British Dental Association

Evidence to

The Doctors’ and Dentists’ Review Body

Northern Ireland

October 2011
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Executive Summary

- At the time of writing DHSSPS has indicated a pay award of 0.5% to item of service fees for the GDS for 2011/12. This comes on top of the very disappointing pay settlement from DHSSPS NI of 2010/11 of 0.5 per cent, a fraction of the DDRB recommendation of 1.44%.

- The BDA remains disappointed by the Government’s decision not to require the Review Body to provide evidence on expenses for dentists in Northern Ireland, or to report on contract values for two years for England and Wales.

- Morale and motivation continue to diminish among general dental practitioners. These are particularly low among those with high HS commitments. This downward trend in morale and motivation has been noted for the last 2 years throughout the UK in our evidence.

- Evidence collected through the BDA’s Dental Business Trends Survey shows that many practices with high HS commitments continue to have trouble recruiting staff and that levels of recruitment are low.

- Staffing levels in the salaried service continues to be a problem, putting more pressure on an already stretched service.

- Morale levels in both general dental practice and salaried dental practice is decreasing.

1. Introduction

1.1 Parameters of the evidence

1.1.1 The British Dental Association (BDA) provides this written evidence to the Doctors’ and Dentists’ Review Body (DDRB) to ensure that it has up-to-date information on morale, motivation, recruitment and retention in primary care dentistry in Northern Ireland in both the salaried sector and the general dental services.

1.1.2 This evidence applies to Northern Ireland only. We are providing evidence for England, Wales and Scotland separately. The evidence is submitted on behalf of dentists providing services on behalf of the Health Service (HS) in Northern Ireland and covers:

- Dentists in vocational training
- General Dental Services
- Salaried Primary Dental Care Services

1.1.3 The British Medical Association (BMA) submits evidence on behalf of all hospital medical and dental staff. We ask DDRB to note that the issues raised by the BMA are applicable to those working in the hospital dental services.
1.2 Outcome of 2010/11 pay uplift for Northern Ireland and 2011-12 Pay discussions with the Department of Health Social Services and Public Safety

1.2.1 The profession is very concerned about the outturn of the pay settlement for 2010/11. In 2010/11 the DDRB used the recognised formula-based approach to take into account the increases in operating costs for dentists, in order to make an informed pay award. For 2010/11 DDRB recommended an increase of 1.44 per cent in order to deliver a zero increase in net income for GDPs. DDRB recommended that DHSSPS Northern Ireland should increase fees by 1.44 per cent, if they did not have sufficient evidence to enable them to make adjustments to the fee scales to account for expenses. DHSSPS did not take the approach recommended by DDRB and instead applied an uplift of 0.5049 per cent (0.9 per cent award x 56.1 per cent) for GDPs in Northern Ireland. What DHSSPS did was apply an efficiency saving to the award, bringing it to 0.9 per cent and then applied a further expenses to earnings ratio of 56.1 per cent, leading to an uplift of 0.5049 per cent. DDRB have written to Michael McGimpsey as part of the DDRB monitoring round to advise that DDRB does not think this approach appropriate as their recommendation already took account of an expenses to earnings ratio of 51.5 per cent. The approach taken by DHSSPS has had the effect of requiring GDPs in Northern Ireland to make greater efficiency savings in their expenses in order to maintain their levels of net income, than is the case in other parts of the UK. This situation is not acceptable for GDPs in Northern Ireland and the result is the further application of stress and demotivation in an already difficult business environment.

1.2.2 Further to the settlement of 2010/11, there still has been an offer from DHSSPS of an award of 0.5% to items of service. DHSSPS assert that this is to cover the pay award for DCP staff earning less than £21,000. It goes no way to meeting the additional increased expenses for the 2011/12 period. BDA submitted expense evidence directly to DHSSPS in April 2011. The evidence can be found in annex 4. This state of affairs is very damaging to the morale of general dental practitioners in Northern Ireland.

1.2.3 The Minister of Health in Scotland has written to DDRB seeking their recommendations in relation to dental practice expenses in Scotland, setting out that the system in Scotland is different from England and has not been considered by DDRB in depth for some time. BDA would assert that the same applies in Northern Ireland and that DDRB should make recommendations to DHSSPS in respect of dental practice expenses in Northern Ireland.

1.2.4 The Salaried Primary Care Dental services were very disappointed by the application of a pay freeze to their services. Those working in the service already feel unfairly under-remunerated in comparison to colleagues in England Wales and the continuation of a pay freeze and the absence of a new contract has further exacerbated problems of low morale.
2. **General Dental Practice**

### Key points

- Morale and motivation is low. Almost half of dentists with 75 per cent or more HS commitment regard their morale as low or very low. It is worst among those with greater HS commitments.

- Pressures of work volume and excessive administration and increasing bureaucracy are the main causes of low and reducing morale.

- Our survey showed that whilst dentists may wish to reduce their reliance on the health service, the economic circumstances have an effect on whether this is actually possible.

- Practices continue to experience problems with recruiting dentists, with those seeking work demonstrating a preference for private work and many practices are choosing not to recruit at present.

- The amount of time spent on administration is increasing.

- Access to Occupational Health Services from November 2011 for GDS dentists and staff is a welcome move for this sector.

- Increases in the expenses elements which are unmet through the payment system are the most significant factor which impacts negatively on how dentists view their role in dental practice now and in the future.
2.1 Motivation and morale

2.1.1 The BDA repeated last year’s focus groups of general dental practitioners following their positive reception by the profession in Northern Ireland. They help provide more detailed and first hand information about the issues that face general dental practitioners. The BDA also conducted its annual Dental Business Trends Survey (DBTS). A report on the focus groups can be found at annex 1, and the DBTS can be found at annex 2.

2.1.2 Motivation and morale continue to be very low in general dental practice. Over 45 per cent of respondents to DBTS in Northern Ireland said their morale was low or very low.

Graph 1: Self-reported morale among general dental practitioners in Northern Ireland (source DBTS)

2.1.3 A paper entitled ‘Burnout and engagement in relation with job demands and resources among dental staff in Northern Ireland’ Gorter and Freeman 2010 investigated the psychological health – in particular, levels of burnout and engagement, job demands, job resources, and general psychological distress – among dental staff in the Western Health and Social Care Board Area of Northern Ireland. The paper concluded that burnout is a serious threat for the dental team in this area of Northern Ireland, especially among general dental practitioners. One-quarter of the dentists were categorised as having a serious burnout risk. Dentists appeared to have the most trouble with the work environment aspects: time pressure and financial worries. Furthermore, the proportion of those suffering from psychological distress was unusually high. In contrast to these findings, encouraging levels of engagement were identified.

2.1.4 This scientific study demonstrates that feelings of being emotionally depleted and suffering from work related stress is highly prevalent amongst dental practitioners in

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1 All references to levels of commitment to the HS are made through self-reported individual income.
this area of Northern Ireland. These issues are very real for dentists and are undoubtedly compounded by their status as business persons who have a commitment to their patients. The study describes the findings in Northern Ireland as unfavourable and alarming when compared with Dutch or other UK dentists.

2.1.5 The study was published in 2010 and the evidence provided to BDA by dentists in Northern Ireland demonstrates that levels of motivation and morale are at lower levels now than in 2010.

2.1.6 The table below shows the specific burdens of dentists in Northern Ireland with an HS commitment of over 75 per cent:

Table 1: Workplace demands in Northern Ireland among dentists with over 75% HS commitment (Source DBTS). Percentages are of the total number of respondents, who could pick as many options as were considered relevant.

<table>
<thead>
<tr>
<th>Workplace demands</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rise in expenses</td>
<td>76.70%</td>
</tr>
<tr>
<td>RQIA</td>
<td>71.80%</td>
</tr>
<tr>
<td>Excessive administration</td>
<td>71.20%</td>
</tr>
<tr>
<td>Decontamination requirements</td>
<td>55.20%</td>
</tr>
<tr>
<td>Lack of time for prevention</td>
<td>39.90%</td>
</tr>
<tr>
<td>Lack of time for quality</td>
<td>38.70%</td>
</tr>
<tr>
<td>Difficulties recruiting staff</td>
<td>26.40%</td>
</tr>
<tr>
<td>Too many patients/long waiting lists</td>
<td>16.60%</td>
</tr>
<tr>
<td>Lack of patients</td>
<td>12.30%</td>
</tr>
</tbody>
</table>

2.1.7 It is clear that regulatory requirements (RQIA, decontamination and the concomitant time taken for administration) are the main causes of additional work demands among the profession. The rising cost of providing care and expense elements of dental practice is also a problem.
2.1.8 The Practice Owner Focus Group Survey supported the DBT’s findings that morale was at a very low point and the problems with increased regulation and meeting additional governance requirements were identified.

“All the regulation and bureaucracy, coupled with all the economic changes that have been have made me feel stressed out.”

2.1.9 The table below shows the job satisfaction of dentists in Northern Ireland to dentistry with an HS commitment of over 75 per cent. More dentists agree that being a dentist a source of frustration rather than one of satisfaction. Most would not recommend dentistry as a career, but are satisfied with the level of care they provide and are currently satisfied with being a dentist. The low morale experienced by dentists is not, therefore, caused by the career choice, but rather by the combination of the business environment in which dentists work and the demands it places upon them which are additional to their primary role of patient care.

Graph 2: Job satisfaction in Northern Ireland of dentists with over 75% HS commitment (Source DBTS)
2.1.10 The DBTS also asks questions about satisfaction with pay and conditions. The table below provides the results for those working in Northern Ireland with an HS commitment of over 75 per cent. The responses below show a general dissatisfaction in all areas. Pressure to meet targets is, however, the greatest burden, while satisfaction with autonomy is the least problematic though by no means satisfactory.

Table 2: Satisfaction with pay and conditions in Northern Ireland among dentists with over 75% HS commitment (figures from 2010 are in brackets) (Source DBTS)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with my pay</td>
<td>0% (2.9%)</td>
<td>28.6% (30.4%)</td>
<td>25% (20.3%)</td>
<td>33.3% (36.2%)</td>
</tr>
<tr>
<td>I am satisfied with the level of autonomy in my job</td>
<td>1.2% (1.4%)</td>
<td>21.7% (36.2%)</td>
<td>37.3% (27.5%)</td>
<td>30.1% (30.4%)</td>
</tr>
<tr>
<td>I feel under pressure to achieve targets</td>
<td>17.9% (14.7%)</td>
<td>41.7% (42.6%)</td>
<td>23.8% (23.5%)</td>
<td>16.7% (17.6%)</td>
</tr>
<tr>
<td>I am happy with the hours I work</td>
<td>6% (11.6%)</td>
<td>40.5% (36.2%)</td>
<td>15.5% (15.9%)</td>
<td>27.4% (33.3%)</td>
</tr>
</tbody>
</table>

2.1.7 The morale and motivation of general dental practitioners continues to deteriorate. Over 96 per cent of respondents to the DBTS with an HS commitment of over 75 per cent reported that their morale had either remained the same or deteriorated. 19 per cent rated their morale as substantially lower. When these survey results are considered together with the results of the Gorter and Freeman scientific study 2010, the picture is one of a work environment driven by time pressures and financial worries, resulting in the deterioration of morale. The data suggests that if dentists were freed and resourced with sufficient time to provide the care they are contracted to do, morale would be higher. It is the bureaucracy, time pressures and administrative requirements that are the greatest burden and that are having the most negative impact on morale.
2.2 Recruitment and retention

2.2.1 Vocational dental practitioners

2.2.1.1 The BDA’s latest UK wide VDP survey carried out in July shows that 97 per cent of VDPs plan to work in dentistry in the UK once they have finished their training. 83 per cent of those who planned to work in dentistry in the UK had found a post and of these 27 per cent found the process fairly or very difficult. This is compared to 22 per cent in 2010.

2.2.2 Associates and other dental professionals

2.2.2.1 According to data from the DBTS there has been a slow-down in recruitment of dentists to dental practices, with over 85 per cent of practices not currently recruiting for HS roles. Of the practices that did recruit almost 54 per cent reported some problems with recruiting dentists into HS work. UK wide practices continued to report difficulties recruiting dental nurses, hygienists and therapists. 62 per cent of practices reported some problem recruiting a nurse and almost 35 per cent report a problem recruiting a hygienist or therapist.

2.2.3 Private and HS dentistry

2.2.3.1 As last year there is a clear indication that private dentistry presents a more attractive work proposition than HS dentistry, with the majority indicating that they intend to increase the amount of private work they do, even in these straightened economic times. Even if these intentions are not fulfilled it is clear that the majority of dentists rate working in the private sector above working in the health service arrangements.

Table 3: Intentions to increase type of work or retire in Northern Ireland (any amount of HS commitment) (Source DBTS)

<table>
<thead>
<tr>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing private work</td>
</tr>
<tr>
<td>Increasing HS</td>
</tr>
<tr>
<td>Planning to retire</td>
</tr>
</tbody>
</table>

2.2.4 Workload and working hours
2.2.4.1 The amount of clinical work being undertaken by dentists with 75 per cent plus HS commitment has dropped slightly according to the DBTS. This is in contrast to the increasing amount of time being spent on administration:

Table 4: Time spent on clinical dentistry and administration in Northern Ireland among dentists with over 75% HS commitment (Source DBTS)

<table>
<thead>
<tr>
<th>Hours spent performing clinical dentistry</th>
<th>Increased substantially</th>
<th>Increased somewhat</th>
<th>Stayed the same</th>
<th>Decreased somewhat</th>
<th>Decreased substantially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours spent on dental administration</td>
<td>3.6%</td>
<td>8.3%</td>
<td>70.2%</td>
<td>11.9%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>29.8%</td>
<td>33.3%</td>
<td>35.7%</td>
<td>1.2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2.2.4.2 Our evidence shows that most administrative work falls to practice owners and they have reported a sharp increase in the amount of administration required. Associates also reported an increase in the amount of administration required of them.

Table 5: Levels of administration among practice owners and associates in Northern Ireland (any amount of HS commitment) (Source DBTS)

<table>
<thead>
<tr>
<th>Practice Owners</th>
<th>Increased substantially</th>
<th>Increased somewhat</th>
<th>Stayed the same</th>
<th>Decreased somewhat</th>
<th>Decreased substantially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Owners</td>
<td>51.5%</td>
<td>35.4%</td>
<td>12.1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Associates</td>
<td>3.5%</td>
<td>26.3%</td>
<td>70.2%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2.3 Conclusion

2.3.1 The morale and motivation among GDPs is low and getting lower. The main causes are an increase in administration and the rise in expenses. Our evidence suggests that dentists are comfortable with the job role of dentist but and that if they were freed up to focus on clinical commitments then motivation and morale would be higher. The BDA strongly recommends that urgent action is taken to relieve the pressures on dentists to improve morale and safeguard numbers in the profession for patient care.

2.3.2 At the time of writing, DHSSPS has just indicated that from 1 November 2011 Occupational Health Services are to be extended to provide access to general dental practitioners and their staff. This is a very welcome development for the dental profession and staff providing general dental services.
3. **Salaried Primary Care Dental Services**

### Key points
- Levels of recruitment remain low leading to increased workloads
- Morale and motivation is deteriorating
- The main causes were identified as low pay and increasing workloads
- There is a need to progress on a new contract for salaried primary care dentists
- Concerns were raised about levels of administration

### 3.1 Introduction

3.1.1 This section presents information about the recruitment, retention, morale and motivation of dentists in the salaried primary care dental services in Northern Ireland. The continued application of the Government’s pay freeze for those earning over £21,000 is disappointing.

3.1.2 The Salaried Primary Care Dental Service, often referred to as the Community Dental Service, is a small, highly specialised service, based in Trusts, which provides dental care to people with special needs. People who use this service are the most vulnerable in our society, and do so because they are unable to have their dental needs met through general dental practice. People with special needs include those with learning disabilities, complex medical conditions, significant mental illness and excessive dental phobia. Special needs patients have complex and often urgent dental needs.

3.1.3 The Community Dental Service has a highly skilled and dedicated workforce of dentists and dental care professionals who provide comprehensive dental services including day case IV sedation and General Anaesthetic services in hospitals throughout all trusts. The Community Dental Service in Northern Ireland employs the equivalent of around 67 full time dentists and a cohort of dental care professionals.

3.1.4 The fastest growing area for this service is the provision of domiciliary care for frail, dependant older people living in residential and nursing homes. As our population becomes older, they are retaining their natural dentition and this makes their dental care more challenging due to the deterioration in their general health. This must be accounted for in any future planning of Community Dental Services.

3.1.5 Savings derived at Health and Social Care Trust are already having a significant impact on the Community Dental Service, often resulting directly or indirectly in a reduction in frontline services. The BDA is extremely concerned about the resources available to the Community Dental Service as the impact this has on the morale of the staff in the service.
3.1.6 The BDA strongly supports the recommendations of the Bamford Review Action Plan to establish regional Consultants in Special Care Dentistry. At present there are a group of special needs patients, with highly complex needs, who are unsuitable for day case general anaesthetic services in local acute hospitals. A Consultant led regional inpatient dental service is urgently required to allow these special needs patients equal access to dental care. The absence of Consultants in Special Care Dentistry in Northern Ireland places the service at a disadvantage and demotivates dental staff by relying on them to cater for the needs of these patients.

3.1.7 The salaried services provide excellent care to the most vulnerable patients but have been experiencing problems recruiting staff members where jobs have become available. If pay is not competitive then provision of services for the most vulnerable will decline and those dentists who remain in salaried service positions will become busier and suffer from even lower morale.

3.2 Recruitment and retention

3.2.1 As in the rest of the UK, resources in Northern Ireland for the salaried services are scarce. This has an effect on the levels of recruitment into the service and the workloads of those who remain in the service. The BDA received several comments from salaried dentists in Northern Ireland in our Salaried Services Morale Survey that reported a lack of resources.

3.2.2 DDRB in both its 2009 and 2010 reports has noted that consideration of new contractual arrangements for this group of staff should be given priority as salaried dentists are the last group of staff within the remit of DDRB to receive modernised terms and conditions. The 2010 report noted its disappointment to hear of the latest delays. To date the situation is experiencing slow progress and whilst BDA is hopeful of progress this poses continued recruitment problems for Northern Ireland where the salary scales and allowance for training are more attractive elsewhere in the UK.

3.3 Motivation and morale

3.3.1 The BDA conducted a survey on the morale of dentists working in the salaried primary care dental services (annex 3). The main findings of the report are included here. This builds on last year’s survey and shows a considerable drop in morale among those working in the service. The main causes of low morale were low pay and increased workload resulting in financial pressure and stress.

3.3.2 More than half (58 per cent) of the respondents stated that their morale was low or very low. Only 13 per cent of respondents stated that their morale was high. Over 70 per cent felt that their morale had decreased in the last year.
3.3.3 The biggest issues affecting morale were the uncertainty surrounding the Community Dental Service as well as pressure within the wider Health and Social care services. Other major factors affecting morale were inadequate staffing levels, increased administrative burdens and the need to have modernisation of the estate from which many staff worked.

“Increased workload, less staff, insignificant pay award, no increase in mileage expenses despite huge increase in cost of fuel. More difficult patients i.e. more elderly and more medically compromised.”

3.3.4 60 per cent of respondents from Northern Ireland to our UK wide survey were dissatisfied or very dissatisfied with the leadership and management within the SPDCS. Only five per cent were very satisfied.

3.3.5 Participants stated that the biggest improvement to their working life would be to have adequate levels of staff across the service; recognised time for administration; better leadership within the service; and, a period of stability with the service.

3.4 Conclusions and recommendations

3.4.1 Staffing and recruitment – There are serious problems with the recruitment of dentists and dental care professionals to the salaried primary care dental services. Generally recruitment is delayed and in highly skilled posts such as those in the CDS this can have a negative effect on both patient care and the morale of staff.

3.4.2 Administration – In light of the cuts in administrative staff many salaried dentists do not have administrative support. There needs to be recognition from the trusts that the administrative burden within the service has significantly increased. This change and additional workload should be reflected in changes to staff and working patterns. Administrative staff should be available to carry out administrative tasks, thus providing dentists with the maximum clinical time.
3.4.3 Future – The Community Dental Service in Northern Ireland operates from a range of Trust premises. Some are state of the art but many are in need of refurbishment to deliver the accommodation necessary for the cohort of patients and staff. The current funding crisis means that necessary development may be further away than ever and this negatively affects morale and retention.

3.4.4 The salaried services provide high levels of care to the most vulnerable groups in society. Yet in Northern Ireland the professionals who are choosing to enter this service are being rewarded with lower pay and fewer opportunities for development than their colleagues in the rest of the UK. The result is a stressed, de-motivated and unhappy workforce.

3.4.5 Access to training – every dentist must maintain their expertise through continuing professional development and in turn this CPD should be relevant to their job role. In Northern Ireland the arrangements for staff to access CPD are somewhat ad hoc and dependent on the arrangements in individual Trusts. This is unlike England and Wales where the contract for SPDCS is inclusive of a payment for training. The result in Northern Ireland is that staff may forego necessary training. In turn the accessibility of training is an important part of the job package and failure to address this issue further erodes skills development, pay progression and consequently morale.

3.4.6 The wider Health and Social Care Services in Northern Ireland are under financial pressures. The future holds many unknowns for healthcare workers including the Community Dental Service.
Annex 1

British Dental Association

General practice
focus groups report
July 2011

Policy Research Unit, British Dental Association
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Background and methodology

During May and June 2011 the BDA Research Unit conducted six focus groups with practice owners across the UK. The focus groups lasted for between two and three hours. The groups were semi-structured with the following discussion topics: expenses, income, patient behaviours, staffing and recruitment, morale, efficiency savings, as well as any specific national issues associated with each country.

An invitation was sent out to 300 practice owners randomly selected across the UK. Fifty-five individuals stated their desire to participate and were invited to attend, and 38 attended the groups. The groups included practice owners from a range of practices, including single handed and larger practices and covering a spectrum from almost 100 per cent private to almost exclusively NHS. The table below shows the number of attendees at each focus group.

Table 1: Attendees, date, and location of focus groups

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belfast</td>
<td>16 May 2011</td>
<td>3 practice owners</td>
</tr>
<tr>
<td>Glasgow</td>
<td>17 May 2011</td>
<td>2 practice owners, 1 practice manager, 1 dental accountant</td>
</tr>
<tr>
<td>Cardiff</td>
<td>23 May 2011</td>
<td>11 practice owners, 1 associate</td>
</tr>
<tr>
<td>Manchester</td>
<td>24 May 2011</td>
<td>9 practice owners, 1 practice manager</td>
</tr>
<tr>
<td>London</td>
<td>31 May 2011</td>
<td>3 practice owners</td>
</tr>
<tr>
<td>Online</td>
<td>2 June 2011</td>
<td>6 practice owners</td>
</tr>
</tbody>
</table>

The focus groups were recorded and transcripts produced from each session and these were coded. The coded information was clustered and thematic groups emerged which has formed the basis of this report.

While the groups included a range of practice owners, focus groups are by definition too small to be representative in a statistical sense. The contents of this report represent the experiences and view of those attending the groups and should not be considered as the views of the BDA.

Acknowledgements

The BDA would like to extend a warm thank you to all of those who took the time to attend the focus groups and share their experiences. Your participation was greatly appreciated.
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Introduction

The focus groups were asked to identify the issues that were affecting them the most as dentists. A range of issues were highlighted that were common across the four nations. The dramatic rise in practice expenses, ranging from materials to staff costs and utilities, was an issue that was repeatedly discussed. Dentists felt that there has been a dramatic increase in the administrative burden placed upon them, specifically surrounding regulation of the profession, which seems excessive and unnecessary. Low morale is an issue for many practice owners, caused by increased pressures to achieve targets, financial worry and a lack of appreciation for the profession.

This report begins with chapters focusing on issues that concern all four nations. This is then followed by a discussion of areas which affect dentistry in each specific nation. Finally, the report summarises the thoughts of the focus group attendees and what they would do to improve their working lives.
Executive Summary

- Practice owners across all countries highlighted that expenses have risen in almost all areas of the business. This increase in expenditure has not been matched in increases in NHS contract values and has gravely affected the profitability of their practices.

- Participants specifically discuss the increase in materials and laboratory bills which have seen a sharp rise over the last twelve months. In addition, the cost of funding the recent changes to decontamination regulations was a contentious issue for the majority of participants. There were huge concerns with the one-off initial capital outlay required to equip and renovate practices meet the new regulatory demands.

- The practice owners were of the general opinion that practice income has been diminishing for a number of years. The recession is thought to have caused significant changes in patient behaviour and it has been observed that patients are delaying both treatment and payment for treatment.

- There was a feeling amongst those present that trust in dentists has been eroded, leading to an over burdensome regulative structure. This has manifested itself with increased levels of bureaucracy required from dentists and practices.

- One of the most contentious issues that practice owners had was the amount of paperwork which has been require to comply with the CQC in England, RQIA in Northern Ireland, HIW in Wales and decontamination regulations. The participants were not only vociferous about the quantity of paperwork but found that it was unnecessary and irrelevant, having been transplanted from hospitals and care homes without much regard for the very different nature of dental practices.

- It was almost unanimously agreed that the current morale of practice owners was universally low and at its lowest point that it has been in years. There were many reasons given for low levels of morale in practice owners. The most prominent was the current financial pressures and bureaucratic changes which have been placed upon them, which has become their biggest worry in their life.
Recommendations:

These are recommendation based on the views of the participants in the focus groups.

1. **Expenses** – Expenses are increasingly being affected by volatile market conditions yet changes reflecting expenses are calculated using historical data. A more robust and reactive system is required to take into consideration current upwards trends in expenses.

2. **Administration** – There has been a huge increase administrative burden placed upon dentists. These additional responsibilities have been undertaken without an acknowledgement of the changes to working patterns. It is recommended that a reduction in the amount of unnecessary paperwork which is required. This could be achieved partially by reducing the duplication which is required or by the NHS allocating protected time in which the paperwork can be completed.

3. **Regulations** – There has been an increase in the regulatory burden on practices in the past couple of years. These increased practice overheads and additional practice improvements have not been recognised within local commissioning. It is recommended that national and local dental commissioning should take into consideration additional funding targeted specifically at practices.

4. **Decontamination** – Concern surrounding the lack of a proven evidence base for decontamination requirements. Without such evidence, there is a call for the regulations to be relaxed both in the timing of the implementation and the required standards, until such evidence can be validated.

5. **Efficiency savings** – With GDPs running their practices as small businesses they are already run to a far high efficiency standard than other primary care providers. Thus, further efficiency savings should not be sought from NHS dentistry.
Expenses

Practice owners across all countries highlighted that expenses have risen in almost all areas of the business. This increase in expenditure has not been matched in increases in NHS contract values and has gravely affected the profitability of their practices.

You name it and it has gone up. (England)

Achieving the balance between the rising cost of running the practice and maintaining the high standard of performance to meet the requirements is becoming extremely challenging under the current climate. (Online)

Practice expenses are on the increase and salaries are not. (Wales)

I think materials have gone up, only because we have to buy them from Europe and the exchange rate has affected it quite a lot. Materials have definitely gone up, and they only ever go up, they never go down! It's everything, electricity, gas, heating lighting, rates have gone up. Everything. (England)

Participants specifically discuss the increase in materials and laboratory bills which have seen a sharp rise over the last twelve months. This was partially explained by the global increases in the price of precious metals and unfavourable exchange rates with the euro. With the recent increase in VAT some participants also felt that it was unfair that they had to pay VAT on equipment and materials while working in the NHS. This combination of factors has resulted in substantial price rises. Yet some felt that companies and laboratories were taking advantage of the situation to raise prices beyond what would be reasonably expected.

Exchange rates for materials and precious metal costs. These are things I think everyone of us would say there has been substantial increases on. We are not talking about 2-3 per cent. It's been substantial. Laboratory costs 20-30 per cent more, I'd say material costs 20 per cent. (England)

The exchange rate has been a big factor in the last couple years. (England)

Our labs put their prices up three times in two years, whereas usually it was every two to three years they would put their prices up. (Wales)

The lab costs have gone up because of the metals. (Scotland)

Cost of gold has gone thought the roof. (Scotland)

All of the utilities have gone up; as soon as the pound drops against the euro they ramp the materials prices up, they don't seem to drop back down again at the end. And it affects things because you face a reduced profit. And it gets to the point where you don't have any money to put aside for contingencies or investment, for giving your staff a decent pay rise, and you're taking a pay cut yourself. The running costs are horrendous. (England)
And another thing is the VAT that went 2.5% in January, but it went up 2.5% the January before and prior to that it was at 15% so now it’s up by a third in 15 months ago and we have no recourse to claim back VAT. (Northern Ireland)

Is there any manoeuvrability on VAT because we do pay a lot on VAT, it’s on your equipment, it’s on your monthly equipment, it’s on your materials and no doubt it’s in your lab bill. (Northern Ireland)

To mitigate against these rising costs, many of the participants have been forced into regular negotiations with their providers or to source materials and laboratories from overseas, something most did not do in the past. Others sought to use cheaper alternatives materials rather than their preferred choice. Another alternative used to mitigate rising expenses was to pass the cost onto patients by raising private fees, an option not available to those exclusively providing NHS treatment.

I have negotiated it, item by item, but the prices are only for me. (Northern Ireland)

So we do all our work as outsourced in Japan and China. And got it all MRA registered and everything MHRA registered. That has cut our costs and we have had to do that. (Scotland)

Lab bills have also increased - but can be mitigated by passing on increases to the patient whenever possible and by reviewing the labs we use - sometimes we have found better work from labs that charge less. (Online)

To mitigate rising expenses we review and increase our private fees annually. (Online)

Seeking such compromises has resulted in additional problems. Negotiating with suppliers takes time and cannot been done every year. Smaller practices felt they were at a disadvantage in negotiations, not being able to guarantee a certain volume of orders in comparison with larger practices. There is also a concern regarding the loss of quality when using cheaper materials or laboratories from overseas to such an extent that some practice owners are refusing to compromise and are having to absorb the additional costs. Some also felt that lower quality lab items were a false economy once you factor in additional time required to fit poor quality work, and to replace failed treatments.

That’s the sort of thing, it does actually take a heck of a lot of time to do that, you are phoning up people and you are going round to different companies but when you have to you do it. And this year I find you’ve got to the point where you have to do it. (Northern Ireland)

You can’t do that [negotiate] year on year (Northern Ireland)

You have to have some man hours though, going through all the brochures and ringing up the suppliers to find out what that is going to cost me today. (Wales)

I am aware that I am pushing the suppliers harder, bargaining with them and in a way I didn’t use to and it has reached the point of no return and we are not getting any further. It has reached rock bottom. (England)
But we had volume – it’s flexing your muscles which is the point I’m saying the profession should do. (Northern Ireland)

But it’s taken a lot of time and if you are drilling teeth all day long you don’t have time to do those sorts of things and that is the killer. (Northern Ireland)

And sometimes it can be a false economy if you use something cheaper and it doesn’t work and you end up re-doing things. So there is a false economy to some extent, you have got to work out what is more costly, if you are using a cheaper material but it is taking you more time then it’s not necessarily a better option. But you just have to keep looking. (Wales)

You might be able to look for a cheaper material but some of the cheaper material you don’t want to use anyway and yes profit is down. (England)

The cost of funding the recent changes to decontamination regulations was a contentious issue for the majority of participants. There were huge concerns with the one-off initial capital outlay required to equip and renovate practices meet the new regulatory demands. This coupled with the on-going costs to validate equipment, hire additional staff to operate it, and the increase in utilities to run it all adds up to a huge new expenditure for something that does not increase revenue in any way and that many dentists feel does not improve patient safety.

To kit a room out is going to cost a lot of money, and tooling up for it, getting the extra sundries. (Northern Ireland)

But you also have to mention the things that we are experiencing for the first time; like having decontamination equipment validated. Which can be very expensive. (England)

You think in a lot of practices it will cost 10-15-20 thousand pounds if you don’t count all the equipment that has to go in it, all the washer disinfectors and all that. (Northern Ireland)

Absolutely going to cost a fortune. Our autoclave was £700 or something like that just to get that done and that is something that we didn’t really do before. It used to be only about three practices used to validate their autoclaves and now we are all going to have to do that. And there is another pile of money going out that we didn’t have any opportunity to get back and we never had to do before. (Northern Ireland)

The expenses have changed hugely by setting up a decontamination room, employing a ‘spare nurse’ to change instruments, using more expensive disposables, having amalgam separators fitted, having to finance at a more expensive rate. (Online)

Staffing levels have increased due to the need for CQC compliance, as has service agreements. (Online)

To run [the decontamination unit] is going to cost 25-30 grand when you pay a nurse to be in it. (Northern Ireland)
We actually need an extra member of staff because of the HTM 01 05. You can’t have it in the surgery so the nurses can’t run to a central sterilisation area and do it. You can’t streamline it so now you have got to have a dedicated member of staff to do all of the sterilisation. (Wales)

While some practice owners have frozen staff pay others have felt the necessity to increase staff wages in order to keep them in competitive in the job market. NHS practices felt they were competing with private salaries, and both reported competition with the salaried services where nurses are comparatively well paid. It was felt by many that giving staff a pay rise in order to retain them was worth the additional expense it would mean to the practice. These rises have had to come from practice profits as increases to NHS contract values over the last two years have been negligible and private practices are also struggling with the economic climate.

We haven’t offered anybody a pay rise this year. (England)

In five years my staff wages, and I’ve only got two staff, went up £10,000, my salary has gone up nowhere near that. (Wales)

That’s another problem, if you are looking for NHS staff, they would far rather go and get more money in a private practice. You really have got to put your staff wages up to get anybody to come and work with you. But your income is nowhere near covering what is, in effect, a private nurse’s salary. That’s the only way you get them. (Wales)

We’ve seen a change. Nurses used to be disposable. You picked one up, you trained, and it’s almost like they were cleaning round you. And there was no respect at all. It was terrible and what we did was when we started, we said we are going to make nurses feel like nurses. So they took a role. I mean our girls are trained in different things, oral cancer, looking at fillings: a bad filling, a good filling. They are almost like dentists. They take a role. They have to look in the mouth. They feel better. We pay them well. We do pay them [well], again it is our own decision to do that. It keeps them there, we see them as being there for life. Again it is reinvestment. (Scotland)

But that is another difficulty, when you look at what they pay in hospital and the community compared to what we can offer. (Scotland)

And they are not only doing that they are stealing staff as well. We’re getting staff stolen in the salaried services, because they are offering dental nurses what are effectively handsome salaries that general practitioners can’t compete with. (England)

In addition to increasing staff wages and the increase to the level of staffing due to decontamination; there had been the additional burden place on practice owners to fund dental nurse registration and training. In the discussions with practice owners they felt that the cost of training is unreasonable. Practices were further out of pocket from having to close surgeries while nurses attended training courses. There was also doubt expressed as to whether these changes were actually having a positive effect on the profession of nursing.
The cost of training staff has gone through the roof as well. (Wales)

Things like training days, increase in core topics, doesn't balance with our income which, value-wise, is getting less and less and less. (Wales)

But registration of dental nurses hasn't helped, many people just stopped. (England)

GDC registration, we have just had their notices through, we pay for ours, I suppose a lot of people do but that had gone up an extra £40, when you multiply that by 8 people on top of what you are paying already. (Wales)

We had a course for staff on Friday so we have to take the day off because it's something they all had to go on so we had to take the day off so not only are you paying for all of them to go but you can't work, you can't earn either. (Wales)

Providing the new legislative training, for example training dental nurses, health and safety and things like that. They just put the prices up and up and up. The company we used to use for training nurses, one year it was £400+VAT, the very next year it went up to £600 + VAT and the year after that it went up to £999+VAT. It's a joke. All these companies know they are onto a winner, because it's legislative they can do what they want. (Wales)

The level of associate remuneration was discussed in each of the focus groups. Many of the participants had put their associate percentage down or were considering it. They considered it imperative to do so and claimed that the days of 50 per cent associate percentages were unsustainable.

The main thing you touched upon is that profits have gone down and those 50/50 days of associates are gone. (England)

Everybody says reduce your associate’s percentage (Wales)

My accountant says it is a reality that we have to seriously consider it. (England)

We did last year and out associate left. (England)

It [a cut in percentage] would be a reality for mine [associate] but she is on maternity leave at the moment. (England)

When you speak to the dental accountants they say there is hardly anyone on 50%, that is what there figures show because everybody is top slicing their UDAs. (England)

With the spiralling cost which we have talked about, yes definitely [unsustainable]. (England)

Other members of the focus groups stated that they would not alter their associate percentages because they felt it may led to losing their staff members, and the desire to retain staff was more important to them and their practice.

45 [per cent] is what you need to pay but we’re on 55 per cent and they get a car right. Because the reason for the car it keeps them for three years…. I see that
everybody who works for me is part of my life and I can’t change that. If anything goes it goes with me first and then it goes last thing down the line. We try to keep everything stable. And have a nice wee time. The old patients come in and see the same dentist for years and we’ve keep it for now.  (Scotland)

Other expenses issues were raised including the cost of CQC burden of IT costs; other bureaucratic expense such as new (and often unnecessary) health and safety regulations (e.g. hot tap signs) and waste disposal.

IT costs as well, the software and hardware maintenance are huge. That’s something we never had in the past but now, the contracts are just huge. (Wales)

But I would say the thing that has definitely been killing us over the last year is the amount of tests and health and safety things that you have to do that you never had to do before.  (Northern Ireland)

CQC cost money to run and we are alone in funding that. (England)

Waste disposal is one of the things that has really rocketed (Wales)

It’s just a racket for waste disposal companies to make money. (Wales)

It was noted that all of the expense related issues above are hitting the practice owners and that many associates are not aware of the additional financial burden affecting practices. The focus groups felt that any additional funding or changes to funding arrangements should be targeted at practices rather than providing a general rise to all dentists.

Those are all our bills that we have got, associates haven’t got any bills their bills haven’t gone up, they are as well off as ever in fact they have had a bit of a raise. They got half a per cent and if I create efficiencies by saving in the lab, they gain.  (Northern Ireland)

I think associates need to bear some of the costs now, they need to share the pain.  (Northern Ireland)

But these things, all these tests, doesn’t have any impact on what the associate is actually earning and yet you are having to pay that all for the practice. So I can see a time when the associate is going to feel it. (Northern Ireland)

I think practice owners are having to take the brunt of the increased expenses, wages, materials, VAT, whatever. (Wales)

In summary, practices feel they are being hit from all angles, not only facing significant rises to the more traditional expenses such as laboratory and staffing costs, but also facing a barrage of new costs that did not exist five years’ ago.

Income

The practice owners were of the general opinion that practice income has been diminishing for a number of years and for a variety of reasons. Most notably the recession is thought to
have caused significant changes in patient behaviour. It has been observed that patients are delaying both treatment and payment for treatment which is having a negative impact on practice income. This caused particular problems in England and Wales where delaying appointments can lead to higher treatment needs for the same UDA rate.

I’m getting a lot more requests to patch something up, rather so they can put off the charge. (England)

Yes and deferring treatment. I think that is happening, or lengthening intervals between courses of treatment because they don’t want to come back so soon. (England)

People didn’t think twice when you said they needed a crown, now they ask ‘do I really need this?’ (Wales)

But recently the amount of people that have lost jobs that are sitting in that limbo where they can’t get any benefits [has increased] so I think a lot of patients stopped coming and a lot of people they know can’t get free dental treatment. So there is a huge drop in the amount of people going generally to NHS practices. (Scotland)

But I think people aren’t in a big hurry to spend masses of money on root treatments and various things that they maybe would have done before. (Northern Ireland)

People are attending less frequently, even taking into account that you are asking them to come less frequently. (Wales)

Compounded by the fact that even regular patients of mine are now coming irregularly and stacking up the fillings so they only pay for one course of treatment and have four fillings done instead of one. They have said this, ‘it’s not worthwhile coming in for one, I thought I’d hang on until I had more than one’. (Wales)

Although there were few practice owners present who engaged in predominantly private practice, it was agreed across the focus groups that many patients were moving away from private treatment in these changing economic times and seeking NHS treatment. This has led to many private practices struggling financially with such a demised income, some having even taken on NHS work in Scotland and Northern Ireland.

Having said that I am aware of some private practices that are significantly feeling the draught of what’s going on at the minute. (Northern Ireland)

The other thing we have found as well is that patients are leaving private practices. They want to leave them and come and join us on the Health Service. Because they can’t afford it. And the private practice fees have gone up and they are joining us on our waiting list. That is happening quite a lot. (England)

I’m aware of several private-ish practices not far from me who are doing a hell of a lot more HS work. The very fact that they are admitting it. (Northern Ireland)

A lot of private dentists are struggling, because the market has changed. (Scotland)
There was a general feeling that patients were expecting more for less. This is apparent in patients becoming more demanding, expecting cosmetic treatment on the NHS and generally unaware of what NHS treatment is available to them.

I think they seem to expect a more and more comprehensive service and then with the introduction of higher patient charges they then think they are not getting value for money. I think at the moment economically, a lot of them can’t afford the Band 3 or a lot of them shy away from it. I’m getting a lot more requests to patch something up, rather so they can put off the charge. (England)

Patients are looking to have a whole lot of work done in a cheaper way, especially under the NHS. (Online)

Income levels are also being affected by the number of missed appointments. There was near total agreement that appointments where the patients fail to attend was deeply affecting their income. This was magnified if the patient was booked in for a lengthy treatment. There was a frustration at the inability to recoup any losses from the patient for the loss of time.

Failed appointments is a challenging issue we have to face under the NHS as we cannot charge these patients and due to repeated failed appointments if we have to let them go, the practice loses the good will of that patient. (Online)

That is an efficiency saving, charge for missed appointments they learn not to miss them and then we save money because we’d actually be working. (England)

That is very annoying, when they don’t turn up because they cannot be penalised. When they don’t turn up that’s time that I could have offered to another people. (Wales)

**Bureaucracy**

There was a feeling amongst those present that trust in dentists has been eroded, leading to an over burdensome regulative structure. This has manifested itself with increased levels of bureaucracy required from dentists and practices. So much so that dentists are finding that they are spending an unnecessary amount of time with their back to the patient in order to complete the required paper work. This is more frustrating for the fact that much of it is perceived to be unnecessary or over the top.

I think most practices would say, a bit of regulation and at a reasonable level, to keep your stuff up to date, your decontamination, all that sort of stuff. I think that’s perfectly reasonable if that’s what was brought in but it’s like a sledgehammer to crack a nut. They have brought in far too much stuff at a much too high of a level. Too much bureaucracy. (Northern Ireland)

We’ve got something like 19 organisations now have the right to inspect our practices. We work, unfortunately, in a no trust environment. Now I know there are some bad people in our profession, as there are in any, but I still think that the majority of practitioners want to provide a good service. (Wales)
It seems to be the opposite trend of they were talking of cutting paperwork for small businesses. And we are just on the complete opposite end of that. Everyone else seems to be cutting paperwork, the Police, everyone, and we seem to be adding it. (Northern Ireland)

Paperwork is just ridiculous, and again it’s not just the fact that there is so much of it, we don’t know how much of it is necessary, we don’t understand it. People who throw it at us don’t understand it, they don’t understand the need for it. Nobody accepts the purpose of it and it just takes up all of your time. It’s just sapping us, absolutely sapping. This stuff with the CRBs, there is a lot of confusion about whether or not our members of staff need these CRB checks. Twice now we have had CQC sending emails to people in our area saying that you don’t have to have your CRBs, you need new ones, you can’t submit the ones that you say you have got through your PCT because your PCT hasn’t told us that you have got it and the fact that even that you’ve got a copy of it is completely meaningless because you got it through the PCT and you have to start again. (England)

You’re getting a patient in and instead of sitting in front of the patient having a chat I’m on the computer trying to tick this box that box, making sure I’ve written up about this. My back is usually always the other way around because I don’t have the time to sit in front of the patient and actually talk to them. Because I’ve got to write everything up that I’m trying to talk about. (England)

One of the most contentious issues that practice owners had was the amount of paperwork which has been require to comply with the CQC in England, RQIA in Northern Ireland, HIW in Wales and decontamination regulations. The participants were not only vociferous about the quantity of paperwork but found that it was unnecessary and irrelevant, having been transplanted from hospitals and care homes without much regard for the very different nature of dental practices.

At one point you had to have a policy on food hygiene. (Northern Ireland)

Too many people trying to stick their noses into how I run my practice. Far too much micro-management and far too much interference from people who don’t understand it. Here today, gone tomorrow, often making us do things that there is no evidence base for but they are politically correct to do. Why don’t they just let us get on with the job we’re trained to do. Show a bit more trust. (Wales)

I think to be honest with you, there is more stuff in the last year or two between the RQIA and the HTM 01 05 that has just never been there before. (Northern Ireland)

Can you guarantee me that when we go round the cycle [of decontamination] that what comes out is absolutely sterile? NO. Then why are we doing this then. (Scotland)

It’s [decontamination regulations] unreasonable. It’s not specific to dentistry; we are classified as independent hospitals. It was written for nursing homes. We have to have a policy on breaking bad news – how to say you have a hole in your tooth. (Northern Ireland)
In addition there is a large amount of duplication between the numerous bodies which oversee the profession. It was thought by many that this would be an easy area in which the burden on dentists could be reduced.

The “big brother watching you” attitude GDC, CQC, IG etc... There is a lot of duplication of information demanded from us. This could be streamlined. (Online)

Eliminating duplication, that way you are not removing any regulation. (England)

The burden has increased so much over the last two years that practice owners are having to either take time off clinical duties or employ additional staff to assist with the extra paperwork. For many of the practice owners the additional administrative burden is having a great impact on their personal life and work life balance. Many of those present discussed how they are having to take paperwork home at the end of the evening and often spent their weekend completing additional bureaucratic tasks.

The amount of time I have spent on administration in the last few years has more than doubled or tripled. Not a penny of money has been given to do it. And the reality is that patients can’t be seen in that time. A week last year that I had to spend doing administration just keeping up with things and I couldn’t see any patients in that few days. I had to take that time off to actually get all the paperwork up to date. (Northern Ireland)

The other thing is that, if the paperwork causes you to take half a day a week off you are not earning fees in that time, I think that suits the government. (Northern Ireland)

Impact on me is more hours spent on non-clinical work with little perceived gain to the practice or patient care - especially with regard to CQC. (Online)

I have to contribute my personal time to be able to keep up with the CQC, IG tool kit, employment regulations, staff training, BDA good practice scheme etc. This takes a lot of time most of the weekends and evenings. (Online)

My personal ‘family time’ has been reduced and the office has become what looks like a war zone. (Online)

Every other profession, like teachers, nothing like this would ever come in without them being allocated half a day. And they certainly wouldn’t be going to meetings every evening in their own time! (Northern Ireland)

The policing is getting a bit childish (Scotland)

One of the many arguments against the increase bureaucratic burden was the annoyance that the system is not concerned with checking the quality of the clinical work, rather their ability to complete governance.

They don’t look at quality, they are just number crunching, nobody is looking at quality up there any more, they are just looking at quantity. (Wales)

It’s significant that Dental Officers are no longer looking at patients. They are not interested in looking to see how good your root filling is. (Wales)
There was also concern as to the level of bureaucracy required in employment law. Many felt that the requirements were more trouble than it’s worth, and in a time when small businesses should be encourage to employ people this was having a negative impact.

“I’m in the process of getting someone to replace her but to be honest with you the hassle of all these stupid damn forms you need to fill in for all the new staff and the protocols you have to go through and all this stuff it actually mitigates against employing new people unless you really have to. There’s too much stupidity in terms of the paperwork you have to do and access checks and all that stuff. (Northern Ireland)

Employment law as well, at the moment it is so in favour of the employee, rather than the employer, and if they want to get the country back on its feet and getting people employed again it is putting us off employing people. (England)

With recruitment, there is just so much more bureaucracy than there ever was before. Which just seems pointless, it puts you off. (Northern Ireland)

Workforce and recruitment

There was a mixed response when discussions turned to recruitment. While many participants had not recruited recently and others have not experienced any problems recruiting, others experienced a wealth of problems. Many of the participants expressed the opinion that the number of unemployed associates exceeded the number of vacancies.

If you ring the BSO they keep a list of dentists and jobs and there are twice as many dentists as jobs. It’s the worst it’s ever been in my 20 years. (Northern Ireland)

Perhaps the situation is going to change with the amount of people who are going to qualify there are going to be a lot more unemployed dentists. (England)

There are two dentists for every job now which is the first time in my 20 years that that has happened. (Northern Ireland)

It was discussed that while there were more associates than positions, a large proportion of those applying for positions were trained overseas. Many participants had concern over the quality of many of the overseas qualified dentists, especially in relation to their ability to perform extractions and avoid inappropriate referrals. There was also concern over the ability of many overseas qualified dentists to communicate with their patients. It was felt that for some dentists their language skills were not adequate to be able to provide the clinical explanations and support required to perform their job proficiently.

We put and add out in the BDJ, there were a load of overseas [dentists]. (Scotland)

I’ve seen some really baddies [work from overseas dentists], I was embarrassed just looking at the thing, some really bad. (Scotland)

If you can understand first of all what the interviewee is saying to you and you are talking one on one on a professional to professional level. But try putting that person in a lay environment where the patient is trying to explain what is happening to them
and the other way around. It’s terrible. In the area where I am there is a lot of Portuguese and Polish patients, it’s on an exponential rise too, and you can’t understand them so try putting another Hungarian or a Yugoslavian in with that you have got fun! (Wales)

There are certain dental schools in Poland where they don’t teach how to extract so they had to refer everything, every extraction, so the oral surgery were getting inappropriate referrals, and there is a lot of knock on. (England)

It was highlighted that in rural areas they struggle to attract dentists and nurses to their areas. They felt that such was the pull to the urban centres that the pool of appropriate candidates was much smaller in rural areas.

It gets harder to recruit as you move away from the city. (Scotland)

Going back to nurses, in the rural community there are no qualified staff. (England)

I think it is a lot harder to recruit of you are rural or in a small town. (England)

We are a city practice, we wouldn’t have the problem recruiting that you would have but people in more rural areas are really struggling. (Wales)

Opinions were divided as to the level of supply of dental nurses. Many felt that there were too many applicants for the number of positions. What was agreed upon was that finding a nurse of the appropriate quality was a difficult task. They agreed that many nurses lacked the appropriate training or were poorly trained. Often participants preferred to train each of their nurses from scratch although they did express disappointment when they had invested the time and money to train a nurse only to have them leave the practice soon after qualifying.

You could recruit ten nurses for everyone. We have CVs in every single week. There is loads of staff out there, there really is. (Scotland)

As a practice we have multiple enquiries from nurses, hygienists for any practice vacancies. (Online)

Nursing, I think it is hard to get nursing staff, decent staff. (England)

What is very difficult to get very good staff who know what they’re doing. (England)

We always train from scratch and have done for years. Supplied quite a few of the local practices with our lovely trained staff eventually but that is just the way it goes. (England)

Well I’ve had the experience of taking them on from scratch training them up for two years and then they qualify and then they are off. (England)

As previously mentioned, practice owners also reported recruitment problems due to the high wage expectations of nurses. Many felt they face stiff competition from private practices and hospitals and find it frustrating that they cannot compete with them in regards to levels of remuneration.
As I say if you are advertising for nurses you have to compete against the private practices. Most of them are private now and they pay higher wages to their staff and we have to pay higher wages just to be grateful that they will come and work with you. You have got to give it or you don’t get anyone. (Wales)

Participants felt that dental nurse registration had put off many dental nurses. It was discussed that forcing academia on to dental nurses often intimidated them and led to their resignation. There were questions as to whether it actually raised the standard of their care; most felt that this was not the case.

As it is, there is generally a shortage of qualified dental nurses in our area. However, the new regulations from the GDC with regards to the requirement of qualified and registered dental nurse has made our staffing issue more challenging. (Online)

When they brought in the GDC registration thing for nurses, I can’t help but think they over-estimated some people’s passion for the job. For some people it’s just a job. Something to do. And they weren’t seeing it as a career path, as a career plan or a profession, they just saw it as a job. (Wales)

We had a nurse on the learning scheme and she’s been doing nursing since she was 16 and she just couldn’t hack all the training. She left. She almost had a nervous breakdown because of it. (Wales)

The courses, the expectations they have in terms of the exams are incredible. (England)

Quality and commitment, because I’ve had a number of them that would have probably been fantastic nurses before they needed to be qualified because they have got the right personality, they are competent they just get stuff done but they are not academic. (England)

The thing about dental nurses is the training. The availability and the cost. (Wales)

I think the registering may have advanced the cause of nursing for a small number. But for a lot of people doing dental nursing I really think they are perfectly happy with in house training. In our practice we have always tried to get them on courses and get them qualified. (Wales)

There was mixed opinion on the profitability of hygienist and therapists. Some participants were of the opinion that if used properly they were profitable for the practice.

There are different financial model which are used in difference practices and they all seem to work and .. it is getting the associates to buy in to it. I mean it is a different way of thinking and a different working. And dentists are sort of set in their ways but it is the newer ones qualified recently who are used to working with therapists who can maximise this sort of thing. (England)

Others found using them not to be profitable, especially in regard to failed attendances of patients, however this varied on how they were paid. In some cases, practices were simply
providing the service because it is something that patients expect. Single handed practitioners were less likely to use them and the only associate in attendance agreed that they could not see the point of utilising them because it would decrease their personal profits.

I have five part-time ones. And I don’t think any of them make me any money! (Northern Ireland)

It’s not a pile but it’s something but I wouldn’t want to do an in-depth analysis of the finances behind the hygienist. Cos I don’t think you’d come out too well. (Northern Ireland)

Those that were involved with the Vocational Training scheme (VT) found that their VT’s often had expectations which wildly outshone the reality of the job.

I see the new graduates coming out, “oh we are told we are going to earning £100,000 a year”, are you on this planet? And they all think they are going to walk into private practice. And they are going to be drumming around and driving their Porsches. And I think it has taken you half a day to do one filling. (Scotland)

VTs are also incredibly cushioned. They are given this very comfortable salary and the get their golden hello, and they sit there and think this is what I’m going to make and I’m 24. (Scotland)

I think it is all about money when they come out. To be honest when I came out I was the same. (Scotland)

There was a feeling that changes in the ambitions of associates, coupled with additional pressures of practice ownership will lead to a shortage of practice ownership in the future. It was stated that even if an associate did have the necessary desire to become a practice owner, there are more financial barriers to practice ownership so that it may not be possible.

The youngsters want to come along and open their own practice, they just can’t do it anymore, it’s stopped. (England)

And the younger ones are coming up and they are not being given the chance to buy practices, they aren’t necessarily in the type of practice for an associateship, where they can learn some of the business practices, and how the practices run and they are certainly not going to learn that in a corporate. There is no succession plan, there is nothing. (England)

But the whole profession is changing and the career profile is going to change as well where there isn’t, as it was for our generation, the aim to become a principal. The aim might just be to clear your debt just coming out of university and then get a salary without the stress. (England)

I remember when I was a young dentist everybody who was working as an associate was looking around to when they owned a practice. And I’m meeting far more associates now who don’t want to move up who don’t want the responsibility. I know
the responsibility has changed a great deal but they don’t see that as part of the job. (England)

Morale

It was almost unanimously agreed that the current morale of practice owners was universally low and at its lowest point that it has been in years.

Miserable. Bitter and twisted. (Northern Ireland)

I have never seen it as low in principals before. (Northern Ireland)

I don’t think it could get any lower. (Scotland)

I mean I am absolutely fed up with it. (England)

It is very poor because of the balance in money. (Wales)

My first day back today and I got to the car park and I phoned my husband and said ‘I just don’t want to go’. (Wales)

There were many reasons given for low levels of morale in practice owners. The most prominent was the current financial pressures and bureaucratic changes which have been placed upon them, which has become their biggest worry in their life.

Main issues that are impacting the morale of practice owners - probably financial pressure due to increased costs versus uncertain future income. (Online)

Stress of being a practice owner is now greater than 3 years ago. (Online)

Morale is rather low due to the huge administrative (CQC, IG) and financial burdens. (Online)

All the regulation and bureaucracy, coupled with all the economic changes that have been have made me feel stressed out. (Northern Ireland)

Many would get out of their practice ownership they would.

We are all looking to retire early aren’t we. (England)

I would get out of it if I could do but I can’t afford it. (England)

I’m actively plotting my way out. (Wales)

There is no way out though. How do you get out because who is going to come and buy it? Is the LHB going to give it to somebody? The contract is worthless. (Wales)

In comparison the practice owners felt that associate morale was much higher. They felt that they did not have the same responsibilities or pressure as themselves which was giving them higher levels of morale.
Associates haven’t a care in the world. They don’t know this is going on. (Northern Ireland)

So I think a lot of associates would say “what problem, what recession”. But if you speak to principals it is very different. (Northern Ireland)

I think when you are a practice owner your morale is a lot lower than an associates who does not have these kind of worries. (Scotland)

My associate is very happy. She does not have to worry about the cost of running the business nor have to think about the paperwork side of it. (Online)

The morale of the associates is probably better, because they are insulated from all of the regulation and the extra hours doing CQC and HTM and all that. (England)

I think that associate morale levels are at an all-time high. The reason is that they have more free time and less concerns about the government changing the playing field in which we practise dentistry. (Online)

Many when asked said that they would not currently recommend dentistry as a career choice, and they certainly would not recommend practice ownership.

My daughter is university age now and I’m telling her to think of something else. (England)

I’d be very upset it either of [my children] went into dentistry. (England)

Mine [child] won’t, she says Mum you’ve just been so stressed and you just aren’t enjoying it. So she can see that. (England)

My advice to guys now is don’t do it [move into practice ownership]. (Scotland)

NHS savings

Participants were asked where and how they thought savings could and should be make in NHS dentistry. The conversation in most of the focus groups revolved around a core service, the salaried service, orthodontic dentistry and bulk buying.

There were discussions in all focus groups around the issue of whether the NHS should move towards providing a core service of treatment and requiring patients to pay for any treatment over and above what is defined as core treatment. Opinions were mixed on this subject but were mainly in the positive. Concerns were expressed that they would only support a core service if it would be properly funded and if the decision to go to core service was seen to come from the Government and not from dentists. Many also expressed the view that the government would not permit this as it would be too destructive politically

I would rather they accord the fees a little bit and just took out a lot of stuff from it that I kind of don’t think should be in it. I would far rather see them paying slightly better fees for realistic core services. (Scotland)
I think if people want to have more complex treatment then they are probably going to have to pay for it more than. I don’t see how, given the current budget you can get away with providing the level of root treatments and crowns and bridges and all that sort of thing under that budget. It’s just not possible to do it. (Northern Ireland)

I think the government should give free check-ups and free oral hygiene instruction and then sorry cleaning teeth is up to people to do, it’s not my responsibility to do that for them year-in and year-out for ever-decreasing profits on my part and mainly for a loss on my part. (Wales)

I think if you took core treatment the things that need to be done, broken fillings, decay that is fine everyone should get that. Crown work where you can’t restore and someone chooses to have a crown done everyone should pay for that. (Scotland)

Whilst I would be in favour of a properly funded core service, my concern is that if we went in and asked for a core service we would end up with a badly funded core service. That would be what we would get which would be worse than where we are now. I would have no faith in politicians negotiating with them to produce a good quality core service because their idea is going to be completely different to ours. (Wales)

Well I don’t think there is enough money in the system to provide a comprehensive service properly for the population. If you take the amount of money spent now and put all of that into a core service then you could have a decent core service, which would be done properly. I would support that, I do suspect that if we moved to a core service they would drastically reduce the money. (England)

We should be looking at telling them what we can do for the money. But I don’t think government, politically, will engage in that because they want to be seen to be providing everything for the money on offer. (Wales)

When participants were discussing ways in which the NHS could make savings the salaried service was spoken about in several of the focus groups. There is a general consensus amongst general practitioners was that similar work is being produced in the salaried service that could be done in general practice for less money and with greater efficiency. They condemned the money that was being spent building and equipping new access centres, where if support was given a general practitioner could be set up in the same area for a fraction of the price.

I would like them to look closer at the salaried service. And I speak as a former salaried dentist. And the money that is spent is vastly in excess to what they generate. (Scotland)

We get £50,000 in surgery now, and if the NHS set an emergency unit in a hospital it is almost £500,000 now. (Scotland)

The other problem i have is the cross over between general practice and community dentistry. And if I see a patient within my practice and they need wisdom tooth out and I say that will be £136. And they say oh no I want to get into hospital. I say right that is fine I’ll send them to the hospital and they get it for free. Why, why should they
get it for free, because they’ll see me in the hospital and I’ll take the tooth out. So it is the same person. And they are not paying me the money in the hospital and paying less. Costs as you were saying earlier about equipping a purpose built community centre and paying for treatment in a hospital environment is hugely in excess to what it is to in my practice. (Scotland)

Many participants mentioned that the referral system is unproductive and causing increased costs. Many of the referral to hospitals are unnecessary and would be far more economical if they were performed in general practice. The problem with this is that the fees for advanced treatment are putting general practitioners off providing these services because they can at times come out at a loss for providing certain treatments. Ensuring that general practitioners receive adequate remuneration for advanced treatment would reduce the number of inappropriate referrals and allow the salaried service to focus on providing a specialist service for more complex treatments and vulnerable patients.

I also think referrals have increased since this new contract, because people don’t want to do complex treatment, even if they can because it’s going to cost them. So when you do send something in that you are not capable of they don’t know [that it is genuine], and they send it back. (Wales)

Inappropriate referrals to hospital, we could reallocate that back to primary care. We know how to run practices we do it very efficiently. (England)

It is a big problem with secondary care because the number of referrals has just skyrocketed. (Wales)

The cost of orthodontics to the NHS was raised as a concern for those in attendance, they thought that the current model for orthodontics was unsustainable and was an area in which savings could be made.

I think what is causing a lot of angst in the budget is orthodontics – it costs a disproportionate amount the orthodontics. (Northern Ireland)

Orthodontics is the big one. It is vastly over paid. (Scotland)

Increasing patient fees as a way of injecting money into the NHS dentistry budget was met with a mixed response. While some felt that patients were able to find money for other pursuits and it is just a case of prioritising their budget to include dentistry, others were of the opinion that patients paid enough already and should not be subject to further rises. They have seen, especially recently, patients delaying treatment, and feel that any further rises is likely put patients off attending and risk the oral health.

The patient fee hasn’t risen in years, the cap is stuck on £384. That could go up, it’s low. It could be a cap to protect the vulnerable but £384 doesn’t buy a lot of dentistry. (Northern Ireland)

I find it’s amazing what they can find money for if they want to, for whitening and all the rest of it. If they think it’s a priority for them then they will find the money and it’s amazing what people will pay for certain things. (Northern Ireland)
Why when you go above £384 should the Health Board pick up the tab for that. If your treatment cost £1000, you should pay 80% of £1000. It is crazy. (Scotland)

I think they pay enough anyway, they don’t like paying what they do. It is unfair. One filling is £47, the same as 10. Patients do realise that and don’t think it is fair and I agree with them. (England)

I think it would just make people stay away. Given the current economic climate people are paying what they can afford, having what they want and I don’t think they can pay any more. (Scotland)

The thing is the costs aren’t the patients fault, the cost are the people putting all this regulation on to the practices, so you can’t clobber the patients anymore. They are the wrong target. (Scotland)

Many felt that there were layers of unnecessary bureaucracy at the local Health Board (HB)/Primary Care Trusts (PCT) level and that this was an area that could be streamlined for savings to be made. Now although PCTs are due to be abolished in 2013, it is yet unknown how NHS contracts will be managed and whether it will continue to have the same inefficiencies.

I think the PCT just needs to be better organised, they are not very organised. When we go down to their offices for meetings and stuff, they have plush offices, IT gets changed every year, oh the system doesn’t work, we’ll get new computers new IT new offices, the wastage that goes on in there is phenomenal and yet when you want something you never get an answer out of them. (England)

Why do we need the LHBs? (Wales)

You have got so many agencies out there, you have HIW, Health Inspectorate Wales, you have the quality assurance system from the LHBs you have the Dental Reference Service, you’ve got Dental Advisors, to some extent, all going round looking at practices. (Wales)

Now where I am, it’s even more ridiculous because they have the cluster formed, they have lost 54% of management costs which means they have lost half of their staff and they are now completely hopeless. (England)

I do get fed up with the PCT interfering. They make everybody’s life a misery. (England)

Efficiency savings

Discussions at this year’s focus groups looked at where additional savings that could be made next year to meet the probable expectations for efficiency savings. It must be noted that many attendees felt that more efficiencies should not be place upon them as they were already one of the most efficient providers in the NHS and there is no room for further savings.

I think the picture you are seeing is that we are all seeing huge increases in our
overheads and then being told that we have a 4% pay rise by making efficiencies, quite honestly that is just an insult, a complete insult. I would hazard a guess that probably few sectors of the NHS are run as efficiently as dentistry is run here. (Wales)

The increase of recall intervals was rejected as an idea by most in attendance. It was noted that they have spent the last few years trying to encourage their patients to attend regularly only to try and change patient behaviour again. They could not see the clinical benefit in such a move and can only see it being detrimental to patient care.

Confusion over recall intervals could adversely impact some practices (Online)

We should be seeing patients based on what their clinical need is, not on efficiency gains. (Wales)

Increasing recall intervals as far as I can see it is of only benefit to the government. I have spent years trying to get everybody to come every six months and now we say we could like to come back in a year that is ok. 'why don't you want me to come back in six months, what you don't want to see me?' they get really offended. (England)

When participants were asked whether they thought that providing more preventative education to patients would be an adequate efficiency saving they felt that they already provided preventative education. A small minority were receptive to the idea that if this was monitored then they would accept it as an efficiency saving.

I feel I already do quite a bit of prevention especially with advice (England)

Yes I'd do a lot more of that anyway. (England)

The suggestion of bulk buying or cooperative buying in the NHS was discussed. While some felt that if administered properly it could bring about savings for dentists and the NHS. Others were sceptical about how this would work in practice. Some have seen similar schemes fail, partly due to the fact that the range of equipment and materials offered was poor.

Is there a danger of the NHS, who would be responsible for buying this stuff in bulk and distributing it, the cost per unit is going to go through the roof. (England)

You are forced to order your stuff of the NHS supplies our choice goes out the window because it is basically a directory and it is a cut down catalogue. So your higher end composites and materials are not in there and your options regarding instruments and everything are drastically cut. (England)

Yes, [to bulk buy] occupational health services. We work for the NHS, if we are injured working for the NHS we don’t get access to occupational health services. (Wales)

The establishing of participation groups for patients was met with mix opinion. While some participants were not opposed to the idea there was no real enthusiasm for this kind of
engagement to take place. Other felt that such groups would only be attended by individuals with personal agendas and little would actually be achieved.

Do people want to sit in a group and say ‘ah, I’ve got a problem’. (England)

The fear is that they would be dominated by people with their own agendas. I remember there was one in Cardiff, and it was just people who had their own little axe to grind, there was no real overall strategy. (Wales)

There are just too many committees anyway, this is just one more committee. (Wales)

Other issues

There was a feeling among some of those who attended that the government would prefer dentists to move towards private care. This was born out of frustration with the current system of NHS dentistry, the financial pressures, and a feeling of being unappreciated.

I think ultimately the government want dentists to go private. (Northern Ireland)

If you look at it from the other side, it’s almost like the government are trying to squeeze NHS dentistry out. (Wales)

They want us to jump ship basically and then we are going to be the bad guys. (Wales)

Some of the participants discussed the rise in malpractice litigation in dentistry. There was genuine concern as to its rise and the need to practice in a more defensive manner.

You have to do the check-up, x-rays and then you have to write an essay so that you don’t get sued! (Wales)

And it’s not fair to expect people to provide that for 3 UDAs, to expect them to achieve a certain standard because you can get sued if it’s not done right. You can say well I had a go, it only takes a smart lawyer to say well you weren’t capable of having a go. (Wales)

We have to practice defensively. I spend hours writing down negative findings, I spend more time with my back to the patient than I ever did writing down negative findings. (England)

England and Wales

There are a few issues that were unique to practice owners in England and Wales. The most notable was frustration with the current contract based on the targeted system of Units of Dental Activity (UDAs). Discussion revolved around the contracts failings and the way in which it has changed working practises.
Many felt that the contract had become unworkable. Participants stated that there were problems with patients with high needs. The remuneration levels of patients of this category often does not cover the work required and can often be loss making. This puts dentists in an undesirable ethical position where they are being financially punished for treating the people who most need it.

My first point is that it is a very high needs area so any new patients that come in require a lot of treatment. The distribution of UDAs just seems unfair because you sometimes need 10-15 appointments to try and get them dentally fit. And that’s for three UDAs. (Wales)

When new patients come in 20 fillings is a norm, not an exception where I am. (Wales)

You are also afraid to take on new patients (Wales)

And how can you have a contract that gives you a perverse incentive not to treat the very people who should be getting it. And that’s what we’ve got. And that can’t be right. That’s just morally awful. (Wales)

Almost to the point where when you get a high tariff treatment come through the door you are sitting there thinking, I’ve got to provide it and I can’t provide it. (England)

And the pressure it puts on you to work in an unethical manner, and I do my best not to. But when you’re sitting there looking at a swinging loss on a treatment because it is underfunded, just the contract works, and the adverse effect it has. (England)

And you are drawing a line between what ethically you should be doing and what is right and wrong. And the contract is forcing people to work in a way they don’t want to work. It forces your hand. And that is the problem with it. (England)

There is no level playing field. So you are getting walloped for your high need patients as much as you regular patients. That is the confounding factor. A new patient confounds the statistics and you are using to put that in. It is just statistics statistics. That is dangerous game. (England)

Many advanced treatments which would be the best course of clinical treatment have seen a remarkable decline because the current system does not provide adequate levels of remuneration. This is not only detrimental to the patients’ needs but is also affecting dentist skill mix.

On the endodontics aspect, they don’t pay for endodontics at all because it’s bracketed in Band 2 but you have still got to fill the tooth on top so either you are placing a filling which is Band 2 anyway or you are putting a crown which is Band 3 and still doesn’t account for the endodontic treatment. (Wales)

I’ve got quite an interest in endodontics and general restorative work but the fact that I get 3 UDAs to do 1.5-2hrs worth of root treatment with a microscope for effectively £30, if they want quality there is no way you can possibly maintain that in the long term with the frankly awful funding system for advanced treatment. (Wales)
I don’t think it’s fair that if a person comes in, particularly a new patient that needs a lot of work, that I should be personally paying for multiple units costing me more money when I would be better off giving them £100 pounds and saying go and find somebody else. (Wales)

Dentists are contracted to deliver a certain amount of UDAs per year and when these have run out they have to turn patients away. Participants felt their PCTs/LHBs were often slow to react to the increased community needs or were unsupportive and failed to address the issue to the detriment of the local communities’ oral health

What am I to do with these extra patients when next year I have all of these extra patients and the LHB is not going to fund me any improvement to the practice to accommodate these extra patients and yet I am supposed to accommodate them. …they will offer me some extra contract value now, up until 2012 March but they have no guarantee what will happen. They are doing it short term so if the appeal goes through they will have a 3 month leeway. So we will have some funding for those 3 months. You really can’t plan like that. If you are running to capacity you need extra staff to service those extra people, at our cost, with no guarantee how are we supposed to take it on. (Wales)

We always run short of UDAs… we’ve already written to our PCT manager and said what are you doing about it this year? Because we need to know now, not in January or February next year. We need to know now so that we can plan it. Every year I’ve had the same, no more UDAs, you know the situation, bog off basically, this year they have said, I’ll get back to you.

There is no capacity to get more UDAs (England)

The UDA system is based on a year of work in 2005, the participants were clear to point out that patient needs and the demographic makeup in many areas has changed over this time. They stated that working on a historic funding criteria meant that dental care was out of step with their community needs.

I think the further we go from 2006 the more difficult it is to justify the difference because it looks so much further and further into the past. In the first couple of years you could make a good case for it. The population has changed. (England)

It is all based on historical stuff. Of course it is not right. (England)

It’s wrong to be paid for what you did five years ago because now we are in the fifth year of the contract. (Wales)

With many regulatory changes mentioned above, the current contract has not provided for practice improvements. There are no provisions for practices to take on more work to fund these improvements; they have to be financed from already stretched profits. This was seen as a dangerous time bomb by many as the combination of this contract and the economic climate mean that many practices will avoid all but the most vital practice improvements.

Lack of funding for practice development in this contract. If you want to go and put in a new surgery in your practice you haven’t got that option to go and do a few more
hours of work a week to pay for it. That’s got to come out of your funding. I think that is having a severe long term effect on modernising. (Wales)

If you want to do any major development in your practice now with this contract you are not going to be able to do it unless you take a big hit out of your income. (Wales)

The rising expenses have meant that several expansion plans for the practice have had to be shelved. (Online)

Whatever small private income you can generate, and that has gone down because of the recession, that used to subsidise the improvements in the practice or trying to do personal development and things like that. (Wales)

Participants, especially those close to retirement had huge concerns about the loss of goodwill they were potentially facing. They expressed concern about the inability to be able to guarantee that your contract will be transferred to a buyer. This has resulted in worry for those close to retirement who have invested a huge amount of time and money into building practices only to see them become potentially worthless.

My practice is absolutely valueless, I can’t sell it and I have no way of working out and saying this is what my practice is worth because if I sell it there is no guarantee that they are going to give those UDAs to the new buyer. (Wales)

And we cannot transfer contracts without the express permission of the PCT. (England)

They have stolen our practices. I bought my practice in 1980 and I’ve invested not just my working life but also a huge financial investment over the years to improving everything and basically on the whim of somebody it could be worthless. They have stolen your practice and they have stolen your business by not letting you expand as any normal business should be able to do. (Wales)

For future planning we don’t know what our good will is going to be. (England)

No guarantee of goodwill (Wales)

There was a genuine concern from practice owners in England about the threat from corporate dentistry. There concerns were various ranging from the quality of care to their engagement with the rest of the dental community. There was a feeling that dentistry could be shifting towards this model of practice and worry about the effects this would bring.

I think there will be more and more corporates, it will get bigger and bigger. (England)

Talking about cost cutting, it does seem to be the way things are supported by the government really, to go does the corporate route because you [independent practices] are too expensive really. (England)

One of the main concerns independent practitioners had regarding corporate practices was whether they were more concerned over the profits of a practice rather than the quality of care it was providing.
I think that sort of serious lack of care. People go in and the corporate just don’t really care about the practice at an individual level that we do. We care about patients. (England)

We want to look after patients, we want to solve issues, as soon as we see a potential problem we are on top of it, dealing with it, and I don’t think that happen in corporates. (England)

I think that is where some of the corporates are going to go wrong in the long term because they are just driven by the accountants higher up the chain and they don’t see what the effect is. (England)

There were concerns raised about the staffing within the corporates. It was widely agreed that the staff turnover within corporate bodies was very high. It was discussed that patients do not like to see a new dentists each time they attend and it affects their reputation within the community. There were also concerns that corporates were poaching staff from rival practices.

Our PCT had a nightmare because two corporates operating in the area cover five practices but these five practices in one year they had to deal with performer numbers for 62 different performers. From 5 practices, 62. That was their turn over. (England)

When they go back they never see the same dentists. (England)

Patients don’t like the corporates; they don’t like to see a different dentist every time. (England)

The PCT who has actually allowed them [corporate bodies] to set up. Five [corporate bodies] and they are taking on new practices who are taking on 25-30 associates….. So the corporates have gone ‘come to us and we’ll give you a clinical directorship of a particular practice’. So they are offering them a golden hello. And it can be significant. I mean typically they are talking £5,000 but it can be £10,000 in certain circumstances. And if you’ve got any educational experience then they really want you. And then they are offering 50% and on top of the 50% they are offering 60% plus the private work which they are negotiating independently. And as a result it is making it extraordinarily difficult for small practices and that have been country village practices which are trying to compete. (England)

The conversations regarding corporate bodies eventually turned to their lack of engagement with the rest of the dental community. They felt that they did not participate or communicate with their community which has led to tension and frustration from the participating practice owners.

Here is one simple question; do we have any corporate input into this focus group? Is there any communication with dentist corporate groups because this is the way that dentistry is moving? How are you going to find out how corporates feel and where is their input? (England)
I look at the VT scheme, as they sort of shrink down, the practices that get taken over by an incorporated company, they don’t participate in the VT schemes. Do you see them at LDC meetings? (England)

I think the elephant in the room are the corporate bodies, at all the meetings I don’t see any corporate input. I don’t see a large input from IDH interacting with GDC about patient need, I don’t see them positively engaging with the dental community. (England)

Comparison with hospitals and GPs

Across most of the focus groups participants compared their treatment and conditions to that of GPs. They felt that their practices were similar and were concerned that they did not receive some of the benefits the GPs. Similarly they felt that GPs were not burdened with some of the regulations practice owners are, and if they were it was properly funded.

It is not the same footing as for GPs, any modernisation they have to do appears to be funded. (England)

But an area I would look at, your GP doctor gets a rent allowance. (Northern Ireland)

They still think that we are like GPs. (England)

But we don’t get the benefits of GPs. (England)

Absolutely. So even little things like the GPs getting looked on much more benevolently by the CQC. (England)

Again GPs get that [IT upgrades] paid for the get it subsidised, we don’t get a penny. (England)

Scotland

Concern about complex treatment not being viable under the NHS contract was felt in Scotland. It was thought that advanced treatments were often loss making and should be either removed from treatment plans or properly funded.

Endo with these instruments is sort of non-viable on the NHS and we all do it, we all do it. (Scotland)

The other one is chrome dentures where you notice it. The price of a chrome denture is. And I joke with my patient and say there is twenty quid go down the road because that would be cheaper than me doing it. (Scotland)

This could be achieved partially, in the participants’ opinion by getting rid of the maximum patient charge limit. Currently the upper limit in Scotland is set at £384. There was a feeling in the group that this limit is now unsustainable, especially for complex or lengthy treatments, and should be removed or raised.
The only time when I think they should pay more is, I think they should get rid of the prior approval limit, the maximum limit rather. And if you have neglected your teeth so much that you require six root treatments and 20 crowns then pay. (Scotland)

One concern amongst the attendees was the over reliance by practices on grants. While they appreciated the additional finding they felt that they could not function if they were to stop which is a big danger to the profession. In addition, in accepting the grants, they often came with very prescriptive conditions which did not allow the practice owner to allocate the money to areas of the business which they felt it was best suited.

As a business the over-reliance on grants income. If we strip grants out, we don’t actually make any money. (Scotland)

We couldn’t possibly do it without getting the rebate. (Scotland)

They give us grants and say you have to do this. (Scotland)

I hate things that force you to work to get things but that is fair within a way (Scotland)

Northern Ireland

There were a few issues unique to practice owners in Northern Ireland. The most notable was frustration with the RQIA and the patient charge maximum limit.

Similarly to Scotland in Northern Ireland the current the upper limit on patient fees is capped at £384. This limit was seen to be unsustainable, especially for complex or lengthy treatments, and should be removed or raised.

Another area is that the patient fee hasn’t risen in years, the cap is stuck on £384. That could go up, it’s low. It could be a cap to protect the vulnerable but £384 that doesn’t buy a lot of dentistry. (Northern Ireland)

The RQIA regulation in Northern Ireland was a cause of concern as with other countries. The participants of the focus group felt that its implementation was happening too fast and was unnecessary.

RQIA, the implementation, both paperwork and the cost of the actual implementation to get yourself up to standard and that sort of thing. I must have spent thousands of pounds in the last few weeks just getting things done that need done for it. (Northern Ireland)

But the way they have done it, they’ve brought it in so quickly with such a short time scale. In England they have over a year to do the CQC stuff and everyone knew what was happening for a year in advance, and we were all sitting there in November going what the hell is happening? And then in the middle of March we are told what we are doing and by the end of May we have to have it all done! (Northern Ireland)
[RQIA] It’s unreasonable. It’s not specific to dentistry; we are classified as independent hospitals. It was written for nursing homes. We have to have a policy on breaking bad news – how to say you have a hole in your tooth. (Northern Ireland)

While there was slight annoyance in the group when discussing the delay to the practice allowance payment, they seem to accept it as long as they received it in the end. They did comment that it was poorly communicated and that payments will only ever get put back and never brought forward.

Well I didn’t know it was going to be delayed. (Northern Ireland)

I was quite looking forward to it and then it wasn’t there. (Northern Ireland)

As you say you are expecting it at a certain time of year and they just drop it on you at the last minute that they are not going to pay it. (Northern Ireland)

They always manage to put things back, they never put them forward. It’s always knocked back. (Northern Ireland)

Improvements and the future

At the end of each focus group we asked participants what change would bring the biggest improvement to their lives as practice owners. There were a range of answers ranging from immediate assistance to more long-term solutions. A large proportion revolved around financial assistance to practice owners specifically, while others were interested in reducing the bureaucratic burden.

There was a strong feeling among practice owners that the large burden of increased expenses is only affecting practice owners. The majority agree that any additional funding should be targeted at practices rather than a general rise to all dentists.

The help should be towards practices as opposed to general dentists as such. Because I think practices now need the help as opposed to associates who make good money. They are doing well just now and it is principals who need sorting out. (Scotland)

I think associates need to bear some of the costs now, they need to share the pain. (Northern Ireland)

But these things, all these tests, don’t have any impact on what the associate is actually earning and yet you are having to pay that all for the practice. So I can see a time when the associate is going to feel it. (Northern Ireland)

I think practice owners are having to take the brunt of the increased expenses, wages, materials, VAT, whatever. (Wales)

There was a call to relax the rigorous regulations surrounding decontamination. There as a call for the regulations to be relaxed somewhat, whether this is in the timing of the implementation or the reducing the required standards. If they regulation could not be
relaxed there was a call for them to be better funded – not just the initial costs but the ongoing expenses would have to be acknowledged.

*I think the HTM 01 05 is the thing that if it was put back even a year or two, or eased.* *(Northern Ireland)*

*Not imposing ridiculous decontamination measures that aren’t even evidence based but cost a fortune to run might be a help.* *(England)*

*Establishing a correct level of regulation.* *(England)*

*To fund decontamination changes, fund the changes which they have brought in as a result of new regulation.* *(England)*

In Scotland there was discussion of whether it would be possible for their local Health Boards to provide a financial guarantee to banks to make it easier to access finance. The recent decontamination requirements mean some practices have to build or renovate a decontamination unit at great expense. With the current economic climate, banks are less willing to lend to small businesses and a guarantee from local health boards would provide a greater access to credit and ease the financial burden.

*You need some sort of guarantor for fully committed NHS dentist if there was some sort of guarantee if that was part of if that would help with banks.* *(Scotland)*

*A Health Board guarantee to a bank would be worth its weight in gold.* *(Scotland)*

With the raft of bureaucratic change there is a feeling amongst dentists that they are no longer trusted. One improvement the participants wished to see is a greater level of autonomy within their profession.

*One thing that will bring biggest improvement in my working life would be, where dentists are given full freedom to work in ethical way without being involved with the limitations from the NHS and having freedom from all sorts of paperwork e.g. CQC, IG etc* *(Online)*

*I think that to give back the decision making to dentists,* *(Online)*

*I’d like to feel like I had a bit more influence on my own destiny. Rather than this feeling of being pushed into things.* *(Wales)*

*I would say, get out and trust me to do the job properly.* *(Wales)*

*I think if we had a lump sum of money and controlled it for ourselves. I think it is a good thing to look at.* *(England)*

With the increases in the amount of paperwork to be completed, one suggestion was to cut the amount of paperwork which is required. This could be achieved partially but reducing the duplication which is required or by allocating time in which the paperwork can be completed.
I think the paper work element [is one thing I would like to change]…It’s all just extra paper work on top of the clinical work and it is definitely affecting my work life balance. (England)

Cut all the bureaucracy and regulation. (England)

We have to set aside special daytime hours to deal with it. (Wales)

Another suggestion put forward but the focus group in Scotland was to provide some recognition for nurses who work within the NHS. They felt that in practices where the NHS commitment in almost 100 per cent nurses were not being recognised as working for the NHS, where in actuality they are working almost exclusively on NHS patients. This makes them significantly disadvantaged to those counterparts who work in the salaried service or even to dentists who receive superannuation for their NHS commitment.

It would have been good if the NHS did, and I did request this once if they took the staff under the umbrella of the NHS. (Scotland)

I wouldn’t necessarily want the practice allowance fees but I like your idea about a core payment for nurses. (Scotland)
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Business Trends Survey 2011

Background

This report details the findings from the 2011 Business Trends survey. The Business Trends survey is carried out annually by the BDA, with the primary aim of providing evidence for the Doctors' and Dentists' Review Body.

Report structure

The 2011 Business Trends survey has been broken into three topical reports:

1. Expenses and finance report
2. Workforce and practice report
3. Morale and motivation report
Method and response

A stratified random sample of BDA members was selected to survey. This sample excluded students, retired dentists, dentists who did not provide any general practice dentistry in 2010/11, and members currently living overseas.

A paper based survey was distributed by mail and was first sent out in May 2011. Reminders were sent to everyone who had not responded in early June and mid-June. A third reminder was sent in early July to all practice owners who had not responded. The following responses were received:

<table>
<thead>
<tr>
<th>Country</th>
<th>Sample</th>
<th>Number of responses</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>3000</td>
<td>1255</td>
<td>42%</td>
</tr>
<tr>
<td>England</td>
<td>1825</td>
<td>775</td>
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<tr>
<td>Wales</td>
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<td>39%</td>
</tr>
<tr>
<td>Scotland</td>
<td>350</td>
<td>156</td>
<td>45%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>450</td>
<td>178</td>
<td>40%</td>
</tr>
</tbody>
</table>

Weighting

To account for the stratified sampling method across the UK, and the additional reminder for practice owners only, the data has been weighted to represent BDA membership as at August 2011 with regards to the proportions of practice owners and associates in each of the four nations. The following weights have been used:

<table>
<thead>
<tr>
<th>Country</th>
<th>Practice owners</th>
<th>Associates</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Wales</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

The data was entered into a database where it was collated and cleaned. It was then imported into SPSS for analysis.

Note

For ease of reporting, predominantly private is used to describe dentists who receive 1-24 per cent of their income from the NHS while predominantly NHS is used to describe dentists who receive 75-100 per cent of their income from the NHS.

The research team is aware that in Northern Ireland the equivalent national health care provider to the National Health Service (NHS) in England is the Health Service (HS). To simplify the reporting in this report where the NHS or NHS commitment in the UK is stated it refers to both NHS and HS.
Business Trends Survey 2011

Expenses and finance report

Background
This section details the findings from the expenses and finance sections of the 2011 Business Trends survey.

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Executive summary

- Rising expenses affected most practices in the 2010/11 financial year, with over a third (39 per cent) of the practices reported substantial increases to expenses, and a further 54 per cent reported smaller increases.
- While one-in-five (20 per cent) practices saw an increase in their turnover, less than one-in-ten (7 per cent) saw an increase in their gross profit in 20010/11, with the increase in expenses the likely cause of this.
- While over a quarter of the practices (28 per cent) experienced an increase in turnover just 11 per cent reported an increase in gross profit in 2009/10. Two thirds of the practices (67 per cent) reported decreased profit.
- Practices in Scotland and Wales were the most likely to report an increase in gross profit compared to those in the other nations.
- Almost three-quarters of the practice owners found that costs had exceeded their expectations in 2010/11.
- Materials costs increased for the majority of practices (95 per cent) in 2010/11 compared with the previous year. The weakened pound was thought by many to be the main factor behind the increase.
- The majority also reported increased expenses relating to equipment consumables (96 per cent). Stricter decontamination requirements have increased consumables costs through increased requirements for single-use files and other supplies such as instrument trays and sterilisation pouches.
- Over half of respondents had defiantly seen a change to their utility bills as a result of changes in decontamination (51 per cent). Quarterly water bills and electricity bills rose by a quarter (24 per cent and 25 per cent respectively) from 2009/10 to 2010/11 due to changes in decontamination. While annual maintenance rose by 39 per cent.
- The average expense ratio (earnings to expenses) was 0.66 in 20010/11 up from 0.64 in 2009/10. The expense ratios were lowest in single handed practices (0.61) and highest in practices with four or more dentists (0.70).
- Staff costs also rose dramatically for many practices. Dental nurse registration was commonly cited as causing increased competition and higher wage demands. Many of the practices were also left with additional costs such as registration fees, training courses, and paid leave to attend courses for many practice owners.
- Dental nurses received average pay rises of 4.5 per cent in 2010/11. Practice managers and receptionists received similar rises of 4.9 and 4.2 per cent respectively.
- A third of all associates earned between £60,001 and £80,000 from dentistry in 2010/11 (before tax and NI). Practice owner pay was more widely distributed but had a modal income of £80,001 to £100,000 which accounts for 15 per cent of practice owners.
- Over one-in-ten (12 per cent) associates with NHS income reported that NHS superannuation payments were not being deducted from their pay.
Practice turnover, expenses and gross profit

The continuing rise in expenses and falling profits are two clear themes which have emerged from this year’s survey. Figure 1 shows that while almost half (47 per cent) of practices turnover had not changed from 2009/10 to 2010/11, three-quarters (75 per cent) of practices experienced a decrease in their gross profit. This is a higher proportion than reported in 2010 (67 per cent).

Similarly, while one-in-five (20 per cent) practices saw an increase in their turnover, less than one-in-ten (7 per cent) saw an increase in their gross profit, with the increase in expenses the likely cause of this.

**Figure 1: Change in practice turnover, expenses and gross profit – 2009/10 to 2010/11**

Practice owners reported a similar change to expenses across the devolved nations and across differing levels of NHS commitment, but differences did emerge in relation to turnover. Practices in Scotland and Wales were the most likely to report an increase turnover (31 per cent and 24 per cent respectively) compared with 18 per cent for England and Northern Ireland (figure 2).
Figure 2: Changes in turnover, expenses and gross profit 2009/10 to 2010/11 by country

Figure 3 and 4 compare the results of the 2011 survey with those from the 2010 survey. In 2010, each of the devolved nations had less practices reporting an increase in turnover in the previous 12 months. The largest drop occurred in Northern Ireland where the proportion of practices reporting an increase in turnover dropped from 40 per cent in 2010 to just 18 per cent in 2011. This was reflected in the portion of practice that reported a decrease in turnover in the last 12 months, where every country showed an increase in proportion.

Figure 3: Change in turnover in the previous 12 months 2010 survey to 2011 survey
A similar pattern was apparent when considering the changes to gross profit. More practices, across each of the countries, reported a decrease in gross profit than had done in the 2010 survey. The largest increase in the proportion of practice owners reporting a decrease was in Northern Ireland where the proportion rose from 64 per cent to 80 per cent.

**Figure 4: Changes to gross profit in the previous 12 months, 2010 to 2011**

Expenses

Rising expenses affected most practices in the 2010/11 financial year with 92 per cent of practices reporting an increase in expenses. As the difficult economic climate has continued over the last 12 months, many practice owners had already seen an increase in expenses. Given these facts we were interested to see how practice costs have compared with the practice owners’ expectations in the 2010/11 financial year.

Almost three-quarters (71 per cent) of the practice owners found that their costs had exceeded their expectations (figure 5). This is a dramatic rise from the 55 per cent that was reported in 2009/10. Practices in England and Northern Ireland (71 per cent and 82 per cent respectively) were the most likely to report costs above expectations.

Almost no practices in the UK (0.1 per cent) reported that costs were below their expectations. Similar to the findings from last year, single handed practices were less likely than their colleagues from larger practices to report that costs exceeded their expectations. In last year’s report it was argued that this may be because smaller practice find it easy to monitor and track their personal expenses, therefore are more likely to have a realistic expectation of costs. Weight can be added to this theory with this emerging trend.
Expenses relating to decontamination were the most commonly cited cause for expenses rising above expectations. These include equipping practices, the one off cost of renovation the practice consumables and on-going maintenance. It was noted that these were out of proportion to the risk that they were preventing.

“Built a de-contamination room; very expensive sundry items; materials have risen greatly LAB fees; cost of gold risen greatly”

“Cost of building on extension to house LDU has exceeded expectations by double since planning it, initially”

“Cost of providing and running costs of LDU are horrendous”

“Increased cost of decontamination room, having to build a separate room (very high building costs). To achieve lost space for decontamination room and many other high costing plans”

“Obviously decontamination costs and validation are the main burden. Have not met all planned investment really because I am cautious about financial outlook for cost of living i.e. inflation costs for the patients”

“Costs and requirements in conforming to HTM01-05 have been far greater than expectations.”

“Costs for compliance or attempted compliance with HTM01-05 mainly consumables”

“CQC and HTM 0105 implementation - flooring, decoration, washer disinfector, new instruments.”

“Decreased income has meant delaying equipment purchase owing to necessary capital expenditure on premises. HTM01-05 compliance has taken precedence”

“HTM 01-05 costs are very high especially small practices. Costs are out of proportion to risks”

Staff costs were also rising more than expected for a number of the practice owners. Dental nurse registration was thought by many to have driven up the wage bill, and ancillary costs
such as paying for registration. There has been an increase in competition for staff which has impacted on wage demands. In many cases, additional staff have had to be employed to meet the decontamination requirements, and to meet rising administrative and regulatory requirements.

“Staff have not had a pay rise in 2 years and I needed to give them one. Also have gone from 1 full time dentist + part time dentist to only 1 full time. Have not decreased staff because CQC expect you to have plenty of staff!”

“Staff wage expectation and needs have increased so I have had to respond by increasing wages.”

“None of the staff will pay for registration, courses etc.”

“Staffing costs have shot up. Wages increase for registered DSAs”

“Extra staff to accompany regulations for decontamination.”

“Provision of decontamination room and extra instruments to go with it. Also having to employ extra member of staff for it and it also slows us down”

“Staff wages have risen by £10,000 in 5 years - I have to compete in getting staff to work in the NHS instead of another dentist’s private practice.”

Increases in the cost of materials and expenses relating to decontamination were the most commonly cited causes for expenses exceeding expectations. The weak pound against the Euro and US Dollar was thought to have contributed to the increase in materials, however, a number of respondents felt that their suppliers have increased prices above and beyond this.

“Dental materials have continued to rise, especially the items that are thrown away (triply sprays, reamers etc.).”

“Increase in materials not in line with NHS increase.”

“Material cost more due to £/euro exchange rate.”

“Materials costs continue to rise, but the ability to pass these costs onto the patient are limited by current economic climate”

“Materials costs have increased substantially and demand for better dentistry has risen. I have not increased my fees.”

“Materials costs me exponentially, lab costs make providing NHS lab work unprofitable. Costs of staff up as they need to be registered - putting up costs”

“Materials have increased to a level which has reduced the amount that I can invest in the practice.”

The increased cost of laboratory items, particularly for items involving precious metals, was another contributing factor to higher expenses, although this was less commonly cited than materials. Many of the practice owners are thought to be shopping around to find a cheaper laboratory.
“Laboratory costs increased due to rise in cost of raw materials and transport. No rise in patient charges/UDA value to offset this rise”

“Lab bills have rocketed.”

“Precious metal prices soaring - affecting lab bills.”

“Gold prices have made NHS precious metal crowns unrealistic. Materials increased 25% in last 3 months”

Increases to expenditure on materials and equipment consumables were the norm for most practices with over 90 per cent of the practice owners reporting an increase in 2010/11 compared with the previous year (95 per cent materials; 96 per cent consumables) (figure 6). There were high levels of agreeability across the nations and with over 90 per cent of practice owners in all countries reporting an increase.

**Figure 6: Percentage of practice experiencing an increase in the following costs compared with 2010/11**

While the proportion of practice owners that had experience an increase in laboratory costs was not as high as materials or consumables, it still consisted of the vast majority of participants. Not a single practice owner reported a substantial decrease in material costs, laboratory costs or equipment consumables.
Within this current economic climate we sought to understand how much planned investment practices undertook in 2010/11. Under half (45 per cent) of practices undertook all or most of their planned investment (figure 7). There was some difference between countries with those in Scotland and England (50 per cent and 46 per cent respectively) more likely to have undertaken most or all of their planned investment in comparison with those in Wales and Northern Ireland (41 per cent and 31 per cent respectively).

In times of fiscal constraint, anecdotally, it is understood that access to credit and bank loans has been restricted. We sought to quantify this and discovered that of those that had applied for credit or a bank loan in the last 12 months a third (34 per cent) had faced problems when doing so (figure 8). This proportion rose to 58 per cent in Northern Ireland and 44 per cent in Scotland.

Of those that faced problems, one of the main issues that they found was that the banks were often unwilling to lend.

“Banks seem to have tightened on everything—not as ready to lend money.”
“Banks want personal guarantees. Hard to get them to commit to lending”

“Bank would not give loan for tax liability though would happily give one to go on holiday”

Some participants reported that the application process was lengthy and they faced frequent delays throughout it. This often manifested itself in prolonged credit checks and excessive supporting documentation.

“Credit checks longer time to get decision”

“Extra fees and levies on our accountants delays in approval now.”

“More delays and requirements, such as seeing 3 years worth of accounts for loans over £25,000”

“Very lengthy application time, lots of checks”

If they were able to secure a credit agreement they often found unfavourable terms and conditions. Often interest rates were much higher than anticipated or fiscally prudent.

“Penalty interest rate applied”

“Despite never having overdrafts and profitable practice consistently for 16yrs in business, my bank would only lend money for my LDU extension if I renegotiated my entire practice loan at a much higher rate than I got it previously”

“Interest rates not competitive”

Expense ratios

Expense ratios represent the proportion of income that is taken up by expenses. In this instance the expense ratio is calculated for the practice as whole rather than individual dentists.

Figure 9: Expense ratio for the 2009/10 financial year, by country, number of dentists and NHS income
The average expense ratio for practice in the 2009/10 was 0.66, ranging from 0.66 in England to 0.69 in Northern Ireland. The expense ratios did not differ much between levels of NHS commitment but did vary by practice size (see figure 9 and 10).

It must be noted that this question was only answered by 60 per cent of practice owners and therefore there may be some bias introduced if the responses of those who did not respond differ significantly from those who did chose to respond. These results should therefore be interpreted with caution.

**Figure 10: Expense ratios for the 2009/10 financial year, by country and number of dentists**

<table>
<thead>
<tr>
<th>Country</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.61</td>
<td>0.66</td>
<td>0.68</td>
<td>0.7</td>
</tr>
<tr>
<td>Wales</td>
<td>0.62</td>
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<tr>
<td>Northern Ireland</td>
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</tr>
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<td>Scotland</td>
<td>0.56</td>
<td>0.71</td>
<td>0.69</td>
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</tr>
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</table>

**Efficiency savings**

In 2010/11 practices were required to make efficiency savings of one per cent in order to maintain income from NHS contacts at their 2009/10 values. It is likely that NHS dentists will be asked again to make efficiency saving for 2012/13 so we asked practice owners where they would prefer to see the efficiency saving coming from.

In England and Wales a third (34 per cent) of practice owners suggested that they would like see an increase in preventative dentistry and a reduction in the highest UDA values (31 per cent). To assist in the implementation of these budgetary restraints, two-thirds (68 per cent) of practice owners in England and Wales would like to see a reduction in the administrative burden. Over half (54 per cent) would like to see a reduction in the range of treatment available on the NHS. By comparison, just over a third (37 per cent) of practice owners in Scotland thought that a reduced administrative burden would help in achieving the desired efficiency savings, and just over a quarter (28 per cent) thought that reducing the range of treatments available on the NHS would help.
Many practice owners felt that it was not possible to make any further savings. It was stated that dentistry is one of the most efficient areas in primary care and any further saving will essentially result in a wage cut of practice owners.

“Can’t see how we can squeeze anymore!”

“Don’t think we could be more efficient I think NHS dentistry is the most cost efficient part of the NHS”

“Extra efficiency a ridiculous expectation on a small business. Should find savings from 2yrs care very inefficient community service”

“It is not possible to make efficiency cuts for NHS treatment as practice expenses have increased so much.”

“Unrealistic to expect efficiency gains from an already highly efficient workforce”

“We cannot make our practice any more efficient without impacting on care quality”

“We cannot get more efficient.”

Other areas in which practice owners felt that efficiency saving could come from were to reform the UDA structure and the possibility of creating a limited service with in NHS contract.

“UDA system doesn't work.”

“Unfair how treatments overvalued in some practice with 'higher UDA' value, and costs are the same and increasing”

“Weighting given to UDA values in areas of deprivation to encourage low income patients to be chased for attendance more frequently.”

“Removing some items of treatment from NHS and providing basic core service.”

“More to a core system, fee per item, gives everyone an incentive”

“Removing some items of treatment from NHS and providing basic core service.”

Staff wages

Almost seven-in-ten dental nurses (68 per cent) and two-thirds of receptionists (63 per cent) and practice managers (62 per cent) in the UK received pay rises during 2010/11 financial year. Figure 11 shows the percentage of practices awarding pay rises in 2010/11 compared with the previous year. With the exception of Scotland, the tendency was for fewer practices to award pay rises in 2010/11.
Of those that were given a pay rise the average pay rise given to dental nurses in 2010/11 was 4.5 per cent the same as offered in 2009/10. Practice in England gave the highest pay increases averaging 4.6 per cent, while those in Scotland were offered the lowest on average (3.9 per cent).

Dental nurse pay was affected by the number of dentists working at the practice, with smaller practice giving larger increases on average.
The average increase for receptionists was 4.2 per cent. The average change was highest in England (4.3 per cent) than the other three countries. Similarly as with dental nurse pay awards, single handed practice on average awarded higher pay rises than practice with more than one dentist.

The average pay award for practice managers was 4.9 per cent, with England having the highest average among the countries (5.1 per cent). There was no correlation between the size of practice or NHS commitment and the level of wage increase offered.
Figure 15: Average percentage change to practice manager wages if an increase was given, 2010/11

Figure 16 shows the distribution of dentists’ annual personal income from dentistry in 2010/11 (before tax and national insurance). As expected, associates tended to have lower annual incomes with a third (32 per cent) of all associates falling within the £60,001-80,000 range, and just under a quarter (23 per cent) within the £40,001-£60,000 range. Practice owners had a wider distribution; while the most common bracket was £80,001-£100,000, this only accounted for 15 per cent of practice owners, and almost one-in-ten (7 per cent) of the practice owners reported incomes above £200,000. About one-in-ten practice owner (11 per cent) and associates (8 per cent) did not answer this question. While it is not clear why they did not answer these questions, if they are different to the dentist who did respond in a substantial way this could cause some of the non-response bias in the results. These results should therefore be interpreted with caution.

Figure 16: Percentage of dentists reporting the following personal annual taxable income brackets before tax and NI from dentistry in 2010/11
There were no clear effects of NHS commitment on practice owners' annual income but the picture was less clear for associates. Associates with 25-75 per cent of their income from the NHS were the most likely to earn over £80,000 (41 per cent compared with 21 per cent for predominately NHS and 24 per cent for predominately private associates) (figure 17 and 18).

**Figure 17: Distribution of practice owners', incomes, by NHS contribution (£)**

<table>
<thead>
<tr>
<th>NHS Contribution</th>
<th>&lt;£40,000</th>
<th>£40,001-80,000</th>
<th>£80,001-120,000</th>
<th>£120,001-160,000</th>
<th>£160,001-200,000</th>
<th>£200,001-240,000</th>
<th>£240,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-100% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 - 74% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 24% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 18: Distribution of associates', incomes, by NHS contribution (£)**

<table>
<thead>
<tr>
<th>NHS Contribution</th>
<th>&lt;£40,000</th>
<th>£40,001-80,000</th>
<th>£80,001-120,000</th>
<th>£120,001-160,000</th>
<th>£160,001-200,000</th>
<th>£200,001-240,000</th>
<th>£240,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-100% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-74% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-24% NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was also a clear difference with gender and annual income especially with practice owners. Male practice owners and associates were far more likely to earn over £80,000 than their female counterparts. Four-in-ten (42 per cent) male associates earn over £80,000 compared to one-in-ten (12 per cent) female associates (figure 19).
Figure 19: Percentage of dentists reporting over £80,000 personal annual taxable income before tax and NI from dentistry in 2010/11, by gender

Decontamination

Recent changes to decontamination regulations have altered the way in which practices operate (e.g. increases in the use of consumables, see Expenses section above). While higher mandatory standards are required in Scotland and Northern Ireland, a significant number of practices in England and Wales have attempted to reach best practice standards which have come at a significant cost.

Almost every practice in the UK now owns at least one autoclave (99.4 per cent), we assume the 4 practices who don’t are using central clinical sterilisation units. Four-in-five (79 per cent) practices own at least one ultrasonic cleaning bath and 42 per cent of practices owns at least one washer disinfector (figure 20 and 21) demonstrating a desire from practices to achieve a higher standard.

Figure 20: Proportion of practices that own one or more of the following pieces of decontamination equipment
To achieve higher standards of decontamination the additional equipment has extremely high on-going running costs and maintenance costs. This has had an effect on practice expenses with practice owners reporting an increase in water bills, electricity bills and annual equipment maintenance bills.

Figure 22 shows that on average practice owners saw their quarterly water bills rise by 24 per cent and their electricity bills rise by 25 per cent. Rises in water bills were rose the highest in Northern Ireland and there was some difference between low and high NHS commitment.

**Figure 22: Average percentage increase from 2009/10 to 2010/11 of quarterly water and electricity bills, by country and NHS commitment**
The cost of annual maintenance on average rose by 39 per cent across the UK (figure 23). In Scotland it rose by 50 per cent in comparison with Wales which rose by 19 per cent. Predominately private practices saw a higher average rise in annual equipment maintenance (48 per cent) than those with a higher NHS commitment.

**Figure 23: Average percentage increase from 2009/10 to 2010/11 of annual equipment maintenance, by country and NHS commitment**

<table>
<thead>
<tr>
<th>Country</th>
<th>UK</th>
<th>England</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>Scotland</th>
<th>0 - 24% NHS</th>
<th>25 - 74% NHS</th>
<th>75 - 100% NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39%</td>
<td>39%</td>
<td>19%</td>
<td>40%</td>
<td>47%</td>
<td>48%</td>
<td>30%</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Associates**

Twelve per cent of the associate dentists with at least some NHS income reported that NHS superannuation payments were not being deducted from their pay at the time of the survey.

**Figure 24: Percentage of associates that did not have NHS superannuation payments deducted from their pay**

<table>
<thead>
<tr>
<th>Country</th>
<th>UK</th>
<th>England</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>Scotland</th>
<th>0 - 24% NHS</th>
<th>25 - 74% NHS</th>
<th>75 - 100% NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12%</td>
<td>12%</td>
<td>14%</td>
<td>5%</td>
<td>3%</td>
<td>17%</td>
<td>11%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Associates in England and Wales were the most likely to report this (13 and 14 per cent respectively, compared with just five and two per cent in Northern Ireland and Scotland). Older associates, male dentists and those with more private income were all more likely than their colleagues to report that the NHS superannuation payments were not being deducted. This may well be due to the fact that they have already taken their pension.
payments are automatically deducted from associates’ earnings in Scotland and Northern Ireland.

Figure 25: Percentage of associates receiving the following payment method for the NHS work they provide

Associates were asked how they were paid for the NHS dentistry they provided. The most common payment method was a percentage of the fees they earned (82 per cent) with the mean percentage earned being 49.8 per.
Business Trends Survey 2011

Workforce and practice profile report

Background
This report details the findings from the workforce and practice profile questions of the 2011 Business Trends survey.

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Executive summary - Workforce

- One-in-four practices (26 per cent) are single-handed. Practices in Scotland were more likely than those in the other devolved nations to have four or more dentists.

- Thirty-nine per cent of practices have predominantly private income (0-24 per cent of their income from the NHS) while 39 per cent have predominantly NHS income (75-100 per cent NHS income). Almost one-in-five (19 per cent) of practices derive all of their income from private dentistry.

- Practices in England and Wales were more likely than those in Scotland and Northern Ireland to be predominantly private. Single handed practices were also more likely to be private than larger practices were (52 per cent of single handed practices were predominantly private compared with 27 per cent of those with four or more dentists).

- At a personal level, younger dentists and associates were more likely to derive the majority of their personal income from the NHS than older dentists and practice owners respectively.

- Half (51 per cent) of the respondents plan to increase the amount of private dentistry they provide in the next three years while just ten per cent plan to increase their NHS dentistry.

- The majority of dentists reported no change in the amount of hours they spent performing clinical dentistry, or the number of patients they saw in 2010/11 compared with the previous year.

- In contrast, 64 per cent of the respondents reported increases in the time they spent on administration. Practice owners were the hardest hit, with 65 per cent reporting increases to the time they spent on administration.

- Eighteen per cent of the respondents plan to retire in the next three years. In addition to reaching retirement age, many of those planning to retire felt that excessive administration had contributed to their decision.
Practice Profile
Twenty-six per cent of the practices in the UK were single-handed; while thirty-two per cent have four or more dentists (figure 1). Practices in Scotland were the most likely to have four or more dentists (42 per cent), compared with 18-34 per cent in the other countries (figure 2).

Figure 1: Practice profile UK

![Practice profile UK chart](image1)

Figure 2: Practice profile, by country

![Practice profile by country chart](image2)

Figure 3 shows that almost half of all practices in the UK were trading as a sole trader (49 per cent), with one-in-five trading as a limited company (21 per cent) and under a partnership agreement (20 per cent). One-in-ten practices (10 per cent) were working under an expense sharing agreement.

Figure 3: Proportion of practices working under differing practice ownership methods
Northern Ireland had the highest proportion of practices practicing as sole traders (58% per cent); while Wales saw a higher proportion of practices trading as a limited company (27 per cent) (figure 4).

**Figure 4: Proportion of practices working under differing practice ownership methods, by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Ltd company</th>
<th>Partnership</th>
<th>Sole trader</th>
<th>Expense sharing arrangement</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>15%</td>
<td>27%</td>
<td>51%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>18%</td>
<td>16%</td>
<td>58%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Wales</td>
<td>27%</td>
<td>12%</td>
<td>49%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>21%</td>
<td>20%</td>
<td>49%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>21%</td>
<td>20%</td>
<td>49%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

**NHS commitment**

Figure 5 demonstrates that almost one-in-five of the practices (19 per cent) derive all of their income from private dentistry. In total, 39 per cent of the responding practices had predominantly private income (0-24 per cent NHS income), and 39 per cent had predominantly NHS income (75-100 per cent NHS income).

**Figure 5: Distribution of the percentage of practice income derived from the NHS**
Looking at the predominantly private practices, there were some clear associations across the countries and the number of dentists. Practices in England were the most likely to have predominantly private income (42 per cent), followed by Wales (29 per cent), Scotland (24 per cent) and Northern Ireland (18 per cent).

Figure 6 shows that single handed practices were the most likely to be predominantly private (52 per cent, compared with 27 per cent of practices with four or more dentists). Caution should therefore be taken in interpreting findings relating to NHS commitment and/or practice size as the interaction between the two variables will influence results. For example, there is a chance that an observed effect of practice size could be due to the differing proportions of NHS and private practices in smaller and larger practices.

**Figure 6: Percentage of practices with predominantly or exclusively private income, by country, location, and number of dentists**
Comparing this to the 2010 Business Trends survey, there has been little change to the proportion of practices with predominantly private income in England (figure 7). Wales saw a four per cent decrease in the number of exclusively private practices (from 14 to 10 per cent), while Scotland saw a decrease in predominantly private practices from 33 per cent to 18 per cent in 2010. Given the smaller sample sizes for Wales and Northern Ireland care must be taken when interpreting these findings.
Figure 7: Percentage of practices with predominantly or exclusively private income, 2009 and 2010

Figure 8 shows the percentage of income derived from the NHS by dentists at an individual level. The figures are broadly similar to the practice figures but tend more towards NHS income. This is to be expected as private practices tend to be smaller (as shown above) and therefore employ fewer dentists per practice.

Figure 8: Percentage of dental income generated by the dentist themselves, that comes from the NHS

Practice owners were more likely than associates to have a higher contribution of private income. This association was clear regardless of practice size.
Age was also a factor, with associates in the 50 or over age group more likely than their younger colleagues to have predominantly private income (41 per cent compared with 38 per cent for the 36-49 year olds and 17 per cent for those aged 35 or under.

**Patient base**

Practice owners were also asked which patient groups they were taking on as new patients at the time of the survey. Private adults and NHS children were the two most commonly accepted groups in all countries except Scotland (were NHS children were the most common, followed by an even acceptance of private adults, NHS exempt and non-exempt adults). Practices in England and Northern Ireland were also more likely to be accepting children as private patients (30 per cent and 29 per cent respectively) compared with 19 per cent in Scotland and 15 per cent in Wales.

**Figure 9: Percentage of practices taking on the following groups as new patients in, 2011**

Over half (51 per cent) of the dentists across the whole UK plan to increase the amount of private dentistry they provide in the next three years while only ten per cent plan to increase the amount of NHS dentistry they provide.

Dentists with 25-74 per cent income from the NHS currently, were the most likely to increase private work (68 per cent). Dentists in Northern Ireland were the most likely to be planning on increasing their NHS dentistry (16 per cent).
Figure 10: Percentage of dentists planning to increase the amount of private/NHS dentistry they provide in the next 3 years

There was a slight reduction between 2010 and 2011 in the proportions of dentists planning to increase the amount of NHS dentistry they provide. Dentists were, however, slightly more likely to plan on increasing private dentistry in 2011 than they were in 2010.

Figure 11: Percentage of dentists planning to increase the amount of private/NHS dentistry in the next 3 years 2010 and 2011
Workload

Over half of dentists in the UK did not see a change in the hours they spent performing clinical dentistry in 2010/11 compared with the previous year (58 per cent). The same was true for the number of patients seen in 20010/11, for which 53 per cent of dentists reported no change on the previous year, while over quarter reported a decrease (28 per cent).

Administration was the area most likely to have increased for dentists. Almost a quarter (29 per cent) of the respondents reported substantial increases and a further 35 per cent reported that the time they spent on administration had increased somewhat.

Figure 12: Percentage of dentists reporting changes in the hours they spent performing clinical dentistry, dental administration, and the number of patients they saw in 2010/11 compared with 2009/10

On-in-five dentists (19 per cent) saw an increase in the hours they spent on clinical dentistry (5 per cent of these deemed substantial increases) and 23 per cent saw a decrease (5 per cent substantial decreases). Patients with a high NHS commitment were most likely to report spending more time on clinical dentistry and those who were predominantly private were the least likely. This is possibly evidence of the drop in demand for NHS dentistry due to the economic climate.

For the purpose of this question 'substantial' change was defined as change that had an appreciable impact on other aspects of the dentists’ work/life, while 'changed somewhat' was a noticeable change that could be accommodated without major changes to other aspects of their work/life.
Dentists in Wales were the most likely to report an increase in the number of patients seen in 2010/11 compared with the previous year. Predominantly NHS dentists were much more likely than predominantly private dentists to report an increase in patient numbers; 28 per cent reported an increase of some scale, while just 7 per cent of predominantly private dentists reported the same.

**Figure 13:** Percentage of respondents reporting changes in the hours they spent performing clinical dentistry in 2010/11 compared with 2009/10

**Figure 14:** Percentage of dentists reporting that the number of patients they saw increased 'somewhat' or 'substantially' in 2010/11 compared with 2009/10
The rise in dental administration in 2010/11 reflects a longer term trend towards more time spent on administration. Figure 16 shows that the administrative burden has increased year on year for many practice owners. While 2008/09 shows the largest number of respondents reporting increased administration, the majority of practices have reported a rise in each of the subsequent years.

Figure 16: Percentage of practice owners reporting an increase in time spent on dental administration compared with the previous year, 2008/9 – 2010/11

Retirement

Eighteen per cent of dentists plan to retire from clinical dentistry within the next three years. As expected, dentists aged 50 and over were the most likely to plan to retire (41 per cent).
There was some difference across the nations, although this appears to be due, in part, to a lower number of respondents in the 50 or over age bracket in Northern Ireland in particular. See below for analysis of the dentists in the 50 or older bracket in more detail.

Figure 17: Percentage of dentists planning to retire or leave the dental profession (clinical) within the next 3 years

![Chart showing percentage of dentists planning to retire by age and country.]

When looking at the 50 or over age bracket in isolation, Wales had the highest number of dentists planning to retire (45 per cent), followed by England (41 per cent), Scotland (36 per cent), and Northern Ireland (34 per cent), see Figure 18.

Figure 18: Percentage of dentists aged 50 or older planning to retire or leave the dental profession (clinical) within the next 3 years

![Chart showing percentage of dentists planning to retire by age and country.]

Dentists who indicated that they were likely to retire in the next three years were asked to give details about the factors leading to their decision to leave the dental profession. Around one-in ten of the dentists also mentioned that stress and work related pressure had influenced their decision.

---

3 This was an open-ended question
Over one-in-four of the dentists who reported that they were planning to retire cited excessive administration as a factor influencing their decision, and a similar proportion sure to increasing regulation as a factor influencing their decision.


“Continuing and increasing burden of compliance issues, administration, and the increasing costs involved in running a practice”

“Excessive audits and paperwork reached NHS remuneration when targets not met. I am only 52 years but would gladly leave if I can get some other income stream”

“Massive increase in risk assessment health and safety and general admin. more litigious environment.”

“Don’t enjoy it as much, too much paperwork & policy to invent!”

“A ridiculous amount and level of regulation and enforced change in practice bureaucracy.”

“Age is one factor but administration pressure is the main push - incorporating over - regulation of the profession and business”

“Compliance requirements seems to be excessive, despite my best efforts, I feel I’m not achieving 100% compliance”

“Disenchanted with red tape and new regulation bodies.”

“Over regulation, health and safety increasing out of proportion. No help from PCTs. I wonder whose practice it is.”

Many of the dentists were disappointed with the additional requirements they face due to Care Quality Commission (CQC).

“Increasing bureaucracy and interference for no clinical reason of outside bodies i.e. CQC.”

“Increasing demands for non-clinical admin. CQC audit sterilisation complete.”

“CQC is not properly constructed, and does not appear to self analyse. infection control is not evidence based.”

Staffing

Dentist profile

Figure 19 shows the age and gender distribution of the dentists who responded to the survey. As expected, practice owners were more commonly in the 50 or over (70 per cent), or 36-49 (63 per cent) age brackets, while associates were most commonly in the 35 or under bracket (87 per cent).

Figure 19: Respondent’s age and gender
Figure 20 clearly shows the changing face of the dental profession, with females outnumbering males in the younger age band, but hugely outnumbered by males in the 50 or over age group.

**Figure 20: Respondent’s gender by age**

**Staffing levels**
Just over a quarter of practices were run by single-handed dentists (26 per cent), but just over one-in-ten (13 per cent) had a single dental nurse. The majority of practices had four or more dental nurses (headcount).
Across the UK, over two-fifths of practices do not employ any hygienists (44 per cent), and a similar proportion, (41 per cent) do not employ dedicated practice managers. Practices in England and Wales were more likely than those in Scotland and Northern Ireland to employ dedicated practice managers.

Predominantly NHS practices were the least likely to employ hygienists, 37 per cent did compared with 66 and 70 per cent in mixed and predominantly private practices respectively.

On average, practices had a headcount of 3.0 dentists, 4.0 dental nurses, 1.0 hygienists, 1.7 receptionists, and 0.7 practice managers. Figure 23 shows the average whole-time-equivalent (WTE) number of staff compared with the average headcount for each role. The difference between the average headcount and WTE staff shows that many members of dental staff are working part-time.
Scotland had the highest average WTE number of dentists (2.8) and dental nurses (4.0) compared to the UK averages of 2.4 and 3.2 respectively. There was also a relationship between the practice’s NHS income and the number of staff, with predominantly NHS practices having, on average, more WTE dentists and dental nurses than predominantly private practices.

Northern Ireland had a higher average number of dedicated receptionists than England, Wales and Scotland. In the case of Northern Ireland, this may be explained by the higher average number of dentists, as large practices are more likely to need dedicated staff in these roles.
The average WTE number of dedicated practice managers did not vary much with an average WTE of 0.5 across the UK.

**Figure 25: Average whole-time-equivalent dedicated practice managers, and dedicated receptionists in practices, by country, and NHS income**

![Graph showing average WTE numbers for practice managers and receptionists across different countries and NHS income categories.]

With the current economic climate affecting turnover and patients’ attendance we sought to understand whether this was having an effect on staffing levels in dental practices. While the majority of practices did not change their levels of dentists, one-in-ten (12 per cent) reduced the hours or number of staff whilst a similar proportion (11 per cent) increase their hours or number of dentists.

**Figure 26: Proportion of practices who have increased or reduced the hours or staff numbers in the last 12 months in the following staff categories**

![Bar chart showing the proportion of practices that have reduced or increased the hours or staff numbers in the last 12 months for different staff categories.]

Therapists were most likely to have had their hours or staff number reduced, however, they were also the most likely to have their hours and number increased (figure 26). A quarter (25
per cent) of practice had increased the dental nurses hours or staff numbers. This could be due to changing decontamination requirements which has resulted in more staff required to meet them.

**Recruitment**

Just over half of the practices in the UK had recruited for a dental nurse in the past 12 months (53 per cent). The level was similar across the nations although the proportion of practice in Wales was slightly lower at 42 per cent.

A fifth (21 per cent) of all practices had recruited for dentists to do predominantly NHS dentistry rising to 33 per cent of predominantly NHS practices. This is lower than reported in 2009/10 (32 per cent across the UK rising to 43 per cent for predominantly NHS).

Recruitment for predominantly private dentists was less common (11 per cent of all practices, and 20 per cent of predominantly private practices had recruited for private dentists).

This difference in private and NHS dentists is likely to be due in part to the current economic climate, and fits with the finding from the *Business Trends Morale report 2011* that predominantly private dentists were much more likely to report low morale due to a lack of patients (31 per cent did) than predominantly NHS dentists (9 per cent).

**Figure 27: Percentage of practices that have recruited for the following roles in the past 12 months**

Of the practices that did recruit for posts in the last 12 months, many reported that they had experienced major difficulty, in doing so and more still reported minor difficulties. Recruitment of NHS dentists and dental nurses appeared to be the most troublesome, causing difficulties for more than half (53 per cent) of the practices who had tried to recruit each of these roles.

**Figure 28: Percentage of practices who recruited for these posts, who reported difficulties**
Practices that reported difficulties were asked to indicate the type of problems they had faced in recruiting for each role. The most common problems were the poor quality of applicants, low number of applicants, unqualified staff and problems relating to remuneration.

Many respondents found that the quality of applicant was low and they were often forced to train from scratch.

“Can only get trainees not experienced staff and this makes the practice team weaker when strong staff go on maternity and then request p/t work lack of continuity.”

“Low quality applications and despite apparently selecting the best person he had completely the wrong attitude to delivery of quality patient care”

“Poor standard of applicants for dental nursing or dental receptionist.”

“Recruited an associate, but his clinical standards were not up to required standards”

“Recruiting dentists private or NHS - lots of overseas applicants were the predominant problem and they often had limited experience of clinical dentistry.”

“We are trying to recruit a dentist for predominantly NHS dentistry with some private. It is difficult to find quality applicants with all the required attributes who have the level of experience and quality we want.”

Many of those seeking to recruit found that there was not a high level of interest in the roles a received a low response rate.

“Advert in BDJ had very low response and only foreign interest. Managed to find a good associate through dental networking”

“Hardly any dentists interested. Mostly didn't have PCT numbers.”
“I have advertised 5 times for a Dental Nurse from October 2009 to Aug 2010. On each occasion I was inundated with replies/CVs (over 100 each time) from long term unemployed who have no interest in the job. Only 1 was interested/bothered.”

“Little choice - many applied but few turned up when invited for interview”

“Very small number of applicants and mostly unsuitable”

Often when applicants applied they did not have the requisite qualification for the roles advertised, especially with dental nurses

“Cannot recruit qualified nurses, lucky if I get one reply to adverts (plenty trainee applicants however). Struggled to find associate of suitable calibre”

“Dental nurses - lack of suitable educated and presentable school leavers for trainees. Lack of qualified nurses. Lack of training vacancies of colleges for trainee dental nurses”

“Difficult to recruit qualified dental nurse so offered a training post for NVQ level 3 dental nursing as a cheaper option”

“On two separate vacancies for dental nurses we had no experienced or qualified dental nurses apply”

Registration and training of dental nurses was a major difficulty for many practices, reducing the applicant pool, and also making it difficult to cover sickness and other absences. Many of the practice owners reported difficulties in finding registered applicants, and in finding training courses to put nurses on.

“Poor facilities to train DSA lack of courses to send them on”

“Suitable applicants and lack of well organised training courses”

“GDC registration for nurses is nightmare for rural practices with training courses”

“Part time nurse have left due to increase in CPD and GDC fees. A lot of practices have lost valued and experienced staff. Plus there is no little quality nurses around”

“Unrealistic demands of dental nurses since registration”

“The fact that dental nurses have to be registered and indemnified”

Some dentists reported trouble finding dentists wanting to work in rural locations.

“Difficulty attracting dentists to rural community”

“Impossible to get dentists to come and work in my area. None want to do NHS. Have had to take a non UK graduates who lack experience”

Associates

Two-thirds (66 per cent) of the associates had a written associateship agreement. These were most commonly held in England (by 67 per cent of the associates) and least commonly
held in Northern Ireland (by 50 per cent). Associates in predominantly private practices were less likely than their colleagues in predominantly NHS practices to have a written agreement (60 per cent and 70 per cent respectively).

Figure 29: Percentage of associates who have a written associateship agreement

![Graph showing the percentage of associates who have a written associateship agreement by country and NHS personal.]

While the vast majority of associates worked at one practice (76 per cent), one-in-five worked at two locations (20 per cent), and a small number worked at three or more locations on a regular basis (4 per cent).

Figure 30: Number of practices the associates usually work in on a regular basis*

![Graph showing the number of practices associates usually work in by country and NHS personal.]

* Includes all practices at separate locations, including those owned by the same owners
Business Trends Survey 2011

Morale and motivation report

Background
This report details the findings from the morale and motivation questions from the 2011 Business Trends survey.

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Executive summary - Morale and motivation

- The overall picture was one of decreasing morale across the UK. Predominantly NHS dentists scored much lower than predominantly private dentists on overall morale levels, and on a number of specific areas of job satisfaction.

- Over a third of the dentists in the UK (43 per cent) report having low or very low morale.

- Dentists in England and Northern Ireland were more likely to report low morale than their colleagues in Scotland and Wales, while predominantly private dentists are less likely to report low or very low morale.

- Almost half of the dentists reported that their morale had decreased in the last 12 months (63 per cent of practice owners and 47 per cent of associates). Predominantly private dentists were less likely to have reported a drop in morale.

- Predominantly NHS dentists were more likely than their private counterparts to feel under pressure to achieve targets and less likely to be satisfied with the care they provide, or with the level of autonomy in their job. Predominantly NHS dentists were also more likely to report experiencing more frustration than satisfaction working as a dentist.

- Predominantly NHS dentists were also more likely to cite a lack of time to provide preventive dentistry, or to provide the quality of care they would like to provide.

- The main concerns for practice owners were excessive administrative requirements and rising expenses. These were closely followed by decontamination requirements as a cause of low morale in practice owners.
Morale levels

Forty-three per cent of the dentists reported having low or very low morale. The proportion of dentists with low or very low morale was higher in England and Northern Ireland (46 per cent and 51 per cent respectively) compared to Wales and Scotland (35 per cent and 31 per cent respectively). Predominantly private dentists the least likely to report low or very low morale (37 per cent reported low or very low morale compared with 47 per cent for predominantly NHS dentists).

Figure 1: Percentage of dentists reporting low or very low morale

When looking at each country in isolation, Scotland showed slightly different patterns from the other countries. While practice owners were far more likely to report low or very low morale than their associate colleagues in the other nations, in Scotland the difference between the two was a lot smaller.
Comparing the 2011 data with 2010, morale across all countries appears to have decreased. The biggest difference was apparent in Northern Ireland were low morale rose from 27 per cent to 45 per cent, and in England were low morale rose from 31 per cent to 44 per cent.

Over half of the dentists reported that their morale had decreased (either ‘somewhat’ or ‘substantially’) in the last 12 months (56 per cent). Practice owners were the most likely to report a decrease in their morale (63 per cent compared with 47 per cent of associates). Predominantly private dentists were also less likely that their colleagues with more NHS income to report decreased morale.
These results were consistent with the self-reported morale levels above, in that the proportions reporting a substantial decrease in morale over the last year were lower for associates, among women, and among dentists with predominantly private income.

**Figure 4: Percentage of dentists in the UK reporting that their morale decreased somewhat or decreased substantially in the last year**

**Areas of satisfaction**

The dentists were asked to indicate their level of agreement or disagreement with the following statements:

- I am satisfied with my job as a dentist
- I would recommend dentistry as a career
- I am happy with the care I am able to provide to my patients
- I currently experience more frustration than satisfaction working as a dentist
- I am satisfied with my pay
- I am satisfied with the level of autonomy in my job
- I feel under pressure to achieve targets
- I am happy with the hours I work

Overall, dentists were most likely to agree that they are happy with the care they are able to provide for their patients (69 per cent agreed or strongly agreed with this statement). Three-fifths agreed or strongly agreed that they are satisfied with their job. A quarter of the dentists were not happy with the hours they work (disagreeing or strongly disagreeing with the statement). Thirty-seven per cent of the practice owners were not happy with the hours they work compared to 15 per cent of associates.

The only major difference across the devolved nations was the number of dentists who felt under pressure to achieve targets. As expected from the nature of the NHS contracts in England and Wales, dentists in these areas were more likely to feel under pressure to achieve targets. Two-thirds of the dentists in England and Wales (64 and 62 per cent
respectively) felt under pressure to achieve targets, compared to over half (55 per cent) of the dentists in Northern Ireland, and a third (31 per cent) in Scotland.
There were some clear differences by NHS commitment that echo the earlier findings. Predominantly NHS dentists were appreciably more likely to agree that they are under pressure to achieve targets. They were also appreciably less likely to be satisfied with the care they are able to provide, and less likely to be satisfied with their level of autonomy.

Figure 5: Level of agreement with the following statements

*Note these statements are framed in the negative

Figure 6: Percentage of dentists in the UK who ‘agree’ or ‘strongly agree’ to the following statements, by NHS income

*Note these statements are framed in the negative
Factors causing low morale

With regards to the specific issues, four-out-of-five of the practice owners cited excessive administration (84 per cent), and rising expenses (84 per cent) as negatively impacting on their morale. These were followed by decontamination requirements (cited as a negative morale issue for 62 per cent of practice owners).

The major concerns regarding administration was that it is excessive, detracting from clinical time, and often does not seem relevant to patient care, as well as the increase in volume in recent years.

“Exponential increase in paperwork very depressing.”

“It is almost impossible for a one man high quality practice to survive. I am booked up 3 months in advance but spend more time on administration than on clinical work (which I love)”

“Endless administration, endless changing requirements in order to comply with ever increasing regulations.”

“Increased burden of administration at a time of uncertainty.”

“Endless administration, endless changing requirements in order to comply with ever increasing regulations. I do not know how younger dentists cope with it as it consumes ever increasing amounts of my free time. Other I am sure do not have the free time.”

“Amount of governance and admin has got ridiculous-CQC HTM0105 impose regulations with little proof that they improve patient safety or care.”

“CQC/H1W and other paperwork - much is unfocused on dentistry just being treated as a hospital. Regulation fail to understand structure of small dental practices”

The rising expenses were affecting levels of morale by increasing the financial burden and pressure on practices and staff.

“Increasing costs are resulting in essentially a pay decrease. Increasing practice costs are resulting in more pressure from practice principal. At present every patient requires lots of treatment - including lots of root canal treatment. I cannot provide the quality treatment I would like to if I have to meet targets. I therefore do not meet targets. I am working harder for decreased pay”

"Expenses going up and up with no increase in pay - this puts pressure on the dentists who is unable to financially reward good staff.”

"Rise in expenses has meant we cannot increase staff as much as we would like. Although staff are fully informed of why this understandably decreasing morale. Can no longer afford to pay associates 50%. 35% more appropriate but don't know how to address this. Admin increase has taken me away from treating patients.”
The main issues for associates in England and Wales were the structure of the UDA bands, and UDA targets were an issue for 59 and 50 per cent of associates in England and Wales respectively.

“At our practice we are under constant pressure to achieve UDA targets yet receive no thanks when we do“

“Frustrated by UDA targets and amount of work that I’m increasingly having to achieve the UDA on a course of treatment. Don’t feel supported by PCT.“

“UDA targets more difficult to achieve, patients save problems until multiple treatments required.“

“Excessive paper work and box ticking. UDA treadmill. Unable to take on complex cases on the NHS without suffering financial penalty.“

“The current UDA system punishes good dentists but I don’t see the proposed changes making much of an improvement.“

“I provide NHS care for children only. However, the UDA value and structure of bands has made me consider whether providing this care under the NHS is viable.“

RQIA registration was an issue for the majority of practice owners (93 per cent) working in Northern Ireland. The main issues for practice owners in Scotland were rising expenses (59 per cent) and excessive administration (52 per cent).

Figure 7: Percentage of dentists in the UK who felt the following issues were negatively impacting on their morale, by job role
There were some differences in the types of issues affecting morale, according to dentists’ NHS commitment. The difference was most striking around the workload issues. Predominantly NHS dentists were more likely to report morale issues from a lack of time to provide preventive dentistry, and care of the quality they would like than their predominantly private colleagues.
Figure 9: Percentage of dentists in the UK who felt the following issues were negatively impacting on their morale, by NHS income

Predominantly NHS dentists were also more likely to report having too many patients; a quarter (26 per cent) reported this problem, compared with four per cent of the predominantly private dentists.
Annex 3

British Dental Association

Salaried Primary Dental Care Services
Morale Survey 2011

July 2011

Policy Research Unit, British Dental Association
64 Wimpole Street, London, W1G 8YS
Background

1. In 2005 NHS Partners conducted a survey into the Salaried Primary Dental Care Services (SPDCS) entitled ‘What makes a career as a salaried primary care dentist rewarding?’. The BDA Research Unit followed this up in 2010 with a report which assessed the morale and motivation of dentists in the Salaried Primary Dental Care Services (SPDCS). This report follows on from the 2010 survey and attempts to continue to monitor the morale and motivation of dentists with in the SPDCS.

Method

2. A portal link to the survey with instructions was sent via email to a random sample of SPDCS BDA members across the UK. The survey was distributed to 1060 members in the last week of March 2011. A reminder was emailed in mid-March and a response rate of 43 per cent was achieved (461 replies). Comparisons have been made between the 2010 report and results found in this survey. There was a small number of responses from those in Scotland and Northern Ireland, so care must be taken when interpreting these results.

Report Structure

3. This report begins with an executive summary of the main findings and the report recommendations. This is followed by the main report. A copy of the survey can be found in Appendix 1 (page 29).
Executive Summary

- More than half (58 per cent) of the respondents stated that their morale was low or very low. Only 13 per cent of respondents stated that their morale was high. Over 70 per cent of felt that their morale had decreased in the last year.

- The biggest issues affecting morale were the uncertainty surrounding the SPDCS and the NHS in general. Other major factors affecting morale were inadequate staffing levels, poor leadership, ill-informed commissioning, increased administrative burden, and the Transforming Community Services programme.

- Just one-in-five participants felt they had sufficient time for clinical administration, and this figure falls to 15 per cent when considering Dental Officers (Band A).

- Inadequate staffing levels were highlighted in last year’s report, yet still only one-in-five (23 per cent) participants felt that the staffing levels were of an adequate level.

- The vast majority (90 per cent) of those in England felt that Transforming Community Services would have an impact on the SPDCS, with more than half (59 per cent) feeling that it would have a large impact on the service.

- There was also concern regarding the wider NHS reforms with more than nine-in-ten (93 per cent) participants in England anticipating an impact to the SPDCS; and over half (58 per cent) believe that it will have a large impact on the service.

- Only a third (38 per cent) of those surveyed said that they would recommend a career in the SPDCS, which is considerably lower than the 45 per cent that said they would in 2010.

- Just under half (47 per cent) of those surveyed were happy with the leadership and management within the SPDCS, a similar figure recorded in 2010, but less than in 2005 (62 per cent).

- Over half of the participants (51 per cent) were not satisfied with their current level of job security. In addition, two-thirds are very concerned, and 27 per cent somewhat concerned about possible changes to their NHS pension. Only 5 per cent were not concerned at all about and prospective changes. Levels of concern were fairly universal across all countries, salary bands, and age groups.

- Participants stated that the biggest improvement to their working life would be to have adequate levels of staff across the service; recognised time for administration; better leadership within the service; and, a period of stability with the service.
Recommendations

2. **Staffing and recruitment** – This has been an issue highlighted by the BDA over the last couple of years, and was one of the major recommendations from the 2010 report. There seem to be an overwhelming need for appropriate staffing levels to be adopted across the service. To achieve this active recruitment policy needs to be put in place and recruitment freezes need to be lifted. If is not addressed it is likely, not only to have a detrimental effect on morale, but the increased workloads will be damaging to patient care.

3. **Administration** – In light of the recent regulatory changes (e.g. HTM 01-05) there needs to be recognition from the trusts that the administrative burden within the service has significantly increased. This change and additional workload should be reflected in changes to working patterns. Time should be set aside so that these tasks can be completed properly so they do not impinge on clinical care or employee work-life balance.

4. **Service monitoring** - The sole use of UDAs as an outcome measure within the service without consideration of the patient mix is damaging to the morale of individuals in the service. Recognition by commissioners of the differences between General Practice and SPDCS is an essential first step in formulating more appropriate outcome measures based on quality, rather than the target driven approach.

5. **Recognition of the service** – commissioners and government need to understand that the care which the SPDCS provides is not the same as General Practice. It would be beneficial if the work of the SPDCS was promoted nationally and locally to both provider and users. The service provides a vital service to vulnerable members of the community and the assessment criteria cannot and should not be the same as used in General practice.

6. **Future** – There are high levels of uncertainty within the service across almost all aspects within the role. Uncertainty regarding the future of the service, the future of the NHS, job security, changes to terms and conditions, and remuneration are all impinging on morale. There is a clear need for a period of stability within the service so that employees can focus on patient care. There is a need for expediency to clarify any proposed changes and a clear long-term plan need to be communicated to all employees.
Respondents

Table 1: Respondent’s profile

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Seventy per cent of respondents were female and 30 per cent were male. The highest percentage of respondents were aged 50 or over (54 per cent) with just over a third aged between 36 and 49 (35 per cent). Over three quarters of the respondents (77 per cent) were based in England, followed by 12 per cent in Scotland. Seventy-nine per cent of those that responded were based in urban locations, with the remainder based in rural locations. This respondent profile is consistent with the profile of all BDA members working the SPDCS.

Senior Dental Officers (Band B) made up the highest proportion of respondents with over a third (37 per cent) currently in this role. This was closely followed by Dental Officers (Band A) who also comprised of over a third of respondents (32 per cent), and Band C Managerial/Clinical Directors with 16 per cent.
Respondents had been in their position for an average of ten years, ranging from those who were new in to post to those that have been in their post for over thirty years. However, the average time the respondents had worked in SPDCS was eighteen years, suggesting a pattern of career progression within the service.
Main Findings

Morale

Overall, the levels of morale were poor, with more than half (58 per cent) of the respondents describing their morale as low or very low. Only 13 per cent of respondents stated that their morale was high, and less than half a per cent (0.4 per cent) reported very high morale. Morale has deceased since 2010, when just over half (51 per cent) of respondents stated that their morale was low or very low.

Those in Managerial/Clinical Director (Band C) roles had the highest proportion of high morale (19 per cent) within the job roles, compared to Senior Dental Officers (Band B), where only 11 per cent had high morale. Those working as dental officers (Band A) had the lowest morale with two-thirds (65 per cent) having low or very low morale.

Individuals working in Scotland had the largest proportion of high morale across the countries where one-in-five respondents (20 per cent) stated they had a high or very high morale, compared to 13 per cent in England.

Figure 3: How would you rate your morale as a dentist in the SPDCS at the moment?

We attributed a score to each aspect (e.g. working hours, benefits) of morale and job satisfaction discussed below and added them to give an overall satisfaction score for each respondent. The overall satisfaction score has a theoretical maximum score of +46 for someone who gave the most positive response to each question, and –46 for the most negative response to each, a score of zero would indicate a balance of positive and negative responses.

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4 Scores were given to questions 4, 5, 6 & 8. Scores were given on a scale from '2' the most positive to '-2' for the least positive.
The overall scores ranged from 37 to -31 with an average score of 4.3. This is a reduction from 2010 when the average score was 4.7. There were some differences in the average scores between the countries with Northern Ireland having the lowest average satisfaction score of 1.3 and even though England had the lowest recorded level of morale it had the highest satisfaction score of 4.5. This suggests that although self-reported morale is low in England, there is greater satisfaction with the individual facets within their roles.

There was also a stark difference between the average morale scores of the salary bands. Managerial/Clinical Director roles (Band C) had the highest average score of 9.3. In comparison Dental Officers (Band A) had an average score of 0.6, showing that they are significantly less happy with aspects of working in the SPDCs.

**Figure 4: Overall satisfaction scores**

When asked whether they felt their morale had changed in the last year, over 70 per cent (71 per cent) of the respondents felt that their morale had decreased by some degree, and over of third (35 per cent) of those said it had substantially decreased. Only seven per cent have felt an increase in their morale on the last year. Dental Officers (Band A) were the most likely to report decreased morale, with 75 per cent reporting this.

The majority of participants in each country stated that they had experienced a decrease in morale over the last year. Northern Ireland had the highest proportion of respondents stating a decrease in morale with three-quarters (75 per cent) stating so. In comparison, 53 per cent of those in Scotland felt that their morale had decreased in the last year.
Negative impacts on morale

Participants were asked what issues were currently having a negative impact on their morale. Several reoccurring issues emerged, with uncertainty within service being most commonly cited issue.

Participants were concerned about the level of uncertainty regarding the future structure of the service and the impact of budget cuts on the SPDCS. While this was a key issue last year, it was not the most commonly cited cause of negative morale. It is apparent that over the last year, and in light of recent political discussions regarding reforming the NHS, the continued uncertainty surrounding the service has become a bigger issue for those in the service.

“Uncertainty about future of NHS as a whole...Uncertainty and lack of faith in new commissioning arrangements in the NHS as a whole and in particular around dentistry.”

“Re-organisation of the local NHS structure and uncertainty about the future commissioning model for dentistry.”

The uncertainty was also fuelled by concerns about funding within the service and cuts which have occurred in the SPDCS budgets recently. The levels of cuts caused concerns for the future of their positions and concern for the vulnerable patients for whom the service is a vital source of health care.

“No one knows what is going to happen in the future when it comes to cuts within the NHS”

“Concerns about the future of SPDCS and how cuts in funding will impact on service provision.”

“Imminent budget cuts and redundancies in an already 'stretched' service.”

“Cuts to the budget while demand for services in increasing.”

“Cost savings leading to anxiety regarding redundancies and pay freezes. Also TCS potential loss of NHS terms and conditions”

This has been compounded by a lack of communication about changes. As well as poor communication, participants felt that they are not being consulted on decisions which were taking place. They felt that they are an invaluable and unused source of information regarding the intricacies of the service.

“Uncertainty about future of clinics as many under threat of closure: Trust management have absolutely no clue what's happening and there is no communication.”

“Line manager Clinical Director, making decisions without staff consultation and lack of information even after decision.”

“Lack of information on which to form a view of the future.”
“Insufficient information on what is happening, no perceived input from staff available.”

“Lack of communication from those in management.”

Another factor having a major effect on the morale of those in the salaried services was poor management and weak leadership by commissioners and managers. This was often magnified by being managed by people without any clinical dental experience. They felt that managements’ lack of knowledge and understanding of dentistry and patient care was having a negative impact on morale.

“We have more managers who have no idea about dentistry, they are telling us what to do. I think we are being lied to when asking difficult questions.”

“Lack of recognition and poor understanding of the nature of the work or type of patient by commissioners and managers.”

“Our organisation has just gone through a management reduction exercise with the loss of 54% of management costs. Leadership is poor as a result, as is communication.”

“Trust management have absolutely no clue what’s happening and there is no communication.”

“Not a professionally led organisation which bullies staff to resign, so cheaper staff can be employed.”

“Ignorant commissioners. Poor leadership.”

Participants felt that this basic understanding and appreciation for the work of the service contributed to unrealistic workloads and poor morale.

“Conflicting imperatives e.g. do higher productivity AND higher quality in the same time; lack of recognition and poor understanding of the nature of the work or type of patient by commissioners and manager.”

“Commissioner’s apparent lack of understanding that treating special care patients requires time, skill and patience.”

“Lack of commissioners understanding of service.”

“Poor understanding of the nature of the work or type of patient by commissioners and managers.”

Inadequate staffing levels was a concern repeated by many. Many participants commented that when positions became vacant they were unable or not allowed to recruit to fill that position resulting in increased workload for those staff remaining. This increased burden, which is viewed as unnecessary, is having a detrimental effect on the morale of those staff remaining and the service as a whole.
“Lack of replacement of key staff (e.g. admin, nurses) owing to NHS cutbacks.”

“Staff who leave not being replaced increasing workload, increased overtime as under staffed.”

“Not enough staff in the service. No genuine attempts to recruit more staff.”

“Inability to recruit staff due to freezes is placing huge burdens on existing staff - there is a lot of “papering over the cracks” going on. This works because staff are conscientious and willing to put in the (increasingly) extra time and effort for the sake of their patients but it is causing massive resentment.”

“Support staff not being replaced as they leave, recruitment block leading to increased clinical work load.”

“Unable to recruit new dentists, which has increased our workload dramatically.”

“Lack of clinicians meaning hugely increased workload.”

In addition to increased workloads from inadequate staffing levels, the target driven Units of Dental Activity (UDA) system in England and Wales is putting additional pressure on those in the service and lowering morale. Many of those surveyed felt that the UDA system used is not an appropriate system to use within the service, due to the nature of patients referred into the system. They felt that the service is not comparable to general practice and therefore similar monitoring and outcome measures should not be used.

“I think that patients’ quality of treatment and what is best for the patient is no longer central to the NHS now but more about how targets can be achieved in order to avoid claw backs and attract funding. This can create an environment where a dental service may follow the government/management lead and so lack of commitment to the patient is possible i.e. just see them as UDAs etc.”

“Unrealistic targets for special care patients, especially around UDA’s.”

“Increased stress on meeting unrealistic UDA targets.”

“Unrealistic activity target which will not be met as insufficient staff. Commissioning refusing to engage with clinicians.”

“The unfair use of the UDA system as a target system - does not measure quality, only quantity.”

The changes within the Transferring Community Services programme is causing concern within the service and impacting on morale in England. There is a level of uncertainty about how the change will affect the services which are being provided. In
addition there is concern about how the change will impact on the individual’s terms and conditions.

“Anxiety of becoming non NHS organisation with TCS.”

“Proposed move to become part of a SET, uncertainty about process of change, threat to T&Cs especially pension and retirement options.”

“Transforming Community Services, we have no clear future, I would like our services to stay within the NHS.”

“Uncertainty around TCS and organisational change/potential threats.”

“Transforming Community Services and leaving the security of the long established NHS umbrella.”

In light of recent regulatory changes the level of administrative and bureaucratic tasks which have to be undertaken has hugely increased. A number of respondents complained that work schedules have not changed to accommodate these additional requirements. This has resulted in both the clinical time being reduced and additional unpaid overtime (late evening and weekends) being worked by some in order to complete these additional tasks.

“Increased administrative workload due to reduction in support staff. Feel clinical skills are being wasted at the expense of doing work which should be done by someone else i.e. dental nurses or admin support. Am expected to take on extra tasks without any amendment to current job plan and expected to simply absorb the extra work. Working from home almost every day despite being ”part-time” to catch up on administrative and urgent referrals etc.”

“Having to work an hour plus extra every night to do paperwork.”

“Increased work load especially administrative tasks. Necessity to work over hours.”

“Less and less time is spent producing clinical work (treating pts) and more and more admin without actually allowing admin time.”

There were significant concerns regarding levels of remuneration. These related to the fairness of the pay scale, pay freezes, and major fears regarding the uncertainty of their pension provision.

“Pay freeze putting a strain on family finances with the background of increasing inflation.”

“Pay discrepancy between salaried and general practice.”

“Poor salary with no pay rise for the past 3 years.”

“No pay rise despite inflation rise, uncertainty about pension value.”
“Pension insecurity. No cost of living increase this and next year resulting in substantial pay reduction.”

Other factors having an impact on the morale within the services were concern for patients; pensions and retirements; the lack of recognition that the service receives; lack of research opportunities; reduced funding/opportunities for training, and the nature of the referrals system.

**Job satisfaction**

Almost half (46 per cent) of those surveyed expressed satisfaction in their current role with just under a quarter (29 per cent) expressing dissatisfaction. Satisfaction with the role is lower than 2010 (52 per cent). Dissatisfaction with the job is less commonly reported than low morale, suggesting that the job itself is not the cause of the poor morale but aspects of the role as discussed individually below.

There were some differences in the levels of satisfaction across the salary bands with the Dental Officers (Band A) having the lowest levels of job satisfaction at two-fifths (40 per cent), and Managerial/Clinical Director roles (Band C) having the highest levels of jobs satisfaction with two-thirds (56 per cent). It is apparent that within each job role there has been a reduction in their job satisfaction since 2010.

Those based in Northern Ireland had the lowest level of satisfaction with two-fifths (40 per cent) of respondents satisfied with their job; dentist based in Wales had the highest levels of satisfaction with 53 per cent satisfied with their current role.

**Figure 5: Please indicate how strongly you agree or disagree with the following statements:**

![Bar chart showing levels of agreement]

**Autonomy**

Respondent’s satisfaction with the autonomy in their role varied, both in general and across the roles. Overall, more than two-fifths (46 per cent) of the respondents were satisfied with the level of autonomy in their job. Dental Officers (Band A) had the lowest...
level of satisfaction with their autonomy with over a two-fifths (42 per cent) dissatisfied and under a third (32 per cent) satisfied. The highest level of satisfaction amongst the differing job roles were Managerial/Clinical Director (Band C) roles where almost two-thirds (59 per cent) were satisfied with the autonomy in their role.

There was some variation between the levels of satisfaction between the locations of the dentists. Of the four countries, Northern Ireland had a higher proportion (50 per cent) of dentists satisfied with their level of autonomy compared to than those in Wales who had the lowest (43 per cent).

Provision of care

Two-thirds (68 per cent) of those surveyed felt happy with the care they are able to provide to their patients. This is a similar level that was found in 2010 (66 per cent). This proportion increases to 70 per cent when considering those dentists based in Scotland and to 74 per cent for those working in rural areas.

While the majority of those surveyed were happy with the care they provided, others saw the reduced care they were able to provide as one of their factors affecting their morale. It was commented that inappropriate targets and staffing levels led to a lack of provision for patients. In addition it was felt by some that certain patient groups were being neglected in order to meet access targets.

“Lack of provision of patient care due to inappropriate/inadequate staffing levels/sites etc.”

“Increasing pressure to reduce time spent with patients who require a lot of time.”

“Special needs patients being made low priority to meet access targets.”

“Working to provide care for Special Care patients it is very disappointing watching resource be diverted from our neediest patients into either undergraduate training or to meet government targets with for example Childsmile and NDIP.”

More frustration than satisfaction

Over half of the respondents (50 per cent) were experiencing more frustrations than satisfaction working in the service. This has risen from 2010 when 46 per cent of respondents had such feeling. This feeling of frustration was most acute amongst those Dental Officers (Band A, 55 per cent) compared with those in specialist roles (Band C, 45 per cent).

There were also differences between the countries with those in England more likely to be experiencing frustration (52 per cent), in comparison with those in Scotland where only a third (35 per cent) of respondents stated so.
Figure XX: Comparison between 2009/10 and 2010/11 of those who agreed or strongly agreed with the following:

- My job gives me the chance to do challenging and interesting work
- I would recommend a career in the SPDCS
- I am satisfied with my job as a dentist in the SPDCS
- I am satisfied with the level of autonomy in my job
- I am happy with the care I am able to provide to my patients
- I currently experience more frustration than satisfaction working in the SPDCS

Challenging and interesting work

The vast majority (73 per cent) of those surveyed found that their job gave them the chance to do challenging and interesting work, with only one-in-ten (10 per cent) disagreeing with this statement, similar to levels found in 2010.

Those in Managerial/Clinical Director position (Band C) were most likely to find their job challenging and interesting with 85 per cent of them stating so. This proportion fell considerably to 59 per cent when assessing those Dental Officers (Band A).

Figure 6: Please indicate how strongly you agree or disagree with the following statements:

- My job gives me the chance to do challenging and interesting work
- I would recommend a career in the SPDCS
- I feel valued in my role

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5 Only includes questions which were asked in both years
Recommend a career in the SPDCS

Only two fifths (39 per cent) of those surveyed said that they would recommend a career in the SPDCS, which is considerably lower than the 45 per cent that said they would in 2010. Those in Managerial/Clinical Director positions (Band C) were more likely to recommend a career within the service; more than half (51 per cent) suggesting they would. Those working as Dental Officers (Band A, 33 per cent) and Senior Dental Officers (Band B, 35 per cent) were a lot less likely to recommend a career in the service.

There was also some discrepancy between age groups. Over half (57 per cent) of those under 35 years old would recommend a career in the service, in comparison with only a third (33 per cent) of those over the age of 50.

Training and development

Two-thirds (68 per cent) of respondents were satisfied to some degree with the current level of training and development they were receiving, which is slightly lower than 2010 where 75 per cent of respondents were happy with the training and development offered.

There were differences in the levels of satisfaction between the pay bands. Those in Managerial/Clinical Directorial roles (Band C) had the highest level of satisfaction in their training and development with more than four-in-five (81 per cent) satisfied. Dental Officers (Band A) had the lowest level, with just over half satisfied (55 per cent).

Many participants, when asked what issues were affecting their morale, stated that their training budgets were not being honoured. They were often having to fund their own developments or were not being offered the opportunity.

“The trust I work for does not honour the contract as they will not release money for training.”

“Lack of PCT’s ability/ willingness to access the indicative training budget. This has not been touched since the new contract.”

“Having course fees paid - at present I have to pay all my own fees for courses, due to no money.”

“Pay and terms and conditions including study leave, which don’t appear to abide with Whitley or the 2007 contract with regard to training budget.”

Some also felt that the number of mandatory training courses had increased unnecessarily and could be reduced.

“Reduce frequency of mandatory training.”

“Mandatory training e.g. skin care, manual handling, etc seems unnecessary as often as we are expected to do it!”

“There seems to have been a huge increase in mandatory training programmes.”
Figure 7: How satisfied are you with the following in your current role?

Leadership and management

In general, just under half (47 per cent) of those surveyed were happy with the leadership and management within the SPDCS, a similar figure recorded in 2010, but less than in 2005 (62 per cent). This figure falls to 38 per cent when considering Dental Officers (Band A), and 41 per cent considering Senior Dental Officers (Band B). However, this increases to two-thirds (69 per cent) when isolating the Managerial/Clinical Director roles (Band C).

There are also apparent differences across the nations. While levels of satisfaction with leadership and management remained at just above half for England (52 per cent), they were significantly lower for those in Scotland (33 per cent) and Wales (21 per cent).

Terms and conditions

Almost two-thirds (65 per cent) of those surveyed were satisfied with the terms and conditions in place within the SPCDS, which is considerably lower than the three-

"Excessive time spent on repetitive Health Board mandatory training."
quarters (78 per cent) satisfied in 2010. There are slight differences between the age of participants with those aged 35 or under having a higher proportion satisfied with their terms and conditions (70 per cent), in comparison with those aged 50 or over (64 per cent).

Figure XX: Comparison between 2009/10 and 2010/11 of those who were mostly or very satisfied with the following:

- Training and development
- Leadership and management
- Terms and Conditions
- Working environment
- Clinical aspects of your role
- Research opportunities
- Career prospects

**Working environment**

Over two-thirds (69 per cent) of those surveyed were satisfied with their working environment, a slight drop from 2010 when 74 per cent were satisfied. There were slight differences between the roles; Managerial/Clinical Directorial roles had the highest levels of satisfaction with just under three-quarters satisfied (73 per cent) and Dental Officers (Band A) had the lowest level of satisfaction in their working environment with 64 per cent satisfied.

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6 Only includes questions which were asked in both years.
Figure 8: How satisfied are you with the following in your current role?

Clinical aspects of your role

The vast majority of participants (90 per cent) were satisfied or very satisfied with the clinical aspects of their role. There was some discrepancy between the salary bands. Almost all (97 per cent) of the Managerial/Clinical Directors (Band C) satisfied with the clinical aspects of their role, compared to 85 per cent of the Dental Officers (Band A).

Workload

Over half of those surveyed were satisfied with their workload (55.7 per cent), with the remainder dissatisfied. Dental Officers (Band A) were more likely to be satisfied with their workload (58 per cent) compared to Managerial/Clinical Directors (Band C, 49 per cent). Two-thirds (67 per cent) of those in Scotland were satisfied with their workload in comparison with half (50 per cent) of those in Northern Ireland.

Job security

Over half of the participants (51 per cent) were not satisfied with their current level of job security. There was a notable difference between the countries with only 40 per cent of those in England satisfied with their job security compared to 70 per cent in Northern Ireland and Wales, and 82 per cent in Scotland.
Research opportunities

Fifty-nine per cent of participants were dissatisfied with the research opportunities available within SPDCS. This is a similar level of dissatisfaction than found in 2010 where 58 per cent of participants were dissatisfied with the research opportunities available.

Across the countries surveyed, those in Scotland were most satisfied with the level of research opportunities; 59 per cent of those surveyed were satisfied. In comparison, those in Northern Ireland had the highest levels of dissatisfaction at 68 per cent.

Career prospects

Forty-two per cent of the participants were satisfied with the career prospects available to them in SPDCS, a similar level to 2010 (44 per cent). The level of those satisfied with their career prospects is at its lowest when considering Dental Officers (Band A), where under a third (29 per cent) were satisfied; and at its highest considering Managerial/Clinical Directors (Band C) at 58 per cent.
Benefits package

Participants were asked how they rate their benefits package overall (including NHS pension, annual leave and study leave). Over half (58 per cent) of those surveyed rate their benefits package positively, and less than one-in-ten (9 per cent) gave the benefits package a negative rating. Managerial/Clinical Directors (Band C) had the highest positive rating towards their benefits package with 70 per cent of those surveyed positively rating the package. Dental Officers (Band A) gave the benefits package the least positive rating with 52 per cent.

Figure 10: How do you rate your benefits program/package overall?

NHS pension

Two-thirds of participants were very concerned, and 27 per cent were somewhat concerned about possible changes to their NHS pension. Only five per cent were not concerned at all about the prospective changes. Levels of concern were fairly universal across all countries, salary bands, and age groups.
Figure 11: Are you concerned about possible changes to the NHS pension?

![Pie chart showing the percentage of responses with 67% very concerned, 28% somewhat concerned, and 5% not at all.]

Satisfaction with pay

Over two-fifths (41 per cent) of the respondents were satisfied with their pay. More than half (51 per cent) of the Managerial/Clinical Directors were satisfied with their pay in comparison with just a third (33 per cent) of Dental Officers.

Paid fairly

While two-fifths of those surveyed were satisfied with their pay, a smaller proportion felt they were paid fairly given their performance and contributions to the SPDCS (37 per cent). Dental Officers (Band A) had the lowest proportion of individuals who felt that they were paid fairly with just a quarter (26 per cent) of the Dental Officers feeling their level of pay was fair. Almost half (49 per cent) of the Managers/Clinical Directors (Band C) felt they were paid fairly.

Figure XX: Comparison between 2009/10 and 20010/11 of those who were mostly or very satisfied with the following:

- I feel under pressure to achieve targets
- I am paid fairly given my performance and contributions to the SPDCS
- I am satisfied with my pay

Only includes questions which were asked in both years
Working hours

Almost three-quarters (74 per cent) of those surveyed stated that they regularly worked more than their contracted hours. There was substantial difference between the job roles and the country of the participants. More than nine-in-ten Managers/Clinical Directors (Band C) regularly worked more than their contracted hours. In comparison, just over half (60 per cent) of Dental Officers (Band A) did the same.

Those surveyed in England (78 per cent) were the most likely to regularly work more than their contracted hours, compared with those in Scotland who were the least likely (56 per cent).

Pressure to achieve targets

The majority (60 per cent) of participants felt some pressure to achieve targets. This was a similar level to 2010 (58 per cent). This proportion decreases to 53 per cent when considering Dental Officers (Band A), and increases to a three-quarters (78 per cent) with Managers/Clinical Directors (Band C).

England had the largest proportion of those who felt under pressure to achieve targets with almost two-thirds (64 per cent), compared with Scotland where just over two-in-five (44 per cent) felt under pressure.

Time for clinical management and administration

In general, just one-in-five (21 per cent) of those surveyed felt they had sufficient time for clinical administration. This figure falls to 15 per cent when considering Dental
Officers (Band A). There was a higher proportion when isolating the Specialists (Band C) but it was still the minority who felt they had sufficient time (30 per cent).

There were also differences across the nations. Levels of satisfaction with time for clinical administration remained at just under a third for Scotland (31 per cent) but was considerably lower for England (20 per cent), Northern Ireland (15 per cent) and Wales (17 per cent).

**Staffing levels**

Inadequate staffing levels were highlighted in last year’s report, yet still only one-in-five (23 per cent) participants felt that the staffing levels were adequate in the SPDCS. This proportion rose slightly to 27 per cent when considering Managers/Clinical Directors (Band C).

Those in Northern Ireland were most likely to consider the staffing levels inadequate with only 10 per cent considering them adequate. Those in Scotland were the most likely to consider their staffing levels adequate (40 per cent did so).

**Improvement to the SPDCS**

When participants were asked what change would bring the biggest improvement to their working life they provided a variety of suggestions for improvement. A number of reoccurring themes became apparent which would improve working life.

By far the most commonly suggested change was to lift vacancy controls and provide adequate staffing levels within the service. This suggestion applied to all grades and staff, from Dental Nurses to Clinical Directors. As vacancy controls have caused major impacts on workload and morale, opening recruitment and allowing positions to be filled as staff leave would mean an instant improvement in working conditions.

“Having funding to provide appropriate level of care for demands of patients in the area ie being able to recruit staff.”

“For our service to be able to recruit new clinicians and DCPs to reduce clinical workload.”

“Increased staffing at all levels, admin, nursing, DCP, senior dentists to enable staff to act fully in their own role.”

“Increased staff numbers to deliver the high quality of care that patients locally deserve.”

“Recruitment to vacant clinical posts, at present there is a recruitment freeze and efficiency savings will probably mean loss of these posts. Sufficient clinical staff would mean patient services would be increased and clinical management could be programmed into weekly schedule for those that have the responsibility.”
“We need more staff to manage patient workload, but many positions have not been filled and there is a reluctance on senior managers to realise the futility of our situation going forward.”

Increased levels of administration were a cause of particular frustration amongst the participants. There were three main proposals as to how best to improve the situation. One was to decrease the levels of administration, especially unnecessary administrative tasks. Another would be if the additional administrative burden was recognised and appropriate time was scheduled into the working day. The final suggestion would be to employ additional support staff to be able to assist with the administrative task, which would allow the clinician to focus on patient care.

“They need to give realistic time for admin but it’s not going to happen because of UDA targets.”

“Admin support to relieve me of some of the paperwork!”

“Appreciation for amount of admin done outside of contracted hours.”

“More time for administrative duties and more administrative support.”

“Less admin which isn’t related to clinical care.”

“I need extra time to cover my admin duties, answer emails and progress the development of the special care service.”

“Reduction in the amount of unnecessary paperwork.”

“Having time on a day to day basis for administration.”

Participants made it clear that a definite improvement to their working life would be achieved if there was better management within the service. There was a clear desire for more clinical leadership, giving those who have a greater understanding of the nature of the service a chance to lead.

“Strong and positive leadership.”

“Working with managers who are not completely focussed on ‘bottom line finances’ and instead more interested in patient care and more understanding of dentistry and our service.”

“Working with a general manager who understands the role of a Special Care dental service.”

“Efficient, caring management who engage in meaningful dialogue with the clinicians and make properly informed decisions with input from the clinical
staff, rather than ignoring them or paying them only lip service. This would also lead to patients receiving better treatment.”

“For management to realise that the type of patient we see in the service is not the typical patient a high street GDP sees and so we cannot work at the same pace as they do - especially as over 80% of my patients are referred to me for care the average dentist cannot provide.”

Whilst respondents generally understood when they entered the service that the level of remuneration was going to be lower than that in general practice, the last few years of pay freezes with the rising living cost have made this gap more apparent. One big improvement to their working life would be a fair pay increase to close the gap between SPDCS and GDP.

“Being valued financially in the same way as GDP’s appear to be. We see the difficult patients they can’t or won’t see yet our salaries are about 50% of average GDP salaries when the figures are published. They now receive their salaries in equal amounts like we do so no longer have the disadvantage of a fluctuating income. Pay parity with equivalent professions as far as salaried dentistry is concerned appears to have disappeared.”

“Pay increase to make up for lost ground over the last decade.”

“Paying us an inflation increase.”

“To keep remuneration and pension in line with inflation at the same level as today.”

“Proper and fair remuneration for SPDCS staff compared to GDS.”

There was a clear desire amongst participants for the service to enter a period of stability. There have been many changes to the service locally and nationally over the past few years and with more proposed changes in consultation employees within the service have not had a period of clarity and stability for many years. This has led to insecurities, uncertainty and the inability to plan in the long term. A period of stability would allow those working to focus on patient care and not have additional concern about the service as a whole.

“A clear direction for salaried services with acknowledgement of the specialist role that is played within the wider dental community.”

“A long term planning so that I could feel more secure, as at the moment the situation is "quite grey"/uncertainty for what is going to happen in the future with the planned changes in dentistry/NHS.”

“A period of stability. We will be waiting a while for this. I love it when the politicians say 'no change is not an option'”
“Certainty about the future. Some stability.”

“Clear idea of what direction the SPDCS and NHS dentistry in general are going.”

“Even a three year plan as to where SPDCS will sit in the new NHS would suffice. At the moment I have no idea if I will have a job in twelve months. Uncertainty is everywhere so I don't think I'm particularly badly off but as usual key figures in the dental world still fail to understand what my role is meant to be so how am I supposed to know?”

In England and Wales in particular there is a call for more appropriate measures to be used to monitor their work. The use of UDAs is seen as an unsuitable measure when considering the types of patients who are being seen. Using the same method that is used in general practice undermines the specialist nature of their work and the reason for which they have been referred. There is a desire for more focus to be placed on quality rather than quantity.

“Reasonable measure of activity, UDA is not an appropriate unit to measure patient activity.”

“Removal of unachievable UDA targets and being allowed to treat patients according to clinical need.”

“Concentration on clinical outcomes rather than UDA scores.”

“Have open clinical meetings with genuine interest to bring change for the benefit of patient care and not 'figures' for management accounting! Counting UDA’s or number of patients in chair for performance in whatever crude way will never improve actual service for the patients.”

“A more appropriate method of measuring special care dental provision than UDA’s.”

Other factors to improve working life that were repeatedly mentioned were recognition for the work they do; consistency with their terms and conditions; a recognition of speciality training and being appropriately remunerated for such skills; improvement in commissioning; tighter control of referrals; and more clinical autonomy.

Transforming Community Services (England Only)

The vast majority (91 per cent) of respondents in England felt that Transforming Community Services would have an impact on the SPDCS, with well over half (59 per cent) feeling that it would have a large impact on the service.

Those in Band C Specialist (74 per cent) and Managerial (69 per cent) positions were more likely to feel that Transforming Community Services would have a large impact on the service.
Concerns about *Transforming Community Services* were expressed by several participants when asked about the issues negatively impacting on their morale. Most were concerned with the uncertainty surrounding the changes and the impact leaving that the NHS would have on their terms and conditions.

“*Anxiety of becoming non NHS organisation with TCS.*”

“*Transforming community services, we have no clear future, I would like our services to stay within the NHS.*”

“*Uncertainty with respect to Transforming community services, delays in implementing TCS.*”

**NHS reforms** (England Only)

There were similar concerns regarding the wider NHS reforms, with more than nine-in-ten (93 per cent) participants anticipating an impact on the SPDCS; and over half (58 per cent) believing that it will have a large impact on the service.

Similarly those in Band C Specialist (71 per cent) and Managerial/Clinical Director (68 per cent) positions were more likely to feel that the wider NHS reforms would have a large impact on the service.

**Economic climate** (England Only)

In general, almost all participants (94 per cent) thought that the current economic climate was having some impact on the SPDCS, with almost two-thirds (58 per cent) reckoning that it was having a large impact on the service.

Those in Band C Specialist (70 per cent) and Managerial/Clinical Director (63 per cent) positions were most likely to feel that the current economic climate would have a large impact on the service.
Appendix 1 - Survey
Salaried services morale survey 2011

1. How would you rate your morale as a dentist in the SPDCS at the moment?
   - Very high
   - High
   - Neither low nor high
   - Low
   - Very low

2. How has your morale as a dentist in the SPDCS changed in the last year?
   - Increased substantially
   - Increased somewhat
   - Stayed essentially the same
   - Decreased somewhat
   - Decreased substantially

3. What are the issues that are currently having a negative impact on your morale as a dentist in the SPDCS?

4. Please indicate how strongly you agree or disagree with the following statements:
   *Strongly agree, Agree, Neutral, Disagree, Strongly disagree*
   - I am satisfied with my job as a dentist in the SPDCS
   - I am satisfied with the level of autonomy in my job
   - I am happy with the care I am able to provide to my patients
   - I currently experience more frustration than satisfaction working in the SPDCS
   - My job gives me the chance to do challenging and interesting work
   - I would recommend a career in the SPDCS
   - I feel valued in my role

5. How satisfied are you with the following in your current role?
   *Very Satisfied, Mostly Satisfied, Dissatisfied, Very Dissatisfied*
   - Training and development
   - Leadership and management
   - Terms and Conditions
   - Working environment
   - The clinical aspects of your role
   - Workload
   - Job security
   - Research opportunities
   - Career prospects
6. How do you rate your benefits program/package overall (e.g. NHS Pension, annual leave and study leave)?
   - Excellent
   - Good
   - Fair
   - Poor
   - Very poor

7. Are you concerned about possible changes to the NHS pension?
   - Very
   - Somewhat
   - Not at all

8. Please indicate how strongly you agree or disagree with the following statements:

   Strongly agree, Agree, Neutral, Disagree, Strongly disagree
   - I am satisfied with my pay
   - I am paid fairly given my performance and contributions to the SPDCS
   - I regularly work more than my contracted hours
   - I feel under pressure to achieve targets
   - I have sufficient time for clinical management/administration
   - The staffing levels are adequate in my service

9. What changes would bring the biggest improvement to your working life?

10. In which country are you based?
    - England
    - Wales
    - Northern Ireland
    - Scotland

11. (England only) How much of an impact do you think the following will have on you as a dentist in the SPDCS?
    Large, moderate, small, none at all, don’t know
    - Organisation changes relating to Transforming Community Services
    - Wider NHS reforms
    - The current economic climate

12. (NI Scotland and Wales only) How much of an impact do you think the current economic climate will have on you as a dentist in the SPDCS?
    - Large
    - Moderate
    - Small
    - None at all
    - Don’t know
13. How would you describe the location of the SPDCS practice where you spend most of your time?
   - Urban
   - Rural

14. How many years have you worked in SPDCS in total (not including career breaks)?

15. What is your job role?
   - Dentist – Band A/Dental Officer
   - Dentist – Band B/Senior Dental Officer
   - Dentist – Band C Managerial/Clinical Director
   - Dentist – Band C Specialist
   - Other, please specify

16. How many years have you been on your current grade?

17. What is your current age?
   - 35 or under
   - 36-49
   - 50 or over

18. What is your gender?
   - Male
   - Female

19. If you have any further comments about morale in the SPDCS or feedback for the BDA, please give details below:
Increases in Dental Practice Expenses 2011/12

Northern Ireland

Executive Summary

- Dentists require an uplift to the expenses elements of 7 per cent for 2011/12 to provide a zero uplift to net pay for the period.
- Laboratory fabricated items have risen in cost to the extent where the cost outstrips the health service fee.
- The costs of a pay award to DCP and practice staff and additional staff training and development costs must be met through an increase to the expenses elements of the pay equation for dentists.
- Loss of Quality Improvement Scheme funding requires the timeline for the policy initiatives associated with decontamination in dental practice to be pushed back by a minimum of two years.
- The monies saved by HSCB in the movement of practice inspections to being paid for by the private purse must be reinvested in the dental service.
- The efficiencies with which the business of dental practice operates must be recognised.
- Budgetary planning must take into consideration the number of dentists and their likely activity against all aspects of the Statement of Dental Remuneration.

1. Introduction

The Health and Social Care Board is charged with commissioning Health and Social care including dental services for the population of Northern Ireland. This is a time of constraints in funding for all services, including health and social care and the Executive was briefed by HSCB to have a full understanding of the issues for HSCB prior to agreeing the budget. Even in advance of defining how the HSCB budget will be spent, HSCB has set out that it has had to set aside planned service developments and workforce control measures in the light of funding constraints.
It is now the turn of the Health and Social Care Board (with Departmental approval as necessary) to define how it will spend the resources available to it. BDA is keen that in making decisions, there will be a clear understanding of the issues which impact on General Dental Services and the public as they access dental services. This paper sets out for both HSCB and DHSSPS the issues which face dental practitioners and dental practices as they strive on a daily basis to meet a continual rise in demand for dental services and the demands of policy imperatives placed upon them.

The rises in demand come through:

- an increased number of patients seeking dental care under the health services
- the wide range of pay and expenses costs which need to be met as part of running a dental business
- meeting new and additional governance requirements and introducing new technology to dental practice
- inflationary pressures on both pay and expenses

HSCB in its own evidence to the Executive attached a value of 5.7% per annum to inflationary demand and demographic pressures alone.

2. Dental Spend

The spending on dentistry is essentially ‘demand led’ which will have activity as its main driver. The spending on dentistry for the period 2009/10 is set out at Annex 1 (all figures supplied by BSO). Whilst the budget is demand led in how the spend is derived at HSCB level, when the funding reaches practice level the practice must pay for the practice overheads (building, heat, light, patient facilities, equipment); the costs incurred in patient treatment (laboratory and materials costs); and staff and other costs.

The figures for General Dental services costs for 09/10 show that the gross cost of the dental service was £93,132,978. £79,380,421 represents the gross monies paid to dentists in respect of treatments provided and the registration of patients for the period.

Dentists’ pay is part of a complex equation whereby practitioners are paid gross sums in respect of specific treatment items. The dentist meets the costs arising and retains the balance for reinvestment and net pay. It is accepted, for the purposes of superannuation calculations, that 56.1% of gross turnover is practice expenses. This is the figure we have used in illustrations of how changes to practice expenses affect the amount retained for reinvestment and pay.

Essentially this can be represented where gross turnover = 100%
The expenditure falling to the dentist = 56.1%
The net profit/pay before tax = 43.9%

Therefore for £100,000 of turnover £56,100 is expenses and £43,900 is retained for investment and pay.
Net pay must be maintained, as outlined by Doctors’ and Dentists’ Review Body (DDRB), then as expenditure rises, in order to keep net pay stable requires a corresponding uplift to be applied to gross turnover.

For example, if expenditure rises by the figure predicted by HSCB of 5.7%, then expenses this year of £56,100 will increase over the period to £59,297. To maintain pay at £43,900 requires gross turnover to rise by 3.2% from £100,000 to £103,197.

3. Practice Expenses

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

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

Using information prepared and collated through a Northern Ireland accountancy firm, relating to year end information during 08/09, BDA has collated the income and expenses data for 30 dental practices across Northern Ireland.

The local evidence on dental practice expenses shows that expenses costs of 56.1% of turnover are accounted for as follows:

- Laboratory fees and materials costs account for 19.34% of turnover
- Staff costs for directly employed staff excluding dentists account for 21.37% of turnover and
- Overhead costs account for 15.39% of turnover.

4. Determining a pay award

In determining a pay award for dental services, the Doctors’ and Dentists’ Review Body uses a recognised formula approach which takes into consideration the expense elements of practice and applies an uplift according to prevailing factors. These figures can be applied to the DDRB formula to give a value for the percentage by which gross payments to dentists should rise to meet changes in dental practice expenses. The outcome using the DDRB formula and the latest quarterly figures for RPI and RPIX, an expenses-to-earnings ratio of 56.1 per cent.

21.37 per cent for staff costs and 19.34 per cent for laboratories and materials costs, with other costs therefore being 59.39 per cent, the uplift according to the formula is 2.82 per cent.

\[ \text{Uplift2011-12} = 0.439 \times x + 0.12 \times \text{HRPSASHE} + 0.109 \times \text{RPIX} + 0.33 \times \text{RPI} \]

where

\[ x = 0 \text{ per cent income uplift} \]
\[ \text{HRPSASHE} = 3.2 \text{ per cent} \]
\[ \text{RPIX Feb 11} = 5.5 \text{ per cent} \]
RPI  Feb 11= 5.5 per cent
Uplift 2011-12 = 0 + 0.384 + 0.6 + 1.832
= 2.82 per cent.

5. Outcome of the 2010/11 pay uplift for General Dental Practitioners in Northern Ireland

In 2010/11 the DDRB used the recognised formula-based approach to take into account the increases in operating costs for dentists, in order to make an informed pay award. The most recent report of DDRB recommended an increase of 1.44% in order to deliver a zero increase in net income for GDPs. DDRB recommended that DHSSPS Northern Ireland should increase fees by 1.44%, if they did not have sufficient evidence to enable them to make adjustments to the fee scales to account for expenses. DHSSPS did not take the approach recommended by DDRB and instead applied an uplift of 0.5049% (0.9%award x 56.1%) for GDPs in Northern Ireland. What DHSSPS did was apply an efficiency saving to the award, bringing it to 0.9% and then applied a further expenses to earnings ratio of 56.1%, leading to an uplift of 0.5049%. DDRB have written to Michael McGimpsey as part of the DDRB monitoring round to advise that DDRB does not think this approach appropriate as their recommendation already took account of an expenses to earnings ratio of 51.5%.

The approach taken by DHSSPS will have had the effect of requiring GDPs in Northern Ireland to make greater efficiency savings in their expenses in order to maintain their levels of net income, than is the case in other parts of the UK. This situation is not acceptable for GDPs in Northern Ireland and needs to be addressed in the expenses element of the pay equation going forward into 2012.

The outcome of this is:

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<td>Gross cost of estimates 09/10</td>
<td>£79,380,421</td>
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<tr>
<td>expenses at 56.1%</td>
<td>£44,532,416</td>
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<tr>
<td>net after expenses</td>
<td>£34,848,005</td>
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The aim of the DDRB recommendation was an uplift of 1.44% on the HS fees to produce a zero uplift in net after expenses, maintaining it at a total of £34,848,005.

To keep net pay the same, whilst applying an uplift to the gross cost of estimates, means that DDRB must have assumed a 2.57% rise in expenditure during the period.

The DHSSPS decision to abate the award and pay 0.9% in expenses (0.5% on fees), means that if net pay after expenses is to remain stable, then expenses would have to reduce by (2.57-0.9) = 1.67%.

An additional uplift of 1.67% to expenses would be required to address the shortfall in the pay round for 2010/11

6. Loss of Quality Improvement Scheme Funding 2010

During 2010/11 HSCB withdrew the Quality Improvement Scheme (QIS) funding which was previously available to practices. All of this funding package of £1.1 million for the year 08/09 would have gone directly to meeting practice capital expenditure to meet an increasing
decontamination agenda. The loss of QIS funding to dental practices represents a very significant reduction in the ability of practices to meet expenses and in real terms, the loss of £1.1 million from the expenses side of the equation is a reduction of 2.47% in the ability of practices to meet expenses. For every pound lost through QIS monies, in order to recoup the funds, without affecting pay, the profession will have had to generate £1.96 in fee income. The alternative of continuing to meet expenses, without increasing fee income, presents a reduction in pay after expenses in the order of 2.47%.

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<tbody>
<tr>
<td>09/10 expenses at 56.1%</td>
<td>£44,532,416</td>
</tr>
<tr>
<td>add QIS monies</td>
<td>£1,100,000</td>
</tr>
<tr>
<td>Out turn of loss of QIS monies %</td>
<td>2.47%</td>
</tr>
</tbody>
</table>

An additional uplift of 2.47% to expenses would be required to address the loss of QIS monies during the period 2010/11

**Elements making up dental practice expenses for the period 2011/12**

7. Laboratory costs

Laboratory costs are incurred in dental practice in the making of crowns, dentures and appliances.

The price of metals continues to rise, affecting the price of lab fabricated items. Dentists are reporting that some laboratory fabricated items are so costly in laboratory fees, when compared with the fee paid through the Statement of Dental Remuneration that they are simply not economic to produce (see Table1, median values for lab items and the lab fee expressed as a percentage of the item of service fee). We asked practice owners in our Dental Business Trends report to give us the price paid for some typical laboratory items in 2009 and 2010. All show an increase.

The intent of the item of service fee must be to fully cover the cost to fabricate the item and the in-surgery costs and surgery time. In no way is it the intent that the practice allowance should subsidise laboratory items or surgery time.
Table 1: Median values for Lab fees expressed as % of item of service fee.

<table>
<thead>
<tr>
<th>Item</th>
<th>Median 2009</th>
<th>Median 2010</th>
<th>% change</th>
<th>Fee paid in SDR 2010</th>
<th>% of fee taken up by median lab costs 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porcelain bonded crown with precious metal</td>
<td>45.00</td>
<td>47.75</td>
<td>6.1%</td>
<td>127.45</td>
<td>37.5%</td>
</tr>
<tr>
<td>Full acrylic dentures</td>
<td>90.00</td>
<td>95.00</td>
<td>5.6%</td>
<td>174.70</td>
<td>54.4%</td>
</tr>
<tr>
<td>Two tooth partial skeleton chrome cobalt denture</td>
<td>126.25</td>
<td>140.00</td>
<td>10.9%</td>
<td>165.80</td>
<td>84.4%</td>
</tr>
<tr>
<td>Two tooth acrylic partial</td>
<td>46.45</td>
<td>50.00</td>
<td>7.6%</td>
<td>68.35</td>
<td>73.15%</td>
</tr>
</tbody>
</table>

Source Dental Business Trends 2010

The costs of fabricating laboratory items when compared against the fees paid for such items via the SDR presents the stark reality of the expenses associated with dental care. What the health service pays for the care in no way covers the cost to produce and provide the item, the professional time and overheads of providing the care. The expenses uplift needs to address the reality of the costs of lab fabricated items. The average increase of the items in Table 1 was 7.6 per cent. In its 39th report for 2010-11, the DDRB formula gave an uplift of 2.8 per cent for the cost of laboratory and materials elements. On average these elements rose by 8.8 per cent. So there is a shortfall of 6.0 per cent in the amount awarded by DDRB and the amount that laboratory and materials costs actually rose. We are therefore seeking an uplift in expenses to recognise the costs of providing patients with lab fabricated items.

8. Materials costs

Dental materials costs will increase at least in line with general inflation over the coming period. Generally many specialised dental materials are manufactured in the Eurozone and will be subject to cost pressures due to the value of euro versus sterling. This adds costs in excess of inflation to the costs of dental materials.
9. Staff costs

Most staff employed by dental practitioners typically fall under the protected category of those public sector employees who will receive a pay award of £250. In order to remain competitive with Trusts and other employers of dental care professionals (DCPs), dental practice owners will be under pressure to award their staff at least £250. These costs will have to be met from practice turnover. It is essential that these additional costs are funded through a rise to practice expenses.

Now that the whole clinical dental team is registered and has compulsory CPD requirements, there are additional staff training costs for practices. All dental nursing staff must be registered or in pre-registration training and the costs of pre-registration courses for dental nurses are considerable. Training requires time out of the surgery and away from revenue generating exercises, so comes at additional cost to dental practices.

The costs of a pay award to DCP staff and additional costs of staff training must be met through an increase to practice expenses.

10. Over head costs

There are a host of overhead costs associated with dental practice. There is the fabric of the building and the facilities. Equally important are the skills of the whole staff complement involved in the practice and the patient experience. Funding must reflect the resources necessary to manage the total overheads in health service dentistry.

Inflation as measured by the Consumer Price Index (CPI) stood at 4.4 per cent in the year ending 31 March 2011, above the Bank of England’s inflation target of 2 per cent. RPI is currently at 5.5 per cent. This is associated with a number of factors, including the restoration of VAT to 17.5 per cent and subsequent increase to 20%, higher oil prices and the past depreciation of Sterling. Retail Prices Index (RPI) inflation, which includes housing costs, is 5.5 per cent.

Inflation is likely to remain above target for a prolonged period. The VAT rise from 17.5 per cent to 20 per cent continues to push inflation up and the Bank forecasts that it is not likely to fall back to target until some time in 2012. Practices will face a rise in equipment and consumables costs because of the rise in VAT.

There are additional factors which affect dental practice. For example, the cost of providing dental care is particularly sensitive to fluctuations in the value of Sterling. This is because a significant proportion of dental materials and equipment is imported and because precious metal prices are denominated in US Dollars.

Dentistry is a fast-moving industry with rapid technological change. This means that in order for dentists to continue to provide high quality patient care with technological change and innovation in dental equipment and to keep up with the increasing expectations of patients, equipment and machinery need regular updating and can quickly become out of date and in need of replacement. Although most dental surgeries will need re-equipping every seven years, the speed of changing requirements mean that often equipment and instruments need to be upgraded more frequently. Clearly, this level of depreciation is a substantial cost to dental practitioners.
11. Decontamination costs

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

Decontamination requires both capital and revenue spend. Capital spend is required to enable the practice to put in place a suitably equipped facility and equipment and instrumentation. Revenue is required for staff and to provide consumables and meet other overhead costs associated with running the facility. The initial outlay and ongoing utility, materials and staffing costs are placing intense financial pressures on practices, which go well beyond the amount and scope of the current practice allowance. The situation is further exacerbated by the loss of QIS monies, which were utilised by practices solely for the purpose of working towards the decontamination requirements of HTM 01/05.

Equipment in the decontamination unit has to be maintained and serviced in line with DHSSPS. As an example, the costs of initial set up a validation of a washer disinfector, with a local supplier is £700+ VAT. This is in addition to the purchase cost and would have to be carried out annually. There is simply no revenue stream within health service dentistry which can manage this type of additional annual cost burden. The loss of QIS monies has placed practices at least 2 years behind on the time line for working towards meeting HTM 01/05 requirements. We would therefore request that the timeline attached to meeting the policy initiative of HTM01/05 and Northern Ireland modifications be re considered and moved to a time in the future when resources can be secured to enable investment to meet the guidance.

12. Regulatory costs

April 2011 sees the introduction of Regulation by statutory rule which introduces regulation of private dental services, categorises dental practices as ‘independent hospitals’ and regulates dentistry as a ‘listed service’. The regulation is aimed at regulating the establishments, registered persons and services in respect of private dental care and will be carried out by the Regulation and Quality Improvement Authority (RQIA). All dental practices and dentists already listed with the HSCB all provide dental care via the health service as well as privately. Therefore, whilst RQIA regulates and inspects private care, in so doing its remit will extend to all of the practices carrying out health service care. It is essential that the normal outlay of practice inspection by the HSCB is reinvested in the dental service in order to offset the costs which will be met by the private purse.

13. Small business environment

Dental practices by their nature and location are providing services to local communities and as a result are often located in converted dwellings or converted commercial premises. The result is that they are often small as they are constrained for space by the existing building, have expanded to capacity or are large enough the deal with the needs of the community they serve. As small businesses, dental practices are run as efficiently as possible. In fact it is in the best interests of the business owner to operate efficiently without waste or inefficiencies and by securing downward pressure on containable costs.
Therefore, when DDRB indicated to Minister McGimpsey that GDPs in Northern Ireland will have had to make greater efficiency savings in their expenses in order to maintain levels of net income, than is the case in the rest of the UK, it is worth noting that in an already efficiently run business of dental practice, there is little additional capacity to make savings of the order of 1.67% (loss incurred in pay 2010/11 pay round) plus 2.47% (loss incurred through QIS). Dental practices would have to reduce their expenses by 4.2% in the current year to remain stable. There are few ways a reduction in expenses of this magnitude could be achieved in a single year and it would require significant service changes such as shelving of capital projects; not equipping already developed decontamination spaces; not implementing a new decontamination regime in order to avoid the increased revenue costs or some other move to reduce costs.

The outcome here is that the business of dental practice is already efficient and exists without unnecessary waste or inefficiencies often associated with parts of the health service. What is required is either additional dedicated funding to assist practices with the essential business costs which are incurred in dental practice, or alteration of departmental policy on decontamination to bring about cost savings.

14. **Complexity inherent to the dental service**

The total population of dentists in Northern Ireland is inclusive of a diverse group of dentists and dental practices offering a range of general dentistry and more specialised services including orthodontics. This is demonstrated through the example of consideration of the health service activity of the population of dentists who carry out more than 30% of their item of service value claims through orthodontic items and those do not (i.e. carry out general dentistry).

Information available from Business Services Organisation shows that in 2008/09 the health service spend on clinical care items of service and treatment was £53,000,499.25. The gross cost of orthodontic items of treatment, provided by dentists who do more than 30% of their treatment claims as orthodontic items, in 08/09 was £7,351,925.90. BSO record 48 dentists as fitting the criteria whereby they do more than 30% of their treatment as orthodontics in Northern Ireland in 2008/09 which equates to each of those 48 dentists claiming on average £153,165.12 in item of service fees. The remaining dental spend on items of service excluding patient registration payments during 08/09 of £45,648,573.35 was split between the remaining 775 dentist contractors listed by BSO and equates to an average gross claim on items of service of £58,901.38.

This demonstrates how the item of service spend associated with a particular aspect of dental care, which is without patient charge, can lead to skewing of the overall picture associated with the item of service spend on dental services.

In planning future calls on the budget for dental services during 2011/12, the budget must be modelled against the number of dentists and their likely activity against all aspects of the Statement of Dental Remuneration.

15. **The dental budget**

During the course of 2010/11, the budget for dental services moved from DHSSPS to the HSCB. At the same time, the budget is now defined as a ‘cash limited’ budget. The concept
of a ‘cash limited’ budget in a service which is ‘demand led’ requires careful management and modelling to inform commissioners about likely spending. It is essential that all the factors set out are considered in informing the budget.

16. Conclusions

It is essential that the front line service of primary care dentistry, provided to the public through independent contractor dentists is protected. Growth in need for dental services is continuing as the population increases in size and in the number of older persons who remain dentate.

The dental service is such that

- The workforce is highly skilled
- The public demand the service locally
- Practices work efficiently, with little downtime, high productivity and effective use of clinical time.

Given the efficiencies that exist, there must be a realistic increase to funding to the sector to enable the increasing costs of dental practice, set out in this paper, to be met.

The DDRB formula and taking into account the problems encountered in 10/11 point towards a need for an increase to dental practice expenses of 2.82% for 2011/12 + 1.67% to address the pay round 2010/11 + 2.47% to address the loss of QIS monies in 2010/11

Thus a minimum increase to expenses of 6.96% is required.

This assumes QIS monies will be available in 2011/12

*Northern Ireland Dental Practice Committee*

*April 2011*
### Payment system for dentists in Northern Ireland

This information describes the elements of Statement of Dental Remuneration which make up the gross payments available to dental practitioners in Northern Ireland.

The information is separated into those payments made to individual dentists and those made to practices. (Excluding payments in respect of expenses associated with vocational training and superannuation payments for dentists).

**Individual payments**

- Item-of-service fees for treatment items
- Patient Registration (Capitation & Continuing Care)
- Sessional payments for provision of emergency dental services
- Seniority payments
- Vocational training allowances
- Commitment payments
- Maternity/paternity/adoptions leave
- Long-term sickness pay
- Continuing professional development allowances
- Clinical audit allowances
- Superannuation

**Practice payments**

- Reimbursement of non-domestic rates
- Practice allowance

### Payment Detail 2009/10

<table>
<thead>
<tr>
<th>Payment Details</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Payments</strong></td>
<td></td>
</tr>
<tr>
<td>Items of Service for treatment items</td>
<td>£61,028,348.00</td>
</tr>
<tr>
<td>Patient Registration (Continuing Care &amp; Capitation)</td>
<td>£18,352,073.00</td>
</tr>
<tr>
<td>Sessional Payments for provision of emergency dental services</td>
<td>£296,741.00</td>
</tr>
<tr>
<td>Seniority payments</td>
<td>£241,708.00</td>
</tr>
<tr>
<td>Commitment payments</td>
<td>£2,692,252.00</td>
</tr>
<tr>
<td>Maternity/paternity/adoptions leave</td>
<td>£855,073.00</td>
</tr>
<tr>
<td>Long-term sickness pay</td>
<td>£15,408.00</td>
</tr>
<tr>
<td>Continuing professional development allowances</td>
<td>£483,641.00</td>
</tr>
<tr>
<td>Clinical Audit &amp; Peer Review Allowances</td>
<td>£12,484.00</td>
</tr>
<tr>
<td><strong>Practice Payments</strong></td>
<td></td>
</tr>
<tr>
<td>Re-imbursement of non-domestic rates</td>
<td>£673,782.00</td>
</tr>
<tr>
<td>Practice Allowance</td>
<td>£7,661,742.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£92,313,252.00</strong></td>
</tr>
</tbody>
</table>

All figures provided by BSO, September 2010

1. **Item-of-service fees for treatment**
Dentists carry out clinical work in return for item-of-service fees. Fees for clinical treatment provide gross payment to dentists to provide the aspects of clinical care for patients as laid out in the Statement of Dental Remuneration.

2. **Sessional payments for provision of emergency dental services**

Dentists in Northern Ireland participate in Health and Social Services Board-run emergency clinics for out-of-hours emergencies. The fee paid for each three hour session is £119.55.

If a dentist is participating in an out-of-hours clinic, they forego the opportunity to be working in their practice.

3. **Seniority payments**

A seniority payment is a payment made to a dentist over 55 years. The payment recognises that dentistry is a physically demanding job, and with age speed of working and hence turnover reduces. A seniority payment compensates an older dentist for work foregone through working at a slower rate.

4. **Vocational training expenses allowances**

Vocational training allowances cover the expenses elements associated with practice-based training for UK graduate dentists, or other dentists who may enter the scheme.

4.1. **Reimbursement of the trainee dentist's salary**

This is a direct reimbursement of an incurred cost.

4.2. **A trainer grant of £753 per month**

This grant is to support the trainer in providing surgery and staff to support the trainee during the course of their training. Each vocational trainee will require a fully-equipped dental surgery and a dedicated dental nurse.

4.3. **Trainer quality assurance grant**

This is a grant paid to trainers to enable them successfully to complete the assessment of the trainee through the training period, using set assessment tools. The grant is up to £10,373 per year. During the training period, the trainer will need to spend a significant amount of time with the trainee to complete the training. The grant compensates the trainer for work foregone during the training period, when the trainer is away from his surgery to engage in necessary activities associated with the trainee’s ongoing training needs.

4.4. **Charter Mark allowance**

Up to £1037 is available per year for training practices which have a recognised quality assurance charter mark, such as BDA Good Practice, Investors in People.

5. **Commitment payments**
Commitment payments are a payment to dentists in recognition of their individual commitment to the health service. The payment per quarter ranges from £27.00 to £1,999.00 dependant on turnover.

The spend on commitment payments is approximately £2.62 million for 09/10.

6. Maternity, paternity, adoptive leave

When a dentist is on maternity, paternity or adoptive leave, they forego the opportunity to do their usual clinical work in the surgery. Payments in respect of maternity, paternity and adoptive leave are time-limited and based on the individual’s historic earnings, up to a maximum of £1,399 per week (up to 26 weeks maternity, up to 2 weeks paternity).

7. Long-term sick pay

Long-term sick pay provides a weekly equivalent of 25 per cent of net earnings up to a maximum of £349 per week for up to 22 weeks for dentists who are out of the workplace due to illness. The allowance is not payable for the first four weeks of sickness.

8. Continuing professional development allowance

The Statement of Dental Remuneration provides dentists with payment when they undertake continuing professional development activities. The maximum payment available per year is £1,369.20 (less any abatement).

When a dentist is undertaking continuing professional development, they forego the opportunity to generate turnover and meet ongoing expenses through clinical work.

9. Clinical audit and peer review allowance

The statement of dental remuneration provides dentists with payment for undertaking a maximum of 15 hours clinical audit/peer review activity over a three year period. The payment is £65.21 per hour (up to a maximum of £978.15 over a three year period).

When a dentist is undertaking clinical audit/peer review, they forego the opportunity to generate turnover.

10. Reimbursement of non-domestic rates

Reimbursement of non-domestic rates is a direct reimbursement of a practice cost. The amount of reimbursement is in direct proportion to the percentage of gross earnings from the health service.

11. Practice allowance

The practice allowance is an allowance to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.