Evidence to the Review Body on Doctors’ and Dentists’ Remuneration for 2019/20

January 2019
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Chapter 1 - Executive summary

1.1. Our evidence last year warned of an urgent looming crisis for retention and recruitment. In England and Wales this has not abated and remains an urgent concern. For the profession at large and across all four countries the threats to sustainability of NHS dentistry, the thinning of resilience by the members of the dental profession and the crisis this beckons, sums up our evidence for 2019/20.

1.2. Dentists across the UK have been left fully exposed during the most prolonged period of austerity in recent history. A perfect storm of rising expenses such as dental materials and laboratory fees essential to deliver NHS dentistry; inflation well-exceeding any annual pay uplift awarded during a period of maximum 1 per cent pay restrictions; cuts to the GDS budget in Northern Ireland through removal of commitment payments and schemes to invest in dental practices, with the imposition of a raft of additional costs in the form of extra regulation - have compounded to impact negatively on dental earnings.

1.3. While the exact challenges may not be the same across each country of the UK for the dental profession, what is clear is that the threat to the delivery of high-quality dental care is at critical levels.

1.4. GDPs have demonstrated resilience over the years, but they are now at breaking point. Recurrent delays in pay uplifts, and low, inadequate NHS fees are increasingly unsustainable and will continue to force practitioners to question their commitment to the health service and move towards private practice.

1.5. NHS recruitment and retention across the profession is challenging. Morale and motivation continue to decline. For how much longer can the Review Body oversee this decline without making a recommendation that attempts to stem the tide?

1.6. Last year the BDA submitted robust and factual evidence about the recruitment and retention problems in England which contradicted the evidence from NHS England. The crisis we are now facing across England in 2018 has shown our evidence to be correct and factual.

1.7. We believe that pay awards for dentists across all the UK countries are affordable.

1.8. We suggest that the Review Body makes a minimum recommendation of 5 per cent on pay (RPI (3 per cent) plus 2 per cent) to begin to redress the balance. We believe that RPI is the best inflation measure to use.
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. Its membership is engaged in all aspects of dentistry including general practice, community dental services, the armed forces, hospitals, academia and research, 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. NHS England now refers to salaried primary dental care services as ‘community dental services’ or CDS and the latter term is used in this evidence, except for Scotland, where the service is called the ‘Public Dental Service’.

2.3 As in previous years, the BDA has once again undertaken a survey of members who are community dentists, practice owners and associates across the UK. We have also conducted Freedom of Information Act requests to obtain the necessary data to outline the scale of problems facing the dental profession. Our full methodology around data collection and analysis is included in Annex A.
Chapter 3 - BDA response to the 46th report

3.1 In July 2018 the DDRB recommendations and the subsequent announcement by the Westminster government around the staging of awards baffled and angered the profession. Over the summer and into early autumn, announcements were made by the Scottish and Welsh Governments on pay uplifts for general dental practitioners. The Westminster Government finally consulted with the BDA on the contract uplift for England in late October and despite us responding very quickly, the uplift was not paid until the beginning of January. At the time of writing, no announcement has yet been made for Northern Ireland. Dentists across the UK have experienced wholly unacceptable delays from all four UK governments when it comes to detail on the size and approach to delivering their annual pay uplifts.

3.2 The profession is angry. Angry about the constraints placed on the Review Body, angry about the drop-in pay over the last decade with no commitment by Government or the NHS to recognise and address the problems, and angry that NHS dentistry is being left to wither on the vine.

3.3 Substantial evidence of recruitment and retention problems was provided by the BDA to the last DDRB review. Nevertheless, the DDRB chose to ignore the collective and well researched UK BDA evidence describing it in July 2018 as anecdotal¹, and instead favoured the UK Governments’ figures that suggested that all was well with NHS dentistry.

3.4 Dentists have shown enormous commitment to the NHS over the past decade to their detriment. Practices can no longer afford to subsidise NHS dentistry, and without adequate remuneration and investment, NHS dentistry and patients will be the loser. This is a situation we do not want to see; we hope this submission serves as a wake-up call to safeguard the future financial viability of NHS dentistry across the UK.

England

3.5 In England the dental profession is outraged about the nature of the 2018/19 award implementation and the way the paltry award of 1.68 per cent (with an additional balancing award in April 2019 of 0.65 per cent) took eight months to be announced.

Northern Ireland

3.6 In Northern Ireland, our members are angry that yet again an award has not been made.

3.7 At the time of writing at the outset of another DDRB process, GDPs in Northern Ireland still have not received an uplift for 2018/19, nor indeed have they any clarity on what uplift, if any, is to be applied. Prolonged delays between the DDRB reporting - the Department of Health making a determination - and implementation of a pay uplift -have been a harsh reality for dentists for many years now, and pre-date the collapse of Stormont.

3.8 Last year, ‘a mechanism was found’ whereby the Department of Finance set a pay policy for 2017/18, and the DDRB recommendation of one per cent was implemented in April 2018 - a full 15 months after the announcement. Time lags of this nature before a pay uplift is implemented undermine the integrity of the process and are simply unacceptable. Our members in Northern Ireland have borne this failure to implement awards over the last few

years and it is time the Review Body made a statement about the impact on the profession in Northern Ireland.

3.9 This year, we take the opportunity to warn we are in unchartered territory as far as the historically low levels of dentists pay in Northern Ireland. The future sustainability of Health Service dentistry should no longer be taken for granted, particularly where the level of remuneration has been so eroded to make little financial sense compared with alternative income streams.

Wales

3.10 In Wales the DDRB recommendations for GDS dentists’ pay has been fully implemented and back dated with an uplift of 0.77 per cent for expenses. Whilst this is a less punitive award compared to the other countries, Welsh BDA leaders consider this is a still yet another pay cut when big increases in expenses costs and RPI are fully taken into account.

3.11 Last year, in its evidence to the DDRB, the Welsh Government statistics failed to account for population growth; which means that NHS dental activity as a percentage of the Welsh population has remained stubbornly at 54 per cent for the last 6 years.

Scotland

3.12 In August 2018 the Scottish Government awarded a 2 per cent increase to self-employed GDPs, net of expenses. Dentists in Scotland have seen a real-terms reduction in pay of around 30 per cent over the last decade and this below-inflation increase will continue this downward trend. The Scottish Government subsequently announced an overall uplift of 2.55 per cent.

3.13 The Scottish public sector pay policy explicitly sets out a guaranteed minimum increase of 3 per cent for those earning £36,500 or less, up to 2 per cent for those earning above £36,500 and below £80,000 and a maximum increase of £1,600 for those earning £80,000 or more. In June 2018, the Scottish Government announced that that Agenda for Change (AfC) staff in the NHS earning up to £80,000 would receive a minimum cumulative uplift of 9 per cent over 3 years, and those earning £80,000 and over would receive a flat rate increase of £1,600 per year. The above Scottish Government announcement in August 2018 extended this offer to salaried (PDS and Hospital) dentists in Scotland.

3.14 In its 2017 and 2018 reports, the DDRB recommended that the value of distinction awards and discretionary points be increased in line with its main pay recommendations for consultants. BDA Scotland welcomed the DDRB recommendations and has expressed its disappointment with the Scottish Government’s decision to freeze distinction awards and not increase the value of discretionary points for hospital dental consultants in Scotland in both 2017 and 2018. The vacancy rates for dental consultants in Scotland have been increasing in recent years and increasing distinction awards and the value of discretionary points may help to attract consultants to work in Scotland and reverse the increasing vacancy rate. We are concerned that these vacancy rates continue to rise, and the impact this will have on frontline patient care.

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Community Dental Services – England and Wales

3.15 Huge problems remain in the community dental services around service provision and tendering which are having a major impact on the service and the staff who work with predominantly vulnerable and at-risk patients.

3.16 In Wales the DDRB recommendations for community dentists have been fully implemented and backdated. Whilst the BDA recognises this is a better deal than in some of the other countries, the view is that this is still a pay cut given RPI. This will be considered further, especially in light of the increasing work loads of CDS dentists due to dwindling numbers in the service. The Community Dental Services in England are under similar decline and were subject to a staged pay award this year.

Reform of the Review Body process

3.17 We have repeatedly made our concerns clear for some years about the review body process. It seems that in 1975, the Chair of the DDRB needed some persuasion to take up the appointment as Chair in a letter written by the Principal Private Secretary at Number 10 Downing St. “It [Government] has recognised that the acceptability of the systems depends upon the maintenance of the confidence for all concerned in the independence and integrity of the Review Bodies, and upon an understanding that the Government will not only not seek to influence the Review Bodies’ finding for political ends, but will also accept and implement their recommendations unless there are clear and compelling reasons not to do so”.

3.18 In August the BDA and the BMA issued the following joint statement and letter to the Secretary of State for Health and Social Care calling for reform of the process:

“Each year both the BDA and BMA provide evidence to the DDRB as part of the process for determining the annual pay uplift for dentists and doctors.

However, the view of the BMA and BDA is that the DDRB process has been modified beyond recognition from its original purpose. This has been developing over a number of years, but is now clearly no longer acceptable to the medical and dental professions. The BMA and BDA believe it is now time for fundamental reform of the pay review process for doctors and dentists, on the basis of the following principles:

i. Restitution of the DDRB’s independence and return to its original purpose.
ii. Revision of its terms of reference to narrow the DDRB’s focus purely on pay uplifts rather than making recommendations on wider contractual matters.
iii. Clear timetables for submission of evidence and publications of the report, and an undertaking that government(s) must not fetter the parameters of the DDRB’s recommendations.
iv. Re-establishment of the undertaking that government(s) will respect and implement the DDRB’s recommendations.”

3.19 We have been told that the Minister is too busy to meet us but that officials will talk to us however these discussions have not yet happened.

3.20 We also urge that the Review Body 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

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5 Letter from 10 Downing St, Principal Private Secretary to the Chair of the DDRB, 6 February 1975
expenses gained from HMRC data is unreliable and would urge the Review Body to revert to its former practice.
Chapter 4 - Targeting awards

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

4.2 As we have said before, we 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.

4.3 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 dentists may also affect the numbers of dentists who tender for contracts, given that it will be clear where the priorities are.

4.4 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.
Chapter 5 - Financial landscape

5.1 We believe that pay awards for dentists across all the UK countries are affordable.

5.2 The dental spend for the whole of the UK on GDS/PDS shows a continued decline up to 2016/17 in real terms. Data for this is taken from the published accounts for each of the Health Departments across the UK. This is set against a continued backdrop of year on year population increases since 1982, with a new high of 66 million population in mid-2017 according to the ONS\(^6\). Growth rates have risen consistently since 2005 between 0.6 and 0.8 per cent. This is combined with a population living longer and a prediction of surpassing 70 million by 2029. There is little attraction to working in a financial constrained system with growing pressures upon it.

UK Gross spend on dentistry (GDS/PDS)

\[\text{Fig 1 UK gross spend in GDS/PDS dentistry} \quad \text{(Source – UK Health Department published accounts)}\]

5.3 Across the UK the challenge facing the dental profession (as with all of healthcare) is an ageing population with growing co-morbidity and keeping their teeth for longer. This means more patients with complex dental needs. The ageing population itself creates a significant increase in workload with regards to treatment complexity and time spent per patient. It is one of the greatest challenges facing oral health services and it is therefore vital, that there is a sufficiently large, trained and motivated range of professionals available to meet their care needs. The extra costs associated with servicing particularly high needs population are growing in respect of the materials used, time taken, and laboratory work generated, and must be adequately addressed through practice and individual remuneration.

5.4 Across the UK, we do not consider it appropriate, nor prudent to withdraw money from an already underfunded dental service. Rather, all funds earmarked for dentistry must be invested in dentistry, particularly considering the high level of need among the wider population, and in going some way to acknowledge the unprecedented financial pressures GDPs have been under in recent years.

\(^6\) ONS 2018 – Overview of the UK population, November 2018. Accessed 7 Nov 2018
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/november2018
5.5 Across the UK the contribution of patient charges continues to increase as government spending decreases.

5.6 In England the patient contribution has increased above inflation for three successive years, with increases of five per cent each year. Since 2012-13, dental patient charges have increased by 23 per cent resulting in a 28 per cent share of gross spend in 2016/17 (Table 1 Annex B).

5.7 In Wales dental patient charges make up 21 per cent of the gross spend in 2016/17. These figures are continuing to rise.

5.8 In Northern Ireland the total cost of primary care dental services (Table 2 annex B) had been increasing year on year, but over the last two years it has fallen to, and remained at, around £121 million per year\(^7\). At the same time as, patient registrations have increased (Table 3 annex B) In Northern Ireland, public spend on Health Service dentistry has decreased fairly significantly, while patient contributions have gone up. Taken along with the increasing underspend within the GDS budget year on year, and the reallocation of the GDS budget to other areas such as pharmacy by DoH, it is no surprise that dental incomes are down

5.9 Significant underspends were reported against the Northern Ireland GDS budget in 2015/16, 2016/17 and 2017/18 of approximately £2m\(^8\), £1.5m\(^9\) and £3.9m\(^10\) respectively. In addition, the patient charge revenue proportion of the GDS budget has increased. Patient charge revenue forms an important part of the GDS budget providing an opportunity to reinvest the additional income in improving dental services. However, this has not happened (with the sole exception of the HSCB Revenue Grant Scheme in January 2018), and these considerable sums of money initially allocated to dental services have been diverted to other sectors and not reinvested back into general dental services. Indeed, a record year-end underspend in excess of £7m\(^11\) is forecasted for the 2018/19 GDS budget, a surplus which has been earmarked to help offset the Pharmaceutical Services deficit.

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\(^7\) BSO, *Family Practitioner Services Statistics for Northern Ireland 2017/18* October 2018 (accessed 05 November 2018)

\(^8\) Health & Social Care Board *Finance Report 2015-16* Month 12 - March 2016 (accessed 05 November 2018)

\(^9\) Health & Social Care Board *Finance Report 2016-17* Month 12 - March 2017 (accessed 05 November 2018)


\(^11\) Health & Social Care Board *Finance Report 2018-19* Month 5 - August 2018 (accessed 05 November 2018)
The Scottish Government’s Draft Budget 2018/19\textsuperscript{12} stated that funding for General Dental Services would increase by 0.2% (from £414m to £414.8m) between 2017/18 to 2018/19. With inflation currently around 2.5%, this represents a real-terms reduction in funding for NHS dentistry in Scotland. In contrast, the 2018 Scottish General Medical Services (GMS) contract\textsuperscript{13} includes an additional £23 million investment in the GMS to improve services for patients where workload is highest.

\textbf{Earnings and taxable income of UK practitioners}

The average taxable income of all self-employed dentists across the UK continues to drop according to NHS Digital statistics\textsuperscript{14}. For individuals making a living providing care to patients within the two NHS systems (Item of service in Northern Ireland and Scotland and a fixed budget system in England and Wales) the outlook is bleak. All parts of the UK have seen huge drops in taxable income with the trajectory of Northern Ireland showing the worst trend. The NHS depends on recruiting and retaining dentists to the system.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{fig3.png}
\caption{Average taxable income for all self-employed primary care dentists (Source – NHS Digital)}
\end{figure}

Dentists across the UK have been left fully exposed during the most prolonged period of austerity in recent history. A perfect storm of rising expenses such as dental materials and laboratory fees essential to deliver National Health Service dentistry; inflation well-exceeding any annual pay uplift awarded during a period of maximum 1 per cent pay restrictions; cuts to the GDS budget through removal of commitment payments and schemes to invest in dental practices, with the imposition of a raft of additional costs in the form of extra regulation have compounded to impact negatively on dental earnings.

\textbf{5.13} GDPs, more than any other health service professionals, are impacted by wider economic conditions. They have been left fully exposed to increased costs due to the devaluation of

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Sterling, and the subsequent rise in the cost of materials. As independent contractors, the significant delays in the application of uplifts makes cash-flow management increasingly difficult. The phasing down of the use of amalgam in dentistry over the next twelve years will significantly increase costs.

Northern Ireland

5.14 Average taxable income of dentists has fallen by 38.1 per cent for practice owners, and by 28.2 per cent for associates between 2008/9 and 2016/17 in real terms. This represents the largest fall in income for practice owners and associates across the UK. In recent correspondence with BDA, Richard Pengelly, Permanent Secretary at Department of Health acknowledged “there has been a material reduction in dentist income over the last 10 years”.

5.15 The cumulative effect of successive, below inflation pay awards; the impact of the zero per cent uplift in 2015/16; tangible cuts to the GDS budget in 2012 and each year since in the form of altering the threshold of Practice Allowance, and the ceasing of commitment payments in 2016, have led to the very considerable erosion of dental incomes in Northern Ireland. Crucially, the removal of commitment payments more than anything else has sent a very negative signal to the profession in how they are regarded by government.

5.16 We believe that significant uplifts to practitioners across the UK are affordable and urgently needed.
Chapter 6 - The policy landscape of dentistry across the UK

6.1 As health is a devolved issue in each of the four countries of the UK, the approach to the delivery of dental services across primary and secondary care comes in varying degrees of difference. Many of the key themes are highlighted here and for the most part affect the UK as a whole. Where there are discreet differences in country, these are highlighted.

6.2 Giving an overview of the dental landscape shows that dentists are facing a raft of challenges and are struggling to keep NHS dentistry afloat against the odds. Our evidence this year reinforces the threats that these policy impacts are having on the profession. Our expected recommendation demonstrates how the Review Body can mitigate the risks to the provision of dental services to patients.

Brexit

6.3 While it is too early to predict what the real impact of Brexit will be on dentistry, even post the EU referendum, there has been a real impact in the form of cost of dental goods - the majority of which are imported from the EU - rising, as Sterling decreased in value.

6.4 There is a very real prospect that essential costs to provide Health Service dentistry will only rise further following the UK’s departure from the EU on 29th March 2019.

6.5 It is imperative that any additional costs - whether they derive from new regulatory requirements, increase in material costs or other factors such as Brexit - are adequately recovered in the fees offered within the GDS. Annual uplifts are key to this process.

6.6 Figures published by the GDC show that the number of registrants who qualified in the EEA has remained largely stable over the last three years and there does not seem to have been a significant change as a result of the referendum result. The number of EEA qualified dentists registered with the GDC stood at 6,819 as of 31 December 2015 and had fallen by 34 to 6,785 as of 31 December 2017. However, EEA qualified dentists account for 16 per cent of those registered and therefore an outcome to the current negotiations that creates new barriers to these dentists remaining in the UK or for EEA dentists to move to work in the UK could substantially exacerbate the existing recruitment and retention problems in the NHS. The developments in negotiations over the future relationship between the UK and the EU, and any impact they have on the number of EEA dentists working in the UK, will need to be monitored closely over the coming months.

Fig 4. Dentist registrants by place of qualification as of 31 December 2017 (Source - GDC)
6.7 It is worth noting that research has found that EEA qualified dentists remain registered with the GDC for significantly shorter periods than UK qualified or ORE registered dentists. The average period of GDC registration for male EEA qualified dentists was found to be 8.1 years compared to 30.6 years for male UK qualified dentists and 27.9 years for male dentists who had registered via the ORE. There was a similar difference for female dentists, with an average registration period of 6.5 years for those qualified in the EEA, 22.8 years for UK qualified dentists and 20.7 years for those registered via the ORE. Of those EEA dentists who registered with the GDC in 2007, 57.85 per cent remained on the register in 2012 compared to 96.27 per cent for UK dentists who had registered in 2007. This indicates that there is much higher turnover within the EEA qualified dental workforce than the UK qualified dental workforce and therefore there is a high risk that this supply of dentists could be destabilised if there is significant adverse change to the relationship between the EU and the UK.

6.8 Around one in 10 dentists in Scotland 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 parts of 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.

6.9 The Scottish Government’s Oral Health Improvement Plan emphasises the valuable skills and experience EU citizens bring to the NHS, and states that workforce planning in NHS dentistry will take account of this contribution. The Scottish Government plans to establish an EU dentists’ network that will provide the opportunity for EU dentists to engage with the Chief Dental Officer on issues relating to Brexit. The Scottish Government will also establish a Dental Workforce Planning Forum chaired by the CDO to provide regular workforce planning across the dental team. It is essential that this Forum takes full account of the risks to the dental workforce (and therefore access and patient care) posed by Brexit and develops appropriate plans to address any potential shortfall.

6.10 The weakness of the pound and the effects of Brexit have seen the cost of materials and equipment in dental practices increasing. Quality of treatment can be improved by increasing fees and taking account of material and equipment costs. It is estimated that the current cost of materials is £40,000 per annum with the addition of £5,000 per annum (due to the devaluation of the pound), giving a total of £4.5m per annum. When awarding uplifts, this must be taken into account.

**Increased expenses and red tape**

**Amalgam**

6.11 Across the UK, dentists have faced new restrictions on the use of amalgam in children under the age of 15 and pregnant and breastfeeding women since 1 July 2018. These restrictions are environmental, rather than being based on any health risk. As a result, dentists are required to use alternative materials that are costlier than amalgam and

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take longer to place. Experts have estimated that composite resin fillings, the most common alternative material, take 1.61 times longer to complete than amalgam.\footnote{Lynch, C.D. et al, ‘No More Amalgams: Use of amalgam and amalgam alternative materials in primary dental care’, 2018, \textit{British Dental Journal}, 225, 171-176}

6.12 In England, this additional time taken to complete fillings will inevitably have an impact on practices’ ability to meet their contracted activity targets. The BDA has estimated that 665,569 fillings will need to be placed using alternative materials. The BDA has sought to negotiate with NHS England on contractual mechanisms that could help to support practices with these additional costs, but, to date, NHS England has not acted to recognise the additional costs faced by practices. This is another pressure that will affect dentists’ morale. In addition, unless the Review Body can factor in expenses, additional costs like these will consume any pay award made.

BSA audits

6.13 Since 2015, the NHS Business Services Authority (BSA) has been conducting dental activity reviews that have applied additional scrutiny to some claims submitted by practices in England and Wales. These exercises go far beyond identifying fraud and instead have simply examined those practices that are outliers against national averages. The BDA believes that these reviews are unjustified and have led to dentists’ under-claiming for legitimate NHS work to avoid being subject to a BSA audit. This under-claiming plays a role in the under-delivery on contracted activity that has seen clawback increase substantially in recent years.

6.14 An FOIA response from the NHS BSA reported that as of 8 October 2018 in England and Wales it had instigated 1,203 reviews since 2015-16; 596 of which remain open. For practices, this can involve significant amounts of work to review claims, the associated patient records and provide a response to the BSA.

Prior approval

6.15 In both Scotland and Northern Ireland, the system of prior approval exists and no longer works as a functioning safeguard in the publicly funded system in the way it was originally intended. In Scotland, since the newly digitised service, practitioners are spending longer (up to 40 minutes) completing and transmitting the prior approval request for treatment. This detracts from time spent with patients. In Northern Ireland the prior approval limit is £280 and has remained static for approximately a decade. Every year more and more treatments require prior approval leading to delays in the appropriate treatment being provided. This disproportionately affects vulnerable patients and we ask that the DDRB recommend that each year the prior approval level in Northern Ireland is raised by £10 until it reaches the levels in Scotland and thereafter rises in line with DDRB awards.

Red tape

6.16 There are increasing demands on practices to comply with a range of regulatory requirements such as the stringent requirements governing decontamination. These requirements consume clinical time, reducing fee earning/UDA generating capacity within a practice whilst simultaneously generating additional costs which have had to be borne by practitioners. Without clinical activity, there can be no turnover. This in turn creates stress for the profession in having to dedicate time which is not remunerated towards essential activities of the practice which only dentists can do.
6.17 In the past, NHS commitment payments would have gone some way towards remunerating non-clinical activity; the essential elements of dentist activity that are currently not supported through the payment system. However, commitment payments ceased in 2016 in Northern Ireland. The commitment payments were put in place as recognition of the commitment of dentists to the Health Service and consequently to encourage retention and improve motivation and allow for an element of career progression. Commitment payments were an important element of net pay for dentists; the removal of which, has been a significant loss to net remuneration as has been demonstrated by the latest NHS Digital report on Dental Earnings and Expenses. Moreover, while Commitment payments were removed in consequence to an era of high overspend in the GDS budget, in an era of significant underspend, and in addressing inadequate remuneration, low morale and growing doubt over the long-term viability of Health Service dentistry, there is a strong case for their immediate reinstatement.

6.18 The increased time dentists are forced to spend on red tape means less time for clinical work. The impact of this can be seen clearly in the NHS Digital analysis on the proportion of time spent on clinical work (Tables 4 and 5 annex B). For practice owners across the UK, this has fallen by around 10-12 percentage points over the last decade.

![Proportion of time spent on clinical work - Practice owners](image1)

![Proportion of time spent on clinical work - Associates](image2)

Figs 5 and 6 Proportion of time spent on clinical work (Source – NHS Digital)

Indemnity

6.19 The BDA’s research has found that both practice owners and associates have seen their indemnity costs increase by well-above inflation. In 2017-18, practice owners paid on average £420 per month for indemnity and for 2018-19 this expense had increased by 9.5 per cent to £460 per month. For associates, indemnity costs increased by 5.6 per cent from £360 in 2017-18 to £380 in 2018-19.

6.20 NHS Digital analysis has found that associates considered the risk of litigation and the cost of indemnity fees to be a leading cause of low morale within the profession. Seventy per cent of associates in Scotland, 78 per cent in England and Wales and 82.3 per cent in Northern Ireland said it had a “major effect” on morale. Practice owners also felt that litigation and indemnity costs were a cause of low morale, with between 60.1 and 67 per cent saying it had a major effect across the UK.\(^{18}\)

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\(^{18}\) NHS Digital, August 2018, *Dental Working Hours: Working Patterns, Motivation and Morale*, p.63-64
Expenses

6.21 Many expenses such as running a chair and employing staff are fixed commitments with ever increasing associated costs. Therefore, clawback and contract reduction have a direct impact on staff employment, particularly dental care professionals. Moreover, such a model will always work against the interests of high needs patients. This requires to be fundamentally changed.

6.22 The DDRB previously called for more work to be undertaken on the formula used to calculate uplifts. In recent years, awards have not kept up with inflation leading to the fall in nominal and real terms. At the lowest level, Scotland was £5k below England and Wales and £7k below Northern Ireland.

6.23 The evidence provided by Scottish Government in 2017-18 on dental practice accounts was not comprehensive and very limited in comparison to, for example, HMRC data on dental earnings and NHS Digital data. Scottish Government carried out a further survey in 2018, working with BDA Scotland and the Scottish Dental Practice Committee which BDA Scotland believed to be user-friendly and less time-consuming than previous surveys. However, the response rate was disappointing and did not yield enough information to be included in the 2018/19 submission. BDA Scotland and the Scottish Government are discussing an alternative approach to gathering expenses information.

6.24 In being concerned about the future sustainability of Health Service dentistry, the ability to invest in one’s own practice is a key factor. In the past decade, inadequate remuneration has directly impacted on the ability to invest in practice.

6.25 Practice owners have voiced their concerns in the most recent NHS Digital Survey which revealed that that only 37.1 per cent of practice owners ‘strongly agreed’ or ‘agreed’ with the statement that they have all the equipment and resources needed to do their job properly - a notable drop of 10.4 per cent since 2015/16.19

6.26 As the NHS Digital report notes, since practice owners are responsible for the equipment provided within a practice, it is telling that this motivation question has seen such a decrease. Anecdotal evidence suggests that replacement of dental equipment has been less frequent in recent years, particularly following the ending of the Quality Improvement Scheme (QIS) funding in Northern Ireland from 2010/11 onwards. This funding previously supported improvements in the delivery of General Dental Services. The thrust of the scheme was to improve working practices that, in turn would lead to service improvements and ultimately benefit patients.

Oral Health Improvement Plan for Scotland

6.27 Scottish Government published its Oral Health Improvement Plan (OHIP) in January 2018. The plan aims “to provide the strategic framework for improving the oral health of the next generation.” It includes 41 action points and several other proposals. The plan is largely aspirational with little detail on priorities, timescales or additional resources.

6.28 Following publication of the plan, the BDA carried out a survey of dentists in Scotland to get their views on a range of proposals contained in the plan. The overall initial

response to the plan was largely negative, with over 60 per cent of respondents having a “negative” or “very negative” impression of the plan, and around 65 per cent having a “negative” or “very negative” outlook for the future. Respondents also had concerns about specific aspects of the plan, including: how dentists will be remunerated, and financial viability; timescales for implementing the various initiatives (though the plan is light on detail regarding milestones); and proposals to reduce the frequency of dental checks and scale-and-polish treatments. These treatments are worth a reported £12 million a year to GDPs in Scotland and a significant reduction in their provision would therefore lead to considerable financial losses for dental practices.

6.29 The Chair of BDA Scottish Council subsequently sent an open letter to the Cabinet Secretary for Health and Sport seeking greater detail on various proposals and to ensure the Scottish Government provides adequate additional funding to implement the plan. The Scottish Government has identified the initial five priorities for the plan, and BDA Scotland seeks regular updates on the progress of these areas for discussion at the various Scottish committees.

Commissioning, contracting and procurement

6.30 As the Review Body is aware, where providers in England fail to deliver at least 96 per cent of their contracted activity and in Wales at least 95 per cent, commissioners can clawback the payments made for this activity. This can have a considerable impact on practice finances, given that the overheads are broadly fixed even where all contracted UDAs have not been delivered. Contracts that consistently underdeliver over two years can have their contract value reduced, or ‘rebased’. Practices are experiencing growing difficulties in achieving their contracted activity and this is posing a serious threat to the financial sustainability of dental practices.

England and Wales

6.31 As we stated in our evidence last year, there has been significant increase in clawback in England; rising from around £55 million in the period from 2013-14 to 2015-16 to £81.5 million in 2016-17 and £88 million in 2017-18. While FOIA requests did not yield consistent or high-quality data, the BDA estimates that only around a quarter of this money is reinvested in primary dental services (see Annex B).

6.32 In each of the last two financial years, around a third of standard GDS contracts have been subject to clawback as a result of being unable to deliver their contracted activity. Further to this, our survey of associates found that, of those with a personal contractual UDA target in England, nearly a third (29 per cent) said that had under-delivered against that target in 2016-17. Figures given to the BDA by NHS England revealed that 7 out of 12 NHS England Local Offices from which information was obtained 84 NHS contracts had been handed back in 2017-18.

6.33 Clawback and handback have resulted in millions of pounds that should be used for dentistry not being reinvested. In the last three years alone, £20 million has been taken out of NHS general dentistry in Wales due to clawback and contracts reductions, but only a small fraction of this has been reinvested into dental practice facilities by one or two Health Boards. Clawback and handback mean that the patient access issues being

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faced in Wales will only worsen, especially when two years of clawback in a practice results in permanent contract reduction.

**Causes of clawback in England and Wales**

6.34 Over the last year, the BDA has undertaken research into the causes of clawback in England; surveying practice-owners, conducting interviews with local representatives and analysing data from the BSA, NHS England and other sources.

6.35 For those practice owners in England that reported that they had been subject to clawback due to under-delivery in 2016-17, the predominant reasons were **associate recruitment problems** and a lack of patients, failed attendance and late cancellation (both 42.9 per cent). Other staffing issues were also reported as prominent factors leading to under-delivery, as was under-claiming, which more than one-fifth cited as a reason for failing to meet their activity target.

<table>
<thead>
<tr>
<th>For what reason(s) was your main NHS contract subject to clawback for under-delivery in 2016/17?</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate recruitment problems</td>
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</tr>
<tr>
<td>Compass / reporting problems</td>
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<tr>
<td>Maternity / compassionate leave</td>
<td>15.4</td>
</tr>
<tr>
<td>Sickness absence</td>
<td>17.6</td>
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<tr>
<td>Performers list / CAPITA</td>
<td>7.7</td>
</tr>
<tr>
<td>Internal practice issues – for example new computer system or building improvements</td>
<td>3.3</td>
</tr>
<tr>
<td>Decided to reduce the proportion of NHS work</td>
<td>13.2</td>
</tr>
<tr>
<td>Decided to increase the proportion of private work</td>
<td>7.7</td>
</tr>
<tr>
<td>Under-claiming</td>
<td>22</td>
</tr>
<tr>
<td>Took the business decision not to meet the target</td>
<td>11</td>
</tr>
</tbody>
</table>

*Fig 7 BDA Survey of Practice Owners 2018 – England respondents*

6.36 The responses from our interviews broadly reflected these themes. Associate recruitment was a significant issue for practices and respondents told us that the NHS was simply not attractive as a working environment and, in some areas, low UDA values were said to be causing difficulties in attracting dentists. The local representatives also said that fear of prompting an investigation by the NHS BSA had led dentists to under-claim for NHS work and this obviously impacted on their ability to meet their targeted activity, despite continuing to provide treatment. A number of respondents described this pressure as a ‘the goalposts being constantly moved’. Respondents also highlighted deprivation and poverty as playing a role in practice under-delivery, in particular due to the above-inflation increases in patient charges. This may be a factor for those citing lack of patients as the reason for under-delivery.

6.37 In Wales, patient issues were the principal reason cited for under-delivery, with half of those subject to clawback stating this was the cause. Associate recruitment, sickness absence and under-claiming were also significant factors, each being cited by nearly a third of respondents (27.8 per cent).
For what reason(s) was your main NHS contract subject to clawback for under-delivery in 2016/17?

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Compass / reporting problems</td>
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<td>Lack of patents / failed attendance / late cancellation</td>
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<td>Maternity / compassionate leave</td>
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<td>Performers list / CAPITA</td>
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<td>Internal practice issues – for example new computer system or building improvements</td>
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<td>Decided to reduce the proportion of NHS work</td>
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<td>Decided to increase the proportion of private work</td>
<td>5.6</td>
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<tr>
<td>Under-claiming</td>
<td>27.8</td>
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<tr>
<td>Took the business decision not to meet the target</td>
<td>5.6</td>
</tr>
</tbody>
</table>

*Fig 8 BDA Survey of Practice Owners 2018 – Wales respondents*

**Practice closures in England and Wales**

6.38 In England, there are many sources of data on the number of NHS contracts. Figures published by the NHS Business Services Authority show that the total number of NHS dental contracts decreased by six per cent between 2015-16 and 2016-17, from 9,537 to 8,927. Meanwhile, the Friends and Family Test Data reports on the number of “dental practices that hold a live contract on the Business Services Authority’s system at the time of submission for the given month, whether data is submitted against them or not. This should include all active practices in England”. These data show that the number of contracts declined from 7,273 in April 2015 to 6,972 in June 2018; a four per cent reduction.
6.39 The BDA has requested information on the number of contracts terminated by the contract holder in 2015-16, 2016-17 and 2017-18 from NHS England under the Freedom of Information Act. Each NHS England Local Office reported different information about the contracts terminated and provided it in different formats so that it is not possible to establish a national trend over time. A subsequent request for the number of contracts terminated solely due to practice closure or conversion to private practice was rejected on the grounds of costs.

**Case study – Queensway Dental Practice, Billingham**

The Queensway Dental Practice in Billingham, near Stockton-on-Tees, with an NHS contract for more than 40,000 UDAs, a contract value of £1.4 million and treating around 12,000 NHS patients handed back its contract in April 2018 and converted to private practice.

**Case study – Bridlington Dental Care, Bridlington**

The Bridlington Dental Care practice closed in June 2018. In a letter to their patients, the practice said “This decision has not been easy, and we have been trying for the last two years to recruit an NHS dentist. We have endeavoured to do our best at all times. There is a national shortage and more so within the East Coast area.”

**Case study – MyDentist practices in Richmond and Catterick**

MyDentist has closed practices in Richmond from 31 March 2018 and Catterick from 30 April 2018, saying “We’ve tried everything to maintain this service, but difficulties in recruiting dentists and ongoing running costs have prevented us from providing NHS dental services sustainably.”

**Case study – Buttershaw Lane Dental Care Unit, Bradford**

The Buttershaw Lane Dental Care Unit in Bradford closed at the end of September 2018, affecting up to 3,000 patients. The practice had an NHS contract for 10,500 UDAs that was worth around £280,000. The practice was said to be in a high-needs area of the city.
In the data that has been provided, NHS England reported that there have been 231 contracts terminated by the contract holder [see Annex B] from 2015-16 to 2017-18. Only the minority of Local Offices provided information as to the reason for the contract termination. While some were for technical reasons, such as practice mergers, there were a number that were due to practice closure or private conversion. In Wessex, of the 44 that were terminated from 2015-16 to 2017-18, 36 were due to practice closure or conversion to private practice. In the Central Midlands, seven of the terminated contracts were due to practice closure and for Staffordshire and Shropshire one contract termination was said to be due the practice leaving the NHS. In the East of England, two terminations were due to retirement, one due to a business decision and difficulty with recruitment and a further contract was terminated to convert to private practice. Of the 31 contracts terminated in the South of England, 19 were due to practice closures.

This reality of a declining number of contracts and practice closures stands in stark contrast to NHS England’s assertion in its December 2017 submission to the DDRB that dentists are ‘enthusiastic’ to undertake NHS contracts (Table 6 annex B).

In its 46th report, the Review Body was interested to note that despite evidence around recruitment and retention problems “no evidence quality problems are starting to emerge”. While open for business practices will fight tooth and nail to keep up the high-quality standards expected of a healthcare profession. A practice is either open and serving patients or it has handed back the contract. Dentists as professionals are handing back contracts if they feel they cannot provide the high-quality care needed. Quality is not a sliding scale. Just because there are no quality problems emerging doesn’t mean the problems surrounding recruitment and retention aren’t there.

Problems with practice closures have been made clear to Welsh Government by dentists’ representatives on several occasions, and yet in their 2017 evidence to the DDRB the Welsh Government did not acknowledge there is a problem with provision of NHS dental services.

Large corporate chains in Wales are finding that NHS contracts are unworkable and, after suffering clawback and contract reduction, are as a result closing in ever larger numbers. In one area alone there have been closures in Knighton, Machynlleth, Dolgellau and just recently Builth Wells. The latter was held by the corporate, MyDentist. The Chief Executive of the largest chain MyDentist wrote to the Times on 10 December pointing out the serious recruitment and retention problems within NHS dental practice.

**Case study – MyDentist practice in Builth Wells**

The MyDentist practice in Builth Wells closed at the end of August 2018. MyDentist said “In common with a number of other dental practices, long-standing difficulties recruiting full time dentists and increased running costs have made it necessary to close the practice.”

**Dental contract reform**

As in previous years, the Review Body indicated a desire to be kept informed of developments on contract reform across the UK.
England contract reform

6.46 The BDA remains fully engaged in the contract reform process. In England, however, we have argued strongly for changes to the current prototype model. As we noted in last year’s evidence, the contract reform prototypes have been extended until March 2020 and we hope that the Department of Health and Social Care (DHSC) and NHS England will look to enter into formal negotiations shortly.

6.47 Since last year’s evidence, the DHSC has published an evaluation of the prototypes’ first year (2016-17). While there are some reasons to be optimistic based on the report, it does provide evidence to support the BDA’s concerns about the financial sustainability of the prototype model. In 2016-17, 24 per cent of wave two and wave three prototypes and 31 per cent of wave one prototypes delivered below 96 of their contract value and would, therefore, have been subject to clawback. Even for those practices that delivered their contact value, the evaluation report notes that a number had incurred increased costs to be able to do so.

6.48 Ministers have indicated that we may see a gradual roll-out of a reformed contract from April 2020. Work is continuing to design the financial model to be used and good progress has been made. The BDA is working on producing a revised model associate agreement that works for practices and associates. The model is likely to mirror the payment arrangements for practices which will be a mixture of capitation payments and UDAs. We will be working closely with NHSE and DHSC to produce a replacement for UDAs soon after roll-out starts to happen.

Wales contract reform

6.49 As in England, the real costs of treating high needs patients in the current system are not accounted for and so the dental practice is in effect penalised for seeing high needs patients. Where there may be high needs patients not currently with a practice their potential treatment costs would not be covered by the UDA value, so there is no incentive for practices to see these patients.

6.50 The contract therefore acts as a strong disincentive for dentists to treat high needs patients owing to the broken business model. It is a misnomer to talk about units of dental activity when they are clearly expected to be infinitely elastic and not a unit in any normal business sense. The UDAs do not work for high needs patients and are consequently not fit for purpose.

6.51 Ideally, the BDA would prefer all practices to be given the type of contract that the two prototype practices in Swansea are operating, which is 85 per cent capitation and 15 per cent quality measures. With such a contract no clawback is imposed, and preventative dentistry is at the front and centre of its operations. The ‘prototype practices’ saw an initial reduction in patient numbers at the early stages because preventative treatment is more resource intensive initially until the high needs patients are stabilized, but two years on and the most recent data show that patient access has returned to the required levels. The same cannot be said for English prototypes.

6.52 One of the key aspects of contract reform propounded by the Welsh Government is the use of skill-mix, which essentially is employing dental hygienists and therapists to take on some of the work usually done by dentists. The BDA has requested from Welsh Government the business model that demonstrates how this skills-mix would work, particularly for single-chair dental practices. There are many fixed overheads in running a dental surgery chair and apart from the salary differential (which is not a great saving) there are no other obvious savings to the practice. DCPs have a limited scope of
practice, even with the upskilling, and tend to be slower and cannot see emergency patients. Should the model need an extra dental surgery chair for DCPs it is unclear a) how this can be afforded by the practice, b) how the return on investment (ROI) makes good business sense, and c) whether patients would be comfortable being seen by several different practitioners rather than just their dentist.

Access to NHS services in Wales and the impact of low patient access

6.53 Dentistry activity is not likely to improve. In fact, it is likely to worsen in the near future as populations grow but the large majority of practices cannot take on new NHS patients and even those that can, often require new patients to join a waiting list. In 2017 the BDA undertook a study of new patient access for all dental practices in Wales and the figures were shockingly low in many instances. On average across Wales only 28 per cent of practices were taking on children (up to 16 years of age or 18 years of age if in full time education) for NHS treatment and even fewer (15 per cent) on average were taking on NHS adult patients. These averages mask certain areas of Wales where access to NHS services is actually far worse.

BDA analysis

Nearly three quarters of children being born in Wales today will struggle to access an NHS dentist.

6.54 The Royal College of Paediatrics and Child Health’s report State of Child Health 2017 lists access to timely primary dental care as a key health objective. The reality is that this objective is currently not possible. If children cannot easily access NHS dentistry, then good oral health cannot be achieved and maintained.

6.55 The outcome of practice closures and closed waiting lists is that patients are having to travel many miles (30 to 90 miles according to BDA analysis) to be treated by a dentist assuming they are lucky enough to find an NHS dentist who has capacity to take on new patients. Dentists who meet their NHS contract target cannot claim for extra work. Both England and Wales need a dental contract that is fit for purpose and a motivated workforce that is fairly remunerated and enables to dentists to see these patients. This must be tackled against the backdrop of recruitment and retention issues we discuss in chapter 7.

Northern Ireland contract reform

6.56 Negotiations towards a new contract for General Dental Services have stalled as we await the findings of an evaluation undertaken by the University of Manchester of the GDS pilots, which ended in August 2016. The BDA does not know when the report will be published, the findings of which will inform negotiations on a new contract, between the BDA and Department of Health.

6.57 Until new contract arrangements are in place, dentists continue to operate in a fixed fee per item system with payments for patient registration and clinical care, with percentage payments (a proportion of item of service fees) making up a practice

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23 BDA response, ‘More than Words’, 2018, to The Welsh Assembly’s Health, Social Care and Sport Committee’s Inquiry into Dentistry in Wales


allowance. In the interim, and for the foreseeable future, item of service payments by their nature must more adequately reflect the resources utilised in respect of professional time, materials and overheads to guarantee the sustainability of Health Service dentistry.

6.58 Discussion of the contract reform process in community dental services is discussed in greater detail in our chapter on community dental services. However, this is the third evidence submission where the revised contractual terms and conditions for CDS dentists have still not been implemented.

Orthodontic procurement in England

6.59 NHS England South region has awarded orthodontic contracts (PDS) across most of the region in the biggest single procurement process that NHS England has undertaken within dentistry since its inception. Although contracts have now been awarded, some lots did not attract many bidders. Many lots were won by corporates. The process is being repeated across the rest of England with NHS England London region close to awarding contracts. NHS Midlands and East procurement is expected later this year. The procurement for the North region was prematurely stopped in mid-December and contractors await information on whether the procurement will recommence or start afresh. For those providers who face loss of livelihood because of this entire procurement process, the expected impacts are huge for the profession and for patients. For many years PDS contracts have been rolled on in preparation for this round of procurement. We are concerned about the business model of time limited contracts (5+5yrs or 7+3yrs) and the financial viability and sustainability of these practices. We anticipate increasing recruitment and retention problems particularly as the end dates to contracts approach with no automatic guarantee of a follow-on contract being awarded.

Workforce and training in Wales

6.60 The future specter of impacted recruitment and retention of dentists in Wales has been made clear to Welsh Government including in the last DDRB evidence. Yet the Government held down the number of training places for dentists, despite continuing and predicted population growth as shown by the public health observatory (2016). They instead proposed increased numbers of training places for Dental Care Professionals (DCPs). This however masks the fundamental issue that we need more dental training places in Wales.

6.61 The last time the Welsh Government systematically considered workforce issues was the survey of 2012. The review stated ’On average during the period 2007-2010, 58 per cent of Welsh-trained dental graduates entered the Welsh workforce after completing Dental Foundation Training year 1. Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales. Of these (58 per cent), 90 per cent undertook DF1 training in Wales and 10 per cent undertook it elsewhere before returning to work in Wales’. The 2012 workforce survey said that ’Welsh trained dentists account for 41 per cent of the dentists currently working in Wales’.

http://www.publichealthwalesobservatory.wales.nhs.uk/demography-overview
27 National Leadership and Innovation Agency for Healthcare (October 2012) An analysis of the Dental Workforce in Wales
Chapter 7 - Sustainability of general dental practice

7.1 Across the UK the BDA is concerned about the sustainability of NHS dental practice. For all the reasons outlined above, the threats and challenges are significant. This is set against a financial (healthcare) landscape that is relatively constrained by historical standards. Whether the age of austerity is finally coming to an end is little consolation to those reliant on the public sector who have seen incomes severely eroded and smaller healthcare providers on the brink of financial collapse. We have also seen large corporates handing back contracts because the practices were not financially viable.

7.2 GDPs have demonstrated enormous resilience over the years, but they are now at breaking point. Recurrent delays in pay uplifts, and low, inadequate health service fees are increasingly unsustainable and will continue to force practitioners to significantly question their commitment to the health service.

Recruitment and retention of GDPs

Recruitment

7.3 Recruitment and retention of staff to an organisation or system depends on many factors. In this case, the NHS is the system and it needs both self-employed and employed people to work in it as one small part of a bigger organisation. Patients rely on all parts of the system working well and being there for them when they need it. What they don’t need is a system that is functioning at over capacity with a workforce struggling to retain valuable clinical staff and/or failing to recruit new ones. It also needs all participants as individuals, professional groups and employing organisations to understand and agree about recruitment and retention problems before they occur.

7.4 Getting dentists to work in the NHS system is difficult, that is why improvements to the offer (financial/ terms and conditions) are vital. Our recent survey of practice owners shows that when questioned about whether practices had difficulty recruiting the two reasons cited the most was ‘few or no applicants’ and ‘difficulty finding a suitable dentist’. Although across England and the UK the reasons for recruitment issues vary between areas, the difficulties faced however, are acute.

7.5 All regions of England apart from London had difficulties with few or no applicants. The Midlands and East region had the most problems (86.7 per cent) yet reported lower figures for unsuitability of applicants because of the fewer number of applications received for posts.

7.6 In the North region with 75.8 per cent of those surveyed expressing difficulties with few or no applicants, 81.8 per cent had problems with the suitability of applicants.

7.7 In London, the problems are different yet no less acute. Despite London reporting fewer difficulties getting applicants, the suitability of applicants, however, was a big problem (87.5 per cent). The South region also reported higher levels of unsuitability of applicants. London also had 50 per cent of respondents indicating that applicants withdrew at short notice. Taking this further 62.5 per cent of respondents in London reported that applicants had a reluctance to work in the NHS. When the rest of the UK is considered, the problematic geography of recruitment and retention becomes even clearer.

7.8 Of all the UK countries, Northern Ireland reported highest difficulties in finding a suitable dentist when trying to recruit (81.8 per cent). Both Wales and Northern Ireland dentists selected few or no applicants when reporting difficulties (100 per cent),
however those reporting that applicants are reluctant to work in the NHS were predominantly English and Welsh dentists. Northern Ireland and Scottish dentists also suggested finding appropriate maternity/sickness cover affected around half of those who responded to this question (54.5 in NI and 48.1 per cent in Scotland). Again, this is due to the contractual differences between the four countries where cover in England and Wales is much rarer.

7.9 Overall, more people expressed a difficulty in finding a suitable dentist to work in a practice in urban areas with fewer or no applicants for posts in rural areas although this is not exclusive. All parts of the UK have reported these issues. NHS committed practices (75 per cent or more NHS commitment) found they received fewer applicants than less NHS committed practices.

**GDS in Wales**

NHS general dentistry in Wales is at a time of significant change. The number of providers who are also NHS performers (providing-performers) across Wales has more than halved in the 8 years from 2010 to 2018, from 418 to 155 a 63 per cent fall. The fall in providing-performers is unexplained because no systematic Wales-wide survey has looked at the causes. However, if numbers continue to decline at current rates, there will be near zero providing-performers left in NHS dentistry in five years’ time working under a traditional independent practice model. NHS Digital (Aug 2018) said: “Whilst the results for Associate dentists are quite similar when comparing England & Wales to Wales only, there are larger differences for Providing-Performer dentists where dentists in Wales tend to work longer hours, take fewer weeks’ annual leave and perform more NHS work.”

7.10 Problems with recruitment and retention of associates, together with a vast reduction in providing-performers, has inevitably resulted in NHS dental contracts being reduced or returned altogether, sometimes with the closure of the practice, resulting in significant numbers of patients being left without access to NHS dental care.

7.11 In 2017, NHS England submitted evidence to the DDRB describing how “dentists are still generally ready, and indeed enthusiastic, to bid for and undertake NHS contracts – including in areas where dentists had previously chosen not to set up or provide NHS services – and NHS access continues to rise.” In August 2018 NHS England and the BDA hosted an associate recruitment and retention workshop and all parties present (including the DHSC) agreed that recruiting and retaining dentists within the NHS in England was a serious problem.

7.12 NHS Digital reported that in 2016/1728 Providing-Performer dentists’ average taxable income from NHS and private dentistry decreased by 7.3 per cent. Associate dentists have also seen a decrease in taxable income by 2.1 per cent. A comparison of average Provider performer taxable income in England £117,400 against £83,700 in Wales shows a very large difference in earnings for that group of dentists (approx. 30 per cent less in Wales). NHS Digital said: “The most common contributory factors [across England and Wales] to low morale are increasing expenses and/or declining income and the risk of litigation and the cost of indemnity fees. Regulations are also cited as a major cause of low morale amongst Principal dentists.”

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28 NHS Digital (30 August 2018) Dental Earnings and Expenses Estimates 2016/17
7.13 In the 2018 dentistry activity statistics published by the Welsh Government it appears there has been little change in the number of dentists per 10,000 of the population. However, this figure does not consider the full-time equivalents (FTEs) providing NHS treatment and is merely a headcount. NHS Digital (Aug 2018) said: “During the last decade there has been a notable drop in the amount of time dentists spend on clinical work across the UK.” The FTEs will be therefore lower. Also, the figure 1,475 includes Dental Foundation Year 1 posts. We therefore believe this latest report does not paint the whole picture.

**Retention**

7.14 You can’t burn the candle at both ends is an old but apt adage. Associate respondents to the BDA annual survey told us that those at both the beginning and the end of their career are the most likely to leave the profession within five years. There are significant threats to the system if both ends of the profession are disillusioned enough to leave.

7.15 Our data shows that three quarters of those who indicated they intended to leave dentistry in the next five years were the 55-64 aged associate dentists. On face value there is an expectation that after a long career, any person will naturally want to retire and take their pension. What is significant here, is the loss of knowledge and experience to the profession.

7.16 Of most concern however is the next biggest cohort of associate dentists who replied to our survey with the intention to leave dentistry within the next five years. That is the generation between 25-34 years of age. 61 per cent of respondents indicated a desire to leave. These people will be between only 2- and 10-years post qualification. The significant investment to train a dentist (that will usually work in the NHS to different degrees) is wasted if that individual leaves.

7.17 What does not come as a surprise is that our survey showed us that 64 per cent of those who wanted to leave had mostly over 75 per cent NHS commitment and those with very high needs patients (those with over 75 percent adult exempt patients) was in over 74 per cent of responses. The high needs high pressure environment of NHS dentistry is the biggest challenge to retention of quality staff.

### BDA analysis

**72 per cent of respondents to the BDA annual survey from Wales said they intended to leave the dentistry within the next five years. The highest of all four UK countries.**

7.18 Data from NHS digital for England demonstrates that of the cohort of ‘leavers’ to the NHS each year, just over one fifth since 2013/14 has been females under the age of 35 years. Including male dentists aged under 35, for the last two years (2015-2017) the total figure of NHS ‘leavers’ aged under 35 was 37 per cent29. That is quite a large number of people leaving the NHS in England and quite a significant financial investment by the NHS being lost from those practitioners no longer using their skill for the NHS. Their loss also exacerbates the recruitment and retention problems facing the profession.

7.19 These findings from our own surveys are supported by analysis from NHS Digital. According to the Dental Working Hours 2016/17 and 2017/18 report:

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• In England and Wales:
  - 62.7 per cent of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 57.2 per cent in 2015/16
  - 56.1 per cent of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 47.6 per cent in 2015/16

• In Scotland:
  - 69.3 per cent of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 57.1 per cent in 2015/16
  - 57.1 per cent of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 45.9 per cent in 2015/16

• In Northern Ireland:
  - 64.0 per cent of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 59.2 per cent in 2015/16
  - 52.1 per cent of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 51.1 per cent in 2015/16

Morale and motivation of GDPs

7.20 Since its 2011-12 peak, the proportion of NHS work undertaken by all dentists has fallen in each UK country. Most notably, in Northern Ireland, there has been a 7.5 percentage point reduction in dentists’ NHS share.

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<td>Scotland</td>
<td>79.7</td>
<td>77.9</td>
<td>77.3</td>
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<td>75</td>
<td>74.9</td>
<td>72.9</td>
<td>72.4</td>
<td>71.2</td>
<td>69.7</td>
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Fig 10 NHS share (Source: NHS Digital)

7.21 The cumulative financial impact, and the very real human impact of working in Health Service dentistry is clearly evidenced by the government’s own figures and paints a particularly bleak picture of what GDPs in Northern Ireland have been warning about for some time. The situation where GDS dentists have suffered a real term 38% decline in income levels over the past 8 years, to the point where over two thirds question their future in the profession, is as serious as it gets. Morale is at an all-time low, with 70% of Practice owners and nearly 60% of Associates rating their morale as ‘very low’ or ‘low’ – this does not bode well for long-term sustainability of Health Service dentistry.

7.22 The difficult financial situation that many dentists find themselves in has had profoundly negative effects on morale and is already having a direct impact on retaining dentists who see a long-term future providing NHS dentistry. The more that the government neglects to invest in GDS dentistry, the more likely it is that dentists will have no choice but to pursue alternative income streams to safeguard the future viability of their practices and livelihoods, and their own wellbeing.

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30 Using NHS Digital figures, calculations for real income by the BDA, using the Retail Price Index (RPI) as the deflator and measure of inflation; with 2008/09 as the base year, we get real falls in taxable income between 2008/9 and 2016/17 of 38 per cent for practice owners and 28 % for associates.


32 Nearly two-thirds of Practice Owners (64%) and over half (52.1%) of all Associate dentists often think of leaving dentistry (either ‘strongly agree’ or ‘agree’ with the statement ‘I often think about leaving general dental practice’) and the percentages agreeing with the statement have increased since the previous survey.

It has been clear from previous evidence provided by the BDA, and that from other sources, that the morale, motivation and professional satisfaction of dentists has been declining in recent years and the most recent evidence indicates that morale remains low. This raises fundamental questions about how long this situation can be sustained for, particularly given the demonstrable relationship between pay, NHS commitment and morale.

**BDA analysis – Northern Ireland**

Morale within the GDS workforce is now so low that from a wellbeing perspective alone we have grave concerns about the future sustainability of health service dentistry. Last year, 63 per cent of practice owners reported their morale as being ‘low’ or ‘very low’; latest figures show morale has worsened even further to 68 per cent ‘low’ or ‘very low’. Clearly, the dental profession feels significantly undervalued in the current arrangement with commissioners.

As in previous years, the outcomes of our surveys of practice owners and associates show low morale in the profession. Less than a third of both associates and practice owners state their morale is high or very high, while more than two-fifths of practice-owners (44.1 per cent) have low or very low morale. It is worth noting that more than half of associates in Northern Ireland and practice owners in Scotland said their morale was low or very low. In Wales, 60 per cent of practice owners said their morale was low or very low and only 12.2 per cent said it was high or very high.

These levels of low morale continue a trend that we have observed in recent years, with the proportion stating their morale is high or very high having fallen substantially across the last three years (Tables 7 and 8 annex B).

These results are similar to those found by NHS Digital, which has observed a pattern of low morale, and found that in 2017-18 around half of all dentists stated their morale was low or very low – lower than that found in our surveys. Practice owners in Northern Ireland were found to have the lowest morale, with 68 per cent considering their morale low or very low, and associates in England and Wales had, relatively, the highest, but still among this group 48.1 per cent said their morale was low or very low.

Figs 11 and 12: Data from BDA Associates (left) and Practice Owners (right) Surveys 2016, 2017 and 2018

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34 NHS Digital, August 2018, *Dental Working Hours: Working Patterns, Motivation and Morale*, p.48
Factors in low morale

7.27 Our surveys again found a stark difference in the morale of associates and practice owners based on their level of NHS commitment. For practice-owners with the highest levels of NHS commitment, 60.1 per cent said their morale was low or very low. This contrasts with only a third of practice owners with an NHS commitment below 75 per cent. Similarly, for associates, 38.7 per cent of those with high NHS commitment said their morale was low or very low, while the same was true for only a quarter of those with lower NHS commitment.

7.28 Our surveys also found a link between higher income and higher morale. Practice owners earning £100,000 or more were less likely to rate their morale as a dentist as low or very low than those earning less than £100,000 of personal taxable income (34.1 per cent and 23.4 per cent respectively). This was also true for associates and the difference between both income brackets was more pronounced than for practice owners, with 24.1 per cent for associates earning £100,000 or more rating their morale as low or very low versus 41.4 per cent for those earning less than £100,000.

7.29 NHS Digital also found that dentists considered income to be a cause of low morale. For England and Wales, Scotland and Northern Ireland respectively, 70.1, 80.3 and 83.3 per cent of practice owners cited ‘increasing expenses and/or decline morale’ as having a major effect leading to low morale. This was the highest for any of the factors NHS Digital asked practice owners to consider. For associates, income was also seen as significant factor in causing low morale; with 60.9 per cent saying so in England and Wales, 50.6 per cent in Scotland and 69.1 per cent in Northern Ireland. However, associates were also found to be very concerned with the risk of litigation and the cost of indemnity fees (see paragraph 6.18-6.19).

7.30 This analysis also found that practice owners in England and Wales with an NHS commitment of between 75 and 100 per cent were more likely to cite increasing expenses and or declining income as a major cause of low morale than those with NHS commitment between 0 and 25 per cent (74.1 and 54.1 per cent respectively). For associates, there was a smaller, but still considerable, difference based on NHS commitment; with 62 per cent of those with the highest NHS commitment citing income as major factor in causing low morale compared to 52.5 of those with the lowest or no NHS commitment. More substantial, however, was the difference in the proportion of associates citing the ‘disparity between treatment complexity and financial return’ as a major cause of low morale. For practice owners in England and Wales, this amounted to a 31.4 percentage point difference.

NHS Digital, August 2018, Dental Working Hours: Working Patterns, Motivation and Morale, p.63
and for associates 18.3 percentage points. While the differences were not the same for each country, there was a general pattern that allowed NHS Digital to conclude that the morale of predominantly NHS practice owners is more adversely affected by the disparity between treatment complexity and financial return and increasing expenses and/or declining income than practice owners who work mostly privately\textsuperscript{36}.

**Motivation**

7.31 Given the significant decline in dentists’ income over the last decade, these are unsurprising findings and are further reflected in dentists’ satisfaction with their pay (Tables 9 and 10 annex B). For both practice owners and associates, a greater proportion are dissatisfied with their pay than agree they are fairly paid. More than half of dentists working in Northern Ireland, Scotland and Wales disagree or strongly disagree that they are fairly remunerated for their work.

7.32 There is a considerable difference between satisfaction with pay based on NHS commitment. Only one-in-six (14.4 per cent) of practice owners with a high NHS commitment agreed or strongly agreed that they were fairly remunerated for their work and more than two-thirds (68.4 per cent) disagreed or strongly disagreed. Meanwhile, for practice owners with a lower NHS commitment 57.2 per cent agreed or strongly agreed and 25.2 disagreed or strongly disagreed. For associates there was a similar picture, with only 22.7 per cent of those with a high NHS commitment feeling they were paid fairly and 58.2 per cent agreeing or strongly disagreeing. While almost the opposite was true for those with a lower NHS commitment, with 57.2 agreeing or strongly agreeing they were remunerated fairly and 25.2 per cent disagreeing or strongly disagreeing.

7.33 NHS Digital also found that dentists were deeply dissatisfied with their pay, with more than half of both associates and practice owners across the UK stating they disagreed or strongly disagreed that they were paid fairly. In fact, for some dissatisfaction was considerably higher, with 69.9 per cent of practice owners and 63.9 of associates in Northern Ireland saying they were not paid fairly and 70.9 per cent of practice owners in Scotland saying the same.

7.34 Considering pay alongside the other motivating factors that our survey asked dentists for their views on, satisfaction with pay has the lowest levels of agreement among associates and is second lowest for practice owners. NHS Digital’s analysis found that satisfaction with pay scored lowest for both groups of dentists across the UK\textsuperscript{37}.

<table>
<thead>
<tr>
<th></th>
<th>Practice owners</th>
<th>Associates</th>
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<tbody>
<tr>
<td>I get support from my colleagues at work</td>
<td>76</td>
<td>77.1</td>
</tr>
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<td>There are opportunities for me to do challenging and interesting work</td>
<td>73.1</td>
<td>61.7</td>
</tr>
<tr>
<td>I am able to provide patient care to a standard that I am satisfied with</td>
<td>70</td>
<td>69.8</td>
</tr>
<tr>
<td>I have clinical freedom in my work</td>
<td>-</td>
<td>72.9</td>
</tr>
<tr>
<td>I feel involved in the decisions that affect my work</td>
<td>-</td>
<td>51.5</td>
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<tr>
<td>I feel secure in my job</td>
<td>72.5</td>
<td>63.9</td>
</tr>
<tr>
<td>There are opportunities for me to develop in my career</td>
<td>61.5</td>
<td>54.4</td>
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</table>

\textsuperscript{36} NHS Digital, August 2018, *Dental Working Hours: Working Patterns, Motivation and Morale*, p.66-67

\textsuperscript{37} NHS Digital, August 2018, *Dental Working Hours: Working Patterns, Motivation and Morale*
There are opportunities for me to develop my skills | 71.7 | 62.1
---|---|---
I am fairly remunerated for my work | 40.6 | 35.7
I achieve a good balance between my work life and private life | 32.5 | 50.8
I look forward to going to work | 40.7 | 41.8
I am enthusiastic about my job | 53.5 | 56.6
Time passes when I am working | 68.2 | 72.4
I am treated with respect by the people I work with | 86.2 | 79.4
I feel valued for the work I do | 66.9 | 54.8

*Fig 15: Percentage strongly agree and agree – BDA survey of Practice Owners and Associates 2018*

7.35 Looking at its ‘motivation index’, which measures average motivation across its six measures, NHS Digital’s analysis has found a strong relationship between a dentist’s NHS commitment and their motivation. For example, practice owners in Northern Ireland with very low motivation had an average NHS commitment of 74 per cent, whereas those with very high motivation had an average NHS commitment of just 17.6 per cent. In England and Wales, the average NHS share for practice owners with very low and very high morale was 77.4 and 42.8 per cent and 79.2 and 57.4 per cent for associates.

7.36 NHS Digital states that its “statistical model predicts that if all other working patterns remained unchanged, but dentists switched from all private to entirely NHS work (from 0% to 100% NHS share) the ‘motivation index’ of Providing-Performers would decrease by 19.3 percentage points and by 17.7 for Associate dentists” and there were similar results in Scotland – decreasing by 18.1 and 12.9 percentage points respectively – and Northern Ireland – decreasing by 34.5 and 29.5 percentage points.

**Consequences of low morale**

7.37 In light of the low levels of morale and significant dissatisfaction with pay, it is not surprising that we found that a clear majority of both associates (60 per cent) and practice owners (61 per cent) would not recommend a career as a dentist. There has been a general downward trend over the last three years in the proportion of dentists that would recommend the profession as a career (Figures 16 and 17). As with the other measures, there is a difference based on NHS commitment. More than two-thirds of associates (67.4 per cent) and practice owners (69.8 per cent) with the highest NHS commitment would not recommend a career as a dentist, whereas 30.8 per cent of associates and 54.6 per cent of practice owners with a lower NHS commitment said the same. Given that we know that many dentists were influenced to pursue dentistry as a career by family members who were dentists, the unwillingness of current dentists to recommend it as a career has the potential to have a damaging long-term impact on recruitment to the profession.

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38 NHS Digital, August 2018, *Dental Working Hours: Working Patterns, Motivation and Morale*, p.27
Figs 16 and 17: Data from BDA survey of practice owners and associates 2018

7.38 The low proportion of the profession willing to recommend a career as a dentist also raises questions about the extent to which many dentists see their futures continuing in dentistry, as has been discussed above. Further to this, our research also found that there was a statistically significant association between practice owners’ and associates’ morale and whether they wanted to leave dentistry or not. The odds of practice owners wanting to leave dentistry were 9 times higher if they reported low or very low morale than if they reported high and very high morale and for associates it was almost 12 times higher.

7.39 It is also clear from our surveys that a significant proportion of GDPs are experiencing stress and burnout. We found that 54.8 per cent of practice owners and 39.9 per cent of associates said that they find their current job very or extremely stressful and a further 31.5 per cent of practice owners and 40.6 per cent of associates said it was moderately stressful. Given this level of stress, it is not surprising that 34.7 per cent of practice owners and 27.3 per cent of associates said that they disagree or strongly disagree that they can cope with the level of stress in their current job. This level of stress is having an impact on the wellbeing of GDPs. More than two-fifths of both practice owners (46.8 per cent) and associates (41.4 per cent) said that they had felt unwell because of stress.
Chapter 8 – Community/public dental services

CDS across the UK

8.1 Despite a formal announcement of an ‘end to austerity’, pay for Community Dentists does not reflect such a policy. It appears that pay restraint remains the primary approach of the government regarding public sector workers. Given the vital work that CDS dentists undertake in ensuring that the most vulnerable members of society are suitably engaged in firstly NHS dentistry, secondly into the wider NHS and often also into social and community services themselves, this ‘gatekeeping’ role seems scantily appreciated by government.

8.2 This year we have submitted 89 Freedom of Information requests to CDS providers across the UK. From these we have received 75 substantive responses. Only in England did all providers not respond as 50/64 requests received a substantive response.

8.3 Beyond the data identified from Freedom of Information requests we have also surveyed BDA members receiving almost 600 responses (annex A).

8.4 As such we are able to present data on not only the structure of the CDS workforce but also the direction of travel of services, the climate in which they are operating and the motivation and morale of the dentists therein.

Workforce data

8.5 In the tables below, we present figures provided to us from our Freedom of Information Act requests on the demographics of the community dental workforce.

8.6 Dentists working in the CDS have traditionally considered such posts to be a vocation and as such have displayed loyalty to the services in which they work. As a result, the majority, 66 per cent, of CDS dentists have now reached the top of their salary scale with no opportunity for progression unless successfully applying for another post.

Fig 18 Workforce WTE v Headcount (Source BDA survey)

8.7 This loyalty to the service is evidenced by the overall age of the workforce. Assuming an average career of 40 years (ages 25-65) then 58 per cent of the workforce is over the half way point of their careers with over a quarter of the workforce in the likely final stages of their careers.
Recruitment

8.8 In previous years we have highlighted that ongoing issues in the CDS have the potential to precipitate a recruitment crisis and we would posit that we have now reached that point.

8.9 In the last two years, 2017 and 2018 the combined CDS’ of the UK have not even sought to recruit to all of the vacancies that have arisen. Despite a selective advertising process, the CDS clearly suffers from a significant current recruitment problem in that, following the exhaustion of the recruitment process, essentially, for every three posts that have been made vacant over the previous two years less than two appointments have been made in return.

8.10 In an attempt to mediate against this clear recruitment problem employers are seeking to take advantage of the clear difference in headcount and whole-time equivalent figures presented above.

8.11 As such, less than one in five CDS staff have not been asked to provide cover for absent colleagues whereas half report that it is a moderate or more frequent event. This 50 per cent threshold was again met when we asked members how often they were required to work more than their contracted hours.
8.12 So, whilst we cannot say that all CDS are undergoing a recruitment problem themselves, it is clear that significant problems in staffing, either because of particular recruitment problems or a disconnect between the work commissioned and the workforce available to execute said work are having a clear, obvious and negative effect on a far larger group of staff than they are not. Consequently, we can report that 82 per cent of CDS dentists believe that their workload is either high or very high.

8.13 The workload pressures being placed upon CDS dentists are having a clear determining effect upon perceptions of pay fairness with almost half of CDS dentists believing that their current pay was unfair.

Morale and motivation

8.14 It should be of no surprise that the working environment described above is having a significant impact upon the morale and motivation of CDS dentists. In its most basic iteration CDS dentist morale should present a cause for concern.
8.15 Such low levels or morale are reflected in the enthusiasm CDS dentists currently have for their work;

8.16 Perhaps most worryingly however is the lack of career progression CDS dentists believe they are currently afforded.

8.17 The structure of CDS' has historically enabled staff to progress though a well-defined career structure, providing training and appropriate remuneration for those with the requisite commitment and skill. However, the majority of CDS dentists now do not believe that the CDS provides opportunities for such career progression. As a result, 45 per cent of CDS dentists now do not see their future in the CDS within the next five years.

8.18 Last year we stated that the goodwill CDS dentists held towards their patients was a resource the NHS should seek to cultivate and that a reasonable investment in the CDS would act as significant multiplier.
8.19 Above are the three most strongly reported motivation factors for CDS. Quite simply, CDS dentists are loyal to their teams and patients. This does not mean that their concerns should be ignored but rather recognised as an opportunity for the NHS to make a reciprocal show of commitment to a cadre that provide so much more to their patients than dentistry alone.

**Patient experience**

8.20 Given the data presented above it is obviously of little surprise that patients are witnessing an impact.

8.21 With regards to accessing appointments we have been told by 16 per cent of respondents that patients can never or rarely gain appointments at an appropriate time. This is despite the fact that 26 per cent of respondents have informed us that appointments times over the previous year have decreased in length. However, the obvious corollary of decreased appointment times is that 17 per cent of respondents tell us that they never or rarely had the requisite time scheduled to provide the treatment necessary. This is of course a particular escalatory problem in the CDS given the complex nature of many CDS patients independent of their clinical need.

**CDS England**

**Tendering in England**

8.22 A significant amount of tendering has been reported by our members with 51 per cent of them (in England) informing us that their service has undergone a tendering exercise in the past year. In many cases the whole of the CDS was being placed out to tender. Furthermore, a number of BDA members have reported that whilst their services have not been placed out to tender they have now passed beyond the end of their initial contract period and are simply delivering services in an essentially 'locum' way. The starkest example of this is in Yorkshire and Humberside where two attempts have been made to re-commission the various CDS services and both have been abandoned. Consequently, these services are refusing to make long-term commitments to staff, foregoing training, promotion and substantive changes and are also no longer investing in replacing, where necessary, the facilities required to treat patients appropriately.

**CDS in Wales**

**Recruitment and Retention in the Welsh CDS**

8.23 The CDS in Wales is under stress and staff morale is low. This is understandable considering the difficulty health boards are having with recruitment and retention of CDS staff due to recent retirements and the lack of interest in joining the CDS by younger dentists. The number of full-time equivalent total dental officers in the community dental service in 2016 (N=79) was the lowest since the peak in 2011 (N=89); a reduction of 11 per cent.
8.24 The most recent available data for 2017 from StatsWales are incomplete due to code 970 for CDS dentists having been retired in the NHS occupation manual with health boards advised to assign those staff to the most suitable code. This has led to inconsistent reporting by Health Boards and the figures for 2017, therefore, should be disregarded.

8.25 Of note, there were 73,724 contacts made by the CDS in 2016-2017. A similar number of contacts, 73,827, were made in 2009/2010 when the CDS in Wales had 11 per cent more FTE staff. Such current work-loads are likely to increase the amount of stress for dentists in the CDS as they are expected to deliver the same service with less capacity. Moreover, this service model does not address the growing Welsh population.

PDS in Scotland

8.26 This is a crucial time for the Public Dental Service (PDS) in Scotland, with changes to the PDS management and recent NHS Board appointments signalling a move away from traditional PDS posts. Many NHS Boards are looking at different management structures and this is a cause for concern.

8.27 A number of PDS posts are not being replaced on a ‘like for like’ basis. In addition, NHS Boards have been reducing the number of posts in the PDS due to the transfer of GDS patients to independent GDP clinics with an overall a reduction of 16.3 per cent in PDS posts between 2013/14 and 2017/18, as detailed in the NHS Scotland Primary Care Dentistry in Scotland annual report 2017/18. The reduction in PDS posts from 2016/17 to 2017/18 was 6.1 per cent.

8.28 There is a lack of PDS dentists to meet an unprecedented high demand for unscheduled care at weekends, in particular elderly patients and patients in nursing homes. NHS Boards are using short-term and fixed-term contracts to employ PDS dentists rather than commit resources to any longer-term investment in the service.

8.29 Funding has not been ring-fenced and continues to be cut. Having fewer dentists will have major impacts on patient care, including a reduction in patient appointments, longer waiting times to see a dentist, and fewer service locations due to the rationalisation of the NHS estate. This means more travel time for patients to access PDS services.

8.30 The PDS has concerns about the OHIP proposal to allow ‘accredited’ GDPs to provide care for people in care homes, and what role the PDS will play in the future. This, and the
continued reduction in the PDS workforce, has led to increased disquiet among the profession about the future of the PDS in Scotland.

**CDS contract reform in Northern Ireland**

8.31 It is with a palpable sense of frustration that we provide a third DDRB submission where we state that the revised contractual terms and conditions for Community Dental Service Dentists have not yet been implemented. This situation is simply farcical and has done considerable damage to morale in the CDS, not least in how they have been made to feel devalued.

8.32 The ballot of all community dentists in Northern Ireland on the proposed new contract closed on 14 March 2016, and an overwhelming majority voted in favour of the new contract, as outlined in the Summary Agreement.

8.33 It became clear in September 2016 that the necessary approvals from the Department of Finance (DoF) had not been secured by the Department of Health to allow for the implementation of the contract, much to our grievance. Since this became apparent, there have been many meetings between the BDA, DoH and the DoF with the aim of ensuring approval, including the revision and resubmission of the previous business case.

8.34 As of 11 December 2018, The Permanent Secretary at DoH reported that DoF approval is in place for the 2015/16 and 2016/17 awards, and a remit is to be submitted for 2017/2018. An Implementation Group will be established to finalise the terms and conditions of service and to oversee the assimilation processes associated with the new contract.

8.35 As the last group of healthcare workers in the UK to have their contract terms and conditions updated, this continued delay in the implementation of the contract has caused significant frustration amongst community dentists in Northern Ireland, and in the wider dental community. There is growing evidence that the service is being negatively impacted in the following ways:

**Recruitment and retention**

8.36 Trying to convince and persuade potential new recruits that a career in the community dental service is desirable is becoming more and more difficult, particularly when having to explain that the terms and conditions are over 20 years old, and new and agreed terms and conditions have yet to be implemented. The uncertainty surrounding the implementation of the contract makes it challenging to promote a job in the salaried dental service as a good career choice and path to follow.

8.37 Already, there are challenges in filling posts, a situation which is set to become much worse without adequate workforce planning. The Health and Social Care Workforce Strategy 2026 acknowledges that ‘significant numbers of the most experienced community dentists are approaching retirement, with up to 40 per cent reported to be potentially retiring by 2025’. The ageing workforce among CDS dentists clearly poses particular challenges for the future, but already underscores the existing difficulties in presenting the service as an attractive career option.

8.38 CDS dentists are also under increasing pressure from having to treat a growing elderly population with increasingly complex needs, with a lack of additional resources; moreover, with waiting lists for GA extractions of special needs patients in some Trust areas being in excess of a year or even 18 months, it gives an indication of the stress both the service, and the staff that underpin it are under.
Morale and motivation

8.39 Perhaps the biggest challenge in CDS is the very low morale of our current workforce. According to the latest BDA CDS member survey (2018), 47 per cent of respondents rated their morale in their work as a dentist as being ‘very low’ or ‘low’, 28 per cent as ‘neither high nor low’; only 15 per cent of CDS dentists said their morale is ‘very high’ or ‘high’. Clearly, these figures indicate the extent to which low morale is apparent within the CDS.

8.40 Of the five factors that negatively impact on morale, the most common factor identified was ‘Pay’ (31 per cent), followed by: ‘Constant changes to contracts/working arrangements’ (25 per cent) and ‘Poor work/life balance’ (25 per cent); ‘Insufficient time with each patient/workload’ (19 per cent); ‘Job security’ (13 per cent). Clearly, there is scope for DDRB to recommend an uplift which addresses the most common factor negatively impacting on morale.

8.41 In conclusion, while salaried staff have shown incredible patience thus far in the process, the mood amongst colleagues is one of increasing frustration, concern, and feeling demoralised that no end appears to be in sight by way of contract implementation. Workforce planning, along with urgent implementation of the new CDS contract are absolute imperatives at this time.

8.42 Community dentists are an integral part of the dental workforce in Northern Ireland, treating some of the most vulnerable and challenging patients. They are highly skilled and extremely dedicated and are providing care which cannot be delivered by other means. They do deserve better; it is imperative that the contract is implemented without delay.

Conclusion

8.43 Across the UK Community and Public Dental Services are stretched. The worsening financial situation across General Dental Practice is adversely impacting the community dental services and the situation cannot continue. The CDS workforce across the UK is struggling to recruit whilst undergoing the loss of experienced staff.

8.44 Previously we have reported on the existence of a significant minority of CDS dentists who are displaying low motivation, morale or job satisfaction. Our research this year does nothing to dispel the existence of this cadre. It does appear however that the environment leading to this negativity is having an impact outside of the CDS.

8.45 The inability of CDS to recruit to vacancies, both historic and arising suggests that the CDS is not seen as a sensible career option among the wider dental profession, this is despite the fact that the majority of CDS posts are open to all registrants.

8.46 The NHS in England recently asked, in their ‘Developing the long term plan for the NHS’ consultation ‘How can we best improve the experiences that people with a learning disability, autism or both have with the NHS, ensuring that they are able to access the full range of services they need?’ It is our contention that CDS dentists more often than not help to facilitate this access the NHS is seeking to ensure, not through commissioning arrangements or contractual provisions but because CDS dentists are de-facto advocates for their own patients.

8.47 Unless the underlying problems in the CDS are addressed it is our contention that recruitment will not improve, and retention will be threatened. This is of course an immediate problem for the CDS but also for the wider NHS access desired.
8.48 The resultant costs incurred by the NHS because of this, or the increased wider health risks to patients should be considered thoroughly. It is likely that a reasonable pay award for CDS dentists would be significantly less costly than such costs.

8.49 We recommend for Community Dental Services the full pay award of RPI plus 2 per cent to reward the continuing loyalty of colleagues and shows commitment to the service by the respective governments.
Chapter 9 - Clinical academic staff

9.1 In order to increase the pioneering research in dentistry and oral health there needs to be a recognition of the problems in clinical academic staff recruitment and retention. Low staffing levels among this group have a profound influence on the quality of the education received by dental undergraduate students and so impact the recruitment of young people into the profession. Subsequently there are less academics able to pursue the research needed for future generations. Clinical academic staff play an essential role within dental schools and perform high quality teaching and research, with clinical skills which should be recognised and rewarded. It is vital to ensure a steady intake and progression of clinical academics to maintain high standards of research and teaching.

9.2 The Dental Schools Council’s (DSC) Survey of Dental Clinical Academic Staffing levels 2018 shows there are significant vacancies throughout clinical academia. There is an overall vacancy rate of 6.1 per cent, this is consistent with previous years, with an overall vacancy rate of 5.3 per cent in 2017 and 6.4 per cent in 2016. In the grade of Reader/Senior Lecturer there is a vacancy rate of 11.1 per cent, that is to say for more than one in every ten of these posts Universities have not been able to recruit a member of staff. The DSC Survey has also highlighted the difficulties in recruitment to specialities, as well as grades. In the past DSC Surveys there has been a pattern of a large numbers of Dental Schools citing difficulties to recruiting to one or more specialties. There were 13 reporting this difficulty in the 2018 Survey and 12 in the 2017 Survey.

9.3 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 own research, where the 2018 BDA’s Clinical Academic Survey of members found 65 per cent of respondents reporting vacant posts that their University had difficulty recruiting to. The 2018 BDA Clinical Academic survey reported that the hardest to fill vacant posts were Reader/Senior Lecturer, which matches the finding of the DSC Survey.

9.4 The number of whole time equivalent academic staff have increased in recent years. The DSC 2018 Survey identifies a 2.2 per cent increase since 2016. Despite an overall increase in staff levels since 2016, with the continuing year on year vacancies, there are likely to greater burdens on existing staff, who must meet the teaching commitments of vacant posts.

9.5 The alternative career for clinical academic dentists is a substantive NHS post. 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 post, 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, where as in Dental Schools an academic has to actively manage their clinical career with his or her academic commitments.

9.6 The DSC 2018 Survey also mentions the recent Health Education England (HEE) Advancing Dental Care report. It notes that academics have expressed concerns over this initiative and the implications to undergraduate teaching if dental professionals are not recruited into academic careers. The implication is that this initiative acts as a disincentive to dentists considering an academic career, over other career pathways within dentistry.
9.7 Another continuing issue that may contribute further difficulty in clinical academic recruitment is pension arrangements. The University Superannuation Scheme (USS) pension, the pension offered by Universities, 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 and therefore make the scheme less attractive in relation to the NHS scheme, which continues to be purely Defined Benefit. This issue has led to industrial action and staff and employer representatives are currently in ongoing discussions. Whatever the result of the discussions it is unlikely the pension arrangements will improve substantially in comparison with the NHS pension scheme.

9.8 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 10 - Our recommendations

10.1 For all dentists we recommend an increase of **5 per cent on pay** (RPI\(^{40}\) (at 3 per cent) plus 2 per cent) to begin to redress the cuts over the last decade and that this is fully back-dated to 1 April 2019.

10.2 We do not recommend targeting awards.

10.3 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**

10.4 For Northern Ireland we recommend the reinstatement of commitment payments and the timely offer of pay awards from 2019/20.

10.5 For England we recommend the reinstatement of commitment payments. We reiterate our ask from 2017 that the Review Body to consider this suggestion and encourage the Health Departments to explore the options with the BDA.

**Hospital services**

10.6 BDA Scotland welcomed the DDRB recommendations to increase the value of distinction awards and discretionary points in line with its main pay recommendations for hospital dental consultants, and expressed its disappointment with the Scottish Government’s decision not to implement these recommendations in both 2017 and 2018.

**Community dental services**

10.7 We recommend for Community Dental Services the full pay award we recommend above to reward the continuing loyalty of colleagues and show commitment to the service by the respective governments.

**Clinical academia**

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

---

\(^{40}\) RPI was 3.3 per cent in September 2018
Annex A – our methodology

The 2018 General Dental Practitioners and Specialist Practitioners survey is the latest in a series of annual surveys conducted by the BDA. In 2018, the survey was conducted between early June and early August. The target population was made of self-identified practice owners and associates members of the BDA across all four UK countries.

As the target population of GDPs in England is greater than the target population of GDPs in other UK countries, we took a random sample of members in England but we surveyed all members in the other UK countries.

The BDA approached 4,586 members, of these 1,129 valid responses were returned which represented almost 25 per cent of the sampled members.

The data were weighted using an enhanced version of last year’s methodology to maintain accuracy and to allow the calculation of confidence intervals.

This does mean that comparisons with previous years are not possible, but the new methodology allows the BDA to build upon the 2018 data creating robust trends for the next few years.

Margin of error by number of respondents and percentage answers to survey questions

<table>
<thead>
<tr>
<th>Number of respondents to survey questions</th>
<th>Percentage answers to survey questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5/95</td>
</tr>
<tr>
<td>50</td>
<td>6.0%</td>
</tr>
<tr>
<td>100</td>
<td>4.3%</td>
</tr>
<tr>
<td>150</td>
<td>3.5%</td>
</tr>
<tr>
<td>200</td>
<td>3.0%</td>
</tr>
<tr>
<td>250</td>
<td>2.7%</td>
</tr>
<tr>
<td>300</td>
<td>2.5%</td>
</tr>
<tr>
<td>350</td>
<td>2.3%</td>
</tr>
<tr>
<td>400</td>
<td>2.1%</td>
</tr>
<tr>
<td>450</td>
<td>2.0%</td>
</tr>
<tr>
<td>500</td>
<td>1.9%</td>
</tr>
<tr>
<td>550</td>
<td>1.8%</td>
</tr>
<tr>
<td>600</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

*To create the 95% Confidence Interval, add and subtract from your percentage, the corresponding percentage in the table. If the exact number you are looking at is not in the table, look at the two rows and two columns framing it.*

RPI

We believe that RPI is the correct measure of inflation to use to calculate any increases. Despite the reduction in use for any new uses the Government continues to use RPI in all manner of policy setting from the Budget to rail fare increases. We believe despite its flaws it is a robust measure of inflation and accurately reflects the fiscal environment.

---

Annex B Data tables

Table 1 - Dental Patient Charges in England (Para 5.6)

<table>
<thead>
<tr>
<th>Year</th>
<th>Band 1</th>
<th>Band 2</th>
<th>Band 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>17.5</td>
<td>48</td>
<td>209</td>
</tr>
<tr>
<td>2013-14</td>
<td>18</td>
<td>49</td>
<td>214</td>
</tr>
<tr>
<td>2014-15</td>
<td>18.5</td>
<td>50.5</td>
<td>219</td>
</tr>
<tr>
<td>2015-16</td>
<td>18.8</td>
<td>51.3</td>
<td>222.5</td>
</tr>
<tr>
<td>2016-17</td>
<td>19.7</td>
<td>53.9</td>
<td>233.7</td>
</tr>
<tr>
<td>2017-18</td>
<td>20.6</td>
<td>56.3</td>
<td>244.3</td>
</tr>
<tr>
<td>2018-19</td>
<td>21.6</td>
<td>59.1</td>
<td>256.6</td>
</tr>
</tbody>
</table>

*Dental patient charges in England.*

Table 2 – Northern Ireland net cost of service against patient contributions (Para 5.8)

<table>
<thead>
<tr>
<th>Year</th>
<th>Net cost of service</th>
<th>Patient payments</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>87.7</td>
<td>17.4</td>
<td>105.1</td>
</tr>
<tr>
<td>2011/12</td>
<td>93.7</td>
<td>18.1</td>
<td>111.9</td>
</tr>
<tr>
<td>2012/13</td>
<td>97.7</td>
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<td>117.1</td>
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<tr>
<td>2013/14</td>
<td>101.7</td>
<td>20.2</td>
<td>121.9</td>
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<tr>
<td>2014/15</td>
<td>101.6</td>
<td>20.9</td>
<td>121.9</td>
</tr>
<tr>
<td>2015/16</td>
<td>100.4</td>
<td>22.5</td>
<td>122.9</td>
</tr>
<tr>
<td>2016/17</td>
<td>97.8</td>
<td>23.6</td>
<td>121.4</td>
</tr>
<tr>
<td>2017/18</td>
<td>96.7</td>
<td>24.5</td>
<td>121.2</td>
</tr>
</tbody>
</table>

*Source: BSO*

Table 3 - Northern Ireland patient registrations against GDS spend (Para 5.8)

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients registered</th>
<th>Over 65s</th>
<th>GDS Public spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>1,203,338</td>
<td>161,767</td>
<td>£96.7m</td>
</tr>
<tr>
<td>April 2017</td>
<td>1,187,184</td>
<td>155,606</td>
<td>£97.8m</td>
</tr>
<tr>
<td>April 2016</td>
<td>1,172,306</td>
<td>149,675</td>
<td>£100.4m</td>
</tr>
<tr>
<td>April 2015</td>
<td>1,159,431</td>
<td>141,855</td>
<td>£101.6m</td>
</tr>
</tbody>
</table>

*Source: Business Services Organisation*

Table 4 – Proportion of time spent on clinical work Practice Owners (Para 6.17)

<table>
<thead>
<tr>
<th>Year</th>
<th>06-07</th>
<th>07-08</th>
<th>08-09</th>
<th>09-10</th>
<th>10-11</th>
<th>11-12</th>
<th>12-13</th>
<th>13-14</th>
<th>14-15</th>
<th>15-16</th>
<th>16-17</th>
<th>17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>England and Wales</td>
<td>82.3</td>
<td>80.9</td>
<td>81.2</td>
<td>80.0</td>
<td>78.2</td>
<td>76.2</td>
<td>73.4</td>
<td>72.1</td>
<td>73.9</td>
<td>72.4</td>
<td>72.1</td>
<td>70.7</td>
</tr>
<tr>
<td>Scotland</td>
<td>82.6</td>
<td>81.7</td>
<td>80.4</td>
<td>80.3</td>
<td>74.5</td>
<td>74</td>
<td>75.4</td>
<td>75.2</td>
<td>73.5</td>
<td>72.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>81.6</td>
<td>80.1</td>
<td>76.4</td>
<td>72.2</td>
<td>69.5</td>
<td>69.1</td>
<td>70.1</td>
<td>70.3</td>
<td>71.5</td>
<td>70.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*42 BSO Family Practitioner Services Statistics for Northern Ireland 2017/18 Family Practitioner Services Statistics for Northern Ireland 2017/18*
Proportion (%) of time spent on clinical work – practice owners (above) and associates (below). Source: NHS Digital

Table 5 – Proportion of time spent on clinical work Associates (Para 6.17)

<table>
<thead>
<tr>
<th>Year</th>
<th>England and Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-07</td>
<td>88.8</td>
<td>90.7</td>
<td>91</td>
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<tr>
<td>07-08</td>
<td>87.7</td>
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<tr>
<td>09-10</td>
<td>88.4</td>
<td>90</td>
<td>87</td>
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<tr>
<td>10-11</td>
<td>86.4</td>
<td>84.4</td>
<td>84.3</td>
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<tr>
<td>11-12</td>
<td>85.3</td>
<td>83.8</td>
<td>83.7</td>
</tr>
<tr>
<td>12-13</td>
<td>79.8</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>13-14</td>
<td>80.2</td>
<td>81.8</td>
<td>82.1</td>
</tr>
<tr>
<td>14-15</td>
<td>78.5</td>
<td>81.8</td>
<td>82.2</td>
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<tr>
<td>15-16</td>
<td>79.2</td>
<td>82.7</td>
<td></td>
</tr>
<tr>
<td>16-17</td>
<td>78.4</td>
<td>82.6</td>
<td></td>
</tr>
<tr>
<td>17-18</td>
<td>78.5</td>
<td>83</td>
<td></td>
</tr>
</tbody>
</table>

Table 6 - Number of contracts terminated in England (Para 6.40)

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of contracts terminated</th>
<th>Total value of contracts</th>
<th>Total No. of UDAs</th>
<th>Total No. of UOAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumbria and the North East</td>
<td>17</td>
<td>£2,814,419.98</td>
<td>151,512</td>
<td>-</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>1</td>
<td>£476,350</td>
<td>17,500</td>
<td>-</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>11</td>
<td>£2,585,925.32</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>South West</td>
<td>5</td>
<td>£773,576.97</td>
<td>31,936</td>
<td>137</td>
</tr>
<tr>
<td>Wessex</td>
<td>44</td>
<td>£7,078,947.94</td>
<td>266,737</td>
<td>-</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>6</td>
<td>£6,455,774</td>
<td>207,223</td>
<td>-</td>
</tr>
<tr>
<td>South of England</td>
<td>6</td>
<td>£773,576.97</td>
<td>31,936</td>
<td>137</td>
</tr>
<tr>
<td>Central Midlands</td>
<td>39</td>
<td>£7,535,163.25</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>Derbyshire and Nottinghamshire</td>
<td>3</td>
<td>£118,675.96</td>
<td>4,056</td>
<td>378</td>
</tr>
<tr>
<td>Staffordshire and Shropshire</td>
<td>22</td>
<td>£1,437,344.92</td>
<td>57,525</td>
<td>-</td>
</tr>
<tr>
<td>West Midlands</td>
<td>10</td>
<td>£768,275.88</td>
<td>39,611</td>
<td>-</td>
</tr>
<tr>
<td>East of England</td>
<td>7</td>
<td>£1,696,290.03</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>South of England</td>
<td>31</td>
<td>£5,445,890.01</td>
<td>157,012.44</td>
<td>27,020</td>
</tr>
<tr>
<td>London</td>
<td>29</td>
<td>£2,149,535.72</td>
<td>58,659</td>
<td>830</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>£40,109,706.95</td>
<td>1,023,707.44</td>
<td>28,502</td>
</tr>
</tbody>
</table>

Data provided by NHS England local area teams in response to a Freedom of Information Act request regarding contracts handed back
Table 7 - How do you rate your morale as a dentist (Associate)? (Para 7.25)

<table>
<thead>
<tr>
<th>Associates - How do you rate your morale in your work as a dentist?</th>
<th>Very high and high (%)</th>
<th>Neither high, nor low (%)</th>
<th>Very low and low (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>35.4</td>
<td>27.9</td>
<td>36.8</td>
<td>379</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>22.7</td>
<td>25</td>
<td>52.3</td>
<td>36</td>
</tr>
<tr>
<td>Scotland</td>
<td>24.2</td>
<td>36.3</td>
<td>39.6</td>
<td>73</td>
</tr>
<tr>
<td>Wales</td>
<td>20</td>
<td>34</td>
<td>46</td>
<td>40</td>
</tr>
<tr>
<td><strong>NHS personal commitment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;75%</td>
<td>23.9</td>
<td>28.8</td>
<td>38.7</td>
<td>329</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>44.8</td>
<td>30</td>
<td>25.1</td>
<td>199</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>31.8</td>
<td>29.3</td>
<td>38.9</td>
<td>528</td>
</tr>
</tbody>
</table>

Data from BDA Associates Survey 2018

Table 8- How do you rate your morale as a dentist (Practice Owner)? (Para 7.25)

<table>
<thead>
<tr>
<th>Practice Owners - How do you rate your morale in your work as a dentist?</th>
<th>Very high and high (%)</th>
<th>Neither high, nor low (%)</th>
<th>Very low and low (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>32.1</td>
<td>27.3</td>
<td>40.6</td>
<td>413</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>20.8</td>
<td>32.1</td>
<td>47.2</td>
<td>41</td>
</tr>
<tr>
<td>Scotland</td>
<td>19.4</td>
<td>28.7</td>
<td>51.9</td>
<td>108</td>
</tr>
<tr>
<td>Wales</td>
<td>12.3</td>
<td>27.7</td>
<td>60</td>
<td>51</td>
</tr>
<tr>
<td><strong>NHS personal commitment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;75%</td>
<td>15.2</td>
<td>24.8</td>
<td>60.1</td>
<td>235</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>36.6</td>
<td>30.3</td>
<td>33.1</td>
<td>344</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>27.9</td>
<td>28</td>
<td>44.1</td>
<td>580</td>
</tr>
</tbody>
</table>

Data from BDA Practice Owners Survey 2018

Table 9 - I am fairly remunerated for my work (Associate)? (Para 7.31)

<table>
<thead>
<tr>
<th>Associates – I am fairly remunerated for my work</th>
<th>Strongly agree and agree (%)</th>
<th>Neither agree, nor disagree (%)</th>
<th>Strongly disagree and disagree (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>39.6</td>
<td>18.7</td>
<td>41.8</td>
<td>359</td>
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<tr>
<td>Northern Ireland</td>
<td>15.9</td>
<td>13.6</td>
<td>70.5</td>
<td>44</td>
</tr>
<tr>
<td>Scotland</td>
<td>29.7</td>
<td>16.5</td>
<td>53.8</td>
<td>91</td>
</tr>
<tr>
<td>Wales</td>
<td>28</td>
<td>22</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td><strong>NHS personal commitment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;75%</td>
<td>22.7</td>
<td>18.6</td>
<td>58.7</td>
<td>344</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>57.2</td>
<td>17.6</td>
<td>25.2</td>
<td>200</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>35.7</td>
<td>18.3</td>
<td>46</td>
<td>544</td>
</tr>
</tbody>
</table>

Data from BDA Associates Survey 2018
Table 10 - I am fairly remunerated for my work (Practice Owner)? (Para 7.31)

<table>
<thead>
<tr>
<th>Practice Owners - I am fairly remunerated for my work</th>
<th>Strongly agree and agree (%)</th>
<th>Neither agree, nor disagree (%)</th>
<th>Strongly disagree and disagree (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>45.9</td>
<td>14.8</td>
<td>39.2</td>
<td>357</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>28.3</td>
<td>20.8</td>
<td>50.9</td>
<td>53</td>
</tr>
<tr>
<td>Scotland</td>
<td>22.6</td>
<td>12.3</td>
<td>65.1</td>
<td>106</td>
</tr>
<tr>
<td>Wales</td>
<td>33.8</td>
<td>12.3</td>
<td>53.8</td>
<td>65</td>
</tr>
<tr>
<td>NHS personal commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;75%</td>
<td>14.4</td>
<td>17.2</td>
<td>68.4</td>
<td>243</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>58.2</td>
<td>13.1</td>
<td>28.7</td>
<td>334</td>
</tr>
<tr>
<td>All</td>
<td>40.4</td>
<td>14.8</td>
<td>44.8</td>
<td>577</td>
</tr>
</tbody>
</table>

Data from BDA Survey of Practice Owners 2018

Erratum

In an earlier version of this evidence, a reference is made to Stats Wales data on CDS FTE for 2017. In light of this new information, this version is updated to reflect the inconsistency in data reporting. The paragraphs affected are 8.23 -8.25.

http://record.assembly.wales/WrittenQuestion/77809

"*The NHS staffing data differs to that published on StatsWales as we have included NHS Occupation codes 970 (Community dentist) and 971 (General Dental Practitioner) and 980 (Dental Public Health). We have always excluded code 971 and more recently code 970 has been retired in the NHS occupation manual with health boards advised to assign those staff to the most suitable code."

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