Survey of Dental Clinical Academic Staffing Levels

A report by the Dental Schools Council

2018
This is a report based on survey results of clinical academic staffing levels in UK dental schools at 31 July 2017.

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1. Background

In the late 1990s, a series of reports highlighted the need for robust data on clinical academic staffing levels as a basis for partnership between the NHS and universities in tackling difficulties facing academic medicine.* In consultation with the Department of Health’s Advisory Group on Medical Education, Training and Staffing, and with the support of the Medical Research Council, the Association of Medical Royal Colleges and the Wellcome Trust, the Medical Schools Council and the Dental Schools Council agreed jointly to undertake a comprehensive survey of clinical academic staff employed by UK universities in medical and dental schools.

Since 2000, the Dental Schools Council has undertaken a regular survey of clinical academic staffing levels in UK dental schools.

2. What the 2017 survey tells us

**Increase in FTE of Clinical Academics, while professorial staffing levels are in decline.**

The results of the 2017 survey of clinical academic staffing levels show that on 31 July 2017 there were 607.3 full-time equivalent (FTE) clinical academics employed at UK dental schools. This represents a 2.2% increase in staffing since 2016, and of 40% since 2004.

**Professors**

Since the 2016 survey, the FTE of clinical academics at professorial level has continued to decline (107.2 FTE), representing a FTE change of -8.3% since 2015 (117 FTE) when professorial FTE was at its highest.

The proportion of staff at each grade varies across the different specialties, as demonstrated by Figure 6. When looking at changes in staffing overtime by specialty, higher proportions of Professors work...
within Restorative Dentistry, while no Professors are employed in General Dental Practice. Unlike Restorative Dentistry, Oral & Maxillofacial Surgery’s clinical academic workforce is comprised of Professors and Reader/ Senior Lecturer grade staff.

**Reader/ Senior Lecturers**

Reader and Senior Lecturers FTE are on the recovery. The 2017 data represent a 12% increase since 2015, where the number of Reader/Senior Lecturers was at its lowest (120.7 FTE).

**Lecturers**

Following a decline in Lecturer grade staff between 2012 and 2015, the FTE of Lecturers has increased by 2.7% since 2015.

**Senior Clinical and Clinical Teacher**

The introduction of the Clinical Teacher as a recognised clinical academic pathway resulted in a significant shift in the makeup of the overall clinical academic team. The number of Senior Clinical Teachers has grown substantially since they were first included in this survey.

Clinical Teachers make up the largest FTE of clinical academic dentists. The FTE of Clinical Teachers and Senior Clinical Teachers has increased by 13.7 FTE since 2016, and 162% since 2007.

General Dental Practice has the highest composition of Senior Clinical Teachers and Clinical Teachers, followed by Restorative Dentistry and Prosthodontics where these grades of academics make up around half of the staff.

**Clinical Researcher**

There has been less of an FTE increase for Clinical Researchers than for the other teaching-focused staff. The numbers of these staff remain small comparative to the other grades in this survey. Following an 83% increase between 2015–2016,
the 2017 data saw a slight decline in FTE. Clinical Researchers are, however, extremely significant, as they represent a future pipeline for the clinical academic workforce.

Figure 1b: Percentage change of clinical academic staffing levels by academic grade since 2007 (FTE)

National and Regional variation

Increase in FTE of Clinical Academics across the devolved nations, except Wales. Around 30% of clinical academics are concentrated in London.

There are 18 publicly funded UK dental schools in the Dental Schools Council, 16 of which offer an undergraduate dental degree (BDS or BChD), usually in addition to postgraduate programmes and courses for dental care professionals. Two dental schools (UCL Eastman and Edinburgh) offer postgraduate programmes only.

The 2017 data show that a majority of clinical academics are located in England (76%), followed
by Scotland (15%), Wales (5.8%) and Northern Ireland (3.6%), which have not changed significantly since the start of this survey (see Figure 2). These proportions are reflective of the registrants by UK regions on the General Dental Council’s (GDC) Specialist register: England (79%), Scotland (10%), Wales (4%) and Northern Ireland (4%).

Looking at the proportion of clinical academics across the four devolved nations, the FTE of clinical academics has increased in all regions, except for Wales. Consistent across England, Northern Ireland and Wales is the decline in the FTE of those of Professorial academic grade, which remains constant within Scotland following an upward trend in Professors between 2008–2013.

Figure 2: Clinical academic staffing levels by country and academic grade since 2007 (FTE)

Figure 3 breaks down the clinical academic staffing further by regions. This shows there is a concentration of clinical academics in London, as around 30% of all dental clinical academics are employed by one of the three London dental schools.
The largest changes in FTE contribution between 2016 and 2017 are found across regions of England. There are approximately 41.3% (13 FTE) more staff in the West Midlands, since 2016. Following increases in FTE in the North East and South West within the 2016 survey, the North East has experienced a -3.9% (1.2 FTE) change and the South West a -5.4% change (2.4 FTE).

Figure 3: Clinical academic staffing levels by country since 2004 (FTE)

3. Funding

This survey’s data found that dental clinical academic posts are funded by a mixture of 75% University funding, 22% by the NHS and 3.3% by Other sources. These breakdowns are similar to previous years and have not dramatically changed over time. The proportion of funding from the NHS is much lower in dentistry than in medicine, where 42% is from University funding and 42% from the NHS (including NIHR).
Funding across academic grades

Higher grade research-active roles (Professor, Reader/ Senior Lecturer and Lecturer) are associated with a higher proportion of university funding in comparison to funding from the NHS or Other sources. Lecturers are funded by nearly a third of NHS funding (28%), compared to the one fifth of NHS funding received in 2007 (17%).
Funding across UK dental schools

The funding profile varies across UK dental schools, as they have different arrangements with their local NHS providers. Edinburgh has the highest proportion of clinical academic staff funded by the NHS (65%), followed by UCLan (47%) and Liverpool (46%). However, these relate to small numbers of staff at these schools, and therefore there may not be anything significant to infer from the differences.

While most schools received between 1.5% and 15.2% of ‘Other’ funding, there are a number of schools which do not have any clinical academics funded by ‘Other’ funding (Aberdeen, Edinburgh, Glasgow, KCL, Queen’s University Belfast).

Figure 5: Funding profile by dental school 2017 (FTE)

4. Specialties

While the FTEs of clinical academics working in most specialities have increased, Oral & Maxillofacial Surgery staffing levels are in a steady decline.
Dentistry itself is a small clinical discipline in comparison to other healthcare professions. There are 13 specialties recognised by the General Dental Council, and for the purposes of this survey we also include staff working in UK dental schools from the areas of Oral & Maxillofacial Surgery and General Dental Practice, as two further speciality groups.

Figure 6: Clinical academic staffing levels by speciality since 2004 (FTE)

The data demonstrate that a vast majority of dental clinical academics’ work in Restorative Dentistry (28%, 168.9 FTE) followed by General Dental Practice when including ‘Other’ (16%, 99.2 FTE) and Oral Surgery (10%, 60.0 FTE). The smallest specialities are Oral Microbiology (0.5%, 3.2 FTE), followed by Dental & Maxillofacial Radiology (1.4%, 7.5 FTE) and Oral & Maxillofacial Surgery (0.9%, 5.3 FTE).

Although the FTE of clinical academics working in most specialities has increased, Oral and Maxillofacial Surgery clinical academics staffing levels are in a steady decline (Figure 8), yet this speciality has the highest number of consultants (340 FTE). In addition it holds two thirds of dental core training posts in London alone, and four fifths outside of London. The requirement to hold both a medical and a dental degree could well be a contributing factor.
Academic and research opportunities have been discussed in the Advancing Dental Care report. Concerns have been expressed regarding the implications to undergraduate teaching if dental professionals are not recruited into academic careers. This has led key stakeholders to propose that there is an extension to part-time arrangements, to provide an opportunity for more
innovative approaches. Additionally, academia and research should be incorporated into all training programmes. These concerns are also referenced in MRC’s Clinical and Health Research Fellowships report, as the number of dental fellows has increased from 23 (2009) to 75 (2017). However, the number of post-doctoral and senior fellowships held is low. No dentists were identified as holding an award more senior than an initial post-doctoral fellowship. The number of those supported to establish a research career has also decreased, with none identified in 2017.

While the appropriate individuals are employed in clinical academia there is a need to also look through the prism of the greater activities that dental schools are involved in, and acknowledge that the demands on dental educators have increased. These demands are not being compensated by an increase in clinical academics, as numbers have remained constant. Current pressures felt by NHS medical and dental consultants are highlighted in the NHS’ 2017 Staff Survey Results. Findings show:

- 91% of consultants are working extra hours.
- 38% have attended work despite feeling unwell from pressure from peers or themselves.
- 33% expressed that they felt unwell due to work related stress.

This is a cause for concern and highlights the importance of maintaining close observations of the levels of these important members of staff.
5. Vacancies

Vacant FTE post cited within Restorative Dentistry and Paediatric Dentistry, with more vacant posts at Reader/Senior Lecturer grade.

There are different institutional policies regarding how established posts and vacancies are recorded, and some institutions do not hold these data at all. The following analysis considers vacant clinical academic posts that the university was intending to retain on 31 July 2017, even if not yet actively recruiting. In some institutions, a post is not considered vacant until it is advertised; in others, vacancies are considered against funding and strategic objectives at institutional level. It should be noted that the information in this section is based on data returned by 16 of the 18 dental schools for 31 July 2017, and a typical response rate of 10 schools over previous years, and so is only indicative of the vacancy level.

A total of 40 FTE of posts (6.1%) were reported as vacant in this survey across the schools which returned data, and these were found across 12 of the 15 specialties. Nearly 12.6 FTE of vacancies were found in Restorative Dentistry, which may be expected given its much larger numbers overall. This represents 6.9% of all available posts in Restorative Dentistry. Paediatric Dentistry had the next highest proportion of vacancies at around 8.0, 14% of the available posts in this specialty.

Figure 9 breaks down the number of vacant posts by specialty. The data highlights that the highest proportion of vacant posts in relation to the total available posts, is found at Reader/ Senior Lecturer level, 13.4 FTE, a -7.2% percentage change since 2007, followed by Lecturers 7.9 FTE (-61%, since 2007).

When looking at the timeline of vacancy levels by academic grade, Professor (5.0 FTE, 0.8%) and
Senior Clinical Teachers (5.3% FTE, 0.9%) have a similar proportion of vacant posts, compared to their total available posts.

An increase in vacant posts is welcomed provided they can be filled, as this means that the clinical academic staffing workforce has the resources and potential to continue to grow and thrive. However, in providing additional comments as part of this survey, 13 out of 18 dental schools cited difficulties recruiting to one or more specialties, which were found across 15 different specialties or sub-specialties, as summarised below:

- When asked what clinical (sub)specialty area to which the institution is finding difficulty in appointing clinical academics to, seven dental schools cited Periodontics, which schools noted to be at senior levels.

- Seven schools highlighted issues recruiting to posts in Restorative Dentistry to senior level academic grade posts, such as Consultant Senior Lecturer posts and Clinical Teacher level. One institution noted that it has had two FTE posts vacant since the 1 January 2016.
• Six dental schools reported issues in recruiting to Orthodontics and Paediatric Dentistry. For Orthodontics, dental schools mentioned the difficulties in recruiting to all grades, while for Paediatric Dentistry, dental schools noted recruitment difficulties across all grades, especially academic consultants.

• While the Medical Clinical Academic Staffing Survey 2018 noted funding as a factor in recruitment to specialties, funding has not been referenced by the dental institutions.10

Further research may be required to look at these issues in greater detail, such as examining geographical spread of vacancies to ascertain whether this is an issue in particular localities and specialties.

6. Seniority of appointment

The largest group of clinical academics was aged 36–45, however, there is a younger workforce of female clinical academics. There is also a gradual decline in male clinical academics at more senior academic grades.

Age

Appointment to a clinical academic dental role takes longer than the typical dental clinical training because, in addition to completing a dental degree (usually five years) and postgraduate specialty training (three to five years), the majority of university appointments at Lecturer and above require a doctorate and an established research track record. This means it is likely that the clinical academic dental workforce will be slightly older than the general dental workforce.

Since the 2016 survey, the proportion of clinical academics aged 36–45 and 46–55 has increased. Figure 9 shows that the largest age group for
clinical academics was 36–45 (33%), followed by those aged 46–55 (28%). A smaller proportion were aged 56–66 (21%) and below 36 (15.8%). This profile is younger than for medical clinical academics, who are most likely to be 46–55 (36%), and is reflective of the GDC’s specialist register where 31-to-40-year-olds (12,144) are the largest age profile, followed by 41-to-50-year-olds (9,793).\(^\text{11}\)

When looking at age against gender, women present a younger age profile than male clinical academics, with 57% aged below 46. Contrasting this, just under half of male clinical academics are under 46 (42%).

**Gender**

In July 2017 there were 334.3 male and 273.1 female clinical academics, which is significantly less than the 20,716 males and 19,711 females recorded on the GDC’s specialist register.\(^\text{12}\)

When looking at the gender representation against academic grade, the data highlight the gradual decline in male clinical academics at more senior
levels, Reader/ Senior Lecturer (58%) and Lecturer grade (43%). However, the proportion of males at professorial grade (78%) has remained fairly constant.

Female representation in the academic grade is increasing: Professor (22%), Senior Lecturer (42%) and Lecturers (58%). Representation of women within Senior Clinical Teacher (44%) and Clinical Teachers (46%) presents slower progress.

Only two females were recorded as specialising in Oral & Maxillofacial Surgery, and three as specialising in Oral Microbiology. Of the 17 clinical academics specialising in Special Care Dentistry, 13 were female. 100% of those at Professor and Reader/ Senior Lecturer grade were female.
Figure 12a and 12b: Academic grade and gender since 2004 (Posts)
7. Profile specialities

Working patterns

There are proportionally more male clinical academics working LTFT than those working FT.

Figure 13 shows the working patterns of men and women at each clinical academic grade. On average, across all grades, a very similar proportion of men and women work LTFT; (59% - 60%). Since 2016, there has been a 0.6% increase in the number of males working LTFT, and 1.6% in the number of females working LTFT.

Of the population of clinical academics more males are working LTFT (33%) than those working FT, and of female clinical academics working LTFT (26%). A small proportion of the overall FTE of female academics at Professorial (4.2%), Reader/Senior Lecturer (11%) and Lecturer (14%) grade are working LTFT, compared to those working FT in these grades.
Ethnicity

BME clinical academics are under-represented at Professorial and Reader/ Senior lecturer grades.

In 2017, 72% of clinical academics identified as White, 25% identified as BME, with 3.9% not recorded. The proportions between White and BME clinical academics marginally differ from that of the GDC’s specialist register, with 52% of registrants identifying as White, 31% BME and 17% unknown. Of those who identify as BME in the survey, 12% are Asian/British, compared to 21% of Asian or Asian British dentists on the register.13

When looking at ethnic profile by academic grade, the data demonstrated that as the level of seniority increases, the proportion of those who identify as White also increases. BME clinical academics are most under-represented at Professorial and Reader/ Senior Lecturer grade (8.5% and 16% respectively), but also at Researcher level they only make up 24%. At Professorial level 91% of clinical academics identified at White, while 8.5% identified...
at BME (Asian/ British Asian) and 0.8% were unreported.

Higher proportions of White clinical academics are found in Oral Microbiology (100%), Oral & Maxillofacial Surgery (100%) and Other (85%). These specialties however have smaller FTEs (3.2–10.9 FTE). Contrastingly higher FTEs of BME clinical academics work within Endodontics (38%), Prosthodontics (34%) and Periodontics (31%).

**Nationality**

**83.6% of the clinical academic workforce are from the UK.**

Looking specifically at nationality, 84% of clinical academics are from the UK, 9.6% from EEA and 6.1% from the rest of the world. The highest proportion of EEA nationals (28%) is of ‘Researcher level, and only 5.1% at Professorial grade.

The survey data demonstrate that 23% of the clinical academic periodontics workforce is from the EEA and the rest of the world, with 83% of researcher grade staff from EEA.
8. Clinical Excellence and Distinction Awards

Variations across the countries in clinical academics holding local and national Clinical Excellence Awards. No Local Excellence Awards held in Wales.

Across the UK, a total of 122 (posts) clinical academic consultants hold a local or national Clinical Excellence Award (CEA): 6.2% hold a national award and 6.0% hold a local award.

Overall and national variation for CEAs

England

Since 2016 there has been a decline in the proportion of clinical academics holding local and national awards. 6.1% of clinical academics hold a local award, and 5.2% hold a national award. Within the Professor grade, 44% hold national awards, with 24% holding local awards.

Scotland

Trends in Scotland represent a slow growth in CEAs, with 9.3% of clinical academics holding a local CEA, and 6.5% a national award. Professors possess 39% national awards, while Reader/ Senior Lecturer grades held 20% of Local CEAs and 4/5s held no awards. The awards budget has been frozen by the Scottish Government since 2010. No new awards have been granted and there has been no progression through the scheme.

Wales

Following a spike in the number of professors who did not hold a CEA, there has been an increase in the percentage of national excellence awards held by 9.9% across all grades. However, since 2015 no local excellence awards have been obtained.
From 2018 we might expect to see changes in the number of Local and National CEAs held. In April 2018 there was a change implemented to the Clinical Excellence Award Scheme. NHS Employers announced that Trusts would run LCEAs until 31 March 2021, however there is a one-to-three-year time limit. Existing LCEAs remain pensionable and consolidated, but will be subject to review in 2021.

From April 2021, there may be local variations to any LCEA scheme or new performance pay scheme. These LCEAs will be non-pensionable and non-consolidated, payable for a period of up to three years.

During the period of reform, consultants who hold existing NCEAs will retain their national awards, subject to the existing review process. However, from April 2018 consultants who hold an existing NCEA and submit an unsuccessful application or review, can revert to an existing level of 8 or 7 award, or nothing.14
9. Highlights and conclusions

Given the important role of the dental clinical academic in the continual advancement of high-quality dental patient care through innovative research and training of the future workforce, the stability of their overall staffing levels is a positive message from this report. The July 2017 data show an encouraging overall 3% rise in their FTE contributions since 2016.

These 607.3 FTE of staff help to ensure that the future dental team is able to ensure their practice is evidence-based and inspires research to look at the future of care. Holding an important role between dental clinical research, practice and training, they are essential for advising policy makers and healthcare teams as to how dentistry fits into the wider healthcare landscape, and how to advance dentistry to meet the needs of future generations.

A shift from research to teaching contracts

The results do, however, raise a potential concern as to the instability of the number of staff on research-active contracts, with a decline between 2016–2017 of Professors, and only small recoveries for Reader/ Senior Lecturer and Lecturer staff on previous periods of decline since 2004. However, these losses have been compensated by the introduction and rise in teaching-only staff, so instead of an overall loss, this can be seen as an evolution of the clinical academic team to a sharper focus on teaching.

Varying levels of staff across the UK

This survey highlighted differences around the UK in the levels of clinical academic staff and different patterns over time. While this may not be problematic, and may indeed be a response to varying local needs, careful consideration of the balance of staff and needs should be looked at in
combination with these developments. The data also show that the levels of staff at each grade across specialties varies considerably, though numbers in some specialties are very small and therefore it is hard to draw any clear patterns.

**Issues recruiting to posts**

The most significant concern emerging from this survey, and one which has been raised by this annual report in the past, is the ongoing difficulties recruiting to vacancies. The survey found a higher proportion of vacancies in research-active roles (particularly Reader/ Senior Lecturer and Lecturer roles), than for teaching-only contracts, and were found to be concentrated in seven out of 15 specialties in 2017. Vacancies are not an issue in themselves and show room for growth in the clinical academic team. However, 12 dental schools stated that they were facing challenges recruiting to posts across 13 specialties. These issues were predominantly relating to senior roles and slightly more so for research-active staff, although not exclusively for either of these aspects.

**Challenges from the political and health landscape**

The dental clinical academic team also faces other challenges for which it will need to be robust and adaptive. The impact of Brexit and the outcome of the negotiations remains to be seen, but it will be essential to monitor the impact on the clinical academic team. Alongside medical and other healthcare professionals, the sector will need to press hard for a settlement that will avoid negative impacts on clinical academic employment in the UK.

The reforms proposed of the higher education sector largely in England, with the introduction of the Office for Students and the Teaching Excellence Framework may also continue to change the overall shape of the workforce, and this may continue to
increase the proportion of staff on teaching-only contracts, and to affect the balance of allocated time for research.

These developments sit alongside an ever-increasing population and demands on dental services, which only increase the importance of the clinical academic team to lead the way for best-practice and to drive innovative solutions to meet dental patient needs.

The importance of collecting staff data

This report, as in previous years, gives the most complete picture of clinical academic staffing levels in dentistry in the UK. Nonetheless there are limitations with the data, and this report captures only the clinical academic contribution of the workforce with a substantive university contract and honorary NHS contract; the contribution to teaching of clinicians employed with a substantive NHS contract is not captured.

The Dental Schools Council recognises the importance of collecting and collating the data reported from this survey to help to ensure the future of the clinical academic workforce. Key to this is collaborative working with the relevant funders and other stakeholders to strengthen the workforce in the face of the challenges ahead for dentistry and the wider NHS team.
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