England Evidence

October 2012

to the Review Body on Doctors' and Dentists' Remuneration

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BDA England only version of the 2013/14 submission to the

Review Body on Doctors' and Dentists' Remuneration

October 2012[1]

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[1] Please note that this version was not submitted to DDRB. The BDA's submission consisted of a single UK wide submission.

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Executive summary

General dental practice

- Morale is very low, with 41.5 per cent of those with an NHS commitment of over 75 per cent responding that their morale is either low or very low in the DBT survey
- Job satisfaction remained high and was highest among those with the lowest NHS commitment
- Levels of satisfaction with pay on NHS contracts was very low with 66.2 per cent of respondents saying they were dissatisfied with pay
- Dentists reported an increase in the levels of both clinical and administrative work
- Most practices were not recruiting associates
- 35.7 per cent of practices that did try to recruit a dentist for predominantly NHS work encountered problems
- The NHS has seen the smallest increase in the number of dentists providing NHS care since the introduction of the current contract
- Even more dentists than last year (15 per cent) are planning to retire (23 per cent)
- NHS Information Centre data shows that average taxable income for all self-employed primary care dentists decreased by 8.2 per cent from 2009/10-2010/11 in England and Wales,
- Practice owners saw an average drop in income of 8.5 per cent in England and Wales.
- Associates saw their income drop by 4.2 per cent in England and Wales

Salaried Services

- We recommend that dentists in the salaried services receive at least the one per cent uplift available to public sector employees
- Over 40 per cent of respondents to the BDA's survey were dissatisfied with pay
- 75 % of clinical specialists are employed at an inappropriate band
- The number of patients being seen has increased according to the *Clinical Directors' Survey*
- Only two Band C clinical specialist posts had been advertised in the last year according to our Freedom of Information Act request
- Morale and motivation is low
- 52 per cent reported having no career opportunities
- The main causes were identified as low pay and low staffing levels, putting pressure on caseloads

- Low staffing levels were a also cause of general concern about the capacity to provide appropriate care for patients
- In a quarter of cases no applications were received for Band A positions.
- Band A vacancies were the most likely not to have any applications shortlisted.
- The salaried service is ageing and there is not enough scope at lower grades for younger colleagues to join

Introduction

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,081 strong membership is engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and includes dental students.

2. Every year the BDA provides information or evidence to the DDRB covering general dental practitioners and salaried primary dental care practitioners. For the last three years we have been very disappointed that governments in England and Wales and Northern Ireland have seen fit not to ask the DDRB to make recommendations, as we value the independent scrutiny it provides. The British Medical Association (BMA) submits evidence on behalf of all hospital medical and dental staff. We ask DDRB to note that the issues raised by the BMA are applicable to those working in the hospital dental services.

3. We fully support the DDRB's position on the application of "efficiency savings":

> "We … believe that it is both unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs…If the Health Departments continue to think it appropriate to impose a requirement on independent contractor GMPs and GDPs to make efficiency savings, then we believe that any such requirement should be a contractual matter, rather than abating our recommended increases.[2]"

4. We also welcome the DDRB's independent analysis of expenses in Scotland in last year's round and its recommendations to meet them and consider it inappropriate that "efficiencies" are sought by government simply by failing to meet rising expenses. In our response to the last DDRB report we recommended that DDRB is recalled:

> "It is essential that the Doctors' and Dentists' Review Body resumes its work urgently and that our arguments about escalating expenses and falling incomes are properly taken into account. But associating what appear to be wholly unconnected conditions with this year's uplift will not encourage the profession to keep an open mind going forward into a new contract. Dentists need to be convinced from the pilots that the new way of working will make a real difference to their ability to provide services for their patients and is likely to result in improved oral health and it is premature to anticipate the outcome.[3]"

5. The result is not an increase in efficiency but pay cuts, lower motivation and increased workloads for dentists and their staff. Efficiency should be a positive. The determination to squeeze work and cut the incomes of individuals who have taken a great personal financial risk to provide healthcare is a perverse method of achieving efficiency. The short-term approach of the imposed cuts benefits neither the provider nor the patient and in the longer term does not support the Department of Health's aims of increasing access and improving quality of care.

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[2] DDRB 2012. Paragraph 12, Pg. IX.
[3] http://www.bda.org/enews/2012-04/expenses.aspx retrieved 04/09/12

6. We were pleased to note that the DDRB recognised in its last report the low morale of salaried dentists and considered it appropriate to recommend that policy changes take the non-financial causes of low morale into account. We are working with the Department of Health in England on the development of a new dental contract for the delivery of services in both salaried and general dental practice, which we hope will go some way to reducing the target-driven nature of the current system, and so improve working conditions. We explain the developments in policy, as requested by DDRB, below.

7. BDA members are sensitive to the on-going economic circumstances affecting the UK. After a two-year pay freeze for salaried dentists and a pay cut for general dental practitioners we believe that this year dentists must receive a reasonable increase in net pay.

8. We continue to support the use of a clear and transparent formula for the assessment of appropriate rises in remuneration. We do, however, also consider it important that any significant changes to the formula should be made with the knowledge and support of the parties involved. We note that the former Secretary of State for Health in England, in his letter to DDRB dated 03 July, supports the use of the formula to provide the best evidence for what contract value uplift is required for the average one per cent pay increase. We continue to support this method, but are very concerned by the suggestion later in the letter that "efficiency savings" could simply negate any uplift and therefore any pay rise. We would welcome DDRB's assessment of this policy as it appears inconsistent to determine what uplift is required to award a pay increase and then apply a cut, therefore negating or at best reducing the pay uplift.

9. As usual, the BDA has conducted extensive research into primary dental practice to inform our evidence. Summaries of the research reports are annexed to the evidence. We repeated last year's focus groups of general dental practitioners following their positive reception by the profession. They help provide more detailed and first-hand information about the issues that face general dental practitioners. The 2012 Dental Business Trends survey (DBT) summary report can be found at annex 1. The Salaried Dentist's Morale Survey summary can be found at annex 2, and the Freedom of Information request report of salaried services recruitment at annex 3. A summary of the VDP survey is at annex 4. A summary of the Clinical Directors' Survey is attached at annex 5. At the DDRB's request, a list of dental schools with student numbers is attached at annex 6. Contextual economic background can be found at annex 7. Full versions of all the reports are available via the BDA's website.

1. Response to last year's award

General dental practice

1.1 General dental practitioners (GDPs) in England were again very disappointed that the Department of Health did not take into account the NHS Information Centre's figures which showed that their taxable income had fallen[4]. While BDA members accepted the need for public sector pay restraint, and so reluctantly accepted a pay freeze, we could not countenance the resulting pay cuts.

1.2 This year's 0.5 per cent uplift was insufficient to meet the increased expenses and general costs of running a dental practice and to provide a pay increase for staff on lower incomes. Both associates and practice owners have experienced large pay cuts and practice owners are struggling to achieve profitable businesses while maintaining patient care. Despite the difficulties they face, the profession has worked hard to provide the best care possible: NHS access and output have increased[5], demonstrating that dentists are running their businesses efficiently by taking pay cuts to fund care. We consider that the Department of Health should accept this contribution to their goals as an efficiency gain, rather than seeking short-term and punitive financial cutbacks from an already strained service.

1.3 Clinical activity is increasing, so the associated costs are increasing, but so is the level of administration. The NHS is getting more work for less money out of dentists who continue to provide high levels of care as demonstrated by recent figures showing that satisfaction with the service provided by NHS dentists is higher than for other clinicians in the NHS[6]. Other 2011 research also demonstrates high patient satisfaction[7].

Salaried services

1.4 We were extremely disappointed by the continued application of a pay freeze for dentists in the salaried services in England. This was applied despite the DDRB's recognition of the low morale among salaried dentists. While we welcomed the recognition and the recommendation that the Department of Health continue to improve conditions, we remain very concerned that low levels of pay and increasing work in the service continue to cause a deterioration in morale.

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[4] NHS Information Centre *Dental Earnings and Expenses, England and Wales, 2009/10* 2011 pg. 5
[5] NHS Information Centre *NHS Dental Statistics for England: 2011/12* 2012
[6] Consumer Focus briefing for Department of Health 2011
[7] TNS BMRB survey 2011 commissioned by Office of Fair Trading, GfK NOP survey commissioned by BDA 2011, Adult Dental Health Survey 2009, Ipsos MORI survey commissioned by General Dental Council 2011, Brayleino research commissioned by British Dental Trade Association 2011

2. Background to the evidence

This section contains our summary of the policy landscape that dentists are operating in England. We hope that the DDRB will take into account the wider policy circumstances when developing their recommendations, where they have been asked to, as it is important to ensure that all aspects which affect the financial wellbeing and motivation of practitioners are accounted for, even if they are not directly quantifiable within the formula. Where the DDRB has not been asked to make recommendations we hope that this section will provide interesting background for future consideration.

2.1 Multiple counting

2.1.1 Following the Review Body's request, we tried to gauge the extent of multiple counting through the DBT survey.

Table 1: Accounting of associates' expenses (source, DBT survey 2012)

Please describe how your associates' earnings appear in your accounts	England		Wales	
	Count	%	Count	%
I have no associates	100	34.60%	24	38.10%
I include the associate contributions to expenses in my earnings figures only	50	17.30%	12	19.05%
I pay associates a net payment per UDA and these payments appear in my total expense	121	41.87%	24	38.10%
Other	17	5.88%	3	4.76%
Total	289	100.00%	63	100.00%

2.1.2 So for England, of those practice owners with associates, 64 per cent paid their associates a net amount per UDA; there is therefore no multiple counting for these practitioners. Table 2 is the equivalent table for associates.

Table 2: Self-reported accounting techniques (source DBT survey 2012)

How does your accountant record your earnings and expenses?	England		Wales		Total	
	Count	%	Count	%	Count	%
Earnings are gross earnings and expenses are expenses paid to the practice and other business related expenses	131	35.3%	32	53.3 %	163	37.8 %
Earnings are net earnings received from the practice and expenses are personal business expenses only	221	59.6%	24	40.0 %	245	56.8 %
Other	19	5.1%	4	6.7 %	23	5.3 %
Total	371	100.0%	60	100. 0%	431	100. 0%

2.1.3 The two results appear to suggest that the extent of multiple counting in England is between 33.1 and 35.3 per cent.

2.1.4 A working group has been established in Scotland to assess the impact of multiple counting and how it can be managed. We recommend that similar groups are established in the other countries of the UK to determine if it is an issue and, if so, how best to manage it. We do not consider it appropriate for action to be taken on the formula or uplift values until this work has been done and a full evaluation has established what effect, if any, it truly has. Any action taken to manage any impact of multiple counting must be in proportion to its effect and prevalence.

2.2 Overview of policy developments

2.2.1 This section provides a brief explanation of the policy developments in England. The BDA noted that the DDRB was interested in the development of the new dental contract in England and in pension changes and requested further information on these topics. We have also included other background information we consider will be of use in assessing the future of the profession. We welcome the DDRB's interest in this area and also consider it appropriate to supply information on the wide range of policy developments that affect dentists' everyday working lives.

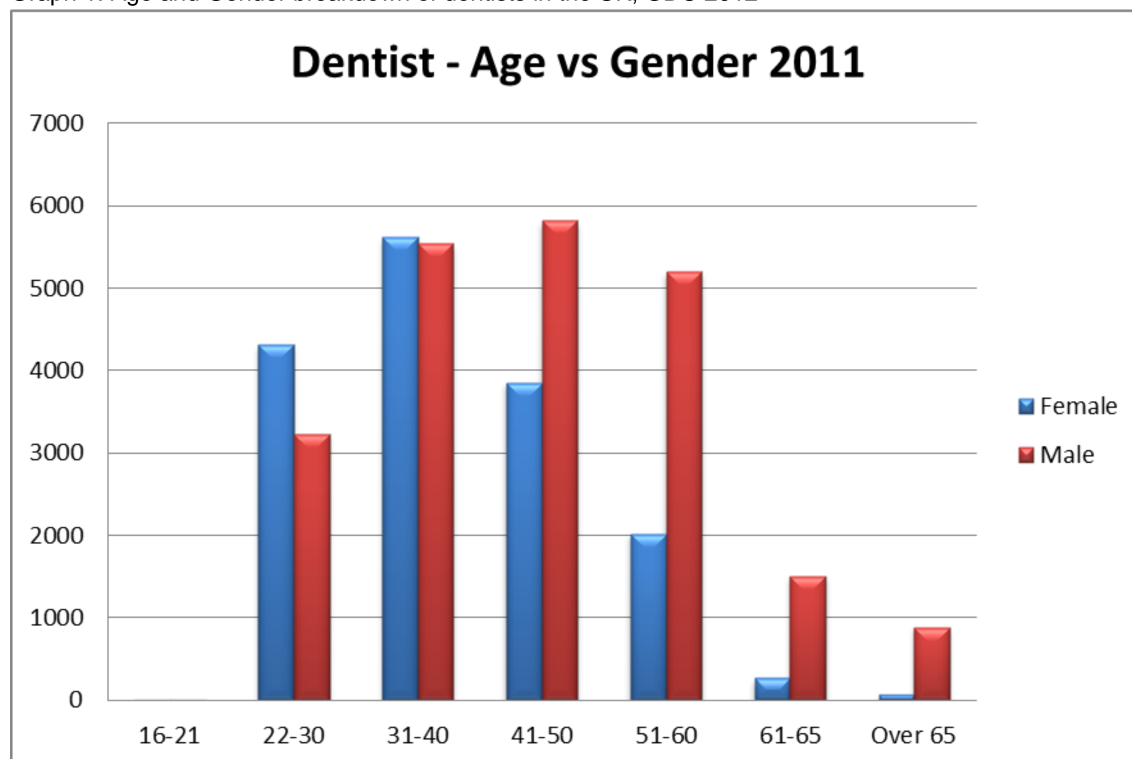
Foundation training

2.2.2 The application system to vocational dental training, or dental foundation training as it is now commonly called, was changed in 2011 for England. The new centralised system was welcomed by the BDA and by students in general who had found the previous system complicated and stressful. The troubled introduction of the new system, however, resulted in a great deal of extra stress and concern for many students. Short deadlines and poor communication were common complaints. While any new system requires time to develop, the reforms caused a significant amount of ill-feeling towards the system from both dentists and students. In an effort to assist in improving the system, we have shared research that we conducted on experiences of the reformed system with the Council of Postgraduate Dental Deans and Directors which runs it.

The dental profession

2.2.3 The demography of the dental profession is changing which has an impact on working patterns, expenses, career pathways and the way services will be provided. The table below shows the gender and age breakdown of the profession using data from the BDA's membership database and the General Dental Council:

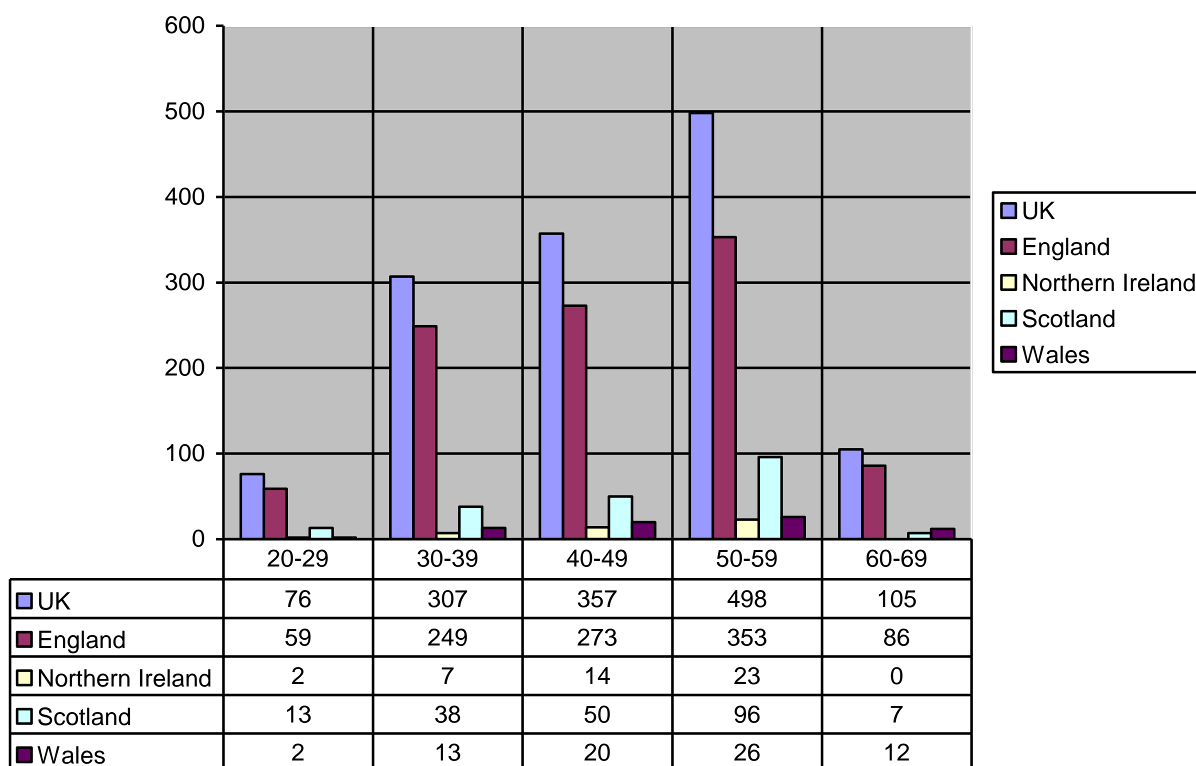
Graph 1: Age and Gender breakdown of dentists in the UK, GDC 2012



2.2.4 The graph above show the changing nature of the profession. The graph clearly shows that the number of women in the profession is increasing, and increasing at a faster rate than the number of men. Overall there are 38,383 registered dentists[8], fewer than half of whom are women. Split by age, however, we can see that the vast majority of male dentists, 13,444, are aged over 41 (this figure includes 34 unknown). Women on the other hand are primarily aged between 22 and 40. This trend of a younger female profession has been building since 2003. The latest data from the NHS IC for England show that 44.5 per cent of the 23,000 NHS dentists were female, up from 43.5 per cent the previous year and 38.8 per cent in 2006/07. The greatest proportion is found in the under-35s, where 55.4 per cent are women, up from 55.2 per cent the previous year.

[8] Figures from the GDC received on 17.02.2012

Graph 2: Age breakdown of salaried services staff in the UK and by country. Data is from BDA's membership of 1343 salaried service members whose age is known and who are registered as working in the UK.



	20-29	30-39	40-49	50-59	60-69
UK	76	307	357	498	105
England	59	249	273	353	86
Northern Ireland	2	7	14	23	0
Scotland	13	38	50	96	7
Wales	2	13	20	26	12

2.2.5 The salaried services in the UK are facing a potential workforce problem as the level of younger dentists lags far behind their older colleagues in each country. Almost 500 of the 1343 BDA members in the salaried services in the UK with a known age are aged between 50 and 59 and only 76 are in their 20s.

Success of VDPs in finding posts

2.2.6 Between June and July 2012, the BDA undertook its annual UK wide survey of *Vocational Dental Practitioners* (VDPs) which asked them about their post-training career plans and experience of searching for a post. 157 VDPs responded to the survey (22% of all those surveyed). Of these, 140 cases gave a complete response to the survey, were in VT/DVT/DFT at time of survey and were due to complete their training in the current year. 78 per cent had found a post by the time of the survey. Whilst there was some difference in the timing of this year's survey compared with previous years, the results are comparable with between 78 and 83 per cent of VDPs reporting that they had found a post in earlier surveys. Among those who had successfully found employment in dentistry by the time of the survey (N=100), 60 per cent said that this post would be in general practice, with 33 per cent finding a role in a hospital and four per cent in the salaried services. Twenty-three per cent of respondents (N=23) stated that their role was in the practice where they had received their training. This figure is similar to that found in the 2011 survey, where 24 per cent of respondents said that they would be staying at their training practice. Both results are, however, lower than that reported in 2006, where 38 per cent of VDPs surveyed planned to stay at their training practice. Finally, 11per cent of those who had found employment in the current survey said that they would be working in a UK country other than the one in which they received their VDP training.

2.2.7 The *Vocational Dental Practitioners* survey also asked VDPs who had found a post about their reasons for selecting a post. The most commonly cited reasons were "career progression opportunities" (65 per cent) and "location of practice" (42 per cent). This suggests that young dentists are motivated by the opportunity to continue to develop skills and do what they are trained to do, rather than being motivated exclusively by pay, which was the fourth most popular reason but was still only cited by just under 20 per cent of respondents. The desire to provide care and feel valued is mirrored in the BDA's DBT survey response as discussed in the relevant sections below.

Working hours and income

2.2.8 The NHS Information Centre data on Dentists' Working Hours 2010-11 and 2011-12 in England and Wales[9] shows that there is a greater tendency among women to work fewer than 35 hours a week. The NHS IC data showed that 46.4 per cent of female survey respondents worked fewer than 35 hours per week, while less than 23 per cent of men worked fewer than 35 hours per week. The BDA's DBT survey showed that women were twice as likely to work under 35 hours, or part-time, than their male counterparts, with 61 per cent of those working under 35 hours being women and 68.6 per cent of those working over 35 hours being men. Data from DBT survey showed that for England 28.7 per cent of men compared to 58.3 per cent of women worked under 35 hours. In Wales 24.7 per cent of men and 47.6 per cent of women worked under 35 hours. In Northern Ireland only 17.3 per cent of men reported working fewer than 35 hours while 51.9 per cent of women reported working hours of fewer than 35 hours. In Scotland 21.7 per cent of male respondents and 47.1 per cent of female dentists worked fewer than 35 hours. The average taxable income for all female primary care dentists in England and Wales was £60,600, compared to £90,900 for men.

Incorporation

2.2.9 Last year the Review Body asked for information on dental incorporation. Since 2005 there has been a steady growth in the number of dentists operating as dental companies[10]. This has coincided with the corporatisation of the dental market with the large corporate chains buying dental practices in England, Wales and Scotland. The net effect has been to reduce the number of self-employed dental practice owners and increase the proportion of associates. In October 2010 Laing and Buisson estimated that ten per cent of the UK dentistry market was held by dental corporates (companies owning three or more dental practices). It should be noted that anecdotally we believe that there are considerable numbers of one or two practice companies in existence but there are no figures for the number of these.

2.2.10 There are no official figures that provide the number of dentists that are directors of dental corporates. DBT Survey 2012 gave the configuration of the respondents' main practice and showed that 22 per cent of dentists were working for a corporate body.

[9] NHS IC *Dentists' Working Hours 2010-11 and 2011-12 in England and Wales*
[10] There is no clear evidence that this growth is replicated in Northern Ireland

Table 3: Practice configuration (source DBT survey 2012)

Which of the following best describes your practice configuration?		
	Per cent	Weighted count
Limited company	22.2	1546
Limited liability partnership	2.3	159
Partnership agreement	13.8	965
Sole trader	53.5	3731
Expense sharing agreement	12.6	881

2.2.11 From 2005 to 2011 there were an increasing number of associates who had incorporated but in November 2011 the Department of Health in England introduced regulations that meant that these dentists were no longer able to be members of the NHS pension scheme. We believe that the effect of this was to promote a move away from incorporated status in this group.

2.2.12 Dentists in England and Wales holding an NHS contract are not able to transfer their contract to their company without the PCT/Health Board's agreement. Agreement is not automatic and normally the commissioner will insist on an additional clause in the agreement restricting the change of control of the company. For this reason we believe that the number of new companies being set up has peaked.

Pension reform

2.2.13 In 2008 following a major review of the NHS Pension scheme tiered contribution rates were introduced for the first time. The initial contribution rates were five per cent, 6.5 per cent, 7.5 per cent and 8.5 per cent. The rates reflected annual pensionable pay. Most dentists found themselves in either the 6.5 per cent or 7.5% per cent.

2.2.14 At the time of publication of the Hutton reports on the future shape of public service pension schemes, the Coalition Government made two decisions:

- To reduce the revaluation factor in public service schemes from RPI plus 1.5 per cent to CPI plus 1.5 per cent
- To increase tiered contribution rates over a three year period by an average of 3.2 percentage points

2.2.15 The increase in contribution rates did not relate in any way to the financial solvency of the NHS Pension scheme but to a need to raise £2.8 billion to reduce the overall financial deficit in the economy.

2.2.16 In addition this increase was not raised equally across public service schemes as the lower paid were to be protected and higher increases were to be met by the higher paid including dentists.

2.2.17 The higher paid, including dentists, would pay 2.4 per cent extra in 2012-2013 and up to six per cent more in total by 2014-15.The highest paid who were paying 8.5 per cent in 2011-2012 would end up paying 14.5 per cent in 2014-2015.In addition those who were in the 6.5 per cent band would pay a disproportionate increase as the band was being split into three separate segments.

2.2.18 Prior to the review in 2008, most dentists were paying a 6% contribution. Many of those individuals ended up paying 7.5% after the review-an increase of 25%. By 2015, those dentists will be paying a tiered contribution rate of 13.5%.This is an increase in cost of 125% over a 7 year period, a huge increase by any standard.

2.2.19 The quadriennial valuation of the NHS Pension scheme which was due to take place in 2008 was postponed by the Government and has not yet taken place and is only likely to be undertaken shortly before the new 2015 NHS Pension scheme starts.

2.2.20 The contribution increases and the replacement of final salary for Officers by a CARE Scheme, together with a delay in Normal Retirement Age to coincide with State Retirement Age, represent a triple deterioration in the terms and conditions of public service workers.

Policy developments in general dental practice

2.2.21 The policy landscape for NHS dentistry in England continues to change causing disruption and uncertainty about the future. Not the least disruptive, though not unwelcome development, is the piloting of aspects of a new contract for NHS general dental practice. Below we discuss some preliminary reactions to the pilots from practices involved and provide some interpretation of the possible impact that a new contract may have on practices. We would like to point out that, although a new contract is not expected to be generally rolled out across England until 2015 at the earliest, many practices will begin to invest in new ways of working and new hardware to support it in advance to ensure a seamless transition for their patients. While we are confident that DDRB will recognise these costs in due course, we feel it is beneficial to provide this information to ensure that DDRB keeps in mind that this is the sort of issue that dentists continuously have to address, and that these costs should not be considered routine.

2.2.22 We consider it more appropriate for the Department of Health to provide DDRB with the policy rationale behind the pilots, as they are a DH initiative. The BDA hosted events for pilot practices to gather information about their experiences of the pilots so far. Participants included practice owners, associates and dental care professionals. These groups were separated to facilitate more open discussion. The key themes that emerged were concerns over associate employment status and unemployment and the increased cost of providing care under the pilot systems. Practice owners reported that they had seen a rise in the use, and so cost, of consumables such as fluoride varnish, printer cartridges and paper for patient reports, more training costs for staff, and in some cases an increased number of staff to manage increased working hours. The initial start-up costs to be involved in the pilots such as IT and software had been partially or fully funded in most cases, but there was a consensus that if practice incomes had not been protected practices would not have embarked on the pilots. Whether these two parameters will be met if a new contract is implemented is not known, but it is clear that the changes a new contract along the pilots' lines would require, cause significant financial anxiety among practice owners and this anxiety is exacerbated by the general consideration that the new system would be, at best, very difficult for single-dentist practices to implement. Associates, despite being self-employed, are not subject to the same concerns as practice owners regarding expenses, but

shared many others. In particular there were reports that the increased time required for the Oral Health Assessment (OHA), which many had not seen reducing, was having an impact on their ability to sustain their private work. In turn this has an impact on incomes and the long-term financial sustainability of practices. This, along with the increased expenses and more time spent on administering the OHA, has been reported to have a negative impact on associate income. These concerns and the potential for alternative ways of working were also reported to lead to associates feeling their positions were threatened by the increased use of hygienists and therapists, not complementing their work but rather being used instead of dentists. Consequently there were increased concerns that as the workforce changes associates' income would be even more squeezed. Despite these concerns there was a general consensus that the way of working that is encouraged by the pilot system is an improvement on the existing contractual arrangement for both dentists and patients. This suggests that dentists really are focused on providing high quality dental care and oral health prevention, but are concerned about the long-term viability of being able to do so if the financial arrangements are not sufficiently robust.

2.2.23 We expect that a more advanced level of computerisation will be required as a result of the Oral Health Assessment. Uncertainty about capacity requirements and implementation dates makes it less attractive for practices to invest in IT infrastructure that may become redundant in a short space of time. While we understand that such considerations will always be difficult to manage while a contract is undergoing reform, we stress that it adds an extra layer of uncertainty for practices which must continue to provide care under the current system.

2.2.24 As well as the contract pilots, which represent the most sweeping reform to dentistry since 2006, the NHS itself is undergoing further reform. As providers of care on behalf of the NHS, dental practitioners are affected by these changes, which include uncertainty over regulation, contract management, pension reform and restricted budgets. The debacle over registration with the Care Quality Commission (CQC) was strongly criticised by the Health Select Committee[11] and although the profession welcomed the vindication that came with recognition of their concerns, we were disappointed that no action was taken as a result and that dentists were still having to pay fees for unwanted, unwelcome and disproportionate regulation. We hope that the Department of Health will take on board the comments DDRB made in the *Fortieth Report* about the impact of policy decisions on morale.

2.2.25 The most significant changes to dentistry from the NHS reforms are the move to a centralised national contract. While this is welcomed by the profession, which has consistently spoken out against the variable quality, standards and rules of local commissioners, there still remain many questions over the future form of local contract monitoring and representation. We consider that the removal of local commissioners should be taken into account when efficiencies in dentistry are sought. The local structures, have yet to have their form confirmed making it difficult for local professionals to see how they should respond to the new requirements of the NHS. The BDA continues to work with the Department of Health on the development of dentistry in the NHS to ensure that patients experience no disruption to their services.

2.2.26 The refusal to pay seniority pay to new applicant dentists in England from April 2011 because of claims that it breaches the Equality Act was received very badly by the profession. Dentists have been paying into the scheme through tacit fee scale/contract value

[11] Health Select Committee *Annual accountability hearing with the Care Quality Commission* ninth report of session 2010-12.

reductions since 1968 but, unlike other professions with similar payment mechanisms, dentists in England have had their payments stopped without warning for new entrants, while others continue to receive them. We have tried to work with the Department of Health to develop a new scheme which would allow dentists to continue to receive payments, but no progress has been made.

2.2.27 Both GDPs and those in the salaried services were pleased to note the Secretary of State's assurance in the House of Commons that dentists would be exempt from market facing pay as they are subject to national market labour forces, not local ones[12]. We would be completely against its introduction for dentistry but note that in some areas employers are beginning to suggest otherwise for salaried services.

2.2.28 As is clear from this short summary of the policy environment in England, dentists are working in very changeable times. Uncertainty over what investment will be required to meet requirements for practice, combined with a poor economic outlook have to be taken into account when considering why dental expenses are as they are and what can reasonably be expected from small privately-owned businesses.

Policy Developments in the salaried services

2.2.29 The Salaried Primary Dental Care Service (SPDCS) as represented by the BDA's Salaried Dentists Committee (SDC) is currently negotiating a new commissioning contract with the Department of Health. The stated long-term aim of any contract is to ensure a consistency of approach within SPDCS services and to enable the SPDCS to be correctly remunerated for the complex patients they treat. SDC has committed to engaging with DH following their indication that they wish to mirror the general dental practice pilots in the salaried services, and eagerly awaits the formal announcement of these pilots.

2.2.30 Following the divesting of provider services under the Transforming Community Services policy, many SPDCS services find themselves hosted by bodies where dentistry is not a primary concern, and as such face a significant and repeated battle to ensure that resources they functioned with when directly funded by Primary Care Trusts are not allocated by the host organisation to a service which they are more experienced in providing.

2.2.31 Salaried dentists are contracted by numerous types of employer. As a result of the Transforming Community Services policy salaried services can no longer be provided directly by Primary Care Trusts who had to divest themselves of their providing function. Subsequently salaried services are now hosted by a mixture of Acute, Community Foundation or Mental Health Trusts, Local Authorities, Social Enterprises or Corporate providers. This has a resulted in a fragmented situation where national terms and conditions remain essential to ensure a unified coherent workforce.

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[12] http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120612/debtext/120612-0001.htm Column 162.

3. General dental practice

As the DDRB has once again not been asked to make recommendations on contract value uplifts we have not included evidence on expenses or a pay submission in our report.

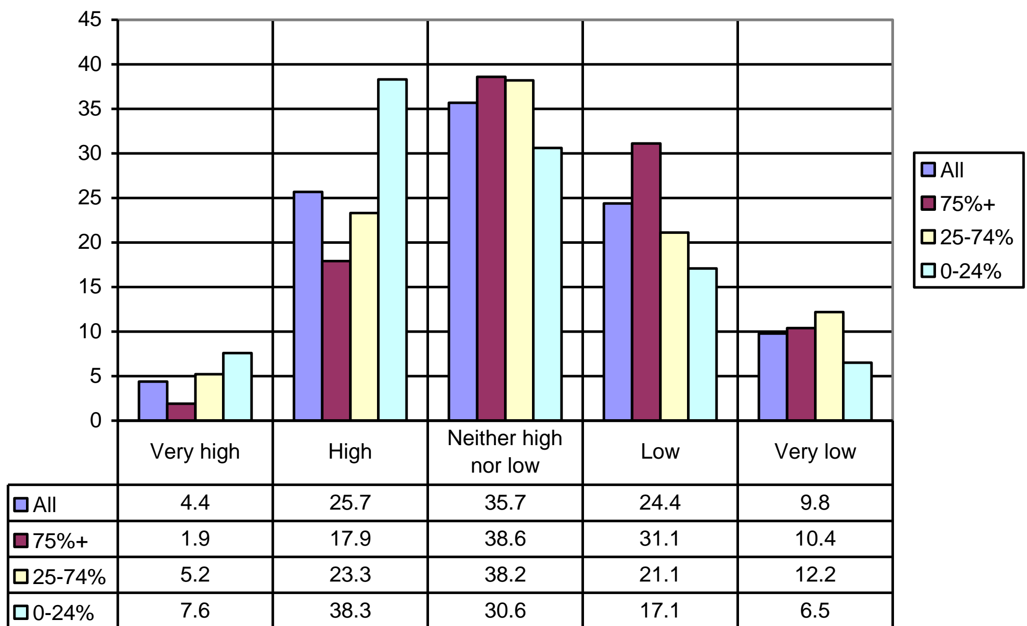
3.1 Morale and motivation in general dental practice

Key points

- Morale is very low, with 41.5 per cent of those with an NHS commitment of over 75 per cent responding that their morale is either low or very low in the DBT survey
- Levels of satisfaction with pay on NHS contracts was very low with 66.2 per cent of respondents saying they were dissatisfied with pay
- Job satisfaction remained high and was highest among those with the lowest NHS commitment

3.1.1 Motivation and morale continue to be very low in general dental practice. Over 41 per cent of respondents to DBT survey in England with an NHS commitment of 75 per cent or more said their morale was low or very low. Highest levels of morale were found among those with the lowest NHS commitment.

Graph 3: Self-reported morale among general dental practitioners in England (source DBT 2012)



	Very high	High	Neither high nor low	Low	Very low
All	4.4	25.7	35.7	24.4	9.8
75%+	1.9	17.9	38.6	31.1	10.4
25-74%	5.2	23.3	38.2	21.1	12.2
0-24%	7.6	38.3	30.6	17.1	6.5

3.1.2 The graph above supports previous evidence submissions that those working with higher NHS commitment have lower morale than those with lower commitment. The table below shows the attitude of dentists in England to dentistry with an NHS commitment of over 75 per cent and highlights issues around having to work to targets:

Table 4: percentage of respondents with over 75 per cent NHS commitment agreeing with the following statements (source DBT survey 2012)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
I am satisfied with my current job as a dentist	10	40.8	24.9	18.2	6.1	0
I receive recognition for the work I do	7.1	33.4	32.8	20.2	6.6	0
There are opportunities for me to progress in my career	7.2	30.3	35.8	18.6	6.4	1.7
There are opportunities available to me to develop my skills	6.7	52	25.6	10.3	5.1	0.4
The practice involves staff in important decisions	8.5	41.6	21.9	19.3	8.5	0.2
I have full clinical freedom in my job	21.2	40.1	18.3	14	6	0.4
My job gives me the chance to do challenging and interesting work	6.8	35.5	29.9	19.9	7.3	0.6
I have sufficient time to complete all my work	3.1	23.9	27.1	31.2	14.3	0.4
I feel good about my job	5.6	36.2	32.6	16.8	8.2	0.7
I often think about leaving general practice	15.7	26.9	23.1	20.7	11.8	1.7

3.1.3 Owing to the changes to the DBT survey this year, the data is not directly comparable with previous years. There are however strong parallels, with a continued level of disagreement about the level of clinical freedom/autonomy dentists have and an agreement that dentistry itself is an interesting career provided clinicians can focus on the provision of care. NHS IC data and the DBT survey both showed that administrative work has increased. The BDA

found that all dentists were spending approximately 18 per cent of their time on administration, while the NHS IC data found it was 17.3 per cent for England and Wales.

Table 5: Satisfaction with pay and conditions in England among dentists with over 75% NHS commitment (Source DBT survey 2012)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
The environment I work in is comfortable and safe	34.1	47.2	12.1	4.9	1.6	0
I get support from my work colleagues	26.8	47.3	19.4	4.1	1.3	1.1
I feel good about working at this practice	23.1	44.5	23.9	5	3.5	0
I feel secure about my job	19.3	38.8	23.1	12.4	6.4	0
I have all the equipment I need to do my job properly	18.5	41.6	19.6	14.5	5.9	0
There are sufficient staff in my practice to complete the required work	19.3	49.5	14.9	14	2.3	0
I feel that my pay is fair	5.5	26.3	27.6	23.6	16.7	0.2
I feel that remuneration for NHS work is fair	3.1	12.1	17.7	33	33.2	1
I am satisfied with the terms and conditions of my employment	5.4	26.6	32.5	21.2	13.4	1

3.1.4 It is clear from the responses above that dentists enjoy the practice of dentistry, feel supported by their colleagues and are happy that they have a level of development and

interest that satisfies them. We believe that the recent pay cuts have had a very negative impact on dentists, with 66 per cent of dentists with an NHS commitment of over 75 per cent saying that pay is not fair. This is an increase of almost 24 per cent over last year (42.6 per cent in 2011 DBT survey), when the full impact of the pay cuts had not been felt. It is unreasonable to expect a profession which takes a significant personal financial risk to provide NHS services to have to accept disproportionate reductions in pay, while increasing the amount of care for patients.

3.1.5 The BDA's Practice Owner Focus Groups supported the DBT's findings that motivation was at a very low point and the problems with increased regulation and other burdensome requirements were identified:

> "A lot of it is tick boxing, it's not the treatment you provide, it's making sure you've written up your notes to cover yourself just in case it goes to litigation. You might do a small filling on a patient but in the back of your mind you think hang on a minute, could this lead to a complaint just because it might flare up?"

> "[One of my biggest concerns is the] time to complete all the regulations and guidelines and policies, then you've got all the costs that go with it. I think we must be probably the most over-regulated profession going."

> "It hasn't been properly tailored to dentistry. HTM 01-05 is not evidence based. CQC was astonishingly irrelevant, most of the things that they were asking us to look at. I haven't been inspected, but from people who have been inspected they don't seem to really understand dentistry, they're obsessed with other things. Information Governance, that was absurd the amount of work that was involved in that, and still is, it's just unbelievable Information Governance. That was my first one, increase in regulation."

3.1.6 The focus groups also showed that expenses and pay freezes were also sources of low morale. The lack of recognition for the personal investment made by practice owners was also a frustration as well as the real impact of falling pay:

> "Money. We've not had any wage rise and yet material costs have all gone up, VAT's gone up, price of gold's gone up so your lab bills are going up. It's really difficult because staff morale can be low because they've not had a wage rise for three years. It's not easy really."

> "Increase in expense to comply with the regulations that have not been funded by the NHS. There's been no increase in fees the last couple of years, we're expected to spend huge amounts of money on all this and have had no remuneration for it at all, it has to come out of private income."

> "Where we could manage the practice ourselves we had to end up hiring another member of staff to actually do all these bits and pieces so we could get on and do our clinical work, and that had an impact on the profits."

> "So they've limited our income, increased our expenses, the £5 in my pocket is the same £5 as in anyone else's pocket, it doesn't stretch anymore."

3.1.7 The negative feelings about the future of the profession were echoed in the DBT survey where 37.4 per cent of respondents said they would not recommend a career in dentistry and only 41 per cent said they would. Among those with a high NHS commitment the figures are lower with 41 per cent saying they would not recommend a career in dentistry and only 34 per cent saying they would. As the professional association for dentists we find these figures particularly disappointing and urge the Department of Health to rectify this disturbing situation.

3.1.8 Those who stated an intention to retire were asked if there were any factors affecting their decision other than age. Of the 24.5 per cent who stated an intention to retire, 90 per cent of those with an NHS commitment of over 75 per cent cited new or onerous regulation as the cause. Falling earnings and increasing expenses were also significant factors.

Table 6: Contributing reasons to retirement in England for those with an NHS commitment of 75 per cent or more (source DBT survey 2012)

Reason	Percentage
Introduction of new and/or onerous regulations	90.2
Increasing levels of bureaucracy	84.3
Increased feelings of stress and pressure	82
Increasing administrative burden	77
Decreasing morale	70.6
Increasing costs of running a practice	64
Falling earnings	46.7
Changes to NHS pension scheme	20.1
An opportunity is available	19.3
Health	17.5
Installation of a local decontamination unit	17
None	1.3

3.2 Recruitment and retention in general dental practice

Key points

- The NHS has seen the smallest increase in the number of dentists providing NHS care since the introduction of the current contract
- Dentists reported an increase in the levels of both clinical and administrative work
- Most practices were not recruiting associates
- 35.7 per cent of practices that did try to recruit a dentist for predominantly NHS work encountered problems
- Even more dentists than last year (15 per cent) are planning to retire (23 per cent)
- Of the 77 Vocational Dental Practitioners who trained in England and intended to work in the UK after they completed training, 6 took a job in either Scotland or Wales instead of England

Dental numbers in the NHS

3.2.1 *NHS Dental Statistics for England: 2011/12*, published by the NHS Information Centre, provide a picture of dentists leaving and joining the service. The report showed that 1,594 dentists left NHS work while 1,715 joined, making an increase in the NHS general dental practice workforce in England of 121 (a total of 22,920 dentists performing NHS care).This is the smallest increase, and greatest rate of leaving, since the introduction of the current contract. The highest rate of leaving was among the under-35s, consistent with previous years. As has also been the case since 2006/07, more men than women were leaving the NHS and more women than men were joining the NHS. This is probably due to the higher proportion of male dentists retiring and the greater number of female dentists graduating.

3.2.2 The proportion of dental practice owners has continued to drop since 2006/07 when 37.6 per cent of self-employed dentists owned a practice. Now only 22 per cent do. The reasons for this may be practice owners incorporating or selling their practices to a dental body corporate. The greatest proportion of both leavers and joiners to the NHS were performer-only, but the proportion of provider-performer leavers was 17.8 per cent, the proportion of provider-performers joining the NHS being only 0.6 per cent.

3.2.3 If the factors that are affecting the low joining levels to the NHS of provider-performers are not addressed then there is the potential that the NHS could face a serious problem with its ability to deliver the care that the population requires. The NHS IC also shows that courses of treatment have increased at a greater proportion than the dental population, showing that those who remain in the NHS are working harder than ever and, as the evidence above shows, working for less.

Recruitment

3.2.4 The majority of practice owners who responded to the DBT survey did not recruit an associate, or see their associates' hours increase. More did, however, recruit into dental care professional roles, such as dental nurses:

Table 7: Recruitment by dentists with over 75 per cent NHS commitment (source DBT survey 2012)

Role	Sought to recruit (%)	Did not seek to recruit (%)	Problems recruiting (%)	No problems recruiting (%)
Dentist (predominantly NHS work)	40	60	35.7	64.3
Dental Nurse	52.7	47.3	41.5	57.1
Dental Hygienists	17.2	82.8	11.1	88.9
Dental Therapist	7.1	92.9	5.8	94.2

3.2.5 Levels of recruitment in practices with a 75 per cent or more NHS commitment were low. Forty per cent of respondents reported that they had attempted to recruit an associate and of these 35.7 per cent encountered a problem with that recruitment. Recruitment rates were higher for dental nurses, 52.7 per cent. The quasi-market status that NHS dentistry operates in, where the size of the market and therefore potential income is capped by the NHS, makes it difficult for practices to develop opportunities for colleagues. In comparison, only 7.9 per cent of practices in England, including all levels of NHS commitment, recruited dentists for primarily NHS work. Practices with a low NHS commitment (0-24 per cent) had the highest rate of recruitment for private dentists at 13.5 per cent. In total of all practices that sought to recruit a dentist for predominantly private work 9.8 per cent encountered a problem with recruitment. 11.1 per cent of practices with a low NHS commitment that sought to recruit encountered a problem. Although only a very small number of predominantly NHS practices sought to recruit a dentist for predominantly private work (3.3 per cent – N: 58), they encountered the greatest number of problems with 12.6 per cent reporting difficulties in recruiting.

3.2.6 The level of recruitment of associates for predominantly NHS work suggests that there is a high turnover in this sector, suggesting that it is difficult for practice owners to retain staff under difficult economic circumstances. With incomes for both practice owners and associates dropping we are concerned that this will continue. High staff turnover can be especially damaging in a healthcare setting where there is the potential for continuity of care to be damaged and the important practitioner/patient relationship to disappear.

3.2.7 Vocational dental practitioners (VDPs) in England who intended to practice dentistry in the UK mostly found places after their training in England. Six, however, found jobs in either Scotland or Wales instead. According to our survey, 102 VDPs who were training in England intended to continue to work in dentistry in the UK. Of these, 77 were able to find a post, 71 of which were in England. It took an average of just under five weeks for these dentists to find a post, and the average number of applications made among 73 dentists was just over 7, resulting in an average of 1.5 interviews. Around 21 per cent of respondents who trained

in England and were successful in finding a position said that finding a job had either “moderately” or “very difficult”, with one VDP commenting

> “Very difficult to get an associate job as several jobs set very high UDA targets and also specify minimum number of years’ experience which limits job opportunities following completion of DF1”.

Another reported that

> “Finding a smaller contract, majority of the contracts I saw wanted someone who could do 7,000-8,000 UDAs in a year, which is great for some people. However, as I am just out of VT, I didn’t feel confident with large contracts, I still feel slow”.

3.2.8 24.5 % of those who trained in England reported that they had been unsuccessful in securing a post at the time of the survey (June-July 2012) These respondents reported said they had looked for a job for an average of 8.3 weeks and made an average of 32.43 applications and had attended an average of 1.48 interviews. Examples of difficulties these dentists faced were reported as:

> “Lack of posts in the location I am looking for. Too many years’ experience required. Too many applicants per post”.

> “Very few positions are advertised for associate positions in the area I am looking and also ones that are available are for dentists with more years of experience”

> “I am looking to relocate to London, which is extremely competitive – requiring years of experience or offering too many UDAs for my competency level”.

3.2.9 We consider it extremely important that these young dentists are not lost to the health service or profession and consider it vital for the future that the financial systems which are increasing competition among dentists do not have an impact on recent entrants to the profession as the comments from both cohorts suggest.

Work distribution

3.2.10 The amount of clinical work being undertaken by dentists with more than 75 per cent NHS commitment has increased slightly according to the DBT survey. This is occurring as the amount of time being spent on administration is increasing dramatically. Figures from the NHS IC’s *Dental Working Hours: England and Wales 2010/11 and 2011/12* report broadly support our findings. According to the NHS IC data, provider-performer dentists were working 27.1 hours on NHS work but spending 23.8 per cent of their time on administration, while performer-only dentists worked 28.4 hours a week on NHS dentistry and spent 14.5 per cent of their time on administration. In total, dentists spent 17.3 per cent of their time on administration. Dentists have to do more of both in order to meet their NHS commitments:

Table 8: Trends in time spent on clinical and administration in England among dentists (practice owners and associates) with over 75% NHS commitment (Source DBT survey 2012)

	Increased substantially (%)	Increased somewhat (%)	Stayed the same (%)	Decreased somewhat (%)	Decreased substantially (%)
Hours spent performing clinical dentistry	5.5	14.2	61.5	14	3.7
Hours spent on dental administration	23.1	34.5	38.1	1.7	0.8

3.2.11 Practice owners alone have seen the amount of time spent on administration increase dramatically with almost 71 per cent responding that their administration has increased somewhat or substantially. 38.2 per cent of associates have also seen the amount of time they spend on administration increase somewhat or substantially. 28.7 per cent of respondents intended to buy or expand a practice in the next year, while 42.2 per cent intended to retire or sell a practice.

Table 9: Future intentions, all dentists in England (source DBT survey 2012)

Intention	Percentage
Buy a practice	14.8
Expand a practice	13.9
Sell a practice	17.7
Retire	24.5

3.2.12 While the two cohorts clearly do not necessarily overlap, there is no reason to suppose that the market will become more open if there are not more entrants. The cost of opening or buying a practice in a poor economic climate and the difficulty in obtaining an NHS contract unless someone voluntarily gives theirs up and the PCT decides to re-commission, will continue to make it difficult for associates to become practice owners or for unemployed dentists to find new places of work. High levels of annual investment are required by practice owners to keep up with latest developments in technology and regulations such as HTM 01 05. Those who intend to expand or buy a practice may also see their intentions thwarted.

3.3 Conclusion

3.3.1 NHS IC data shows a significant drop in income despite government pledges of a pay freeze

3.3.2 Morale is low among general dental practitioners

3.3.3 DBT survey shows that 66 per cent of general dental practitioners with a high NHS commitment are dissatisfied with NHS pay

3.3.4 NHS IC data shows that while the number of NHS dentists is increasing it is increasing at its lowest levels since 2006

3.3.5 Both NHS IC and DBT survey data show that time spent on administration is increasing

3.3.6 The BDA strongly recommends that the contract value uplift as shown using the DDRB's formula is applied in full to provide the profession with the one per cent uplift and to meet the rise in expenses following two years of pay cuts despite government's stated aims of implementing a pay freeze. We are very concerned that a failure to do so would result in a further reduction in morale.

4. Salaried Primary Care Dental Services

Key points

- We recommend that dentists in the salaried services receive at least the one per cent uplift available to public sector employees
- Over 40 per cent of respondents to the BDA's survey were dissatisfied with pay
- 75 % of clinical specialists are employed at an inappropriate band
- Almost half of positions advertised were for Band A posts and almost half were for Band B posts.
- In a quarter of cases no applications were received for Band A positions.
- Band A vacancies were the most likely not to have any applications shortlisted.
- The number of patients being seen has increased according to the *Clinical Directors' Survey*
- Only two Band C clinical specialist posts had been advertised in the last year according to our Freedom of Information Act request
- Morale and motivation is low
- 52 per cent reported having no career opportunities
- The main causes were identified as low pay and low staffing levels, putting pressure on caseloads
- Low staffing levels were a also cause of general concern about the capacity to provide appropriate care for patients
- The salaried service is ageing fast and there is not enough scope at lower grades for younger colleagues to join

This section presents information about the recruitment, retention, morale and motivation of dentists in the salaried primary care dental services in England. We welcome the average one per cent uplift to all public sector employees following two years of pay freezes and cuts to resources, but we do not consider this to be sufficient to sustain the service. The salaried services provide excellent care to the most vulnerable patients but have been experiencing reduced morale and dissatisfaction. If pay is not competitive then provision of services for the most vulnerable will decline and those dentists who remain in salaried service positions will become ever more unable to provide the care they feel their patients need and will suffer from even lower morale. While pay is obviously an issue and we recommend that salaries in the salaried service are comparable to the general dental practice market, a greater issue is fair pay for work performed. As mentioned in our summary above, many specialists are

working at a Band B level despite provision in contracts for Band C. The failure to promote these specialists to Band C posts means that they are getting paid at a Band B level for performing a Band C function, which is unacceptable and unsustainable.

4.1 Recruitment and retention

4.1.1 As with previous evidence we had two sources for our information on recruitment and retention in salaried services: Our *Annual Survey of Clinical Directors UK*, and a Freedom of Information request in April and May this year to all salaried primary care dental providers on their recruitment experiences (annex 5 and 3). The result of under investment has been increasing waiting times, increasing length of treatment appointments and increased length of recall between appointments, as well as decreasing morale.

4.1.2 The BDA's Clinical Directors' Survey showed that across 18 services the number of dentists employed at Band B level had reduced by a total of 5.3 whole time equivalents (WTE), between March 2011 and March 2012. While the survey showed a slight increase in the number of WTE dentists in Band C posts, 1.2 WTE, this was accounted for by only two services and in fact only one service increased actual headcount. The Freedom of Information Request found that only two Band C posts had been advertised at all. 13 services had increased the total number of whole time equivalents in Band A posts by 1.64 WTE, between March 2011 and March 2012. The increases were not, however, uniform. No services reported an increase in the number of Band C managerial posts, while two out of 17 reported a decrease. Only two out of eight clinical directors reported an increase in the number of Band C specialist dentists. We find this lack of expansion into Band C particularly frustrating, especially given the purpose of changing the contract over fours ago to recognise specialists. In addition, the Clinical Directors' Survey shows that despite the introduction of the contract supporting Band C posts 75 per cent of registered specialists are still working at a Band B level. It is no wonder that our morale survey showed that over 52 per cent did not feel that there are adequate career opportunities and that almost 64 per cent do not think there are adequate staff in their service. Despite these reports of low staffing levels only half of services had advertised for a position at any grade, and this equated to 45.8 whole time equivalent positions, for the whole of England. Half of these positions were reported to be for Band A posts, and half for Band B posts. In a quarter of cases, however, no applications were received for the Band A posts, and in total only half of all advertised positions actually led to an appointment. The Band A positions were the least likely to result in an appointment. These figures demonstrate that there are still recruitment problems in the salaried services This does not represent anything like the investment in recruitment that we consider necessary for the long term good of patients and the service.

4.1.3 The Clinical Directors' Survey showed that there had been an average increase of 3.6 per cent in the number of patients seen in the salaried service in England. We ask the DDRB to note that the salaried services are doing more for less and that the impact of not increasing staffing levels at appropriate grades to manage patient requirements is having a detrimental effect on morale and on the care patients receive as we show below.

4.1.4 The failure to adequately reward hard working colleagues was a theme at the BDA's salaried focus groups and was considered to have severe implications for retention in the service. One participant reported:

"We are in grave danger of losing an extremely experienced colleague who is a specialist in special care dentistry….. [She] is very clearly Band C specialist work and we cannot get her upgraded to a Band C. It doesn't matter which approach we take, it gets knocked back every time. They will not find the money to pay her to upgrade her to a Band C. It's extremely hard for her to say well I'm only going to do the Band B parts of the job'. "

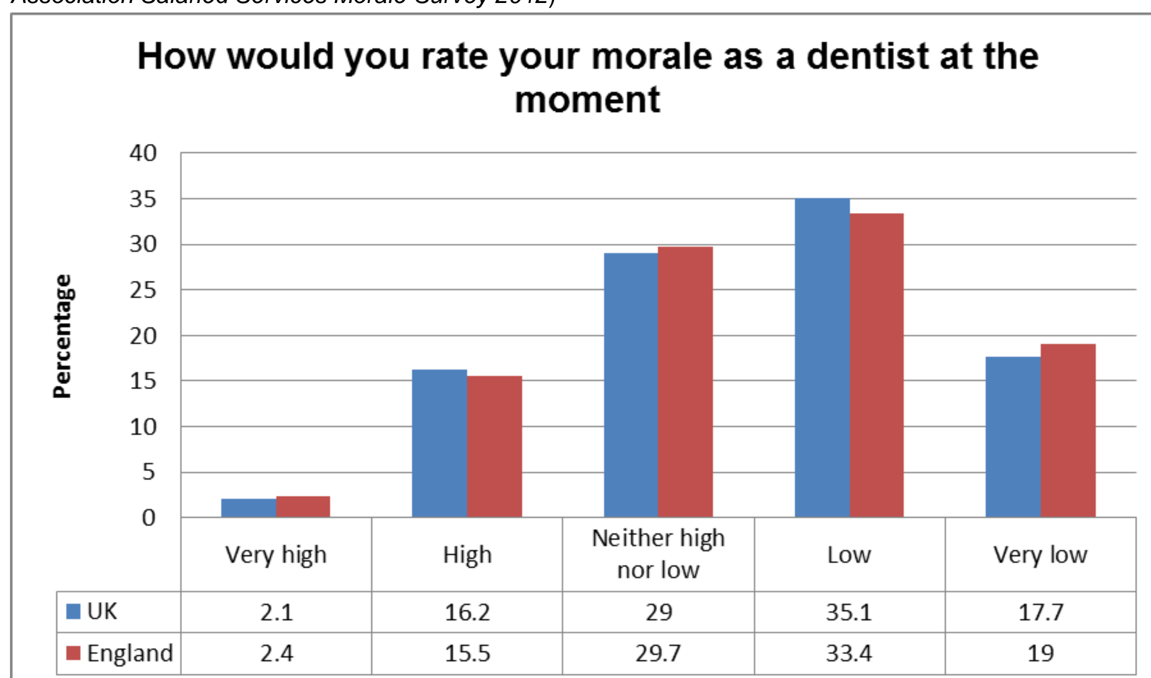
4.2 Motivation and morale

4.2.1 The BDA conducted a survey on the morale of dentists working in the salaried primary care dental services (annex 2). The main findings of the report are included here. This builds on previous surveys and shows morale to be roughly the same as last year with no improvement. The main causes of low morale are supported by the low recruitment data, inappropriate pay scales and increased workload shown above.

4.2.2 Despite having low or very low morale, most dentists in the salaried services are satisfied that they can deliver the care required and think their job is interesting. What this shows is that it is not the clinical aspect of dentistry that is causing the low morale. When faced with individual patients, dentists are still working to the same high level. It means, however, that they have to work much longer hours and it increases stress and lowers morale. This takes place against the backdrop of feeling unappreciated and unimportant compared to other services. This trend is unsustainable and unjustified for a frontline service treating those with the highest need.

4.2.3 More than half (52.4 per cent) of the respondents stated that their morale was low or very low. Only 17.9 per cent stated that their morale was high.

Graph 4: How would you rate your morale as a dentist in the SPDCS at the moment? (Source *British Dental Association Salaried Services Morale Survey 2012*)



	Very high	High	Neither high nor low	Low	Very low
UK	2.1	16.2	29	35.1	17.7
England	2.4	15.5	29.7	33.4	19

4.2.4 A core issue affecting morale was the impact of an excessive caseload preventing dentists from seeing patients as often as they would like. Staffing levels continued to be a major

issue with over 75 per cent of respondents characterising their service as understaffed. A lack of career progression also continued to be a problem, with 52.8 per cent of respondents saying that they did not feel they had opportunities to progress.

Table 10: The impact of excessive caseloads (Source *British Dental Association Salaried Services Morale Survey 2012*)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
My excessive case load puts pressure on me to cut clinical standards	17.6	23.2	23.2	29.6	6.3	0
Due to my excessive caseload I am unable to see patients as frequently as clinically necessary	39.7	40.4	11.3	7.8	0.7	0
I do not feel that I am given sufficient time in appointments to complete the treatment necessary	21.1	33.8	19	23.9	2.1	0

4.2.5 48.5 per cent of dentists in the salaried service in England reported that their caseload was excessive and 80 per cent agreed that this excessive caseload was having a negative impact on their ability to see patients as often as clinically required. In addition 54.9 per cent considered that they had insufficient time in an appointment to provide the care required because of excessive caseloads. The Salaried Services Morale Survey also showed that over 75 per cent characterised their service as understaffed. If the salaried services are to continue to provide the care that patients expect and deserve these staffing issues must be addressed.

4.2.6 Excessive caseloads are having a negative effect, not only on dentists but on patients, whom dentists do not feel they have sufficient time to treat fully. The table below shows that dentists enjoy the work of being a dentist and providing care, and many chose a career in the salaried services so that they would be able to live up to the NHS's goal of providing high

quality clinical care for those who need it. It is very disappointing to see that so many dentists consider this to be an unmet goal.

4.2.7 Among the many causes of low morale in the salaried services is the freezing of posts and the subsequent impact this has on the morale of those committed to a career in the salaried service, a lack of visible career progression is a significant factor according to 52.8 per cent of respondents. In addition, the NHS has failed to fully implement the agreement to deliver Band C posts so that specialists will be appropriately remunerated for the duties they perform. Many respondents to the Salaried Services Morale Survey felt unrecognised and unengaged (37.4 per cent and 55.2 per cent). We consider that the implementation of the agreed contractual arrangements for Band C posts would go some way to alleviating this cause of low morale. The result of under investment in the service has been increasing waiting times, increasing length of treatment appointments and increased length of recall between appointments, as well as decreasing morale which is particularly observed among younger dentists working within the service. We do, however, welcome DDRB's continued support in the development of better working conditions as highlighted in last year's report

Recommending a career and causes of low morale

4.2.8 Only 31.8 per cent of those surveyed said that they would recommend a career in the SPDCS, which is down from 44 per cent in 2010 and 38 per cent in 2011, while 38.4 would not. More dentists in the salaried services were frustrated with their work than last year, but still agree that it provides an interesting environment to work in. The problem is not about the dentistry but appears to be about pay, bureaucracy and career progression.

Table 11: Dentists who agreed with the following: (Source *British Dental Association Salaried Services Morale Survey 2012*)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
I receive recognition for the work I do	4.1	31.6	26.8	26.1	11.3	0
There are opportunities for me to progress in my career	2.8	17.6	25.2	30.7	22.1	1.7
There is strong support for training in my service/trust	7.6	30.6	26.5	21.6	13.4	0.3
Managers involve staff in important	7.2	16.2	20.7	29	26.2	0.7

decisions						
I have full clinical freedom in my job	10.7	40.5	21.8	18.7	7.6	0.7
My job gives me the chance to do challenging and interesting work	17.5	58.1	15.8	5.8	2.7	0
I have sufficient time to complete all my work	5.2	25.6	15.2	34.9	18.7	0.3
I often think about leaving the salaried service	16.7	24.3	18.4	24	14.9	1.7
I feel good about my job	7.9	35.5	27.9	15.9	12.4	0.3

4.2.9 Low levels of recognition, poor engagement from managers and pressures on time are the major reasons for low morale according to the results above. This supports anecdotal evidence and the trend we saw in last year's evidence where the main problem was not the dentistry, as evidenced by over 75 per cent of respondents saying they find their work interesting. The problems are issues which prevent clinicians acting as clinicians.

4.2.10 As we saw last year, job security continues to be a major cause of concern for many (49.2 per cent) dentists in the salaried services. When time pressures are already considered to be causing major problems, a lack of job security is very concerning.

Table 12: Dentists who agreed with the following: (Source *British Dental Association Salaried Services Morale Survey 2012*)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
The environment I work in is comfortable	22.3	49.7	15.1	9.2	3.8	0

and safe						
I get support from my work colleagues	21.6	56.4	13.1	6.2	2.4	0.3
My trust/local health board is a good employer	5.1	30.8	36.3	17.8	8.9	1
My immediate supervisor does a good and efficient job	13.7	37.7	21.2	15.4	10.6	1.4
I feel secure about my job	7.6	21.6	20.6	28.9	20.3	1
I have all the equipment I need to do my job properly	11.3	37	20.5	23.3	7.5	0.3
There are sufficient staff in my service to complete the required work	7.2	18.2	10.3	38	25.7	0.7
I feel that my pay is fair	7.2	28.1	23.3	22.6	18.2	0.7
I am satisfied with the terms and conditions of my employment	10	35.7	19.2	18.6	15.5	1

4.2.11 The table above shows that dentists are not satisfied with their pay in the salaried services and reiterates the low staffing level concerns. While managers were considered un-engaging in the previous table, supervisors were considered to be doing a good job, as were other colleagues. This shows the support that dentists in the salaried services offer each other in pursuit of high quality care and we consider that such dedication should be adequately rewarded.

4.3 Conclusions and recommendations

4.3.1 **Future –** We remain very concerned about the future of the salaried services. The lack of career progression and failure of the NHS uniformly to implement band C posts will have severe repercussions on the ability of the service to meet demand in the future.

4.3.2 **Progression –** Over 50 per cent of respondents did not feel there was any opportunity to progress in their career. This must be addressed if morale is to improve.

4.3.3 **Funding –** While recruitment data shows that competition for places is higher than previously and so suggests that there is no problem, the real issue is masked: there is insufficient recruitment. The practising population is ageing, preventing new entrants to the service. More places need to be created to ensure that there is a suitably qualified and trained workforce capable of replacing those who retire.

4.3.4 **Pay –** The salaried services have had a pay freeze for the last two years. They welcome the one per cent pay increase announced for all public sector workers. We would like to reiterate, however, that if a dentist is trapped on the wrong grade (a grade that does not reflect the work they perform) then the pay rise is based on the incorrect amount in the first place. It is imperative that those in the salaried services are paid appropriately and this means ensuring that they are on the correct grade to begin with.

4.3.5 **Caseload –** Excessive caseloads are having a severe effect on morale in the workforce and also impact negatively on the ability of the profession to deliver care for their patients.

5. Clinical academic staff

5.1 We are providing evidence on the recruitment and retention of clinical academic staff. Although this staff group is outside the formal remit of the Review Body, they have a profound influence on the quality of the education received by dental undergraduate students and so ultimately affect the recruitment of young people into the profession. Clinical academic staff play a key role within dental schools and exhibit very high levels of teaching, research and clinical skills which should be rewarded. We thank the Review Body for considering our evidence on clinical academic staff in previous years and invite it to do so again this year.

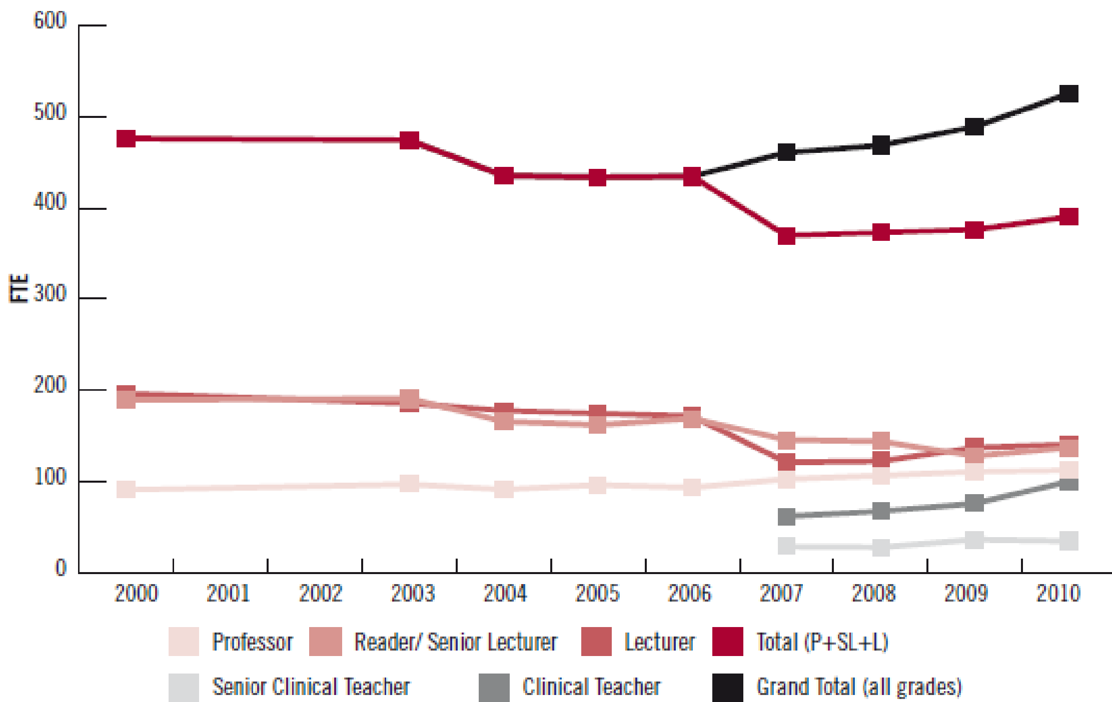
5.2 The Dental Schools Council (DSC) carried out its annual report on academic staffing levels and published the most up-to-date figures in May 2011. Although the DSC recorded an increase of 7 per cent in the number of clinical academic staff it notes that this disguises an alarming 18 per cent drop in the number of professors, senior lecturers and lecturers. The DSC also notes that:

> "Analysis reveals that six of the fifteen dental specialties have a total academic staffing level of less than 18 FTE, compared with three specialties in 2000. Less than 15% of the academic team is at Lecturer grade for Oral & Maxillofacial Surgery and Oral Pathology. Across all specialties, there were 44 FTE vacant posts. Nine dental schools report other difficulties in recruitment, including a small pool of potential applicants with sufficient expertise, and uncertainty around future funding leading to recruitment freezes."

5.3 As a strong academic presence is important to the continuing high standard of education and development of new technologies and techniques, we are alarmed that some specialties are so understaffed and that universities have trouble recruiting. Issues with staffing at professor and senior lecturer level appear likely to continue as these groups are ageing faster than clinical teachers.

5.4 The graph below from the DSC report shows that the academic branch of the profession is continuing to suffer from low recruitment:

Graph 5: Timeline of clinical academic staffing level by academic grade since 2000 (FTE) (source DSC 2011)



5.5 The number of dental students is also increasing every year and, with the increase in tuition fees, students will be expecting greater value for money which may well include expectations on academics' time. In order to support strong education we urge increasing support to ensure that dental academia is a strong, viable and appealing career choice.

Annex 1

Summary of Dental Business Trends Survey 2012

Summary

This report provides the findings from a survey of dentists carried out by the British Dental Association (BDA) to assess current business trends in UK dentistry.

The survey was carried out in the summer of 2012 with practice owners and associates who are current members of the BDA. The survey sought to investigate the following areas:

- Dental workloads
- Morale and motivation in the profession
- Financial circumstance of dentists
- The dental workforce

Fieldwork for this survey took place between 21st June and 8th August 2012 via a paper survey. The survey population included all dentists working in general dental practice (GDP) who were members of the BDA and for whom the BDA had current and reliable information.

Of the 4,225 members who were invited to participate, 1,120 participants responded, giving a response rate of 27 per cent.

Findings from the survey fell into four main areas:

About the respondents and their practices

- Almost two-thirds of participants were from England.
- Over half of the participants were male. However, there were some differences between the genders split of practice owners and associates. Almost three quarter of practice owners were male, compared to 42 per cent of associates.
- The majority of participants were aged 45 to 54 years, with an average age of 44. The average age of practice owners was 49 and the average age of associates was 41
- Almost half of all responds claimed that 99 to 75 per cent of their income derives from NHS dentistry.
- Two-fifths of practice owners had a high NHS commitment (74-100 per cent NHS), while a fifth of practice owners had an income that was exclusively from private dentistry.
- The large majority of associates had a high NHS commitment (75-100 per cent NHS); while one in ten associates had an income that was exclusively from private dentistry.
- A quarter of practices had five or more dentists with an average of 3.6 dentists per practice.
- The majority of practices had two or three surgeries in their practice with the average number of surgeries being 3.4 surgeries.
- Most practices were held as a sole trader while almost a quarter were held as a limited company.

Dentists' financial circumstances

- Practices saw an average increase of one per cent in practice turnover from 2010/11 to 2012.
- Practice expenses increased by nine per cent on average from 2010/11 to 20111/12.

- On average the gross profit practices made fell by four per cent from 2010/11 to 20111/12.
- The resulting change to practice turnover and expenses saw the expense ratio rise from 0.66 in 2010/11 to 0.68 in 2011/12.
- Practice owners reported an average increase in materials of ten per cent, equipment consumable of eight per cent, and laboratory expense of 6 per cent.
- The modal average of gross earning for practice owner was between £80,001-£100,000; and for associates between £60,001-£70,000.

Morale and Motivation

- A third of respondents reported that their morale was low or very low.
- The most common contributing factor to low morale was excessive regulation and administration, remuneration under the NHS and falling income.
- Almost 60 per cent of respondents had a high level of job satisfaction; however, those who work in predominantly private practice were more likely to have high job satisfaction that those that had a high NHS commitment.
- Forty per cent of those with a high NHS commitment felt that they were recognised for the work that they do, compared to almost 70 per cent of those with a low NHS commitment.
- While just over 40 per cent felt that their pay was fair, only 11 per cent felt that remuneration on the NHS was fair.
- Only two-fifths if respondents would recommend a career in dentistry.

Workload

- On average dentists spend just under 37 hours in their week working, of which almost seven hours is spent on administration.
- There is a clear difference between the working patterns of practice owners and associates. Practice owners spend an average of 41 hours per week working, of which 22 per cent is administrative. Associates spend 32 hours per week working, of which 11 per cent if administrative.
- Over half of participants have seen an increase in the number of hours they spend on administration per week.
- Missed appointments account for over two hours per week on average.

Workforce

- The average number of dentists working in a UK practice is 3.6 with a whole time equivalent of 2.4.
- Within the dental workforce, the dental nurse was the position that was most commonly recruited for in the past 12 months. However, it was the position that practice owners had the most difficulties with recruitment.
- Practice owners were more likely to recruit a dentist for predominately NHS work rather that predominately private work.
- Almost a quarter of dentists stated that they are planning to retire over the next three years. The main contributing factors for this, other than age, were the introduction of new and onerous regulations, increasing levels of bureaucracy, and the increasing administrative burden.

Annex 2

Summary of the Salaried Primary Dental Care Service Morale Survey

Summary

This report provides the findings from a survey of salaried dentists carried out by the British Dental Association (BDA) to assess morale and motivation in the salaried primary dental care service (SPDCS) in the UK.

The survey was carried out in the summer of 2012 with dentists in the salaried services who are current members of the BDA. The survey sought to investigate the following areas:

- Levels of morale in the service
- Levels of motivation in the service
- Impact of understaffing in the service

Fieldwork for this survey took place between 20st July and 8th August 2012 via a paper survey. The survey population included all dentists working in SPDCS who were members of the BDA and for whom the BDA had current and reliable information. Of the 1,264 individuals who were invited to participate, a total of 415 participants responded. This gave us a response rate of 33 per cent. Findings from the survey fell into four main areas:

About the respondents and their practices

- Three-quarters (74.1 per cent) of respondents were based in England.
- Over two-thirds (69.1 per cent) of respondents were female.
- Just over half of respondents (52.3 per cent) of respondents are over the age of 50.
- The majority (77.9 per cent) were based in an urban location.
- Over a third of respondents were employed in Band A positions, and a similar proportion were in Band B positions.
- More than two in five (44.8 per cent) respondents had been working in the service for more than 20 years, at an average of 18 years.
- Three in five (60.3 per cent) respondents had been at their current grade for ten years or less years, with an average of 11 years.

Dentists' morale

- More than half (52.7 per cent, N=206) of respondents reported that their morale as low or very low.
- Those in Band C Managerial roles were less likely to report low or very low in comparison with those in more clinical roles.
- Three in ten (30.4 per cent, N=31) respondents who had been working in the SPDCS for less the ten years reported high or very high morale. This is in contrast to 13.7 per cent (N=39) those who have been working in the SPDCS for 10 years or more.
- Participants were asked what is having a negative impact on their morale. Participants most commonly cited inadequate staffing levels in their service and that there is an inability or unwillingness to fill empty positions, as the issues which were impacting on their morale

- Dissatisfaction with management was frequently noted among participants as an influence on their morale. One of the main complaints regarding the managers in the service was their general lack of understanding of the service, as well as their unwillingness to consult or take advice from clinical staff.

Motivation

- Over 40 per cent of participants did not consider their pay fair and a third are not satisfied with the terms and conditions of their employment.
- Only one in five (20.8 per cent, N=81) salaried dentists felt there were opportunities to progress their career in their service; while more than half (53.0 per cent, N=207) did not believe that this was true.
- A third (33.7 per cent, N=132) of salaried dentists feel that they receive recognition for the work that they do compared to 39.6 per cent (N=155) who feel they do not.
- Less than half (48.7 per cent, N=192) of salaried dentists felt that their supervisor was doing a good job.
- A third (33.8 per cent, N=133) of salaried dentists felt secure in their job, Under a quarter (23.6 per cent, N=34) of participants with a Band A job role felt secure about their job, in comparison with 43.5 per cent of those in Band C Managerial posts.
- Three in five participants (61.0per cent, N=240) considered the staffing levels inadequate with only a quarter (25.6 per cent, N=101) stating that there they have sufficient staff in their service.
- Two in five salaried dentists (41.0 per cent, N=167) often think about leaving the salaried services. Only a third (33.0 per cent, N=128) would recommend a career in the salaried services.

Workload

- Almost half of participants (46.8 per cent, N=184) believe their current caseload is excessive.
- The majority of participants (76.7 per cent, N=141) felt they were unable to see patients as frequently as clinically necessary due to their excessive caseload.
- A third of participants (38.1 per cent, N=71) felt they were under pressure to cut clinical standards because of their excessive caseload
- Half of participants (51.3 per cent, N=95) felt that they are not given sufficient time in appointments to complete the all the necessary treatment.

Staffing

- Almost three quarters of participants felt that their service was currently understaffed.
- Participants stated that the main impact of the understaffing in the service has been on patient waiting times and lists. This, in turn, has led to increase pressure on staff and an increase in patient complaints.
- Many participants felt that the current levels of staffing has is threatening the quality of care patients receive.
- Participants have seen an increased stress levels and stress related illness among staff because of inadequate staffing levels.

Annex 3

Summary of the Freedom of Information Request on the Recruitment of salaried primary dental care dentists in England

Summary

This report provides the findings from a FOIA request of providers of community dental services by the British Dental Association (BDA).

The survey was carried out in the summer of 2012 with providers of community dental services. The survey sought to investigate recruitment of dentists in community dentists.

Fieldwork for this survey took place between August and October 2012 via electronic FOIA requests. The targets for the requests were identified using existing BDA data sources. However, many of the service providers had merged or changed provider making identification of all services challenging.

Of the 109 originally identified services, which accounted for all PCT areas, 109 services were contacted and responded. The original 109 services providers have been condensed to 65 providers, of which 31 have currently responded. This provided a current response rate of 48 per cent, and coverage of 65 PCT areas

The main findings were:

- Half of the identified community dental services (accounting for 40 PCTs) advertised for at least one position between 1st September 2011 and 28th February 2012.
- A total of 59 positions for dentists were advertised during this period, accounting for 45.8 WTE.
- Almost half of positions advertised were for Band A posts and almost half were for Band B posts.
- Only 2 Band C positions were advertised for during this period.
- On average 7.2 applications were received for each position.
- In 5 cases no applications were received.
- Band A had the highest average number of application for a role.
- On average 2.3 applications were shortlisted.
- In a quarter of cases no applications were received for Band A positions.
- Band A vacancies were the most likely not to have any applications shortlisted.
- In total only half of all advertised positions led to an appointment.
- Band A vacancies were the least likely to result in an appointment.

Annex 4

Summary of the Vocational Dental Practitioner's Survey

The BDA has conducted annual surveys of Vocational Dental Practitioners (VDPs) since 2006. The survey was initially commissioned to assess the impact of the reforms to NHS dentistry on the ability of VDPs to secure employment. The aim of the 2012 survey was to understand the labour-market experience of VDPs in the UK and had the following objectives:

- To assess levels of recruitment among VDPs;
- To understand VDPs' experiences of finding and looking for a post;
- To identify any barriers to finding employment among VDPs.

The target population for the survey was all VDPs in the UK who were due to complete their VDP training before October 2012. The effective survey population included BDA members and non-members who had not opted out of receiving communications from the BDA and for whom up-to-date contact data were available on BDA data systems (N=741). Fieldwork for this survey took place between 11th June and 23rd July 2012. The survey was administered online using SurveyMonkey®.

Of the 741 VDPs who were invited to participate, 157 responded to the survey (22 per cent of those surveyed), with members being slightly more likely to respond than non-members. Among respondents, 140 completed the survey, were in VT/DVT/DFT at the time of survey, and were due to finish their training before October 2012.

The main findings from the survey were as follows:

- The majority (92 per cent, N=130) of respondents planned to work in dentistry in the UK in their post-training year, down from 97 per cent in the 2011 VDP survey;
- Almost all VDPs (95 per cent, N=133) agreed that their VT/DVT/DFT year had prepared them well for their next post in dentistry;
- Just over three-quarters of respondents (78 per cent, N=100) had found a post by the time of the survey. This figure is comparable to previous VDP surveys where the proportion has ranged from 78 to 83 per cent, although variation in the timing of the survey makes it difficult to compare the results from these directly.

VDPs' new posts

Among those who had successfully found employment in dentistry by the time of the survey (N=100),

- Sixty per cent said that their new post would be in general practice, with 33 per cent finding a role in a hospital and four per cent in salaried services;
- Twenty-three per cent said that their new post was in the same practice where they had received their training. This figure is similar to that found in the 2011 survey, where 24 per cent of respondents said that they would be staying at their training practice;
- Around one in five expected to work in two posts;
- Among those VDPs who knew the number of hours they would be working in their new position, the majority (87 per cent) expected they would be working 35 or more hours per week;
- Finally, 11 per cent said that they would be working in a UK country other than the one where they received their training.

Remuneration in VDPs' new posts (general practice settings only)

Across all UK countries, among those who expected to work in general-practice settings (N=60), almost all (92 per cent, N=56) expected that they would be working in a practice providing a mixture of NHS and private care. None expected to be working in an exclusively private practice.

VDPs who had secured a new post in general-practice settings were also asked about their remuneration packages. Because of the variation in dental contracts, those whose new posts were in England or Wales were asked a different set of questions about their pay than those with posts in Scotland or Northern Ireland.
Among VDPs planning to work in a general-dental practice setting in England or Wales (N=48),

- Almost all (96 per cent, N=46) expected to receive a set payment for each UDA they complete;
- They expected to receive a median UDA value of £21.00 (N=32) before expenses are deducted, or £10.00 after expenses (means of £21.38 and £10.31 respectively);
- Two-thirds expected to receive a percentage of the private fees they earn and a median of 50 per cent of gross earnings for private work (N=33).

Among those VDPs planning to work in a general-dental practice setting in Scotland or Northern Ireland (N=12),

- All said that their new post(s) were in practices providing a mixture of private and NHS care;
- All expected to be paid on the basis of a percentage of fee per item and all but one expected to receive a percentage of fees earned;
- Seven VDPs said that they expected to receive the NHS GDS allowances as part of their remuneration package, and none expected to receive a bonus;
- On average, they expected to receive 48 per cent of gross earnings for their NHS work and 50 per cent for private work (N=10).

All VDPs who expected to work in general practice in the UK (N=59) were asked about their expected earnings in the year following VT/DVT/DFT. Fifteen per cent of VDPs expected to earn between £30,000 and £40,000 per annum; around one in five expected to earn between £40,000 and £50,000; and one third expected between £50,000 to £60,000. Finally, a minority (one in five) expected to receive earnings in excess of £60,000.

Finding and choosing a post

Among those who had already found a post (N=100),

- just under half said that they had found finding a post either "very" or "moderately easy";
- By comparison, three in ten said that they had found it "moderately" or "very difficult" to find a post;
- On average, it took just under five weeks for them to find a post (N=93);
- However, for almost one quarter of these VDPs, it had taken them between six and ten weeks. And it took more than one in ten of these VDPs 11 or more weeks to find a post;
- Finally, they made an average 5.7 applications and attended an average of 1.3 interviews before securing a post.

VDPs were also asked about the reasons for selecting their new post. The most commonly cited reasons for selecting were "career progression opportunities" (65 per cent, N=64) and "location of practice" (42 per cent). Whilst pay was the fourth most common reason for

selecting a post-training post, it was still cited by almost one in five (19 per cent, N=19) of those who had already found a post.

VDPs who had not found a post by the time of the survey

VDPs who had not yet found a post (N=29) were asked about their experience of looking for a post. Among these,

- Almost all (93 per cent) said they were looking for a post;
- While all were considering posts in general-practice settings, just three were considering a hospital post and two were interested in working in salaried services;
- These VDPs identified the pay rate as the most important factor when choosing a post (82 per cent did so, N=22), followed closely by patient mix (78 per cent, N=21) and the availability of posts in their preferred locality (74 per cent, N=20).

Those VDPs who had not yet found a post were asked about their experience of looking for a post. For example,

- They said that they had already spent a median of eight weeks looking for a post by the time of the survey;
- The majority (61 per cent, N=14) said they had spent between six to ten weeks searching for a post;
- On average, they had made 30 applications by the time of the survey. However, these VDPs had only attended an average of 1.5 interviews (N=25);
- Almost all of these VDPs reported experiencing difficulties in their job search and they cited a number of barriers to finding a post including: limited availability of suitable posts; limited opportunities in their preferred locality; lack of experience; and too much competition.

Annex 5

Summary of the Survey of Directors of Salaried Dental Services in the UK

A survey of clinical directors is conducted annually as part of a BDA research programme that underpins its submission of evidence to DDRB. The aim of the 2012 survey was to examine changes in the recruitment and employment of the dental workforce in the Salaried Services. The specific objectives of the research were to:

- Estimate current levels of recruitment and retention among SPDCS dentists;
- Examine the changing pattern of recruitment and retention in Salaried Services over the past year;
- Identify any barriers to recruitment into the Salaried Services.

The survey was administered by post and with fieldwork taking place between 1st May and 23rd July 2012. Taking into account the relative population size and historic response rates, it was decided to survey all those in the population (a population sample).

The target population of the survey was all Clinical Directors of salaried dental services across all four UK countries: England, Scotland, Wales, and Northern Ireland. The effective survey population included only those for whom there were up-to-date contact information held within BDA data systems (N=93).

Of the 93 clinical directors surveyed, 40 responses were received, one of whom was not a clinical director. This gives a response rate of 43 per cent, which compares with a response rate of 47 per cent in the survey of clinical directors conducted in August 2011.

Key findings from the survey include:

Changes in Labour force between 31st March 2011 and 31st March 2012

Among clinical directors in England who had posts that were approved to be filled, we found:

- An increase in the headcount total for Band A dentists of +5.60. However, this overall increase can be accounted for by reported increases in just two salaried services in England. Most clinical directors (N=13) in England reported no change, and one reported a reduction in the number of Band A dentists employed in their service;
- A reduction in the number of Band B dentists employed in salaried services in England (in percentage terms, of 7.5 per cent of the total headcount summed across cases). Corresponding with this, six (out of eighteen) clinical directors in England reported a reduction in the number of Band B dentists employed in their service;
- No overall change in the Band C Managerial/Director headcount figures for salaried services in England.
- Only one service in England reported an increase in Band C specialist posts.

Among clinical directors across all UK countries who had posts that were approved to be filled and where valid data were available (N=28), we found:

- A slight increase of 9.6 (3 per cent) in total headcount numbers for Band A/1 dentists;
- A reduction in the total headcount among Band B/2 dentists (all countries); for example, when summed across all 18 cases for which there were valid data, there were 11.7 fewer dentists employed in this category in March 2012, compared with March 2011.

Numbers of specialists by grade

- Among those salaried services in England which employ specialists, 64 per cent of the total number of specialists employed were found to be inappropriately graded;
- Given that Band C managers are not officially in specialist posts, it is appropriate to exclude them from the base used in this calculation. On this basis, we found that there were 40 specialists employed in salaried services in England (across 24 services). Of these, 30 were specialists paid at Band A or Band B, which implies that 75 per cent were inappropriately graded.

Patient demand

- Between 2010/11 and 2011/12, there was an average increase of 320 patients treated in the services managed by respondents in England; this represents an increase of 3.6 per cent;
- The corresponding figures for all UK countries show an average increase of 216 patients, representing a 1.7 per cent increase.

Revenue budgets

- Between 2011/12 and 2012/13, there was a reduction in average revenue budget for services in England – a reduction of £138,452 or 6.4 per cent;
- For all UK countries, there was a reduction in salaried services' average revenue budgets of £75,538 between 2011/12 and 2012/13 (an average reduction of 3 per cent).

Referrals

- Over three-quarters of clinical directors in England and the UK reported that referrals to their service had increased over the past year;
- Across both England and the UK as a whole, most respondents (70 per cent) reported increases in adult referrals to their services for sedation or due to anxiety or phobia;
- Across all UK clinical directors, two-thirds (N=23) reported increased referrals for domiciliary visits.

Waiting times

- The majority of directors of salaried services in England reported that waiting times had increased over the past year for new patient assessments, treatment and recall appointments; for example, two-thirds (N=16) reported that waiting times for new patient assessments had increased;
- For both England and the UK, around two-thirds of respondents reported that their services were not meeting the 18-week pathway waiting times for special care GA restorative service for adults and children.

Recruitment

Respondents were asked about the reasons for why vacant posts in their service had have been approved to be filled. The reallocation of funding and the removal of funding were most commonly identified as reasons for why those posts that had become vacant had not been approved to be filled.

Respondents were also asked whether dentists in their service had been required to work extra hours or to cover for colleagues (either paid or unpaid). Among the 21 UK clinical directors who responded to this question,

- Almost all said that dentists in their service had been required to cover for colleagues at some point over the past year;

- Around half said that dentists in their service had had to work extra paid hours over this period;
- Around one quarter reported that dentists in their service had worked extra unpaid hours.

Finally, respondents were asked about the impact of not filling vacant posts on their service. Three of the most common issues highlighted included:

- Increased workload leading to staff stress and increased sickness;
- Increase in waiting times. Inability to meet national guidelines/ targets, with consequent negative effect on patient care and oral health;
- Increased patient complaints.

Annex 6

Dental Student Numbers in the UK

1. As requested in the fortieth report we have included information on student numbers. As part of its annual engagement with dental schools, the BDA collects student numbers directly from the schools. The table below shows the current number of students in dental courses in the UK[13]:

Table 1: Dental Student Numbers in the UK, BDA.

School			Student numbers			
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Aberdeen	n/a	19	23	18	15	75
Barts and The London	66	63	57	69	63	318
Graduate entry (4 year course)	n/a	15	27	20	20	82
Total	66	78	84	89	83	400
Belfast (Queens)	56	50	40	52	40	238
Birmingham	79	69	76	80	71	375
Bristol	76	78	77	72	71	374
Cardiff	79	80	71	61	73	364
Dundee	71	68	77	57	61	334
Glasgow	94	85	94	99	85	457
Kings - 5 year course	132	122	130	113	131	628
Graduate entry (4 year course)	n/a	34	25	32	31	122
3 year course	n/a	n/a	8	8	8	24
Total	132	156	163	153	170	774
Leeds	99	89	84	84	92	448
Liverpool - 4 & 5 year	65	84	78	86	81	394

[13] This information was collected over the telephone from the administrators of the departments. It was finalised in October 2011, figures may have changed since compilation.

course						
Manchester	84	77	80	79	72	392
Newcastle	90	101	91	67	92	441
Peninsular	n/a	72	59	56	70	257
Sheffield	79	91	79	77	78	404
University of Central Lancashire	n/a	32	32	31	29	124
TOTAL	1,070	1,229	1,208	1,161	1,183	5,851

2. More detailed breakdowns of student numbers and backgrounds are available through both the Universities and Colleges Admission Service (UCAS) and the Higher Education Statistics Agency (HESA) for a fee.

Annex 7

Economic Background 2011-13

1. 2011 was beset by continuing problems for the economy. The International Monetary Fund described the global status as "weak", and this has affected investment and growth in all areas of the global economy, but especially in areas of business which rely on continuous investment and are influenced strongly by government decisions such as healthcare, and for private contractors of the NHS in particular who have joint commitments.

> Following a barrage of unfavorable (*sic.*) shocks in the first half of 2011, global economic activity has weakened and has become more uneven.[14]

2. Against this backdrop of global uncertainty dental businesses have continued to try to grow and invest to ensure that they can offer the best patient care available. The European Central Bank summarised the situation in the UK in May 2012:

> In the United Kingdom, economic activity has continued to be subdued. In the first quarter of 2012 real GDP declined by 0.2% quarter on quarter, mainly owing to a substantial contraction in construction activity. However, business survey data during the first quarter of 2012 have been relatively upbeat, while industrial production and consumer confidence have shown signs of weakness. The labour market situation has remained weak amid some signs of stabilisation, as the unemployment rate is relatively high (8.3% on average in the three months to February) and employment growth is sluggish. Looking ahead, the economic recovery is likely to gather pace only gradually, as domestic demand is expected to remain constrained by tight credit conditions, ongoing household balance sheet adjustment and substantial fiscal tightening.
>
> Annual CPI inflation increased to 3.5% in March from 3.4% in February, while CPI inflation excluding energy and unprocessed food remained unchanged at 2.9%. Inflation is likely to decline slightly further in the short term. In the longer term the weak economic outlook and the existence of spare capacity will probably contribute to a further dampening of inflationary pressures. On 5 April the Bank of England's Monetary Policy Committee maintained the official Bank Rate paid on commercial bank reserves at 0.5% and the stock of asset purchases financed by the issuance of central bank reserves at a total of GBP 325 billion[15].

3. With consumer confidence weak and unemployment high spending on healthcare, especially on services that patients regard as non-urgent or routine, come under threat[16]. Despite this the dental profession has managed to increase access and provide more care to more patients at any other time since 2006[17]. Far from penalising dentists who are showing themselves to run efficiently already, we consider that it is important for government to

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[14] International Monetary Fund, *Regional Economic Outlook: Europe, Navigating Stormy Waters* 2011
[15] European Central Bank, *Monthly Bulletin May*, 2012
[16] As evidenced by the 2009 Adult Dental Health Survey which found that almost 20 per cent of adults had delayed treatment because of cost and more recently HPI's market research in to healthcare spending http://money.aol.co.uk/2012/05/28/worrying-trend-over-health-tests/ last accessed 01.06.12
[17] NHS Information Centre *NHS Dental Statistics for England: 2011/12* 2012

support them through these tough economic times and to recognise the contribution dentists make to the NHS through increased access and activity as an efficiency.

4. Growth in 2011 was slow and inflation finished higher than planned. This made the financial environment tougher than anticipated in that year. While it is anticipated that the economy will improve in 2012, the Office for Budget Responsibility (OBR) does not expect real growth to return to the economy until 2014[18]. Any improvements in the economy are expected, by the OBR, to be offset by continuing difficulties on mainland Europe:

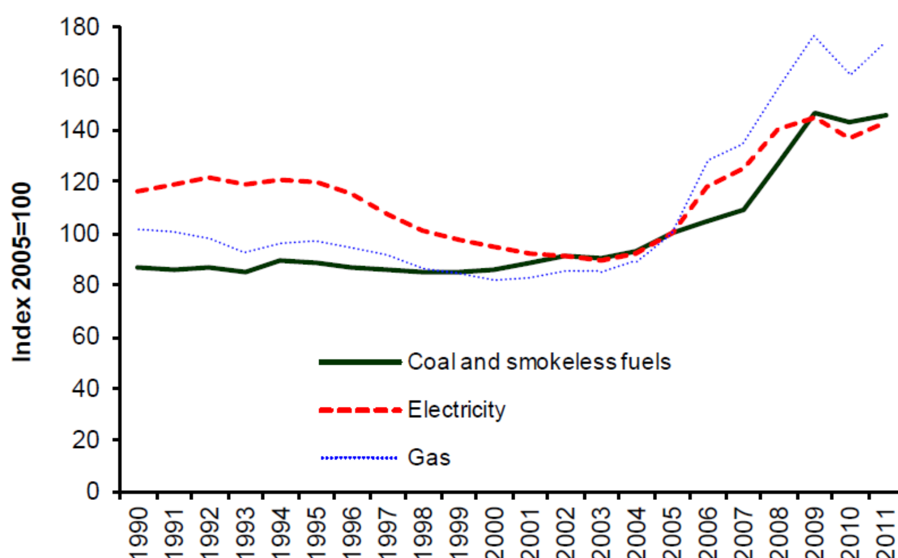
> We expect the beneficial effects of falling inflation to be offset by uncertainty over the euro area and tighter credit conditions feeding through to the wider economy[19].

5. As uncertainty in the Euro-zone continues we can expect this to have an increasingly deleterious effect small businesses and their ability to access credit for development.

6. The OBR reported that average earnings growth was weak with average weekly earnings in the private sector growing by 2.2 per cent at the end of 2011[20]. Overall annual real wage growth the OBR estimates at 0 per cent. This contrasts starkly with the data from the NHS Information Centre showing that dental earnings dropped by 8.2 per cent in England and Wales, and 8.7 per cent in Northern Ireland.

7. The graph below from the Department of Energy and Climate Change shows the increased costs of utilities clearly[21]:

Graph 1: Fuel price indices in the domestic sector in real terms 1990-2011



8. The London Bullion Market Association states that all of the contributors to their forecast report on the price of precious metals expect their cost to rise by at least 10 per cent in 2012[22]:

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[18] Office of Budget Responsibility *Economic and Fiscal Outlook* March 2012, pg. 34, paragraph. 3.9.
[19] Ibid. pg. 8, paragraph. 1.18
[20] Ibid. pg. 82, paragraph. 3.102
[21] *Quarterly Energy Prices* Department of Energy and Climate Change September 2012, pg. 10
[22] London Bullion Market Association *Forecast 2012* 2012 http://www.lbma.org.uk/assets/LBMA_Forecast2012_01.pdf retrieved 04.09.12

Table 1: Precious metal prices, the London Bullion Market Association

Metal	1st Week January 2012	Average 2012 Forecast	2011 Year Average
Gold	$1,603	$1,766	$1,572
Silver	$28.96	$33.98	$35.11
Platinum	$1,412	$1,624	$1,720
Palladium	$655.00	$735.52	$733.63

9. This will have a knock on effect on the cost of providing dental care. In addition to the basic increase in the cost of the raw materials, exchange rates continue to fluctuate affecting the cost of purchasing. In 2008 the pound to dollar exchange rate was 0.55, by 2011 it had risen to 0.62[23].

10. Dental practices are performing a vital public service, yet the wider economy is threatening their viability, an exposure not suffered directly by the majority of the NHS. Government priorities in cutting funding to the services in real terms make it harder for dentists to have the personal confidence to invest in their business.

11. In the BDA's annual Dental Business Trends Survey (DBT) survey we asked practice owners if they had applied for a loan and if so, if they had experienced any problems. In the UK 90 per cent of those who had applied for a loan were able to get one. In Northern Ireland, however, this dropped to only 64 per cent. On average across the UK 30 per cent had a problem but in Scotland and Northern Ireland the rates of problems were higher at 57 per cent and 48 per cent. Problems encountered included high interest rates and high securities. Although over 90 per cent of applications were successful, a significant number had experienced problems and this should be borne in mind when considering factors causing stress for private contractors of NHS services. Overall, 57 per cent had still planned to embark on improvements to their practice. The average amount practice owners in the UK intended to spend on practice improvements was £36,000, while the average actual amount spent was £25,297. It should also be borne in mind that this is occurring at a time of increased mandatory expense for the implementation of HTM 01 05 and for any upgrades required to meet regulatory instructions from CQC and other regulators.

12. The profession has continued to be frustrated by the enforced compliance with the non-evidence based decontamination guidance HTM 01 05 and its variable application across the UK. Among the 1100 respondents to our DBT survey 57 per cent had planned to carry out modifications to their practice. 70 per cent of these intended to invest in new clinical equipment or renovation suggesting that compliance with HTM 01 05 and regulators is a core source of spend.

13. As small providers in a quasi-market, dental practices are exposed to wider economic concerns and government priorities looking for efficiencies in the NHS. We question whether the "efficiency savings" that are required from dentistry are best sought from dentists or from the inefficient and variable commissioning structure.

14. Inflation for 2011 finished at 4.5 per cent[24], far above the Bank of England's intended target[25]. This lack of control over the economy and thus over consumers' spending and saving, has made it difficult for business to invest or to grow. The situation at the start of

[23] http://www.forecast-chart.com/usd-british-pound.html
[24] Office of Budget Responsibility *op. cit.* pg. 79, table 3.5
[25] Bank of England *Inflation Report February 2012* pg. 7

2012 was little better. Although interest rates began to drop and most commentators are confident that by the end of the year CPI will be running at around 2.5 per cent[26], the rise in the cost of inter-bank lending has meant that credit remains expensive. Consumer habits are also difficult to predict and there has been a drop in healthcare spending in the private market as people continue to cut back on costs[27]. This will often mean delaying treatment which, under the current system, makes it harder to dentists to provide the care required in a way which is financially viable.

[26] E.g. Confederation of British Industry *Economic Forecast* February 2012, OBR *op. cit.* Table 3.5
[27] See footnote 3 above.