.

6.11 The most cited difficulties they experienced were having few or no applicants, and the scarcity of registered, qualified or experienced dental nurses – respectively 79 and 78 per cent of respondents who said they had experienced difficulties recruiting dental nurses to their main practice in financial year 2018/19 (basis = 318).

6.12 In particular, GDPs are reporting an ongoing widespread regional dental nurse shortage in Northern Ireland. The most recent survey - October 2017 Health & Social Care Board survey – reported that 33 per cent of practitioners had an unfilled nursing position. A significant shortage which is placing unsustainable upward pressure on dental nurse salaries. Often, a practitioner is unable to fill a post with a qualified dental nurse and instead employs a trainee nurse – a practice which has resulted in NI trainee dental nurses commanding wages 10 per cent higher than the UK average.

6.13 Problems recruiting dentists and problems recruiting dental nurses are compounding the problem. The crisis in the service needs to address both recruitment of dentists and dental nurses.
Recruitment of dentists

6.14 The Government needs to acknowledge that they cannot afford NOT to increase pay to aid recruitment. Whilst conditions in the NHS remain at critical levels, the Governments of the UK must invest in the current workforce.

6.15 Our annual survey question to members about their career intentions, focusing on those with over 75 per cent commitment to the NHS (n=747) showed that of those who responded as part of this commitment level, 60 per cent planned to leave the NHS (compared with 64 per cent in 2018), which is further broken down as 57 per cent of practice owners (compared with 65 per cent in 2018) and 61 per cent of associates (compared with 64 per cent in 2018). Although the sample size for Northern Ireland, Wales and Scotland is too small to cite specific figures, for practices with over 75 per cent commitment, the responses still tell a similar story. This is still a large number of people with an intention to leave the NHS.

6.16 In England, 65 per cent intended to leave the NHS or reduce their commitment to it (compared with 67 per cent in 2018). In Scotland and Wales between 51-54 per cent wanted to leave the NHS. Northern Ireland is slightly different with around 62 per cent intending to stay in the Health Service (compared with 58 per cent in 2018). The financial and political situation in Northern Ireland may go a long in explaining this where the move to private practice is not as viable an alternative option as the other three countries.

6.17 When we asked respondents about their recruitment of dental associates in the last year, of the 41 per cent who had sought to recruit (compared with 35 per cent in 2018), 68 per cent of them had had difficulties (compared with 71 per cent in 2018). Again, the usual responses top the list “few or no applicants” followed closely by “finding suitable dentist” which mirror our research in previous years.

6.18 These issues of recruitment are having a knock-on effect on service provision and has been highlighted in the national media and is beginning to be spoken about by Ministers but much too late in our opinion. In March 2018, the health minister Steve Brine MP acknowledged these recruitment problems in response to a written parliamentary question:

“NHS England advises that it has recently been getting reports from some providers of difficulties in recruiting and retaining dentists particularly in more remote areas. NHS England is working with local commissioners to investigate how widespread this is and is keeping the issue under active review.”

6.19 Focusing on Scotland, around one in 10 dentists is from the EU, and in some NHS Board areas – for example, Dumfries and Galloway – this figure is over 40 per cent. There is therefore, a significant risk that Scotland will face a shortage of dentists if these numbers fall once the UK leaves the EU, and there is insufficient recruitment of local dentists to fill the gap. Tighter rules on visas for non-EU dental workers could compound recruitment problems, and there is already evidence that some practices – particularly in rural areas – are struggling to fill vacancies.

England

6.20 In September, the NHS England response to the Health Select Committee inquiry into dental services in 2019 stated “Regional areas are experiencing challenges in recruitment of dentists willing to work under solely or predominantly NHS arrangements.” This is important because those regional areas are spreading and the challenges increasing. Coastal communities are hard hit with practices handing back contracts. Rural areas are struggling to attract dentists. The North

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8 Our annual question appeared in the same format but in a different survey this year for continuity.
East of England traditionally a strong hold of NHS dentistry is being held together with sticky tape. Unless collective action on all fronts is taken, and soon, the situation will only worsen.

6.21 In basic terms, most of the dental profession in England working in primary care are not practice owners and this means the capacity, interests and aspirations of the workforce are fundamentally different to what they have been historically. As the number of dentists is rising, difficulties for practices to recruit associates prepared to provide NHS care are nevertheless getting harder. Some of this is put down to the rise of part-time working. Many GDPs regardless of gender are choosing to work in clinical dentistry part time rather than full time. For patients seeking care, the increased patient charges year on year are putting many of. Parts of England are struggling to attract associates to work in NHS practices and hardest hit are the areas with the most demand for NHS services.

Retention

6.22 To ensure that NHS dentistry is sustainable, dentists need to be able to have as a likely prospect that their incomes are increasing rather than continue to decline. As we have previously reported, goodwill towards propping up the NHS only goes so far. The amount of clawback and handing back of contracts is a clear example of contract holders being driven to giving up NHS contracts and commitment.

6.23 In our most recent survey we asked all practice owners and associates across the UK about their career intentions and of the n=1677 who responded, 23 per cent intend to retire (22 per cent of those with over 75 per cent commitment to the NHS (n=747)). When broken down by age the greatest proportions with the intention to retire were those unsurprisingly in the 50-59 age bracket (50 per cent) and 60 years plus (83 per cent) of those with over 75 per cent NHS commitment.

6.24 Associates as we have already described, particularly young associates, are learning that NHS dentistry is a place of fear and that surplus amount of time is spent trying to pre-empt scrutiny and probity claims in place of proper patient care. They are choosing to work part-time in dentistry, not simply part-time in general practice.

6.25 The BDA annual survey 2019 has shown that dentists under 40 have a greater intention to reduce NHS work and increase private work. Of all dentists (n=1677) 25 per cent intend to increase the amount of private work that they do however 35 per cent of dentists with over 75 per cent NHS commitment (n=747). As age increases, the desire to increase private work decreases. Across all dentists who responded, 59 per cent of under 30 intended to increase private work (61 per cent with 75 per cent NHS commitment) followed by 40 per cent of between 39-40 which rises to 49 per cent with over 75 per cent NHS commitment.

6.26 However, as previously described, half of the profession is under 40 and if many older and experienced dentists are choosing to retire with considerable numbers of younger dentists intending to increase their private practice. The issues of retention are very acute.

Morale and motivation

6.27 The morale and motivation in profession can be pegged against the number of services providing dentists with advice, support and treatment for stress, burnout and addictive behaviours which are triggered often by the stress of working in a fee per item or UDA system where pay is low. For a dentist struggling or in crisis, there is the now the following services. Sadly, the stress of providing NHS dentistry is now becoming its own industry.

a. Dental Health Support Trust,
b. BDA Benevolent Fund,
c. Mental Dental,
6.28 A few years ago, only two of these were available but the need has burgeoned. The lowest age of dentists seeking help is now 20 to the BDA Benevolent Fund. This is the environment in which NHS/HS dentists are working. The whole culture needs to change and hand in hand with that is an investment in dentistry and in the workforce itself.

6.29 Probity and the climate of fear affects all dentists across the UK and it must not be underestimated in the effect it has on morale and motivation. Defensive is practised across the country and many younger dentists have now only worked in this toxic environment. This helps to partly explain why fewer are choosing to work any great amount in the NHS.

6.30 The failure to address issues dentists care about has left many practitioners with the perception that the Departments of Health across the UK places little value in their contribution.

Morale and motivation in Northern Ireland

6.31 As one might expect morale and motivation in Northern Ireland is suffering due to the widespread perception amongst dental practitioners that the Department of Health does not value dentistry. A perception reinforced by repeated 12-month plus delays to pay uplifts plus a growing cumulative burden of falling incomes, climbing expenses, disproportionate regulation, and the rising risk of litigation.

6.32 This cumulative burden has had a significant impact on morale, particularly in Northern Ireland where only 14 per cent of Northern Ireland dental practitioners rated their morale as high, or very high – the worst in the UK. Unless morale improves, there is a danger that health service dentistry in Northern Ireland will be regarded as unviable.

Chapter 7 – Sustainability of Community/Public dental services

7.1 For many in the Community Dental Services, the spotlight is always on the GDS practitioners and often their value is overlooked. The annual remit letter from the DHSC asks that the DDRB make a recommendation on General Dental Practitioners but failed to mention community dental services. We have written to the Department of Health and Social Care in England to ask them to ensure that community dentists are explicitly mentioned in future remit letters.

7.2 The DDRB must continue to make recommendations for CDS dentists. The Community Dental Service provides services to the most vulnerable patients, typically those that are unable to attend high street practices. Consequently, many CDS patients (adults and children) present with complex medical histories and multiple needs. This patient complexity clearly impacts upon appointment times (see appendix A) as well as the skills necessary to treat such patients. We ask the DDRB to look carefully at the service in this year’s report.

7.3 CDS dentists in England work under a discreet Salaried Primary Dental Care Services contract with most staff employed by NHS Trusts and hence working under NHS terms and conditions or employed by a Community Interest Company or Social Enterprise which holds a PDS agreement for primary care dentistry, and typically often matches NHS terms and conditions of employment. Whilst DDRB uplifts are added to NHS pay scales the same cannot automatically be assumed for salaried dentists working to matched pay scales for independent providers.
7.4 In previous years we have based our evidence on the results of our own member research and those of Freedom of Information Act requests made by BDA analysts. It has become increasingly difficult to receive timely FOIA data from services and this allied with a recognition of the Review Body’s comments on the disparity of data between the parties in the process, we have elected to use data from the NHS Staff Survey to inform our evidence this year. We trust that the Review Body will accept these as representative of ‘an objective picture of the position in relation to dentistry’.

7.5 As we have repeatedly stated, CDS dentists are a mature and established workforce with a long service commitment to their branch of practice.

7.6 It is clear, therefore that the most appropriate epithet that should be applied to the CDS workforce is ‘competent’. From this competence, it is therefore of no surprise that CDS dentists report particularly high levels of implicit trust from their management. Theses dentists in turn are empowered by their management to take initiative-based leads on behalf of their patients (see appendix B for an illustration). Less than 20 per cent of CDS dentists are not given frequent opportunities to display their initiative.
We have reported previously that CDS dentists believed their workload was high, (This 50 per cent threshold was again met when we asked members how often they were required to work more than their contracted hours 2018.) it should therefore come as no surprise that a clearly obviously larger number of CDS dentists are unable to manage the conflicting demands on their time than are able to. Given the experience of the group of dentists in the CDS, this inability to meet time demands is far more likely to be driven by external factors than any within the staff group themselves.

CASE STUDY 1:

“In my trust all band A dentists and most Band B dentists are not allowed non-patient facing clinical management time (admin). Any communication/correspondence required from that day’s list of patients must be done after work. Many dentists finish late most days and how late depends upon how many letters they have to write”.

7.8 The ability to meet time pressures does not occur in a vacuum, a clear majority of CDS dentists believe that their organisation does not have enough staff in place.
7.9 This resonates with the evidence we submitted last year which highlighted that for every three posts that became available only two were filled. A key driver to these recruitment problems is the retention of existing staff.

CASE STUDY 2:

“An increasing number of young dentists recruited only stay for a year or so and some less than a year. This is due to the type of work they are sent to do (prison dentistry) or being moved about at a regular basis from one clinic to another”.

7.10 The scarcity of staff has an impact on decisions made by managers with regards to what they reasonably expect from CDS dentists.

Impact on dentists

7.11 Vulnerable patients requiring complex treatments provided by services with too few staff pushed too hard has had a predictably obvious outcome. The results of the NHS Staff Survey starkly illustrate both, what is happening to mitigate against these increased pressures and, the price being extracted from CDS dentists for such sacrifices.

Almost two thirds of CDS dentists are working some unpaid overtime every week. This again resonates with our evidence last year where we stated that 50 per cent of CDS dentists were often
required to cover for colleagues and were required to work more than their contracted hours. It is particularly disappointing to note that this year’s evidence suggests that much of the overwork we highlighted last year is being undertaken for free.

7.13 Unsurprisingly, the necessity of this unpaid overtime is having a clear and obvious detrimental impact on CDS staff.

![Work related illness](image)

Fig 14: Work related illness

**Pay and career**

7.14 Resultantly, 41 per cent of dentists aren’t happy about pay and this dissatisfaction sees one third of CDS dentists often thinking about leaving their jobs.

![Satisfaction with pay](image)

![Thoughts about leaving](image)

Fig 15: Satisfaction with pay  
Fig 16: Thoughts about leaving

**Conclusion**

7.15 CDS dentists in England are working with fewer colleagues for more hours. Much of this work is unpaid and is causing work related illness.

7.16 CDS dentists are a resource the NHS should be exploiting positively, not negatively. Rather than treating the CDS as a dental outpost, the NHS should recognise the experience and creativity of CDS dentists and invest in them. A small investment in pay for CDS dentists will return a
significant increase in overall NHS contribution as CDS dentists provide so much more than dentistry for their patients.

7.17 It is not unreasonable for the NHS to consider how they remunerate clinicians who strive on behalf of the most vulnerable members of society and whether the terms and conditions such clinicians work under illustrates how much of a priority vulnerable patients actually are.

**CDS in Wales**

7.18 Supplemental information from Wales indicates that the number of CDS dentists (data includes those salaried to provide GDS type services) in whole time equivalent is increased not declining as described above in para 7.3. Headcount and whole time equivalent data for CDS dentist numbers for Wales however must be read with caution. The data from Stats Wales are not reliable due to changes in reporting practices since 2016/17.

7.19 The latest available figures on patient contracts in the CDS from Stats Wales only go to 2017-18. The figures show a downward trend, despite the apparent increase in WTE of the CDS dental workforce. This is likely due to a change in the way staff were included and the total now includes some dentists with minimal clinical duties.

![Patient contacts in the CDS](image)

[Fig 17: Patient contacts in the CDS in the last decade]

[A patient is the number of individuals seen during the financial year, regardless of how often they are seen, how many episodes of care they undergo, and how many CDS staff they are seen by.] Figures from Stats Wales

**The future of the PDS in Scotland**

7.20 The BDA is concerned about the future of the Public Dental Service (PDS) in Scotland, including continued funding cuts (3.6 per cent reduction in 2018/19), staff reductions (an overall fall of 15 per cent of PDS posts between 2014/15 and 2018/19) and the consequent impact on patient access. Continued reductions in PDS capacity (and the departure of experienced staff) may jeopardise the long-term viability of the service, and there are also concerns about the non-clinical management structures of the PDS in some NHS Boards.

**CDS Northern Ireland**

7.21 The NI Community Dental Service is struggling to reconcile existing resources with the additional pressures created by an ageing population. At the same time, the service is tackling
the dual challenges of a rapidly ageing workforce and the worst child oral health outcomes in the UK. To date, the long-awaited Skills for Health Dental Workforce Review Report which was finalised in Summer 18, has not yet been published.

7.22 CDS dentists make up only 7 per cent of the total regional dental workforce and provide oral care for some of the most vulnerable people in our society. It is therefore not surprising that CDS dentists are shouldering a relentlessly increasing number of older dentate patients requiring specialised dental care – often in difficult, and time-intensive, domiciliary care environments. It is plainly obvious to both dentists, and the HSCB\(^9\), that the CDS requires significant investment if the service is to meet the forecasted need.

7.23 As workload pressures increase, there are increasing concerns within the CDS about long-term workforce strategy and widespread low morale. CDS members have reported significant challenges in filling posts at all levels. This is concerning, as significant numbers of the most experienced community dentists are approaching retirement, with up to 40 per cent reported to be potentially retiring by 2025.\(^10\) We note, and welcome, the upcoming 2020 CDS Workforce Review.

7.24 Assimilation of the CDS contract finally took place in April 2019, with pay arrears backdated to April 2015. This ends a negotiation process that began over a decade ago in 2008. The new contract should be cause of optimism amongst the profession, but the overly long and trying process has taken its toll on CDS staff morale.

7.25 Finally, CDS staff are concerned about the current policy vacuum. The Regional Oral Health Strategy dates back to 2007. Practitioners believe that it is hopelessly outdated – it’s based on obsolete 2003 data - and has failed to tackle Northern Ireland’s growing oral health challenges. For example, 23,000 children’s teeth were extracted under General Anaesthetic (GA) in Northern Ireland in 2017/18 - three times pro-rata than England.

7.26 The House of Commons Northern Ireland Affairs Committee in its Health Spending in Northern Ireland report recently highlighted the significant oral health challenges that urgently need to be addressed and recommended that the Department for Health commit to developing a new Oral Health Strategy.

7.27 These issues have together severely impacted morale in the profession. Low morale has been evidenced across the profession, in all areas of the UK, with 47.0 per cent of CDS dentists experiencing high occupational stress and 83.34 per cent of CDS dentists experiencing burnout.\(^11\)

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**Chapter 8 – Sustainability of clinical academic staff**

**Recruitment of Clinical Academic Staff**

8.1 We present evidence of dental clinical academic staff because of the huge impact that this branch of dentistry has now and in the future, in terms of educating new dental undergraduates to enter the profession, to provide an NHS service to patients through the teaching of dental students and the cutting-edge research of new ideas and developments that will keep moving dentistry forwards. Dental school is the foundation stone for anyone entering the dental profession and the recruitment and retention of academics is absolutely vital to the whole profession.

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\(^9\) ibid
\(^10\) Health and Social Care Workforce Strategy 2026, Department of Health, May 2018
\(^11\) A survey of stress, wellbeing and burnout in UK dentists, BDJ, January 2019
8.2 The Dental Schools Council’s (DSC) Survey of Dental Clinical Academic Staffing levels 2018 showed significant vacancies throughout clinical academia, with an overall vacancy rate of 6.1 per cent. This is consistent with previous years which is not satisfactory (overall vacancy rate of 5.3 per cent in 2017 and 6.4 per cent in 2016) for the future of the dental profession.

8.3 For Reader/Senior Lecturer grades there is a vacancy rate of 11.1 per cent, which means that for more than one in every ten of these posts, Universities have not been able to recruit. The DSC Survey has also highlighted the difficulties in recruitment to specialities, as well as grades. In previous surveys there has been a pattern of a large numbers of Dental Schools citing difficulties to recruiting to one or more specialties. Of the 16 UK dental schools, there were 13 reporting this difficulty in the 2018 Survey and 12 in the 2017 Survey.

8.4 The consistent level of vacancies in certain posts and the year on year overall vacancy levels, combined with sustained recruitment problems in certain specialties, indicate the difficulties Dental Schools have in recruiting clinical academic staff. This is supported by the BDA’s 2018 Academic Survey which found just over half of respondents said they were aware of vacant posts that their University was having difficulty filling. This will lead to a greater burden on existing academics, as they will have to meet the teaching commitments of vacant posts.

8.5 In addition, the BDA’s own research into clinical academics suggest significant numbers of academics are intending on leaving the profession in the next five years. The BDA’s 2018 Academic Survey found 30 per cent of those who replied to the survey intended to leave, with the vast majority intending to retire.

8.6 The alternative career for clinical academic dentists is a substantive NHS post but this is a loss to dental academia. A dentist that is fully qualified and has undertaken postgraduate specialty training can chose to apply for NHS substantive posts, rather than a seek clinical academic posts, where appointments at Lecturer and above are likely to require a doctorate and an established research track record. In the NHS there is a clarity of purpose from only having clinical work, whereas in Dental Schools an academic must actively manage their clinical career with their academic commitments. Given the vacancy levels highlighted above, ensuring clinical academia is an attractive career is vital to ensure that academia is not further eroded.

8.7 Another contributing factor is pension arrangements. The University Superannuation Scheme (USS) pension, is currently comparable to the NHS pension scheme; however, the 2017 USS Actuarial Valuation is proposing changes that will close the Defined Benefit section of the scheme making the scheme less attractive in relation to the NHS scheme, which continues to be purely Defined Benefit. This issue has led to industrial action in 2018 and further industrial action in November and December 2019, with the staff pension contribution rate increasing further in 2020.

8.8 The overall picture for clinical academic recruitment remains challenging, whether by grade or specialty, and the current uncertainty over the USS pension and the HEE Advancing Dental Care initiative act as potential disincentives to undertake a dental academic career. All these factors indicate that it is imperative the Dental Schools maintain pay parity for clinical academics with their substantive NHS colleagues. If this does not occur and Dental Schools pay policies diverge from the NHS, then the problems of recruitment and retention of clinical academics are likely to worsen significantly. If this was then to have an impact on the delivery of undergraduate and postgraduate teaching, then the entire dental profession would suffer.
Chapter 9 - Our recommendations

9.1 We ask the Review Body to recommend a pay uplift of at least five per cent to attract dentists to work in the NHS.

9.2 We do not recommend targeting awards.

9.3 We also urge that the DDRB starts again to make a separate recommendation on expenses for GDPs. With the four countries treating expenses differently there is a widening disparity between remuneration levels. We have never agreed that information on practice expenses gained from HMRC data is unreliable and would urge the Review Body to revert to its former practice.

General dental practice

9.4 We recommend for all General Dental Practitioners a pay increase of at least five per cent.

9.5 To address the unsustainable levels of low morale in Northern Ireland and to break the unsustainable cycle of 12-month plus delays to pay uplift awards the BDA requests that the DDRB states clearly that these delays are unacceptable and places a time constraint on the Northern Ireland Department of Health by recommending that the Department implement the 2020/21 pay award within three months of publication. Timely implementation, would break the unsustainable cycle of delays and would go a long way towards demonstrating that NI dental practitioners are valued, thereby having a much-needed positive impact on morale.

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

Community dental services

9.7 We recommend for Community Dental Services a pay increase of at least five per cent.

Clinical academia

9.8 It is imperative the Dental Schools maintain pay parity for clinical academics with their substantive NHS colleagues.
Appendix A – CDS patient with complex needs

An adult patient with a severe learning disability and a complex medical history was exhibiting signs of dental pain. The patient wasn’t able to tell dental staff he is in pain, but he lives with his parents who noticed his behaviour was becoming more aggressive and he was hitting his face and crying after eating. The dental team were unable to carry out a good examination of his teeth to establish if there was a dental cause for the pain, as due to the patients severe learning disability he would not let anyone examine his teeth. The Community Dental Team carried out a capacity assessment and the patient was not deemed to have capacity to decide if dental treatment was in his best interests. The dental team organised for a best-interests meeting to take place, involving his family, Consultant psychiatrist and the learning disability nursing team. It was concluded that there were reasonable grounds to think that his change in behaviour could be due to dental pain and therefore the decision was made to proceed with comprehensive dental care under general anaesthesia.

The consultant psychiatrist contacted the dental team following the best interests meeting to enquire if we could take blood tests and do an ECG and MRI scan of his brain under the same general anaesthetic. The patient had never previously cooperated to allow blood tests even when given oral sedation. Due to his severe learning disability the only way he could cope with an MRI scan would be under a general anaesthetic. The patient was also under Gastroenterology who had separately made a request for a CT scan under GA. The dental team acknowledged that a general anaesthetic would be distressing to the patient given his severe learning disability. We therefore decided to try to take the lead and coordinate doing all procedures under one general anaesthetic. This would involve anaesthetising the patient in the dental operating theatre and carrying out his dental treatment, taking bloods and doing an ECG then transferring him whilst under the anaesthetic to a different part of the hospital to have a CT scan of his abdomen then his MRI scan of his brain carried out. The anaesthetic department agreed 2 anaesthetists could be present to allow safe transfer of the patient whilst anaesthetised and a second ODP with MRI training was also agreed to be on the team. The dental team had to coordinate with the radiology department to ensure access to both the CT and MRI scanners could be arranged at the appropriate times. It was agreed the most appropriate place to wake the patient up following his scan was in main theatre recovery area. As the patient was prone to aggressive behaviour if distressed a separate recovery area was allocated to him so he could be recovered in a calm environment. The dental team organised for a side room to be allocated on a ward so he could recover prior to discharge in a quiet environment.

On the day of the general anaesthetic, he needed a large oral pre-medication for sedation. To allow him to stay as calm as possible his parents were in the anaesthetic room whilst induction of the general anaesthetic took place. The dental team carried out a thorough examination and x-rays of his mouth. Routine blood tests and an ECG were also carried out. The patient was then transferred, whilst anaesthetised to the CT scanner then to the MRI scanner and finally to the pre-assigned recovery area in main theatres so he could be woken up in a quiet environment. His parents were waiting in the theatre waiting room they could be with him as soon as he woke up to try to make him less anxious. The procedure all went smoothly and the patient was discharged later the same day. His parents were very grateful to all the dental and medical staff involved.

The dental team took the lead on the patient’s care and coordinated across dental and medical specialties. This would have taken a lot of unremunerated time and effort from the dental team to make this happen. If it was done in clinic time it would have taken away valuable time seeing other patients.
Appendix B – CDS patient waiting times

Patient under 16 seen at Dental Referral Clinic at Congenital Heart Centre (CHC) by specialist in paediatric dentistry. Referred by Community Dental Service for comprehensive care under general anaesthesia at CHC, because of severe cardiac condition causing ‘blueness’, portal vein thrombosis, portal hypertension (followed up by regional children’s hospital liver transplant unit), hearing impairment, low platelet count, enlarged spleen, low white cell count, learning disability and autism. Multiple medications.

Attended with mother and father, who both have some degree of learning disability. c/o nil but parents say cannot know when in pain because of LD and autism. Parents unclear about child’s medical history. Was under care of local children’s hospital, local congenital cardiac unit and regional renal unit at larger children’s hospital.

Had previously been seen by the assessing dentist with hospital orthodontic consultant for orthodontic treatment planning prior to general anaesthesia. This was a specially arranged joint consultation, because of the patient's inability to cooperate for examination, and the community dentist was able to assist the orthodontist in her examination.

Current examination revealed gross decay and crowding. Child very uncooperative for examination and only way to be treated was under GA. This had been confirmed by 3 previous community dentists. Parents mentioned would be having an ENT procedure soon. Diet and oral care advice given. Explained to parents could not put on GA waiting list until confirmed the following:
1. Orthodontic treatment plan
2. Fitness for anaesthesia with consultant paediatric cardiac anaesthetist – make aware of all med conditions and suggest might need to go to regional non-cardiac hospital because of liver issues
3. Need for any ENT or other procedures by consultant ENT consultant

Discussion made more difficult because of parents' limited knowledge and understanding of child's conditions

Post visit:
1. Went to orthodontic department and obtained orthodontic treatment plan letter
2. Email to anaesthetist and ENT consultant
3. Replies from above – safe to anaesthetise and did not seem to have any current ENT needs
4. Contacted cardiac liaison nurse to alert to family’s need for support for the procedure
5. Request follow up visit to confirm treatment plan and obtain consent and put on w/l

Appointment and non-patient facing time for cardiac dental appointment: 2 hours
Previous appointments – orthodontic – 1 hour (clinician had to go to another hospital)
Assessment in CDS beforehand – 45 mins

Waiting times in the CDS are long because care for CDS patients has to be carefully planned and coordinated with numerous other professionals.
Appendix C – Our correspondence

Edward Scully  
Deputy Director, Primary Care Policy  
Department of Health and Social Care  
Skipton House  
80 London Road  
London, SE1 0LL

Sent by email

Dear Mr Scully,

I am the Chair of the (DDRB) Review Body Evidence Committee for the British Dental Association. I represent the interests of the dental profession across high street services, community dental services and academia in drafting the profession’s evidence to the DDRB on dental recruitment and retention, morale and motivation. I must therefore convey the frustration felt across the profession by the continued delay in publishing the 47th DDRB report and the DHSC’s response.

It is now the middle of July and I am extremely concerned about the delay to this year’s DDRB report which we had expected to see well before now. Year upon year the process has suffered ever increasing delays. Practitioners are left waiting to find out mid-way through the financial year what uplifts to contracts might be offered and then further months until the award is implemented. For small businesses this uncertainty is very destabilising. It also has a negative effect on the very morale and motivation, recruitment and retention issues that are at the core of the DDRB’s remit. This continued delay is having a negative impact on a profession dedicated to providing NHS care to patients in already over-stretched financial circumstances. My colleagues are deeply dissatisfied that this delay each year has become business as usual.

As a gesture of good faith towards the profession, I ask that you advise me when we can expect the Review Body report and DHSC response to be published.

I look forward to your response.

Yours sincerely

[Signature]

Eddie Crouch  
Chair, BDA Review Body Evidence Committee
Eddie Crouch
Chair, BDA Review Body Evidence Committee
British Dental Association
64 Wimpole Street,
London
W1G 8YS
19 July 2019

Dear Mr Crouch

Thank you for your letter of 12 July regarding your concerns about the timing of the 47th DDRB report. I do appreciate how frustrating waiting for the DDRB report and the Government response is for those affected.

The Government received the latest report in June, in line with the DDRB’s indicative timetable for this year’s report and has since then been carefully considering the recommendations. You will understand that I can’t give a date when the response will be out but will be aware of the various media reports today suggesting it may be imminent.

The Pay Body timetable was moved in 2017, so that reports were submitted to the Government last year and again this year in May/June. This was part of wider changes to Government fiscal timings.

Once the current report is out I will be happy to discuss further but I wanted ahead of that to come back to you, both to acknowledge the frustration the timings are clearly causing, but also to explain that, at least part of this, is not delay in responding but the impact of a revised central timetable.

I hope this is helpful in explaining where things are with both the DDRB report itself and the Government response.

Yours sincerely,

[Signature]

Ed Scully
Department of Health and Social Care
Deputy Director Primary Care
The Rt Hon Rishi Sunak MP
Chief Secretary to the Treasury
HM Treasury
1 Horse Guards Road
London, SW1A 2HQ

Sent by email

Dear Mr Sunak,

I am the Chair of the (DDRB) Review Body Evidence Committee for the British Dental Association and represent the interests of the dental profession across high street services, community dental services and academia in presenting the profession’s evidence to the Review Body on Doctors and Dentists Remuneration. I am writing to express the frustration and anger of the profession at the continued and now repeated delays in the DDRB process and consequent delays in implementing recommendations.

This situation cannot continue. DHSC officials responded to me in July 2019 that the changes to the Review Body timetable that have led to such unacceptable delays to implementation are as a result of changes to government fiscal policy. If this is indeed correct, the change has negatively impacted on the process.

For the dental profession, late uplifts cause financial instability, particularly for dental practices which are mainly small independent businesses providing dental services. Delays and backdating of uplifts cause problems in terms of recruitment and retention of dentists and dental practice staff and for the stability of financial practice management. This is set against the ever increasing expenses that go into running a high-quality dental practice delivering care to patients.

I urge you to look closely at this issue and find a way to ensure that the timetable for the DDRB process and any uplifts and awards are recommended and implemented at the start of the financial year to which they relate.

We will continue to make the point to the Review Body, but I am sure that they are similarly frustrated if they have no control over the timetable.

I look forward to your response.

Yours sincerely

Edie Crouch
Chair, BDA Review Body Evidence Committee
Mr Eddie Crouch  
Chair  
British Dental Association Review Body Evidence Committee  
By email to: nicola.hawkey@bda.org

Dear Mr Crouch,

Thank you for your correspondence of 5 September to Rishi Sunak about the timetable for the annual pay review process for doctors and dentists. As this is a health-related matter, your correspondence has been passed to the Department of Health and Social Care. I apologise for the delay in replying.

The Department fully understands the concerns you raise and is aware that the recent change to the pay round timetable has affected a number of public sector pay review bodies and the professions they serve.

After the decision was made to end the public sector one per cent pay cap in autumn 2017 the pay round, which had normally started around July each year, was delayed, as Departments worked to ensure the change in pay policy was reflected in their evidence. It was important that the following stages of the round were not compressed and that the Review Body on Doctors’ and Dentists’ Remuneration was given sufficient time to consider all the evidence presented to it. This affected the timing of the remit letter for the 2019/20 pay round and the subsequent stages.

Now that Parliament has been dissolved before the General Election, the Department cannot comment further on this matter. What happens on the issue of public sector pay in the future will be a matter for the incoming Government.

I hope this reply is helpful.

PRIVATE SECRETARY