



BRITISH DENTAL ASSOCIATION

**Written evidence to the
Review Body on Doctors' and Dentists'
Remuneration**

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Submitted for the thirty-eighth report 2009

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1. Executive summary

- 1.1 The British Dental Association is asking for a 5.3% net uplift to GDP remuneration. This is based on reported average increases in dental staff pay of 5.3% in 2008; we consider that GDPs should receive equivalent remunerative increases to their dental team members.
- 1.2 Other branches of dental practice should receive corresponding increases in order to maintain income relativities and not adversely affect movement of dentists between branches of dental practice.
- 1.3 In our evidence we highlight that GDPs are exposed to prevailing economic conditions more than other healthcare professionals and that this should be taken into account in determining the increase in uplift.
- 1.4 The Association draws the Review Body's attention to a number of high profile initiatives in dentistry over the past year including, in England, the House of Commons Health Select Committee report on NHS Dental Services; the 2008-9 NHS Operating Framework and the NHS Next Stage Review. In Wales a new National Oral Health Action Plan was launched and a "Task and Finish" Group considered dental contracts. Scotland has seen the completion of the Dental Action Plan 2005-8 but we remain concerned that there is a lack of clarity as to its real outputs. Colleagues in Northern Ireland are continuing negotiations on new contractual arrangements in the GDS.
- 1.5 We report on the high levels of student debt and the influence this appears to be having on career intentions; the low level of morale amongst vocational dental practitioners and the continuing difficulties in recruiting VDP trainers.
- 1.6 In the chapter concerning General Dental Practitioners we note that NHS income as a proportion of overall income remains in decline. Our survey of GDP business trends shows that recruitment is problematic for many practices and that administrative burdens have increased significantly. The 2006 contract is still having detrimental impact on the dental profession with its effects, for example regarding clawback, hitting the viability of continued NHS practice.
- 1.7 The picture for salaried primary dental care services (SPDCS), specifically regarding the new contract in England, is one of success. We urge the devolved

administrations to implement comparable arrangements at the earliest opportunity.

- 1.8 A 2008 BDA survey of Clinical Directors showed that recruitment was a problem for 62% of the UK SPDCS and that referrals to the service are increasing.
- 1.9 The Association reports on the position in dental public health in chapter six; these staff play a vital role in dental commissioning and it is crucial that their number is increased as the demands of local commissioning come to the fore in 2009.
- 1.10 Finally we offer comment on declining clinical academic staff numbers as this ultimately impacts on workforce supply.

2. General evidence

Parameters

2.1 The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for its thirty-eighth report covering the year 2009–10. 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 (NHS) in all four countries of the United Kingdom (UK) and covers:

- Dentists in training
- General Dental Services and Personal Dental Services
- Salaried Primary Dental Care Services
- Dental Public Health
- Academic institutions (i.e. Clinical Academic Staff).

2.2 The British Medical Association (BMA) will submit evidence on behalf of all hospital medical and dental 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.

Summary of recommendations

2.3 For the Review Body to recommend an increase of 5.3% in GDP net income. The 5.3% figure should apply to all staff groups in order to maintain the income relativities within the profession and not adversely impact on workforce numbers within each group.

Response to the review body's thirty-seventh report

- 2.4 The Review Body's recommendations remain vitally important to our members. Information from the National Association of Specialist Dental Accountants (NASDA) this year¹ suggested that NHS income in 2006/7 increased in line with the DDRB-recommended three per cent; this despite the vast changes taking place in dental contracting and commissioning in dental services across the UK, with greater challenges to come. Recommended increases are generally being reflected in dentists' incomes; although it should be noted that clawback of proportions of GDP contract values will affect income levels substantially for some.
- 2.5 The Association notes that the thirty-seventh report and its implemented recommendations recognised the principle, but not the full impact, of growing costs on maintaining a viable NHS dental practice.
- 2.6 The award of a gross 3.4% increase to general dental practitioners (GDPs), intended to deliver a 2.2% increase to levels of take-home pay has shown that the Review Body and the government acknowledge the real exposure of dentists to prevailing economic conditions - almost certainly more than that faced by other sections of the healthcare workforce. We hope that this recognition will be re-affirmed this year and prove instructive to deliberations in the light of the present economic downturn.
- 2.7 Notwithstanding this important and valuable recognition of principle in respect of costs and expenses, the implemented increase was nevertheless significantly short of the BDA's requested 7% increase and also below the increases in earnings experienced across the economy as a whole and increases specific to the public sector. For example, HM Treasury figures reported that earnings growth in the UK in the 12 months to April 2008 was 3.9%, with increases in public sector earnings averaging 4.1%. Assuming activity was unchanged, NHS dentists' earnings are not keeping pace with the wider labour market which is of some disappointment and concern.

¹ March 2008

- 2.8 Should this earnings gap widen, potential future NHS dentists are increasingly likely to explore alternative careers, either outside the NHS or outside dentistry.
- 2.9 Regarding the consideration of affordability in recommending pay awards we were pleased with the Review Body's comments on the Health Departments submissions that "when expenditure plans are presented to us, pay appears to be the residual after account has been taken of all other priorities". In this context, revenue from private practice, for independent contractors, has become vital to support practice business costs and facilitate the delivery by a motivated workforce of the ambitious initiatives set out by government for NHS dentistry.
- 2.10 Last year the Health Department in England reported to the Review Body a £100m investment in capital support for infrastructure / premises over 2006-8; we were pleased that the Review Body requested further information on this spend (paragraph 4.30 of the report) and look forward to seeing detail of the distribution from the Department in its submission this year.
- 2.11 The Association was pleased to note the Review Body's understanding and appreciation that the different national arrangements for salaried dentists are having an unwelcome effect on recruitment and retention. We share the concern and hope that the devolved nations will take on board these remarks, seeking a speedy implementation of an appropriate modernised contractual framework for this group.

The economic environment

- 2.12 As outlined in paragraph 2.6, we feel it is important for the Review Body to continue to acknowledge that GDPs, more than any other NHS health professionals, are beholden to the state of the wider economy, feeling the effects of a negative downturn most strongly through rising business costs set against their now fixed NHS incomes - the nGDS contract has removed the flexibility previously available to NHS GDPs to run their businesses accommodating such fluctuations. It is likely that any negative economic impact on private dentistry will also affect NHS services due to its cross subsidisation of NHS care - NHS dentists will suffer from lesser economies of scale.

2.13 The current difficulties facing the economy are well documented. Of most concern is the high level of prevailing inflation which has immediate effect on the overhead costs of running a dental surgery, such as staff wages, utility costs and practice maintenance costs.

Inflation

2.14 National statistics published in September showed inflation rates in the 12 months up to August 2008 of 4.7% in the Consumer Prices Index (CPI); 4.8% in the Retail Prices Index and 5.2% in the RPIX (which excludes mortgage payments). The significant causes of these increases were gas and electricity prices; consumer gas prices increased by some 27.7% year on year in August and electricity bills went up by 18% in the same period. We understand that in Northern Ireland our members are being affected by a 52% increase in electricity prices introduced between May and September 2008.

2.15 A further experimental measure that could prove to be informative, the Services Producer Price Index (SPPI), which covers business to business costs such as property rentals, is also on an upward trend, the 2008 Q2 figure being 3.8% up from 3.5% in the first quarter. For information, the BDA is presently carrying out work on the costs of practice where, amongst other things, it is hoped to establish a clearer picture of the numbers of dentists who rent their premises rather than buy, which then can be taken into account in future evidence. We already have data on the proportion of rented practices in Scotland from our January 2008 research, where 23% rent.

2.16 For those that rent their premises, we would highlight that it is usually a condition of the lease that rents, even in a time of economic downturn, are subject to upward-only review; and while the purchase price of property is falling in general terms, costs are still high, particularly for new entrants wanting to start up a new practice – the very group that needs to be encouraged in the promotion of dental access.

Interest rates

- 2.17 While the trend of the Bank of England base interest rate is downwards, from a high of 5.75% in July 2007 to the present rate of 5% in September 2008, the “credit crunch” has made the real price charged by banks for business loans higher due to reductions in banks’ liquidity; these are also less easy to obtain. Future investment in practices is likely to be influenced by these conditions.

Earnings growth

- 2.18 We have highlighted the disparity in earnings growth between the dental profession and the wider economy in our remarks on the Review Body’s 2008 report. Recurring recommendations of this nature will undoubtedly negatively affect morale in the short term, retention in the medium term and recruitment in the long term.
- 2.19 National Statistics reported on 13 August 2008 that the annual rate of growth in average earnings excluding bonuses was 3.7% in the three months to June 2008.
- 2.20 Earnings growth in the private sector has again outstripped the public sector. Incomes Data Services reported in July 2008 that the median pay rise in the private sector was 3.8% in the three months to the end of May 2008. Of the 168 pay awards effective in this period, 41% were at or above 4%. The public sector figure was 2.7% - a lower figure, but nonetheless still in excess of the 2.2% awarded to dentists last year.
- 2.21 The private sector pay analysis impacts on dentists in the wages they provide for their team members, who can be considered private sector for these purposes; for example, the pay increases given to dental nurses on average were 5.3% in the 12 months to March 2008 (BDA dental business trends data 2008), which is on a par with the average annual increase awarded between 2001-7 of 5.6% (BDA DCP pay survey), so the level of increase given to dentists in the previous round did not match the percentage growth of practice staff salaries, one of the contributing factors to the formula.

Dentistry in the UK 2007-8

- 2.22 Throughout the UK, dentistry has featured significantly in the healthcare debate over the last twelve months, reflecting the increased political priority afforded to it and particularly to delivering improved access.
- 2.23 As a general comment on access, before looking at each nation's work in this area, it is worth first defining what is meant by access. Without a workable definition, any investment provided to promote access could end up being woefully under-utilised. Is access merely an increase in numbers demanding NHS dentistry? Is it ensuring that those with an unmet clinical need are treated? We asked the English Health Department to define access in our submission to this year's Health Select Committee inquiry (see below). We still await the Department's views on a definition.

Contract overview

- 2.24 The new General Dental Services (nGDS) contract continues to impact on dentists in England and Wales and this is explored more in section four. Of specific note in Wales, a "Task and Finish Group Review" of the nGDS arrangements reported to the Minister on 11 July 2008 that the UDA as a sole outcome measure was inadequate" and that work is continuing on developing a basket of indicators.
- 2.25 Discussions continue on new GDS arrangements that will appropriately serve Northern Ireland; pilots are being agreed to run during 2009 for a 2010 implementation at the earliest.
- 2.26 In Scotland, additional expenditure was announced for the GDS last year but it is not at all clear what has been delivered by the government since. We would urge a clarification at the earliest opportunity.
- 2.27 The SPDCS contract in England has been successfully implemented and trusts in Wales are to implement shortly. In Scotland the salaried dental service is still awaiting the results of the Project Board set up by SGHD to provide recommendations on the amalgamation of the salaried GDS and the

Community Dental Service following the publication of the Taylor Report in 2006. Despite efforts by the BDA in Scotland and the Scottish Committee for Community and Public Health Dentistry (SCCPHD), no progress is being made at the Scottish Joint Negotiating Forum (SJNF) over improvements to terms and conditions, pay modernisation and assimilation of the new English SPDCS contract.

- 2.28 In light of the agreement to introduce a new contract for salaried primary care dentists in England and Wales, the BDA has opened discussions with the Northern Ireland DHSSPS to seek to reach agreement on a new contract for CDS dentists in the province. Initial discussions have been positive and it is hoped agreement can be reached for a possible introduction of new terms in 2009.

Registration of dental care professionals (DCPs)

- 2.29 All DCPs had to register with the General Dental Council in order to continue in practice this year. Despite concerns that the deadline of 31 July 2008 would not be met by many, it appears that the vast majority of dental team members have indeed registered.

- 2.30 The BDA estimates that in 2009-10 the fiscal impact of dental nurse registration and their associated continuing professional development (CPD) will be in the region of £25 million – this figure includes the cost of registration, plus the cost of attaining verifiable CPD, as well as the cost of providing locum nurse cover. The Association would assert that the majority of this ‘new staff expense’ is borne by the practice owner and we also wish to draw to the Review Body’s attention that the estimate presented does not include basic dental nurse training which can cost a practice as much as £1,500 per new dental nurse.

- 2.31 BDA research this year showed that 79% of respondent dentists with a substantial NHS commitment (i.e. 75% and over) were assuming some or all of the costs of DCP registration. Professional registration will put upward pressure on the salaries that DCPs, including agency staff, are able to command. The welcome requirement for DCP CPD will lead to “down time” in practices, which will affect dentists’ ability to reach contracted activity levels.

- 2.32 Whether directly linked to registration or not, in general dentists are giving their staff above-inflation pay increases of 5.6%, as highlighted above.

England

Health Select Committee inquiry

- 2.33 An inquiry into NHS dental services was conducted by the House of Commons Health Select Committee (HSC), reporting on 2 July 2008². The BDA was pleased that the report recognised the shortcomings of the 2006 nGDS arrangements in England and its detrimental impact on the profession.
- 2.34 There are several conclusions of the report that we feel are particularly important to the review body's deliberations, as follows:
- 2.35 The Select Committee noted the fears that many dentists will leave the NHS in 2009 and asked the Health Department to monitor closely the career plans of NHS dentists (paragraph 186). The BDA has worked to ascertain an evidence base on this matter and reports to the Review Body on the career plans of future dentists, according to our dental student survey (section three), and existing dentists from our 2008 research on business trends (section four, GDPs).
- 2.36 The Select Committee also noted the BDA's concerns that dental school graduates will choose not to practise in the GDS following graduation and recommended that the Health Department ensure that GDS dentistry remains an attractive career option (HSC paragraph 197).
- 2.37 The report observed that the recruitment of overseas dentists had enabled PCTs to replace much of the lost NHS dental capacity following the introduction of the contract (paragraph 198). The Association would comment that relying on overseas recruitment to address this problem is at best a short-term measure; we have evidence showing that some of the eastern European dentists that formed such a large proportion of overseas dental recruitment initiatives in 2005

² <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/28902.htm>

are already returning home because economies there are improving so dramatically; this has also been reported in the media.³

- 2.38 Finally in this overview, the Select Committee noted concerns that the 2006 GDS contract had transferred financial risk from the NHS to dentists (paragraph 203), as the traditional autonomy enjoyed by dentists in determining their business location, profile and revenue (including goodwill) has been eroded. The Association considers that the new contract could put many practices into a position of cash loss in light of an inflexible contract with increased risk but no guaranteed return on investment.
- 2.39 We comment further on the Select Committee's findings in the section on the GDP contract. We understand that the Department of Health will be responding to the Select Committee report by 7 October. The Association will be responding fully to the Select Committee report in due course, following the conclusion of a consultation process among our members.

Operating Framework and access initiatives

- 2.40 The Health Department's operating framework for 2008-9 raises the profile and priority afforded to dentistry within the sector and not least for this reason is welcomed. Further, it was pleasing to note the 11% global increase in proposed dental spend, allocated to PCTs (nine per cent of the total) and SHAs (two per cent) in order to promote access.
- 2.41 What is disappointing about this announcement is that the funding increases that were headlined as promoting access, it turned out, also had to fund the 2008 pay award. A projected allocation of 1.5% was allowed for this based on the increase requested by the Health Department in 2007-8. As the implemented award for general dental practice was 3.4%, the real sums available for access were significantly reduced. Further, we consider that the funding increase would have contributed to filling the reported shortfall in Patient Charge Revenue that remains an issue in many areas as reported in oral evidence to the HSC by PCTs. We have concerns about this apparent lack of transparency on funding at SHA and PCT levels relating to UDAs.

³ <http://www.guardian.co.uk/business/2008/aug/24/migrantworkers>

2.42 This illustrates a deficiency in the way the Health Department budgets; it seemingly has deliberately created a situation where any award that is made in excess of its submitted evidence negatively impacts on funds available for patient care, which we consider both puts the Review Body in an unenviable and difficult position and is grossly unfair on the profession, which is keen to deliver improvements to patient care but also needs to have regard to maintaining a viable NHS practice. Front line health professionals should not have to reconcile this conundrum.

2.43 As it is related to the preceding point on budgets, we comment here that our concerns about the nGDS contract framework imposed by the government similarly works against putting patients at the heart of all the NHS does. Responding to the 2007-8 end of year dental statistics published on 21 August 2008, Susie Sanderson, Chair of the BDA's Executive Board stated that:

"These reports provide further evidence of the persisting problems with the 2006 NHS dental reforms. More than a million people have now lost access to NHS dental care. Those that are able to access care are confronted with a system that discourages modern, preventive care by placing targets, rather than patients, at its heart. This is difficult for dentists, who want to focus on providing the best possible care for their patients".

2.44 It is regrettable that a recommendation on the pay award so directly and negatively impacts on the potential for service improvement and the quality agenda that features so prominently in the NHS Next Stage Review, which is to set the agenda for the next decade and relies heavily on the professions for its delivery.

NHS Next Stage Review

2.45 The NHS Next Stage Review was published by Lord Ara Darzi on 30 June 2008, entitled "High Quality Care for All"⁴. In addition to the main report, the Review comprised a number of work streams, the stream most pertinent to the Review Body's remit being that considering the future NHS workforce.

⁴ <http://www.ournhs.nhs.uk/> viewed on 22 August 2008.

- 2.46 The report of this education, training and workforce stream, “A High Quality Workforce”⁵, sets out guiding principles to shape an ambitious agenda, including new arrangements for workforce planning.
- 2.47 The core principles which inform the proposed agenda are listed as being:
- focused on quality
 - patient centred
 - clinically driven
 - flexible
 - valuing people
 - promoting lifelong learning
- 2.48 The Association notes that the present nGDS contract does not sit easily with supporting the realisation of these principles. Dentists’ work is currently target-driven and they remain on a treadmill; this has negative implications for patient care and dentists’ working lives.
- 2.49 The report outlines in paragraphs 103 to 125 new machinery for collecting and responding to information relating to the supply of, and demand for, the NHS dental workforce.
- 2.50 A new body, Medical Education England (MEE) and national professional advisory boards (to include dentistry), will be advised by a Centre of Excellence. The Centre will “develop technical planning assumptions...collate, synthesise and analyse SHA plans...provide an evidence based analytical function for workforce supply and demand modelling...[and] analyse labour market dynamics”.
- 2.51 The proposals are still at an early stage of development but there is clearly a wide gap between what presently exists and what is hoped for in the documentation. We would welcome clarification from the Health Department that resources will be made available to support this machinery effectively.

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840

Wales

- 2.52 A sub-group of the Welsh Assembly Government Task and Finish group which was established to examine the first year working of the 2006 contract has now made recommendations on the future role of the community dental service in Wales. This report is currently (September 2008) with the Minister awaiting her recommendations.
- 2.53 With regards to specific pay matters however, the Welsh Assembly Government has already agreed to implement the new SPDCS contract previously agreed and implemented in England (the SPDCS is called the Community Dental Service (CDS) in Wales). It has also agreed to backdate the pay award to June 2007.
- 2.54 In March 2008, a National Oral Health Action Plan for Wales was launched. The plan includes “the piloting of a child oral health improvement programme, and strengthening the CDS to focus on the delivery of fluoride supplementation programmes to improve care for children with chronic tooth decay”. Two pilot programmes are scheduled for September 2008.
- 2.55 It is understood that the Local Health Boards returned £8m revenue to the Welsh Assembly, plus clawback. Even though the budget is ring-fenced until 2012, the reorganisation of the LHB/NHS Trust infrastructure in Wales will have an impact on stability.

Scotland

Dental Action Plan 2005-8

- 2.56 The action plan has now completed its three year period. Most of the outlined objectives within it have been introduced, with the exception of allowing GDS support staff (nurses and other DCPs) to join the NHS pension scheme. We still await a breakdown of the actual expenditure within the GDS for any of the three years despite repeated requests. Therefore we can make no comment on how much has actually been achieved in real terms. The Scottish Government has committed to keep the level of expenditure at current levels.

2.57 Overall the picture in Scotland is one of confusion regarding what is actually happening on the ground. More money has been committed to the GDS, but due to the above we do not know how much has been delivered. On the expenditure side Scottish GPs are spending record amounts to meet the ever increasing decontamination requirements, considered in section four.

Northern Ireland

Primary Dental Care Strategy

2.58 In November 2006, the Department of Health Social Services and Public Safety published its Primary Dental Care Strategy for Northern Ireland. This Strategy together with Northern Ireland's Oral Health Strategy of June 2007 sets out the aims for primary dental care within Northern Ireland.

2.59 The intention is to meet those aims through negotiating a new contract for high street dentists in Northern Ireland and this work continues between BDA and DHSSPS with the aim of piloting new contract arrangements during 2009, prior to implementation from 2010 at the earliest.

2.60 Whilst progress on negotiating a new contract is positive and constructive, there is still a significant amount of time to elapse before the implementation of any new contract arrangements. During this time it is important that the morale of the profession is supported, to enable it to positively implement necessary changes to ways of working.

2.61 Already devolution has made some impact, with Minister engaging seriously with the profession and recognising that previous administrations had not done enough to address the drift of dentists away from the health service. However whilst new arrangements for health service dentistry in Northern Ireland are being developed there is a need for significant investment that places high quality patient care at its heart and develops the infrastructure to enable improved and expanded practice facilities to meet demand in underserved areas.

3. Dentists in training

Student debt and career intentions

- 3.1 BDA research shows that as of August 2008 the level of final year dental student debt is currently averaging £24 860. There has been a huge increase in the number of students with the highest debt since our last survey; those owing amounts over £36 000 increasing from 11% (2004) to 19% (2008).
- 3.2 Those with no debt exhibit a similar trend, the percentages with nil debt increasing from 11% to 18% over the same period. When the reasons for this were investigated, it could be seen that this group had a broadly comparable sum made available by the end of their course through parental contribution (£27,700). The two groups described, at the extremes of the distribution curve, represented the two largest single groups in the BDA's analysis.
- 3.3 It is unfortunate, especially in the light of universities' widening participation and access agendas, that parental contributions are so significant a factor supporting dental undergraduate education, the alternative being amassing a significant debt that impacts on students' career choices; we question whether this supports the achievement of a representative NHS workforce?
- 3.4 As debt levels get higher for more and more students, the future dental workforce, despite any desire they might have had to work in the health service, will either leave the profession or work in private dental practice in order to pay off their debt. Debt is increasingly influencing career choices and comments from our research illustrate this picture:
- *Search for career with higher salary in order to pay off debts quickly*
 - *I feel that if I acquire a large debt I may want to undertake more private work to clear the debt quickly*
 - *I will be more inclined to work privately as I am estimated to owe between 80 & 90 thousand pounds by the time I graduate, because this is my 2nd degree; if this amount was less I would work on an NHS contract.*

- *If I wasn't in great debt by the time I graduate, I would spend more time doing NHS dentistry then later in my life introduce private dentistry to my career but because of the high expenses I am not left with any other option.*
- *If my debt is too high I would be more likely to choose a higher paying job, so private instead of NHS practice.*
- *Paying off my debt is my first priority when I start my career so I can begin to look at widening my career options for the future*
- *More debt will encourage me to move towards private practice earlier in order to pay it off as quickly as possible.*

3.5 Dentists generally go into the private market to provide a higher quality service, to have more time available to give to patients and to have the ability to achieve an improved work life balance. It appears that debt levels are so concerning to this cohort that they want to work in the private market to clear their debts as soon as possible.

3.6 Only one respondent (from Scotland) commented that they would definitely work in wholly NHS practice and this was due to being in receipt of a Scottish bursary.

3.7 BDA research is backed up by a study in the European Journal of Dental Education⁶ which states that

Although they had not yet begun to work in the NHS, students were developing views on the government's handling of NHS dentistry. Many participants considered that the NHS was not providing sufficient remuneration to compensate for the commitment and hard work involved in training as a dentist. The support, funding and priority placed on dentistry by government was seen as a major influence in the students' considerations not to work for the NHS, with the evolving changes perceived as making the situation worse.

'Students were trying to make sense of what was happening to 'dentistry', and were at different stages in the process. Some were just becoming aware that there was significant change in the wider world, whilst others were identifying the need to protect themselves in the current context. The evolving changes to health policy

⁶ 1396-5883 - 'Understanding the motivation: a qualitative study of dental students' choice of professional career' - J.Gallagher, W Clarke and N Wilson - 19 November 2007 (published 2008)

and the system of remuneration for dentists were reportedly impacting on the vision of dentistry as a professional career for many students. Many stated that the uncertainty had made them unsure about what their future career would hold and about the availability of jobs and job security in the dental profession in the future.

3.8 The BDA is concerned not only about current levels of debt, but also that the publicly-funded resources required to train a dentist, which are not insignificant⁷, will be lost to the health service as it becomes unsustainable for young dentists to practise to any significant level in the NHS. Financial assistance to students in order to alleviate debt, such as extending the student bursary scheme is needed in the NHS to ensure that an appropriate workforce is recruited in the coming years. We consider that the Scottish Bursary Scheme is a good model to explore for roll out across the UK. We are also aware of a bursary scheme in North Wales; the success of this scheme however is qualified because graduating students are not offered VT places which has impact on their morale.

3.9 By way of a final comment in respect of dental undergraduates, we would commend to the Review Body a report by a number of health sector professional associations and trade unions, including the BDA, on the need to better support healthcare students, published in August 2008⁸, entitled "Student experience – the case for change". The report highlights, amongst other things, that healthcare student support falls short of Joseph Rowntree Foundation minimum guidelines on maintaining an adequate lifestyle and also recommends that medical and dental students should have access to the NHS bursary scheme for all years of their courses.

Vocational dental practitioners (VDPs)

Morale

3.10 The BDJ recently reported a survey of VDP morale (June 2008⁹). This survey of 862 VDPs (661 replies, response rate 76%) reports on morale and retention issues. The findings are instructive and a summary is detailed immediately below:

⁷ There will be approximately 778 students starting a five year BDS in September 2008, in England. The training cost of this cohort would be £107 million through the course of five years.

⁸ <http://www.bda.org/education/docs/StudentExperience-Thecaseforchangereport.pdf>

⁹ Gilmour, J. and Stewardson, D.A. "Morale of vocational dental practitioners in the United Kingdom"; British Dental Journal 2008; 204:E18, viewed online on 23 August 2008.

From the results of morale studies conducted in other fields, discontent among VDPs could result in a reduction in the quality of patient care, and lead to dentists leaving the NHS or perhaps leaving the profession entirely. At this time of major change within NHS dentistry, morale among dentists is of great importance.

The higher morale scores seen in this survey among Scottish and Northern Irish VDPs in comparison to their English and Welsh peers might reasonably be attributed to the introduction of the new contract in England and Wales.

It is rather worrying to find such low levels of morale among all the UK VDPs. Only in Scotland did the majority attain mean morale scores over 50% while in England and Wales a greater proportion had morale below 50%. The results presented here suggest that the NHS is viewed negatively by the next generation of English and Welsh dentists while Scottish VDPs generally responded more positively to all the statements than any of the other VDP groups.

The morale of VDPs in each of the four countries of the UK is lower than expected. All VDPs responded negatively regarding the effect of the NHS system on treatment and were concerned about future changes to the NHS.

- 3.11 This research on morale amongst VDPs is of concern to the Association, as, together with the student debt findings reported above, it shows a cumulative pressure building on dentists as they progress through their careers to seek more rewarding career alternatives either in the private sector or outside dentistry. The research findings highlight again the negative impact of the 2006 nGDS contract on the profession's morale.

Recruitment

- 3.12 The BDA repeated its regular survey of post-vocational training employment in 2008 and the findings show that issue of recruitment has not improved, with one in five reporting that they had not yet found a post – a figure comparable with previous research in 2006 and 2007. For those who had found a post, 67% had not stayed on at their training practice, despite 41% of this number wanting to do so. It should be noted that the opportunity for VDPs to remain in their training practice in England and Wales is determined by whether the PCT/LHB will grant growth funding, whereas in Scotland and Northern Ireland this remains the decision of the trainer; we consider therefore that the situation in England and Wales is likely to be comparably worse than elsewhere.
- 3.13 The problem of structural NHS unemployment reported to the Review Body last year remains true, i.e. that a dental graduate with commitments that tie them down to a particular area might not be able to secure a VT place and therefore would also be unable to provide NHS services as they are denied a performer

number made necessary under the nGDS contract in England and Wales. This is yet another “push factor” that forces young dentists away from the NHS and into the private market.

VDP Trainers

- 3.14 In its last report the Review Body asked for clarification as to whether the number of VDP trainers impacts on the recruitment of VDPs; we discuss this issue here as our findings suggest that it does.
- 3.15 For example, BDA research amongst GPs in Scotland from January 2008 confirmed that a key motivation for dentists in Scotland becoming VDP trainers was to assist with recruitment, as it was “a good method of finding good associates”.
- 3.16 The situation in England and Wales is more difficult however, as trainers need to secure growth funding from the PCT/LHB in order to keep VDPs in a practice, which is acting as a potential block on the recruitment of VDPs. In addition, as VDP funding is non-recurrent and many trainers are appointed for a one year period, those who might become trainers have insufficient incentive to replace an outgoing associate with a VDP as they would give up recurring funding from their contract value for non-recurring VDP funding. Furthermore, re-establishing the full contract value at a later date might be difficult if this original funding was being used to commission services elsewhere in the PCT area in the meantime.
- 3.17 The situation in Northern Ireland reflects the fact that there is an adequate supply of graduates coming through the dental school system, but a lack of practices coming forward to provide VDP training facilities, which is a significant barrier to recruitment of GPTs and VTs alike.
- 3.18 There is a need to increase the number of VDP trainers in line with the increase in dental graduates; the stated obstacles to recruitment of this group need to be removed.

Workload and remuneration

- 3.19 The results of our Scotland survey showed that many potential trainers were put off assuming the responsibility for VDP training, citing the high levels of bureaucracy, prohibitive workload levels in the practice and no space being available. The current trainer grant in Scotland is £12,972; we consider that this grant should be increased substantially in order to recognise appropriately the present workload demands of being a trainer.
- 3.20 More positively, there have been a number of changes made to components of the trainer grants in Northern Ireland this year with three additional allowances¹⁰ introduced to underpin delivery of high quality training. This is a welcome approach which has brought in approximately £12,000 on top of existing trainer and salary allowances but which, it should be acknowledged, has meant a significant increase in the workload of trainers in order to meet the eligibility requirements for these extra monies.
- 3.21 In England and Wales it remains less financially attractive to take on training responsibilities; the current payment for trainers is only £8,586 per annum. This comparatively low figure is having a significant impact on trainer morale and without a change for the better it is likely that the future supply of trainers will be compromised. Already we are aware of a major shortage of trainers in some areas leading to a “doubling up” with a trainer taking responsibility for more than one VDP and we are aware of one particular example where a trainer has four VDPs.
- 3.22 Trainers are currently having to spend much more time supervising VDPs both clinically and with administrative work, especially since the introduction of the new competency framework against which trainers are expected to sign off their VDPs; this is a significant additional responsibility and these extra commitments need to be recognised to make it more viable for trainers to take on a VDP.
- 3.23 To illustrate, trainers would normally provide weekly tutorials, formal assessments and review of portfolios, case-based discussion and clinical advice and assistance as necessary; they would also attend deanery study days and

¹⁰ A Quality Assurance Grant of £10220 was introduced, together with a Charter Mark (£1022) and a Postgraduate Qualification Award (also £1022). The basic trainer grant is £742 per month and there is a £2473 reimbursement of trainee salary also provided.

evening trainer meetings. The recent requirement for a formalised evidence-based assessment of VDPs against competency frameworks, taken on in addition to established workload, can be particularly onerous. For example, in the competency framework used in NW deanery there are 203 sub-competencies against which a VDP trainer needs to assess a trainee; the evidence that contributed to each assessment must also be noted. Taking and recording such evidence takes considerable additional time. This is all new work as assessment was until now “impressionistic” and recorded evidence was not required. Assessment is supposed to be robust with possibly more than one degree of assessment for each sub-competency; gaining this evidence is also time-consuming.

- 3.24 We believe that an increase in the trainer grant in England and Wales of some 25 – 30% would be justifiable in recognition of this increased workload.
- 3.25 An alternative approach to an increase in trainer grants which might also appropriately promote recruitment and retention is the award of a trainer’s educational allowance. This has been paid to GMP trainers in the past few years to reflect the extra commitment to CPD required of GP trainers. One of the criteria by which potential GDP trainers are judged is a high commitment to CPD. While there is no specific extra CPD requirement GDP trainers are unlikely to be appointed unless they can demonstrate a considerably higher commitment to CPD than the average.
- 3.26 We acknowledge that the Review Body would benefit from being provided with a clear quantifiable picture of changes in trainer workload to come to a decision on this issue and as such we propose to conduct a survey over the next year in order to report to the Review Body in the next round. We would be happy to investigate the possibility of conducting this research on a joint basis with the Health Departments.
- 3.27 As an interim measure we would ask that trainer grants in England and Wales are increased by at least 5.3% in line with our requested headline award.

Recommendations

- 3.28 That the Review Body recommends an increase to VDP salaries of 5.3%.
- 3.29 That the Review Body notes the national positions on grants to VDP trainers and recommends an increase in trainer grants in England and Wales by at least 5.3% pending the receipt of further research-based evidence next year.

4. General Dental Practitioners

UK-wide considerations

- 4.1 GDPs are being forced to re-balance their practice to protect their businesses, not least, for example, in light of capped NHS contract values and restrictions on goodwill.
- 4.2 NASDA figures reported in March 2008, covering the tax year 2006-7, show a continuing trend of declining NHS income as a proportion of overall income. The statistics were based on a sample of roughly 1000 dentists and showed the split of fees as follows:

	NHS	Private
Year ended March 2005	55%	45%
Year ended March 2006	48%	52%
Year ended March 2007	47%	53%

Overview of recruitment, retention and morale

- 4.3 A 2008 BDA survey asked specific questions of GDP practices across the UK concerning recruitment, retention and morale as pertained to the GDS as follows:

- Whether recruitment was a problem?
- Whether NHS commitment levels would be retained for at least the next three years?; and finally
- to provide a judgement on whether the morale of dentists in practices had changed over the last two years.

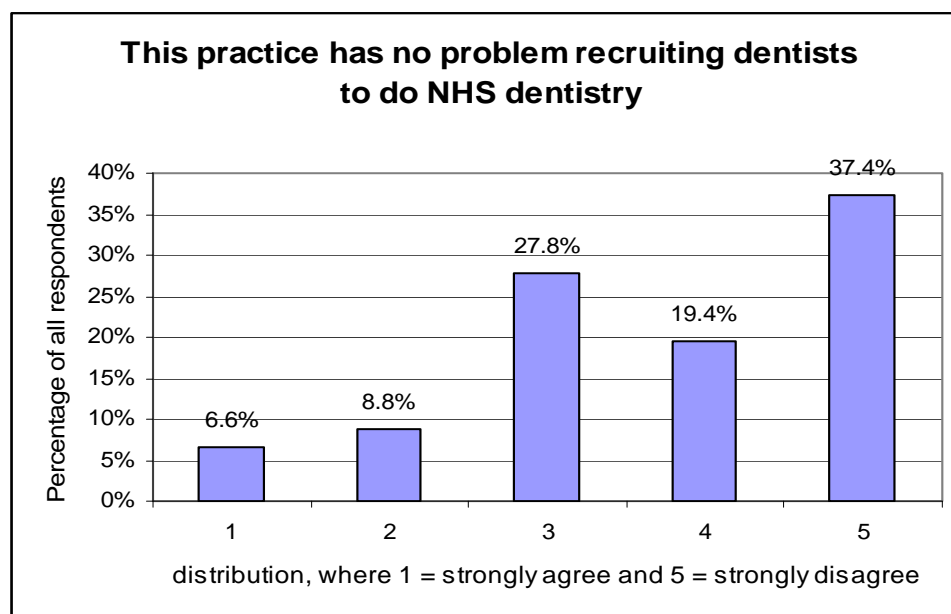
- 4.4 The findings were as follows:

Whether recruitment was a problem?

- Practices were asked to indicate on a scale of one to five how strongly they agreed or disagreed with the statement “The practice has no problem

recruiting dentists to do NHS dentistry”, where 1 = strongly agree and 5 = strongly disagree.

- 57% of all respondents gave a score of 4 or 5 to this question, suggesting recruitment of NHS dentists is a problem.



Whether NHS commitment levels would be retained for at least the next three years?

- Practices were asked to indicate on a scale of one to five how strongly they agreed or disagreed with the statement “My practice is expected to retain its current level of NHS commitment for at least the next three years”, where 1 = strongly agree and 5 = strongly disagree.
- 32.7% responded with a score of 4 or 5 to this question. In the light of NASDA data on the reduction in GDPs NHS income as a percentage of total income over time it can be inferred that this number expect their commitment to decrease. Further, BDA research showed that 32.3% of respondents reported that their NHS clinical work had reduced in the last two years. The trend is a downward one.

Whether the morale of practices’ dentists had changed over the last two years?

- Respondents were asked to rate on the same 1 – 5 scale whether the morale of the dentists within their practice had fallen in the last two years. 29.7% of

all respondents strongly agreed with this statement, rating it 1. The combined percentage rating for those answering 1 and 2 was 52.4%.

- There is a marked difference between the morale of those with a substantial NHS practice (greater than 75%) and those with a substantial private practice (0-24% NHS). The committed NHS practitioners strongly agreeing with the statement (scoring it 1) comprised 39.3% of their respondent group. Only 17.6% of those working in a substantial private practice felt that morale of dentists had declined.

BDA's 2008 Business Trends and Workload Survey

- 4.5 The BDA has conducted research among GDPs on aspects of their businesses in 2008, including the proportions of time given over to particular aspects of practice and the cost pressures experienced over the year.

Changes in practice

- 4.6 We asked practices to rate whether their NHS clinical work, private clinical work and administration levels had increased, decreased or stayed the same over the last two years. While the data is applicable to the UK, it is worth keeping in mind that an aim of the nGDS contract in England and Wales was to reduce the amount of time given over to administrative tasks and make the system simpler.
- 4.7 To make a comparison across the variables, we have taken the percentages of respondent practices reporting an increase in clinical work and administration and subtracted the percentage reporting a decrease across the same variables. A negative score reports a decrease in activity and a positive figure an increase. The results are as follows:

NHS clinical work:	- 9.2
Private clinical work	+ 40.8
Administration	+ 73.3

- 4.8 As well as showing a clear picture of increased administrative activity, there is also evidence of a retention problem in NHS dentistry, if not in headcount, then in proportions of activity given over to NHS clinical work.
- 4.9 We asked dentists to cite the main reason they considered to have contributed to this increase in administrative activity. The main reasons for the increases in administration were identified as being:

Administration associated with NHS dentistry	45%
Clinical governance – health and safety	18%
Other general business administration	18%
Clinical governance – decontamination and cross-infection control	12%

- 4.10 Where an increase to administrative activity was cited, we asked dentists what was the main impact this had on their practice? The most common reason cited was longer hours being worked outside of surgery time, quoted by a considerable 58% of respondents. The next most common reasons were increased pressure on the dental team (23%) and reduction in clinical time (9%). These statistics build up a picture of increased workload and stress. Furthermore, that the burden of administration displaces clinical care is not, we suggest, putting patients at the heart of the NHS.

Cost and expenses pressures

Comment on Information Centre expenses research

- 4.11 The Information Centre dental earnings and expenses information based on HMRC data collection for 2006-7 was published on 16 September 2008. We have not included extensive commentary on this report in this submission as we consider that while the data reported could be of use in future years, it is not comparable with previous years' data collection (i.e. before the 2006 contract), for example, the time series are different; also it is an unrepresentative period which incorporated the impact of a number of transitional arrangements, such as the method of orthodontics payment. We welcome the work being done and we are most likely to include reference to it in future submissions.

Staff

- 4.12 In earlier paragraphs we have quoted the mean increase in dental nurses pay, of 5.3% between April 2007 and March 2008. The business trends survey told us that those dentists working in a mixed practice gave a pay increase to their nurses of 5.87%. The mean increase over the same period for receptionists was 5.77% and for practice managers, 5.21%.
- 4.13 The BDA's specific survey of DCP pay done in late 2007 showed a particularly significant increase in the pay of self-employed hygienists in the period 2001-7, with an average per annum increase of 9%. The higher rates paid to this staff group could be explained by the increased number of hygienists in the private dental market. Self-employed hygienists working in predominantly private practices (less than 25% NHS income) made up 20% of our survey sample in 2001 but 55% in 2007. These trends show that NHS dentists are having to pay significantly higher rates of pay to compete in the recruitment and retention of hygienists.
- 4.14 Staff wages make up only part of staff costs. In our introductory paragraphs we highlighted that dentists were often assuming the costs of DCP registration and, thereafter, CPD. 70% of respondent practices paid the DCP registration fee in full and 57% of practices fully supported the costs of verifiable CPD.

Hepatitis B vaccinations

- 4.15 In Wales, the Welsh Assembly Government allocated £100k for the reimbursement of costs associated with hepatitis B vaccination for practice staff, but we understand that uptake has been low; there is no occupational health service for primary care and the working group that was looking at this has not met for some time.
- 4.16 In Northern Ireland only the 60 practices in one Board area out of the total of 361 practices in Northern Ireland are offered hepatitis B vaccination or any form of occupational health service to dentists and their staff. The remaining 301 practices all have to pay privately for staff to receive hepatitis B vaccinations and any other occupational health consultations. We understand that the level

of provision of occupational health services in Scotland varies by Health Board area.

Decontamination

- 4.17 The specific costs of implementing the decontamination agenda are investigated in this section. This issue concerns the installation of a dedicated Local Decontamination Unit (LDU) in premises to sterilise dental equipment, replacing previous centralised units that covered a number of practices in specific areas. The costs of installing LDUs will ultimately affect all UK practices, giving rise to new costs for equipment, infrastructure and maintenance. Scotland has been a forerunner in implementing the programme.
- 4.18 The BDA survey of GDPs in Scotland shows that 45% have installed an LDU. Our survey also shows that in the last three years 41% of practices have spent between £10,000 and £50,000 and 16% had spent over £150,000. This is capital expenditure only. What we do not have are figures for the revenue costs associated with this spend. Both the BDA/SDPC and the Scottish Government are gathering evidence of these increased costings.
- 4.19 The BDA Northern Ireland survey of dental practices of November 2007 showed that a minimum of 16% of practices do not have room at their current site to house a separate decontamination room and as a consequence will need to move premises at some point in the foreseeable future. Whilst some funding has been provided through Boards and the Department, the BDA believes that further discussions will need to take place to ensure that sufficient funding is made available to meet the future requirements of decontamination.

Waste disposal

- 4.20 On the related issue of waste disposal, we would highlight an additional cost pressure reported in Wales that the waste collections organised by FPCs / LHBs have ceased since the introduction of the new doctors contract, which shifts this cost burden onto dental practices.

4.21 In Scotland waste collection is now provided in all boards but only for fully committed practices so 30% either do not have it provided or have to pay the health board.

Pensions

4.22 Over the last three years the Review Body has given a net uplift and then recommended a gross uplift to deliver this net award for GDPs. However in each of the three years the Health Departments have chosen to use for dynamisation purposes the lowest of the award given, net or gross. This has resulted in the dynamisation factor being used on two years the net and in one the gross. Discussions with Health Departments have failed to resolve this. The BDA is taking appropriate advice on how to now proceed.

4.23 From 1 April 2008 changes to the NHS pensions have resulted in new dentist contributions levels. Up until this date all made a contribution of 6% of net or deemed net income. However since then there are four contribution rates (5% - 8.5%). The result is that the full time NHS GDS dentist that Health Departments refer to now makes a contribution of 8.5% of relevant income. This is a 40% rise in contribution or a 2.5% drop in net pay. The salaried service will also be paying more.

4.24 When the nGDS was brought into England and Wales the NHS commitment payments awarded by the DDRB several years ago were incorporated into contract values. These commitment payments were net payments and therefore superannuation was applied at 100% with no expense ratio applied. With the incorporation into the contract, the 56.1% expense ratio has been applied. This means that GDS dentists have lost the ability to pay this money into their pension. The chair of GDPC will be having discussions with the Health Departments to try and resolve this issue.

England and Wales

Access

- 4.25 The *NHS Dental Statistics, 2007-08 Annual Report* published by the NHS Information Centre on 21 August detailed a further decline in the number of patients able to access NHS dentistry in England in the previous 24 months, with more than one million fewer patients visiting an NHS dentist in the 24 months prior to 31 March 2008 compared to the 24 months prior to 31 March 2006. A similar picture was presented by the equivalent report of the Statistical Directorate of the Welsh Assembly Government.
- 4.26 To address this well-anticipated decline, on 6 August 2008 the Health Department in England announced increased levels of commissioning; commissioned UDAs for 2008-9 as at 30 June 2008 were 81 million, a 1.7% increase on 2007-8 levels (it should be noted that this announcement is regarding the intent of PCTs rather than delivered activity).
- 4.27 The Association welcomes genuine moves to improve patient access to dentistry. The BDA believes that any increase in commissioned work should clearly support effective improvements in access to high quality care based on need. It should be carried out with appropriate professional engagement and also ensure that the creation of a new access-driven “treadmill”, with its associated negative impact on morale, is avoided.
- 4.28 We next outline several factors pertaining to the Review Body’s remit which are a source of some anxiety in respect of increased commissioning.
- 4.29 Of some concern for recruitment and retention is the conclusion of the BDA’s own research, and also that of NASDA, which shows that additionally commissioned work is being undertaken by fewer dentists. For example, NASDA data analysis states that “we think that dentists who are committed to the service are picking up more work as other dentists leave the NHS. In summary there are fewer dentists doing more NHS work”.

- 4.30 BDA research done this year confirmed that dentists with an already substantial NHS commitment (75% or over) had increased their NHS clinical commitments; the survey showed also that of all those dentists increasing their NHS commitment, 45% had seen a decrease in their practice profitability.
- 4.31 Reliance on continuation of this trend to support the NHS dental service is ill-advised. The taking on of additional NHS work by fewer practitioners is unsustainable in light of long term workforce demographics reported to the review body last year (paragraphs 2.32 to 2.35 of the 2007 BDA submission¹¹).
- 4.32 Further, as outlined in the section on student debt, the return on government investment in dental education is not being realised if there is a large proportion of the potentially available dental workforce not providing services for the NHS.
- 4.33 If the additionally commissioned work is being done by fewer dentists, then it also follows that NHS dentistry is being carried out in fewer locations, impacting on the access agenda.
- 4.34 We consider that the above factors lend support to the BDA position that the nGDS arrangements do not provide appropriate incentives that will encourage greater numbers to work for the NHS. The contract works against recruitment, retention and morale. The contract is considered in more detail next.

The contract

- 4.35 Last year our evidence focused on how an untried and untested contract, based on a sole UDA measure, was offered to the profession on a “take-it-or-leave-it basis”.
- 4.36 As the Review Body will be aware, GPs are still subject to the transition period up to April 2009, at which time PCTs will take on more responsibility for commissioning and the income guarantee to dentists will be removed. This has created an atmosphere of uncertainty for many dentists. The action they might take in response, in order to protect their practices and careers, will only be truly known after at least two years of the post-2009 arrangements. Nonetheless, in

¹¹ BDA evidence 2007 - <http://www.bda.org/about/docs/Final%20BDA%20evidence%20to%20DDRB%202008-09.pdf>

the context of the continued drift to private practice already reported, it is clear that the new contract does not offer a supportive environment to practice high quality and viable NHS dentistry.

- 4.37 The government's own review of the contract after one year acknowledged that access had not increased, and that many dentists had been lost to the NHS – around 500 on the Department's reckoning, but on our estimates, 1000 was presented as a truer figure.
- 4.38 The Association reported that the contract had failed to deliver its intended benefits – including freeing up time for dentists to spend more time with their patients, reduce their workloads and remove them from the drill and fill treadmill. Our analysis conducted earlier in 2008 continued to show that administrative burdens were increasing rather than going down, described in paragraph 4.7.
- 4.39 This year, as introduced in section two, the House of Commons Health Select Committee conducted an inquiry into NHS Dental Services.

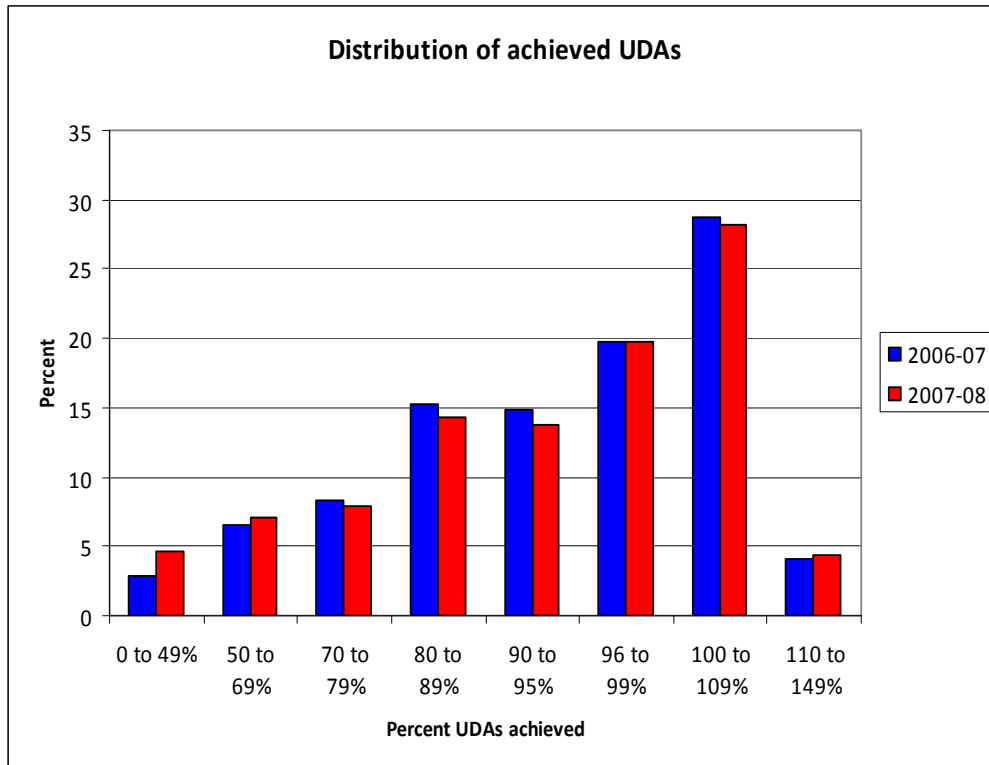
Health Select Committee findings

- 4.40 The Health Select Committee, on the weight of evidence presented by a range of stakeholders, came down significantly in favour of the arguments put by the BDA on behalf of the profession. In considering the contract, the Select Committee reported that:
- The contract has so far failed to improve access;
 - Some PCTs don't have sufficient commissioning expertise [for example a lack of Consultants in Dental Public Health];
 - UDAs are unpopular and were untested;
 - There was a need for professional expertise and engagement in commissioning;
 - More incentives to support preventive care are necessary;
 - The Health Department should publish an analysis of its five year plan, covering what level of services are required, including how many dentists will be needed.

- 4.41 That the Select Committee agreed with much of the BDA's analysis is welcome, and a useful steer from an independent body on the real state of NHS dentistry.
- 4.42 The Select Committee expressed surprise at the Department's contention that there was an evidence base for simpler courses of treatment. The Information Centre's report on Treatment Band Analysis showed a continuation of this trend. Dentists are performing in line with Department expectations.

Freedom of Information request on 2007-8 contract performance

- 4.43 We have received data from NHSBA DSD on contract performance for 2007-8. The information shows that there is a similar picture this year as there was last year of those not meeting their targets. We would have expected this figure to decrease, but it is obviously still the case that the negative impact of the new contract is still being felt by many.
- 4.44 Results from a dataset that has had outliers removed shows that in 2007-08, 48 per cent of NHS contracts did not achieve the minimum 96 per cent UDA target – this percentage is identical to that in 2006-07. The average percentage of UDAs achieved across all contracts in 2007-08 is 90 per cent – i.e. on average each contract missed the 96 per cent UDA target by six percentage point. This mean figure is lower than the 92 per cent recorded in 2006-07. Furthermore, the distribution of achieved UDAs in 2006-07 and 2007-08 (see graph below) has remained remarkably similar in both years.

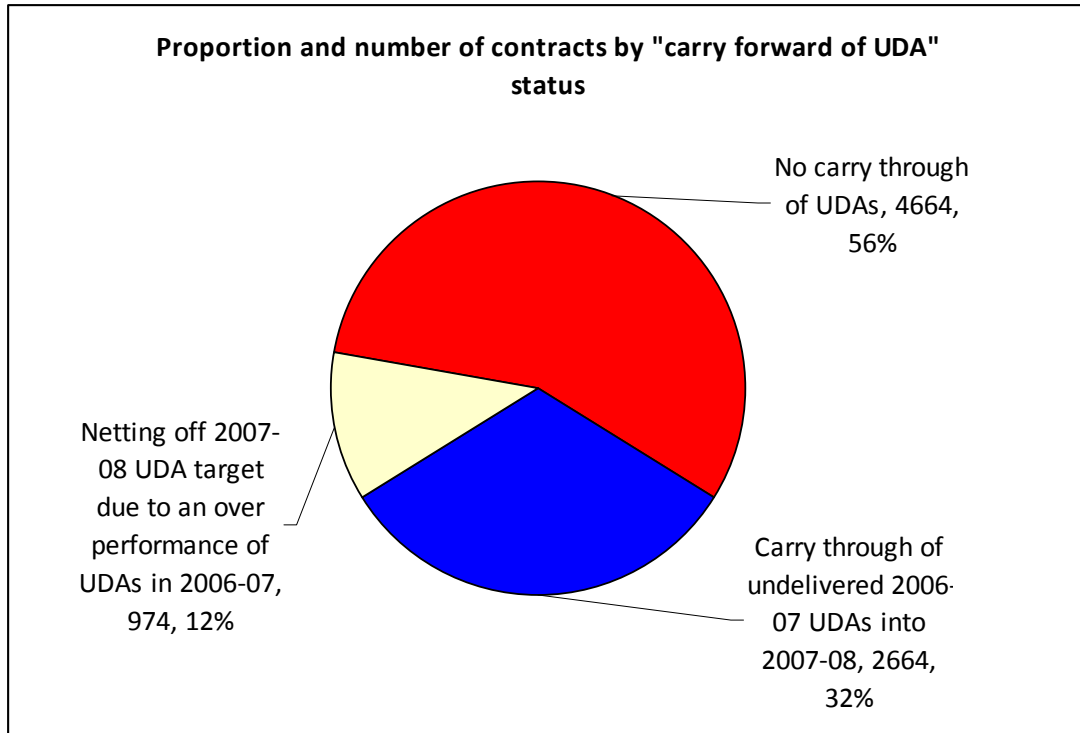


4.45 Last year we reported on the varied PCT responses to UDA targets being missed, which can be summarised as:

- (i) Carrying over unmet UDA targets to the following year. This adds to dentists' workload in following years, impacting on morale;
- (ii) Implementing financial penalties for not meeting UDA targets – funds are “clawed back”. This option negatively affects practice viability and retention.

4.46 For those who had their missed UDAs carried over, their workload this year has of course increased, making it difficult to reach their annual target and reducing morale on the new UDA treadmill. The complete picture of performance against targets is presented below.

4.47 In 2007-08 there were 4,664 (or 56 per cent) contracts that did not have any UDAs carried through from the previous year, 2,664 (or 32 per cent) contracts that had UDAs carried over from 2006-07, and 974 (or 12 per cent) contracts had an over performance from 2006-07 netted off their 2007-08 UDA target – see pie chart following.



- 4.48 Unsurprisingly, contracts that had a carry through of non-delivered UDAs from 2006-07 into the next year were less likely to have achieved their UDA target in 2007-08 – 59 per cent of these contracts did not achieve their 2007-08 UDA target and delivered on average 89 per cent of their UDA target for 2007-08.
- 4.49 The issue of proportions of dentists' contract values being "clawed back" for not delivering the stated number of UDAs impacted hugely on the profession last year, with some being forced out of practice. That broad performance has remained consistent over years one and two of the contract means that many will experience threats to their business viability again this year.
- 4.50 It is a disappointing feature of the new contract that dentists are punished for missing a UDA target through clawback, but are not recognised or rewarded for exceeding any target set, so the costs of improving access (improved access being the only reasonable way to describe "over-performance") are borne by the dentist personally.
- 4.51 This year we received reports from members that PCTs were adopting different views on how they handled issues of financial penalty or clawback. On the positive side we understand that some PCTs are not claiming back monies at all, and a small number are taking account of the fixed costs that a dentist

incurs over the year irrespective of the levels of activity achieved. These approaches are welcome. Recognition of the fixed costs of dentistry is a particularly enlightened approach that will assist dentists in their business continuity and ability to provide NHS services.

The real impact of claw back on remuneration, retention and morale

- 4.52 Although NASDA information indicates that NHS income in 2006-07 increased in line with the DDRB recommended three per cent the Association believes that the continued effect of claw back will erode the impact of this and subsequent DDRB recommendations. Anecdotally, some Primary Care Trusts and Local Health Boards are slow to implement contractual claw back therefore in many instances post new contract data relating to turnover, income and output (i.e. UDAs) may be revised (downwards) over time.
- 4.53 Furthermore, many Primary Care Trusts and Local Health Boards are clawing back on the gross contract value irrespective of the fact that the vast majority of the fixed running costs of a practice need to be paid for regardless of underperformance and that dental expense inflation is at a rate above the DDRB recommendations. For example, the 2007-08 DDRB recommendation of a 3.4 per cent uplift on contract values which would result in a 2.2 per cent increase in net income explicitly assumes dental expense inflation of 4.5 per cent – this therefore implies that a one percent claw back on the gross contract value will result in a 2.4 per cent decrease in net income. Although the BDA does not have figures on the number of dental practices that have suffered claw back in 2006-07 or 2007-08, information from the Dental Services Division shows that almost half of all NHS contracts in England and Wales did not achieve their UDA target in 2007-08 – putting this another way almost half of all practices in England and Wales may potentially face claw back in 2008-09.
- 4.54 The effect of claw back is to destabilise the dental practice by introducing a further element of uncertainty in business planning. Financial penalties, in essence, require the delivery of the same number of UDAs in the subsequent year for a reduced income stream – driving down the UDA value in the next period. Thus a dental practice is faced with a decreasing real UDA value, even

though the expenses required to complete their UDA requirement will rise. This makes it even more difficult to fulfil their NHS requirement in the subsequent period without jeopardising the financial viability of their practice. Thus, a vicious cycle can be established.

Examples

A single-handed dentist in the east Midlands has a contract for 8,000 UDAs. The contract value and UDA target were given to him in 2006 when he brought the practice from a part-time dentist. The PCT gave him the target with no discussion and said that 8,000 for one dentist was an average and reasonable amount. The dentist was unable to meet the target in the first year being short by about 1,000 units. The same thing happened in 07-08 despite the dentist working very hard with extended hours. The PCT is now wanting to clawback about £40,000 in six months and is cutting the contract amount. The dentist is in agreement that his contract amount and UDA amount needs to be reduced to an amount he can achieve but if he has to pay the clawback and the additional amount he has been overpaid this financial year, his financial position will be very difficult. He is looking very seriously at selling the practice because the situation is not one in which he wishes to continue to work.

A PCT in the south east wants to clawback £30k from a dentist for 2007-8 when he only achieved 90 per cent of the target; he had lots of laboratory work to come through over the April deadline which was the reason for the shortfall. The member told us that he was providing a good service and sticking to the regulations. He will be put into a very difficult financial position if the money has to be paid back at £10,000 per month and was very worried. The issue was compounded by the fact that he was going on holiday the day after he received the letter and there was no-one at the PCT that he was able to speak to.

Underspends and under-commissioning

- 4.55 Of some significant concern are reports that there have been underspends on the dental budget in Wales. In 2006-7 £6.58 million was returned to the Welsh Assembly Government by Local Health Boards from a total budget of £130 million including patient charges. In 2007-8 the return was almost £2 million. Further, at least one LHB has acknowledged that dental services have been under-commissioned in order to anticipate any shortfalls in patient charge revenue.
- 4.56 We are also aware that funding allocated to dentistry in England did not reach its intended target this year, not least because of the long lead-in times that PCTs need to set up and start delivering projects - this means that many will

only become effective in 2009, rather than 2008, and money has been lost to the service this year.

Depreciation under the new contract

- 4.57 Before the new contract, investment in equipment and budgeting for depreciation was also straightforward. Typically a practice might depreciate on a ten year straight-line basis, in line with accounting conventions, as there was nothing to imply that the contract would not continue over the medium or even long term.
- 4.58 With the inception of the new contract in England and Wales, this certainty has been removed. The corollary is that in order to reflect related costs, the practice must budget for depreciation of the same assets over a much shorter period, with three years being a much more realistic proposition than ten.

Inconsistency with the prevailing government agenda

- 4.59 In the outline of the NHS Next Stage Review, we noted that the nGDS contract appears inconsistent with the principles of the “Darzi” Review. It is extremely peculiar that the government remains wedded to a target-based system that works against patients and the profession. It is difficult to see how dentists can easily deliver Lord Darzi’s vision when they are restricted in what they can achieve by a treadmill-based contract.

The true costs of 21st century dentistry

- 4.60 The BDA recently revised its values statement in respect of dental practice, coincidentally in the weeks before the Darzi Review reported. There is much similarity in the vision. The BDA statement is as follows:

2008 BDA Values Statement on Dental Practice

- *The principal role of dentists is to promote the health and well-being of their patients.*
- *The BDA supports the principle of comprehensive dental services available to all.*
- *The BDA will work to create an environment where the patient-practitioner relationship is central to service planning and delivery and is properly supported.*

- *The BDA believes that the following principles and standards should apply:*

- *A high standard of patient-focused care and a high quality patient experience*
- *An open and communicative attitude towards patients and colleagues*
- *A preventive approach to oral health*
- *A positive approach to continuing education and professional development*
- *A service free from adverse financial pressures and with reasonable workload*
- *Proper engagement with the dental team*
- *Appropriate engagement with other members of the health and social care workforce*
- *An appropriate environment supporting the above.*

4.61 The UDA system as presently constituted does not reflect the true costs of providing a patient-centred quality dental service, which include the costs such as set-up, maintenance, staff, capital, but also the time costs of fully involving patients in their care, communication with patients, taking a medical history, explaining care options to patients and helping them make an informed choice on what treatment they want, and the costs of cross-infection control. These are the costs of modern dentistry that the NHS Next Stage Review asks for, but the contract prevents.

Northern Ireland

4.62 In late 2007 the BDA carried out research amongst GPs in Northern Ireland on practice costs. The findings of most direct interest to the Review Body are the views of the profession on continued practice viability; it was felt that poor NHS fees and the historical under-funding of dentistry was the biggest current threat to practices. This has left dentists in Northern Ireland with little choice other than to change the balance of their practice towards more private work, best illustrated by the finding that in 2010 the average proportion of practice income from health service work is anticipated to be 57%, down from 79% in 2006.

4.63 Measures can be put in place to stem the continued drift of dentists to the private sector. For example, the practice allowance provides a welcome means of contributing to the costs of running a dental practice. However, the criteria used are crude and could be refined to more fairly reflect health service commitment. Worryingly, and as a consequence of the flawed eligibility criteria,

the BDA is now seeing some practices withdrawing from the health service in their entirety or closing altogether.

4.64 As noted above, negotiations are continuing on the development of contracting pilots in 2009 for possible implementation in 2010 at the very earliest.

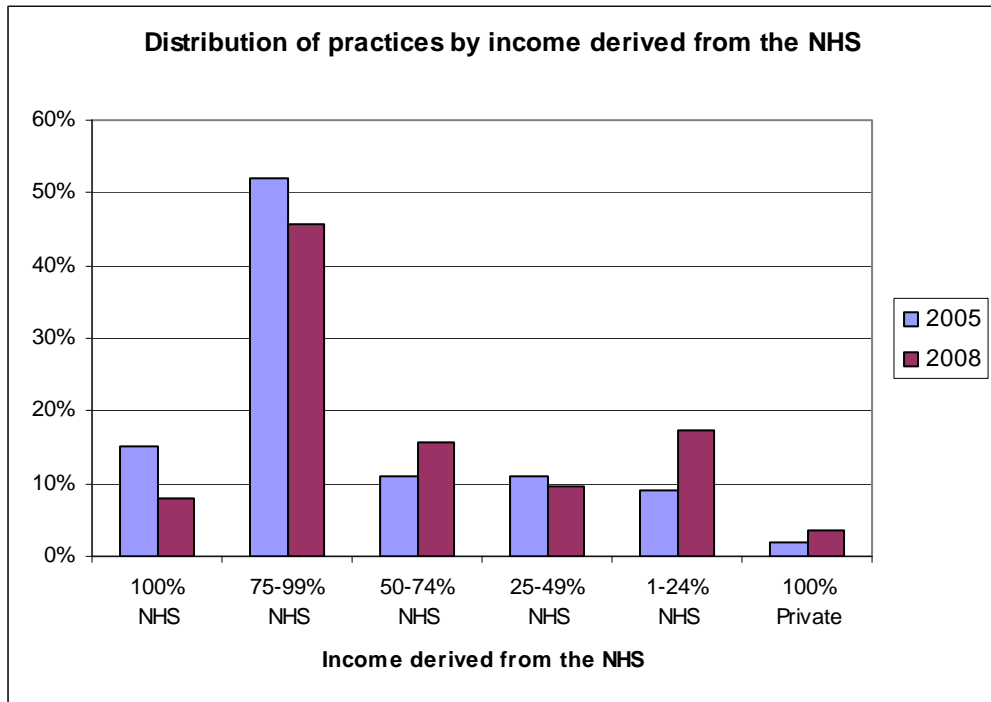
4.65 During the April 2007 to April 2008 period £7.9 million has been applied to Health Service dentistry in Northern Ireland. The funding measures, whilst welcome, have not been sufficient to achieve the Minister's aim of addressing directly the problems of gaps in provision and significant additional new investment continues to be required to enable practices to afford to invest in existing or new infrastructures for health service dentistry.

Scotland

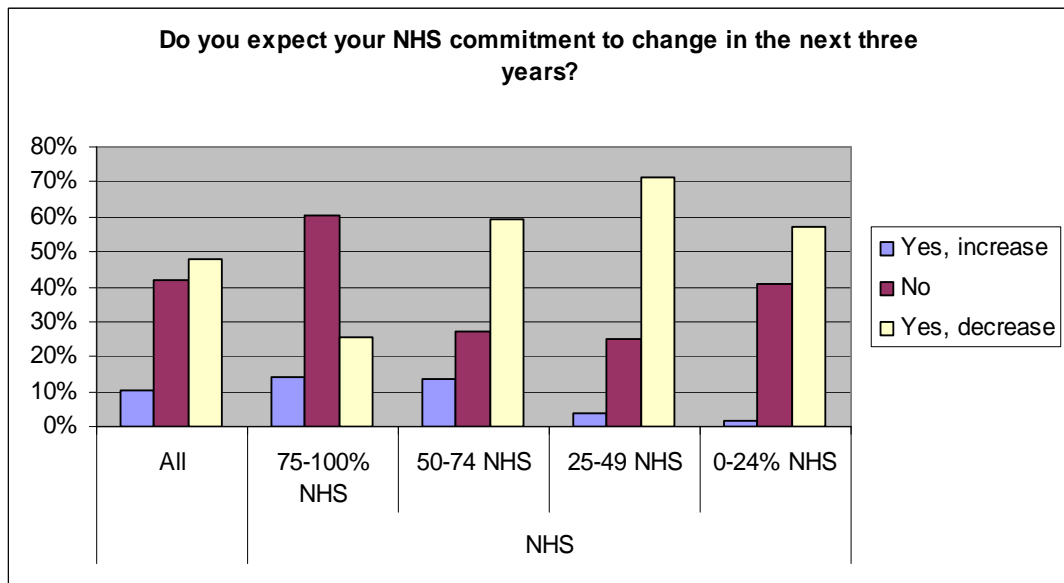
Survey of GDPs in Scotland 2008

4.66 BDA research amongst GDPs in Scotland completed in January 2008 repeated our research from 2005 in order to gain a longitudinal picture of NHS dentistry in Scotland and a clear idea of the situation in respect of recruitment, retention and morale. The main findings are as follows.

4.67 Since 2005 there has been a reduction in reliance on NHS income to make up the total remunerative package. There were fewer practices with 100% or 75-99% of income in 2008. The number of practices earning 100% income from the NHS went from 15% in 2005 to 8% in 2008. The number of practices earning 75-99% from the NHS reduced from 52% to 46%. There were increases in the number of practices earning 50-74% income from the NHS (from 11 to 16%), and the biggest increase was in the number of practices earning 1-24% of their income from the NHS which rose from 9% in 2005 to 17% in 2008.



4.68 48% of respondents in 2008 reported that they expected their commitment to the NHS to decline over the next three years.



Fees and allowances

NHS Committed practices

4.69 This new and overly restrictive definition of a committed practice implemented in 2005 resulted in approximately 30% of NHS GDS practices not qualifying for

newly available money. An agreement was reached in May 2008 with the Scottish government which should allow some of these practices to qualify for some of the money. However we still await its implementation and to date there has been no change in those accessing the funds.

Deprived Area Allowances

4.70 These were introduced in year 2006-7 and due to the inability of the then Scottish Executive Health Department to have them in place, a one-off solution was implemented. This resulted in over 305 individual GDPs receiving up to £9,000. This has been replaced with a new fee enhancement which is patient based and means that all practitioners receive a variable amount dependent on patient post codes. This change has meant a considerable drop in payments to the previous receivers. Also with the figure now present there has been a 29% drop in the total amount paid in the previous year.

Rent Allowance

4.71 This has been introduced and is in place for those committed practices. It is based on net internal area.

Premises

4.72 With the December 2009 deadline to have an LDU in place approaching, our survey shows approximately 255 practices have no room for an LDU and more can only accommodate one with the loss of surgery area. This is a major concern for these practices, their staff and patients as the future. SDPC is working with SGHD to meet this issue.

4.73 The SGHD recently announced primary care premises funding of £75m over two years for Dentists, Doctors and Pharmacists. While GDS practices were mentioned as a priority we still await the detail and the conditions that will apply. The actual announcement states that bids have to be submitted and agreed with NHS Boards by 6 October 2008, a seemingly impossible timetable. SDPC has taken up this proposed date in discussion with SGHD and as a result the date has been put back to 27th October - still a tight deadline. Within the annex the SGHD set out their target of ten practices and 60 actual surgeries within these practices. This is less than one per HB in Scotland.

Care Commission

4.74 We have ongoing concerns about the costs needed to achieve proposed levels of compliance and to meet the governance requirements.

Out Of Hours Services

4.75 This is a terms of service requirement no longer applicable in England and Wales. We would seek an increase over the level of the rate of inflation to compensate for anti social hours, weekends and public holidays including Christmas and New Year.

Conclusion

4.76 As there is still confusion on exactly what has been spent, what the future revenue costing will be for the GDS in Scotland, we would seek an above inflation increase. To achieve this with funding equivalent to the salaried service we would require increases in overall funding to four times the existing amount.

Recommendation

4.77 The Association recommends that GDP net pay is increased by 5.3%. This figure is based on the need to award GDPs a pay increase at least equivalent to that of their dental team members.

4.78 As reported above, the BDA Dental Business Trends Survey 2008 indicates that in 2007-08 dental nurse pay rose by 5.3 per cent and we are using this figure as the basis of our claim.

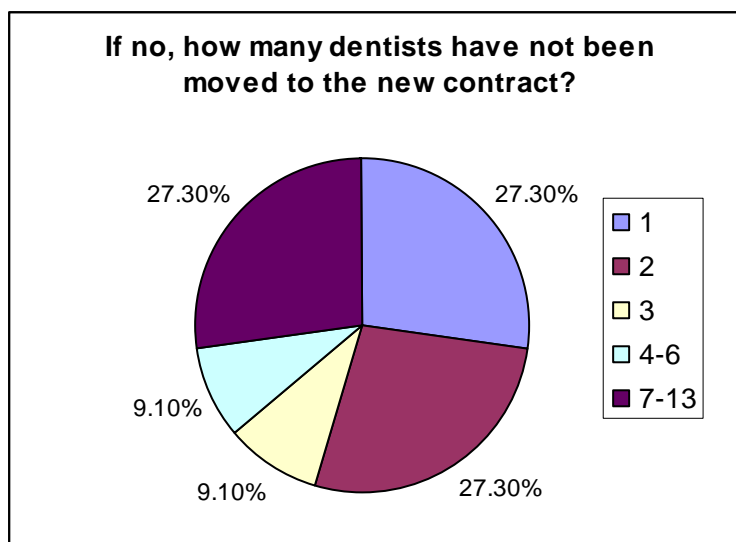
5. Salaried Primary Dental Care Services

The new contract update and negotiating arrangements

- 5.1 The SPDCS contract in England can be regarded as a success story. The Association hopes that comparable, fully funded, equivalent arrangements will be implemented shortly so as to not unnecessarily distort the recruitment and retention picture across the UK.

England

- 5.2 In England the new proposals for a SPDCS contract were accepted overwhelmingly by the profession in November 2007 and the contract was implemented from 8 January 2008 onwards. A number of events hosted by Primary Care Contracting were held across England in order to assist implementation.
- 5.3 By July 2008 a BDA survey of Clinical Directors had ascertained that 78% of PCTs had transferred all their dentists to the new arrangements. The 22% that hadn't achieved a full transfer of staff reported that this was largely due to delays in the payroll or other PCT systems that were expected to be resolved shortly, or in a small number of cases because of SPDCS dentists choosing to stay on local contractual arrangements. A number of other minor reasons were given. The numbers not transferring are small – for the 22% of services where not all had transferred, the breakdown of numbers of dentists involved was as follows:



5.4 In the survey it was reported that 73% of PCTs had provided back pay. As far as we can establish, the position as at August 2008 is that all services in England have now provided back pay.

Complexity

5.5 Part of the new contract was a determination of the complexity of the service by the PCT; if the service was deemed medium or high rather than standard, dentists in clinical director posts could progress further up the scale.

5.6 Of the services that had an agreed complexity level, 6% were standard, 49% medium and 46% high. Of the services that had not an agreed complexity level, only 6 services anticipated problems in doing so. This outcome clearly shows the complex and challenging nature of clinically leading the majority of SPDCS services.

5.7 The BDA met with NHS Employers (NHSE) on 18 August to talk about DH plans to transfer the Joint Negotiating Forum arrangements for SPDCS in England to NHSE later this year. The BDA welcomes this move and look forward to working in partnership with NHSE over issues relating to maintenance of the new contract in England. We hope that this forum will include representatives from the other countries. A final meeting of the JNF with DH is scheduled to be held on 6 October 2008.

Wales

- 5.8 The new contract was issued to NHS Trusts in Wales on 1 May 2008. As we understand the position in September 2008 we are aware that all NHS Trusts in Wales are working to implement the contract but most Trusts have only been able to apply changes to pay rates going forward; back payments remain outstanding in all NHS Trusts.
- 5.9 In August 2008 the BDA held a learning event for BDA accredited representatives (ARs) and clinical directors in Wales. The aim was to help managers and staff to understand the main elements of the contract and to facilitate its implementation. Unlike England, the Welsh Assembly Government chose not to hold such events.

Scotland

- 5.10 There is now an element of confusion within the SDS in Scotland resulting from recommendations of the Scottish Executive's Review of the Primary Care Salaried Dental Services in Scotland, published on 1 October 2004. The review, now known as the Taylor Report, recommended integration of the salaried GDS and the Community Dental Service; the date for this integration having now slipped from 1 April 2008 to 1 April 2009. The SGHD has been unable to provide any update on progress resulting from the Project Board set up to give recommendations on the integration. This Project Board reported to SGHD at the end of December 2007. The negative effect on morale and recruitment within the salaried service is becoming more obvious as April 2009 beckons.
- 5.11 The BDA/SCCPHD is encouraged by the results of the negotiations between the NHS Employers in England, the Department of Health and the BDA that produced the new English SDS contract. However, Scottish JNF is not making any progress with SGHD over terms and conditions of the SDS in Scotland. Indeed the SDS is now one of the last groups of NHS staff to be involved in pay modernisation, the existing terms and conditions dating from 1986. Attempts to

negotiate a Scottish version of the new English contract have not made any progress. This has resulted in pay differentials now existing between England and Scotland covering all grades of staff.

Northern Ireland

5.12 As stated in our overview of contracts in earlier paragraphs, in light of the agreement to introduce a new contract for salaried primary care dentists in England and Wales, the BDA has opened discussions with the Northern Ireland DHSSPS to seek to reach agreement on a new contract for CDS dentists in the province. Initial discussions have been positive and it is hoped agreement can be reached for a possible introduction of new terms in 2009.

Survey of clinical directors 2008

5.13 The BDA conducted research amongst UK clinical directors of the SPDCS, reporting in July 2008 on recruitment and retention, workload issues and implementation of the new SPDCS contract in England. An overall response rate of 53% was achieved and the results are presented in support of our evidence, herewith.

Recruitment and retention

5.14 62% of the UK service reported difficulty in recruiting dentists. Particular difficulties were experienced in SPDCS areas serving treated patient populations in the range 5001 – 15000 (2007-8), where the corresponding figure was 68%. In 11 services, posts have been frozen.

5.15 Over a third of clinical directors, 36%, reported losing clinicians to the GDS, PDS or private practice.

5.16 We are aware that recruitment in Scotland is again proving so difficult that SGHD is pursuing once more a recruitment process for dentists from Poland.

Workload and referrals

5.17 The majority of clinical directors reported an increase in referrals for children, patients with special needs, patients for sedation, domiciliary visits, and other patients since April 2007. Increases in referral numbers were most common with patients for sedation (83% had seen an increase) and domiciliary visits (81% had seen an increase).

5.18 Clinical directors who had experienced increased referrals were asked how these increases had impacted on waiting times for general and specialist services and on overall patient numbers. The majority of clinical directors with increased referrals reported that waiting times had increased for both general services (65%) and for specialist services (80%). Seventy-three percent of these clinical directors felt that overall patient numbers had increased as a result of increased referrals.

5.19 A commonly stated reason for increased referrals was a lack of availability of GDS services in the area, and specifically a lack of GDPs who provide domiciliary visits, for example:

- Limited availability of NHS care from independent GDPs has led to a very large demand on our service across the board

- Massive increase in number of domicilaries as the general dentists in the area no longer provide house calls

5.20 Many of the clinical directors felt that increased awareness or publicity of the salaried services had also contributed to the increase. A significant number also mentioned that dentists who qualified abroad or were newly trained appear to refer more because they may be still acquiring the range of skills required to treat more difficult cases.

Recommendation

5.21 SPDCS dentists should receive the same rise in income as other dentists working in primary care to reflect the recent increase in workload and also the

more complex nature of the patients treated. Recruitment is still difficult despite the new contract and services are still operating at staffing levels below those required to see patients within the desirable timescale.

- 5.22 We recommend that the salaried primary dental care services receive a 5.3% pay increase to retain comparability with dentists in other branches of practice.

6. Dental Public Health

Capacity and Capability

- 6.1 Last year the BDA reported in evidence on its involvement in the Department of Health's Dental Public Health Capacity and Capability Project. In March 2008, we used our networks to try to assist the Department in getting a higher response rate to their survey. Several months on it is extremely disappointing that (*at the time of writing*) a report that was promised in May 2007 for the end of that year has still not been produced.

New workload pressures from local commissioning

- 6.2 We previously reported the role CDPHs play in commissioning dental services and planning of local health strategies. Their workload continues to increase significantly with the continued move towards true commissioning and the devolution of the primary care dental budget, together with the inclusion of commissioning of secondary care, in addition to practice based commissioning.

Adult Dental Health Survey

- 6.3 We welcome the Department's commitment to a 2009 Adult Dental Health Survey in England, Wales and Northern Ireland. This will enable NHS commissioners and CsDPH to make long term decisions especially in the area of oral health inequalities, but whether there will be authoritative advice available from CsDPH is debateable.

7. Clinical Academic Staff

- 7.1 We are providing evidence on the recruitment and retention of clinical academic staff, as though this staff group is outside the formal remit of the Review Body, their numbers have influence on the quality of teaching available to dental undergraduates, and on promotion of the “Darzi” quality agenda through translatable patient-centred research. We thank the Review Body for considering our evidence on clinical academic staff in previous years and invite it to do so again this year.
- 7.2 The opening of new dental schools across the UK at Peninsula, Aberdeen and University of Central Lancashire is welcome, but in the context of dental academic staff, the impact on recruitment and retention is significant. This along with the increased student numbers will appear as an overall increase in academic staff numbers. However, what is occurring is an overall reduction in staff: student teaching ratios as staffing numbers have not kept pace with increased students. In addition, the new schools are being populated by staff transfers from existing schools further lowering staff: student ratios.
- 7.3 Data on dental academic staffing levels from the Dental Schools Council (DSC) published in June 2008 referring to statistics to the end of 31 July 2007 shows a hugely significant decrease in the numbers of dental academic staff when using the traditional clinical academic model. Particular specialties are now under threat. The DSC moderates the presentation of this decline by claiming that a rise in the number of Salaried Dentists and GPs, employed as Clinical Teachers, has largely offset this decrease:

As at 31 July 2007 there were 370 Full Time Equivalent (FTE) clinical academics and 90 FTE clinical teachers working in the UK's 16 Dental Schools. Due to discrepancies in the reporting of clinical teachers in previous years' surveys, this can be interpreted as a 15% decline of clinical academics (equivalent to 65 FTE posts), a 23% decline since 2000 – or a 6% increase of all clinical staff (30 FTE posts), 97% of the total clinical academic staffing level reported in 2000.

- 7.4 The increase in clinical teacher posts can be explained through the necessity of establishing new methods of delivery, such as community-based and outreach teaching, which have been introduced to ensure the survival of dental teaching. Many clinical teachers are SPDCS staff (directly employed by their PCT, but

with an honorary contract with the dental school) or GDPs, which takes them away from the provision of frontline NHS service delivery. Dental clinical academics are a victim of their own success, finding innovative methods of maintaining the teaching service in the context of an under-funded HE sector.

7.5 At a meeting with the CDO for England in July 2008, the BDA raised concerns about the local implementation of the Walport Report (the 2005 report concerning delivery of improved clinical academic training and career pathways)¹². This related to the methodology used by PCTs/dental schools in England to bid for and allocate resource to fully funded NHS dental academic training places. This needs a clear resolution in order to support adequately the future academic workforce.

7.6 As in previous submissions, we re-iterate the continued importance of pay parity being maintained with NHS colleagues in order to make academic careers a viable option for those dentists wanting to pursue work in education and research. This includes fair and equal access to additional Programmed Activities (PAs, the currency of the NHS consultant contract and academic contract) to properly recognise the work that is agreed in the integrated job plan. Both the BDA and BMA have evidence to indicate that clinical academics are awarded less additional PAs than their NHS counterparts. This fair and equal access also applies to the Clinical Excellence Awards scheme.

¹² “Medically- and dentally-qualified academic staff: Recommendations for training the researchers and educators of the future” the report of the Academic Careers Sub-Committee of Modernising Medical Careers and the UK Clinical Research Collaboration March 2005.