



**Evidence to the Review Body on Doctors' and Dentists'  
Remuneration for 2015/16**

**September 2014**

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## 1. Introduction

- 1.1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its membership is engaged in all aspects of dentistry including general practice, community dental services, the armed forces, hospitals, academia and research, and includes dental students. Every year the BDA provides evidence to the DDRB covering general dental practitioners, community dentist/salaried practitioners and clinical academic staff. The BDA has conducted its annual surveys, and relevant results are included here. References in this report to the NHS should also be taken to apply to the Health Service in Northern Ireland unless indicated otherwise in the text. NHS England now refers to salaried primary dental care services as community dental services and the latter term is used in this evidence, except for Scotland where the service is called the Public Dental Service.
- 1.2 In 2014/15 uplifts for general dental practitioners were less than 2 per cent. Community dentist/salaried practitioners have received no uplift in their pay scales (apart from in Scotland). Figures from the Health and Social Care Information Centre for all four countries for 2012/13 show continuing falls in taxable income for general dental practitioners providing NHS care. This is unsustainable.

## 2. Response to last year's report

- 2.1 The BDA welcomed the recognition by the DDRB that government awards had failed to deliver the pay freezes announced as part of the government's pay policy but had instead resulted in a pay cut. We are also conscious of the statement that the recommendations made using DDRB's formula would not have provided pay freezes either.
- 2.2 We were very disappointed that in England, Wales and Northern Ireland the DDRB's awards were not paid in full. Contracts in Wales were only uplifted by 1.47 per cent despite having the lowest taxable income for all of the countries. As we will demonstrate later in our evidence, dentists working in England and Wales have experienced a 25 per cent cut in average taxable income between 2006/7 and 2012/13 and this failure to pay the DDRB award in full will mean another fall in 2014/15 inevitable.
- 2.3 The Scottish Dental Practice Committee (SDPC) noted the Scottish Government's agreement to fund the DDRB recommendations in full. Despite the 1.71 per cent uplift, the BDA believe that this award failed to reflect the cumulative impact of rising inflation in dental costs for practitioners in Scotland. Over the five year period between 2010 and 2014/15 the cumulative total uplift in fees for GDPs was 4.22 per cent which the SDPC believe is woefully inadequate for practices facing increasing inflationary pressures. The legacy of the Scottish Government's failure to recognise the financial pressures on practitioners and honour the DDRB awards in the period 2010-13 is the continuing downward trend in GDP income, with no signs of bottoming far less rising.
- 2.4 For 2014/15 the DDRB considered the specific context of expenses in General Dental Services in Northern Ireland. The result has been a dedicated award for 2014/15 of 1.76 percent to deliver 1 per cent to net pay. We ask that DDRB continue this dedicated approach and at the same time, BDA Northern Ireland will seek to refine our evidence so the approach may develop in responsiveness.
- 2.5 The Department of Health Social Services and Public Safety in Northern Ireland has indicated that the award of 1.76 percent will be implemented. To date this has not been finalised and the expectation is that the increase, when implemented, will be backdated to 1 April 2014.
- 2.6 The profession was deeply dismayed by government uplift decisions for the hospital and community dental services in England and Wales.. The decision not to apply the one per cent uplift uniformly, when it will not even match the increase in the cost of living was strongly condemned by

the profession's leaders. We do not consider it appropriate that uplifts are offset against incremental uplifts which reflect the growing knowledge, skill and commitment of dentists in the community/public dental services.

- 2.7 The BDA continues to support an independent pay review process and supports DDRB's request for an unrestricted remit.

### **3. Policy updates from UK countries**

#### **UK**

##### **General Dental Council increase in the Annual Retention Fee**

- 3.1 At the end of June 2014, the General Dental Council launched a consultation on raising the Annual Retention Fee for dentists from £576 to £945 for 2015, a 64 per cent increase. Dentists have no choice but to pay, in order for them to practise lawfully. The move has resulted in unprecedented condemnation from the profession. As well as further damaging professional morale, the proposed cost increase would affect dentists' incomes, particularly those who are part-time. If the retention fee is increased substantially, we ask that the Review Body recognise this in the award for this year. We expect that the GDC will make its decision on 30st October 2014.

#### **England**

- 3.2 The NHS contract reform process is continuing and in April the Department of Health announced a move towards contract prototypes in 2015/16. We continue to push for progress and discussions with the Department of Health continue albeit very slowly. In the summer, the Department produced contract reform engagement documents on clinical philosophy, quality and outcomes and remuneration to update the profession and obtain feedback. Among other things, the Department asked for views on the amount of payment for activity should be included in a revised contract. The Department's apparent direction of travel towards a 'blended' contract with significant recognition for activity causes us some concern. We hope that substantial progress will be made in the next twelve months towards the introduction of an improved contract for general dental practice in England.
- 3.3 NHS England sought to impose 4 per cent efficiency savings on general practice contractors in 2014/15. During discussions, the DH proposed an 8 per cent reduction in the pay of foundation dentists from 1 September. Late in the process, the Department announced that the cut would not be going ahead but the issue would be revisited in the 2015/16 round. Discussions are continuing on changes to sickness and family leave payments for GPs to impose a cap on the amount payable and a requirement to return to NHS practice. Those discussions about efficiencies are being held between the BDA and NHS Employers under a mandate from NHS England. We continue our opposition to efficiency savings which can only add to GDP costs and workload.
- 3.4 In 2013, the BDA published Commissioning Salaried Primary Dental Services, a report which outlined concerns about the impact of an overstretched workforce, issues with funding, and the importance of ensuring the development of appropriate contractual arrangements for the CDS. The report's publication coincided with the announcement that NHS England would establish a vulnerable groups task force, something which the BDA has enthusiastically participated in.
- 3.5 The Community Dental Service has also joined the service contract reform programme in England, with three sites testing a modified care pathway and IT package. Clinical Directors from the three pilot sites have met throughout 2014 to discuss pilot progress and the BDA has contributed to the Department of Health's contract reform engagement exercise on behalf of its CDS members.

#### **NHS pensions**

- 3.6 Following the introduction of tiered contributions in the 2008 review of the NHS Pension Scheme, pension costs have risen dramatically for dentists. For the majority of dentists their contribution rate has more than doubled since 2007 when 6% was the standard contribution rate. 7 years later most dentists now pay 13.5% while some pay 12.5% and the highest paid contribute 14.5%.

- 3.7 The Department of Health in England has now published similar planned contribution rates for the next four year period. Without any improvement in the benefit structure, the cost of membership of the NHS Pension scheme has effectively doubled over that timeframe.
- 3.8 While it was accepted that it was necessary to protect the lower paid, nevertheless more highly paid dentists (and doctors) have had to shoulder a disproportionately high burden. That situation will become worse from the commencement of the new 2015 NHS Pension Scheme in April next year as there will be no more final salary basis for CDS dentists in the scheme. The scheme will become Career Average Re-valued Earnings only using an accrual rate such as that used for GPs at present.
- 3.9 Tiered contribution rates had some justification against the background of promotional pay scales but are no longer relevant following the demise of final salary.
- 3.10 The position has worsened further due to the reduction in both the Lifetime Allowance to £1.5 million and then subsequently to £1.25 million for the 2014-15 tax year and the Annual Allowance to £50,000 and then to £40,000, the latter for the 2014-15 tax year.
- 3.11 The combination of increased contribution rates and a reduction in tax relief has led to many dentists having to decide to opt-out of the NHS Pension scheme and/or private pension schemes. In addition, many younger dentists do not join the NHS Pension scheme at all or withdraw at an early age because of the crippling effects of the high contribution rates and the burden of paying off student debt.
- 3.12 With the decision of the Government to delay normal retirement age in future to be equivalent to State Pension Age, it means that dentists who do not have any protection from the new scheme arrangements, basically those aged 47.5 years or less as at April 2012, face the prospect of not retiring until 67 or 68 since they are effectively not granted any mitigation through the Working Longer report. Such individuals could then face an actuarial reduction of 5% per annum on the future service portion of their pension, should they wish to retire at age 60, for example. If state pension age was 68 then the actuarial reduction on their future service pension would be 40% of that which is hugely penal.
- 3.13 Community dentist/salaried practitioners will no longer have access to the final salary basis in future. It is possible that many may decline promotion given that the financial incentives are reduced, and that a number of senior posts may remain unfilled as a result. Many individuals who have struggled on within the NHS despite carrying a health problem may decide to apply for ill-health retirement thus further reducing the numbers contributing to the NHS Pension Scheme.
- 3.14 Increased contribution rates and reduced tax relief available are leading to an increasing number of dentists opting out of the NHS Pension scheme. This presents an additional burden to those who remain in the scheme as the reduction in yield is likely to fuel further increases in contribution rates in the scheme over time. It also has an adverse effect on morale and endangers the service. All of the above has led to an increasing reduction in total reward (earnings and pensions) to all dentists over their lifetime.

## Scotland

### The impact of the recovery of overpayments on the morale of the GDP workforce

- 3.15 BDA Scotland welcomed the implementation by the Scottish Government of the DDRB's recommended 1.7 per cent uplift, however the benefits in year, were significantly outweighed by the impact of the recovery of overpayments recovered from 2,130 dentists. The overpayments were due in large part to errors derived from the system of continuous registration introduced in 2010, against the advice of the dental profession in Scotland. The financial impact on dentists saw clawback of amounts totalling up to £25,000 for some practitioners. The clawback amounts were recovered over a two month period and will impact on taxable income for the year to 31st March 2014.
- 3.16 The impact of the recovery exercise in Scotland has been extremely damaging to the motivation and morale of independent dental practitioners. This was further exacerbated when it was announced that the costs of the 2.51 per cent uplift in treatment fees, a cost to Scottish Government of £3.5 million, was to be funded, in 2013/14, from the monies recovered from practitioners rather than the injection of any new monies.

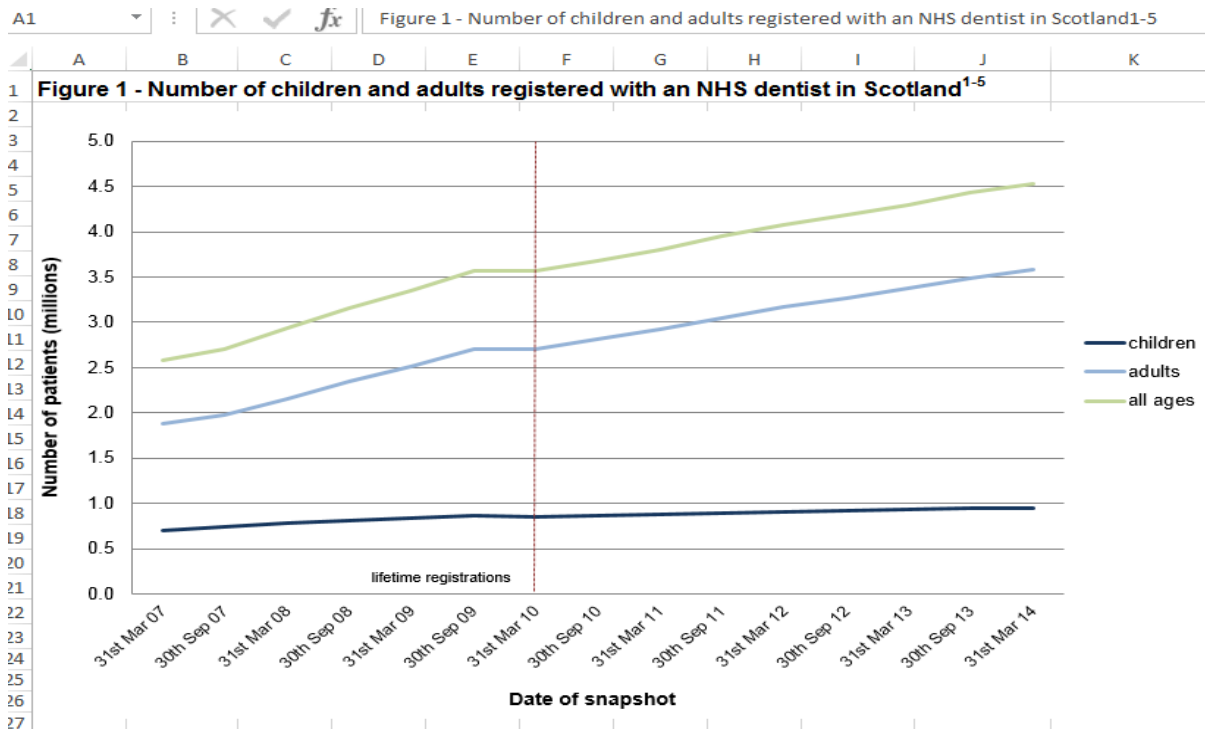
### Allowances

- 3.17 We have previously indicated to the Scottish Government, and in our past evidence to the DDRB, the importance of the allowances that are available to dentists in Scotland. These allowances are necessary mainly because GDS fees are wholly inadequate for supporting the delivery of the highest quality dental services under the NHS. The General Dental Practice Allowance, in particular, is vital for maintaining the viability of dental practices.
- 3.18 In terms of earnings it is important to note that with effect from 1st October 2013 an earnings cap on the General Dental Practice Allowance (GDPA) was introduced by Scottish Government. In effect all practices with a turnover in excess of £670,000 would previously have received a 12 per cent allowance for fully committed practices, and a 3 or 6 per cent allowance for partially committed practices. There was also a provision of a time-lag period of 4 months, within which payments did not immediately cease for any practice which in any quarter did not meet its NHS commitment criteria. Under the previous arrangement dentists had a 4 month notification period before payments cease. This time-lag was removed with effect from 1 November 2013. The removal of the time-lag meant that payment of the additional 3 or 6 per cent of the GDPA and reimbursement of practice rental costs ceased in any quarter that a practice did not meet the NHS commitment criteria.
- 3.19 The GDPA was put in place to offset the rising cost of compliance with infection control requirements, decontamination, certification, validation, Health and Safety, IR(ME)R and disposal of single use items after use, while holding the fee per item cost within inflationary parameters.
- 3.20 Placing a cap on the GDPA has placed a significant financial burden with some practices having to make drastic cost reductions as a result. In some cases this has meant the loss of hundreds of thousands of pounds necessitating reductions in staffing including practice administration, dental nurses, hygienists and therapists.
- 3.21 These cost saving measures will inevitably negatively impact on standards of patient care and health and safety. We consider this to be a retrograde step for patient care, and Scottish GDPs have voiced their condemnation of Government's actions in this respect. A number of large multi-surgery practices set up to enable improved registration rates and ensure equitable access to services, have faced severe financial difficulties due to the imposition of the cap on this allowance.

## Move to a fixed budget

3.22 It is the view of the BDA that any move to a fixed GDS budget in Scotland would be unsustainable in being able to provide the same level of NHS service provision as is currently delivered under a non-cash limited budget, especially with an increasing dental workforce and rising numbers of registered patients. The latest information published by PSD in August 2014 states that in March 2014, 4.5 million children and adults are now registered with a dental practitioner in Scotland, a 17.5 per cent increase on the 3.7 million people registered with a dentist in March 2010. These figures are outlined in Figure 1.

**Figure 1 Number of children & adults registered with a dentist in Scotland 2007-2014**



3.23` The move by Scottish Government to impose a fixed rather than a demand led budget, places a restriction on resources which will undoubtedly have an adverse effect on patient care with clinical decisions more likely to be driven by cost, in the face of rising materials expenses and laboratory fees and NHS fees being insufficient to cover those costs.

3.24 Staff salaries are being affected, as practice owners continue to find it difficult to keep up with inflation. The findings of the BDA Dental Business Trends survey for 2013 revealed that over a third of practice owners in Scotland rated their morale as a dentist as being low or very low at the current time. The same BDA research showed that, unsurprisingly, patient care is the strongest motivator for dentists. The potential detrimental effect of low morale and poor motivation within the profession on patient care should not be ignored.

3.25 There are currently 3,178 dentists practising in Scotland <sup>1</sup>this is a 1.1 per cent increase on the numbers in 2013 and increase of 10.4 per cent on the number of dentists in 2010. Table 1 illustrates the growth in numbers of dentists in Scotland between 2007 and 2014.

<sup>1</sup> Source PSD statistics March 2014



**Table 1 the number of dentists in Scotland 2002-2014**

NHSScotland Workforce Statistics		This is an ISD Scotland National Statistics release.													
NHS General, Community & Hospital Dentists by NHS Board															
Scotland	Headcount														
March															
		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Change 13 - 14
<b>All Dentists</b>		-	-	-	-	-	-	-	-	3,227	3,407	3,543	3,519	3,545	0.7%
General Dental Service		2,037	2,078	2,105	2,153	2,301	2,474	2,576	2,739	2,847	2,940	3,115	3,144	3,178	1.1%

3.26 Against a backdrop of an increasing number of dentists in Scotland it is important to note a decreasing number of payments are being submitted by dentists for authorisation. The number of payments authorised in 2013/14 totalled £199,908,976. Based on information provided by Practitioner Services Division the value of payments has reduced from £49,977,244 in Quarter 1 of 2013/14 to £49,797,757, for Quarter 1 of 2014/15 a reduction of £179,487 per quarter, and a potential cumulative decrease in the value of payments of £717,948 by the end of 2014/15.

### Northern Ireland

3.27 2014 was the first time that DDRB has made a recommendation specific to Northern Ireland and this approach is to be welcomed.

3.28 The 41<sup>st</sup> DDRB report highlights that an uplift to net pay requires an uplift to expenses in order to deliver an uplift to net pay. The approach taken by DHSSPS during the period of pay cap and pay freezes has been to freeze all elements of remuneration including those for expenses. The net effect has been to deliver successive pay cuts rather than the uplift determined. For example BDA evidence to DHSSPS on expenses relating to the need for an uplift for 2011/12 and 2012/13 set out the growing gap between the funding for Health Service dentistry and the cost of provision of Health Service dentistry. The BDA noted that funding was rising at a rate very significantly below the cost of inflation (as measured by CPI).

### Commitment allowances

3.29 The situation going in 2015/16 is set to become much more severe. DHSSPS has made significant cuts to the budget for General Dental Services. One aspect of the cuts is to reduce and then eliminate the Commitment Allowance through 2014/15 and 2015/16. The Commitment Allowance delivers around £3.1 million directly to dentist pay. There is no element of expenses. The reduction in pay delivered through loss of Commitment Allowance is the loss of £3.1 million to pay for just over 1000 GDS contractors. Whilst this is an average of £3,100 per dentist, it is important to note that those dentists most committed to the Health Service will lose the maximum amount of £12,000. Overall the impact of loss of commitment payments will be felt most by those dentists with the most significant number of health service patients and Health Service commitment. In turn, these are the dentists with the lowest taxable income from Health Service and private dentistry according to the HSC IC Dental Earnings and Expenses, UK, 2012/13 Report..

3.30 The risks associated with reduction and loss of commitment payments need to be recognised. Firstly the DDRB recommendation of 2000 whereby the scheme was introduced to reward the loyalty of GDPs and provide some form of career progression is lost. The encouragement of retention within the GDS will also be lost. For individual dentists the

valuable remuneration represented by Commitment Payments will need to be recouped. If £3.1 million to net pay is to be recouped through GDS clinical activity, this would cost the GDS budget £5.95 million (assuming the income weighting applied by DDRB in the 42<sup>nd</sup> report). An alternative would be for the GDS to remunerate dentists through an allowance for non-clinical work as a replacement for the Commitment Payment.

### Dentists' working hours

- 3.31 Consideration of the HSC IC Dental Working Hours UK 2012/13 and 2013/14 figures for Northern Ireland show that average working hours per week for principal dentists in 2013/14 is 42.9 hours. For associates this average working week in 2013/14 is 33.8 hours. For the period 2008/09 to 2013/14 total working hours reported for Principals and Associates have changed little. What has changed significantly is how that time is now allocated in clinical versus non clinical work. All dentists report the average proportion of clinical work for the period 2008/09 to 2013/14 as reducing.

**Table 2 Proportion of working hours spent on clinical activity by HS dentists in Northern Ireland**

Percentage of working hours spent on clinical activity		
Dental type	08/09	13/14
Principal	81.6	69.1
Associate	91.0	84.3

**Table 3 Average total hours worked per week and average hours of clinical activity per week by principals and associates**

<b>Hours worked per week total and clinical</b>		
<b>Dentist type</b>	<b>08/09</b>	<b>13/14</b>
Principal total hours	41.3	42.9
Principal clinical hours	33.7	29.6
Estimated population	400	384
Total clinical hours for principal dentist populations	13480	11366
Associate total hours	33.9	33.8
Associate clinical hours	30.8	28.5
Estimated population	349	513
Total clinical hours for associate dentist populations	10749	14620
Total clinical hours for all dentists	24229	25986

- 3.32 If the data on clinical hours worked per week is aggregated to the population size, for 2008/09 and 2013/14 then the change in total clinical hours available to dentistry over the period 2008/09 to 2013/14 has increased by a total of 1757 hours or 61 associates.
- 3.33 What is significant from consideration of working hours is the amount of time that all dentists are having to dedicate to non-clinical activity. For dentistry, clinical activity is the main method income generation. Without clinical activity, there can be no turnover. This in turn creates stress for the profession in having to dedicate time which is not remunerated towards essential activities of the practice, which only the dentist can do.
- 3.34 In the past, the Commitment Allowance would have gone some way towards remunerating non clinical activity, but as it is being phased out as part of DHSSPS cuts to the budget for General Dental Services, another mechanism needs to be introduced to recognise the essential elements of dentist activity as part of General Dental Services which are currently not supported through the payment system.

#### **Prevailing economic conditions in Northern Ireland**

- 3.35 Dentists in their business are sensitive to the on-going economic circumstances in Northern Ireland, the UK as a whole and Europe more broadly. Northern Ireland is facing a stark economic outlook in 2014/15 and onward. The impact of the Northern Ireland Executive decision not to implement Welfare Reform is set to have a detrimental impact on budgets and the potential impacts of health have been set out in some detail both by the Minister for Health Social Services and Public Safety and the Chief Medical Officer (September 2014). The outlook is stark and it has been made clear by the Minister on 21 August 2014 that patient safety would be 'compromised' by the cuts proposed and the cuts would 'destroy our Health Service'. However for contractors the reality is that any compromises must be avoided in the absence of sufficient funding. Therefore it is imperative that

dental services operating within the health service are funded sufficiently to deliver on the primary imperatives of quality and safety.

## **Review Body requests**

- 4.1 DDRB requested that parties comment on particular general issues. This section contains our responses to the questions that are not answered in the community dental services and general dental practice sections.

### **Affordability in the NHS**

- 4.2 We are not in a position to state whether the NHS budget in total is sufficient to meet all its demands. As the DDRB has repeatedly pointed out, general dental practitioners are small businesses and we consider it unreasonable for continuously low awards to undermine the business viability of dental providers and reduce the pay of dentists. Within dentistry however, it is clear that there are considerable sums of money being retained or clawed back by NHS England which were initially allocated to dental services but which have been diverted into other sectors. Rather than pointing to a problem with affordability, we consider that this represents extremely poor management of budgets. While we understand that dentistry budgets are no longer ring-fenced, we do not consider it appropriate to withdraw money from an already underfunded service. Instead, the dental budget needs to increase in real terms if services are to continue to be provided to a high standard and dentists are to be remunerated appropriately. We also recommend that any money which was initially allocated by area teams to dental services, but was unspent or clawed back, should be reinvested into dentistry so that local budgets are not eroded. If more NHS dental care is being provided by more dentists then budgets need to increase.

### **Changes to terms and conditions**

- 4.3 Occupational health provision has been cut for non-dentist staff working for primary care contractor professions. It is unacceptable that the Health Service is avoiding responsibility for people who provide care in its name. Providing this cover privately for staff will represent an additional financial burden for practice owners.

### **Dental Foundation Training**

- 4.4 As mentioned above, the Department of Health consulted on an 8 per cent reduction in the pay for dentists undertaking Dental Foundation Training. We consider it absolutely inappropriate for savings to be sought from this group. Following a sustained campaign by the BDA the Department withdrew its proposal and DFT pay was not reduced in September as planned. Similar proposals for a reduction in salaries were made in Wales and Northern Ireland, but again eventually were not introduced. We were very relieved about this but are concerned that the proposal will be repeated for 2015/16. We ask the DDRB to comment on whether it is appropriate for this group of young professionals to be singled out for a pay cut.

## Contract reform

**“The parties to consider how our recommendations on pay might fit alongside new contractual arrangements”**

- 4.5 The Department has announced some contract prototypes to begin in 2015/16. It is still too early to answer this question with any degree of certainty. Current DH thinking seems to be that contractors should be paid by a blend of capitation, quality and activity. At present it is not clear what the relative proportions will be. We believe that contractual remuneration should be based as much as possible on capitation. Payments for quality and outcomes should be additional to current contract values. Payments for activity can produce perverse incentives and it will be complex for providers to combine payments for capitation and activity with their associates.

**“We would welcome evidence for future rounds on how our pay recommendations can help facilitate NHS developments, and other issues related to the ‘patients at the heart’ strand of our remit.”**

- 4.6 NHS developments and innovation require investment in people and infrastructure. In general dental practice, stopping real cuts in contract values and fees enables practices to invest in people, equipment and facilities. In the community dental services, poorly paid staff will not be retained in the service and patient care will suffer. Dentists will only be able to invest in facilities, improving patient care, if they have adequate remuneration.

## Motivation

**“The parties to consider research that will lead to a better understanding and definition of the various factors impacting on motivation.”**

- 4.7 In a survey last year, presented as part of our evidence, we asked GPs and community dentist which, from a range of options, they considered motivated them in their work as a dentist. We then asked which of a series of factors, relating to the motivational options, were experienced in their workplace. We also provided open text for respondents to tell us directly what they considered motivated them. The options that we gave respondents to choose from were selected after extensive literature searches on the subject of motivation. These are factors which explain the decision to act in a certain way. The main factor that explained why a dentist chose to act as a dentist was the desire to provide high quality care to patients. The second major factor was pay. This shows the importance of a reward structure which contributes to an explanation of action. The intrinsic explanation is that dentists are motivated by a desire which explains why they chose a career in a health profession rather than another, the extrinsic motivator is that they will provide a service in return for something. Other factors that help people continue to do what they want to do, i.e. meet their intrinsic motivation, are things such as good colleagues, good management and job security. These are not factors alone that would explain why someone does something but in conjunction with the desire to provide care explains why someone continues to provide that care. Reality dictates that people need to earn money. As a result payment in return for service will help explain why that service is provided. These two aspects of motivation, why are you what you are and why do you continue to do what you do, need to be carefully understood and balanced. Our perception is that dentists are no longer recommending dentistry as a career to their children.
- 4.8 What we found clearly expressed was that dentists continue to act as dentists because that is what they are trained to be, but that an internal desire to provide care can be threatened by frustrations with lower than expected remuneration. When the internal and external factors that motivate someone are thrown into conflict, we can expect morale to drop. Morale is a very important factor in sustaining an effective workforce. As pay continues to fall those who want to continue being a dentist must draw more and more on other, internal, sources of motivation. This is unsustainable

and leads to the “burnout” of dentists that we have seen in recent years. In short, motivation explains why someone does what they do and why they keep doing it. In the case of dentists, as for everyone, there are a range of reasons, the chief of which is a desire to provide high quality dental care to patients, but it is clear that being paid in line with expectations helps maintain dentists’ motivation.

- 4.9 When general dental practitioners in Northern Ireland met with representatives of DDRB in May 2014, there was discussion about morale and motivation and the links to pay. It is evidenced in a study by Gorter and Freeman<sup>2</sup> which investigated the psychological health, in particular levels of burnout and engagement, job demands, job resources, and general psychological distress that burnout is a serious risk for general dental practitioners in the area of Northern Ireland studied. The study was administered in Spring 2007 and concluded that burnout is a serious risk for the dental team and especially general dental practitioners in the region of Northern Ireland studied. The results showed that one quarter of the dentists were categorised as having serious burnout risk. Dentists appeared to have most trouble with aspects of work environment, time pressure and financial worries. Furthermore, the proportion of those suffering from psychological distress was unusually high. We ask DDRB to put this conclusion of a study administered in 2007 into the context of Health Service dental care in 2015/16. The GDS is an environment in which dentists are experiencing bombardment through the addition of highly detailed governance, probity and scrutiny checks. These are impacting on the day-to-day business of direct clinical care as dentists are having to take time away from clinical care to deal with (clinical) governance and scrutiny. Time away from the chairside is time without generation of fee income and consequently increases the stress felt by the individual practitioner.
- 4.10 This year the Health and Social Care Information Centre included some motivation questions in its Dental Working Hours Survey. The results were not included in the final report but we hope that further motivation research will be included in the survey and then the results published.

**“The parties to set out their individual interpretation of ‘motivation”.**

- 4.11 GDPs need to be motivated to treat the high number of patients necessary to maintain access to NHS dentistry. Being self-employed, the level of remuneration acts as a key motivator. For community dentist/salaried practitioners their patients are very important but given the continual erosion of pay, increased pension contributions and very difficult working conditions there is going to become a point that even these dentists will decide to retire early or leave the service because they feel exploited.

### **Regional pay**

**“The parties to consider providing evidence to support regional pay.”**

- 4.12 We do not support regional pay for community dentist/salaried practitioners. Instead of a fair, transparent national system, regional pay would mean different rates for dentists doing exactly the same jobs, just because of where they live. It may lead to shortages of community dentist/salaried practitioners in low cost areas of the country, which often experience the worst oral health. These are also already the areas with the greatest recruitment issues.

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<sup>2</sup> Gorter RC, Freeman R. Burnout and engagement in relation with job demands and resources among dental staff in Northern Ireland. Community Dent Oral Epidemiol 2010

## **Legal obligations on the NHS**

**“All countries to consider the seniority payment schemes for both GMPs and GDPs to assess their compliance with age legislation and to make changes where necessary, and to report back to us next year.”**

- 4.13 Seniority pay is a very important benefit for GDPs and its withdrawal for new applicants in England in 2011 led to universal condemnation. When seniority pay was introduced over 40 years ago to compensate older practitioners for falling productivity, the money was top sliced from the dental budget, and continues to be so, so contract values for dentists are lower than they would have been had seniority pay not been introduced. Dentists rightly think of it as their money. If a decision was made that it should be withdrawn, then it must be retained for those currently in receipt of it and removed over a long period so adequate notice is given. If withdrawn the money must be used for other payment of benefit to all practitioners for example in pension improvements, additional payments for quality or grants for a range of items and activity that will improve clinical practice including equipment, IT or clinical audit/further training.

**“The parties to report to us next year on whether there are discrimination issues linked to the length of pay scales for any of our remit groups, and if there are, how they intend to address them.”**

- 4.14 Salary scales in the community/public dental services are short and we do not believe that there are any discrimination issues. Progression depends on performance and is not automatic.

## 4. General dental practice

- 5.1 This section covers general dental practitioners throughout the UK. Where there are country specific issues these are described.

### Taxable income for general dental practitioners

- 5.2 The *Dental Earnings and Expenses 2012/13 Initial Analysis report* for the four countries again showed a fall in NHS general dental practitioners' mean and median average taxable income. The median values are considerably lower than the mean values. So again in 2012/13 instead of experiencing a pay freeze NHS general dental practitioners are receiving a pay cut.

### England and Wales

- 5.3 Mean average taxable income from NHS and private dentistry:
- for all providing-performer dentists (those who own a practice and also provide NHS dental care personally) was £114,100 compared to £112,800 in 2011/12, a 1.2 per cent increase
  - for all associate dentists was £60,800, compared to £61,800 in 2011/12, a 1.5 per cent decrease
  - for all self-employed primary care dentists was £72,600, compared to £74,400 in 2011/12, a 2.4 per cent decrease,

Median average taxable income from NHS and private dentistry:

- for all Providing-Performer dentists was £95,800, compared to £95,300 in 2011/12
- for all associate dentists was £56,400, compared to £58,200 in 2011/12
- for all self-employed primary care dentists was £61,300, compared to £63,300 in 2011/12.

### Northern Ireland

- 5.4 Mean average taxable income from both Health Service and private dentistry:
- for practice owner dentists was £110,900, compared to £112,500 in 2011/12, a 1.4 per cent decrease
  - for associate dentists was £53,000, compared to £55,700 in 2011/12, a 4.9 per cent decrease
  - for all self-employed dentists was £71,600, compared to £75,800 in 2011/12, a 5.6 per cent decrease.

Median average taxable income from both Health Service and private dentistry:

- for practice owner dentists was £69,600, compared to £82,500 in 2011/12
- for associate dentists was £50,000, compared to £52,600 in 2011/12
- for all self-employed dentists was £55,400, compared to £60,000 in 2011/12.



## Scotland

### 5.5 Mean average taxable income from NHS and private dentistry:

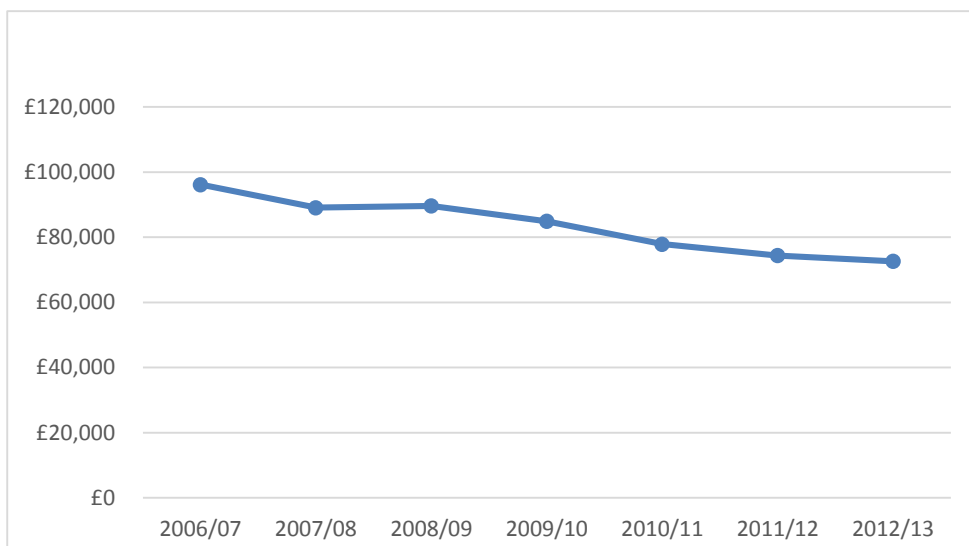
- for practice owners was £97,400, compared to £102,900 in 2011/12 a 5.4 per cent decrease
- for associate dentists was £57,200, compared to £57,600 in 2011/12 a 0.6 per cent decrease
- for all self-employed dentists was £68,800, compared to £71,700 in 2011/12, a 4.0 per cent decrease

### Median average taxable income from NHS and private dentistry:

- for practice owners was £91,800, compared to £96,900 in 2011/12
- for associate dentists was £53,600, compared to £55,200 in 2011/12
- for all self-employed dentists was £60,100, compared to £63,200 in 2011/12.

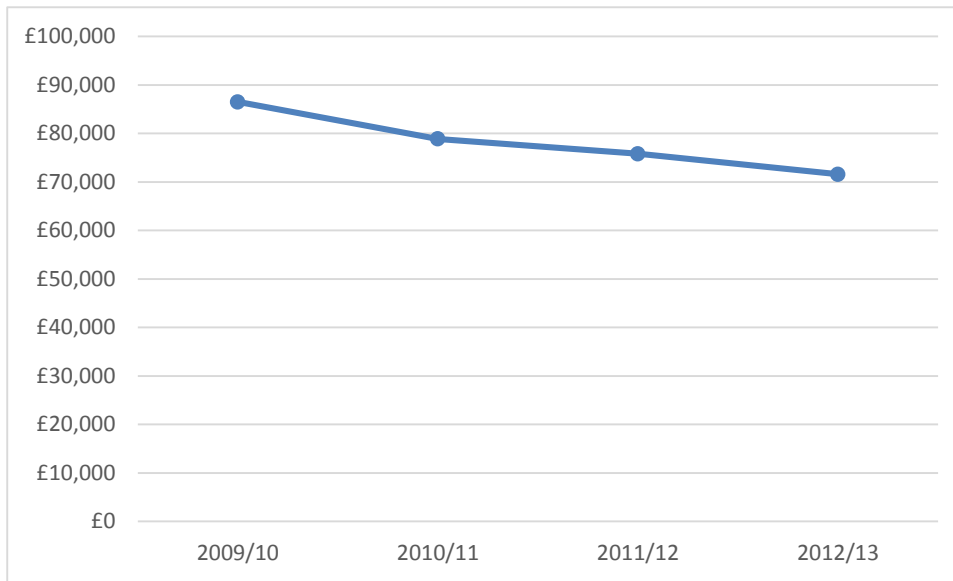
### 5.6 Figures 2, 3 and 4 show reductions in taxable income for GDPs in the four countries.

**Figure 2 Taxable Income in England and Wales**



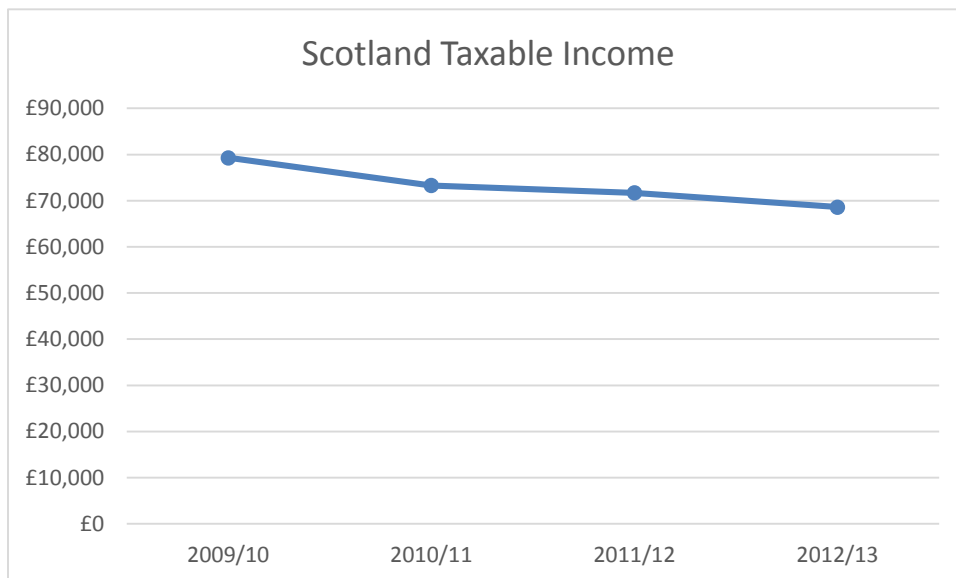
**Source:** Health and Social Care Information Centre Dental Earnings and Expenses England and Wales reports 2011/12 and 2012/13

**Figure 3 Taxable Income in Northern Ireland**



**Source:** Health and Social Care Information Centre Dental Earnings and Expenses Northern Ireland reports 2011/12 and 2012/13

**Figure 4 Taxable Income in Scotland**



**Source:** Health and Social Care Information Centre Dental Earnings and Expenses Scotland reports 2011/12 and 2012/13

- 5.7 Between April 2006 and March 2013 mean average taxable income for GPs in England and Wales fell by 24.5 per cent. In Northern Ireland between April 2009 and March 2013 it fell by 17.2 per cent and in Scotland it fell by 13.5 per cent. These are astonishing falls and are not sustainable in the future.
- 5.8 Mean average taxable incomes in all four countries for GPs who say that they spend 75 per cent or more of their time on NHS work are shown in the table below.

**Table 4: Taxable incomes for highly NHS committed general dental practitioners by country**

England	£72,700
Northern Ireland	£75,700
Scotland	£68,500
Wales	£60,800

**Source:** Dental Earnings and Expenses 2012/13 Initial Analysis

- 5.9 As can be seen, on average, highly NHS/HS committed GDPs have less taxable income than the average for all GDPs.

### **Northern Ireland**

- 5.10 There are specific issues regarding income which BDA Northern Ireland wishes to bring to the attention of the Review Body. Earnings and Expenses for dental practitioners are set out in the HSC IC Annual Dental Earnings and Expenses reports. The most notable factor in considering these reports must be that earnings and expenses are recorded for both Health Service and private care and then considered together. The reality of this approach is that the true picture of health service earnings and expenses cannot be evidenced where there is inclusion of income and expenses from private dentistry. This is witnessed in the report at Section 8 on Earnings and Expenses by Percentage of Gross Earnings for Health Service Dentistry. Here it can be seen that those dentists 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 £58,000. Those whose Health Service earnings accounted for 25 per cent or less, and between 25 and 75 per cent of their total gross earnings had taxable incomes of £78,500 and £105,400 respectively. The 2012/13 sets out a position for Dental Practice which when taken in the context of General Dental Services represents a critical and pivotal position.
- 5.11 Successive reports demonstrate that all dentist earnings are reducing. Total expenses are reducing. Associate pay is reducing and arguably this factor is responsible for the reduction in average total expenses per practice owner.
- 5.12 The report for 2012/13 sets out the situation as it exists in advance of the impact of very significant cuts to the General Dental Services budget which are being implemented over the period April 2013 to July 2015.

**Table 5. Changes in practice owner average taxable income, associate average taxable income, average gross earnings per practice owner and average total expenses per practice owner over the period 2009/10 to 2012/13**

	Practice owner average taxable income	Associate average taxable income	Average gross earnings per practice owner	Average total expenses per practice owner
2009/10	£122,900	£62,700	£344,600	£221,700
2010/11	£114,200	£59,400	£331,000	£216,800
2011/12	£112,500	£55,700	£318,600	£206,100
2012/13	£110,900	£53,000	£316,000	£205,200
Percentage change between 09/10 and 12/13	-9.76%	-15.5%	-8.3%	-7.4%

### **Productivity**

- 5.13 At a time when average income is falling, dentists are working harder and increasing productivity. For example in Northern Ireland patient registrations continue to increase. For the period June 2011 to end March 2014, patient registrations have increased by 98,532 or 9.3 percent. In England twenty nine point nine million patients were seen in the 24 month period ending June 2014, a 1.8 million (6.3 per cent) increase from the March 2006 baseline.

### **Scotland**

- 5.14 *The Forty Second Report of the Doctors and Dentists Review Body (DDRB)* published in March 2014 demonstrates the continuing decline in dentists' income in Scotland compared to intended / recommend increases by the DDRB.
- 5.15 Table 6 of the DDRB Forty Second Report highlights that dentists' income has declined by 16.5 per cent between 2008 and 2011/12. It is important to note declining income for dentists against a backdrop of declining payments and increasing numbers of practitioners providing GDS services. The net effect is an overall deterioration in the financial position for dentists striving to maintain quality of care for patients within a fee rate system which does not reflect the increasing costs of providing treatment within a high quality practice environment.

**Table 6 Changes in Scottish dentists' income compared to recommended/intended increases**

Scotland		GDP (all dentists)		
Financial year	Income	Change on previous year	Uplift intended from previous year	Intended efficiencies from previous year
2006-07				
2007-08			3.4%	
2008-09	£85,000		2.0%	
2009-10	£79,300	-6.7%	2.2%	
2010-11	£73,300	-7.6%	1.5%	
2011-12	£71,700	-2.2%	0% (zero)	1% on expenses

Source: Income from HSCIC – Dental Earnings and Expenses: Scotland (various years).

In 2012 –13 the Dental Earnings and Expenses Survey for Scotland, defined a further reduction in the average income for dentists, from £71,700 in 2011/12 to £68,800, an additional decrease of 4%.

On the basis of the information outlined in Table 6 (source the DDRB 42nd Report) above and subsequent information made available through the Dental Earnings and Expenses Survey for Scotland in 2012/13 Scottish Government would have to uplift the fees by 19.1 % to enable dentists to achieve the same level of average income as the income level in 2008.

### Morale and well-being of GDPs

- 5.16 As mentioned above it is unfortunate that the HSCIC are not going to publish the results of the motivation questions asked as part of the Dental Working Hours Survey this year. We did not conduct any research on motivation of general dental practitioners this year because we wanted to rely on the results from the HSCIC. We have no reason to believe that the results of our motivation research, conducted last year, would be any different this year. We did ask about morale, and the results for associates and practice owners are shown below.

**Table 7 responses to the question “How do you rate your morale as a dentist?”**

Base: associate dentists		
Level of morale	Number	Column percentages
Very high	36	9.0
High	96	24.0
Neither low nor high	119	29.8
Low	90	22.5
Very low	57	14.3
Don't know	2	0.5
Total	400	100.0
User missing/data unavailable	4	

Source GDP Morale, Well-being and Stress survey 2014

**Table 8 Responses to the question “How do you rate your morale as a dentist?”**

**Base: all practice owners**

Self-rated morale	Number	Column percentages
Very high	39	8.6
High	106	23.2
Neither low nor high	129	28.3
Low	127	27.9
Very low	55	12.1
Total	456	100.0
User missing/data unavailable	5	

Source: GDP Morale, Well-being and Stress survey 2014

- 5.17 Morale is low amongst many GDPs with practice owners having lower morale than associates.
- 5.18 Wellbeing among GDPs was found to be, once again, below the national average amongst the general population. The national average figures are shown in brackets.

**Table 9 Wellbeing figures for practice owners – national averages shown in brackets**

	Mean (2014)	Very low (0-4)	Low (5-6)	Medium (7-8)	High (9-10)	Base N	Missing N
Life satisfaction	6.1 (7.4)	25.3	22.7	37.3	14.7	450	11
Life worthwhile	6.8 (7.7)	17.3	20.0	38.7	24.0	450	11
Happy yesterday	6.4 (7.3)	25.0	18.5	35.5	21.0	448	13
		Very high (6-10)	High (4-5)	Medium (2-3)	Low (0-1)		
Anxious yesterday	4.6 (3.1)	40.9	19.1	24.7	15.3	450	11

Source GDP Morale, Well-being and Stress survey 2014

**Table 10 Wellbeing results for associates – national averages shown in brackets**

	Average (mean)	Very low (0-4)	Low (5-6)	Medium (7-8)	High (9-10)	Total %	Base N
Life satisfaction	6.2 (7.4)	23.0	23.0	42.8	11.1	100.0	395
Life worthwhile	6.6 (7.7)	16.4	23.5	42.4	17.7	100.0	396
Happy yesterday	6.4 (7.3)	21.3	22.0	35.9	20.8	100.0	395
		Very high (6-10)	High (4-5)	Medium (2-3)	Low (0-1)		
Anxious yesterday	4.7 (3.1)	41.9	19.7	25.3	13.1	100.0	396

Source GDP Morale, Well-being and Stress survey 2014

5.19 Anxiety levels among GPs was higher than the national average, supporting our finding above that morale is low. If left unchecked, these factors will have a serious and detrimental effect on general dental practice.

### Pay progression in general dental practice

5.20 The DDRB asked for some case studies showing typical pay progression for general dental practitioners. We are not able to provide this information. There is no real pay progression in general dental practice at present apart from the transition from foundation dentist to associate and then obtaining seniority pay at 55 in Wales, Scotland and Northern Ireland. Pay rates for associates vary widely and it has been very common in the past six years for practice owners to reduce associate pay in the face of rising expenses and stagnant contract values. Associates are paid on a percentage of earnings or an amount per UDA. This percentage or amount only changes when the practice owner and associate agree it should or the volume of work increases. In England and Wales the volume of NHS work/budget is capped. In Scotland and Northern Ireland the budget is now also capped.

### Recruitment and retention of general dental practitioners

5.20 Below we present the headcount figures for general dental practitioners in England and Wales who provided some level of NHS care in 2013. Regional data for England is available in the Health and Social Care Information Centre’s report *Dental Statistics for England 2013/14*.

5.21 As can be seen below, the number of dentists providing NHS care continues to increase even though our previous research showed that wellbeing and motivation in the NHS General Dental Practice is low. This suggests that dentists provide NHS care because the NHS is the chief purchaser of their skills and they wish to continue practising as dentists, rather than because it is intrinsically desirable. It is also important to note that the NHS dental budget is fixed.

**Table 11: Number of dentists with NHS activity 2006/7-2013/14 in England**

<b>Dentist</b>	20,815	21,343	22,003	22,799	22,920	23,201	23,723
<b>Joiners</b>	1,709	1,803	1,899	1,955	1,715	1,693	1,740
<b>Leavers</b>	1,275	1,239	1,159	1,594	1,412	1,218	N/A
<b>Net change from previous year</b>	655	528	660	796	121	281	522
<b>% change from previous year</b>	3.2	2.5	3.1	3.6	0.5	1.2	2.2

Source: HSCIC 2014

5.22 This year’s BDA Vocational/Foundation Dentist survey (161 respondents, response rate 42.4 per cent) showed that there are some difficulties for these dentists to obtain work as associates in general dental practice. The cost of educating a dental student is £200,000<sup>3</sup>, so any dental graduates who do not go on to provide care represents a considerable lost resource. The majority of respondents (88.7 per cent, N=134) had found a dental post for after their DVT/DFT training was completed.

<sup>3</sup> Hansard: 14 Sep 2012 : Column 427W, available from: <http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120914/text/120914w0004.htm> last accessed 27.08.13

**Table 12 Response to the question “How easy or difficult was it to find a post?”**

<i>Row percentages</i>								
<b>“How easy or difficult was it for you to find a post?”</b>								
	<b>Very easy</b>	<b>Moderately easy</b>	<b>Neither easy or difficult</b>	<b>Moderately difficult</b>	<b>Very difficult</b>	<b>Don’t know</b>	<b>Base N</b>	<b>Missing</b>
<b>2013</b>	25.0	31.4	22.1	16.4	5.0	0	140	12
<b>2014</b>	25.6	28.6	18.0	24.1	3.8	0	133	1

**Base:** All FDs/VDPs planning to work in dentistry in the UK after completing their training and who had found a post by the time of the research

**Source** BDA DFT/VDP survey 2014

**Table 13 Setting of FDs/VDPs new posts**

<i>Column percentages</i>			
<b>Setting of new post</b>	<b>New post is in Scotland or Northern Ireland</b>	<b>New post is in England or Wales</b>	<b>New post in any UK country</b>
General practice	60.9	51.8	53.4
Hospital	34.8	39.1	38.3
Community dental services (CDS)	4.3	3.6	3.8
Hospital and CDS			2.3
Other (including specialist care)	0	5.4	2.3
<b>Base N</b>	<b>23</b>	<b>110</b>	<b>133</b>

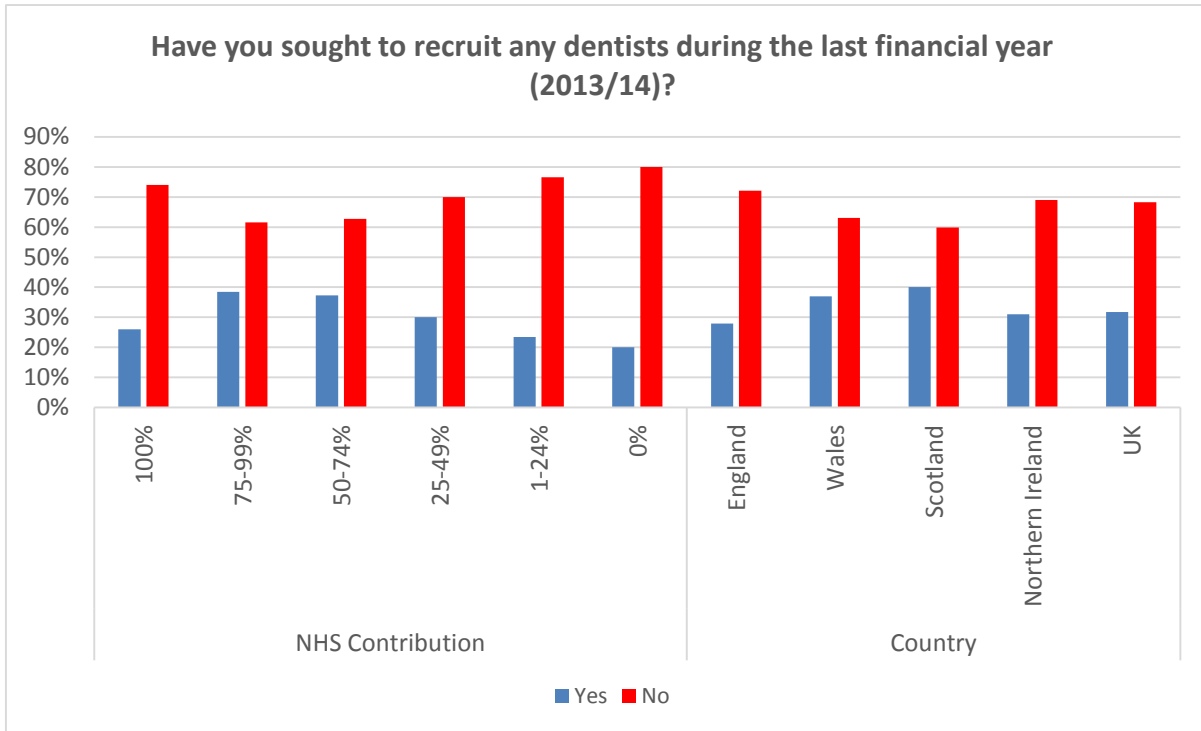
**Base:** Dentists who were currently in DVT/DFT at the time of the survey and who were due to finish their training before October 2014 and who had found a new post (or posts).

*Note – some cells less than five cases*

- 5.23 Last year the DDRB noted our concerns over the recruitment of associates in some areas. This situation is shown by the tables and figure that follow to remain unchanged. Continuous falls in income are no doubt contributing to this trend; associates are less likely to move because rates of pay on offer at other practices may well be lower.



**Figure 5 Practice owners who had sought to recruit one or more dentists during the last financial year (2013/14)**



Source Dental Business Trends 2014

5.24 Just under a third of practices tried to recruit an associate in 2013/14.

**Table 14 Of those that recruited, how many applications were received in total for this position or these positions?**

		Mean	N
NHS Contribution	100% (Exclusively NHS)	29.75	12
	75-99%	25.40	121
	50-74%	47.39	38
	25-49%	37.30	20
	1-24%	18.43	28
	0% (Exclusively private)	91.00	23
Country	England	46.93	124
	Wales	10.89	27
	Scotland	22.20	70
	Northern Ireland	43.81	21
Total		35.48	242

5.25 The much larger average number of applications for fully private practices will be due to the attractiveness of private practice and also because these practices will attract dentists from overseas who are not able to practise in the NHS easily. The low number of applications in Wales is reflective of the fact that there are real recruitment problems.

**Table 15 Did you experience any problems when recruiting for this position or these positions?**

		Yes	No	Total N
NHS Contribution	100% (exclusively NHS)	53.8%	46.2%	13
	75-99%	30.0%	70.0%	130
	50-74%	20.0%	80.0%	40
	25-49%	13.0%	87.0%	23
	1-24%	25.0%	75.0%	28
	0% (exclusively private)	36.0%	64.0%	25
Country	England	29.0%	71.0%	138
	Wales	32.1%	67.9%	28
	Scotland	26.4%	73.6%	72
	Northern Ireland	23.8%	76.2%	21
Total		28.2%	71.8%	259

- 5.26 According to our survey, roughly 28 per cent of practices experienced a problem in the recruitment of associates. This was particularly apparent for practices in Wales and those who were more heavily NHS committed. We believe that there is still a recruitment problem with associates in some areas of the country.
- 5.27 As our recent research on GDP's stress and wellbeing shows, life is hard for many dentists. Leaving the NHS to convert to private care is still an option and is achievable with careful planning. Practice owners and their staff may well be looking at their options, stay in the NHS and face year on year pay cuts and pressure from the NHS or take a planned risk and offer only private care. Incomes have been forced down and younger dentists are working in multiple locations. If they have to increase their working hours, and pay continues to fall, dentists will face increasing pressure and stress levels. This will ultimately affect patient care as dentists begin to experience increased levels of burnout. While we understand that public finances remain stretched, GDPs are small businesses who contribute to the local economy as well as provide care. They need support to continue to provide these functions effectively. Recruitment and retention data mask the serious problems facing dentists.

### **Expenses in general dental practice**

- 5.28 In order to recruit and retain good members of the dental team, provide stability for patients and motivate staff, many NHS practices have found that they have had to provide comparable rates of pay to private dental practices. This was reported by dentists in our Dental Business Trends survey as reasons for recruitment difficulties for dental staff.

### **Capital investment**

- 5.29 Findings from the Dental Business Trends survey revealed that just over half of practice owners planned to invest in their practices in the 2013/14 financial year with an average investment amount of £35,977.60.

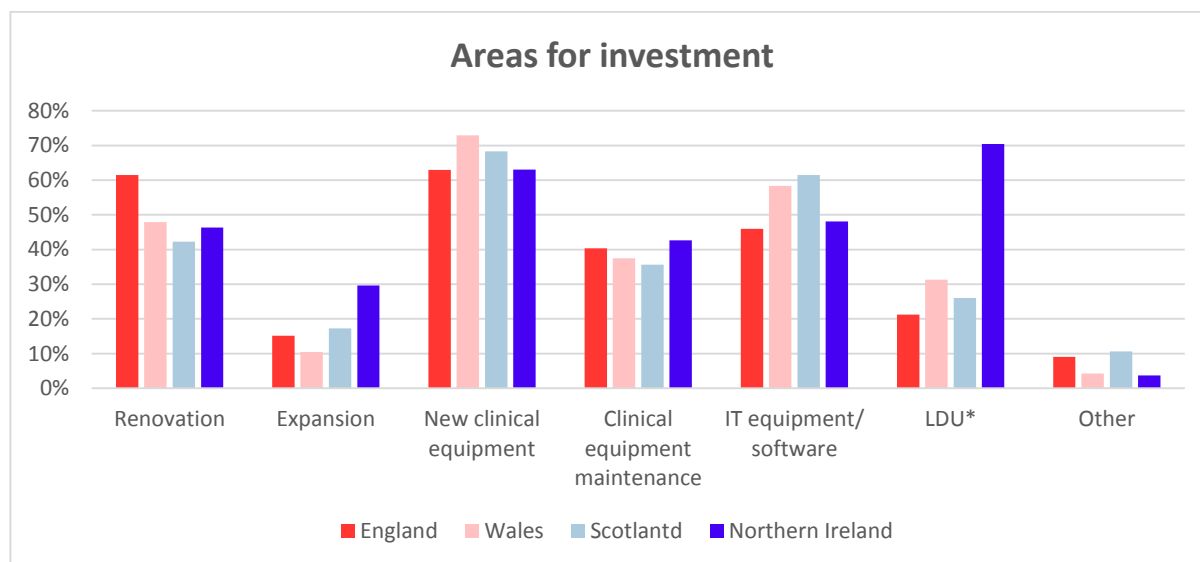
**Table 16 Responses to the question “Did you plan to undertake any investment in your main practice in the 2013/14 financial year?”**

		Yes	No	Total N
<b>NHS Contribution</b>	100% (Exclusively NHS)	32.7%	67.3%	52
	75-99%	55.5%	44.5%	362
	50-74%	63.1%	36.9%	111
	25-49%	52.5%	47.5%	80
	1-24%	62.6%	37.4%	131
	0% (Exclusively private)	55.0%	45.0%	129
	Would prefer not to answer			2
<b>Country</b>	England	52.9%	47.1%	524
	Wales	57.8%	42.2%	83
	Scotland	57.1%	42.9%	189
	Northern Ireland	72.0%	28.0%	75
<b>Total</b>		<b>55.9%</b>	<b>44.1%</b>	<b>871</b>

Source Dental Business Trends 2014

5.30 For those that planned to invest the areas of investment are shown in the figure below.

**Figure 6 Areas of planned investment by country**



Source Dental Business Trends 2014

**Table 17 Areas of planned investment by NHS commitment**

		Renovation	Expansion	New clinical equipment	Clinical equipment maintenance	IT equipment/software	LDU*	Other	Total
NHS Contribution	100% (Exclusively NHS)	53.3%	33.3%	40.0%	33.3%	53.3%	33.3%	6.7%	15
	75-99%	52.0%	20.2%	64.1%	37.4%	52.0%	27.3%	7.6%	198
	50-74%	45.7%	11.4%	58.6%	41.4%	48.6%	28.6%	11.4%	70
	25-49%	50.0%	11.9%	61.9%	26.2%	54.8%	19.0%	7.1%	42
	1-24%	68.3%	11.0%	67.1%	43.9%	52.4%	31.7%	6.1%	82
	0% (Excl private)	54.8%	19.2%	78.1%	45.2%	43.8%	35.6%	9.6%	73
	Would prefer not to answer	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	1

Source Dental Business Trends 2014

5.31 Levels of actual investment were not as high as planned for many of the practices as shown in the table below.

**Table 18 How much investment was actually carried out?**

		All	Some	None	Total (N)
NHS Contribution	100% (Exclusively NHS)	53.3%	40.0%	6.7%	15
	75-99%	62.1%	31.8%	6.2%	195
	50-74%	59.7%	34.3%	6.0%	67
	25-49%	64.3%	31.0%	4.8%	42
	1-24%	58.8%	40.0%	1.3%	80
	0% (Exclusively private)	61.1%	37.5%	1.4%	72
	Would prefer not to answer	100.0%	0.0%	0.0%	1
Country	England	59.2%	35.4%	5.4%	277
	Wales	59.6%	34.0%	6.4%	47
	Scotland	66.7%	30.3%	3.0%	99
	Northern Ireland	62.3%	37.7%	0.0%	53
Total		61.1%	34.5%	4.4%	476

Source Dental Business Trends 2014

## **Expenses in Scotland**

- 5.32 Dental practices in Scotland now have some additional costs following withdrawal of service provision.

### **Occupational health costs**

- 5.33 The additional financial burden of occupational health costs in Scotland:

Occupational Health Services (OHS) certification required, including, HEP C for all associates, HIV certification for all associates, TB status for all clinical staff. Mantoux testing for all those clinical staff who had not had their BCG. This includes payment for the nurses testing.

A list of costs incurred:

- PVG application per person: £59.00
- HIV blood test: £29.50
- Hep B antibody test: £39.25
- Hep C antibody test: £41.50
- BCG: scar check: £17.50, Mantoux test: £41.00, BCG vaccination: £29.00

### **The costs of Protecting Vulnerable Groups (PVG) clearance in Scotland**

- 5.34 All clinical staff must have PVG clearance. Previously all dentists had to have Disclosure but that has been superseded by PVG and all clinical staff now need to have PVG clearance for the purposes of the Combined Practice Inspection. The costs for PVG clearance are currently £84 per member of staff which includes £59 for the fee and an additional £25 to cover the administration costs.

### **Laboratory items**

- 5.35 Practitioners in Scotland have seen significant increases in costs associated with laboratory items, with an average unit price increase of 10 per cent for bonded crowns with precious metal.

### **Utilities costs**

- 5.36 Water, electricity and equipment maintenance all contributed to higher expenses costs this year with NHS committed practices experiencing the biggest outlay. Since December 2012, all NHS practices in Scotland have been required to house a local decontamination unit. Although some capital funding was made available by the CDO to some practices to support the installation of the LDUs, the significant revenue costs must now be borne entirely by practice owners.
- 5.37 With year-on-year increases to the costs of running their practices, practitioners are finding it more and more difficult to invest in their practices. Findings from the DBT survey revealed a drop in the number of practice owners who planned to undertake any investment during the 2012/13 financial year, compared with last year. Of those that did plan to invest, only an average of 50 per cent actually managed to complete that investment.

### **Revenue costs of local decontamination units**

5.38 The capital investment costs for LDUs in Scotland were largely funded by Scottish Government however providing “state of the art” decontamination in practices generates significant and increasing revenue costs. Areas where additional costs have been incurred by practices, since 2010, include the following cost elements:

- additional electricity and water costs associated with running washer disinfectors
- ongoing consumables costs i.e. detergents, printer rolls etc. associated with the equipment
- the cost of an additional full time staff member to work, operate and maintain the LDU
- the costs of additional validation, testing, servicing and maintenance of equipment
- the costs of wrapping instruments.

5.39 Based on information provided by a range of dental practitioners the annual average cost to practices of adopting these measures for a single surgery practice is estimated at £4,522.00 per annum and for a three surgery practice the estimated additional cost is £8,180.00 per annum.

### **General dental practice expenses - Chief Dental Officer Working Group**

5.40 As stated earlier, the BDA is a strong proponent of partnership working and was part of the group that was convened by the CDO to consider gaps in evidence highlighted by the DDRB in its 40th Report. The Scottish Government-led group has only met once within the last year with the last meeting having taken place in December 2013. At that meeting, the parties reached agreement in principle for a survey of general dental practitioners to be conducted in order to obtain more robust data on practice expenses. Scottish Government confirmed in June 2014 that it is their intention to procure external consultancy support to take forward a detailed analysis of expenses which would inform and enable the development of a dental expenses formula specifically for Scotland. In addressing this issue of providing better quality evidence to the DDRB, BDA Scotland is working with Scottish Government in taking forward an external consultancy project to address the issue of multiple counting. The primary aim is to procure external consultancy which will draw on data from a sample of 80-100 practices reflecting both the mix of rural and urban practices including small practices and large multi-dentist practices. The study sample will include only those practices where 90 per cent or more of practice income is generated through NHS activity. The final report will include an analysis of data for the last three accounting years which will inform the 2015/16 DDRB submission of evidence. It is anticipated that a reasonable sample size could be used in order to produce anonymised practice accounts information and that the sample would focus on practices that are NHS committed. The BDA hopes to be able to provide further information to the Review Body at the supplementary evidence stage.

### **Northern Ireland**

5.41 As it currently stands, dental practice is generally delivered through mixed practice where each practice will invariably deliver a mix of health service and private dental care. That mix can vary at each practice from almost wholly health service to exclusively private. DDRB should be concerned only with health service dentistry. Private dentistry impacts on the figures which DDRB uses to inform its recommendations. Since private dentistry has higher costs to patients the turnover from private care will exceed that for similar time spent providing HS care. By considering private and health service care in the same equation there will then be a likelihood that the increased turnover created through private dentistry will mask the reality of the health service situation. In order to consider this in more detail, BDA Northern Ireland has commissioned some work in considering the expenses elements of practice where the practice is almost entirely operating within the health service.

- 5.42 The overall aim of the work is to improve the understanding of total expenses for HS dentistry and to explore the elements in the equation which make up contractors turnover and how these are translated to income. This is work in progress and at the time of writing this work is incomplete.

### **Practice expenses and the formula in Northern Ireland**

- 5.43 In determining a pay award for dental services, the Doctors' and Dentists' Review Body uses a formula approach which takes into consideration some expenses elements of practice and applies an uplift according to prevailing factors.
- 5.44 The formula presumes that dental practice is a business environment which is experiencing a stable state. This would work if dental practice was simply a waiting area and clinical area and costs were associated with the clinical aspects of care and the matters which are addressed inside the surgery room. Each year the dentist would receive an uplift to net pay and the concomitant factors of heat and light to the surgery room, staff costs and lab and materials costs would be uplifted against the presumption that the single dentist turned out the same output of clinical work and did not experience new costs or the need for extra staff or resources. If the practice expanded, then the additional dentist would be paid in the same way as the first. The assumption again would be that the surgery facilities and resources were covered, so long as they did not increase beyond the baseline level for which the formula accounts.

### **Practice Allowance**

- 5.45 As far back as 2004 the DHSSPS introduced a Practice Allowance. This is a clear recognition that the DDRB formula could not address the whole complement of expense elements of modern dental practice. In 2004 the rationale provided by DHSSPS in introducing the Practice Allowance was that:

'The department recognises the additional administrative burden facing practice owners, largely because of regulation and clinical governance requirements and the impact this has on effective management of practices. To this end a new Determination XI has been inserted into the Statement of Dental Remuneration (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.'

- 5.46 Going back to the DDRB formula, it is clear that the formula can really only account for the costs that are incurred inside the clinical room where fee income is generated. Dental practice now requires the fee income generated by the dentist to carry a host of additional expenses which go well beyond those considered by the formula. For example the formula does not enable new expenses to be considered. The result is that dentistry is caught in a funding system of fixed fees for items of service which recognises the lab, materials and staff costs but does little to recognise the facilities and governance which must exist within the practice but beyond the surgery door. Here we are considering areas such as decontamination (where dedicated capital intensive facilities have to be provided and subsequently resourced), practice improvements such as disabled access (where policy dictated these have to be provided), IT to enable information governance payments to be received, and other inescapable expenses such as provision of defibrillators or purchases dictated by the Health Service and policy makers. A business operating outside the fixed fees of health service dentistry can manage its fees in order to deal with these examples of inescapable expenditure. The Health Service dentist is faced with fixed fees which mean that dealing with new expenses presents stark financial and stress challenges. One solution is to recognise the value of the Practice Allowance as a mechanism for funding practice expenses and uplift its value in a way which is more responsive to HS Practice expenses.
- 5.47 The Practice Allowance as introduced in 2004 to the remuneration system for dentists in Northern Ireland is a payment made to the practice on behalf of all the dentists working there. It is a

payment which comes into the practice twice yearly and is based on the fee income. The practice allowance is expected to deal with expenses of running a practice such as IT, governance requirements, and decontamination. All of the income to the practice through the practice allowance is spent on various expenses. None of the payment becomes dentist pay. The practice allowance should increase at a rate which is in keeping with dental practice expenses and should recognise and account for new, additional and inescapable expenses.

### **Fee income**

- 5.48 Fee income is generated through the dentist carrying out treatment items and being paid for them. In turn the dentist pays the expenses incurred and retains the remainder for pay and future investment. Fee income is inclusive of monies which go to expenses and those which are retained as dentist pay. The current DDRB formula recognises dentist income, staff costs, laboratory costs, materials and other costs and is a useful mechanism for uplifting fees.

### **Commitment payment**

- 5.49 Commitment payments were introduced in 2000 as scheme to reward the loyalty of GDPs to the health service and consequently to encourage retention and improve motivation and allow for an element of career progression. The intention of Commitment payments is that they have no element of expenses and form part of net pay.
- 5.50 Commitment payments are currently being phased out as part of cuts to the budget for General Dental Services. The BDA believes the extent of the cuts to Commitment Payments will impact most significantly on those dentists who are most committed to the Health Service. At the same time, the Dental Working Hours survey shows that dentists have to spend more time doing activities related to their work which are not clinical and therefore do not generate recompense. The payment system for GDS dentists should recognise that provision of GDS services requires significant amounts of non-clinical activity and this should be recompensed.

### **Conclusion**

- 5.51 The current DDRB formula accepts the aspects of expenses which are generated in the dental surgery room where the patient is treated by a dentist supported by a DCP, using dental materials and laboratory fabricated items. The formula does not fully reflect the resources required for the dental practice environment beyond the surgery door. The formula does not reflect new capital or revenue expenses, for example the call for practices to have defibrillators in place.
- 5.52 The Practice Allowance is currently linked to fees. If fees rise by 0.5% so will the value of the practice allowance. Because the practice allowance is for expenses, we suggest that it should be uplifted to recognise general expenses inflation and more specifically dental costs. In addition there should be a factor added to the practice allowance to reflect new inescapable capital and revenue costs associated with health service dentistry.
- 5.53 Dentists are now required to spend increased hours on activity which is essential but not clinical in nature. This type of activity requires remuneration as it is necessary, the opportunity cost is that it prevents dentists from undertaking remunerative clinical activity.
- 5.54 The DDRB formula is a reasonable means of uplifting fees for items of service.



## The formula

5.55 We support the continued use of the DDRB formula. The information produced in the HSCIC Dental Earnings and Expenses reports remains robust and we support the continued use of ASHE for staff pay and RPI/RPIX (and their successors) for inflation of other factors. The DDRB asked the parties for some very detailed and specific information this year and for it to be agreed. The request for sets of accounts was also made.

5.56 The BDA always tries to provide comprehensive and robust evidence to the Review Body. Evidence gathering and assimilation takes up substantial resources. This year we have tried to obtain some of the information needed by the Review Body for all four countries. We have not been able to obtain all that has been requested but we believe that it will enable the DDRB to continue to make recommendations on an overall uplift rather than just an uplift for net pay.

**“ the parties work together to agree appropriate coefficients to represent staff costs, laboratory and materials costs and other costs, either by agreement on existing indicators, or through further work on how such costs should be recognised. Two years’ of data will be necessary for an assessment of the annual change in expenses to be made and used as alternatives to RPI, RPIX and ASHE in the formula.”**

5.57 In England and Wales we have received no approach to work together on this issue. We are prepared to put our best efforts into this. In England we have written to NHS England to ask for discussions. As reported elsewhere in the evidence the Scottish Government is working with BDA Scotland on this issue.

**“Provide a comprehensive list of all expenses and reimbursements associated with both general medical and dental practice.”**

5.58 The health departments should be able to provide a comprehensive list of reimbursements. Our list of practice expenses is as follows:

- Employed staff (dental hygienists, dental therapists, dental nurses, dental receptionists, dental practice managers and dental technicians) including pay, NI, training, travel/subsistence expenses, occupational health, possibly registration fees
- Premises costs including mortgage, rent rates, council tax, performing rights licences
- Utility costs
- Equipment purchase costs
- Equipment maintenance costs
- Materials costs
- Laboratory costs
- Consumables costs
- Costs for child safeguarding, practice regulation
- Costs of borrowing
- Insurance and indemnity
- Professional expenses, mileage

**“Provide a comprehensive breakdown of all staffing costs, including the number of employees and hours worked, their roles, the balance between partners (providers) and salaried staff (performers), and their pay, for both general medical and dental practice.”**

5.59 At a national level the relative numbers of practice owners and associates is given in the HSCIC Dental Earnings and Expenses 2012/13 Initial Analysis report. In general dental practice there are very few employed performers. The HSCIC Dentist Working Hours survey report provides information on working hours on a national level. In the BDA’s view comprehensive information regarding practice employees will be very difficult to obtain except on the basis of a very small number of random cases, We will forward some information that we have from last year’s Dental Business Trends survey that was not included in our evidence last year as supplementary evidence.

**“Reach agreement on how efficiencies should be taken into account.”**

5.60 We have written to the relevant Health Departments asking for discussion on this matter.

5.61 **“Provide information on NHS income and associated expenses, on a country specific basis, for both GMPs and GDPs, and to consider what adjustment to account for non-NHS work should be made to the weightings used in our formulae.”**

5.62 We believe that the formula should stay as it is. It is too complex to account for non-NHS work and we believe that the relative weightings of components for care are the same for NHS and non-NHS. It is just the private cost represents the full cost of providing care.

**“We ask that the current plans in England to publish details of practice income take account of our data requirements.”**

5.63 We cannot comment on this issue.

**“Agree an approach as to how shifts in the composition of the workforce should be taken account of.”**

5.64 We agree that the workforce balance is changing and we have asked the English Health Department for discussions on this point and would be happy to discuss the issue with the other departments.

**“Agree an approach as to how any change in the status of businesses should be taken account of.”**

5.65 As above.

**“Address the ongoing data requirement to assess the extent of multiple counting of expenses in dental tax returns.”**

5.66 As we have said before, multiple counting applies only to Scotland and Northern Ireland. We gave the DDRB evidence on this in the past. We think it should be discounted for England and Wales. As described elsewhere in the evidence we are working with the Scottish Government on this issue.

**“Provide data on the distribution of the number of hours worked, including the mean and median.”**

5.67 This is contained in the Dental Working Hours report for 2013/14 for dentists.

**“Consider how the commissioning approach for UDAs might conflict with the formula-based approach”**

5.68 We remain highly critical of UDAs but of course if providers are tendering the risk is that the lowest pounds per UDA will win the contract. If a low UDA value wins a contract then it follows that performers will also be engaged on a lower fee level. We have already seen one large corporate not implement DDRB uplifts for their associates. The issue is that the associates' pay is no longer related to contract value uplift so the market is in force. The market is increasingly corporate-based which brings a much more commercial focus into play.

**“Consider how any new dental arrangements would work with the formula-based approach”**

5.69 It is too early to be able to predict how DDRB will play into any change to the contract in England. We know the DH wants to go with a blended approach which will include capitation payments, quality payments and activity payments.

**Recommendations for general dental practice**

5.70 Whilst we continue to support the formula as a starting point for an uplift, essentially we believe it must start to redress the fall in taxable income for GDPs over the last few years in all four countries.

5.71 We believe the current coefficients in relation to the expenses part of the formula are the best available and should be used again this year. The formula in Scotland includes an adjustment for rent reimbursement. We do not agree with this and believe that the way the expenses element of the formula is calculated should be as it is in England and Wales.

5.72 In terms of the pay uplift element in the formula, our view is that to ensure GDPs' pay keeps pace with inflation that an uplift equal to CPI should be used. Currently this is 1.5 per cent.

5.73 However, once the uplift amount is determined using the formula, we propose that an additional 1.5 per cent should be added year on year for the next 10 years to start to redress the hugely challenging situation that GDPs are in across all UK countries.

## 6. Community dental services/public dental services

- 6.1 Although the public sector pay announcements means that for England, the DDRB has been asked not to make a recommendation for this country, for the sake of consistency we continue to provide information on community dentist/salaried practitioners in the UK. Indeed, we would welcome the DDRB continuing to offer comment in relation to the position of all community and salaried practitioners across the UK. Where issues are country specific this is noted. The services are referred to by different names in the countries of the UK and in Scotland the name is the Public Dental Services, we have referred to them as salaried practitioners, for the other countries we refer to the community dental services and community dentists.
- 6.2 We share the DDRB's frustration that there is a lack of consistent data on the number of community dentist/salaried practitioners employed in the health service. If the health services do not know how many people they employ and at what level they are, then claims of lack of affordability must be treated sceptically. We continue to collect as robust data as possible on all aspects of the services, some of which we report in evidence.
- 6.3 The pre-announced public sector uplift for 2015/2016 has once again undermined the independent process of the DDRB. The freezing of incremental pay in England and Wales and the application of pay awards as non-recurrent "bonuses", risks severely devaluing the contractual arrangements in the community dental services. The long term effect will be that the salaries for people considering a career in the community dental services will be so low that recruitment of able dentists will be impossible, as inflation forces the real value of salaries down.
- 6.4 This year we did three pieces of research on the community/public dental services in the UK:
- a survey of community dentists/salaried practitioners' well-being and working conditions in which we surveyed all BDA member dentists in the community/public dental services in the UK. The response rate for this survey was 34 per cent
  - a series of questions asked under the Freedom of Information Act of all community/public dental services known to the BDA in the UK (104 services)
  - a survey of BDA Accredited Representatives who are community/salaried practitioners who represent the BDA in each organisation providing community/public dental services.

This research provides a bleak picture of the current experience of community dentist/salaried practitioners which is certainly not going to be improved by the restricted pay awards they will receive in 2015/16.

### Workforce data

- 6.5 We identified 104 community/public dental services and sent each a FOIA request. Some community dental services are community interest companies and are not obliged to respond to FOIA requests but the response rate was excellent with 88 services responding. We hope that, in the absence of proper workforce data from the NHS, this will help the DDRB have a better understanding of the structure of the workforce.

**Table 19 Number of community dentist/salaried practitioners/salaried practitioners in England and Wales**

	Headcount		WTE	
	N	%	N	%
Band A	561	40.6	363.3	38.5
Band B	474	34.3	325.5	34.5
Band C Managerial	88	6.4	77.7	8.2
Band C Specialist	100	7.2	70.8	7.5
Other dentist*	160	11.6	106.8	11.3
Total	1,383	100	944.2	100

*Note other dentist are largely likely to be those on hospital terms and conditions  
Source BDA FOIA of community/public dental services in 2014*

**Table 20 Number of community dentist/salaried practitioners/salaried practitioners in Scotland**

	Headcount		WTE	
	N	%	N	%
Dental Officer	155	65.7	111.5	63.0
Senior Dental Officer	51	21.6	41.9	23.7
Specialist Dental Officer	3	1.3	1.7	1.0
Assistant Clinical Director	3	1.3	2.7	1.5
Clinical Director or CADO	12	5.1	9.0	5.1
Other dentist	12	5.1	10.2	5.7
Total	236	100.0	176.9	100.0

**Source BDA FOIA of community/public dental services in 2014**

**Table 21 Number of community dentist/salaried practitioners/salaried practitioners in Northern Ireland**

	Headcount		WTE	
	N	%	N	%
Dental Officer	46	67.6	27.2	61.9
Senior Dental Officer	17	25.0	12.6	28.5
Assistant Clinical Director	2	2.9	1.2	2.7
Clinical Director	3	4.4	3.0	6.8
Other dentist	0	0.0	0.0	0.0
Total	68	100.0	44.0	100.0

Source BDA FOIA of community/public dental services in 2014

- 6.6 This gives a total UK workforce as a minimum of 1,687 staff and an estimated total of 1900 community dentist/salaried practitioners and salaried practitioners.
- 6.7 In the tables below, we present figures provided to us from our Freedom of Information Act request on the demographics of the community dental workforce.

**Table 22 Number (headcount) of male and female dentists currently employed by age in the UK**

	Total %		Column %
	Male	Female	Total
<25 years	0.1	0.8	0.9
25-34 years	4.8	13.8	18.6
35-44 years	7.9	22.0	29.9
45-54 years	9.6	19.8	29.4
55-64 years	6.3	12.3	18.6
65+ years	2.1	0.4	2.6
Total row %	30.8	69.2	100.0
Base N	423	949	1372

Source information from 74 services responding to the question in the BDA FOIA

**Table 23 Number (headcount) of male and female dentists currently employed by age in England and Wales**

	Total %		Total %
	Male	Female	
<25 years	0.2	0.6	0.8
25-34 years	5.4	14.2	19.6
35-44 years	8.5	22.3	30.8
45-54 years	9.1	18.6	27.7
55-64 years	6.7	11.4	18.1
65+ years	2.5	0.4	2.9
Total row %	32.3	67.7	100.0
Base N	366	766	1132

*Source Information from 61 services from the BDA FOIA 2014*

**Table 24 Number (headcount) of male and female dentists currently employed by age in Scotland**

	Male %	Female %	Total %
<25 years	0.0	2.3	2.3
25-34 years	2.3	15.4	17.7
35-44 years	5.1	19.4	24.6
45-54 years	13.1	24.0	37.1
55-64 years	4.6	12.6	17.1
65+ years	0.6	0.6	1.1
Sum%	25.7	74.3	100.0
Total N	45	130	

*Information from 9 services from the BDA FOIA 2014*

**Table 25 Number (headcount) of male and female dentists currently employed by age in Northern Ireland**

	Male %	Female %	Total %
<25 years	0.0	0.0	0.0
25-34 years	1.5	1.5	3.1
35-44 years	4.6	23.1	27.7
45-54 years	9.2	29.2	38.5
55-64 years	3.1	27.7	30.8
65+ years	0.0	0.0	0.0
Sum%	18.5	81.5	100.0
Total N	12	53	

Information from 4 services from the BDA FOIA 2014

- 6.8 Our FOIA research showed significant proportions of community dentist/salaried practitioners were at the top point of their pay band. This is worrying. It shows lack of input of younger staff and also a stagnant workforce.

**Table 26 Percentage of staff at the highest point of their pay grade England and Wales**

	At highest point on the pay scale	
	N	%
Band A	298	53.1
Band B	264	55.7
Band C Managerial	61	69.3
Band C Specialist	51	51.0
Other dentist	27	16.9
Total	701	50.7

Source FOIA 2014



**Table 27 Percentage of staff at the highest point of their pay grade Scotland**

	At highest point on the pay scale	
	N	%
Dental Officer	90	58.1
Senior Dental Officer	38	74.5
Specialist Dental Officer	0	0.0
Assistant Clinical Director	1	33.3
Clinical Director or CADO	7	58.3
Other dentist	3	25.0
Total	139	58.9

Source BDA FOIA 2014

**Table 28 Percentage of staff at the highest point of their pay grade Scotland**

	At highest point on the pay scale	
	N	%
Dental Officer	37	80.4
Senior Dental Officer	13	76.5
Assistant Clinical Director	0	0.0
Clinical Director	2	66.7
Total	52	76.5

Source BDA FOIA 2014

- 6.9 Given that current policy in England and Wales is to treat community dentist/salaried practitioners at the top of their pay scales differently from those that are not at the top it is important that the DDRB understand the relative proportions of these practitioners. These data show a worrying trend in the community dentist/salaried practitioner/salaried dentist workforce. Dentists are at the top of the pay scale and just soldiering on towards retirement. It is just not a healthy picture for a workforce that provides care for the most vulnerable in society.

### **Recruitment information**

- 6.10 We recognise that vacancy data is poor, but as this information is not collected centrally we have relied on our Freedom of Information Act request again to show recruitment figures.

**Table 29 Current number of vacant posts, vacant posts that were advertised in 2013/14 and vacant posts that were filled in 2013/14 in England and Wales**

	Current number of vacant posts		Vacant posts that were advertised in 2013/14		Vacant posts that were filled in 2013/14	
	N	% of current workforce	N	% of current workforce	N	% of advertised posts
Band A	30	5.3	90	16.0	89	98.9
Band B	24	5.1	35	7.4	29	82.9
Band C Managerial	4	4.5	6	6.8	6	100.0
Band C Specialist	6	6.0	13	13.0	13	100.0
Other dentist	22	13.8	12	7.5	15	125.0
Total	86	6.2	156	11.3	152	97.4

**Table 30 Current number of vacant posts, vacant posts that were advertised in 2013/14 and vacant posts that were filled in 2013/14 in Scotland**

	Current number of vacant posts		Vacant posts that were advertised in 2013/14		Vacant posts were filled in 2013/14	
	N	% of current workforce	N	% of current workforce	N	% of advertised posts
Dental Officer	3	1.9	7	4.5	5	71.4
Senior Dental Officer	4	7.8	3	5.9	3	100.0
Specialist Dental Officer	0	0.0	1	33.3	0	0.0
Assistant Clinical Director	0	0.0	0	0.0	0	-
Clinical Director or CADO	0	0.0	0	0.0	0	-
Other dentist	0	0.0	1	8.3	1	100.0
Total	7	3.0	12	5.1	9	75.0

**Table 31 Current number of vacant posts, vacant posts that were advertised in 2013/14 and vacant posts that were filled in 2013/14 in Northern Ireland**

	Current number of vacant posts		Vacant posts that were advertised in 2013/14		Vacant posts were filled in 2013/14	
	N	% of current workforce	N	% of current workforce	N	% of advertised posts
Dental Officer	0	0.0	5	10.9	5	100.0
Senior Dental officer	0	0.0	1	5.9	1	100.0
Assistant Clinical Director	0	0.0	0	0.0	0	-
Clinical Director	0	0.0	0	0.0	0	-
Other dentist	0	-	0	-	0	-
Total	0	0.0	6	8.8	6	100.0

Source: FOIA 2014

- 6.11 From the above information it appears that there is a problem with recruitment to Band B posts in England and Wales.
- 6.12 Our survey of BDA member Foundation Dentists showed that very few saw the community dental services as a viable career, with only 3.7 per cent of respondents finding a post in community dental services after training. To ensure the long-term sustainability of the service it needs to recruit young dentists and provide comparable rewards to those received by dentists in other parts of the profession and other professions in the health service.
- 6.13 The BDA's *Survey of Community dentist/salaried practitioners' Well-being and Working Conditions* suggests that working conditions are poor. Forty seven per cent of respondents reported having to cover for absent colleagues usually or always. This suggests that absence rates are high as stress and burnout take their toll.

## Retention of community dentist/salaried practitioners

6.14 The table below shows the percentage of temporary positions at each grade.

**Table 32: Percentage of services employing staff in temporary positions, by number of positions and grade in England and Wales**

	In a permanent post		In a temporary post	
	N	% of total workforce	N	% of total workforce
<b>Band A</b>	513	91.4	43	7.7
<b>Band B</b>	450	94.9	25	5.3
<b>Band C Managerial</b>	91	103.4	4	4.5
<b>Band C Specialist</b>	89	89.0	10	10.0
<b>Other dentist</b>	111	69.4	53	33.1
<b>Total</b>	1,254	90.7	135	9.8

Source BDA FOIA 2014

**Table 33: Percentage of services employing staff in temporary positions, by number of positions and grade in Scotland**

	In a permanent post		In a temporary post	
	N	% of total workforce	N	% of total workforce
<b>Dental Officer</b>	152	98.1	0	0.0
<b>Senior Dental Officer</b>	50	98.0	0	0.0
<b>Specialist Dental Officer</b>	3	100.0	0	0.0
<b>Assistant Clinical Director</b>	3	100.0	0	0.0
<b>Clinical Director or CADO</b>	12	100.0	0	0.0
<b>Other dentist</b>	3	25.0	0	0.0
<b>Total</b>	223	94.5	0	0.0

Source BDA FOIA

**Table 34: Percentage of services employing staff in temporary positions, by number of positions and grade in Northern Ireland**

	In a permanent post		In a temporary post	
	N	% of total workforce	N	% of total workforce
<b>Dental Officer</b>	41	89.1	0	0
<b>Senior Dental Officer</b>	15	88.2	0	0
<b>Assistant Clinical Director</b>	1	50.0	0	0
<b>Clinical Director</b>	3	100.0	0	0
<b>Total</b>	60	88.2	0	0

Source: BDA FOIA 2014

- 6.15 Given that those in the community services have ranked job security as important to their motivation, it is very concerning that so many posts are temporary. A reliance on temporary posts will not improve morale and may damage motivation.

#### **Workload and referrals into the service**

- 6.16 As the oral health needs of the UK population change, the demands on the community dental service increase. Our survey of our 98 Accredited Representatives (ARs) showed an almost universal rise in referrals into the service.

**Table 35 “Over the past year, has the number of patient referrals into your service...”**

Has number of patient referrals....	N	Column percentages
Increased?	54	79
Stayed the same?	4	6
Decreased?	2	3
Don't know	8	12
Total	68	100

Source BDA AR survey 2014

- 6.17 ARs were asked for the reasons for the increase in referrals. Common reasons were greater numbers of older patients with complex needs, increasing numbers of children with high levels of disease being referred into the service, growing migrant populations with high levels of disease as well as local factors such as referral centres, changing policies of dental hospitals. As the UK population changes the need for a strong, motivated workforce in the community dental services will become more acute.

## Morale and well-being of community dentist/salaried practitioners

- 6.18 The BDA's *Survey of Community dentist/salaried practitioners' Well-being and Working Conditions 2014* found that they felt their service was failing to provide enough support to deliver all the care required. With insufficient staff, insufficient time, insufficient involvement of staff in decisions and insufficient opportunities to progress, it is little wonder that a substantial proportion of staff have little confidence in their services.

**Table 36: Level of agreement with statement: "My service is meeting the needs of patients"**

My service meets the needs of patients	N	Percentage of responses
Strongly disagree	41	8.9
Somewhat disagree	98	21.3
Neither agree or disagree	51	11.1
Somewhat agree	173	37.5
Strongly agree	97	21.0
Don't know	1	2
Total	461	100
Missing	20	

Source: BDA's *Survey of Community dentist/salaried practitioners' Well-being and Working Conditions 2014*

- 6.19 Over 30 per cent of respondents do not agree that their service is meeting the needs of their patients. For a profession whose main motivating factor was shown to be patient care, this is deeply frustrating and demoralising. The pay award for 2014/15 caused considerable upset in the profession and it is no wonder that this group feel undervalued and that so many reported low levels of job satisfaction.

**Table 37 Response to the question "How satisfied or dissatisfied you are with your present job overall?"**

	N	Column percentage
High job satisfaction	225	47.5
Neither low nor high job satisfaction	30	6.3
Low job satisfaction	218	46.0
Don't know/would prefer not to say	1	.2
Total	474	100.0
Missing cases	7	

Forty eight per cent of respondents reported being satisfied with their job, while 46 per cent were dissatisfied. This dedication and continued efforts by the profession to put patients at the heart of services should be recognised and reflected in pay.

- 6.20 Dentists' satisfaction with the service is low. More dentists will be required and we are concerned that if conditions and satisfaction do not improve, the service will not be in a fit state to meet demand for care from an ageing population in the future. Morale across the UK was reported as very low and stress as very high:

**Table 38 Self-rated levels of morale of community dentist/salaried practitioners in the UK**

Self-rated morale	N	Column percentage
Very high	21	4.4
High	88	18.6
Neither low nor high	148	31.3
Low	136	28.8
Very low	80	16.9
Total	473	100.0
Missing values	8	

Source: BDA's Survey of Community dentist/salaried practitioners' Well-being and Working Conditions 2014

- 6.21 Over 45 per cent of respondents rate their morale as low or very low. This is concerning and something must be done to improve morale in the community dental services. It cannot be the aim of the government for clinical care to be delivered by a workforce with this level of low morale.

**Table 39 Levels of stress in the community/public dental services in the UK**

	Frequency	Percentage
Not at all stressful	6	1.3
Mildly stressful	74	15.8
Moderately stressful	204	43.5
Very stressful	127	27.1
Extremely stressful	56	11.9
Would prefer not to say	2	4
Total	469	100.0

Source: BDA's Survey of Community dentist/salaried practitioners' Well-being and Working Conditions 2014

6.22 39 per cent of respondents reported that their job as a community dentist/salaried practitioner was very stressful or extremely stressful. This was an increase of two per cent on last year. These figures compare with estimates of 15 per cent of workers in the British working population (HSE, 2012). That is, community dentist/salaried practitioners are over twice as likely to report high levels of job stressfulness compared with all other employees.

6.23 This year we asked community dentist/salaried practitioners questions devised by the Health and Safety Executive “HSE measure of psycho-social working conditions” (source: HSE, 2007, 2010). These questions fell into seven management standards:

- **Demands** made of workers including issues such as workload, work patterns and the work environment
- **Control** exercised by workers, including how much say the worker has in the way they do their work.
- **Support** given to workers, including the encouragement, sponsorship and resources provided by the organisation, line **management** and colleagues.
- **Relationships** with and between workers, including promoting a positive working environment to avoid conflict and dealing with unacceptable behaviour such as bullying.
- **Role** certainty among workers. Whether all workers at every level understand their role within the organisation and whether the organisation ensures they do not have conflicting roles.
- **Change** to the conditions of workers. How organisational change (large or small) is managed and communicated within the organisation

6.24 The answers to the questions are used to produce a numerical score between one and five which gives the higher to lower risk factor for occupational stress. We compared the scores for community dentist/salaried practitioners/salaried practitioners with the latest available figures for the UK population.

**Summary: descriptive statistics for the 7-factor 35-item HSE Management Standards Indicator tool. Salaried dentists compared with GB workers**

	Demands*	Control	Management support	Peer support	Relationships	Role	Change	Overall
Salaried dentists (2014)	2.81	2.92	2.91	3.41	3.38	3.84	2.6	3.1
Working population GB (Mean) (2010)	3.55-3.60	3.35	3.75	3.95-4.00	4.15-4.20	4.70-4.75	3.5-3.6	

6.25 We then put our results for community dentist/salaried practitioners/salaried practitioners into the HSE tool that helps organisations look at where action is needed to reduce workplace stress. As can be seen below, five out of seven areas require urgent action with the remaining two showing clear room for improvement.







Results using HSE Analysis tool – using HSE 2004 population data as comparison

	Your Results	Suggested Interim Target	Suggested Longer Term Target
Demands	2.81	3.13	4.25
Control	2.92	3.33	4.33
Managers' Support	2.91	3.60	4.60
Peer Support	3.41	3.75	4.75
Relationships	3.38	4.00	4.75
Role	3.84	4.60	5.00
Change	2.57	3.33	4.00

Note: 2004 population data are built into the HSE management tool – the most recent population data on working conditions is from 2010

Key:

Data-set: Psychosocial Working Conditions in Britain in 2004

	<b>Doing very well - need to maintain performance</b> Represents those at, above or close to the 80th percentile <sup>†</sup>
	<b>Good, but need for improvement</b> Represents those better than average but not yet at, above or close to the 80th percentile <sup>†</sup>
	<b>Clear need for improvement</b> Represents those likely to be below average but not below the 20th percentile <sup>†</sup>
	<b>Urgent action needed</b> Represents those below the 20th percentile <sup>†</sup>

6.26 A highly stressed, de-motivated workforce with low morale is not in anyone's interests and we urge the health departments and health services to take urgent action to relieve the burden on community dentist/salaried practitioners. As well as reporting low morale and high levels of stress, those in the community/public dental services also displayed a lower wellbeing score and greater

anxiety than the general population. The table below shows the self-reported wellbeing of those in the community dental services. The general populations' wellbeing, as reported by the Office of National Statistics, is in brackets.

6.27 We asked community dentist/salaried practitioners four questions about their wellbeing as follows:

- **Overall, how satisfied are you with your life nowadays?**  
*Please indicate your response on the scale below ranging between 0 (Not at all satisfied) and 10 (Completely satisfied)*
- **Overall, to what extent do you feel the things you do in your life are worthwhile?**  
*Please indicate your response on the scale below ranging between 0 (Not at all worthwhile) and 10 (Completely worthwhile)*
- **Overall, how happy did you feel yesterday?**  
*Please indicate your response on the scale below ranging between 0 (Not at all happy) and 10 (Completely happy)*
- **Overall, how anxious did you feel yesterday?**  
*Please indicate your response on the scale below ranging between 0 (Not at all anxious) and 10 (Completely anxious)*

6.28 The community dentist/salaried practitioners/salaried practitioners responding to our survey were less happy and more anxious than the general population. Table 39 below shows the distribution of responses for community/public dental services. The average rating is given and the average rating for the UK population is shown in brackets.

**Table 40 responses to well-being questions**

	Very low (0-4)	Low (5-6)	Medium (7-8)	High (9-10)	Average (mean)	Base N
Life satisfaction	22.2	24.8	40.8	12.2	6.1 (7.4)	468
Life worthwhile	15.5	18.9	42.9	22.7	6.8 (7.7)	466
Happy yesterday	23.3	21.6	36.8	18.4	6.3 (7.3)	468
	Very high (6-10)	High (4-5)	Medium (2-3)	Low (0-1)		
Anxious yesterday	34.5	20.8	23.3	21.4	4.1 (3.1)	467

Source: BDA's Survey of Community dentist/salaried practitioners' Well-being and Working Conditions 2014

6.29 It is clear that those in the community/public dental services continue to report a lower level of wellbeing and greater levels of anxiety than the general population. If the service is to continue to be able to offer care to the most vulnerable in our society, greater investment in its staff is required. To ensure that staff are motivated and in a position to continue to offer care to their patients, more has to be done to safeguard their well-being.

## The Public Dental Services in Scotland

- 6.30 Since the inception of the new Public Dental Service (PDS) in Scotland, the Scottish Government has failed to provide any strategic context for the service which outlines for practitioners the role and function of the service.
- 6.31 The new PDS was established with effect from 1<sup>st</sup> April 2013 and over a year later the Scottish Government has failed to publish their long awaited PDS "Strategy" or the Prison Dental Service Framework paper which was consulted on in June 2013.
- 6.32 For salaried practitioners in Scotland, the Scottish Government has made little progress in outlining the training and development pathways to support recruitment and retention of dentists, there is no clear or consistent information on funding of the service.
- 6.33 In addition, salaried practitioners within the PDS are required, as a result of the new arrangements to submit their clinical activity information through the existing Statement of Dental Remuneration (SDR) which is wholly designed for the purposes of remunerating independent general dental practitioners is in large part unsuitable for specialist dentistry. A national Working Group set up by Scottish Government at the request of the BDA to resolve issues relating to the SDR subsequently collapsed at its first meeting. The lack of progress on the issues relating to the operational administration of the new PDS, and the inappropriate use of systems and recording mechanisms designed primarily for independent GDPs, has had a major impact on the morale and motivation of salaried dentists in Scotland. This flawed approach to capturing robust clinical information has an adverse effect on the meaningful use of appraisal systems and the ability of practitioners to achieve progression through the grades.
- 6.34 The lack of direction in defining the role of the new PDS has resulted in confusion whether the service should provide primary care general dentistry or targeted specialised services or both. This has resulted in plans being taken forward by some NHS Boards for the planned closure of some PDS clinics, reducing access for patients in local communities and withdrawing services to regional 'hubs'.
- 6.35 Owing to the lack of a Scottish Government strategy, financial planning and leadership for the new PDS, many NHS Boards plans often involving clinic closures, appear to be driven by financial expediency rather than service quality and access to care.

### Recruitment, Retention and Training of Salaried Dentists

- 6.36 The lack of clarity on the role and function of the new PDS is having a serious impact on dentist morale and motivation. In many areas of Scotland, dental officer posts are being designed on the basis of short term, often one year appointments, as NHS Boards effect the transfer of large numbers of patients from the salaried service to local independent GDPs.
- 6.37 The confusion over role, funding and a de facto recruitment freeze with all posts requiring Scottish Government approval, combined with lack of a clearly defined training pathway can only continue to have a serious and damaging impact on the recruitment of new staff and the morale and retention of existing staff. The uncertain future of the DF2 training, limited specialised training and a lack of a specialist training pathway is extremely detrimental to the future of the service.
- 6.38 The PDS in Scotland has an adverse age profile with many of the current specialists are coming to the end of their careers. The ageing workforce coupled with the lack of specialist training programmes in a variety of specialties, including Special Care Dentistry, has the potential to create a workforce skills crisis, which in turn will have a major effect on the recruitment, motivation and retention of dental practitioners.

## **Contractual changes in Northern Ireland**

- 6.38 Negotiations are continuing on a revised contract for community dentist/salaried practitioners in Northern Ireland.

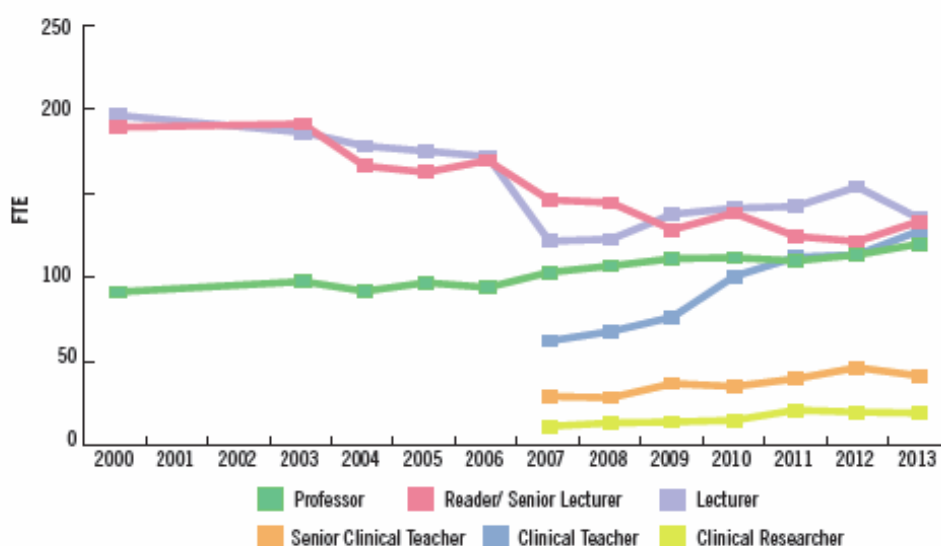
## **Recommendations for community dentists/salaried practitioners**

- 6.39 We ask DDRB to make a strong statement in its report about the decision of governments not to award a consolidated pay rise to community dentists/salaried practitioners instead of a one per cent rise. This decision will not help to recruit, retain or motivate community dentist/salaried practitioners who are facing mounting work pressures that are affecting their wellbeing.
- 6.40 If the DDRB is asked to make a recommendation for salaried practitioners in Scotland we recommend an increase of 3 per cent to ensure their income keeps pace with inflation.

## 7. Clinical academic staff

- 7.1 There has been an increase in the total number of clinical academic posts, but that must be set in the context of the recent creation of three new dental schools. However there has been a decline in the number of research-active and ‘traditional’ academic posts which have declined by 11 per cent since 2006. Some of these research posts have been replaced by “learning and scholarship contracts” that do not require research to be performed. This is partly due to the Research Excellence Framework (REF) where schools are being strategic to improve their ranking.
- 7.2 The relatively low pay and many years of training of clinical academic staff are continuing to have an effect on recruitment. Research active staff are vital for the UK to continue to achieve excellence in oral and dental research. Over 80 per cent of dental schools have voiced concerns regarding a national shortage of suitably qualified applicants for senior clinical academic appointments across a range of specialities.

**Figure 7 Timeline of clinical academic staffing levels by academic grade since 2000 (FTE)**



**Table 41 Vacant posts by academic grade**

	FTE clinical academic dentists	FTE vacancies	Total available posts	Reported vacancies as a percentage of total available FTE posts
Professor	119.5	2.0	121.5	1.6%
Reader/Senior Lecturer	132.9	20.2	153.1	13.2%
Lecturer	134.9	8.6	143.4	6.0%
<b>Total (P+SL+L)</b>	<b>387.3</b>	<b>30.8</b>	<b>418.1</b>	<b>7.4%</b>
Senior Clinical Teacher	41.2	1.6	42.8	3.7%
Clinical Teacher	127.2	6.2	133.5	4.7%
Clinical Researcher	19.0	0.8	19.8	4.2%
<b>Total (SCT+CT+R)</b>	<b>187.4</b>	<b>8.7</b>	<b>196.0</b>	<b>4.4%</b>
<b>Grand Total (all grades)</b>	<b>574.7</b>	<b>39.4</b>	<b>614.1</b>	<b>6.4%</b>

*This table and figure are taken from: ‘A survey of staffing levels of clinical academic dentists in UK dental schools as at 31 July 2013’ A report of Dental Schools Council May 2014.*