BDA

Northern Ireland Evidence

October 2012

to the Review Body on Doctors' and Dentists' Remuneration

www.bda.org

BDA Northern Ireland only version of the 2013/14 submission to the Review Body on Doctors' and Dentists' Remuneration October 2012[1]

Contents

- **Executive Summary** 3
  - **General Dental Practice** 3
  - **Salaried service** 4
- **Introduction** 5

1. Response to last year's award 7
  - **General Dental Practice** 7
  - **Salaried service** 7

2. Background to the evidence 8

2.1 **Overview of policy developments** 8
  - General Dental Practice 13
  - Salaried Services 17

3. General Dental Practice Northern Ireland 18
3.1 Expenses 20
3.2 Morale and Motivation 25
3.3 Recruitment and Retention 29
3.4 Conclusion 31

4. Salaried Services Northern Ireland 32

5. Clinical Academics 33

- Annexes 35

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

Executive summary

General dental practice

- The BDA seeks a recommendation from DDRB that recognises this very difficult business environment for practitioners in Northern Ireland and that reflects the cost of meeting the new and continuing governance requirements, the effect of the previous inadequate pay awards from DHSSPS and the impact of the imposed award from 2011/12 and the proposed measures for 2012/13 as well as the growing disparity between the prevailing price rises, as measured by the Consumer Price Index which have been consistently above 3.0 per cent and the DHSSPS pay awards.
- NHS Information Centre data shows that average taxable income for all self-employed primary care dentists decreased by 8.7 per cent in Northern Ireland
- In Northern Ireland practice owners saw a drop of 7.1 per cent in taxable income.
- In Northern Ireland associates saw a drop of 5.3 per cent in taxable income.
- The NHS Information Centre Data shows that 64.5 per cent of all dentists have total taxable income below £75,000. This is a sharp increase compared to 2009/10 when this figure was 58.6 per cent. The data describes the experience of BDA members that more dentists are earning lower levels of taxable income than previously.
- Over 78 per cent of respondents to DBT survey said that pay for HS work was not fair.
- Morale is low. Over 37 per cent of dentists rated their morale as low or very low. Morale was worst amongst those with HS commitments of between 25 and 74 per cent, with over 60 per cent of this group rating their morale as low or very low
- Pressures of work volume and having to spend significant time on unpaid administration rather than revenue generating clinical time and increasing bureaucracy are the main causes of low and reducing morale
- The amount of time spent on administration is increasing in large part due to the increasing regulatory requirements and administrative burdens placed on practitioners.
- Access to Occupational Health Services from November 2011 for GDS dentists and staff was a welcome move for this sector
- Increases in the expenses elements which are unmet through the payment system are the most significant factor which impacts negatively on how dentists view their role in dental practice now and in the future
- The proposed changes from DHSSPS Northern Ireland for the financial year 2012/13, if adopted, will negatively affect the delivery of dentistry in Northern Ireland, damage dental businesses and have significant effects on morale, motivation, retention and recruitment amongst General Dental Practitioners in Northern Ireland.

Salaried Services

- The BDA seeks at least the one per cent uplift for those in the Salaried Services in Northern Ireland.

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.

[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 The profession is very concerned about the pay settlement of 0.5 per cent to the GDS for 2011/12 towards the uplift to pay for employed practice staff earning less than £21,000. We note that there is a continuing two year public sector pay freeze through 2012/13 for the public sector workforce earning in excess of £21,000 per annum on a full-time equivalent basis. The 'pay freeze' has been interpreted by DHSSPS Northern Ireland and applied to the General Dental Services as a freeze on all HS remuneration received by dentists (excepting 0.5% increase to item of service fees for 11/12 to meet the £250 pay award to directly employed staff earning less than £21,000).

1.2 BDA believes a pay freeze should be applied to elements of pay only as increases in expenses in a fixed fee system lead to a drop in net pay. This is not the intention of the Government pay freeze. DHSSPS Northern Ireland decided to reject evidence submitted by the BDA in April 2011 on the need for a substantive award to meet the additional increased expenses for the 2011/12 period. This decision has significantly damaged the morale of general dental practitioners in Northern Ireland.

1.3 Practice expenses can largely be attributed to four main categories of expenditure. These are:

- Laboratory fees and materials costs
- Staff costs for directly employed staff excluding dentists
- Overhead costs (premises, direct costs and other overhead costs)
- Decontamination and governance including clinical governance

1.4 In its 40th Report DDRB stated that in the period 2008/09 to 2010/11 all expenses for practices in Northern Ireland had risen by 8.1 per cent. The expense awards applied to Items of Service fees by DHSSPS have been 0.21 per cent in 2009/10, 0.5 per cent in 2010/11 and 0.5 per cent 2011/12. For the DHSSPS pay freeze to achieve its stated aim the increase in expenses must be matched by an increase in funding; if it isn't the net turnover practitioners receive will fall. If this funding gap is not resolved it will continue to negatively affect morale, motivation, recruitment and retention.

1.5 BDA has written to DHSSPS Northern Ireland asking them to follow the decision by the Minister of Health in Scotland to write to DDRB seeking their recommendations in relation to dental practice expenses in Scotland. BDA has requested that DDRB should make recommendations to DHSSPS in respect of dental practice expenses in Northern Ireland.

Salaried services

1.6 The Salaried Primary Care Dental services in Northern Ireland were disappointed by the continued application of a pay freeze. The absence of developments towards a new contract has further exacerbated problems of low morale experienced by those working within the salaried service.

2. Background to the evidence

This section contains our summary of the policy landscape that dentists are operating in Northern Ireland. 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 Overview of policy developments

2.1.1 This section provides a brief explanation of the policy developments in Northern Ireland. We have 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.

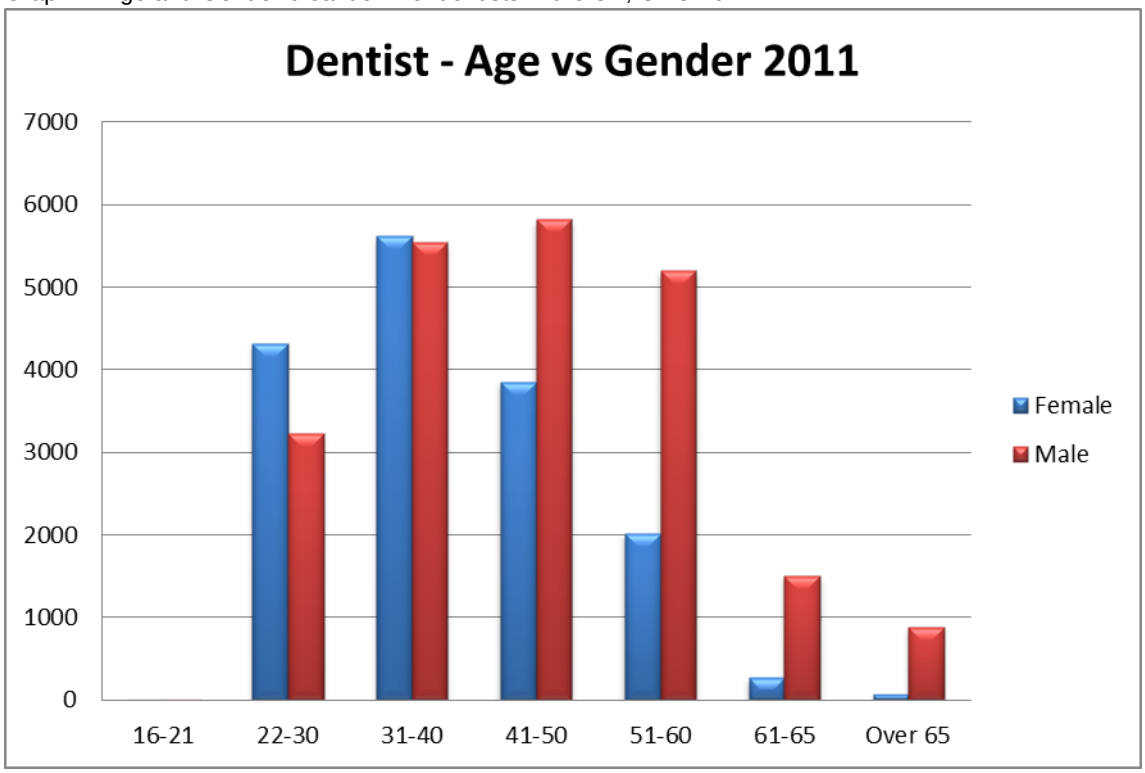
Foundation training

2.1.2 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

2.1.3 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:

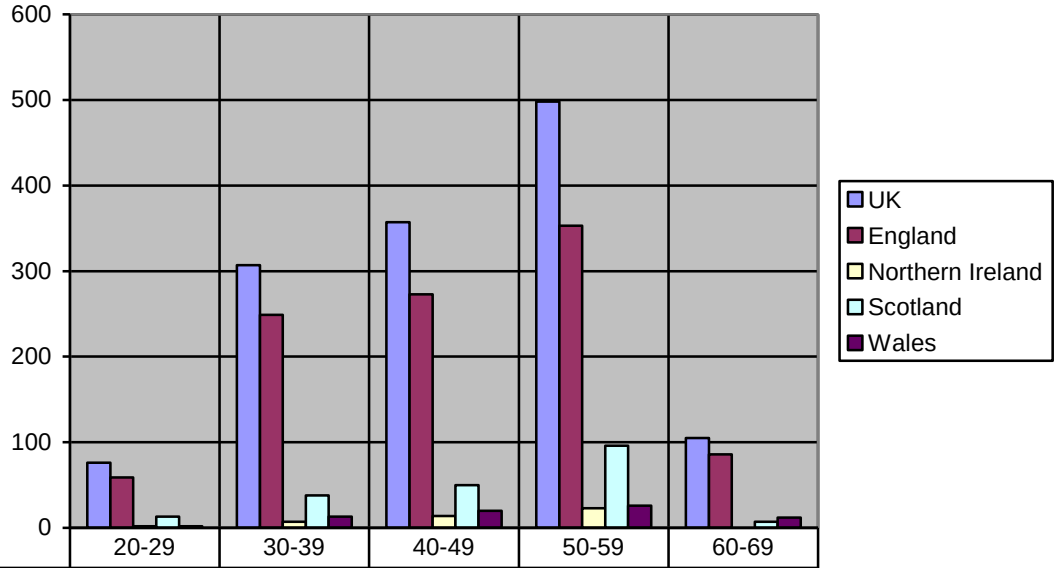
Graph 1: Age and Gender breakdown of dentists in the UK, GDC 2012



2.1.4 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[4], 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.

[4] 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

2.1.5 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

2.1.6 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.

2.1.7 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

2.1.8 The NHS Information Centre data on Dentists' Working Hours 2010-11 and 2011-12 in England and Wales[5] 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

2.1.9 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[6]. 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.

2.1.10 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.

Table 1: Practice configuration (source DBT survey 2012)

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

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

2.1.11 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.

2.1.12 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.

2.1.13 While we are aware that in Northern Ireland some practices have incorporated, there is no data on the number of practices which have incorporated.

Pension reform

2.1.14 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.

2.1.15 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

2.1.16 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.

2.1.17 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.

2.1.18 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.

2.1.19 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.

2.1.20 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.

2.1.21 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

2.1.22 In November 2011 DHSSPS Northern Ireland advised BDA of proposals that they intended to make in order to deliver savings of at least 10 per cent from the GDS budget from 2012/13 onwards[7]. BDA have rejected these proposals as being damaging to the provision of General Dental Services in Northern Ireland. If implemented they will have a significant effect on the ability of practitioners to deliver primary care dental services. This would have a very serious effect on the morale and motivation of general dental practitioners as well as affecting the ability of businesses to function effectively in such a regime.

2.1.23 The continued policy of DHSSPS to enact a pay freeze on all aspects of remuneration has meant that practitioners in Northern Ireland have suffered an actual pay cut rather than a pay freeze. BDA have argued that to deliver a pay freeze DHSSPS need to deliver an uplift to funding to meet the rising costs of delivering primary care dental services in Northern Ireland. The failure to do so by DHSSPS is reflected in the data from The Information Centre that shows for the year 2010/11 an 8.7 per cent drop in the average taxable income for all self-employed GDS dentists across Northern Ireland[8]. The cost of this policy decision by DHSSPS to freeze spending has been borne by dentists.

2.1.24 From 30 November 2012 DHSSPS will expect practices to meet decontamination requirements. These are based on an enhanced version of HTM 01 05 set out by DHSSPS in its circular PEL 10 04. These requirements mean practitioners in Northern Ireland must meet decontamination requirements in excess of other parts of the UK. The measures set out in PEL 10 04 will place additional, mandatory capital and revenue costs and financial and administrative burdens on practices. There is the initial capital cost of complying with the requirements but there are also the on-going running costs of operating the decontamination

[7] Set out in the BDA document, *Impact of DHSSPS cuts to GDS funding 2012/13: The impacts on health service dentistry in Northern Ireland as a whole and on individual dentists*, pages 6-11, http://northernireland.bda.org/Images/effects_of_proposed_changes_to_hs_provision_in_northern_ireland_march_2012.pdf

[8] Dental Earnings and Expenses, Northern Ireland 2010/11, October 2012, page 14. http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/dentalworkinghoursandexarnings1011supplementalfolder/DentalEarningsExpenses_NorthernIreland_201011_v1.0.pdf

guidelines. In many cases practices will have to employ extra staff and there is also the cost of paying for servicing and maintenance of equipment.

2.1.25 The costs of meeting the mandatory decontamination requirements are not accounted for in the Item of Service fees and there is no capacity within the formula to integrate new costs proactively. A practice allowance is available, but its value is linked to the Item of Service award and has been eroded in real value by the awards of 0.5 per cent in 2009/10 and 2010/11. Also as noted above the linking of the practice allowance to the Item of Service fees means that it is not possible to adjust the allowance sufficiently to meet the magnitude of the costs associated with the mandatory decontamination requirements.

2.1.26 Practices are also currently working to comply with the continuing registration and annual inspection of practices by the Regulation and Quality Improvement Authority (RQIA), which began its first round of annual, post registration inspections in April 2012. Meeting the governance requirements of RQIA and DHSSPS Minimum Standards for Dental Care and Treatment is part of the reason why principal dentists in Northern Ireland report spending more than one out of every four working hours on non-clinical (and thus non-income generating) tasks.[9]

2.1.27 In their response to the DDRB 40th report[10] DHSSPS stated that a key departmental policy remained increasing productivity. For dentistry DHSSPS prioritised access to General Dental Services. In Northern Ireland in September 2009 882,533 patients were registered with a dentist in the Health Service arrangements. By September 2012 this figure had risen to 1,136,889 patients. This is an increase of 254,356 registered patients in three years.

2.1.28 According to a response from DHSSPS on June 22, 2012[11], to a written question on the number of patients registered at practices funded by DHSSPS directly through a PDS contract (awarded to Oasis Healthcare), as at March 2012, there were 47,361 patients registered on the PDS contract. This means that GDS practitioners in Northern Ireland are responsible for the registration of over 205,000 new patients since September 2009, (over four out of every five new patients registered in the period). The profession has been disappointed at the emphasis from officials on the PDS contract and the repeated failure to recognise the effort of GDS practitioners is thought to be one of the contributory factors for the very low levels of morale.

2.1.29 In response to the same question the Minister reported that the value of the awarded PDS contract was £5.7m per annum. This means that DHSSPS spend per patient for the PDS contract is £120.35 per annum. Similarly for the financial year 2010/11 (the year for which the most recent official figures are available to BDA) the gross spend on the GDS budget was £105,134,00. At that point there were 1,001,063 patients registered on the GDS. The spend by DHSSPS for each patient registered with GDS was therefore £105.02.

2.1.30 The difference between the spending on the GDS and the PDS is actually greater than this as the GDS clinical spending figures include the spending on orthodontic treatments which cost the department over £8.5m in 2010/11, a treatment not available on the PDS. If the

[9] Dental Working Hours, Northern Ireland 2010/11 and 2011/12 Experimental Statistics, October 2012, page 8. http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/dental%20working%20hours%201011and1112/Dental_Working_Hours_Northern_Ireland_201011_and_201112_experimental_Statistics_Report.pdf

[10] DDRB 40th Report, Appendix D, page 81 - *INFORMATION FROM THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY IN NORTHERN IRELAND (DHSSPS) FOR 2012/13 PAYROUND page 6* http://www.dhsspsni.gov.uk/non_medical_ddrb_information_from_northern_ireland__2012_13.pdf

[11] http://aims.niassembly.gov.uk/questions/writtensearchresults.aspx?&qf=0&qfv=1&ref=AQW 12576/11-15

costs of like for like treatments were compared the spend per patient on the GDS would be even lower.

2.1.31 In the response of 22 June 2012 the Minister also notes that the dental treatments for those patients on the PDS contract had been assessed to cost in 2011/12 was £1.5m (including patient contributions). The clinical spend by DHSSPS for each of the patients registered with one of the PDS contract practices therefore can be calculated as £32.09. BDA know from the figures released for the GDS that the spend on Items of Service for 2010/11 was £62,319,790. This is a spend on treatments per GDS patient of £62.25. This means that for GDS dentistry 59 per cent of the funding received is for the performance of dental treatment. For the PDS contract the spend on dental treatments only accounts for 27 per cent of the total funding received. For the ratio between clinical and non-clinical funding of the GDS budget to match that provided by DHSSPS on the PDS contract the total value of the GDS budget would have to rise to just over £230.8m (an increase of 119.5 per cent). Similarly if the DHSSPS provided the PDS contract with a dental treatment to non-dental treatment ratio at the same level as that facing GDS practices its annual value would be £2,576,000 annually.

Table 2: Spend on patients in Northern Ireland by contract

	GDS	PDS
Period covered	2010/11	02/2011 – 01/2012
Number of patients registered	1,001,063	47,361
Item of Service Spend	£62,319,790.92	£1,520,000
Gross Cost of Service	£105,134,000.00	£5,700,000
Spend per patient per year	£105.02	£120.35
Clinical spend per patient per year	£62.25	£32.09
Percentage of clinical spend per patient	59%	27%

2.1.32 The funding provided by DHSSPS for the PDS recognises that the cost of providing general dental services is actually far higher than DHSSPS currently remunerates GDS practitioners in Northern Ireland. In their response to the DDRB 40th report[12] DHSSPS stated that improving productivity remained a key priority. The funding of GDS practitioners suggests that those who provide high productivity and cost effectiveness relative to similar providers are not being rewarded equitably or appropriately.

[12] DDRB 40th Report, Appendix D, page 81 - *INFORMATION FROM THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY IN NORTHERN IRELAND (DHSSPS) FOR 2012/13 PAYROUND page 6* http://www.dhsspsni.gov.uk/non_medical_ddrb_information_from_northern_ireland__2012_13.pdf

DDRB Formula

2.1.33 In determining a pay award for dental services, the Doctors' and Dentists' Review Body uses a formula approach which takes into consideration the expense elements of practice and applies an uplift according to prevailing factors.

2.1.34 The figures for expenses elements can be applied to the DDRB formula to give a value for the percentage by which gross payments to dentists should rise to meet changes in dental practice expenses.

2.1.35 The value can be calculated using the DDRB formula and the March 2012 figures for RPI and RPIX[13], an expenses-to-earnings ratio of 56.1 per cent as follows:

2.1.36 Uplift 2012-13 = 0.439 * x + 0.12 * HRPSASHE + 0.109 * RPIX + 0.33 * RPI

where

x = 0 per cent income uplift

HRPSASHE = 0.4 per cent

RPIX Mar 12 = 3.8 per cent

RPI Mar 12 = 3.7 per cent

Uplift 2012/13 = 0 + 0.048 + 0.4142 + 1.221

= 1.68 per cent.

2.1.37 This calculation uses NI evidence for dental practices income and expenditure values to calculate HRPSASHE which can be derived as follows in respect of staff costs, laboratories and materials costs and other costs.

> 21.37 per cent for staff costs and 19.34 per cent for laboratories and materials costs, with other costs therefore being 59.39 per cent. HRPSASHE is 40 per cent of total or 0.4 which delivers an uplift according to the formula of 1.68 per cent.[14]

2.1.38 DDRB state, in the 40th Report Summary and Recommendations, that it is

> "both unnecessary and inappropriate to include efficiency savings in our funding formulae for …GDPs as the impact of efficiency savings will become apparent, albeit with a time lag, in the data used in the formulae. If the Health Departments continue to think it appropriate to impose a requirement on independent contractor …GDPs to make efficiency savings, then we [DDRB] believe that any such requirement should be a contractual matter, rather than abating our recommended increases."[15]

[13] http://www.ons.gov.uk/ons/rel/cpi/consumer-price-indices/march-2012/stb---consumer-price-indices---march-2012.html#tab-Other-measures-of-RPI-inflation-

[14] Review Body on Doctors' and Dentists' Remuneration Thirty-ninth Annual Report 2011, pages 61-65. http://www.ome.uk.com/DDRB_Reports.aspx

[15] Review Body on Doctors' and Dentists' Remuneration Fortieth Annual Report 2012, page IX. http://www.ome.uk.com/DDRB_Reports.aspx

2.1.39 The DDRB formula does not recognise the whole complement of expense elements which modern dental practice must incorporate. DHSSPS acknowledged this when in 2004 they introduced the Practice allowance. DHSSPS reason was that:

> "The department recognises the additional administrative burden facing practice owner, largely because of regulatory and clinical governance requirements and the impact this has on the effective management of practices. To this end a new Determination XI has been inserted into the SDR to allow the payment of a practice allowance. The aim of this allowance is to assist with the costs associated with running a health service dental practice. The amount of allowance … [at the time of introduction was] based on the average gross income for a practice … [providing] a greater financial reward to practices providing higher levels of health service treatment. The amount … [was] determined by the average gross earnings of the practice, multiplied by the number of dentists within the practice on the 1 April in the financial year in which the allowance is to be paid."[16]

2.1.40 The DDRB formula assumes that existing expenses continue but it has no mechanism for considering new areas of expense, like the decontamination costs described above.

Policy Developments in the salaried services

2.1.41 Substantive negotiations have not yet started to seek to implement modern terms and conditions of service for Community Dental Service dentists in Northern Ireland, following the introduction of new terms for their colleagues in England and Wales in 2008, and the beginning of negotiations to introduce new terms for salaried dentists in Scotland.

2.1.42 It is disappointing again that no progress has been made, making this the only group of staff in the NHS, after the introduction of new terms for Scottish salaried dentists, to remain on terms and conditions dating back to 1989.

2.1.43 The Northern Ireland Executive had indicated in March 2012 that they were prepared to open negotiations, as they had previously. However, they once again failed to materialise.

2.1.44 The BDA calls upon the Review Body to once again comment on this and urge the Northern Ireland Executive to enter into substantive negotiations.

[16] Dental Branch Annual Report 2004/2005, page 12.

3. General dental practice[17][18]

Key points

- The pay award for 2011/12 of a 0.5 per cent uplift to the Item of Service fees was imposed on the profession after being rejected by BDA as insufficient to meet the rising costs of provision of Health Service care in Northern Ireland.
- DHSSPS presented proposals for the GDS budget for 2012/13 in November 2011. BDA rejected these as being too damaging to the profession in Northern Ireland. A public consultation on these proposals is due.
- NHS IC data for 2010/11 shows average taxable income for all general dental practitioners fell 8.7 per cent between 2009/10 and 2010/11 from £86,500 to £78,900.
- Practice owners in Northern Ireland saw an average of a 7.1 per cent fall in taxable income and associates a 5.3 per cent drop between 2009/10 and 2010/11. The average income for principals dropped to £114,200 from £122,900 while the average income for associates dropped from £62,700 in 2009/10 to £59,400 in 2010/11.
- The Information Centre Data shows that 64.5 per cent of all dentists have total taxable income below £75,000. This is a sharp increase compared to 2009/10 when this figure was 58.6 per cent. The data describes the experience of BDA members that more dentists are earning lower levels of taxable income than previously.
- Morale and motivation is low. Over 37 per cent of dentists rated their morale as low or very low. Morale was worst amongst those with HS commitments of between 25 and 74 per cent, with over 57 per cent of this group rating their morale as low or very low
- Pressures of work volume and having to spend significant time on unpaid administration rather than revenue generating clinical time and increasing bureaucracy are the main causes of low and reducing morale
- The amount of time spent on administration is increasing in large part due to the increasing regulatory requirements and administrative burdens placed on practitioners.
- Access to Occupational Health Services from November 2011 for GDS dentists and staff was a welcome move for this sector

[17] Data on Average earnings for all self-employed GDS dentists is taken from *Dental Earnings and Expenses, Northern Ireland 2010/11*, The Information Centre October 2012, page 14.
http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/dentalworkinghoursandexarnings1011supplementalfolder/DentalEarningsExpenses_NorthernIreland_201011_v1.0.pdf
It is worth noting that the figures from The Information Centre do include private earnings. The average income from Health Service Dentistry will be lower for all categories of dentist.

[18] Data on working hours for all self-employed GDS dentists is taken from *Dental Working Hours, Northern Ireland 2010/11 and 2011/12 – Experimental Statistics*, The Information Centre October 2012, page 14

- Increases in the expenses elements which are unmet through the payment system are the most significant factor which impacts negatively on how dentists view their role in dental practice now and in the future
- The proposed changes from DHSSPS Northern Ireland for the financial year 2012/13, if adopted, will negatively affect the delivery of dentistry in Northern Ireland, damage dental businesses and have significant effects on morale, motivation, retention and recruitment amongst General Dental Practitioners in Northern Ireland.

The provision of Health Service Dentistry remains the focus for the majority of dentists in Northern Ireland. More than half of all dentists in Northern Ireland have earnings from the Health Service that account for at least 75 per cent of their gross earnings. According to the data from The NHS Information Centre 'those whose Health Service earnings accounted for at least 75 per cent of their gross earnings, had the lowest taxable income from Health Service and private dentistry at £62,500.[19]

The high proportion of dentists heavily committed to the Health Service is in part a factor of the very poor economic situation in Northern Ireland. As DHSSPS evidence to the DDRB 40th Report noted

> "The global economic downturn continues to have a severe impact on the NI labour market. The decline in private sector business activity, persistent economic inactivity and increases in claimant count unemployment are particular causes for concern."[20]

This leads both to an increased number of people seeking treatment through the Health Service, which reduces the gross earnings for practitioners and also to create a more difficult operating environment for small businesses.

The nature of the provision of dentistry creates further challenges. A dentist can only increase the number of patients seen within a practice beyond the physical ability of the practitioner to treat patients by increasing the number of practitioners in the practice. It is also the case that for each patient two trained and registered professionals are required, the practitioner and the dental nurse.

Against this challenging economic background DHSSPS have continued to place additional regulatory burdens on practices, including RQIA inspection and the imminent enhanced decontamination requirements set out in the local document PEL 10 04, while concurrently removing funding items to mitigate these burdens as happened with the removal or QIS funding.

Without significant adjustment to the funding available to practitioners dentistry in Northern Ireland faces a sustained period of rising costs and regulatory burdens and increasing challenges to the viability of Health Service dental practice.

---

[19] Dental Earnings and Expenses, Northern Ireland 2010/11, The Information Centre, October 2012, page 27. http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/dentalworkinghoursandexarnings1011supplementalfolder/DentalEarningsExpenses_NorthernIreland_201011_v1.0.pdf

[20] DDRB 40th Report – Appendix D, *INFORMATION FROM THE DEPARTMENT OF HEALTH, SOCIAL SERVICESAND PUBLIC SAFETY IN NORTHERN IRELAND (DHSSPS) FOR 2012/13 PAY ROUND* page 1. http://www.dhsspsni.gov.uk/non_medical_ddrb_information_from_northern_ireland__2012_13.pdf

3.1 Expenses evidence

Key points

- The expenses increases in the provision of HSC dental services arise through:
  - The increasing operating expenses over the period and the prevailing price rises as measured by the Consumer Price Index
  - the wide range of pay and expenses costs which need to be met as part of running a dental business within the health service arrangements
  - meeting continuing and new governance requirements
  - inflationary pressures on pay and expenses
  - The effect of previous inadequate pay awards from DHSSPS and the impact on expenses arising through the loss of dedicated QIS funding
- The increases in expenses has a significant effect on the morale and motivation on practitioners in Northern Ireland.
- It also significantly affects the ability of practices in Northern Ireland to recruit and retain staff, particularly relative to other parts of the UK and to other sectors without the same levels of regulation or costs facing dentistry in Northern Ireland.

Laboratory and materials costs

3.1.1 The increased costs of materials and laboratory work have continued in the period to the end March 2012. Practices have reported increased costs caused by inflationary pressures on both the prices of the materials they purchase and the laboratory work they require.

3.1.2 Rising costs for laboratory costs had been experienced by 62.5 per cent of practices in Northern Ireland, while 81 per cent of practices had experienced increases in their material costs

3.1.3 Laboratory-based dental care has continued to increase in 2011-12. This means an increased proportion of practice expenses being taken up by laboratory costs. As well as the increased spend on laboratory work caused by increased volume, practice owners have also reported an increase in the base-line costs of laboratory work. Practice owners are, as a result, facing a dual increase in laboratory expenses. The reported change in the cost of materials can be seen in table 13 below.

Table 3: Average reported change in materials, laboratory and equipment costs and percentage reporting an increase versus decrease. (Source DBT survey 2012)

Expense	Change (+/- %)	Percentage of respondents reporting an increase	Percentage of respondents reporting a decrease
Materials	4.57	81.3	6.3
Laboratory expenses	3.76	62.5	0
Equipment consumables	7.55	81.3	0

3.1.4 As well as increases in staffing, laboratory and materials, practice owners have seen increased costs on equipment and consumable, as can be seen in the table above. Materials in Northern Ireland are reported to have increased by an average of 4.57 per cent, with laboratory bills up by 3.76 per cent and consumables increasing by 7.55 per cent. As HS practices are unable to increase their charges to offset the increase in the cost of providing care they have to absorb these increases themselves.

Overheads and premises costs

3.1.5 There are a host of overhead costs associated with delivering health service dentistry and these must be able to be met through the GDS payment system. There is the fabric of the building and the facilities, equipment and the costs of provision of HS dental care. Equally important are the skills of the whole staff complement involved in HS practice and the patient experience. Funding must reflect the resources necessary to manage the portion of the overheads attributed to health service dentistry.

3.1.6 Inflation as measured by the Consumer Price Index (CPI) stood at 3.5 per cent at the end of March 2012[21], above the Bank of England's inflation target of 2 per cent. At the end of March 2011 CPI was 4.0 per cent. Throughout the last twelve months CPI has always been at least 2.9 per cent above the 0.5 per cent fees increase awarded for the year 2011-12.[22]

Decontaminations costs

3.1.7 Dental practices are expected to meet the DHSSPS policy initiative on decontamination in dental practice, whereby by end of November 2012 practices should reach compliance with the DHSSPS policies. DHSSPS policy on decontamination in Northern Ireland requires compliance with best practice by end November 2012.

3.1.8 Decontamination requires both capital investment and revenue spend. Capital investment is required to enable the practice to put in place a suitably equipped facility and equipment and instrumentation. Revenue is required for staff and to provide consumables and meet other overhead costs associated with running the facility.

3.1.9 The initial outlay is a substantial sum for practices. It is, however, the on-going resources and staffing costs which are placing intense financial pressures on practices. These go well

[21] http://www.ons.gov.uk/ons/rel/cpi/consumer-price-indices/march-2012/stb---consumer-price-indices---march-2012.html#tab-CPI--Percentage-change-over-12-months

[22] CPI was 3.4 per cent in February 2012. See ibid. and figure 1 below.

beyond the amount and scope of the current practice allowance. It is also the case that the effect of the on-going limited fee uplifts is to reduce the ability of the practice allowance to meet the costs of dental practice. This is because the practice allowance is derived from the fee structure within the Statement of Dental Remuneration. It can only rise within the structure of any fee award. While the fee awards are capped and the real costs associated with dental business are rising at a rate above that of inflation the practice allowance real value will decrease.

3.1.10 Increases in electricity and water have been exacerbated by decontamination requirements and the overall economy. The cost of annual water and electricity bills and equipment maintenance, can be seen below:

Table 4: Reported annual utility bills for all dentists (Source DBT survey 2012)

Expense	Annual bill
Water	£639.14
Electricity	£2762.43
Equipment maintenance	£5798.52

3.1.11 The total amounts cited above are not comparable to previous years' submissions, but we will use this as a baseline for future years' submissions to see how these costs change.

3.1.12 We anticipate that these figures will increase substantially in the future as a result of RQIA inspections, which began in April 2011 and the move toward best practice decontamination requirements from December 2012.

3.1.13 Northern Ireland respondents to our DBT survey 2012 reported high levels of planned and actual investment. 72 per cent of all respondents in Northern Ireland planned some level of investment, with almost 77 per cent of these intending to invest in new clinical equipment. It is reasonable to assume that a lot of this investment is as a result of the HTM 01 05 requirements. The average intended investment in Northern Ireland was £58,796. This rose to almost £86,000 for those with an NHS commitment of 75 per cent or more. 40 per cent of these dentists made the total investment and a further 20 per cent made most of the investment and 13 per cent failed to actually invest at all. At a time of extreme financial pressure dentists in Northern Ireland are still prepared to spend significant sums on investment for the sake of their patients.

3.1.14 By increasing access to increase turnover the practice actually increases their costs, minimising the benefits of providing more care. The more care that a dentist provides the greater their material and laboratory costs. Dentists continue to work on the dental "treadmill", increasing access to increase revenue but having to spend more in order to increase access.

Table 5: Percentage of respondents with over a 75 per cent HS commitment reporting the change in the number of patients seen each week and proportion of private dentistry provided (source DBT survey 2012)

	Increased substantially	Increased somewhat	Stayed the same	Decreased somewhat	Decreased substantially
Number of patients seen each week	3.1	16.2	67.7	8.7	4.4
Proportion of private dentistry provided	13.6	40	30.5	13.6	2.3

3.1.15 The table above shows that practices are unable to increase the amount of HS work they provide and are attempting to find new revenue streams through private work, though this would appear to be difficult in the current economic climate.

Staff costs

3.1.16 Most staff employed by dental practitioners fall under the protected category of those public sector employees earning less than £21,000 and who can expect to receive a pay award of £250.

3.1.17 There are additional staff costs in pre and post registration training of staff who expect to be or are GDC registrants. The course fees for NEBDN Certificate in Dental Nursing are listed in Further Education College brochures as being 'full cost recovery' with course fees in the order of £878 (2011-12). Courses leading to City and Guilds or NVQ qualifications for job roles outside of dental nursing can be viewed as competing with the career of applicants to dental nursing. These courses are free or available at much lower costs of up to £328 (the exception being City and Guilds Level 3 Diploma in Children's Care Learning and Development at £1,085).

3.1.18 This is a further example of the cost burden of staff training being placed on the dental practice, but without the availability of dedicated resource to support staff training.

3.1.19 The 2012 *Dental Business Trends Survey* (DBT) showed that 12.2 per cent of respondents increased their dental staffing levels in the last year (year 2011-2012) DBT survey also showed that the average hourly pay increase for dental care professionals was approximately £250, in line with the public sector policy on pay.

3.1.20 Practice owners continue to fund additional continuing professional development for staff.

3.1.21 Average working hours in Northern Ireland were reported at almost 39 hours per week in the DBT survey with practice owners working almost 44 hours a week.

3.1.22 The data from the Information Centre for Northern Ireland for 2010/11 shows that for All dentists in Northern Ireland Gross Earnings, Expenses and Taxable Income have fallen by 7.8 per cent, 7.0 per cent and 8.7 per cent respectively. 76.7 per cent of respondents to the DBT survey reported no change in associate pay.

3.1.23 Principal dentists saw Gross Earnings fall by 3.9 per cent, Expenses fall by 2.2 per cent and Taxable Income fall by 7.1 per cent. At a time when practices have been attempting to reduce the costs of their business to maximise efficiency their Gross Earnings, and Taxable Income have actually fallen. This suggests the severity of the business conditions facing practitioners in Northern Ireland currently. BDA would support further examination for this drop in both Taxable Income and expenses.

Table 6: reported percentage changes in total practice turnover, expenses and profits for practice owners with over 75 per cent HS commitment (source DBT survey 2012)

	Change (+/- %)	Percentage of respondents reporting an increase	Percentage of respondents reporting a decrease
Total practice turnover	2.06	43.8	12.5
Total practice expenses	7.88	70.6	11.8
Total gross profit	-9.611	11.8	64.7

3.1.24 Compared to the increase in turnover of 2.06 per cent in Northern Ireland the increases in expenses of 7.88 per cent is far above inflation and show a real expense that cannot be accounted for in inflationary terms. This represents a real increase in the cost of providing dentistry in Northern Ireland. This worrying trend of expenses fast outstripping turnover is a danger to the future viability of dental provision in Northern Ireland. One of costs such as installing equipment or building extra rooms to meet decontamination regulations may partly account for this increase, but running costs associated with the requirements are shown to be high in the table above.

3.1.25 We strongly recommend that the DHSSPS recognises the very real problems facing HS dentistry in Northern Ireland. The high level of need in the population coupled with the quasi-market of a capped budget in the HS makes the running of dental practice extremely difficult and stressful as can be seen in the section below.

Loss of Quality Improvement Scheme Funding 2010 onward

3.1.26 During 2010/11 HSCB withdrew a stream of funding (Quality Improvement Scheme (QIS)) for HS dental practice, dedicated to support improvements in the delivery of General Dental Services. The thrust of the scheme was to improve working practices that, in turn would lead to service improvements and ultimately benefit patients. Quality Improvement Scheme (QIS) funding was first introduced in 2002/03 and was previously available to provide funding towards practice expenses. The fund provided approximately £1m to dedicated practice expenses each year, with an additional £1.5m made available in 2007/08.

3.1.27 The funding formerly used for QIS has been reallocated to the GDS budget and will now pay for items of service. The effect on practices is that they have lost funding towards expenses to the value of £1.16m from 2010/11 onwards.

3.1.28 Practice expenses are inclusive of capital and revenue costs and the QIS monies were generally used by practices to provide assistance towards capital costs. The loss of this funding has directly affected the ability of practices to meet those capital costs

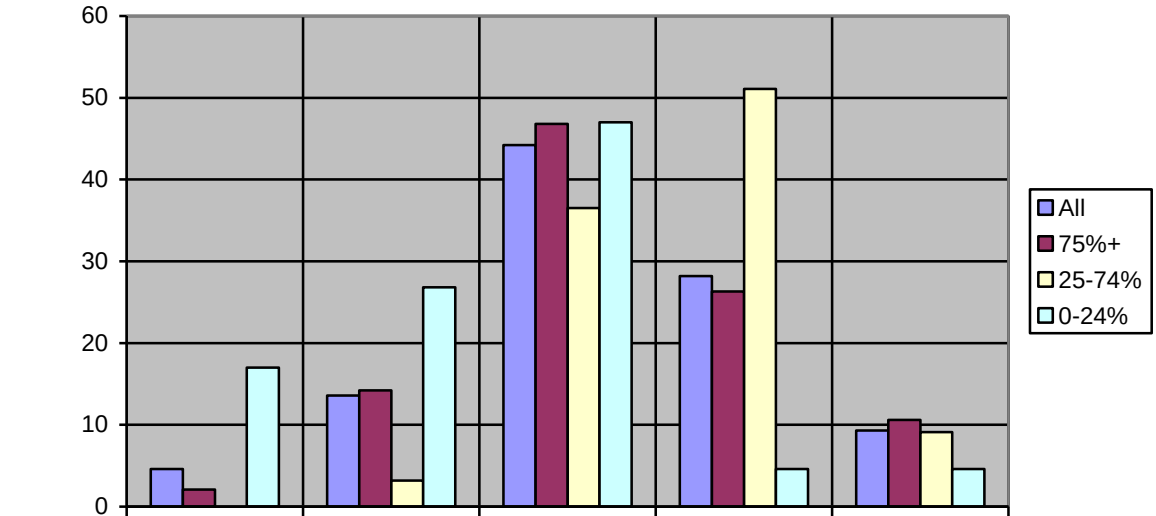
3.2 Morale and motivation

Key points

- Morale and motivation is low. Over 37 per cent of dentists rated their morale as low or very low. Morale was worst amongst those with HS commitments of between 25 and 74 per cent, with over 60 per cent rating their morale as low or very low
- Pressures of work volume and excessive administration and increasing bureaucracy are the main causes of low and reducing morale
- The proposed changes from DHSSPS Northern Ireland for the financial year 2012/13, if adopted, will negatively affect the delivery of dentistry in Northern Ireland, damage dental businesses and have significant effects on morale, motivation, retention and recruitment amongst General Dental Practitioners in Northern Ireland.
- BDA is aware of the increasing levels of personal and professional stress across the profession in Northern Ireland.

3.2.1 Motivation and morale continue to be very low in general dental practice. Over 37 per cent of respondents to DBT survey in Northern Ireland said their morale was low or very low.

Graph 3: Self-reported morale among general dental practitioners in Northern Ireland by HS commitment (source DBT 2012)



	Very high	High	Neither high nor low	Low	Very Low
All	4.6	13.6	44.2	28.2	9.3
75%+	2.1	14.2	46.8	26.3	10.6
25-74%	0	3.2	36.5	51.1	9.1
0-24%	17	26.8	47	4.6	4.6

3.2.2 The highest levels of morale are seen in those with the lowest HS commitment. The reasons for this are explored in the table below. The table below shows the attitude of dentists in Northern Ireland to dentistry with a HS commitment of over 75 per cent:

Table 7: percentage of Northern Ireland respondents with over 75 per cent HS 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	9.6	48.3	22.7	13.1	6.4	0
I receive recognition for the work I do	6.2	25.1	33	26.2	7.5	2.1
There are opportunities for me to progress in my career	2.1	31.3	40.7	20.6	5.4	0.9
There are opportunities available to me to develop my skills	3.2	51.5	29.2	11.8	4.3	0

The practice involves staff in important decisions	10.7	39.5	25.5	16.6	5.6	2.1
I have full clinical freedom in my job	26.6	43.2	18.3	9.7	2.1	0
My job gives me the chance to do challenging and interesting work	8.3	52	25.3	13.3	1.1	0
I have sufficient time to complete all my work	5.3	31.8	24.6	27.7	7.5	3.2
I feel good about my job	8.4	41	31.4	10.7	6.4	2.1
I often think about leaving general practice	11.8	21.5	20.6	33.3	9.6	3.2

3.2.3 Owing to the changes to the DBT survey the data is not directly compatible 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.

3.2.4 As the professional association for dentists we are very concerned that only 33 per cent of respondents state that they actively wish to stay in general dental practice, while over 40 per cent actively think about leaving. We urge the DHSSPS to take steps to address this before skilled professionals leave the Health Service.

Table 8: Satisfaction with pay and conditions in Northern Ireland among dentists with over 75% HS commitment (Source DBT survey 2012)

Statement	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly disagree (%)	Not applicable (%)
The environment I work in is comfortable and safe	35.2	50.7	8.6	5.4	0	0
I get support	27.9	49.6	20.2	2.2	0	0

from my work colleagues						
I feel good about working at this practice	25.8	55.5	11	6.5	1.1	0
I feel secure about my job	13.7	41	25.7	16.4	3.2	0
I have all the equipment I need to do my job properly	16.9	50.4	26	5.6	1.1	0
There are sufficient staff in my practice to complete the required work	17.2	62	13.1	7.7	0	0
I feel that my pay is fair	6.4	24.9	23.6	31.4	13.7	0
I feel that remuneration for HS work is fair	2.1	7.5	12	31.4	47	0
I am satisfied with the terms and conditions of my employment	2.1	25.2	31.1	23.8	13.6	4.1

3.2.5 It is clear from the responses above that dentists in Northern Ireland with a HS commitment of over 75 per cent are concerned with the levels of remuneration from HS dentistry. As, however, less than half think that their pay is unfair we can conclude that the majority of concern is with the funding approach taken by the DHSSPS and not with contract holders. We recommend that steps are taken to review the pay for dentists in Northern Ireland in light of these findings.

3.2.6 The Practice Owner Focus Group Survey supported the DBT's findings that morale was at a very low point and the problems with increased regulation and other burdensome requirements were identified:

> "Yes, I think you have to make a choice of your free time or, I've got a young family now, tend to not do enough work, not do enough admin at home and then go in to work and I've got all this crap dumped on top of me and obviously it increases my stress levels, up at half five etc., but you know whereas if I didn't have a young family and I could do a lot more of

the admin at home at night it probably would be less stressful than work, but I just can't, because I just can't sit at the computer every night."

"Well obviously the RQIA, all the different things that we're forced to jump through hoops for that have no real benefit to patients or treatments and they're basically a box ticking exercise, so the people at the top can say look we've done x, y and z, we are regulating that."

3.2.7 The negative feelings about the future of the profession were echoed in the DBT survey where 41.5 per cent of respondents with a HS commitment of over 75 per cent said they would not recommend a career in dentistry and only 29 per cent said they would. Those with a HS commitment of between 0 and 24 per cent, however, were more likely to recommend a career in dentistry with 69 per cent agreeing and only 22 per cent saying they would not.

3.3 Recruitment and retention

Key points

- Of the 50 per cent of respondents who intended to recruit a dentist for predominantly HS work, over 40 per cent encountered problems in re-cruitment
- 46.2 per cent of those seeking to recruit a dental nurse encountered problems with recruitment
- Hours spent on clinical dentistry and administration are increasing, which is a major cause of frustration
- On average, almost 22 per cent of a practice owner's time is spent on administration

3.3.1 77.1 per cent of respondents with a HS commitment of 75 per cent or more reported through the DBT stability in the number of dentists in their practice. and only 18.1 per cent reported increased numbers of dentists.

Table 9: Recruitment intentions among Northern Ireland dentists with over 75 per cent HS commitment (source DBT survey 2012)

Role	Intend to recruit (%)	Do not intend to recruit (%)	Problems Recruiting (%)	No problems recruiting (%)
Dentist (predominantly HS work)	50	50	40.4	59.6
Dental Nurse	47.5	52.5	46.2	53.8
Dental Hygienist	15.4	84.6	0	100
Dental Therapist	8.8	91.2	0	100

3.3.2 Half of respondents reported that they had attempted to recruit an associate and over 40 per cent of these had encountered a problem in recruitment.

3.3.3 The amount of clinical work being undertaken by dentists with more than 75 per cent HS commitment has increased slightly according to the DBT survey, this is occurring as the amount of time being spent on administration is increasing dramatically. Dentists are having to do more of both in order to meet their HS commitments. This increased amount of work for diminishing levels of financial return appears to be one of the main causes of dissatisfaction with working in the HS. Anecdotal reports from the BDA focus groups and also in the free text areas of the DBT survey show that increasing administration is a major source of frustration for dentists.

Table 10: Time spent on clinical and administration in Northern Ireland among dentists with over 75% HS commitment (Source DBT survey 2012)

	Increased substantially (%)	Increased somewhat (%)	Stayed the same (%)	Decreased somewhat (%)	Decreased substantially (%)
Hours spent performing clinical dentistry	1.3	17	73.9	3.5	4.3
Hours spent on dental administration	21.7	38.7	38.3	1.3	0

3.3.4 Almost seven hours were reported as being spent on administration every week, with over seven being reported as average in highly committed HS practices. Practice owners did most administration, accounting for over 9.5 hours a week on average according to DBT survey.

3.3.5 The nature of the administrative tasks in a practice can be delineated into two categories, those tasks which can be passed on to practice staff and those which must be undertaken and authorised by the dentist. The increase here is administrative tasks undertaken by the dentist. The Information Centre data on Dental Working Hours, Northern Ireland, 2010/11 and 2011/12 – Experimental Statistics shows that All dentists spend 20.3 per cent of their time on non-clinical work. For Principals this rises to 27.8 per cent of their time, or more than one hour in every four spent on non-clinical (and hence not income generating) work in the practice.[23]

3.3.6 22.2 per cent of respondents intended to buy or expand a practice in the next year, while 4.9 per cent intended to retire or sell a practice.

[23] *Dental Working Hours, Northern Ireland, 2010/11 and 2011/12 – Experimental Statistics*, The Information Centre, October 2012, page 8

Table 11: Future intentions (source DBT survey 2012)

Activity	Percentage
Buy a practice	7
Expand a practice	18.1
Sell a practice	14.8
Retire	5.8

3.3.7 The strain that insufficient income placed on retention of staff, as well as its impact on the business in general, was summed up in the practice owner focus groups:

> "[Expenses have gone up] across the board, everything from staff pay, just the nursing and reception staff, you can't, it's very hard to say to them we're going to give you a one per cent rise, so the rise is automatically above that. the cost of materials just seems to keep going on up and up without bearing any relation whatsoever to inflation, and cost of having to implement HTM 01-05, spending time away, getting yourself sorted out for RQIA."

3.4 Conclusion

3.4.1 Morale is lowest among those with highest HS commitments

3.4.2 Over 75 per cent of those with a significant HS commitment are dissatisfied with pay

3.4.3 Levels of dental administration are increasing, with the greatest burden falling on practice owners

3.4.4 In Northern Ireland Gross Earnings for All Dentists have fallen by an average of 7.8 per cent while Taxable Income has fallen by an average of 8.7 per cent, against a back drop of practices cutting costs and reducing expenses by 7.0 per cent.

3.4.5 We recommend an uplift recommendation from DDRB that recognises this very difficult business environment for practitioners in Northern Ireland and that reflects the cost of meeting the new and continuing governance requirements, the effect of the previous inadequate pay awards from DHSSPS and the impact of the imposed award from 2011/12 and the proposed measures for 2012/13 as well as the growing disparity between the prevailing price rises, as measured by the Consumer Price Index which have been consistently above 3.0 per cent and the DHSSPS pay awards.

4. Salaried Primary Dental Care Services

4.1 At the time of writing no formal negotiations have started to seek to implement modern terms and conditions of service for Community Dental Service dentists in Northern Ireland, following the introduction of new terms for their colleagues in England and Wales in 2008, and the beginning of negotiations to introduce new terms for salaried dentists in Scotland.

4.2 It is disappointing again that no progress has been made, making this the only group of staff in the NHS, after the introduction of new terms for Scottish salaried dentists, to remain on terms and conditions dating back to 1989.

4.3 The Northern Ireland Executive had indicated in March 2012 that they were prepared to open negotiations, as they had previously. However, they once again failed to materialise.

4.4 The BDA calls upon the Review Body to once again comment on this and urge the Northern Ireland Executive to enter into negotiations.

4.5 The morale and motivation of the salaried primary dental care providers in Northern Ireland is also affected negatively due to the comparisons made with the terms and conditions of colleagues in England, Wales and Scotland where similarly qualified practitioners are seen to have improved career structures and remuneration.

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.

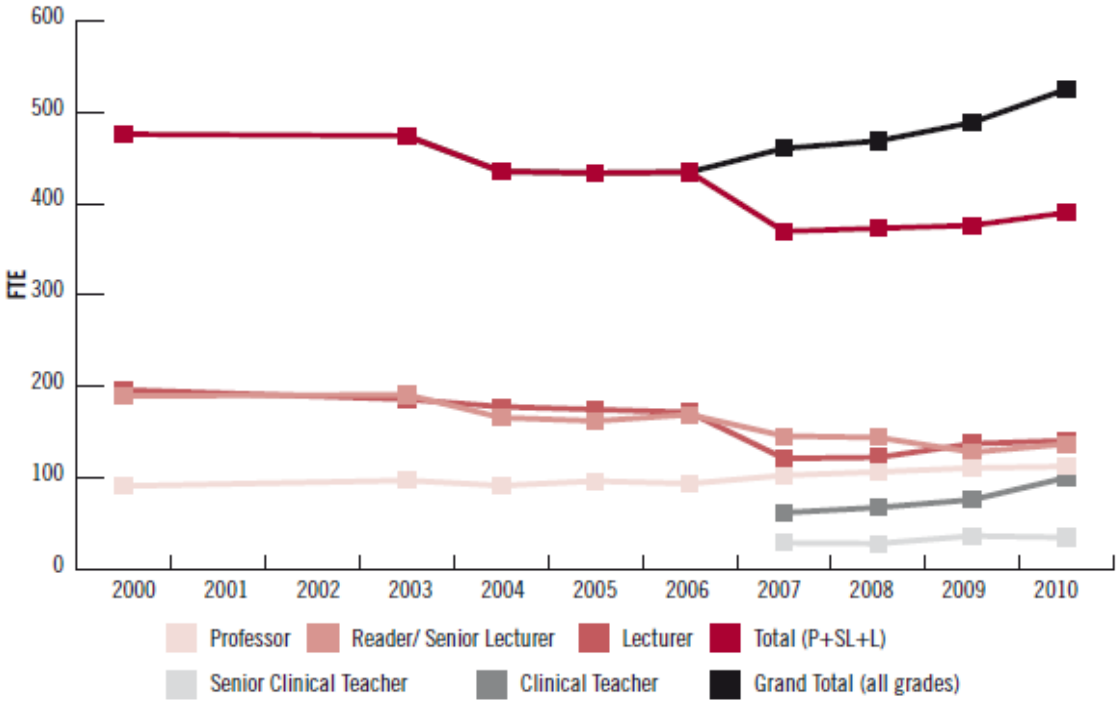
5.2 The Dental Schools Council (DSC) carried out its annual report on academic staffing levels and published the most up-to-date figures in May 2011. Although the DSC recorded an increase of 7 per cent in the number of clinical academic staff it notes that this disguises an alarming 18 per cent drop 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 4: 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[24]:

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

[24] 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.[25]

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[26].

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[27]. Despite this the dental profession has managed to increase access and provide more care to more patients at any other time since 2006[28]. Far from penalising dentists who are showing themselves to run efficiently already, we consider that it is important for government to

[25] International Monetary Fund, *Regional Economic Outlook: Europe, Navigating Stormy Waters* 2011
[26] European Central Bank, *Monthly Bulletin May*, 2012
[27] 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
[28] 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[29]. Any improvements in the economy are expected, by the OBR, to be offset by continuing difficulties on mainland Europe:

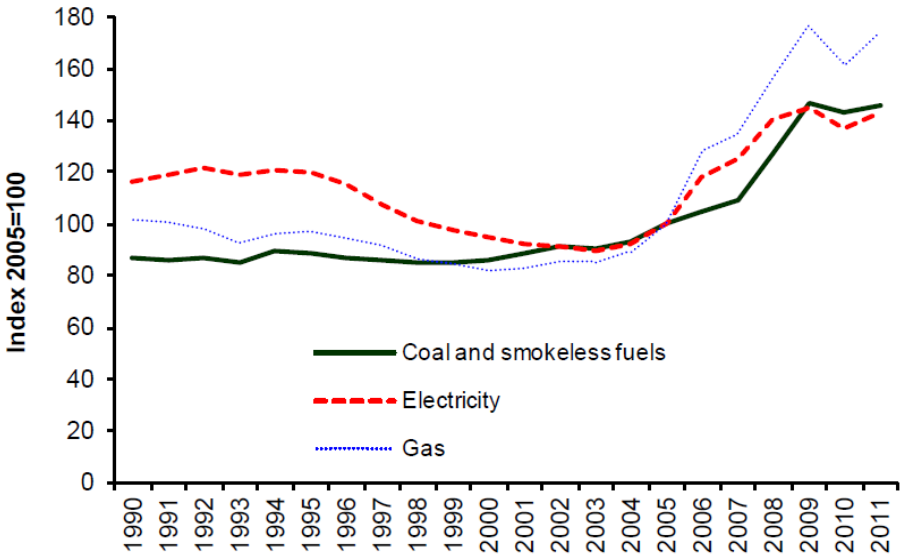
> We expect the beneficial effects of falling inflation to be offset by uncertainty over the euro area and tighter credit conditions feeding through to the wider economy[30].

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[31]. 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[32]:

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[33]:

[29] Office of Budget Responsibility *Economic and Fiscal Outlook* March 2012, pg. 34, paragraph. 3.9.
[30] Ibid. pg. 8, paragraph. 1.18
[31] Ibid. pg. 82, paragraph. 3.102
[32] *Quarterly Energy Prices* Department of Energy and Climate Change September 2012, pg. 10
[33] 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[34].

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[35], far above the Bank of England's intended target[36]. 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

[34] http://www.forecast-chart.com/usd-british-pound.html
[35] Office of Budget Responsibility *op. cit*. pg. 79, table 3.5
[36] 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[37], 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[38]. 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.

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