BRITISH DENTAL ASSOCIATION

Evidence to the Doctors' and Dentists' Review Body

October 2003

For the Thirty-Third Report 2004

Access to NHS dentistry, Carmarthen, Wales, 2003

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GENERAL EVIDENCE

The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for their Thirty-third Report covering the year 2004/05. It is written under the terms of reference introduced in 1998 and all subsequent amendments. The evidence is submitted on behalf of dentists practising in the National Health Service and covers those working in:

- General Dental Services
- Salaried Primary Dental Care Service – including the Community Dental Services and those in Dental Public Health
- Personal Dental Services
- Clinical Academic Staff.

The British Medical Association will be submitting evidence on behalf of all hospital staff. We ask the Review Body to note that the issues raised by the BMA are applicable to those working in Hospital Dental Service.

Overview

The British Dental Association (BDA) has been working towards a smooth transition from the current system of remuneration and delivery of NHS dentistry to the new system beginning on the 1st April 2005 as the implementation of the Health and Social Care Bill (England) comes into effect. The Parliamentary Bill basically devolves the commissioning of dental services and funding locally to Primary Care Trusts in England.

The BDA has been working in conjunction with the Shadow Special Health Authority/ DoH on agreeing the details of the base contract for practitioners that is needed to implement the new commissioning arrangements and to date some progress has been made on determining the broad content of the contract. The BDA is also representing the profession on the Department of Health's Dental NHS Patient Charges Working Group with the aim of devising a new patient charges regime that is less complex and more understandable to both patients and practitioners. Other concerns of the profession, that we are working to address, include issues relating to superannuation, the IT strategy, and the role of stakeholders with local commissioning.

Workforce shortages

The BDA believes that there is a serious shortage of dental personnel in the UK. In the GDS alone we estimate that there is a workforce shortage of around 4,000 full time practitioners. The dental workforce has been considered in all three countries of Great

Britain, although the review in England has still not been published by the Department of Health. Such shortages in the workforce are often best demonstrated through poor access to services. In Carmarthen this year over 600 people queued to register with an NHS dentist.

An under resourced system

It is also our belief that NHS dentistry has been historically under resourced. Since the effective abolition of TAGI/TANI, by the DDRB, we have calculated that funding for the GDS has been some £240 million below what it would have been under the previous system. The lack of funding for modernisation and enhancements to dental facilities (in both salaried services and general practice) is compromising the quality of patient care. Some bodies corporate have embarked on a programme to improve the environment in which dental care is undertaken and this policy has been well received by their patients, both private and NHS. All NHS patients should have access to similar levels of patient care in a modernised NHS dental environment.

The present system further worsens workforce issues. General dental practitioners are reducing their commitment to the NHS or are converting their practices to largely private dental services – for example in the early 90s, over 90 per cent of GDS practitioners derived 75 per cent or more of their income from the NHS, today, a decade on, only around 60 per cent of GDS practitioners derive 75 per cent or more of their income from the NHS. Their colleagues in the salaried services suffer from difficulties in recruitment and retention. The BDA Community Dental Services Recruitment and Retention Survey (2002) found that around 10 per cent of all community dental officer posts were vacant and that the average length of time that these posts remained vacant was 12 months.

The present cycle of an under resourced NHS dental system which exacerbates workforce problems and ultimately adversely impacts on patient care and access needs to be addressed now. The Review Body have the opportunity to address some of these issues, in the 12 month run in period from 1st April 2004, before the implementation of the Health and Social Care Bill (England).

The BDA now presents to the Review Body its General Dental Services and Salaried Services evidence and subsequent recommendations which we believe need to be implemented in 2004/05 to ensure that NHS dental services of "tomorrow" achieve the levels of patient care from a motivated and fully resourced NHS workforce.

GENERAL DENTAL SERVICES EVIDENCE: SUMMARY

Access to NHS dentistry remains a very serious problem for patients. General Dental Practitioners are becoming more and more frustrated with the present system that applies increasing pressure to them to compromise their role as health care professionals. It is accepted that the implementation of the Health and Social Care Bill (for England) in 2005 has the potential to address some of the anomalies contained within the present system of remuneration but the continued failure to retain practitioners within the NHS, the difficulties associated with accessing much needed capital support, low returns on capital expenditure and continued dental practice inflation all remain key concerns to practitioners.

This year the GDS Evidence highlights:

- The effective NHS dental workforce (in terms of the number of whole time equivalent practitioners) has fallen from 98 per cent in 1992/3 to 67 per cent a decade later.

- Conversions into private practice indicate that around 1,000 whole time equivalents are likely to be lost annually between 2000 and 2005

- We have identified over 200 actual vacant surgeries or "dental chairs" across England and Wales due to a failure in recruiting and retaining associates. Based on the available data this would suggest that there are at least 550 vacant surgeries in England and Wales.

- Organisations that assist in private practice conversion, such as Denplan, DPAS and Practice Plan, have converted 200 NHS dental practices to largely private practices in the year to September 2003, and anticipate that this figure will reach 260 for the year 2003. There are only around 11,000 practices in all.

- Across England and Wales we have identified 40 NHS dental practices that have closed down in the last two years through an inability to sell them as a going concern. Based on the available data this would suggest that there have been at least 100 NHS dental practices that have closed down in the last two years (across England and Wales) due to an inability to sell them on.

- Summing up these findings on practice closures and conversions implies that over the last two years at least 500 NHS dental practices have either converted to private status or have closed due to not being able to find a buyer.

- Dental inflation for 2003/04 is estimated to rise by 4.3 per cent.

- In 2003/04 reducing the administrative burden of a full time, wholly committed NHS practitioner could allow them to increase the amount of clinical time spent with

their patients by an additional 15 per cent or alternately reduce the pressures placed upon them due to their excessive workload.

We believe strongly that the following recommendations will contribute significantly to slowing the decline in the number of whole time equivalents in the NHS. They may stabilise the current NHS commitment of practitioners and may slow down the number of NHS practices choosing to convert to private status. Such recommendations will allow practitioners to focus on delivering higher levels of patient care and will contribute to the alleviation of NHS access issues. It is important that in the 12 months in the run up to the implementation of the Health Bill (in England) that the NHS retain a motivated and committed NHS workforce and that NHS practices and their facilities remain in the public sphere to deliver the Governments vision of a modernised NHS dental service.

To aid in the retention of NHS practitioners, we ask the Review Body to recommend that:

- Any fee scale award on gross fees allow for the "lag effect"
- A GDP who opts to take their pension at age 60 but continues to work should not lose their entitlement to seniority payments or to commitment payments.
- That the maximum payments for seniority be raised to the same level as that for Scottish GDPs and eventually to be brought in line with the GMPs seniority scheme.

To ensure that practitioners are reimbursed appropriately in the light of increasing dental practice expenses, we ask the Review Body to recommend that:

- That any fee scale rise acknowledges the estimated 4.3 per cent rise of dental inflation (this year). As such we ask for an increase in the fee scale of 4.1 per cent.
- There is a review undertaken of GDPs expenses with the view to having a system in place by 2005 that can adequately deal with differing regional expense pressures.

To ensure that practitioners are reimbursed appropriately for their administrative burden, we ask the Review Body to recommend that:

- A practice allowance of up to £3,000 is introduced, pro rata, to GDS practice owners.

To ensure that practitioners and their staff are adequately trained for the changes occurring from the eventual implementation of the Health Bill (in England), we ask the Review Body to recommend that:

- The number of Continuing Professional Development sessions that can be claimed in 2004/05 is raised by six sessions and a training grant of £1,000 is made available, for this year only, to go to the practice owner, to enable staff training.

GENERAL DENTAL SERVICES EVIDENCE

1.1 In our supplementary evidence to the DDRB last April we ended by stating the view of many general dental practitioners that *"The future is a promise; the present is uncertainty"*. Today that same sentiment prevails within the profession. The final fee uplift for 2003/04 of 3.225 per cent has done little to galvanise the professions' confidence in the NHS in the short term, although we welcome the improved funding for the commitment payments scheme.

1.2 For the first time ever the Review Body made a fee scale recommendation accurate to three decimal places, which exactly matched the annual increase offered in the three-year pay offer, which was rejected earlier in the year by the profession. The impact of this on the profession was a further loss of confidence in the independence of the Review Body. This has resulted in increased frustration within the profession at the continued lack of governmental commitment in delivering high levels of services to NHS patients. We now consider that practitioner morale has been driven even lower and the commitment of those remaining in the NHS is waning rapidly. The BDA Dental Business Trends Survey (2002) shows that 59 per cent of committed NHS practitioners are less confident about the future of the NHS than they were two years ago.

1.3 Implementation of the Health Bill in England is now 18 months away, however regarding any Review Body recommendations the time period under consideration is only 12 months. In that time many practices and practitioners, currently committed to the NHS, are likely to be driven to abandon their NHS commitment altogether to ensure practice viability. It is vital that the Review Body understands that there may not be the workforce or the practice facilities by 2005 to deliver the vision of a modern NHS dental service as outlined in Options for Change.

1.4 Access to NHS dentistry remains at the forefront of patient frustration. Only recently (July 2003) hundreds of people from across mid and west Wales spent hours queuing to be accepted for NHS care by a dentist based in Carmarthen. The queue started to form at 6am and by 9am was estimated to be 600 strong. However, only the first 300 could be accepted (through a numbered ticket system) and the rest, sadly due to capacity constraints, had to be turned away. Similar events have been played out in other parts of the UK although without the national press and media attention received in Carmarthen. The BDA has repeatedly advised the Government that such scenes would become a reality, and when the Audit Commission (2003) warned that four out of ten dentists in England and Wales were not accepting NHS patients, such scenes became inevitable.

1.5 The failure to retain practitioners within the NHS has resulted in a national workforce shortfall of around 4,000 dental practitioners. Within the current GDS workforce issues, a lack of capital support, anomalies arising from the remuneration system and rising expenses are all acting to drive practitioners out of the NHS. Implementation of the Health Bill (England) aims to reform the system, but in the run up period (2004/05) action needs to be taken to ensure that the workforce and their practices remain committed to delivering NHS dentistry.

Workforce

1.6 The issue of retention of dentists within the GDS is well recognised as many practitioners have been moving out of undertaking NHS work and into private work. The OME Survey of GDPs' Workloads (2000) indicates that in 2005 only one third of practitioners' will devote 70 per cent or more of their time on NHS work; additionally, around one in ten practitioners' do not expect to be part of the NHS dental workforce at all. When the survey was undertaken in 2000 the proportion of practitioners devoting 70 per cent or more of their time on NHS work was just over two-thirds (see table 1). This suggests that between 2000 and 2005 around 1,000 full time wholly committed GDS dentists are to be lost from the GDS each year.

Table 1: Expected ratio of time spent on GDS to private work, currently (2000) and expected in 2005

% GDS: % Private	2000 (%)	2005 (%)
100:0	25	8
90:10	33	8
80:20	8	7
70:30	5	9
60:40	2	7
50:50	3	10
40:60	3	3
30:70	5	5
20:80	7	10
10:90	6	9
0:100	1	8
Not in the profession	-	11

Source: Survey of GDPs Workloads (OME, 2000)

1.7 The BDA Dental Business Trends Survey (2002) has shown a sharp rise in the proportion of practice owners experiencing difficulty in the recruitment of associates. In 2002, 44 per cent of practice owners less committed to NHS work reported that the recruitment of associates was "hard". However, the situation is even more acute for committed NHS practice owners. In 2002, 66 per cent of

committed NHS practice owners reported that the recruitment of associates was "hard" [1] - this is up from 55 per cent in 2001 (see table 2).

Table 2: Recruitment of associates over the last two years

Difficulty experienced by practice owners in recruiting associates	**Hard (%) 2002**	**Easy (%) 2002**	**Hard (%) 2001**	**Easy (%) 2001**
Overall	57	7	47	10
NHS commitment: High	66	4	55	7
NHS commitment: Low	44	11	37	11

Source: Dental Business Trends Survey (BDA, 2002)

1.8 Failure to retain GDS dentists is now manifesting itself in practice closures and vacant surgeries across the country. Paragraph 1.47 shows that we have been able to identify at least 40 NHS dental practices that have closed down due to an inability to be sold on, in addition we have also identified over 200 vacant surgeries or "dental chairs" (in England and Wales) that remain unfilled due to a failure to retain and recruit associates willing to take an NHS list. Based on the available data (from a sample of areas that contain around one third of the population of England and Wales) it is likely that there are over 550 vacant surgeries in England and Wales. In the British Dental Journal of October 2003 there were 254 dental practices across the country attempting to fill practitioner positions. The situation of vacant surgeries also adversely affects their respective practice owners as the empty surgery becomes a financial loss to the practice; fixed or sunk practice expenses (e.g. rents, interest payments on capital expenditure and depreciation) continue to be paid, however the turnover of the surgery is zero. This financial liability thus acts to further drive committed NHS practitioners (in particular practice owners) out of the NHS. The loss of practices providing NHS care cannot be in the public interest at a time when access to NHS dentistry is such a problem.

1.9 Evidence from Denplan[2] for the nine months to September 2003 shows that 115 practices have already been converted out of the NHS and the total for the year is forecast to be over 150 practices. These figures demonstrate a conversion rate of between 12-13 practices each month (see table 3). The evidence indicates

[1] From this point on where there is reference to a practitioner that is less committed to NHS work this is defined as where less than 75 per cent of income is derived from the NHS, conversely those more committed to NHS work are defined as those who derive 75 per cent or more of their income from the NHS. Also "hard" incorporates responses defined as "difficult" or "very difficult", similarly "easy" incorporates responses defined as "easy" and "very easy", this applies to all subsequent tables.

[2] Denplan, Practice Plan and DPAS are organisations that assist in the conversion of dental practices to independent status. Basically, these organisations implement and administer payment schemes (e.g. capitation, private fee per item, or a mixed system) that are independent of the NHS, i.e. private conversions.

that the total number of conversions in 2003 will be the highest annual total, for Denplan, since 1999. There is currently strong demand for private conversions in Northern England and in Northern Ireland, both of which have long been regarded as bastions of NHS dentistry. Such activity is indicative of the disastrous failure to retain practitioners' within the NHS.

1.10 In addition, Practice Plan (see footnote 2) is currently converting between 6-9 NHS dental practices each month, with around 80 per cent of these being full conversions to independent (i.e. private) status. Practice Plan is also dealing with at least forty enquiries from NHS practitioners seeking to convert some or all of their practice to independent status. Interestingly NHS practitioners are looking to increase the speed at which they wish to convert their practices. This desire for faster conversions has been on the rise for the last two years and has accelerated significantly in the last six months. Practice Plan cites these trends as a direct consequence of practitioners becoming disillusioned with the NHS and thus choosing to opt out of the NHS altogether.

1.11 DPAS (see footnote 2) has also experienced a noticeable increase in the number of NHS conversions over the last year, and are assisting in, on average, two new practice conversions each month. Their experiences have shown that the recent increase has largely been due to the uncertainty as to what awaits practices in 2005 with the change to local commissioning.

Table 3: Current dental practice conversion rates, 2003

Organisation	Conversion rate	Estimated conversions in 2003
Denplan	12-13 per month	150
Practice Plan	6-9 per month	90
DPAS	2 per month	24

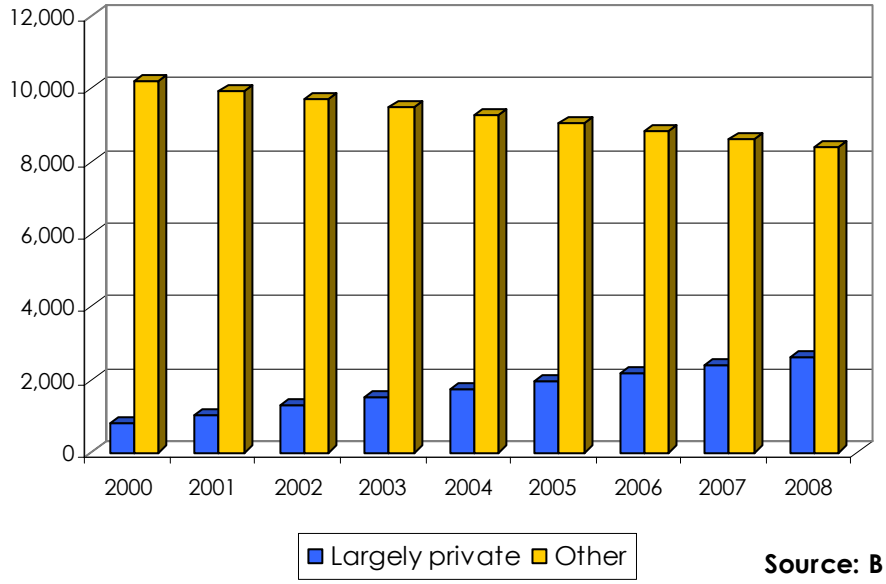
Source: Denplan, DPAS, Practice Plan (2003)

1.12 Overall these findings indicate that, in the year to September 2003, around 200 dental practices have converted to private practice and that by the end of the year this figure will exceed 260 or 2.4 per cent of the total number of dental practices in the UK. We consider this a significant reduction in NHS service provision, especially, given that results from the BDA Omnibus Survey (2001) indicate that around seven per cent of practices already consider themselves to be largely private practices.

1.13 This reinforces the findings presented in the BDA Research Bulletin (January 2002), which indicated that 17 per cent of dental practices (which have not converted to private status) are currently in the process or are planning to move towards being largely private practices. More practices in the south of England were seeking to become largely private and this sentiment seems to be constant amongst differing age cohorts – it is not just the more senior dentists that are

seeking to make the move towards offering private work, but also more newly qualified dentists. Across all practices the average time anticipated to convert their practice to a largely private practice was three and a half years with an upper quartile of five years. This suggests that by 2007 there may be over 2,000 largely private practices in the UK (or around one in five practices being largely private) – see figure 1. This equates to a conversion rate of around 300 practices per annum, a rate that has been confirmed from the evidence collated from Denplan, DPAS and Practice Plan.

Figure 1: Estimated growth in the number of largely private dental practices in the UK



Source: BDA

1.14 This evidence strongly refutes the statements by the Department of Health, in their oral evidence to the Review Body two years ago, where they stated that "…they did not recognise any major hemorrhaging in the workforce" (DDRB 31st Report para 3.14) and "… the Department therefore considered that the drift out of NHS dentistry was around one to two per cent a year" (DDRB 32nd Report para 2.34). Access to NHS patient care is being compromised as dental practices move out of the NHS. With the implementation of the Health Bill in England only 18 months away, it is imperative that the NHS retains an adequate workforce to deliver the vision of a modernised NHS dental service. This includes keeping facilities, surgeries and capital equipment available for NHS patients, and not exclusively for private patients. Continuation of the current rates of conversion could mean that the workforce and the practices required by the NHS in 2005 simply may not exist.

Commitment payments and the "lag effect"

1.15 NHS dental treatments that begin before the 1st April (when a new fee scale increase is normally implemented) are subject to be charged based on the previous fee scale. As practitioners undertake the treatments started prior to any fee scale increase they incur a financial penalty that is positively related to the time spent in the new fiscal year undertaking such treatment. This is referred to as the 'lag effect' and occurs on item of service claims following a fee scale increase. As such, a fee scale increase on gross fees does not result in the full fee scale increase filtering through onto the gross fees. The 'lag effect' also has repercussions on the level of commitment payments distributed to practitioners in the first fiscal quarter of each year. Thus, holding all other factors constant, a fee scale increase on gross fees will result in practitioner's gross income rising by less than the fee scale increase.

1.16 As we noted in our evidence to the Review Body last year, the Department of Health stated to the GDSC (in October 2002) that the full effect of freezing the threshold bands on commitment payment would equate to around £800,000 each year. This admission, although relating to commitment payments, confirms the existence of a 'lag effect', something that the Department of Health has been reluctant to admit to the Review Body.

1.17 The BDA estimates that the 'lag effect' of the 3.225 per cent rise in the fee scale for 2003/04 is almost £4 million. To compensate for the 'lag effect' any actual fee scale increase needs to be increased by 7.43 per cent of the intended fee scale increase. As such the intention of the DDRB of raising gross fees by 3.225 per cent in 2003 could only have be achieved by an actual fee scale increase of 3.465 per cent.

1.18 We welcomed the strengthening of the commitment payments scheme in 2003/04 via the additional funding as well as the opening up of the scheme to assistants. The BDA's analysis, presented to the Review Body last year, showed that the commitment payments scheme has contributed, in part, to retaining existing levels of commitment to the NHS for those dentists receiving commitment payments. We fundamentally believe that the commitment payments scheme is effective in stabilising practitioners' levels of commitment to the NHS, and that the scheme has contributed in stabilising the NHS commitment of practitioners that receive such payments.

In the light of the issues raised above, the following recommendations would have a significant positive impact on retaining a committed NHS workforce that will be able to deliver high quality NHS care to patients when the Health Bill is implemented, we ask the Review Body to recommend that:

~ Any fee scale award on gross fees allow for the "lag effect"

Seniority payment and retention

1.19 There is concern at the failure to retain older and more experienced NHS practitioners within the NHS. Since April 2003 practitioners up to age 70 (previously age 65) can continue as GDS principals. However, this has no real impact if these practitioners have already left the NHS or the profession as a whole. It is imperative to retain senior practitioners within the NHS well into the initial implementation of the Health Bill in 2005.

1.20 The Statement of Dental Remuneration states that seniority payments are additional monies that are paid to GDS practitioners who have reached the age of 55, and are designed primarily to reward practitioners for staying within the NHS and to compensate them for a reduction in their ability to carry out their work in the GDS at the same pace as younger colleagues. Under the present remuneration system seniority payments and practitioners' entitlement to commitment payments cease for those practitioners who start to draw their pension. This system can therefore result in a drop in a practitioner's gross GDS income, even if their GDS output remains constant. Such a system therefore discriminates against more senior practitioners, and acts as a significant disincentive to retaining these practitioners[3] within the NHS.

1.21 The DDRB Report (2001) recognised this anomaly for general medical practitioners, who are also under the DDRB's remit, and recommended that from 1st April 2001 there should be a seven per cent increase in general medical practitioners seniority payments, over and above the proposed 3.9 per cent increase in intended average net income (or IANI). This was stated to be an integral attempt to improve GMPs' motivation, recruitment and retention. Since then, the seniority payment scheme for medical general practitioners is to be improved further still to reward GMPs' experience. The new scheme will deliver a 30 per cent increase in total resources over current spend by 2005/06, based on years of NHS service.

1.22 The Department of Health in its Evidence to the Review Body (2003) stated that senior practitioners (i.e. aged 55 or over) receive incentive payments (through seniority and commitment payments) of £11,215, however the conditions to receive these include grossing over £129,000 and having 1,650 registered patients. The main problem with this is that these payments are dependent on gross earnings and generally senior practitioners tend to gross less because of the age factor and physical limitations. As a result, levels of both commitment and

[3] At age 60 practitioners can draw their pension and return to work with unabated earnings provided that they take a one month's significant break from NHS employment. However when a practitioner reaches the age of 60 it is rarely, if ever, advisable not to draw one's pension. For example an average practitioner aged 60 who delays taking their pension by one year would have to live another 30 years drawing his increased pension to break even. This phenomenon provides the incentive to draw a pension at aged 60, even though the dentist may work on for another 10 years.

seniority payments drop. Many dentists at this age are also practice owners and due to the fact that some overheads are fixed cost, practitioners suffer decreasing returns. A compounding factor is the increasing time burden required to manage a practice.

1.23 The current system of seniority payments in England for practitioners allows a maximum payment of £7,049 in 2003/04. However, in Scotland, the maximum payable from 1st April 2003 has risen from £7,000 to £13,100; the Scottish Executive believes this measure will enhance the retention of dental practitioners with an aim of improving access to NHS dentistry across Scotland.

In the light of the anomaly in the current remuneration system and the importance of retaining practitioners, in particular senior practitioners, within the NHS, we ask the Review Body to recommend that:

~ A GDP who opts to take their pension at age 60 but continues to work should not lose their entitlement to seniority payments or to commitment payments.

~ That the maximum payments for seniority be raised to the same level as that for Scottish GDPs and eventually to be brought in line with the GMPs' seniority scheme.

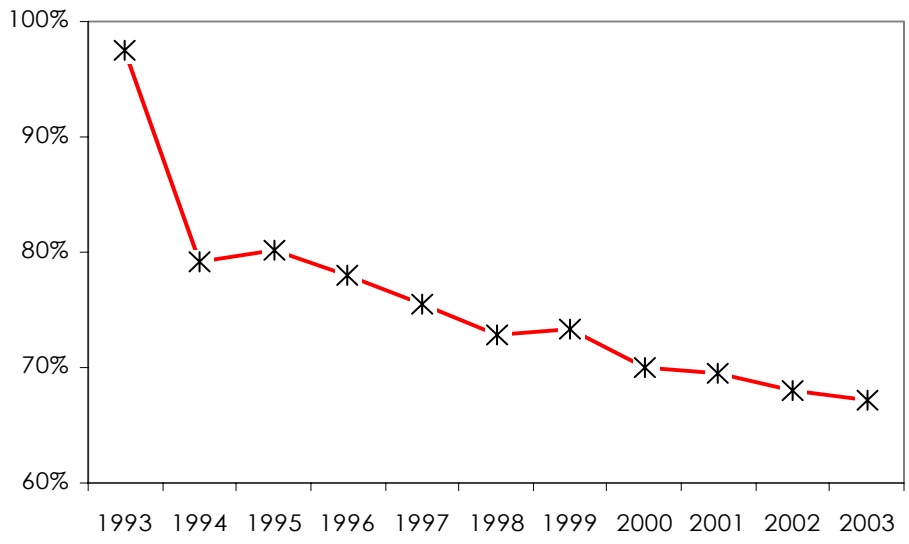
Whole-time equivalent GDPs

1.24 The Review Body has again asked for an agreed estimate for the total remuneration for a whole time equivalent GDP. This exercise has been undertaken many times, the last time being in the OME Workloads Study 2000. Uplifting the results from the OME study by subsequent fee scale increases shows that in 2003/04 the personal gross fee earnings for a full time wholly committed NHS practice owner is £138,000 and for an associate is £116,000 (these figures are gross fee earnings before expenses and tax).

1.25 Our information would suggest that in 2002/03 there are around 13,000 whole time equivalent GDS dentists. This figure tallies with our calculations presented to the Review Body last year (which used an alternate methodology) for the number of NHS whole time equivalents in the GDS[4]. The number of whole time equivalent GDPs as a proportion of the dental workforce (for England and Wales) has continued to decline. The effective dental workforce dedicated to NHS work, in terms of the number of whole time equivalent practitioners, has fallen from 98 per cent in 1992/3 to 67 per cent a decade later (2002/03) – see figure 2.

[4] In our Evidence to the Review Body last year, using another methodology, we stated that for Great Britain in 2000/01 there were 12,900 NHS whole time equivalents in the GDS.

Figure 2: Number of GDS WTE as a percentage of the total workforce (England and Wales)



Source: BDA

1.26 It is clear from the above that the effective size of the GDS workforce providing NHS treatment is in decline. This is despite continued increases in the absolute size of the dental workforce. It is imperative that measures are taken now to stabilise the current NHS commitment of GDS practitioners to ensure that the Governments' vision outlined in Options for Change (England) becomes a reality.

Expenses

1.27 The BDA Dental Business Trends Survey (2003) shows that 41 per cent of dental expenses are salaries and wages; 16 per cent are attributed to laboratory costs; dental consumables account for 14 per cent; 11 per cent of expenses related to premises costs; and 18 per cent relates to other non capital expenditure.

1.28 As outlined in last year's supplementary evidence and oral evidence one of the major stumbling blocks in the acceptance of the three-year pay offer related to the issues of expenses and dental inflation. For many practitioners, in particular practice owners, the three-year pay offer amounted to a reduction in income. The fee scale increase of 3.225 per cent for 2003/04 is insufficient to cover the expense element of the majority of committed NHS dental practices in the UK.

1.29 The BDA Professionals Complementary to Dentistry (PCD) Survey (2003) has shown that in the two years up to 2002/03 the increase in the average hourly rate for trained dental nurses was 12 per cent (or approximately six per cent per annum). This rate of increase is corroborated with official Government statistics that have shown a 13 per cent rise in the average earnings (excluding bonuses) for health

and social work employees[5] in the two years to 2002. The reliability of the results of the BDA PCD Pay Survey has also been borne out by official pay statistics provided in the Annual Earnings Survey. The results of the BDA survey also shows that the hourly rate for receptionists and practice managers have both risen by five per cent annually. As such, PCD wages and salaries in isolation increase overall practice expenses by between 2-2.5 per cent annually.

1.30 The tightness of the labour market for PCDs is driving the upward pressure on wages and salaries. Practices more committed to NHS care are finding it relatively more difficult to maintain PCD pay at levels that attract or retain staff – see table 4.

Table 4: Recruitment of PCDs over the last two years

Difficulty in keeping PCD pay at a level that attracts and/or retains staff	**Hard (%) 2002**	**Easy (%) 2002**	**Hard (%) 2001**	**Easy (%) 2001**
Overall	73	14	61	23
NHS commitment: High	80	8	70	15
NHS commitment: Low	66	22	51	32

Source: Dental Business Trends Survey (BDA, 2002)

1.31 The National Statistics publication Focus on Consumer Price Indices (2003) indicates that in 2002/03, inflation[6] was 2.1 per cent. Taking a simple formula for dental expense inflation[7] we estimate that expenses rose by 3.9 per cent in 2002/03; the corresponding fee scale increase in this period was lower at 3.6 per cent.

1.32 Looking to this year and using inflation forecasts from Forecasts for the UK Economy (2003)[8], dental expense inflation is estimated to rise by 4.3 per cent. Simple modelling of a three-practitioner practice (made up of one practice owner and two associates all of whom are full time and wholly committed to the NHS) shows that the 3.225 per cent fee scale increase in 2003/04 will lead to an actual increase in combined practice net remuneration of only 2.1 per cent. However, the practice owner's net remuneration remains largely unchanged as

[5] Labour Market Trends 2003 – code JVVR

[6] Defined as "All items RPI" - code CHAW.

[7] The calculation of dental inflation, assumes that practices expenses are distributed according to the findings of the BDA Dental Business Trends Survey (2003), see paragraph 1.27. Wages and salaries account for 41 per cent of practice expenses, 11 per cent is attributed to premises costs and 48 per cent is accounted to other costs. Dental inflation can thus be estimated using the following formula: 0.41*[movement in JVVR] + 0.59*[movement in CHAW]. It must be emphasised that this formula does not take into account the mounting pressure of dental expenses, such as dental indemnity, the Disability Discrimination Act, GDC retention fee etc.

[8] Available from the HM Treasury website

he/she absorbs the estimated increase in the practice expenses. This phenomenon is borne out in the latest Inland Revenue evidence on earnings and expenses for the year 2001/02 which states that between 2000/01 and 2001/02 (where the fee scale rose by 3.9 per cent) the estimated average gross GDS fee earnings for non-associate dentists rose by four per cent, however the average net GDS fee earnings only rose by two per cent.

1.33 In addition, practitioners face many other factors that are adding upward pressure on their overheads and practice expenses; these include the increase in the GDC retention fee, and professional indemnity cover, both of which are compulsory. The GDC annual retention fee is to rise by a further 46 per cent between 2003 and 2005. Dental Protection Limited, who offer professional indemnity to around 70 per cent of UK practitioners, have increased their subscription fee for a full time GDP from £738 in 2001 to £1,160 in 2003 – a rise of 57 per cent.

1.34 The Review Body has repeatedly been misled by the Department of Health on the interpretation of the annual Inland Revenue survey on practice expenses. It is our contention that the fall in the expenses ratio since 1990/91 is due predominantly to the shift towards private practice and not that practitioners are spending less. Scenario building can show that in committed NHS practices, the impact of any practitioner reducing their NHS commitment pushes down the practice expense ratio – see Box A.

1.35 Evidence from actual audited practice accounts[9] for committed NHS practices shows clearly the rates of increase of various expense categories. In one Manchester surgery, with two committed NHS practitioners, expenses rose by 10 per cent in 2001/02, which included a nine per cent increase in staff costs and a five per cent increase in rates. In the five years to 2001/02 expenses for this surgery rose by 35 per cent, including a 41 per cent increase in staff costs at the same time as NHS fee scale increases over this period amounted to only 15 per cent.

1.36 In another four practitioner dental practice based in West Yorkshire (that is 97 per cent committed to the NHS) the expense ratio has risen – from 48.6 per cent to 51.9 per cent - between 1999 and 2002. Between 1999 and 2002 the practice turnover has risen by 14 per cent (an average rise of five per cent) while expenses have risen by 22 per cent (an annual average of seven per cent). The average annual increase in staff costs over this period was 9 per cent and was 34 per cent for repairs and renewals.

[9] The examples are actual audited practice accounts for NHS dental practices. They are anonymous to respect individual's confidentiality but can be verified by accountants should this be necessary.

BOX A: Private work and the expense ratio

The following figures are based on the estimated GDS expenses per principal (1994/95) from the Inland Revenue survey on practice expenses. The first scenario assumes an NHS practice with two practitioners; note the effect on the average expense ratio.

SCENARIO 1	**Dentist A**	**Dentist B**	**Average**
Turnover (Gross)	£84,556	£84,556	£84,556
Laboratory	£6,834	£6,834	£6,834
Dental consumables	£8,222	£8,222	£8,222
Premises	£5,012	£5,012	£5,012
Salaries	£16,314	£16,314	£16,314
Other	£8,036	£8,036	£8,036
Capital Allowance	£1,728	£1,728	£1,728
Total expenses	£46,145	£46,145	£46,145
Profit	£38,411	£38,411	£38,411
Expenses ratio	54.6	54.6	54.6

The next scenario shows that dentist B has managed to convert 50 per cent of their patients to non NHS and has an private hourly rate that is double the NHS rate. As a consequence of this dentist B has increased their laboratory costs by 50 per cent, as they are using a higher standard of laboratory work. Other costs do not vary with output.

SCENARIO 2	**Dentist A**	**Dentist B**	**Average**
Turnover (Gross)	£84,556	£126,834	£105,695
Laboratory	£6,834	£10,251	£8,543
Dental consumables	£8,222	£8,222	£8,222
Premises	£5,012	£5,012	£5,012
Salaries	£16,314	£16,314	£16,314
Other	£8,036	£8,036	£8,036
Capital Allowance	£1,728	£1,728	£1,728
Total expenses	£46,145	£49,563	£47,854
Profit	£38,411	£77,271	£57,841
Expenses ratio	54.6	39.1	45.3

This example demonstrates that the expense ratio for committed NHS dentists is higher than for less committed dentists. As such reported aggregated trends cloud the true picture; expenses are being underrepresented for those dentists deriving the majority of their income from the NHS. This finding is illustrated in paragraph 1.37 with actual audited accounts.

1.37 In a Manchester based practice comprising of two practitioners working four days a week (with an NHS commitment of 90 per cent), the practice turnover has risen on average by six per cent in the period 1995 to 2000, however expenses have risen by seven per cent. Salaries and associate costs have risen on average by 19 per cent per annum and repairs and renewals by 33 per cent, over this period. The audited accounts of this practice clearly show the impact that the move to private practice has on expense ratios, as outlined in paragraph 1.34 and Box A. The practice expense ratio continued to rise over the period 1995 to 1998 – from 59.7 per cent to 63.9 per cent. In 1999 one of the practitioners reduced his commitment to the NHS (so that the practice NHS commitment dropped to around 70 per cent) and in the subsequent two years the expense ratio began to decline.

Practice expenses have been rising and the majority of this burden of this has fallen upon the practice owner. Fee scale increases have not been taking account of dental inflation adequately and regional pressures upon expenses cannot be addressed through such a mechanism. Consequently, patient care (particularly in terms of the time patients wish to spent with the practitioner) is being been compromised as practitioners struggle to replace both staff and equipment. We ask the Review Body to recommend that:

~ That any fee scale rise acknowledges the estimated 4.3 per cent rise of dental inflation (this year). As such we ask for an increase in the fee scale of 4.1 per cent.

~ There is a review undertaken of GDPs expenses with the view to having a system in place by 2005 that can adequately deal with differing regional expense pressures.

Capital support and return on capital

1.38 Research entitled Small Firms: Big Business, by the Small Business Service (DTI), has identified that the three primary concerns of small business owners are regulation, cash flow and difficulty obtaining finance and taxation. Cash flow and difficulty obtaining finance has been identified as a factor that threatens the survival of businesses. This evidence reinforces the problems faced by practice owners.

1.39 Many dental practices, and in particular practice owners, committed to the NHS are finding that their practices are becoming less and less viable. Additionally, practice owners are finding that their NHS practices have rates of return on capital that approach zero, and as such NHS practices are difficult to sell on – some NHS practices simply close.

1.40 There is a clear pattern with regard to maintaining practice investment plans. Those practice owners who are highly committed to the NHS are less likely to maintain their practice investment plans than private practice owners. In 2001 two in five committed NHS practice owners failed to maintain their investment plans (see table 5). The current NHS system for remuneration has failed to deliver much needed capital support to practices that are committed to the NHS. This consequently undermines NHS patient care and restricts patient choice.

Table 5: Maintaining practice investment plans over the last two years, 2001

Have you been able to maintain your investment plans over the last two years?	**Yes (%) 2001**	**No (%) 2001**
Overall	65	35
NHS commitment: High	57	43
NHS commitment: Low	74	26

Source: Dental Business Trends Survey (BDA, 2001)

1.41 Bodies corporate, such as James Hull and Associates and Oasis, are currently investing in high quality, modern practice facilities. This is so that they can attract practitioners as well as provide the highest care and choice for patients. Patient feedback from Oasis has shown that patient satisfaction is high where practices have been refurbished and modernised. Regular monitoring and patient feedback confirms Oasis's policy of investing over 10 per cent of turnover back into practices is stimulating patient recommendations and driving growth. James Hull and Associates also echo these findings. The quality of the surroundings in which care is provided is important to their patients. Patients have informed them that the modern environment helps them to feel less stressed and provides a more pleasurable experience that motivates them to attend for preventative treatment and advice and not just when they are in pain. It is important to note that both organizations provide NHS treatment.

1.42 Bodies corporate can often utilise innovative methods of acquiring capital support for such activities, for example access to funds from the stock market and venture capital, which is denied to high street (non branded, non corporate) dental practitioners.

1.43 The NHS LIFT Scheme has proved to be problematic in delivering adequate capital support in a realistic business manner. Qualitative research with practitioners involved in LIFT Schemes (in Manchester and Birmingham) shows that practitioners are experiencing numerous problems with the LIFT Scheme. The heavy involvement of private stakeholders has resulted in vastly increased premises rental costs to participating practitioners (for example a 99 per cent committed NHS practitioner in Manchester has been offered LIFT premises that

result in his practice rental costs rising three-fold[10]); in addition, LIFT Scheme projects often do not contribute towards equipping practices. Therefore potential participating practitioners are faced with significantly increased expenses without a corresponding increase in practice turnover. As there is no increase in turnover the increased expenses are borne entirely by the practice owner, thus the immediate profitability of the practice and its longer-term viability are significantly reduced.

1.44 Other problems with the LIFT Scheme include uniform rental rates across sub-regions – implying that the more deprived areas have relatively higher rental rates compared with less deprived areas; practitioners lose the patient goodwill when they sell their current practice to move to new LIFT sites as the practice valuation is based solely on the value of the land; the lack of transparency of how and which practitioners are selected for inclusion in LIFT Schemes; and considerable problems finalising agreements regarding the repayment of capital costs between the various stakeholders. The outcome is that the dental profession is not accessing much needed capital support.

1.45 Evidence from the BDA Dental Business Trends Survey 1998-2002 also shows that financial advisors, both banks and accountants, do not see treatment of NHS patients as squaring up with the financial viability of practices. Evidence collected between 1998 and 2002 indicate that both banks and accountants have been continually advising practice owners to increase the number of private patients and to reduce the number of NHS patients that they see. Historically, almost one in three practitioners have reported their accountant has advised that they increase the number of private patients that they see. One in five practitioners have received similar advice from bank managers. Accountants and bank managers are experts in their respective fields and base their advice on the actual profitability of practices. Such a finding implies that the financial world does not view NHS dentistry as a financially viable proposition compared with private dentistry and with investment in other sectors.

1.46 The BDA Survey of Welsh GDPs (2002) indicated that almost one in five (or 20 per cent) of practitioners in Wales intend to retire in the next five years. Of those planning to retire around one in four feel that their practice will not exist after their retirement. Worse still, where practitioners have been attempting to sell their practices, almost half have been trying to sell their practices for more than 12 months and a quarter have been trying for over 24 months. If these practices are not sold on, they will cease to exist. Access to NHS patient care is thus being compromised and exacerbated in Wales. It appears that a career in NHS

[10] A particular LIFT Scheme in Manchester is offering premises at a discounted rent of £22,000 per annum on a 25-year lease. This represents a three-fold increase on the current rent paid by an interested practitioner. The discount has been offered as the proposed premises are to be shared with CDS, however, without the discount the rental increase would be more than six-fold. Twenty-five year leases can also burden a practitioner into their retirement and compounding this issue is the fact that the per annum rent increases as the length of the lease decreases.

dentistry will reward many practitioners with a zero return on their long-term capital investment.

1.47 Losing practices providing NHS care cannot be in the public interest at a time when so many people cannot access an NHS practitioner. Last year we presented evidence to the Review Body on NHS dental practices that have closed through an inability to sell them on. We have undertaken such research again this year, at the request of the Review Body, and we have identified at least 40 NHS dental practices in England and Wales that have closed down altogether in the last two years, as practice owners have been unable to sell them on – see table 6. Based on the available data (from a sample of areas that contain around one third of the population of England and Wales) it is likely that over 100 NHS dental practices have closed across England and Wales, in the last two years, due to an inability to sell them on.

Table 6: NHS Dental practice closures and dental vacancies in the last two years

Area	**Practice closures**	**Dental vacancies**
Rotherham	3	11
North Derbyshire	1	12
South Derbyshire	1	14
North Notts	1	10
Nottingham	0	4
Northwest Lancashire	2	20
Stockport	0	-
Leicestershire	0	3
Lambeth, Southwark and Lewisham	3	-
North Lancashire	1	17
Barnsley	1	4
Salford and Trafford	0	-
Kent	1	-
Doncaster & S Humber	2	3
Oldham, and Tameside & Glossop	2	16
Northeast Lancashire	1	30
North London	0	-
Lincolnshire	4	12
Denbighshire & Conway	4	8
South and West Devon	4	6
Wakefield, Calderdale and Kirklees	3	9
Someset	1	6
Newcastle (West) and Teeside	2	-
Northants	2	3
Sheffield	1	20
TOTAL	**40**	**208**

Source: BDA, 2003

1.48 In some cases practitioners are being forced to hold on to practices or to rent out premises at unfavorable rates. Alternately, practitioners are being offered derisory amounts for the sale of their practices. This is leaving many senior practitioners frustrated that a career of delivering NHS dental care with self funded investment in their practices is resulting in such a negligible return of capital. Based on the information available at least 500 NHS dental practices have been lost from the NHS in the last two years as a result of private practice conversion or practice closure (due to an inability to sell on). It is likely that even before the implementation of the Health Bill in England occurs, a similar number of dental practices may be lost from the NHS.

1.49 Unfortunately, these issues have manifested themselves as negative perceptions in the next generation of practitioners. Historically, a career pathway for a new GDP would involve being a practice owner. However the proportion of associates attracted to becoming a practice owner has been declining since 1998. The BDA Dental Business Trends Survey (2002) indicates that currently over half of all associates with a high commitment to NHS work have become less attracted to becoming a practice owner over the last two years. Evidence from the BDA's Young Dentists' Committee cites that the reasons for this include an unwillingness to accept the debt of a practice against its future financial rewards; uncertainties surrounding NHS dentistry making it difficult for young practitioners to obtain backing from financial institutions; and the continuing and increasing NHS bureaucracy. Additionally, the structure of the dental workforce is changing and as such the aspirations of the workforce is changing. These structural changes occurring within the workforce have resulted in younger practitioners becoming less and less willing to become practice owners.

1.50 There are many factors that have been, and are currently, combining to destabilise the way in which the industry is organised. For more than a decade the Government has failed to retain practitioners in the NHS. Fee scale increases have failed to take account of rising practice expenses and the growing administrative burden now being placed upon practitioners and in particular practice owners. Consequently, newer generations of practitioners are become less and less attracted to the prospect of buying a practice. For the Health and Social Care Bill in England to successfully deliver the vision of NHS dentistry outlined in Options for Change it will need a motivated NHS workforce and practices in which to deliver NHS dentistry. There is no guarantee that either of these will exist in 2005 and beyond. The picture is bleak.

Practice cost allowance

1.51 The OME Workloads Survey 2000 highlighted that the average practitioner was spending almost five hours a week on administration, a decade earlier this figure was lower at just over four hours a week. Full time wholly committed GDS practitioners spent 5.63 hours a week undertaking administration. More recently a

BDA survey on GDPs in Northern Ireland showed that around ten percent of a practitioner's time is devoted to undertaking administration, this figure is further supported by the BDA Dental Business Trends Survey (2002) which indicates that over 90 per cent of practitioners undertake up to ten hours administration a week. The ever growing administrative burden affecting NHS practitioners leads to reduced clinical hours being delivered by the workforce as a whole, thus exacerbating problems with access and restricting patient care and the time the practitioner can spend with their NHS patients. The administrative burden (or non-remunerative time) that practitioners' undertake has been increasing over time. This not only has an impact on the turnover and profitability of NHS dental practices, but the longer hours are also seriously affecting practitioner morale. More importantly, however, is the adverse impact on patient care as clinical time competes with the ever-growing administrative burden.

1.52 In the Health Departments evidence to the DDRB in November 1999, they estimated an NHS hourly rate of £57. Uplifting this by the subsequent fee scale increases and using findings from the Heathrow Timings Exercise (1999) and the OME Workloads Survey (2000), indicate that in 2003/04 relieving a full time, wholly committed GDS practitioner of this administrative burden would allow them to increase the amount of clinical time spent with their current GDS patients by an additional 15 per cent or allow practitioners to reduce their workloads.

1.53 Evidence from one large NHS dental practice in Sheffield (with 16 members of staff) has shown that the implementation of a practice manager can help improve the practice profitability. The delegation of practice management and administrative duties from the practice manager to another individual leads to increased turnover (as the practitioner has more clinical time) and greater control on costs (a responsibility of the practice manager). This is only viable for larger practices due to the shortage of managers and their cost

1.54 The introduction of a practice allowance for practitioners will improve NHS dental services for patients and would help to address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support, information collection and provision. Such an allowance would also contribute to the retention of practitioners within the NHS. A banded practice allowance based on gross earnings would be simple and transparent to implement.

In the light of the issues raised above the following recommendations would have a significant positive impact on the time spent by practitioners on GDS patients, could increase the number of GDS patients seen, may improve the efficiency of the practice and may increase practitioners' morale. We ask the Review Body to recommend that:

~ A practice allowance of up to £3,000 is introduced, pro rata, to GDS practice owners.

Other

1.55 The Chief Dental Officer for England has described the changes to be introduced through the Health and Social Care Bill as bringing in 'far-reaching reform of NHS dental services'. In the year 2004/05 general dental practitioners in England and Wales will need to attend meetings with PCTs to learn about new systems and new ways of working. They will also need to hold practice meetings and arrange training sessions to familiarise their staff with the new arrangements and any consequential changes to procedures, such as new patient charges and new monitoring arrangements.

1.56 These meetings will be at the expense of clinical time for which there will be no reimbursement. We believe that this shortfall could be addressed by raising the number of Continuing Professional Development sessions, which can be claimed for one year only in England and Wales. We estimate that a total of six sessions will be necessary for this training and information sharing to take place.

To ensure that the dental profession is prepared for the new system in 2005, training and dissemination of information is required. We ask the Review Body to recommend that:

~ The number of Continuing Professional Development sessions that can be claimed in 2004/05 is raised by six sessions and a training grant of £1,000 is made available, for this year only, to go to the practice owner, to enable staff training.

1.57 Paragraph 2.99 of the 2003 report refers to Department (England) £59 million being ring fenced for modernisation funding. In 2002/3, the Welsh Assembly Government made £900k available for refurbishment of dental practices in Wales. No funds have been identified for use in the current financial year.

1.58 The Review Body asked the Welsh Assembly Government to consider testing a practice allowance in Wales. To date no approaches have been made to the General Dental Practice Committee in Wales with a view to undertaking such an exercise.

SALARIED PRIMARY DENTAL CARE SERVICE EVIDENCE: SUMMARY

The Salaried Primary Dental Care Service (SPDCS) continues to experience considerable problems. Reported concerns about recruitment and retention of clinicians continue, the effects of *Shifting the Balance of Power* are starting to be felt in increased workloads for Dental Public Health staff and Clinical Directors. In addition the reforms proposed in the Health and Social Care Bill in England will have a profound effect on the Service in the coming years by removing the distinction between SPCDS staff and GDS staff. It remains to be seen what impact this will have on the Service.

The DDRB will be aware that the Central Committee for Community and Public Health Dentistry (CCCPHD) agreed with the Department of Health a three-year pay deal, introduced from April 2003. Alongside this a fundamental review of the SPCDS will be conducted, to report finally in April 2005. As part of this review issues around pay and conditions will be considered in the first stage and it is hoped that any agreement will be reported to the Review Body for implementation in April 2004.

We are, therefore, not submitting detailed evidence for SPCDS staff to the DDRB in this evidence, but will highlight our areas of concern for the Review Body's information.

In summary:

- The BDA and the Department of Health have agreed to a three-year pay deal for the Salaried Primary Dental Care Service (SPDCS). This amounts to 10 per cent over the period, giving an annual rise of 3.225 per cent.
- As part of this deal the BDA and Department have agreed to distribute £5m of Modernisation Funding to the SPCDS. The BDA has suggested to the Department of Health a mechanism for bids for this money.
- The parties have agreed to a reversion mechanism to the Review Body should inflation fall below or above set targets.
- The BDA and the Department of Health have agreed a fundamental Review of the SPDCS in England, to be conducted by the Chief Dental Officer. The Review is due to report in stages in both April 2004 and late summer 2004.
- Reviews are being conducted, or considered, in all other countries of the United Kingdom.
- Dental Public Health Staff have agreed to align their terms and conditions of Service with those for Hospital Medical and Dental and Public Health Medicine Staff and we are seeking an increase in the allocation of consultant discretionary points.

- Following Shifting the Balance of Power, the BDA have conducted a survey of workloads for Clinical Directors and Consultants in Dental Public Health (see annex A), which shows an appreciable increase in some duties.
- The BDA will be suggesting, through the DH Review process interim measures which will include a multi-PCT Clinical Director Allowance and;
- The introduction of Professional/Clinical Excellence Awards for the SPCDS.

SALARIED PRIMARY DENTAL CARE SERVICE EVIDENCE

Introduction

2.1 Following the 31st Report of the DDRB the BDA was once again disappointed that most the urgent issues affect staff pay and morale within the SPDCS had once again not been addressed by the Report. Continued assertions by the Department of Health that a fundamental review of the service would address the issues raised in the fullness of time did not compensate for a failure to put in place measures to help the decline of the Service in the short term.

2.2 Following the publication of the Report the BDA was approached by the Department of Health to agree to a three-year pay deal for primary care dentistry. This was rejected by GDPC, but accepted by the Central Committee for Community and Public Health Dentistry (CCCPHD). As part of this agreement the BDA sought agreement that the Review of the service should be pursued and that the issues raised by the BDA in its evidence to DDRB in recent years should be addressed. This agreement was reached and the Review has commenced. This was reported in the 32nd Report of the DDRB.

2.3 As part of the agreement the SPDCS for the first time will have access to modernisation funding, which should enable some services that have not had access to PDS monies the chance to modernise their facilities. The Service has welcomed this.

2.4 Following consultation with the profession, it was agreed through JNF that dental public health staff would have the opportunity to move to the revised terms and conditions of service for Hospital Medical and Dental and Public Health Medicine Staff (TCS). Those staff wishing to retain existing terms and condition were able to do so, but all new appointments would be made under the new TCS. Future negotiations for this group of staff will be conducted via the appropriate negotiating machinery and staff will now also have access to the new Consultants' Contract.

2.5 A survey was carried out by the BDA to investigate the effect of *Shifting the Balance of Power* (April 2002) on the relative job demands and responsibilities of Clinical Directors, Consultants' in Dental Public Health and Dental Practice Advisors. The results of the survey show a substantial increase in Dental Public Health Consultant and Clinical Director workload. The BDA will be recommending to the Department of Health Review of SPCDS changes to the Clinical Director's multi-services allowance as an interim measure to address this additional workload.

2.6 The BDA would also seek a recommendation from the DDRB to increase the allocation of discretionary points per consultant in order that consultants' in Dental Public Health can have increased access to these awards to reflect their increased workload and job complexity.

2.7 The BDA will also once again press for Professional/Clinical Excellence awards as an interim measure from the DH Review to bring the Service into line with NHS Comparators until the pay and grading structure of the Service can be fully addressed in the Review.

Three year pay deal

2.8 The details of the three-year deal were published as appendix B to the supplement to the Thirty-Second Report of the DDRB. Attached at Annex B is the agreed reversion mechanism.

2.9 The parties agreed that the deal, if the parties are unable to agree, should be referred to the Review Body should inflation fall below 1.725 per cent or rise above 4.725 per cent. The DDRB is asked to agree its willingness to participate in this process should it be necessary.

2.10 Also to be agreed is the exact mechanism through which £5m of modernisation monies will be distributed to the SPDCS. The objective is to ensure that those service that have not had access to PDS funding will receive the majority of the additional funding, in order to attempt to achieve a degree of consistency in the standard of facilities across the service, or indeed within services whereby PDS money has gone towards funding improved facilities for access services, whilst CDS services have not received such investment.

2.11 The CCCPHD welcomed the opportunity to agree to the Deal, enabling a degree of pay stability to be introduced to the service, helping with planning and creating stability during the Department of Health's Review. We await the outcomes of the Review with considerable interest; it has been made clear to the BDA from within the Service that much is riding on this for staff and we look forward to making progress on many fundamental issues described in the Reviews' Terms of Reference.

Department of Health's Review of Salaried Primary Dental Care Service

2.12 The Terms of Reference for the Review are attached at (Annex C), as is the methodology for the Review (Annex D). The Review Body will note from the context of the Review that the Review is aligned closely to the wider changes being discussed for the whole of primary care dentistry flowing from the Options for Change work and the subsequent Health and Social Care Bill currently being debated in Parliament.

2.13 The Review will be conducted in two phases, the first, to report in Spring 2004, will concentrate on in the context of preparation for PCT Commissioned primary dental services, issues of service organisation, management/leadership and size of services as well as pay, taking note of the issues raised in the Mercer's Report. It is hoped that some issues may be completed in time for implementation by April 2004. If this is the case both parties will report agreement to the Review Body.

2.14 The second phase of the Report will look at the medium term (2005-06 onwards – with the potential for a 10 year vision) and report on competencies, role, education and training and career pathways by late summer 2004. Work will then be taken forward during 2004/5 on terms and conditions of service and pay for the workforce involved, including consideration of developing as part of mainstream medical and dental grades.

2.15 The BDA will participate fully in this process and looks forward to the outcomes addressing some of the fundamental issues affecting salaried primary care dentistry. Particularly in the context of Equal Pay Legislation, given the likelihood of current salaried staff working alongside former GDPs in newly established PCT contractual arrangements on 2005.

2.16 Much detailed work will need to be completed. It is difficult, therefore, for the BDA to comment in any detail at this stage of the Review. The BDA, alongside the Department will keep the Review Body informed of the progress of the Review and will seek its agreement on any proposed changes.

2.17 Reviews may be conducted in Scotland, Wales and Northern Ireland. The BDA has been advising caution to colleagues in devolved administrations to seek to ensure that the results from the Department of Health's Review are completed before outcomes of these reviews are implemented. Whilst we agree that there should be a degree of managed divergence in devolved countries, we would wish to see that divergence applied to issues that can be agreed with the profession that do not fundamentally affect basic terms and conditions that should remain equivalent across the UK.

Alignment of dental public health terms and conditions of service

2.18 It was agreed, via the Joint Negotiating Forum, that Dental Public Health Staff should be given the opportunity to move onto the newly aligned terms and conditions for Hospital Medical and Dental and Public Health Medicine Staff. The move would not be compulsory and staff that wished could retain their existing terms and conditions. All new appointments will be made under the new terms and conditions. Future negotiation for the staff group will be conducted via the appropriate mechanisms.

Conclusion

2.19 The BDA asks the Review Body to note the information submitted by CCCPHD on behalf of Salaried Primary Care Dentists. We would also ask that the Review body make a recommendation to increase the allocation of consultant discretionary points.

CLINICAL ACADEMIC STAFF (CAS)

3.1 We continue to welcome the positive and supportive comments made by the DDRB in their reports in relation to the principle of pay parity and that there are sufficient incentives to ensure that sufficient doctors and dentists enter dental and medical clinical academia.

3.2 We hope that all aspects of the new consultant contract will be fully translated across to clinical academics, including backdating to 1 April 2003 and that the Department for Education and Skills makes provision to fully fund the new contract in England. We remain concerned that there remains the possibility that pay parity could be lost for some clinical academics in the devolved nations, which could potentially have a detrimental effect on recruitment and retention. We hope that the Review Body will continue in its support of pay parity for all clinical academics in the UK.

Annexes

Annex A: Shifting the Balance of Power: Survey of Clinical Directors and Consultants in Dental Public Health 2003

Annex B: DDRB Reversion Mechanism

Annex C: Review of Salaried Primary Dental Care Services in England 2003/04: Terms of Reference

Annex D: Review of Salaried Primary Dental Care Services in England 2003/04: The Review Process

Annex A

British Dental Association

Shifting the Balance of Power
Survey of Clinical Directors & Consultants in Dental Public Health 2003

Report for DDRB Evidence

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Shifting the Balance of Power
Survey of Clinical Directors & Consultants in Dental Public Health 2003

Report for DDRB Evidence

1 Background

In April 2002 a structural reorganization of the management of healthcare services in England was introduced. This shifted the balance of power from Local Health Authorities to Primary Care Trusts (PCTs) and Strategic Health Authorities (StHAs). The BDA were interested to ascertain the effect of this reorganization on the relative job demands and responsibilities of Clinical Directors and Consultants in Dental Public Health.

In April 2003 surveys were sent to all Clinical Directors (133 in total) and all Consultants in Dental Public Health (61 in total) in England. After two reminders, 74% of the Clinical Directors (98 responses) and 64% of the Consultants in Dental Public Health (39 responses) had replied.

The surveys included questions about job content and specific responsibilities, the results of which are detailed in this report. The questionnaire for Clinical Directors also asked if they were required to give dental public health or general dental practice advice, but did not look at the relationships between Clinical Directors and Consultants in Dental Public Health. As such, the context within which Clinical Directors give such advice is not reported. However, in the responses to these questions there were examples of Clinical Directors, Consultants in Dental Public Health and Dental Practice Advisors providing advice to PCTs through a network approach.

The survey also asked respondents whom they were employed by (which PCT, StHA, etc.) and who they worked with (which PCTs, StHAs, etc.). The responses to these questions are being used to compile a database of Clinical Directors and Consultants in Dental Public Health which will include details about where they are employed and which PCTs and/or Strategic Health Authorities they work with. The final section of the survey asked respondents to identify the dentist on the PEC of each PCT they work with. This information is being used to compile a database of dentists who sit on the PEC of their PCT.

2 Results of the survey of Clinical Directors

Response rate 74% (98 replies)

Clinical Directors were asked if they felt that the content of their job had changed since Shifting the Balance of Power. As shown in Tables 1.1 and 1.2, the majority (80%) of respondents considered that their job content had changed and nearly all of these felt that their work had increased in volume (95%), diversity (93%) and complexity (92%) since the structural reorganization.

Table 1.1: Has the content of your job changed since Shifting the Balance of Power?

	% respondents
Yes	80
No	20

Table 1.2: If yes, how has it changed?

	% respondents		
	Increased	Decreased	No change
Volume of work	95	--	5
Diversity of work	93	--	7
Complexity of work	92	1	7

Clinical Directors were asked if they were ever required to give Dental Public Health (DPH) or commissioning advice. Provision of such advice should normally be in the remit of the Consultant in Dental Public Health for the PCT (rather than the Clinical Director). However, as shown in Table 1.3, the results indicated that 70% of respondents had been asked to give advice of this nature. They were also asked if they were ever asked to give advice to General Dental Practitioners (GDPs). Advice of this type would normally be provided by Dental Practice Advisors, but (as shown in Table 1.3) 55% of the Clinical Directors who responded to the survey had been asked to advise GDPs.

Respondents were asked to specify the exact type of dental public health or general dental practice advice they were asked to provide. Further information about the responses to these questions can be obtained from Claire Lowe at the British Dental Association (c.lowe@bda.org) if required.

Table 1.3: Are you ever asked to give advice of either of the following kinds?

	% respondents	
	Yes	No
Dental Public Health or commissioning advice	70	30
Advice to General Dental Practitioners	55	45

3 Results of the survey of Consultants in Dental Public Health

Response rate 64% (39 replies)

As in the survey of Clinical Directors, Consultants in Dental Public Health were asked if the content of their job had changed since Shifting the Balance of Power. Nearly three-quarters (73%) of respondents felt that their job content had altered. Almost all (96%) of these considered that their volume of work had increased and the majority felt that their work had increased in both complexity (81%) and diversity (77%).

Table 2.1: Has the content of your job changed since Shifting the Balance of Power?

	% respondents
Yes	73
No	27

Table 2.2: If yes, how has it changed?

	% respondents		
	Increased	Decreased	No change
Volume of work	96	4	--
Diversity of work	77	8	15
Complexity of work	81	8	11

Consultants in Dental Public Health were also asked if they managed any staff in the salaried dental services. As shown in Table 2.3 only 8% of respondents had such a managerial role. These results are reassuring as this role should be fulfilled by the Clinical Director of the PCT rather than the Consultant in Dental Public Health.

Table 2.3: Do you manage any staff in the salaried dental services?

	% respondents
Yes	8
No	92

4 Conclusions

The purpose of this survey was to ascertain the effect of Shifting the Balance of Power (April 2002) on the relative job demands and responsibilities of Clinical Directors and Consultants in Dental Public Health in England. The results of the survey revealed that most Clinical Directors and Consultants in Dental Public Health considered that their jobs had changed since the structural reorganisation, and indicated that the majority of respondents felt that their work had increased in volume, diversity and complexity.

The survey showed that most Clinical Directors are asked to give Dental Public Health and commissioning advice, a responsibility which should be undertaken by Consultants in Dental Public Health. In addition, many Clinical Directors are asked to give advice to GDPs, a role which should be fulfilled by Dental Practice Advisors.

Annex B

CCCPHD Exec (03) 07
(This paper replaces the paper previously issued under this reference)

To: CCCPHD Executive Committee

RE: DDRB Reversion Mechanism

Executive Summary:

As part of the 3 year pay deal it has been agreed that in the event of RPI(X) falling outside the agreed range, the deal would be re-negotiated. The following is the form of words drafted by the BDA to cover that eventuality.

In the event that RPI(X) were to fall out of the agreed range of 1.725% - 4.725%, both Sides agree that the annual figure of 3.225% would be renegotiated through the channels of the UK Joint Negotiating Forum (JNF), with the a view to reaching agreement.

In the event that agreement were not to be achieved, the Doctors and Dentists Review Body (DDRB) would be invited to consider the issue at the request of either party or by the joint agreement of both parties. In those circumstances the DDRB would be free to call for such evidence from the parties, separately or jointly, as it may require, and the parties would be free to provide such evidence as they may, separately or jointly, wish the Review Body to consider.

Rob Leitch
Committee Secretary
3 September 2003

Annex C

Department of Health

Review of Salaried Primary Dental Care Services in England 2003/04

Terms of reference

Building on the principles of *Agenda for Change* for non-medical NHS staff groups, the work being undertaken to modernise medical staffing and the analysis in the 2002 OME Mercer report, the CDO for England will lead a review, with the BDA, the NHS Confederation and other stakeholders, to develop:

- a clear future direction for the salaried primary care dental service, consistent with StBOP and *Options for Change*;
- competences, roles, education and training and career pathways for salaried primary care dentists;
- a revised pay and grading structure to support that direction.

The review will be in two parts.

The first part will concentrate on what can be done within 12 months, for the financial year 2004/05. This will be completed by Winter 2003. In the context of preparation for PCT-commissioned primary dental services which will commence following passage of the Health & Social Care Bill, this phase will address issues of service organisation, management/leadership and size as well as of pay (changes could be implemented April 2004), taking into account what was said on these subjects in the Mercer report.

The second part will look at the medium term (2005/06 onwards – with the potential for a 10 year vision) and report on competences, roles, education and training and career pathways by April 2004. Work will then be taken forward during 2004/5 on terms and conditions of service and pay for the workforce involved including consideration of developing as part of mainstream medical and dental grades.

As part of the above, the review will:

- Set the contribution of salaried dentists within the overall context of primary care dentistry, taking into account the contribution of other members of the dental team;
- Provide fair reward for the duties and responsibilities attached to a particular post;
- Provide for full recognition of the differences in job weight across the salaried primary care dental service;
- Provide incentives for dentists to give of their best and reward those who give the most to the NHS;
- Be consistent with pay and pay principles for other staff groups, incl Equal Pay Legislation;
- Encourage dentists to undertake further training (e.g. for a Certificate of Completion of Specialist Training) and provide context and support for this (Improving Working Lives) and/or undertake CPD activities to enhance their skills and competences for the benefit of the NHS;

- Provide a clear career structure, with appropriate "stopping off" points which fit with the needs of the NHS and fits with the aspirations of salaried primary care dentists;
- Provide a pay system which reflects and rewards career progression, providing an incentive for dentists to achieve their full potential;
- Allow for current salaried primary care dentists to move across to the new career and pay structure (and actively encourage them to do so);
- Take account of the need for specialisation in salaried dental services outside hospitals and ensure consistency with the principles of delivery of specialist services elsewhere in medicine and dentistry;
- Take full account of risks and benefits of a new pay system.
- Need to also address pensions and the reality of portfolio careers so that if dentists move between salaried and independent work there is a level playing field.

Both parts of the report will be published, together with the Government's response.

3rd September, 2003

Annex D

Department of Health

Review of salaried primary dental care services in England 2003/04

THE REVIEW PROCESS

1. Introduction

As part of a three year pay agreement with the profession effective from 1st April 2003 the Department of Health is to undertake a review of the salaried primary dental care services (SPDCS). Terms of Reference [ToR] for the review to be chaired by the Chief Dental Officer (England)have been agreed with the profession. BDA have provided their thoughts on the initiation of the review process. This paper sets out, informed by BDA suggestions, the process to be followed.

2. Context for the review

The ToR identify a range of matters for consideration in the review. They also set out the wider context within which the review should take place, including:

- *Shifting the Balance of Power in the NHS* (StBOP). This must now include current Departmental change.
- wider NHS pay and workforce modernisation, most importantly *Agenda for Change* (AfC) the work around modernising medical careers.
- the new agenda for dentistry – especially *Options for Change in NHS Dentistry* (OfC) & the dentistry provisions of the Health & Social Care Bill 2003.
- the review will encompass the whole salaried NHS dental sector i.e. Community Dental Service (CDS), Personal Dental Services (PDS), Dental Access Centres (DACs), salaried General Dental Practitioners (GDPs).

To that contextual list should now be added the recently agreed Standing Dental Advisory Committee review of dental specialisms.

This wider context is very important for everyone – for the NHS, for the profession, the public and for DH. The review will look to the future, rather than to the present or past.

A further issue down-track in the new world of a unified primary dental care service will be the prospect that a greater proportion of the primary dental care workforce may want to work on a salaried basis – so what may seem modest numbers in terms of the current workforce may grow substantially – with the associated implications for the scope of the review. This has also informed DH thinking about the review process.

3. Parties to the review

The ToR have also identified that the review will not be a traditional DH/BDA process but will be conducted with a range of wider interests/stakeholders. In the context specifically of any subsequent consequential negotiations on pay and TCS employers will as usual be negotiating with the BDA.

This will be an England-only review. Northern Ireland has recently completed a review and Wales have signalled their intent to carry out any review via the Welsh JNF. Scotland have already started to develop their own agenda for their salaried service. DH will brief counterparts from other countries and BDA can similarly use its internal mechanisms.

4. Key shaping issues for the review

To summarise the key shaping issues, therefore, DH will ensure that:

- the review is firmly embedded in the wider context of NHS reform.
- the review is set firmly within the context of future PCT responsibilities for a unified primary dental care service, of which salaried dentists are likely to be a part – but at the discretion of the PCT.
- the review will be conducted in a way which ensures a range of perspectives "at the table".

5. The process for the review.

Against that background, and taking into account Staff Side proposals to initiate this project, the following process is outlined.

The review (as already agreed with the profession) is to proceed in two stages initially, going through to the start of the next financial year. A small **steering group** will be established with DH, BDA (JNF Staff Side), NHS Confederation and patient representation to give strategic steer to the review as it proceeds. CDO (England) will chair the steering group, with Deputy CDO as alternate chair. Attached is the membership (Annex).

To support the review process DH will seek to appoint an **HR specialist well-versed in the NHS** and particularly the agenda around AfC and the modernisation of the medical workforce to work on the review.

The HR person will work on a day-to-day basis to the Department of Health's **Project Lead** (John Langford). Together these resources will comprise a **project team** who will agree overall direction of the project with the steering group and carry out the bulk of the work.

The review will involve a wider range of perspectives and interests than can be represented in the steering group. A **reference group** will be established which although not meeting often (at least physically) will continue throughout the various phases of the project – thereby providing consistency and continuity - and act as a sounding board for the project team and steering group. Physical meetings might be limited to three (see outline timescale below). CDO will again chair the Reference Group, with DCDO as alternate chair.

The **reference group membership** will have both clinical and NHS management components. A spread of professional and geographical interest will be secured. Members will be appointed by the Department of Health and will serve in a personal capacity.

The Staff Side Chair will be asked to nominate a range of salaried service clinicians from which SPDCS clinical members will be drawn. The range of clinical interests to be included will need to reflect the various strands of salaried service provision.

An NHS GDP perspective will also be essential since the review is looking to the future and a unified primary dental care service. DH will therefore invite proposals from the BDA and FGDP for membership from GDPs with a track record in working innovatively in the NHS.

The planned composition of the Reference Group is attached (annex).

Other means of canvassing views or testing ideas may also come into play during the review process. Having a standing reference group will not preclude other ways of seeking wider opinion or views if this is considered necessary at some stage in the project. For example, it might be considered appropriate as part of the project to survey a sample of clinicians or NHS managers, or use focus groups to test the desirability and acceptability of a solution to a particular problem. But such tools should emerge from the needs of the project as it moves forward, not be pre-determined.

The process also recognises that **the BDA, for example, might wish to consult their members** to solicit information and/or opinion. That is entirely legitimate, but should occur outwith the project structure – that is for them to determine (and if necessary resource).

6. Running the project

The **project structure** is being put in place as quickly as possible. This means:

- recruiting project team.
- establishing steering group – first meeting early/mid September.
- concurrently - setting up the Reference Group initial meeting and inviting participation – first meeting early October.

Initial tasks will include:-

- commissioning relevant background briefing for the reference group (to ensure they understand the context in which they are to work, and so they all start from a consistent base of knowledge):
  - workforce and activity profiles.
  - briefing on NHS dentistry future – H&SC Bill – including a picture of what an integrated primary dental care service, including salaried dentists, might look like.
  - briefing on workforce modernisation – esp. modernisation of medical careers.
  - briefing on salaried dental service issues already "on the table" – e.g. from DDRB evidence & DDRB views, Mercer report.

7. Determining priorities for the work

As the review is to proceed in two phases it will be necessary to reach an early view as to what issues should be considered in the project overall and, in particular, what issues are to be considered in phase 1.

The Steering Group and the (first meeting of the) Reference Group will be used to identify the big issues and their phasing for consideration in the review – many will be identified from the initial briefing but others may come out of discussion.

This will ensure that:

- the big issues and timing are out on the table early in the process.
- JNF Staff Side will contribute to this process via their membership of the Steering Group.
- issues are considered in the context of the future, not the present or past.
- there can be a rounded discussion with clinical and NHS managerial perspectives about the issues and priorities.
- the autumn is spent working on solutions not on problems.

8. Possible timetable
NB subject to discussion with HR manager (once appointed).

Early/mid September 2003: Steering Group meets for first time

Early October: Reference Group meets (receives information/briefing; identifies the big key issues & their priority [phase 1 or 2]; starts thinking about solutions for phase 1 issues).

Through ***autumn***: project team work on solutions, in conjunction with key stakeholders & RG members.

December/early January: 2nd Reference Group meeting – check direction of travel against updated horizon scan; sign off phase 1 solutions; scope phase 2 big issues & possible solutions.

January through March/April – project team work on phase 2 solutions, in conjunction with key stakeholders and RG members.

April 2004 – implement agreed phase 1 solutions.

April – 3rd Reference Group meeting – check direction/horizon scan; sign-off phase 2 solutions.

Thereafter – consider with Staff Side and DDRB any issues relating to TCS, with view to negotiation/evidence during 04/05 for implementation (if affordable/desirable etc) from April 2005.

Dental Policy Branch
4th August 2003 – updated 3rd September 2003.

Attached:
Annex: Proposed membership of key bodies.

Steering Group.

Membership:

- DH reps:
  - CDO (chair)
  - Deputy CDO (alternate chair)
  - Project lead
  - Dental policy
  - HRD (1)
- NHS Confederation (1).
- BDA (2) (Chair & Vice-Chair of Staff Side)
- Patient rep.
- Supported by: HR project manager.

Reference Group.

Membership:

- Chair – CDO.
- Alternate chair (Deputy CDO)
- Project team.

Plus – serving in a personal capacity:

- NHS management:
  - PCT CE
  - Commissioner of CDS/PDS.
  - Consultant in dental public health.
  - HR Director – with experience of CDS/PDS & of medical workforce issues.
  - Medical Director – with experience of CDS/PDS & medical manpower issues.
  - Clinical Director of a good PDS which incorporates CDS.
  - StHA/WDC Director of Workforce Development/Re-design.
  - Dental Postgraduate Dean.
  - StHA Modernisation Director.

- Salaried service clinicians from services with a track record of innovation (drawn from recommendations of Staff Side Chair):
  - SDO x2
  - DO x2
  - DAC x2

- General dental practitioners with substantial NHS commitment & track record in service innovation (2).

Steering Group members will be encouraged to attend meetings of the Reference Group.