



# BRITISH DENTAL ASSOCIATION

Evidence to the Doctors' and Dentists'  
Review Body

September 2005

For the Thirty-Fifth Report 2006

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# GENERAL EVIDENCE

## *Introduction*

1.1 The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for their Thirty-fifth Report covering the year 2006/07. It is written under the terms of reference introduced in 1998 and all subsequent amendments. The evidence is submitted on behalf of dentists practicing in the National Health Service and covers those working in:

- General Dental Services
- Salaried Primary Dental Care Service
- Dental Public Health
- Personal Dental Services
- Academic institutions (i.e. Clinical Academic Staff)

1.2 The British Medical Association (BMA) 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 the Hospital Dental Service.

## *A difficult year for the profession*

1.3 Since our last evidence was presented to the Review Body the BDA has continued to work with dental practitioners to prepare them for the 1 April 2006 reforms to NHS dentistry, as the implementation of the Health and Social Care Act (England) comes into effect.

1.4 It has been an extremely challenging 12 months for the dental profession. Delays in key milestones, such as publication of the new GDS and PDS regulations, information on the proposed new NHS patient charges system and the time taken for the publication of the Salaried Services Review has resulted in a tangible sense of anxiety and uncertainty from the profession. This anxiety has not been helped when over the last year practice owners were strongly encouraged to adopt Personal Dental Service (PDS) arrangements before unexpectedly being informed by the DoH that no new PDS applications would to be accepted and that current PDS arrangements would be superseded by the new GDS regulations.

1.5 As the Review Body considers this evidence, there will be less than six months before the implementation deadline for the reforms to NHS dentistry. Prior to the BDA suspending talks with the DoH on 7 December 2004, both parties were working towards a 12 month pre-implementation timeframe for practitioners to consider and make decisions on their futures within NHS dentistry. With certain proposed transitional arrangements for reform beginning in January 2006, much of the profession feels that it has been backed into a corner. Their options have been compromised as the pre-implementation timeframe has been reduced. When commenting on the new NHS patient system

the Public Accounts Committee (2004) expresses concern “... *that the time needed for the consultation and ministerial debate will leave little time for convincing dentists to agree to the new patient charges by April 2006. The Department will need to manage the risks inherent in this to prevent an exodus from the NHS at the eleventh hour*”.

- 1.6 The delays and a lack of detail regarding the reform process have increased the chance that a similar outcome to that of the early 90s fee cut will occur within the profession as practitioners gradually withdraw their NHS commitment. The National Audit Office Report (2004) has also identified this as a significant risk and notes “... *given the scepticism of some dentists compounded by the lack of detail on how the new system will operate we consider that there is a risk that dentists will reduce their NHS commitments, as they did in the 1990s following cuts in fees ... the risk continues thorough the transition and may not materialise until the end of the period*”.

### ***Too little funding, too late***

- 1.7 In its analysis of the expenditure on dentistry, the National Audit Office (NAO) identified that NHS spending on General Dental Services (GDS) per capita has increased by nine per cent since 1990–91, compared with a 75 per cent increase in overall NHS funding per capita<sup>3</sup>. The NAO also note that, in the five years after the early 90s fee cut, there was year-on-year under spend totalling £330 million, or some five per cent of gross expenditure<sup>4</sup>.
- 1.8 This reiterates and supports the BDA’s position regarding NHS dentistry, that it has been historically under funded. In our Evidence to the Review Body for its 33<sup>rd</sup> Report the BDA stated that from 1994/95 the under funding within the GDS alone has been around £240 million.
- 1.9 Despite the Government announcing a dental funding package, in July 2004, which would see NHS dentistry receiving an additional £250 million by 2005/06 this is still £80 million below the NAO identified under spend of £330 million in the GDS in the five years after the early 90s fee cut. Further still, the BDA understands that, the funding to attract 1,000 whole time equivalent (WtE) practitioners into the GDS by October 2005 and that the financial cost of Review Body recommendations relating to 2005/06 and 2006/07 is to be funded from this £250 million. The BDA estimates that only around £30 million of the £250 million is realistically available to attempt to address the historic under funding of NHS dentistry. Despite the picture of a historically under funding GDS, the Government has earmarked the funding to develop and grow NHS primary care dental services. It is now blatantly clear that NHS dentistry is under funded. Although the BDA consider the 2004 funding announcement as “a step in the right direction,” it is adamant that substantially more funding is necessary to deliver the Government’s vision of a high quality integrated NHS dental service in England.

### ***Moving towards implementation***

- 1.10 The Government confirmed on the 7 July 2004 that the reforms to NHS dentistry will take place on 1 April 2006, as the implementation of the Health and Social Care Act (England) comes into effect.

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<sup>1</sup> Page 5, paragraph 2: House of Commons Committee of Public Accounts, Department of Health: Reforming NHS dentistry, Thirtieth Report of Session 2004-05.

<sup>2</sup> Paragraph 29: Reforming NHS Dentistry: Ensuring effective management of risks, NAO (2004).

<sup>3</sup> Paragraph 1.12: Reforming NHS Dentistry: Ensuring effective management of risks, NAO (2004).

<sup>4</sup> Paragraph 1.20: Reforming NHS Dentistry: Ensuring effective management of risks, NAO (2004).

- 1.11 Discussions between the BDA and the DoH resumed on 21<sup>st</sup> February 2005; however, no discussions took place between the DoH and the BDA prior to the Government publishing its consultation document on NHS patient charges (July 2005), publishing the new GDS and Personal Dental Services (PDS) regulations (August 2005), and publishing a policy paper that outlines the underpinning principles contained within the upcoming Statement of Financial Entitlement (August 2005). The profession is still waiting for the completion of the Salaried Services Review; however, the Government has indicated that it is likely to be published in late summer 2005.
- 1.12 The timeframe has now been set. Practitioners will have very little time to consider their options with all the appropriate and necessary information needed to do this. The BDA is extremely concerned that financial information for practitioners may not be forthcoming until January 2006 and that as certain transitional arrangements begin in the New Year the profession will only really have a maximum of three months to make properly informed decisions regarding their futures. Allowing only three months for practitioners to make properly informed decisions, as part of a reform process that began over five years ago, is irresponsible and potentially undermines the overall success of these reforms.
- 1.13 BDA research indicates that only 16 per cent of the profession have any confidence in their PCT's ability to implement the reforms in April 2006<sup>5</sup>. Indeed, in the Public Accounts Committee report (2004) it notes that *"The Department has set itself an ambitious programme for reforming NHS dentistry. Some key milestones have been missed ... The Committee are extremely concerned that in this vital area of services to the public the Department required Primary Care Trusts to take over the management of new contracting arrangements without ensuring that they had the necessary expertise and resources"*<sup>6</sup>.
- 1.14 The BDA is alarmed that the DoH has not piloted its proposed banded charges system in a single practice before national implementation. The recent Government 'push' for practices to sign up to PDS arrangements provided an ideal opportunity for testing such a system, if only to see the impact on practice patient charge revenue levels. It is fair to say that in the run up to the biggest reorganisation of NHS dentistry since 1948, the profession has been inadequately informed, is disappointed with the lack of progress made by the Government, and, consequently, is lacking confidence in PCTs' ability to implement the untried reforms effectively. The profession sees the current climate as extremely unstable and justifiably is concerned for its future.
- 1.15 The BDA now presents to the Review Body its evidence and subsequent recommendations which we believe need to be implemented in 2006/07 to minimise any instability of the NHS dental workforce during the early phase of the reform to NHS primary dental services.

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<sup>5</sup> BDA Omnibus Survey, April – June 2005.

<sup>6</sup> Page 5, paragraph 1: House of Commons Committee of Public Accounts, Department of Health: Reforming NHS dentistry, Thirtieth Report of Session 2004-05.

## GENERAL DENTAL SERVICES

### *Reaction to the 34<sup>th</sup> Report of the Review Body*

- 2.1 The Doctors' and Dentists' Review Body (DDRDB) recommendation of a 3.4 per cent uplift on gross fees for 2005/06 did little to inspire the dental profession in the final year before the reform to NHS dentistry. Despite the Government continuing to consider dentistry as part of the National Health Service (NHS) family, the award did nothing to make the profession feel wanted by the NHS.
- 2.2 The BDA welcomes the more transparent approach used by the Review Body in its formulation of the 3.4 per cent uplift. It was also heartening to see the Review Body accepting the BDA's assertion that to increase a GDPs net earnings by a specific percentage, where dental expenses are rising at a higher rate, requires a headline uplift that is above the actual increase being sought on GDPs' net earnings.
- 2.3 The BDA also commends the independent work done by the Review Body in examining the usefulness of the Inland Revenue expense ratio, as presented in Appendix H of the Review Body's 34<sup>th</sup> Report. Appendix H supports the BDA's notion that in a modern mixed dental practice, private dentistry subsidises NHS dentistry. The work also rejects the DoH assertion that nothing useful can be gleaned from the findings from the Inland Revenue survey. The BDA, the Review Body secretariat and the DoH have met regularly over the last year to assess the work undertaken by the Inland Revenue with the aim of producing more detailed information on dental expenses. Within this small working group constructive joint working has been realised.
- 2.4 The 3.4 per cent award on top of the previous two uplifts of 3.225 per cent and 2.9 per cent is equivalent to a compounded 3 year uplift of 9.8 per cent. By coincidence, the Government's offer of a three year 10 per cent pay deal for general dental practitioners (GDPs) that was rejected by the BDA General Dental Practitioners Committee (GDPC) in 2003 has in fact been delivered by the independent Doctors' and Dentists' Review Body.
- 2.5 In addition to what was considered an inadequate uplift, considerable disappointment has been expressed on the continual refusal by the Review Body to recommend a practice allowance which takes steps towards reimbursing practitioners for the continuing and increasing administrative and legislative burden they bear as contractors to the NHS.
- 2.6 Although the BDA, the Review Body secretariat and the DoH have established a working group looking at dental expenses, the BDA believes that the Review Body have missed an opportunity, in such an important year, by not recommending, or indeed commissioning its own, independent research to explore dental expense inflation. This could have included a prospective impact assessment exercise to establish the costs that would be faced by GDPs to provide the quality of care demanded to achieve the standards outlined by the Disability Discrimination Act, cross infection control requirements, outreach training and placement of Dental Care Professionals (formerly known as Professionals Complementary to Dentistry).
- 2.7 The joint working on dental expenses (as outlined above) has addressed in part recommendation nine from last year's Review Body Report. However, progress on developing a mechanism for assessing changes in dental expenses in the transitional year ahead of the new arrangements has been slow. The

BDA would urge the Review Body to continue to support this joint working and also to undertake its own independent research which can feed into the development of a commonly accepted mechanism for assessing prospective changes in dental expenses.

### *Slow progress with the Department*

- 2.8 This time last year the BDA reported that it had met regularly with the DoH to discuss and move forward the reforms to NHS dentistry. The BDA also commented that these meetings were constructive and allowed the BDA to comment and build upon DoH initiatives for the new GDS contract and regulations, among other issues; however, the BDA would like to reiterate that the relationship with the DoH was that of a consultation and it was in no way a negotiation.
- 2.9 In early September 2004, the BDA had commented on a proposed GDS contract and had a commitment from the DoH to review continually, with the BDA, the newly reformed NHS dental system. In addition, the DoH were committed to undertake independent research looking at, for example, the relative weightings for the courses of treatment on the proposed base contract (now known as Units of Dental Activity or UDA) and valuing non-clinical time.
- 2.10 Although the BDA had major concerns on many aspects of the proposed GDS contract, it was felt that small steps were being taken in the right direction. Of primary importance to the BDA was that the proposed GDS contract be published in October 2004; at that time a full 12 months before the implementation of the reforms.
- 2.11 On the 24 September 2004, the Government presented an ultimatum, that the BDA must “*sell and endorse*” the proposed GDS contract. This late change in Government direction has strained relationships between the BDA and the DoH over the last year. Although the BDA continued discussions with a new DoH team, it took the difficult decision to suspend discussions with the DoH on 7<sup>th</sup> December 2004.
- 2.12 Discussions between the BDA and the DoH resumed on 21 February 2005. In the meantime the DoH announced that the date for implementation of the reforms for NHS dentistry was to be delayed again and would now be April 2006. Since the BDA resumed discussions with the DoH a general election was held and this further delayed constructive discussion between both parties.
- 2.13 On the 7 July 2005, the DoH published its long awaited consultation on a proposed new NHS dental patient charges system and on 1 August 2005 published the new GDS and PDS regulations. More recently, the DoH have published a policy paper which outlines the underpinning principles contained within the upcoming Statement of Financial Entitlement
- 2.14 Between 7 December 2004 and the July 2005 announcements the BDA had only had two formal meetings with the DoH. The lack of both joint working and information from the DoH is disappointing to the BDA and has led to uncertainty and anxiety within the profession. The risks associated with this approach in dealing with the profession has been highlighted by the NAO (2004) when it welcomed the initial decision to postpone implementation (to October 2005) but urged the

Department to be “... more transparent about their plans and timetable for managing the chance process to achieve the revised target date, and ensure that these are conveyed to dentists and patients<sup>7</sup>”.

- 2.15 The new GDS and PDS regulations that were published on 1 August 2005 introduce the concept of UDAs to measure activity or NHS commitment. This concept is identical to the Weighted Courses of Treatment (WCoT) approach to measuring activity or NHS commitment as presented to the BDA in the proposed GDS contract of September 2004. Broadly speaking, a practitioner will be paid the same as he or she received in the period October 2004 to September 2005 in exchange for delivering an NHS commitment equal to 95 per cent of the UDAs provided over this same period.
- 2.16 To date the BDA has submitted its formal response to the DoH consultation on the proposed new NHS dental charges system and has informally written to the DoH with a range of concerns that it has in regards to the new GDS and PDS regulations. These include ensuring that practitioners can continue to prioritise NHS services to children and exempt adults; removing the rigid output-target based system which will do nothing to get practitioners off the treadmill; and addressing the increased NHS administrative burden on already-stretched practices. The DoH has agreed to meet with the BDA in early October 2005 to work through these concerns. However, given the recent history of the DoH, the BDA is unconvinced that this and any subsequent meetings will prove fruitful.
- 2.17 The BDA remains wholly unconvinced that the current proposals for reform will do anything to improve practitioners' working lives. It does not adequately slow the treadmill that GDS practitioners have long complained about, let alone truly free practitioners to focus on preventative dentistry. While it may go some way towards addressing the Government aim of increasing access to NHS dentistry in the short term, the BDA remain concerned that one treadmill will simply be replaced by another.

### *Access to dental services remains an issue*

- 2.18 It is apparent to the BDA that the political goalposts for reforming NHS dentistry have been shifted. The Government has moved its focus away from addressing long-term issues such as under funding and the associated pressures of working within the NHS and concentrated wholly on a short-sighted view of alleviating access.
- 2.19 The continuing problem of access to NHS dentistry is a legacy of continuing poor Government policy. Demand for dental services is outstripping supply and consequently GPs are finding that they have to close their books. In 2000, 10 per cent of GPs were not taking on new child patients, 27 per cent were not taking on new exempt adults and 12 per cent were not taking on new adult patients. Five years on these percentages had risen to 15 per cent, 37 per cent and 15 per cent respectively.
- 2.20 In addition to the rising percentage of GPs not taking on new patients, many are not taking on new NHS patients in an attempt to maintain their practice's financial viability. In 2000, 84 per cent of GPs were accepting new children for NHS treatment; by 2005 this had dropped to 75 per cent. More pronounced reductions can be seen for exempt adults (65 per cent in 2000 to 44 per cent in 2005) and for adults (53 per cent in 2000 to 27 per cent in 2005).

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<sup>7</sup> Paragraph 30: Reforming NHS Dentistry: Ensuring effective management of risks, NAO (2004).



- 2.21 The Public Accounts Committee (2004) identified relatively few dentists in socially deprived areas and poor NHS provision in more affluent areas. The Committee warned that the reforms to NHS dentistry have taken too long to be finalised and are at risk of failing. The Public Accounts Committee also said that Government inertia is to blame for two million people in England having no access to NHS dentistry.
- 2.22 More recently the Healthcare Commission<sup>8</sup> (2005) reported that in early 2005, 57 per cent of people in England were registered with an NHS dentist. Twenty-three per cent were registered as a non-NHS patient and the remaining 20 per cent were not registered with a dentist. The Report also found that 69 per cent of those not registered with an NHS dentist reported that they would like to be registered with an NHS dentist; this implies that in 2005 there are still around 15 million people (or 30 per cent of the population) in England who would like to be registered with an NHS dentist. This is significantly higher than the Government's estimate that there are only two million people in England with no access to NHS dentistry.
- 2.23 Despite the continued access problem for NHS dentistry, the Healthcare Commission found that 78 per cent of people were completely able to understand their treatment plans and 77 per cent were definitely involved in their decisions about their dental care as much as they wanted to be.
- 2.24 The BDA has continually highlighted to the Government that unless the reforms adequately address the main issues that practitioners have working within the NHS, then many practitioners will simply choose to gradually withdraw their NHS commitment before finally leaving the NHS completely. The Public Accounts Committee (2004) has highlighted this risk, and has stated that there may be a "*mass exodus at the eleventh hour*".

### *The dental workforce*

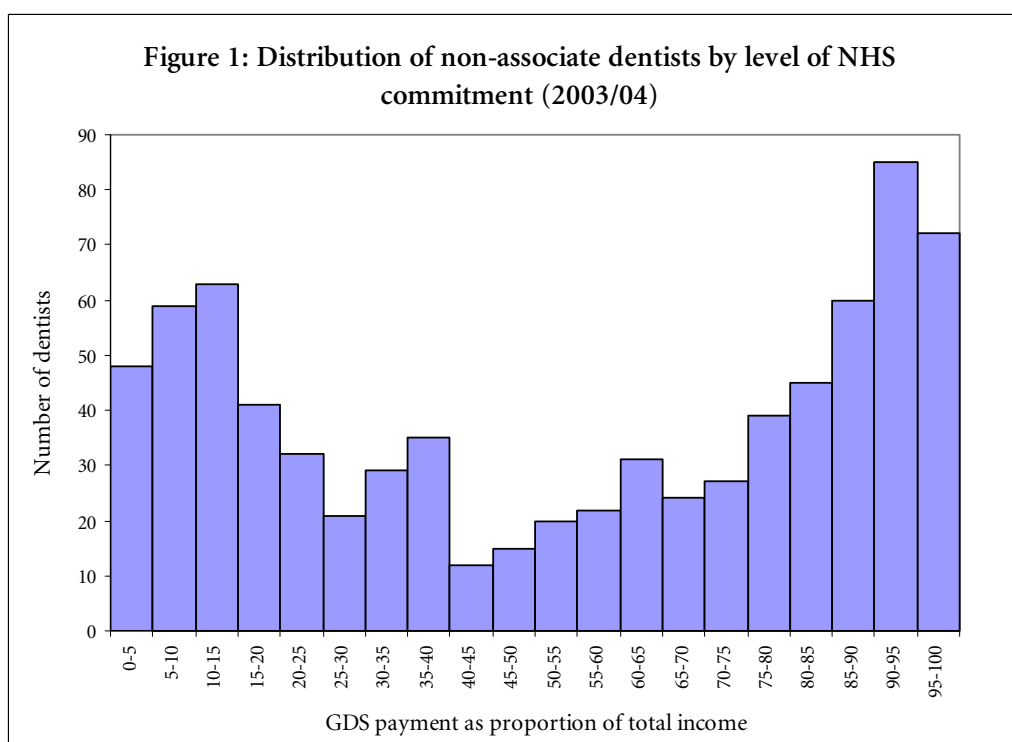
- 2.25 The *Report of the Primary Care Dental Workforce Review* stated that in 2003 the under supply of WtE dentists in England was 1,850. The BDA strongly disputes this figure and considers the under supply of WtE dentists across the UK to be around 4,000. However, other independent commentators conclude that the under supply is more acute and that the NHS needs to recruit an extra 5,200 dentists (University of Bath, 2004). Nevertheless, the challenge set by the Government has been to recruit 1,000 WtE dentists into the GDS by October 2005, a figure that even the DoH acknowledges as being at least 850 less than is needed to bridge the gap identified by the DoH in its *Report of the Primary Care Dental Workforce Review*.
- 2.26 Despite the DoH reporting that progress has been made to recruit 1,000 WtE practitioners into the GDS, via domestic and overseas initiatives, information on the deployment of these practitioners has not been forthcoming. However, it remains to be seen whether or not the DoH will actually achieve its target of recruiting 1,000 WtE dentists into the GDS by October 2005 and, indeed, whether or not they will all be deployed and delivering high quality NHS dental care by 1 April 2006.
- 2.27 The DoH has actively been looking to recruit dentists into England on salary packages that are around £50,000. This is lower than the average net earnings for a committed NHS practitioner. These dentists are therefore effectively being underpaid by the Government to deliver high quality NHS dental services to patients in England. Situations are likely to arise where these qualified professionals

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<sup>8</sup> Healthcare Commission, Primary Care Trust: Survey of Patients (2005)

compare their workload and earnings with their professional colleagues, both within and outside the practice, and consequently begin to consider their options within the UK dental market. To retain these practitioners the DoH will either need to increase their earnings or risk losing them to the private dental market. The starting position adopted by the DoH with regard to recruiting overseas dentists to ‘plug the gaps’ has in no way addressed the issue of retaining these practitioners in the medium to longer term of the reform process.

2.28 The proposed new GDS regulations make it very difficult for practitioners to adopt a practice model whereby only children and exempt patients are treated under the NHS. Information on the distribution of NHS commitment (from the H&SCIC 2005) indicates that around one third of practitioners are deriving 30 per cent or less of their income from the NHS (see figure 1). Anecdotally, a large proportion of these practitioners will be operating a practice model as described above. Through discussions with representative practitioners, the BDA believes that a great many of these practitioners will gradually withdraw their NHS commitment over the three year transition period; this equates to approximately 6,000 practitioners. Whilst this is not 6,000 WtE practitioners, the secondary risk associated with this withdrawal of commitment is that of losing access to the dental practices and premises, surgeries and equipment which previously were being used to treat patients under the NHS.



2.29 There is a real risk that the measures announced by the Government to address the under supply of the workforce will fall short, and the situation of under supply will continue to be a prominent feature of dental services in England over at least the next two decades. The measures by the Government to address the under supply of the workforce are short-sighted and do little to address retention of either the current or the future workforce within the new primary dental care services. Further still, the BDA believes that the current Government problem of access to NHS dentistry stems from the historic under funding of GDS dentistry. It is imperative that the Review Body make strong recommendations in this first year of the transition period to retain the NHS commitment of those that will be entitled

to a new GDS or PDS contract from the 1 April 2006. The BDA would urge the Review Body to consider not only the likely risk of practitioners abandoning their NHS commitment, but also the associated withdrawal of the practice premises and equipment that was previously available from undertaking NHS dentistry.

### *Dental expense inflation*

- 2.30 In our previous Evidence to the review Body, the BDA outlined a pilot approach for looking at dental expense inflation and using this to feed into the calculation for the associated fee scale uplift. The BDA was encouraged to see that the recommendation of the 3.4 per cent uplift on the fee scale for 2005/06 used this more transparent approach in its calculation.
- 2.31 The BDA also welcomed the Review Body’s view that fee increases in line with the Government inflation target (CPI) would not “ensure stability in the run up to the new contractual arrangements,” something that the DoH has stated that it wants. The BDA is also pleased that the Review Body has accepted that an inflation target award would lead to a fall in the real remuneration of GDPs and that a fee scale recommendation ahead of the inflation target is necessary.
- 2.32 The BDA would strongly urge the Review Body to continue to consider these principles as vital in the first full year of the new arrangements. Any recommendation on gross earnings that result in a real reduction in GDPs net earnings in 2006/07 (as a consequence of dental expense inflation being higher than the gross earnings uplift) will simply result in many GDPs gradually withdrawing their NHS commitment over the three-year transition period.
- 2.33 The *General Dental Practitioners Earnings and Expenses 2003/04* (as prepared by H&SCIC), has provided detailed information on dental expenses. Between 1999/2000 and 2003/04 average dental expenses have risen from £79,295 to £97,060; a 22.4 per cent increase (see table 1). Over this time average gross earnings have risen by 21.8 per cent; the NHS fee scale has risen by a compound rate of 14 per cent; and average net income has risen by 21 per cent. Between 1999/2000 and 2003/04 the average annual increase in dental expenses has been 5.6 per cent, compared with an average fee scale increase of 3.5 per cent.

*Table 1: Gross earnings, expenses and net income for non-associates, GB*

	99/00	00/01	01/02	02/03	03/04	% change
Average gross earnings	£143,230	£150,395	£162,902	£167,286	£174,420	21.8%
Average gross expenses	£79,295	£84,064	£92,472	£94,734	£97,060	22.4%
Average net income	£63,935	£66,332	£70,429	£72,553	£77,360	21.0%

*Source: H&SCIC (2005)*

- 2.34 Strict infection control guidelines and the resultant move toward single use items (i.e. disposables) have been key drivers in the recent driving up of dental expenses inflation. The *BDA Survey of Dental Expenses (2004)* also highlighted insurance costs, training costs, waste management costs and cross

infection control costs as key factors that have contributed to rising practice expenses over the previous two years.

- 2.35 It is very clear that NHS fee scale increases between 1999/2000 and 2003/04 have not kept pace with dental expense inflation. Between 1999/2000 and 2001/02, dental expenses increased by 17 per cent, however fee scale increases only amounted to six per cent. Consequently, as a result of two years of inadequate fee scale uplifts, dental expense inflation rose at a rate lower than the fee scale uplifts between 2001/02 and 2003/04 as a brake was put on dental practice expenditure. Dental practices, particularly those committed to the NHS, have responded in such a manner so as to ensure their financial viability and existence.
- 2.36 The BDA would request that the Review Body recognise this significant gap between dental expense inflation and the fee scale uplifts between 1999/2000 and 2003/04 in its recommendation for the 2006/07 uplift for GDPs.
- 2.37 In its Report last year, the Review Body opted to use Retail Price Index (RPI) as a measure to reflect all other dental expense rises (i.e. dental expenses less staff costs). Between 2000 and 2004 the RPI rose from 170.3 to 186.7, a rise of some 9.6 per cent (or around 2.4 per cent per annum). However, the H&SCIC (2005) shows that over this period dental expenses rose by 22.4 per cent or an average of 5.6 per cent per annum.
- 2.38 Focusing on staffing costs, salaries and wages of Dental Care Professionals (DCP) are the largest component of dental practice expense. In its recommendation last year, the Review Body considered the measure that best represents the earnings growth of staff in dental practices is that given by the change in the hourly rate of pay of the full sample of dental nurses, as recorded in the *Annual Survey of Hours and Earnings (ASHE)*. The BDA believes that there is considerable evidence to indicate that over the last five years that salaries and wages of DCPs have been growing at a higher rate than the 3.8 per cent measure used by the Review Body in its recommendation last year.
- 2.39 The H&SCIC (2005) has produced information on the average expense breakdown in Great Britain between 2001/02 and 2003/04. During this period employee expenses rose from an average of £28,500 to £31,790; a rise of 12 per cent or around six per cent a year. In our Evidence to the Review Body for its 33<sup>rd</sup> Report 2004, the BDA stated that the *BDA Professionals Complementary to Dentistry Survey (2003)* showed that in the two years 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). Finally, information from the *Annual Survey of Hours and Earnings* has shown that between 2001 and 2004 the mean gross hourly pay for a dental nurse has risen from £6.01 in April 2001 to £7.05 in April 2004; a rise of 17.3 per cent or an average annual increase of 5.25 per cent (see table 2).

Table 2: Gross hourly pay for dental nurses, UK

	2000	2001	2002	2003	2004
Mean gross hourly pay	£5.75	£6.01	£6.55	£6.79	£7.05
Year on year change	-	4.5%	9.0%	3.7%	3.8%

Source: *Annual Survey of Hours and Earnings (ASHE, 2001–2004)*

- 2.40 There remains a shortage of available DCPs and the forthcoming DCP reforms (including registration) has meant that practitioners have had to tap into a pool of academically higher qualified people when recruiting. As a direct consequence of these shortages and the intense competition from other industries for academically higher qualified people, practitioners need to award above average wage increase to both retain existing DCPs and to recruit new DCPs. Practice owners are also unanimously concerned about step change increases in future salaries and the wages of DCPs, as a consequence of dental nurse registration, driving up future practice expenses between 2005 and 2008.
- 2.41 The evidence presented above (from several sources) clearly indicates that wages and salaries for PCDs have been rising at an average rate of between 5–6 per cent per annum since 2000. Over this period the fee scale uplifts recommended by the Review Body have lagged behind this important driver of dental expense inflation.
- 2.42 Between 1999/2000 and 2003/04 the H&SCIC has shown that dental expense inflation rose at an average of 5.6 per cent per annum, and also supports the BDA’s assertion that over this period wages and salaries for PCDs have been rising on average by between five and six per cent per annum. The BDA would urge the Review Body make a recommendation for 2006/07 that in part considers this historic discrepancy between the fee scale uplifts and the rise in dental expense inflation.
- 2.43 The BDA believes that given the evidence on recent trends in dental expense inflation (above) that using the RPI as a proxy for all other dental expenses and the hourly wage information for dental nurses (from ASHE) as a proxy for the wages and salaries of DCPs does not address dental expense inflation adequately.
- 2.44 Using simple linear regression methods the BDA estimates that in 2006/07, wages and salaries for DCPs will rise by 4.5 per cent and that all other dental expenses are set to rise by 3.3 per cent. In a year of transition it particularly important that the Government show a renewed commitment to GDPs and look to retain NHS commitment of the current workforce. The BDA would therefore ask the Review Body to make a recommendation to uplift GDPs net earnings by 4.5 per cent, the same rate as the forecast growth in wages and salaries for DCPs.
- 2.45 Taking the formula as outlined in paragraph 3.85 of last year’s Review Body report, the BDA would ask the Review Body to make a recommendation for at least a 5.8 per cent uplift on gross earnings for GDPs, which would deliver at least a 4.5 per cent increase to the net earnings for GDPs.
- 2.46 The BDA believes that an uplift of at least 5.8 per cent will in part address the recent gap that has existed between fee scale increases and dental expense inflation. It will go some way to stabilising the workforce in this first year of the transition period and will send out a strong signal that the Government is committed to retaining the current high level of NHS dental care to patients.

### *Practice Allowance*

- 2.47 In our evidence to the Review Body for its 33<sup>rd</sup> Report, the BDA estimated that in 2003/04 relieving a full time wholly committed GDS practitioner of the administrative burden of running their practice would allow them to increase the amount of clinical time spent with their current GDS patients by an additional 15 per cent or to allow practitioners to reduce their workloads. The BDA consider that this is still the case and would urge the Review Body to introduce a practice allowance to address the ever increasing burden of running a dental practice within the NHS.

- 2.48 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.
- 2.49 The BDA conducted a short email survey in 2005 of committed NHS Dental Practices in Scotland to establish the impact of the Scottish Dental Practice Allowance. 55 surveys were distributed and 19 were completed and returned (a response rate of 35 per cent). Whilst the findings are not statistically robust, some clear messages emerged from them. The Scottish Dental Practice Allowance does allow committed NHS practitioners to address increasing requirements in relation to high quality premises, health and safety staff support and information collation and provision.
- 2.50 More important, however, is the finding that half of the respondents stated that the introduction of the Scottish Dental Practice Allowance and the 2005/06 increase in the level of the allowance has significantly helped in maintaining their practice profitability (or viability). The BDA believes that the evidence indicates that the introduction of the Scottish Dental Practice Allowance (and the 2005/06 increase in the level of the allowance) has, in part but recognisably, addressed the additional expense incurred in the running and operating of an NHS dental practice and gone some way towards relieving practitioners of the increasing administrative burden associated with running an NHS dental practice.
- 2.51 During the first year of the three-year transitional period of the reforms to NHS dentistry, all practitioners will be assessing whether or not they can continue to provide a high level of NHS care. Practitioners who find that their practices cannot remain viable under the new system will withdraw from the NHS. It is not only the withdrawal of the NHS workforce that will impact on the ability for delivering NHS dentistry, but perhaps more critically the associated withdrawal of practice premises that are currently providing NHS care. The BDA strongly believes that an introduction of a practice allowance, similar to that in Scotland, will maintain the viability of NHS practices and will contribute to ensuring that current premises and equipment used to deliver NHS dentistry are not withdrawn wholesale from the dental market.

In the light of the issues raised in our Evidence, the following recommendations would have a positive impact, in the first year of the reforms of NHS dentistry, on retaining both NHS commitment and practice premises and equipment within the NHS; we ask the Review Body to recommend that:

~ The fee scale increase for 2006/07 is at least 5.8 per cent.

~ A practice allowance is introduced which is valued at six per cent of a practice's NHS contract value (paid quarterly) to the practice's NHS contract holder.

~ The Review Body undertake its own independent research on dental expense inflation which can feed into the joint working between the BDA, the Review Body secretariat and the DoH.

## SALARIED PRIMARY DENTAL CARE SERVICES

### *DoH still to finalise the Review of SPDCS*

- 3.1 The Thirty-Fourth Review Body Report (2005) endorsed and recommended the final year of the three-year pay deal and uplifted salaries and allowances for all practitioners in the Salaried Primary Dental Care Services (SPDCS) by 3.225 per cent. Acceptance of that three-year deal was based on an understanding that a review of SPDCS in England would take place. As the Review Body considers this Evidence, the DoH has yet to have published its final report that incorporates the responses from the consultation, even though reform implementation is less than six months away. The BDA remains extremely disappointed with the slippage in the timeframe of this Review.
- 3.2 The delay in the publication of the Review has already severely disadvantaged the ability for SPDCS to compete when local commissioning begins in 2006. For example, uncertainty about the future role of SPDCS combined with some PCTs having budget deficits has led to vacancy controls within the SPDCS. This can, and indeed will, constrain the capacity of the Service to compete with other dental service providers in the provision of high quality local dental services. Further still, the hamstringing of the Service's ability to be immediately involved in local commissioning may also make it harder to retain staff. SPDCS staff may find more attractive opportunities in the new GDS system and, further still, other dental service providers (who have a competitive advantage over the SPDCS) may seek to secure the specialist experience that SPDCS staff have to offer.
- 3.3 At the end of March 2005, the BDA submitted its response to the long awaited DoH consultation on the future of Salaried Primary Dental Care Services. The BDA broadly welcomed the publication of *Creating the Future: Modernising Careers for Salaried Dentists in Primary Care* as a clear indication that the DoH is committed to developing the SPDCS. However, the BDA has some key criticisms of the Department's document.
- 3.4 Many, if not all, of the fourteen proposals in the Review, intended to embody the Department's vision, represent worthy aspirations that cannot but be endorsed by all those working in SPDCS. The BDA is critical, however, that the document lacked much in the way of detail regarding how precisely these aspirations are to be practically achieved and implemented.
- 3.5 The lack of detail and clarity in this regard may both be the result of an apparent tension between the proposed national strategic vision for SPDCS and the planned reform of NHS Primary Care dental services as a whole under the Health and Social Care Act 2003. On the one hand, the Department of Health is seeking to put in place a coherent national vision for SPDCS. On the other, it is planning to give PCTs control over all NHS primary dental care (both salaried and otherwise); allowing bespoke local commissioning arrangements within an integrated framework.
- 3.6 The BDA considered it a serious omission that the Review did not mention Special Care Dentistry nor did it acknowledge the work done within salaried services by practitioners working with patients with special needs. The BDA was surprised and disappointed that the Review did not recommend or support the establishment of a Special Care Dentistry specialism.

- 3.7 For the last two years the BDA agreed not to submit detailed evidence to the Review Body in order that BDA initiatives could be considered as part of the Review as 'early implementer' proposals which could then be agreed and submitted as joint evidence to this Review Body round. When agreeing to the three-year pay deal for SPDCS staff, CCCPHD acted in good faith to the implicit commitment by the DoH that "early implementer" proposals would become reality by April 2004. However, the DoH did not consider the BDA's initiatives sufficiently persuasive to be able to submit joint evidence to the Review Body.
- 3.8 Even if the Review were to be published in the near future, the delay has already put SPDCS at a competitive disadvantage; implementing the recommendations with the limited resources currently available to both the PCTs and the SPDCS will take significantly longer than the six months before 1 April 2006.
- 3.9 As a consequence of the Department of Health's failure to appreciate both the urgency and impact of the situation for the future of SPDCS, the BDA regrets the decision not to have submitted detailed evidence on SPDCS to the Review Body over the past two years. There have to date been no 'early implementers' and further still it is highly likely that there will not be any. As such, the BDA consider that they have been deliberately misled by the DoH on what was a major factor in agreeing to the three-year pay deal for SPDCS staff. Consequently, the SPDCS are inadequately prepared for the upcoming reforms to NHS dentistry; there is considerable anxiety and confusion among SPDCS staff; and the morale within the Service, at already low levels, has been further eroded.

#### *Increasing workloads for SPDCS staff*

- 3.10 Over the last year, as the implementation date for the reforms of NHS dentistry moves closer the workload for staff in SPDCS has been mounting. Many PCTs are in debt and the BDA believes, even through future funding for NHS dentistry is to be ring fenced, that the burden of these debts along with inadequate central funding for pre-implementation planning has created additional pressure on SPDCS staff.
- 3.11 There is general difficulty in recruiting appropriate numbers of SPDCS staff. Further still, many PCTs continue to regard the SPDCS as a 'safety net' irrespective of their capacity constraints and do not comprehend the time consuming nature of the client groups that SPDCS staff treat. This has increased the workload of those SPDCS staff in post and contributed to lower levels of morale within the Service. For example, anecdotal evidence has shown that over the last 12 months there have been increases in the volume of referrals from other dental services, especially from practices that have adopted PDS arrangements.
- 3.12 There is a national shortage of Dental Public Health (DPH) staff. Consequently, many PCTs are turning to Clinical Directors to provide the knowledge and experience so that PCTs can prepare for reform implementation. This creates a 'domino effect' on the workload of SPDCS clinicians. As Clinical Directors spend more of their time undertaking responsibilities that would normally be undertaken by DPH staff, their day-to-day clinical work is compromised and other SPDCS staff, such as Dental Officers (DO) and Senior Dental officers (SDO), are stepping in to counter any potential repercussions on front-line clinical care.



- 3.13 The range of services provided through SPDCS means that it is ideally placed, although disadvantaged by the delay of the SPDCS Review, to provide services that tackle recent political initiatives. Delivering the initiatives within the *Choosing Health* white paper and the various National Service Framework documents; addressing the rising inequalities in children's oral health across the United Kingdom; and the implicit commitment arising from the recent Declaration on child oral health by the European Chief Dental Officers' will all draw upon the experience of SPDCS staff. With PCTs perpetuating the historic 'safety net' view of the Service, and the raft of current and future public health initiatives, it is almost certain that PCTs will turn to the SPDCS to deliver and for that reason it is certain that the future workload for DOs and SDOs will continue to rise.
- 3.14 As touched on above, over the last 12 months, many PCTs have been turning to SPDCS Clinical Directors to help prepare the PCTs for reform implementation and local commissioning as from 1 April 2006. Some Clinical Directors have been advising on the whole of primary care (not just SPDCS); writing and contributing to the local dental strategies; providing dental education and training; assisting with overseas recruitment; and preparing for contract negotiations and commissioning implementation protocols. This new workload can, in some instances, amount to an additional 30–40 per cent of the normal workload of some SPDCS Clinical Directors. What is clear, however, is that the burden of this work falls initially upon the Clinical Director and, through the 'domino effect' on other SPDCS staff.
- 3.15 The DoH has been unwilling to recognise the overall increasing workloads of SPDCS staff, nor the new work being undertaken as some Clinical Directors step in to fill the void of DPH staff during the long lead up to the reform of NHS dentistry. Despite the increased workload the Service is still providing a high quality service to their unique client groups. However, there is anxiety amongst SPDCS staff which is having a palpable negative impact on morale within the Service.
- 3.16 Recognising and valuing the increased workload of the SPDCS is of primary importance to ensure stability of the SPDCS workforce in the first year of the reform to NHS dentistry. However, the Service is confined to a restrictive pay scale which cannot adequately reward increasing workloads as a consequence of the move towards local commissioning of dental services. There is also considerable evidence indicating that the future workload of the Service is set to rise. The BDA would therefore urge the Review Body to recommend an uplift on the salaries and allowances for all SPDCS practitioners of seven per cent from 1 April 2006.

### ***GDS initiatives are hampering SPDCS recruitment and retention***

- 3.17 The BDA believes that SPDCS salaries are uncompetitive, particularly in relation to the salaries that have been offered over the last 12 months under PDS arrangements. Staff working in SPDCS have historically been individuals who did not want to work under the GDS treadmill. If the reforms to the GDS component of NHS dentistry truly remove practitioners from the GDS treadmill (as is stated by the DoH) then retention and recruitment into SPDCS will become even more of a challenge, as practitioners that previously would have considered a career in the SPDCS are tempted into a new GDS free of the old GDS treadmill.
- 3.18 Anecdotally, over the last year there has been a steady trickle of staff moving from SPDCS to practices operating under PDS arrangements, as more competitive salaries are being offered and the treadmill has been removed, thus allowing practitioners to spend more time with their patients. Under PDS

arrangements, full time committed NHS associates with four years' work experience (without postgraduate qualifications) are currently being offered around £70,000 compared with a Senior Dental Officer (SDO) salary scale that starts from £45,131 in 2005/06. It is worth emphasising to the Review Body that the majority of SDOs earning £45,131 in 2005/06 would have far in excess of four years' experience, a postgraduate qualification and, most importantly, a historically high commitment to delivering NHS care to the population.

- 3.19 The Government has made a commitment to recruit 1,000 WtE practitioners into the GDS by October 2005. Part of this includes the recruitment of some 650 practitioners from overseas, to be placed in practices that are operating under PDS arrangements. As highlighted in our GDS evidence, the DoH is offering these overseas recruits salaries around £50,000. As a comparison the Dental Officer (DO) scale in 2005/06 started at only £31,290. Further still, under current PDS arrangements first year associates (committed to the NHS) are receiving a salary of around £42,500.
- 3.20 The superior salary packages being awarded to experienced associates and post Vocational Training practitioners under PDS arrangements are dramatically undermining recruitment and retention within SPDCS. In addition, overseas recruitment aimed at addressing access is a short-sighted fix that undervalues the important role that SPDCS practitioners play, and indeed will continue to play, in an integrated primary dental care system. It is also harming, in particular, the morale of DOs and SDOs.
- 3.21 The advent of major changes in the delivery of dental services has only increased speculation about the location and nature of future employment in the Service. For example, PCTs and SHAs have recently been instructed to consider seeking alternative providers of services currently provided directly by PCTs, including the SPDCS. In the same initiative, SHAs have been charged with examining PCT structures, again with the potential to disrupt the service. The reform to the General Dental Service contract is further raising uncertainty among the SPDCS about how this will affect the Service's current patient base. All this is raising concerns about future employment security in the SPDCS.
- 3.22 The BDA would urge the Review Body to recommend the introduction of a Commitment Payments Scheme to recognise SPDCS staff for their long-standing commitment in delivering NHS care and more importantly to retain SPDCS staff and boost morale within the Service.

In the light of the issues raised in our Evidence, the following recommendations would stabilise the SPDCS workforce over the next three years. These initiatives would boost morale and have a significant positive impact on the retention of experienced and committed NHS staff working in the SPDCS; we ask the Review Body to recommend that:

~ Salaries and allowances for all practitioners in the SPDCS are uplifted by seven per cent for 2006/07.

~ A Commitment Payments Scheme is introduced, pro rata, to SPDCS practitioners, so that five years of experience is rewarded with a payment of £2,500; 10 years with £5,000; and 15 years with £7,500.

## DENTAL PUBLIC HEALTH

- 4.1 The assimilation of Dental Public Health staff into the terms and conditions of service for Hospital Medical and Dental and Public Health Medicine Staff has been completed. Staff are undertaking the process of either moving to the new consultant contract or remaining on their existing terms and conditions. In the case of the former we are monitoring its implication to ensure equity across the country. The BDA are in discussions with the BMA and NHS Employers about future joint mechanisms for negotiating for this group of staff.
- 4.2 For PCTs to fulfil their responsibilities to commission appropriate local dental services, PCTs need specialist advice on both oral health needs and how local commissioning can appropriately meet these needs. Over the last year, anecdotal BDA evidence has indicated that there is a national shortage of Dental Public Health staff.
- 4.3 This shortage has been identified in the *Dental Public Health Workforce in England* status report (January 2005). The preliminary findings show that the number of Consultants in Dental Public Health (CsDPH) working in England has remained relatively stable over the last five years. However, there has been an increase in part-time working which has resulted in an overall reduction of the dental public health workforce. Furthermore, almost half of the current CsDPH in England will retire in the next 10 years.
- 4.4 As a direct consequence of the shortage in DPH staff, those currently in post have experienced a significant increase in their workloads. The Report also indicates that around a quarter of PCTs do not have access to advice from Consultants in Dental Public Health. This lack of access to DPH staff is also having negative repercussions on SPDCS Clinical Directors that are helping to address this shortage.

In the light of the issues raised in our Evidence; we ask the Review Body to recommend that:

~ Funding is made available so that any initiatives to raise the number of Dental Public Health staff can be rapidly achieved.

~ The number of Specialist Registrar training posts in Dental Public Health is increased to maintain the consultant workforce as a consequence of impending retirements and part-time working.

## CLINICAL ACADEMIC STAFF

- 5.1 We continue to welcome the positive comments that the Review Body makes each year supporting the principle of pay parity between Clinical Academic Staff (CAS) and NHS clinicians and the recognition of recruitment and retention issues.
- 5.2 Across England, there continues to be discrepancies in the average number of Programmed Activities (PAs) being negotiated with dental clinical academics. These range from the basic 10 through to 11 following hard-fought mediation and appeals processes, with all Schools interpreting clinical academic contracts quite differently to their NHS Trusts. The '*two employer*' issue continues to plague the smooth implementation of the contract in some areas.
- 5.3 Anecdotal evidence now indicates that dental careers within a hospital environment are developing at faster rates than that within academia. Further still, continued growth in the opportunities from private practice is beginning to adversely impact upon the recruitment of clinical academic staff. These trends are borne out in the recent review of Clinical Academic Staff by CHMS and CDHDS which indicated a 17 per cent decrease in clinical academic staff since 2003 and another 6 per cent of dental clinical academics in the year from July 2003 and July 2004. Despite this, the Departments of Health are increasing dental undergraduate numbers across the UK. For example at the Leeds Dental Institute, last year's intake of 53 students (home and EU) has been permanently increased to 75, plus an additional nine students for 2005 only. Bristol Dental School's intake has been doubled to 84 home students. The lack of clarity from the Department of Health in England has left an unclear picture of how it intends to effectively implement this increase when faced with a significant shortage in staff numbers and resources.
- 5.4 The BDA are extremely concerned that these increases, alongside the inconsistent implementation of the consultant contract and together with other factors such as the Research Assessment Exercise (RAE), will simply further compromise resources that are already stretched to capacity. This will result in too few staff to handle this influx of students and too little incentive for dental clinical academics to remain in post. The result may be that the competence of future dental graduates cannot be guaranteed.