British Dental Association

Evidence to

The Doctors’ and Dentists’ Review Body

Scotland

October 2011
Contents

Executive Summary

1. Introduction

2. General Dental Practice
   2.1 Motivation and morale
   2.2 Recruitment and retention

3 Salaried Primary Dental Care

Annexes

Annex 1: Dental Business Trends Report – UK

List of tables and graphs:

Table 1: Workplace demands in Scotland among dentists with over 75% NHS commitment (Source DBTS) – Pg. 5

Table 2: Satisfaction with pay and conditions in Scotland among dentists with over 75% NHS commitment (Source DBTS) – Pg. 7

Table 3: Intentions to increase work or retire in Scotland (Source DBTS) – Pg. 8

Table 4: Time spent on clinical and administration in Scotland among dentists with over 75% NHS commitment (Source DBTS) - Pg. 8

Table 5: Levels of administration among practice owners and associates in Scotland (Source DBTS) – Pg. 9

Graph 1: Self-reported morale among general dental practitioners in Scotland (source DBTS) – Pg. 4

Graph 2: Job satisfaction in Scotland of dentists with over 75% NHS commitment (Source DBTS) – Pg. 6
Executive Summary

- Self-reported morale and motivation is getting worse. It is worst among those with greater NHS commitments.
- The rise in expenses and excessive administration are the main causes of low morale.
- More dentists would expand their private practice than increase their NHS commitment.
- Practices experience problems with recruiting dentists for NHS work.
- The amount of time spent on administration is increasing for those with higher NHS commitments.

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 dentistry. This evidence applies to Scotland only.

1.1.2 The evidence is submitted on behalf of dentists providing services on behalf of the National Health Service (NHS) in Scotland and covers general dental services. There is also a short update on the current situation in relation to the primary care salaried dental services.
2. General Dental Practice

2.1 Motivation and morale

2.1.1 The BDA conducted its annual Dental Business Trends Survey (DBTS). The survey report can be found at annex 1.

2.1.2 Motivation and morale continue to be very low in general dental practice. Almost thirty-one per cent of respondents to DBTS in Scotland said their morale was low or very low. Higher rates of morale are associated with lower levels of NHS commitment:

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

1 All references to levels of commitment to the NHS are made through self-reported income earned through NHS work.
2.1.3 Table one shows the specific workplace demands faced by dentists in Scotland with an NHS commitment of over 75 per cent:

**Table 1: Workplace demands in Scotland among dentists with over 75% NHS commitment (Source DBTS)**

<table>
<thead>
<tr>
<th>Demand</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rise in expenses</td>
<td>59.2%</td>
</tr>
<tr>
<td>Excessive administration</td>
<td>52%</td>
</tr>
<tr>
<td>Lack of time for quality</td>
<td>36.3%</td>
</tr>
<tr>
<td>Lack of time for prevention</td>
<td>35.8%</td>
</tr>
<tr>
<td>Difficulties recruiting staff</td>
<td>35.2%</td>
</tr>
<tr>
<td>Decontamination requirements</td>
<td>31.8%</td>
</tr>
<tr>
<td>Too many patients/long waiting lists</td>
<td>15.6%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>12.8%</td>
</tr>
<tr>
<td>Not enough patients</td>
<td>13.4%</td>
</tr>
</tbody>
</table>
2.1.4 Graph two shows the attitude of dentists in Scotland to dentistry with an NHS commitment of over 75 per cent. A large number of dentists agree that being a dentist is frustrating rather than satisfying. Most, however, would still recommend dentistry as a career, are satisfied with the level of care they provide and are satisfied with being a dentist. The low morale experienced by dentists is not, therefore, caused by the career choice, but rather the business environment in which they work, as further demonstrated by table one above.

**Graph 2: Job satisfaction in Scotland of dentists with over 75% NHS commitment (Source DBTS)**
2.1.5 The DBTS also asks questions about satisfaction with pay and conditions. The table below provides the results for those working in Scotland with an NHS commitment of over 75 per cent. The responses below show a general dissatisfaction in all areas. Pay is, however, the greatest concern, while satisfaction with autonomy is the least problematic though by no means satisfactory.

Table 2: Satisfaction with pay and conditions in Scotland among dentists with over 75% NHS commitment (2010 figures in brackets) (Source DBTS)

<table>
<thead>
<tr>
<th></th>
<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>4% (2.2%)</td>
<td>27.7% (41.4%)</td>
<td>29.7% (16.3%)</td>
<td>32.7% (29%)</td>
<td>5.9% (11.1%)</td>
</tr>
<tr>
<td>I am satisfied with the level of autonomy in my job</td>
<td>4% (8%)</td>
<td>41% (42.3%)</td>
<td>31% (26.9%)</td>
<td>19% (16.2%)</td>
<td>5% (6.7%)</td>
</tr>
<tr>
<td>I feel under pressure to achieve targets</td>
<td>3% (11.3%)</td>
<td>27.7% (30.1%)</td>
<td>30.7% (28.9%)</td>
<td>33.7% (26.5%)</td>
<td>5% (3.3%)</td>
</tr>
<tr>
<td>I am happy with the hours I work</td>
<td>8.9% (6.4%)</td>
<td>42.6% (49%)</td>
<td>22.8% (13.8%)</td>
<td>21.8% (21.2%)</td>
<td>4% (9.6%)</td>
</tr>
</tbody>
</table>

2.1.6 The morale and motivation of general dental practitioners continues to deteriorate. Over 85 per cent of respondents to the DBTS with an NHS commitment of over 75 per cent reported that their morale had either remained the same or deteriorated. 33.7 per cent rated their morale as somewhat lower than last year. It is the bureaucracy, targets, dissatisfaction with pay 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 Associates and other dental professionals

2.2.1.1 According to data from the DBTS there has been a partial freeze in recruitment, with over 63 per cent of practices not recruiting a dentist for predominantly NHS dentistry in the last twelve months. Of the practices that did recruit 62.5 per cent reported some problems with recruiting dentists into NHS work.
2.2.1.2 Practices with NHS contracts continued to report difficulties recruiting dental nurses, hygienists and therapists. 44.9 per cent of practices reported some problem recruiting a nurse and 68.2 per cent report a problem recruiting a hygienist or therapist. 47.3 per cent of practices, however, did not recruit a nurse and over 72 per cent of practices did not recruit a hygienist or therapist.

2.2.2 Private and NHS dentistry

2.2.2.1 As last year, there is a clear indication that private dentistry is more attractive than NHS dentistry, with the majority intending to increase the amount of private work they do, even in these straightened economic times. Table three shows those with 75 per cent plus NHS commitments agreeing or strongly agreeing with the options to increase private work, increase NHS work or retire:

Table 3: Intentions to increase work or retire in Scotland (any amount of NHS commitment) (Source DBTS)

<table>
<thead>
<tr>
<th>Scotland</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing private work</td>
<td>46.7%</td>
</tr>
<tr>
<td>Increasing NHS</td>
<td>13%</td>
</tr>
<tr>
<td>Planning to retire</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

2.2.3 Workload and working hours

2.2.3.1 The amount of clinical work being undertaken by dentists with 75 per cent plus NHS commitment is increasing according to the DBTS. This is in addition to the increasing amount of time being spent on administration. Dentists are having to do more of both in order to meet their NHS commitments:

Table 4: Time spent on clinical and administration in Scotland among dentists with over 75% NHS commitment (Source DBTS)

<table>
<thead>
<tr>
<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 performing clinical dentistry</td>
<td>3%</td>
<td>14%</td>
<td>76%</td>
<td>6%</td>
</tr>
<tr>
<td>Hours spent on dental administration</td>
<td>6%</td>
<td>38%</td>
<td>54%</td>
<td>2%</td>
</tr>
</tbody>
</table>

2.2.3.2 Most administrative work falls to practice owners and they have reported a sharp increase in the amount of administration required. Associates too, however,
reported an increase in the amount of administration required of them. Dentists are providing more clinical care and undertaking more administrative work and many received a pay cut last year. It is no wonder that 43.8 per cent practice owners and 27.2 per cent of associates reported stress levels of four or five out of a scale of five in the DBTS.

Table 5: Levels of administration among practice owners and associates in Scotland (any amount of NHS commitment) (Source DBTS)

<table>
<thead>
<tr>
<th></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>9.4%</td>
<td>46.9%</td>
<td>41.7%</td>
<td>2.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Associates</td>
<td>3.8%</td>
<td>29.1%</td>
<td>62%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

3. **Salaried Primary Dental Care**

3.1 As reported to the DDRB last year, the BDA in Scotland is continuing to work jointly with the Scottish Government Health and Social Care Integration Directorates (SGHSCID) on the development of a new primary care salaried dental service. Recruitment, retention and morale are key issues that are covered during our regular meetings with the Chief Dental Officer (Scotland) and Workforce Directorate civil servants. The parties have been trying to obtain robust workforce data on salaried dentists, both headcount and whole time equivalent, via the NHS Boards and this is proving to be somewhat challenging. We will be working jointly with clinical dental directors and SGHSCID over the coming months, as part of the on-going negotiations on the new salaried service, to determine the numbers of dentists, numbers of posts, numbers of vacant posts and any issues around recruitment and retention.
Annex 1

BRITISH DENTAL ASSOCIATION

Business Trends Survey

Full report

May to July 2011

British Dental Association Research Unit

64 Wimpole Street, London W1G 8YS
Staffing ................................................................................................................................. 47
Dentist profile .......................................................................................................................... 47
Staffing levels .......................................................................................................................... 48
Recruitment ............................................................................................................................. 52
Associates ............................................................................................................................... 54

Morale and motivation report .................................................................................................. 56
Background ............................................................................................................................... 56
Contents .................................................................................................................................... 56
Executive summary ................................................................................................................... 57
Morale levels ............................................................................................................................. 57
Areas of satisfaction .................................................................................................................. 60
Factors causing low morale ...................................................................................................... 62
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>
<td>42%</td>
</tr>
<tr>
<td>Wales</td>
<td>375</td>
<td>146</td>
<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:

Weighting 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.

Contents
- Executive summary ................................................................. 16
- Changes to practice turnover, expenses and gross profit ....................... 17
- Expenses .................................................................................. 19
- Expense ratios ......................................................................... 24
- Efficiency savings ..................................................................... 25
- Staff wages ................................................................................ 26
- Decontamination ....................................................................... 31
- Associates ................................................................................. 33
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 2010/11, 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**

![Figure 6: Percentage of practice experiencing an increase in the following costs compared with 2010/11](image)

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 choose 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>Number of Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.61</td>
</tr>
<tr>
<td>Wales</td>
<td>0.62</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>0.65</td>
</tr>
<tr>
<td>Scotland</td>
<td>0.56</td>
</tr>
</tbody>
</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.
Figure 11: Percentage of practice awarding pay rises to the following DCP groups, 2009/10 to 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).

Figure 12: Average percentage change to DCPs wages of those awarded an increase during 2010/11

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 (£)**

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 18: Distribution of associates’, incomes, by NHS contribution (£)**
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 owns at least one ultrasonic cleaning bath and 42 per cent of practices owns at least one washer disinfect (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 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>0 - 24% NHS</th>
<th>25 - 74% NHS</th>
<th>75 - 100% NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>39%</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>England</td>
<td>39%</td>
<td>40%</td>
<td>48%</td>
</tr>
<tr>
<td>Wales</td>
<td>40%</td>
<td>47%</td>
<td>37%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>47%</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>NHS Practice</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>12%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>England</td>
<td>12%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Wales</td>
<td>14%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>17%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Scotland</td>
<td>17%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>0 - 24% NHS</td>
<td>11%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>25 - 74% NHS</td>
<td>16%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>75 - 100% NHS</td>
<td>16%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Male</td>
<td>16%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Female</td>
<td>16%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>8%</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. Superannuation
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.

Contents
- Executive summary ................................................................. 36
- Practice Profile ................................................................. 37
- NHS commitment .............................................................. 37
- Patient base ........................................................................ 40
- Workload .............................................................................. 43
- Retirement ........................................................................... 45
- Staffing ............................................................................... 47
- Dentist profile ..................................................................... 47
- Staffing levels ..................................................................... 48
- Recruitment .......................................................................... 51
- Associates ............................................................................ 54
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

Figure 2: Practice profile, by country

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>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>15%</td>
<td>27%</td>
<td>51%</td>
<td>7%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>18%</td>
<td>16%</td>
<td>58%</td>
<td>7%</td>
</tr>
<tr>
<td>Wales</td>
<td>27%</td>
<td>12%</td>
<td>49%</td>
<td>12%</td>
</tr>
<tr>
<td>England</td>
<td>21%</td>
<td>20%</td>
<td>49%</td>
<td>10%</td>
</tr>
<tr>
<td>UK</td>
<td>21%</td>
<td>20%</td>
<td>49%</td>
<td>10%</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**

<table>
<thead>
<tr>
<th>Country</th>
<th>1-24% NHS</th>
<th>0% Exclusively private</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>Wales</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Scotland</td>
<td>32%</td>
<td>25%</td>
</tr>
<tr>
<td>1</td>
<td>21%</td>
<td>1%</td>
</tr>
<tr>
<td>2</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>3</td>
<td>13%</td>
<td>1%</td>
</tr>
<tr>
<td>4+</td>
<td>9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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).
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.
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\(^2\).

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.

\(^2\) 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.
Figure 13: Percentage of respondents reporting changes in the hours they spent performing clinical dentistry in 2010/11 compared with 2009/10

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 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**

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**

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.

Figure 23: Average headcount and whole-time-equivalent staff in the following roles in each practice

* Based on a 35 hour week

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.

Figure 24: Average whole-time-equivalent dentists and dental nurses in practices, by country, and NHS income
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**

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**

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
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**

*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.

Contents
- Executive summary ................................................................. 57
- Morale levels ........................................................................... 57
- Areas of satisfaction ............................................................... 60
- Factors causing low morale .................................................... 62
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).

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 where low morale rose from 27 per cent to 45 per cent, and in England where 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 than 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.
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 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.