
# BRITISH DENTAL ASSOCIATION

## Evidence to the Doctors' and Dentists' Review Body

**October 2006**

**For the Thirty-Sixth Report 2007**

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

Two thousand dentists walked away from NHS general dental practice in England and Wales in April 2006. Research by the British Dental Association suggests that there is a very real risk that many more practitioners plan to follow suit within the short to medium term. Highly qualified colleagues within the salaried dental services have been re-directed from their core activity of treating special needs groups to become a catch-all within an under-resourced and under-valued primary care service. Vulnerable groups of patients most in need of high volumes of treatment have been made into a burden on hard-pressed practitioners working within a system compromised by perverse incentives.

As a consequence of these developments, the government's stated intention of improving patient access, taking dentists off the treadmill and enhancing the emphasis on preventive care appears to have materially failed. Instead, a workforce plagued by uncertainty within the NHS, looks increasingly likely to exercise choice in the provision of dental services and move towards providing care in the more attractive private sector; an environment in which they have more control, certainty and security in their future.

To add to these pressures towards decline in the NHS, Government figures published in September 2006 show dental practice expenses have risen at a rate much higher than the increases anticipated in earlier Review Body reports. Impending developments within all aspects of clinical practice look set to accentuate and heighten these inflationary pressures. Notably, the registration of dental care professionals and significant changes in cross infection control protocols are likely have disproportionate impacts on the running costs of dental practices.

We therefore urge the Review Body to consider the recommendations below as an essential package, which when implemented together address the most important issues relating to recruitment, retention and morale of practitioners working in the NHS. The three integrated recommendations will help stabilise the current dental workforce and will retain NHS commitment levels during and beyond the remaining two years of the transition period.

***General Dental Services (GDS)***

In the light of the issues raised in our evidence, we ask the Review Body to recommend the following package:

- *The uplift applied to general dental practitioners' gross earnings base for 2007/08 is at least 4.3 per cent, and that:*

- *£97 million is made available so that a practice allowance can be introduced in the year 2007/08, and that:*

- *£45 million is made available so that a new scheme, based on experience, can be introduced in 2008/09 to replace the outgoing seniority payment scheme.*

***Salaried Primary Dental Care Services (SPDCS)***

The BDA acknowledges the continuing negotiations with NHS Employers in England for new terms and conditions, and the impact that this may have on the devolved countries. At this time, therefore, we ask the Review Body to recommend that:

- *Salaries and allowances for all practitioners in the SPDCS are uplifted by 4.7 per cent for 2007/08 (this is in addition to the new terms and conditions to be implemented by 1 April 2007 in England).*

# 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 36th Report covering the year 2007/08. 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 Services
- Dental Public Health
- Personal Dental Services
- Academic institutions (i.e. Clinical Academic Staff)

1.2 The British Medical Association (BMA) will submit 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 destabilised workforce***

1.3 Since our last evidence to the Review Body the BDA has continued to work with dental practitioners to help them to deal with the recent reforms to NHS dentistry. We have provided support during a transition process that has been poorly managed and implemented with indecent haste. These imposed changes have caused enormous disruption to dental practice and have generated real and substantial fears about the future of the NHS and the viability of practices in which practitioners have invested significant amounts of their own money.

1.4 Vital details of the reforms were provided very late, leaving many practitioners with insufficient time to consider properly the impact of the new contracting arrangements. The majority of general dental practitioners were given a maximum of three months to decide upon the general implications and sometimes as little as two days to consider the very complex contractual terms of a 160-page document containing some 380 clauses. Salaried primary dental care service practitioners in England are unlikely to have concrete details of their new terms and conditions until early 2007.

1.5 The chaos that has been produced by these changes has already resulted in around two thousand practitioners leaving the NHS, with more likely to follow over the short and medium term. The BDA reminds the Review Body that the National Audit Office Report (2004) identified this as a significant risk and concluded *"… the risk continues through the transition and may not materialise until the end of the period"*. This precipitous and hasty implementation has generated enormous distrust. Practitioners feel that they have been poorly treated, unappreciated and offered a contract on a 'take-it-or-leave-it' basis without adequate time to consider the most significant change to their practising arrangements they are ever likely to make. Consequently, significant numbers are actively considering whether they can continue to provide high quality dental services within the NHS.

1.6 The profession believes that the reforms have been rushed, with many aspects being untested. Many general dental practitioners remain unconvinced that the reforms will do anything to get them off the treadmill. One of the intentions of the Department was to remove practitioners from the fee per item treadmill, with the Audit Commission (2002) stating that *"… the second main change required is to end the piecework 'treadmill' system, because most of the problems stem from this"*. In fact, one treadmill has simply been replaced by another.

1.7 Many practitioners felt they had no choice but to sign the new contract, despite their misgivings. However, one in ten general dental practitioners did refuse to sign the new contract and completely withdrew their commitment to the NHS. Our research suggests that some younger practitioners are finding it harder to secure dental employment of their choice, with many vocational dental practitioners questioning their long-term prospects and seeing their future in private dental care or, in some cases, in other careers altogether.

1.8 In late 2005 the Department of Health reported a net increase of 1,100 practitioners into the General Dental Services, achieved partly through overseas recruitment. But this increase must be balanced with the loss of those practitioners who refused to sign the new contract. Shortages of staff are also evident in other parts of the profession and the BDA believes that the Department must introduce longer-term measures to retain highly qualified dental staff within the NHS. These workforce shortages not only make accessing NHS dental services more difficult for patients, but also place increasing workload pressures on practitioners and their dental teams.

***More funding still required***

1.9 The National Audit Office (2004) highlighted that NHS spending on General Dental Services (GDS) per capita has increased by only *nine* per cent since 1990/91. This compares with a 75 per cent increase in overall NHS funding per capita. Given that

this is the most recent Government analysis on the funding shortfall in NHS dentistry, the BDA reiterates the unavoidable conclusion that NHS dentistry has consistently been grossly under-resourced.

1.10 The BDA has acknowledged that the £250 million funding announcement in 2004 and the £100 million capital investment programme announced in 2006 are 'steps in the right direction' but remains adamant that substantially more funding is necessary to deliver the Government's vision of a high quality, integrated NHS dental service in England. It is also the case that this is matched capital funding that takes no account of ongoing revenue responsibilities that fall solely to the practitioners themselves. Receiving such funding requires financial outlay from the practitioner and a long-term commitment to maintain and upgrade.

***Reorganisation of primary care trusts***

1.11 In England, the reorganisation of primary care trusts during the implementation of the new dental contract has added to the uncertainty and further marginalised practitioners to the periphery of the NHS. At a time when primary care trusts needed to be focused on understanding dental services, many were, understandably, preoccupied with their own future. The rushed implementation of the new contract then placed significant and unrealistic pressures on primary care trusts.

# GENERAL DENTAL SERVICES

***Reaction to the 35th Report of the Review Body***

2.1 The Doctors' and Dentists' Review Body (DDRB) recommendation of a three per cent uplift on the gross earnings base under the new contract for 2006/07 has done nothing to show support to the profession. An important opportunity to restore some confidence about the future of NHS dentistry and to invest in the future of the service was missed. Government's investment in dentistry continues to lag far behind that spent on other areas of the National Health Service.

2.2 The Review Body acknowledges that *"… to address problems of access, more of the average GDP's time needs to be bought back for NHS dentistry"*. Given that the BDA made only three recommendations, none of which were accepted in full, we cannot understand how the actions of the Review Body will do anything to encourage general dental practitioners to spend more of their time undertaking NHS work. The BDA continues to believe that the implementation of a package of recommendations is necessary to address some of the underlying issues that face practitioners working in the NHS. We remain convinced that, in isolation, a recommendation on uplifting gross earnings will fall well short in making the NHS an attractive and viable career choice for general dental practitioners.

2.3 The BDA remains disappointed with the continued reluctance by the Review Body to recommend a practice allowance. The BDA submitted evidence on the positive impact of the Scottish Dental Practice Allowance. This evidence was corroborated by the Scottish Executive Health Department which indicated that, even though this measure was not introduced with recruitment and retention in mind, it had a positive impact on commitment to NHS work. The BDA continues to believe that the introduction of a practice allowance in England is a critical component in stabilising current levels of NHS commitment.

2.4 Although the BDA, the Review Body secretariat and the Department of Health (DoH) have an established working group examining dental expenses, the BDA believes that the Review Body missed an opportunity, in such an important year, in not recommending that baseline independent research be undertaken to explore dental expense inflation. This could have included a prospective impact assessment exercise to establish any significant factors on the horizon that were likely to influence dental expense inflation. Such information would have helped the Review Body to make more realistic and appropriate recommendations for this year and in the future.

2.5 The BDA remains concerned at the retrospective approach that the Review Body continues to take when assessing movements in dental expenses. For example, dental nurse registration has been introduced in the last 12 months and new cross infection control guidelines are expected to be introduced in late 2006. Both of these have economic costs associated with them that will impact upon practitioners in this financial year. The retrospective nature of the Review Body's approach to making uplift recommendations thus fails to consider the impact of these factors on the current net remuneration of general dental practitioners. The BDA would urge the Review Body to adopt a more prospective approach in determining its recommendations to ensure that some stability and confidence can be restored within the profession.

2.6 Finally, the BDA does welcome the more transparent approach used by the Review Body in its formulation of the three per cent uplift, and is pleased that where official data appeared inconsistent with other sources of information (i.e. when seeking to establish the increase in staff costs) that the Review Body demonstrated flexibility and sought to use more realistic data in making its recommendation on the uplift.

***Implementation of the new NHS Contract***

2.7 The BDA consistently urged the Department of Health to engage more with practitioners, to listen to their concerns and fears, and to give the profession a reasonable lead-in time, which was originally agreed to be 12 months. This would have allowed practitioners to consider the implication of the reforms to their individual practice and to make an informed choice on their future. It is apparent that many of the problems that are occurring in the first few months of the reforms could have been avoided had the Department allowed a realistic lead-in time.

2.8 Instead, the Department of Health opted to make public key documentation, such as the new GDS and PDS regulations, the Statement of Financial Entitlement and the final patient charges regulations, very late in 2005. These documents were not sent directly to practitioners or dental practices and in many instances primary care trusts were also unwilling to send copies to practitioners who requested them. Yet this information was vital for the profession to be able to plan their businesses for the short and medium term. The information was also important so that practitioners could make a choice as to whether or not they felt that their future remained within the NHS or in the private sector.

2.9 More damaging was the Department's decision to send out individual General Dental Services (GDS) prescribing profiles in the run up to Christmas 2005. Both the lateness and the actual timing of the delivery (during a holiday period) impacted

adversely upon practitioners' ability to consider the information properly and in detail.

2.10 The GDS prescribing profiles contained the key details of the new NHS contract being offered to individual practitioners, outlining the workload (in terms of units of dental activity) and the contract value being offered to practitioners. The late delivery of general information was compounded by the fact that in many instances the contracts themselves were subsequently delivered only days before practitioners were required to sign them. It resulted in practitioners being left with little option but to sign a very demanding and legalistic 160-page, 380-clause contract.

*Inflating the workload of practitioners in the new system*

2.11 Practices that had moved to a Personal Dental Services contractual arrangement were not provided with prescribing profiles which outlined workload in terms of UDAs. This left the setting of the practice's UDA requirement at the discretion of the primary care trust. Consequently, many practices which had been encouraged by the Department to move to PDS arrangements that allowed them to adopt a more preventive approach and remove themselves from the treadmill, found themselves with UDA requirements that were far higher than should have been the case in a 'like for like' situation.

2.12 The BDA also identified some significant errors in the calculation of the number of units of dental activity that practitioners were required to undertake, with these errors acting to inflate the workload (as measured by UDAs) for all practitioners[1]. Practitioners needed to have faith in the accuracy of their calculated UDA activity level (as outlined in their GDS prescribing profiles) when considering whether or not to accept a new NHS contract. Such basic errors left the profession confused and suspicious of the levels of activity expected of them from 1 April 2006.

2.13 Having identified these errors in the calculation of UDAs, the BDA has repeatedly asked the Department of Health for the algorithm that was used in calculating baseline UDAs. However, the BDA's request for this important information has been ignored. The BDA remains concerned that the Department did not see fit to consult with the BDA on these important calculations.

2.14 The Department's rigid assumption that under the old system every practitioner saw registered children every six months further inflated almost every practitioner's

[1] For example, where a crown has fallen out and the dentist and patient agree to build up the remaining tooth with a pin or screw core before re-cementing, under the old GDS most dentists would claim item 1734 (pin or screw core) and item 1782 (re-cement). In the new GDS item 1734 was placed in band 3 and item 1782 in the urgent treatment band. Therefore in the calculation of baseline UDAs the code 1734 was identified as band 3 and thus weighted as 12 UDAs. This is incorrect as there is no laboratory work involved. In the new GDS the re-cement of a crown is to be undertaken within the urgent treatment band. This means that dentists would only generate 1.2 UDAs, although for the purposes of establishing a baseline UDA activity level, 12 UDAs would have been allocated for such a treatment.

UDA requirement. Recent National Institute for Health and Clinical Effectiveness (NICE) guidelines suggest that the frequency of examinations should be driven by patient need rather than by artificial standard recall periods. Effectively, practitioners who had been applying these guidelines with dentally stable, well-maintained patient bases were penalised by this assumption.

2.15 Most significantly, practitioners working in areas with fluoridated water supplies (where dental caries experience is low) suffered disproportionately as they had already taken on much larger lists as a result of the low need for interventions (e.g. Birmingham).

2.16 Taken together these must be seen as the Department of Health directly penalising practitioners who adopted clinically effective procedures in accordance with best practice.

2.17 Specific guidance was given to primary care trusts that the assumption that children were seen twice a year was not negotiable. Consequently, even when practitioners could demonstrate to the PCT that this assumption resulted in an inflation of their workload in the new system, they were informed that to reduce their UDA requirement would lead to a corresponding downgrade in their contract value. The BDA believes that such a directive makes a mockery of the flexibility that primary care trusts are supposed to have when locally commissioning dental services. It also reflects more widely the rigidity and inflexibility of the contract.

2.18 The effect of this erroneous assumption has been profound in respect of expected output volumes and corresponding contract values. When the Department of Health declared secure funding for activity at a rate of 95 per cent of the previous year, these assumptions had not been stated. The BDA sees these impositions as an attempt to renege upon the original promised terms. The net result is that, for some practitioners, the required workload is actually higher than in the baseline year.

2.19 These anomalies give the BDA no confidence that the rest of the calculation has been conducted in a fair and appropriate manner. This concern is exacerbated by the Department's reluctance to allow the BDA to have access to the calculation algorithm.

*Workforce poised to reduce NHS commitment*

2.20 The vast majority of practitioners received the new NHS contract only days before implementation of the reforms. They were then urged by their primary care trust to sign up to the contract or risk losing their entitlement to a new contract should it not be signed before 1 April 2006. The Department thus left much of the profession with little room to consider options and in effect forced a great many practitioners into

accepting the new NHS contract. This is supported by official Department data which reports that around one-third of new NHS dental contracts were signed in dispute.

2.21 The BDA believes that there is a limit to how much re-commissioning can occur within a given primary care trust area. Even prior to 1 April 2006, many dental practices were operating at capacity and could not take on more patients. As more and more practitioners reduce and/or withdraw their NHS commitment, capacity constraints will reduce the opportunities for the re-commissioning of UDAs.

2.22 In anticipating the introduction of the new contract, the Public Accounts Committee (2004) predicted that there may be a "… *mass exodus at the eleventh hour*". It seems that the Public Accounts Committee had a clear understanding of the inherent risks of the reforms to NHS dentistry, and the 2,000 practitioners that left the service at the inception of the new arrangements may not have come as a surprise to them.

2.23 This immediate withdrawal indicates the attitude only of the early movers. The BDA continues to believe that the systematic reduction of NHS commitment is far from complete. Evidence from surveys and practitioner behaviour suggests that more dentists are likely to change the mix of the care they provide in favour of private practice, thus putting the future of the NHS general dental services and patient care at risk.

2.24 Under the old NHS system practitioners 'registered' patients into their care and were therefore able to establish continuing care relationships with them. This allowed ongoing education and oral health improvement. The consequence was that many patients required minimal levels of intervention.

2.25 It was this patient base upon which activity levels were assessed when calculating UDA values for the current system. The way the UDA system is set up means that practitioners receive the same UDA allocation for one filling as they do for ten (or many more). This is far from the 'like-for-like' calculation that was promised would be employed when considering activity.

2.26 The time allocation for treating one modest case under the old system is, therefore, the same as a complex one under the new arrangements. Dentists must attempt to get 'a quart into a pint pot'.

2.27 Again, this unfairness works to the advantage of the PCT and Department of Health but substantially to the detriment of some practitioners who will struggle to maintain the same putative outputs. Practitioners have a choice of whether to offer treatment on the NHS or privately. With such adverse drivers within the NHS arrangements, many practitioners may conclude that the viability of their practices demands

realistic returns and therefore leave the NHS either through partial or total withdrawal. It will be a grave disadvantage to patients who want to access NHS care and especially those with high needs for whom the system drivers are contrary to their requirements.

*Patient charges to subsidise the Health Budget*

2.28 The budget set by Government effectively fixes the total spend for dentistry in England and Wales. Whilst the total may have been predictable, the relative contribution of state and patient clearly were not. In some areas, the new system of charging has resulted in patients contributing disproportionately to the budgeted amount.

2.29 The net result of this is that, set against original budget forecasts, despite a fixed ceiling, the proportional contribution by patients is much higher and therefore the contribution from central funds is much lower. As a result, patients are effectively subsidising the health budget.

2.30 The BDA is concerned that this means that funds committed by central government to be spent on the provision of dentistry may be spent elsewhere. Given the recognised under funding of NHS dentistry, we would urge the Review Body to seek undertakings from the Department of Health that these funds are retained within dentistry and used to pay for necessary improvements to the system highlighted in this evidence, particularly in the three-year transition period.

*Disputed contracts*

2.31 In May 2006, the Department of Health stated that 33 per cent of contracts had been signed in dispute. Given that this was a contract that the Department claimed would be of benefit to practitioners and patients alike, the BDA considers this demonstrates a misjudgement of the situation.

2.32 Three months into the reforms, Government data indicated that over two-thirds (69 per cent) of disputes had not yet been settled. Twenty-three per cent of all signed contracts were still in dispute, and this represented over one third (36 per cent) of the total number of UDAs commissioned.

2.33 At the same time, the BDA surveyed Local Dental Committee (LDC) Secretaries to assess the impact of the new contracts locally. Seventy-three LDC secretaries in England and Wales responded, a response rate of 70 per cent.

2.34 The survey indicated that nine per cent of dental practitioners did not sign up to the NHS contract; a finding echoed by the Department. By that time, around two-thirds

of contracts signed in dispute had not yet been resolved, and of those that had been resolved 57 per cent had not been resolved to the practitioner's satisfaction.

2.35 Given the rate at which contracts signed in dispute are being resolved, it appears that it may be well into 2007 before all the disputes are dealt with. The BDA is convinced that a lack of appropriate resources to implement the new contract at primary care trust level, combined with their impending reorganisation, has been stalling the resolution of contract disputes.

2.36 The *July 2006 BDA Omnibus Survey* identified the main reasons why dentists signed contracts in dispute. The principal reasons given were: *"the UDA target was set too high", "full year funding not forthcoming", "additional contractual clauses added by primary care trusts"* and *"the loss of goodwill associated with signing the new contract"*.

2.37 The same survey revealed some alarming statistics. These showed that more than three months into the new system, 53 per cent of general dental practitioners had not yet resolved their contractual dispute. More worryingly, 37 per cent who had resolved the dispute felt that the outcome was unsatisfactory and, as a consequence, around a quarter of them were now considering leaving the NHS altogether. A disturbing indicator of practitioners' lack of trust and confidence can be derived from the fact that 29 per cent of practitioners who signed contracts in dispute envisage that the dispute will not be resolved satisfactorily and will therefore consider leaving the NHS.

2.38 In addition, the survey revealed that practitioners were actively planning to reduce their NHS commitment over the three-year transition period. The current average NHS/private mix is 56:44. This is anticipated to move to 48:52 in 12 months, and further still to 35:65 in three years' time.

2.39 The results also showed that one in four practitioners intended to move towards private practice, with an average timeframe of conversion to private practice of 2.7 years. It is of no surprise that the average time of conversion coincides with April 2009 when the ring fencing of dental funds and the income guarantee for practitioners are removed.

*Replacing the seniority payments scheme*

2.40 Seniority payments are to be lost as part of the practitioner remuneration package from 1 April 2008. The Department of Health has stated that a new scheme would replace the current seniority payment scheme. Despite the BDA submitting a blueprint for an experience related payment scheme that would appeal to the

profession, and in line with the medical model, the Department has not taken this issue forward.

2.41 Seniority payments remain a sensitive subject for general dental practitioners as they are viewed as deferred payment, towards which all practitioners contribute throughout their service to the NHS. It is very important to the profession that any scheme that is designed to replace seniority payments must be initiated as soon as possible.

2.42 There is a real risk that those practitioners who were due to receive seniority payments after 2008 will opt to withdraw their NHS commitment should a replacement scheme not be forthcoming.

*Failure to attend*

2.43 The BDA advised the Department that, in certain areas, charging for failure to attend acted as a real deterrent to wasting NHS resources. The *July 2006 BDA Omnibus Survey* found that 41 per cent of general dental practitioners noted that patients had been more likely to miss their appointments since 1 April 2006. This has a detrimental effect on access to NHS dental services and is a squandering of scarce NHS resources.

2.44 The increase in the number of patients likely to fail to attend their appointment is undoubtedly due to the Government decision to outlaw failure to attend charges under the new NHS patient charging regime. For the Department to state that a dentist who experiences a missed appointment can use that time to treat emergency patients shows a fundamental lack of understanding of how a successful business is run; this change in patient behaviour makes it increasingly difficult for dentists to plan and fulfil their contractual UDA obligations.

2.45 Those practices in more deprived areas are likely to suffer most from patients missing appointments, and as such are likely to experience greater difficulty in fulfilling their contractual UDA obligations. This will jeopardise the financial viability of the practice. Practices in deprived areas often do not have the choice to change their NHS commitment due to the socio-economic profile of their patients. In the longer term these commercially unviable practices may simply close down, and this cannot be in the interest of their patients.

2.46 The recent *House of Commons: NHS Charges Report* (2006) encourages the Government to undertake a review of charges across the NHS which promotes more responsible use of services, including the consideration of a fee for patients who do not attend or fail to cancel GP or hospital appointments. The BDA would urge the

Government to include the impact of re-introducing a failure to attend charge for NHS dental services as part of the scope of the Review.

*Reform impacts on goodwill*

2.47 BDA research in 2004 indicated that the vast majority (88 per cent) of general dental practitioners who bought or sold a practice in the previous two years had a valuation of goodwill included in the price. Anecdotally, the percentage of NHS gross annual receipts used to calculate goodwill is between 20-40 per cent.

2.48 The new contractual arrangements may have a major impact on the value of their goodwill of a practice. Under the new arrangements there is no guarantee that a primary care trust will commission NHS dental services from a dental practice if a new owner takes control. As a consequence, potential new owners will need to negotiate their own prospective contract value before deciding whether to acquire the practice.

2.49 The value of goodwill is crucial as one of the principal sources of collateral against which many practice owners borrow money (e.g. for capital improvements) from banks. It is also considered as a significant element in retirement planning and one upon which many practitioners are relying. In essence, this represents a realisation of the funds that dentists have personally invested in the infrastructure of the NHS.

***Workforce, Recruitment and Retention***

2.50 Given the unreasonably short lead-in time that dentists had for the new contract, it is likely that a very significant number have been forced into accepting the new contract as a 'least-worst' immediate option. These dentists are now considering their longer-term options. The National Audit Office (2004) stated 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 through the transition and may not materialise until the end of the period*".

2.51 The *Report of the Primary Care Dental Workforce Review* stated that, in 2003, the under-supply of whole-time equivalent (WtE) dentists in England was 1,850. As stated in our last submission to the Review Body, the BDA strongly refutes this figure and believes that the under-supply of WtE dentists across the UK is at least double that stated by the Department. The BDA estimated the under supply of WtE dentists across the UK to be around 4,000. A University of Bath study (2004) concluded that the under supply was even more acute, at 5,200 dentists.

2.52 Nevertheless, in July 2004 the Department of Health set a target to recruit the equivalent of 1,000 more WtE dentists to the NHS to alleviate local access problems

around the country. In early November 2005 the Government announced that it had exceeded this target. The Government claimed to have bought into the NHS the equivalent of 1,453 WtE practitioners in the space of 12 months; a net increase of 1,100 dentists. Almost half of the extra capacity can be attributed to overseas recruitment[2] .

*Overseas Dentists*

2.53 The BDA is concerned that many of the overseas practitioners recently recruited into the NHS have not been trained to provide dental care at the rate at which NHS practitioners have historically had to deliver, with committed NHS practitioners seeing upwards of 30 patients each day. The BDA wishes to see the excessive workload of committed NHS practitioners, including those from overseas, reduced and practitioners to be removed from any sort of treadmill.

2.54 The BDA believes that such large anticipated workloads may have two effects. In the short term there is likely to an under achievement of desired volumes of output. In the longer term colleagues may find the expectations oppressive and unsustainable. The BDA believes that it is only a matter of time before overseas practitioners begin to move towards providing more private care in an attempt to reduce their workload.

2.55 As a result, the stop-gap of overseas recruitment will represent a very temporary and incomplete solution. At an even higher level, it also calls into question whether the outputs expected of long-term historic NHS performers represent a reasonable workload.

2.56 The BDA has warned against relying on quick solutions to tackle the shortage of dentists. If the Government is serious about keeping existing practitioners within the NHS and solving the current dental crisis, it must focus on making the NHS attractive to practitioners who have demonstrated loyalty to it for many years.

*Vocational Dental Practitioners*

2.57 In June 2006 the BDA undertook a *Post Vocational Training Employment Survey* to assess the impact that the reforms to NHS dentistry, including the overseas recruitment drive, have had on the ability for vocational dental practitioners to find and secure employment in the new world of NHS dentistry.

2.58 The research found that, at that time, 18 per cent of vocational dental practitioners had not yet found employment. This equates to around 120 domestically qualified

[2] The composition of the 1,000 whole time equivalent target is: Department of Health recruitment from Poland - 216; Other international recruitment – 297; International Qualifying Exam – 230; Domestic recruitment – 88; PCT expansion of local NHS capacity – 622; TOTAL 1,453 (Source: DoH)

dentists. Of the vocational dental practitioners who had not yet found employment, 83 per cent stated that their job hunting experience was more difficult than expected, with an average of seven applications made before finding employment. Twenty per cent of them had made 10 or more applications to date.

2.59 Many overseas practitioners that have recently entered the workforce were earmarked for specific dental positions, usually within a practice operating under the old Personal Dental Services (PDS) contract. This works to the disadvantage of home-grown vocational dental practitioners, who do not have the assistance of the Department in helping them to identify and secure employment. The BDA will monitor the situation of vocational dental practitioners and their post-VT prospects carefully over the next year. It seems wasteful to the BDA to neglect the proper deployment of the Department's own investment (i.e. UK graduates).

*The combined effects*

2.60 In November 2005, the Department of Health announced that *"… thanks to a successful recruitment campaign"* it had managed to bring into the NHS the equivalent of 1,453 WtE dentists over the previous 12 months, with almost half coming from overseas recruitment.

2.61 For the purpose of overseas recruitment the Department has sought to recruit dentists on salary packages of around £50,000. This figure is lower than the amount quoted by the Government for the earnings of a committed NHS practitioner.

2.62 If these figures are accurate, it is likely that situations will arise where some overseas practitioners will compare their workload and earnings adversely with their UK trained colleagues, both within and outside the practice, and consequently begin to consider their future outside the NHS.

2.63 Since this announcement the Department has acknowledged that, as from April 2006, one in ten practitioners had refused to sign a new NHS contract; this amounts to losing around 2,000 dentists from the NHS. In our evidence to the Review Body last year the BDA stated that there was the potential for approximately 6,000 practitioners to gradually withdraw their NHS commitment over the three-year transition period. It is now apparent that around one-third of the predicted 6,000 have already withdrawn from the NHS.

2.64 The Government, in November 2005, stated that it had experienced a net increase of 1,100 practitioners into the GDS over the previous 12 months. The fact that around 2,000 practitioners withdrew from the NHS in April 2006 implies that there has actually been a net decrease in the GDS workforce of around 900 practitioners (i.e.

the November 2005 net increase stated by the Department minus the 2,000 practitioners that withdrew from the NHS on 1 April 2006).

2.65 The BDA remains convinced that the situation of undersupply will continue to be a prominent feature of dental services in England over at least the next two decades. Government measures 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.

2.66 The BDA would urge the Review Body to consider not only the likely risk of further large numbers of practitioners abandoning their NHS commitment, but also the associated withdrawal of their experienced dental teams and the impact this would have on the remaining service providers.

2.67 In addition to the absolute numbers of dentists declining within the service, the outputs of those present is also likely to reduce. The changing demographic of the indigenous dental profession heralds a move away from full-time dental practice towards practitioners more disposed to part-time practice with career breaks and greater focus on work-life balance.

2.68 As a result, the outputs of what may appear to be a similar workforce are likely to be substantially less. The issues relating to overseas recruits are outlined above. The net result of all of this is likely to be a more acute shortage of practitioners, particularly in the NHS.

***Capital Investments, Practice Overheads and Expenses***

2.69 In May 2006 the Department announced a £100 million capital investment programme for dentistry. This money is to be spent over two years, £40 million in 2006/07 and £60 million in 2007/8. Whilst the BDA welcomes this announcement, it is important to appreciate that this capital funding comes after years of chronic Government under-investment in NHS dentistry. The BDA will also be watching closely how and where the money is spent, and whether it indeed does reach those dental practices most in need.

2.70 The BDA believes that much of this money will be spent on fulfilling ever increasing cross infection control and clinical governance guidelines, and is unlikely to begin to address the historical under-investment in NHS dentistry. The BDA is convinced that additional funding is required to upgrade and renew dental practices so that the NHS can deliver dental services in 21st century premises.

2.71 The BDA applauds the Review Body's continued use of a more transparent approach in calculating and recommending appropriate uplifts and is encouraged by

the Review Body's acknowledgement that contract uplifts in line with the Government inflation target (CPI) would lead to a fall in the real remuneration of GDPs. As a further enhancement of this approach, the BDA would now urge that the Review Body adopt a more prospective view when assessing the uplift in contract values for 2007/08. It is the BDA's contention that by not doing so the Review Body's recommendations may fail to adequately address the continued rise in dental expense inflation.

2.72 The lag between actual increased expenses and retrospective adjustment in fees has, in the past, left practitioners with no option but to correct the situation by subsidising their NHS dental care with private dental care. The reforms to NHS dentistry make this option increasingly difficult to take and the BDA is concerned that practitioners will now address the situation by removing themselves entirely from an under-funded system.

2.73 The new NHS contract has effectively capped a practice's NHS income. In the old GDS system practitioners could at least 'pedal harder' to generate more income to cover rising expenses. This is no longer the case. Consequently, underestimating dental expense inflation will reduce a practitioner's net income in real time and over time may render the practice non-viable and subject to significant cash flow difficulties.

2.74 The BDA believes that there continues to be significant upward pressure on dental practice overheads. In our evidence to the Review Body last year the BDA reported on three separate sources of data, all of which indicated 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"*. Last year the Review Body used an even lower figure of 3.6 per cent to estimate the growth rate of dental staff wage inflation.

2.75 Dentists are highly supportive of the development of the skills of the whole dental team but there remains a shortage of available DCPs. Consequently practitioners have had to tap into a pool of more highly academically qualified people when recruiting. As a direct consequence of these shortages and the intense competition from other industries, practitioners need to award above average wage increases in order to both recruit and retain DCPs.

2.76 Dental nurses have two years from 1 July 2006 to become registered with the General Dental Council (GDC); a move which the BDA acknowledges will enhance patient care. To become registered, dental nurses will be required to have specific qualifications or demonstrate appropriate training and experience. Where dental

nurses require qualifications or additional training the cost of this will to be borne out of practice turnover.

2.77 In addition, there is 'downtime' associated with dental nurses obtaining appropriate qualifications or training which will either result in lost output or increased staff expenses in acquiring cover. The BDA *Professionals Complementary to Dentistry Pay Survey 2002/03* demonstrated that dental nurses with qualifications could command wage rates that were 12 per cent higher than the UK average.

2.78 Upward pressure on wages and salaries for DCPs is set to continue to remain high over the next two years, and the BDA continues to believe that the wages and salaries of DCPs will rise at an annual average rate well ahead of inflation.

2.79 The anticipated guidelines in the new *A12: Infection Control in Dentistry* publication are expected to have significant impacts on many dental practices. There are not only capital costs involved in installing new equipment, e.g. washer/disinfectors and amalgam separator units, but there are ongoing training and revenue costs associated with them.

2.80 There is also 'downtime' associated with the use of new equipment, e.g. installation, maintenance and time taken to use the equipment. This associated 'downtime' now also has a direct economic cost in terms of units of dental activity that cannot be generated.

2.81 Advances in approaches to cross infection control mean that practices will need to consider the replacement of their existing autoclaves with vacuum autoclaves. The increased use of washer disinfectors within the cleaning cycle will incur the cost of the device itself, plus the on going maintenance and servicing costs.

2.82 Most significantly, the procedure will need more floor space within the practice (which may in some cases lead to a need for relocation). There will also be a significant increase in the number of pieces of equipment and instruments to allow for the extended cycle time. In some cases this will require several new complete sets of instruments to allow a proper sterilization cycle to occur whilst maintaining volumes of activity.

2.83 In addition, there will be staffing requirements to carry out this process and it is almost inevitable that there will be a time efficiency loss in the process. Add to all of this the need for maintenance and materials involved, and it can be seen that the ongoing financial implications may be profound.

2.84 There is also anecdotal evidence suggesting that some primary care trusts are threatening not to commission from dental practices that do not follow best practice

in infection control and clinical governance. As a matter of principle, the BDA would encourage all dental practices to comply with best practice guidelines for infection control and clinical governance; however this would require additional funding from the Government to be realised. Whilst a great many dental practices do follow best practice guidelines, the rest have systems in place that are deemed adequate and suitable by the Department of Health. Pressures from PCTs to have best practice systems (or risk the PCT refusing to commission with them) are expenses that constitute a direct burden to the practice.

2.85 Data from the HM Treasury document *Forecasts for the UK Economy* (August 2006) indicates that average earnings are forecast to rise by 4.7 per cent in 2007 and that inflation as measured by the Retail Price Index (RPI) is forecast to rise by 3.7 per cent in 2007[3].

2.86 The BDA believes that these two indicators can be used as a proxy measure for wage and salary inflation of DCPs, and all other dental expense inflation in 2007/08, respectively. The BDA would therefore ask the Review Body to make a recommendation to uplift GDP's net earnings by 4.7 per cent in 2007/08, the same rate as the forecast growth in wages and salaries for DCPs.

2.87 Taking the formula used in last year's Review Body report to calculate the uplift, the BDA would ask the Review Body to make a recommendation for at least a 4.3 per cent uplift on gross earnings for GDPs, which would deliver at least a 4.7 per cent increase to the net earnings for GDPs.

2.88 The BDA believes that an uplift of at least 4.3 per cent, as part of a package of three recommendations, will stabilise the workforce during the transition period. It will also send out a strong signal that the Government is committed to retaining the current high quality level of NHS dental care to patients.

*Practice Allowance*

2.89 In its 35th report 2006 the Review Body stated that the BDA's request for a non-targeted practice allowance was not *"… appropriate at this stage in the transition"*. This conclusion was based on the Department's assertion that the reform to NHS dentistry would drive down practice expenses and on the grounds that such a practice allowance would have *"… serious implications for affordability"*.

2.90 The BDA does not share the Department view that practice expenses will decline significantly, and cannot see how a reduction in practice expenses would necessarily benefit patient care. In fact, as outlined earlier in our evidence, the BDA believes

[3] The BDA has used the 'high' end of the forecast for average earnings and RPI growth in 2007 as we believe that these correlate more closely with the actual movements in dental practice expenses.

that dental practice expense inflation is set to increase due to factors such as rising wages and salaries of dental care professions (DCPs), strict infection control guidelines and the resultant move toward single use items (i.e. disposables), increasing pressures to comply with clinical governance, and rising insurance, training and waste management costs.

2.91 The BDA continues to believe that the introduction of the Scottish Dental Practice Allowance and the subsequent increase in the level of the allowance in Scotland has, in part, addressed the additional expense incurred in the running and operating of an NHS dental practice. We believe this allowance goes some way towards relieving practitioners of the increasing administrative burden associated with running an NHS dental practice, and, most importantly, helps to maintain the financial viability of committed NHS dental practices.

2.92 As the Scottish Dental Practice Allowance begins to bed in, there is growing anecdotal evidence that it is having a positive impact on the recruitment, retention and morale of general dental practitioners in Scotland. The BDA reminds the Review Body that the Scottish Executive Health Department (SEHD), in its previous submission of evidence to the Review Body, indicated that even though the Scottish Dental Practice Allowance was not introduced with recruitment and retention in mind, it may have had an impact on commitment to NHS work.

2.93 During the transitional period of the reforms to NHS dentistry, practitioners will be assessing whether or not they can continue to provide a high level of patient care in the NHS. Practitioners who find that their practices cannot remain viable under the new system are, ultimately, likely to withdraw from the NHS, or at the very least, reduce their NHS commitment.

2.94 The BDA continues to believe that the introduction of a practice allowance in England, as part of a package of recommendations, is an essential measure that will improve NHS dental services for patients. The practice allowance, in part, by improving the financial viability of committed NHS dental practices will address the risk associated with running a dental practice.

2.95 The BDA strongly urges the Review Body to support the introduction of a practice allowance for practitioners in England. The BDA would welcome the opportunity to discuss with the Department of Health and the Review Body the best way to develop an appropriate practice allowance for England, whether it be based on a practice's NHS contract value or on another formula.

***General Dental Services (including PDS) in Wales***

2.96 The Welsh Assembly Government said it would invest extra funding for the new contract which would see an additional £30 million invested in NHS dentistry from 2006/07 onward, an increase of 35 per cent over the forecast expenditure for 2005/06. In addition, a separate budget is being held centrally by the Welsh Assembly Government to fund targeted development of dental services. Vocational training, clinical audit and peer review (including clinical governance, training and development) are also now managed centrally.

2.97 The old *Welsh Dental Initiative* scheme which allowed for capital expenditure in practices seeking to expand their NHS patient numbers was suspended prior to the introduction of the new contract. Since then, £100 million has been allocated for capital funding for primary care dentistry in England. However, the Minister in Wales has said that no capital grants to practices are being made available in the current year and nor are any being planned for the next financial year [Response to Assembly question WAQ 47576].

2.98 Commitment to the NHS in Wales remains high and this is borne out by the uptake of the new contract; only two per cent of practitioners in Wales declined to sign a new GDS or PDS contract by 1 April 2006. [Health and Social Services Committee paper HSS (2)-12-06(p5) – 5 July 2006]. However, despite such a high take up rate, the Welsh Assembly Government has stated that approximately 74,000 former NHS patients are now without a dentist [Response to Assembly question WAQ 47577].

2.99 The BDA is aware that a number of contracts were signed in dispute and to date a high percentage of these remain unresolved. The BDA estimates that as many as 30 per cent of contracts in Wales may have been signed in dispute. Many of the disputes have arisen because practices were encouraged to enter a PDS type arrangement up to 31 March 2006 on the understanding that the Welsh Assembly Government wished to retain the number of patients being seen in the practice as a measure of assessing NHS commitment. The introduction of UDAs, as a measure of NHS commitment and output, has resulted in a situation where many practices are now required to complete more UDAs than they consider fair and equitable.

2.100 Practitioners in Wales are also reporting that it is difficult to achieve UDA targets, especially in areas of poor oral health where the dental need is for large amounts of simple restorative work. This type of work may involve multiple visits but only attracts three UDAs. The BDA has asked the Welsh Assembly Government to consider an intermediate UDA band which could be applied to patients who have not previously been in regular care and who have a high need for simple restorative work of a type which would not attract 12 UDAs. In England, similar ideas have

been suggested to the Department in the lead up to reform implementation, and have more recently been raised again at the Department of Health's Contract Implementation Review Group.

2.101 There has also been a considerable expansion in the availability of orthodontic treatment in Wales in the last three years, with a number of new specialised practices being opened. Their patients come from a wide area covering multiple Local Health Boards (LHBs). A number of these new practices were in the early stages of growth during the test period for assessing NHS funds for subsequent years. They have now found that their funding is sufficient only to allow for completion of existing courses of treatment and does not allow the practice to start new courses. Where the LHB in the area in which the practice is sited has provided extra funding to allow for growth, they are placing restrictions on the patients such that they will only fund those from their own area. It is reported that waiting lists are lengthening at an alarming rate.

2.102 The funding for vocational training is being held centrally and administered by the dental postgraduate department. The BDA is pleased to acknowledge the work undertaken by Assembly officials to ensure the continued viability of the schemes in Wales into 2006/07. However, concerns remain where LHBs are refusing to offer 'year two' contracts that would allow trainees to stay in their training practices as practice performers, something that is also occurring in England. The Welsh Assembly Government repeatedly states that it wishes to expand the number of dentists in Wales, yet it allows LHBs to reject applications for new contracts. This action cannot be of benefit to the patients who are receiving care under NHS regulations. If trainees are not replaced these patients are unlikely to be able to continue to receive NHS care in their existing, or even another, local practice.

2.103 The BDA is aware that the LHBs have the funds to be able to award contracts but, anecdotally, they seem more committed to seeking partnership arrangements with large dental groups and bodies corporate which recruit their workforce from outside Wales. As early as August 2005, the Welsh Assembly Government was advising LHBs to enter into discussions with a number of large dental providers with a view to them providing services in Wales.

2.104 Local Health Boards also seem wary of their allocations from the Welsh Assembly Government which they are supposed to use to commission NHS dental services and are very concerned about the proportion funding that comes from patient charges. Consequently, some LHBs are ignoring the anticipated patient charge income during the commissioning process, which in effect reduces the funding that they are prepared to allocate to practices, especially where a practice wishes to grow.

***General Dental Services in Scotland***

2.105 At this stage BDA Scotland will not put forward any evidence, but may do so in supplementary evidence.

***The need for a package of recommendations***

2.106 The BDA urges the Review Body to consider the recommendations below as an essential package of measures which, when implemented together, address the most important issues relating to the recruitment, retention and morale of practitioners working in the NHS.

2.107 The introduction of a practice allowance and an experience related rewards scheme (to replace the outgoing seniority payments scheme) will act to retain practice owners and older, more experienced practitioners within the NHS. The practice allowance will both partly offset the business risk of providing NHS dentistry and ensure that committed NHS practices remain financially viable in the reformed NHS dental service.

2.108 These three recommendations, as part of an integrated package, will stabilise the current dental workforce and will retain current NHS commitment levels during and beyond the remaining two years of the transition period. The simultaneous implementation of these recommendations will help to position the NHS as an attractive career option, especially compared with private dentistry.

2.109 Recruitment into the NHS, retention within the NHS and morale of committed NHS practitioners can all be improved. We remain hopeful that the Review Body will endorse and recommend in full the three recommendations outlined below.

In the light of the issues raised in our Evidence, we ask the Review Body to recommend the following package:

~ The uplift applied to general dental practitioners' gross earnings base for 2007/08 is at least 4.3 per cent, and that:

~ £97 million is made available so that a practice allowance can be introduced in the year 2007/08, and that:

~ £45 million is made available so that a new scheme, based on experience, can be introduced in 2008/09 to replace the outgoing seniority payment scheme.

# SALARIED PRIMARY DENTAL CARE SERVICES

3.1 The Doctors' and Dentists' Review Body recommendation of a 2.4 per cent uplift on salaries and allowances for dentists in the Salaried Primary Dental Care Services (SPDCS) to be applied across the board in 2006/07, together with the Review Body's reluctance to consider a Commitment Payments Scheme for salaried dentists, was met with disappointment by the salaried practitioners.

3.2 Since the BDA last submitted evidence to the Review Body, negotiations have commenced for new terms and conditions for Salaried Primary Dental Care Service dentists in England. The BDA does not intend to submit evidence other than jointly with NHS Employers as supplementary evidence, due to be submitted by 3 November 2006. It is expected that this joint evidence will take the form of a separate letter to the Review Body.

***Salaried Primary Dental Care Services in England***

3.3 The Department of Health wrote to the BDA on 9 February 2006 stating that it had asked NHS Employers to take forward the negotiations on new pay, terms and conditions for Salaried Primary Care Dentists. This letter also informed the BDA that the negotiations were to be based on a 10 per cent pay envelope, i.e. when the new pay system has been fully implemented this would lead to 10 per cent additional investment, over and above, the estimated 2006/07 pay bill for salaried primary care dentists.

3.4 The negotiations aim to agree a new pay and career structure for Salaried Primary Dental Care Service practitioners. The new terms and conditions for SPDCS practitioners are also anticipated to lead to an enhanced patient experience through:

- more efficient deployment of skills
- encouragement of higher levels of competence
- better integration of salaried dentists into the wider dental workforce, both generalist and specialist
- improving the recruitment and retention of dentists into salaried employment
- improving the quality of clinical leadership.

3.5 The mandate for the negotiations reflects proposals outlined in *'Creating the Future – Modernising Careers for Salaried Dentists in Primary Care'*. Of the specific

proposals outlined in the document the BDA hopes that the negotiations will deliver the following:

- *Career pathways for salaried primary care generalists designed to distinctively acknowledge, develop and reward their crucial role*
- *Salaried generalists wishing to develop themselves as Dentists with Special Interest (DwSI) supported through a clear framework of development and reward within the generalist career pathway*
- *A new single pay spine developed for all salaried primary care generalists, including those with a special interest*
- *Future career pathways for salaried primary care-based specialists designed to acknowledge, develop and properly reward these important clinicians*
- *Those adopting a career as a salaried primary care-based specialist rewarded comparably with hospital-based colleagues by utilising existing medical and dental specialist grades*
- *Career development facilitated by the implementation of person annual appraisal and Personal Development Plans linked to General Dental Council re-certification for all salaried generalists and specialists.*

3.6 The negotiations commenced on 9 June 2006 and to date we have met on four occasions with negotiations progressing well.

3.7 As outlined above, the negotiations on the terms and conditions of SPDCS dentists involve a funding envelope of 10 per cent over and above the 2006/07 expenditure. The BDA remains hopeful that the new terms and conditions will be implemented by 1 April 2007, and would ask the Review Body to recommend an uplift on salaries and allowances in 2007/08 for all SPDCS dentists of 4.7 per cent in addition to the new terms and conditions to be implemented by 1 April. This uplift is in line with that sought by the BDA for general dental practitioners in 2007/08.

***Community Dental Services in Wales[4]***

3.8 The Community Dental Service (CDS) in Wales is currently managed by eight NHS Trusts across Wales. In autumn 2005 the Welsh Assembly Government invited comments on a consultation on the future of the CDS in Wales in a document *'Bridges to the Future'*. The document outlined their proposals for organisational reform of the service and career pathways for dentists employed in this service.

[4] The term 'Salaried Primary Dental Care Service' (SPDCS) has not been adopted in Wales.

Following a review of the responses, the Welsh Assembly Government issued its proposals in July 2006.

3.9 It is proposed that the service in north Wales would remain under the same arrangements as are currently in place. The south west services, which operate under five NHS Trusts, would be merged in two phases. The first would merge Ceredigion, Pembroke and Carmarthen, and in the second, this combined group will merge would Swansea and Powys.

3.10 In their response to the original consultation, the south east Wales services of Gwent and Cardiff and Vale Trusts opposed a merger. The Welsh Assembly Government proposes that a feasibility study on merging these two services should take place in 2007/8.

3.11 The potential creation of three services across Wales would bring the CDS in line with the Welsh Assembly Government's intention to develop and commission NHS services based on three regions. However, the Welsh Assembly Government review of the CDS may result in fewer people applying for posts in services that are likely to be restructured. Already, some services are seeing dentists moving from the CDS into general practice or being attracted into bodies corporate.

3.12 The proposals for developing the career structure of the CDS are likely to follow those being negotiated in England, following the Chief Dental Officer for England's review. The Welsh Assembly Government has observer status at the negotiations taking place between the BDA and NHS Employers. But the Welsh Assembly Government commitment to mirror any recommendations from this group is muted by its statement that an Assembly official would attend as an observer *'to feedback on their suitability for introduction in Wales'*.

3.13 Over many years, increasing pressures have been placed upon the CDS in Wales and the service has found it increasingly difficult to fulfil its role in looking after vulnerable older patients and patients with special needs. It is becoming apparent that whilst the new GDS contract was supposed to facilitate access to the contractor services, this is clearly not the case. All the CDS services across Wales report an increase in the number of referrals to their services for routine care. Domiciliary services are now less likely to be provided by GDS dentists and these patients are being referred in increasing numbers to the CDS.

3.14 In response to the funding announcement for SPDCS in England, the Welsh Assembly Government has stated that *'the wider issues of funding any new pay structure and associated terms and conditions will be addressed separately once negotiations between NHS Employers and the BDA begin to crystallise'*. Further still, in England it was recently announced that £100million had been made available

(over 2006/07 and 2007/08) for capital investment in primary care dentistry. Guidance issued states that Primary Care Trusts may use the funds for, amongst other things, supporting managed Salaried Primary Dental Care Services. Similar funding has not been made available in Wales.

3.15 It is of concern that the Welsh Assembly Government may rely on money formerly spent on General Dental Services to fund costs associated with reform, rather than provide additional funding. In its proposals the Welsh Assembly Government reminds Local Health Boards (LHBs) that *'it does not wish to see CDS vacancies frozen whilst LHBs and Trusts work on merger plans'* and that *'LHBs have received significant funding for primary care dentistry and some of this might be utilised in developing salaried primary care dental services.'* [Letter to LHB Chief Executives dated 14 July 2006]

3.16 Past experience of the Welsh Assembly Government is that there is a great deal of uncertainty about the time it takes to introduce changes in Wales that are a consequence of changes introduced in England. The greatest concern to those who currently manage the CDS in Wales is that if the proposals for England are seen to offer an enhanced career structure and remuneration, then recruitment and retention of younger dentists beginning their career in the CDS will become more difficult in Wales. Senior clinicians who have settled in Wales and who have family commitments will be less likely to move, though may still consider moves to adjacent English services should the opportunity arise.

***Primary Care Salaried Dental Services in Scotland***

3.17 A Review of the PCSDS, which includes dental public health, was commissioned by the Chief Dental Officer (Scotland) at the beginning of 2002. Although Ministerial approval has been granted, the final report and recommendations arising from the Review have not yet been published. At this stage BDA Scotland will not put forward any evidence, but may do so in supplementary evidence.

In the light of the continued negotiations with NHS Employers in England for new terms and conditions, and the impact that this may have on the devolved countries, we ask the Review Body to recommend that:

~ Salaries and allowances for all practitioners in the SPDCS are uplifted by 4.7 per cent for 2007/08 (this is in addition to the new terms and conditions to be implemented by 1 April 2007 in England).

# DENTAL PUBLIC HEALTH

4.1 For Primary Care Trusts (PCTs) to fulfil their responsibilities to commission appropriate local dental services they need specialist advice on both oral health needs and how local commissioning can appropriately meet these needs.

4.2 The reform to NHS dentistry has had a direct impact on the workload of Dental Public Health (DPH) staff. In the run up to implementation of the new NHS contract DPH staff worked with their Primary Care Trusts to help ensure a smooth transition into the new system. There was always a perception that the increased workload of DPH staff in the run-up to reforms would significantly ease after 1 April 2006, however, this was not the case. As a consequence, many DPH staff are finding it increasingly difficult to focus their efforts on pure dental public health initiatives and delivering the *Choosing Oral Health* agenda.

4.3 In our evidence to the Review Body last year, the BDA stated that there was anecdotal evidence indicating a national shortage of DPH staff, which was also identified in the January 2005 *Dental Public Health Workforce in England* status report. Preliminary findings from the *Dental Public Health Workforce in England* status report indicate that an increase in part-time working has resulted in an overall reduction of the dental public health workforce. Furthermore, almost half of the current Consultants in Dental Public Health (CsDPH) in England will retire in the next 10 years.

4.4 The final report of the *Dental Public Health Workforce in England* has, to date, not yet been published and this is leading to uncertainty about the future. However, the BDA looks forward to being a stakeholder in the Department's group that will take forward the recommendations of the workforce review. There is also growing concern about how the reorganisation of PCTs will impact upon the staffing and workload of DPH staff. Anecdotally, we know that some DPH staff are considering alternative careers within the dental profession. Losing DPH staff at a time where there is a national shortage cannot be in the interest of the public, and will only serve to further exacerbate the workload of DPH staff in post.

# 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 Last year the BDA expressed genuine concern that there were too few staff and too few incentives for dental clinical academics to remain in academia and to teach the increase in dental undergraduate numbers. We reported on the review of Clinical Academic staffing levels by the Council of Heads of Medical Schools (CHMS) and the Council of Heads and Deans of Dental Schools (CHDDS). This year's report was published in June 2006 and although there had been an increase in 2005 of just one per cent on the previous year, the report notes that this is still seven per cent lower than 2003. The BDA's view remains unchanged.

5.3 The recent NHS Walport initiative for clinical fellows and lecturers and also the HFCE initiative for senior lectures are welcomed. However, dentistry has remained the poor relation, very few (a total of nine clinical fellows and five lecturers) being awarded in our subject area.

5.4 The allocation of Programmed Activities (PAs) for dental clinical academics are a basic 10 PAs and only rarely 11 PAs, compared to their medical counterparts where allocations of up to 12 PAs are relatively common place. This lack of perceived parity is an effective deterrent to younger clinicians considering taking up a dental clinical academic career.

5.5 The BDA continue to be extremely concerned that the massive increase in student numbers, alongside the inconsistent implementation of the consultant contract, together with other factors such as the Research Assessment Exercise (RAE), will further compromise resources. These are already stretched to capacity, leaving 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.