



General Dental Practice Committee

Increases in dental practice expenses

2011-2012

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Executive Summary

- There is considerable economic pressure on dental practices with adverse trading conditions. Inflation and dental inflation are significant.
- Again this year we have found rising practice expenses, particularly regarding laboratory and materials costs and pressures on staff pay.
- Increasing regulatory requirements are imposing efficiency gains on practices.
- The incidence of patients failing to attend for their appointments because NHS practices are unable to charge for missed appointments is on the increase and represents a substantial efficiency loss.
- We have identified efficiency gains of 8.93 per cent being required to be made in the current year (2010-11) by the average NHS practitioner in order to maintain the status quo.
- Using the current DDRB formula, we identify a required 2.3 per cent rise. Adding to this a minimum £250 rise for practice staff, serious shortfalls in the previous award for materials and laboratory increases, this rises to 3.32 per cent.

1. Introduction

- 1.1 This paper provides evidence from the General Dental Practice Committee (GDPC) on rises in expense levels for NHS general dental practice in England. Our research shows that expenses are rising, fuelled by currency exchange rates, gold and precious metal prices, increasing professional requirements and red tape. It is extremely difficult for general dental practitioners to make additional efficiency gains while having to comply with all of the required standards for practice and providing safe and effective patient care for increasing numbers of patients.¹
- 1.2 We note that the Department is going to decide on whether or not to increase NHS contract values for general dental practitioners and if so by how much. An efficiency gain of up to 4 per cent is sought by the Department of Health. This departure from the established DDRB procedure is not helpful to the profession and will damage morale and motivation.
- 1.3 We believe that a formula approach should be used (similar to the formula used in the 39th DDRB report) to arrive at a minimum uplift for NHS contract values that takes some account of rising practice expenses. This paper provides our calculations for a reasonable rise in practice expenses and

¹ NHS Dental Statistics for England – 2010/11, First quarterly report.

quantifies efficiency gains that practitioners will have to make before anything additional has been imposed.

2. The economic environment

2.1 As self-employed business people, general dental practitioners are affected by the general business and economic environment. Firms and households are aware that public spending cuts are coming and have changed their behaviour accordingly: consumers are more cautious about their spending and firms are reluctant to invest or hire new workers.

2.2 The impact of the current economic environment on dental practices as small and medium-sized businesses

2.2.1 The Bank of England base rate has remained at historic lows of 0.5 per cent and a £200 billion programme of quantitative easing has been introduced. In spite of this, firms, especially small and medium-sized businesses, are still finding it difficult to borrow: either they cannot easily find loans or, even if they can borrow, banks have told us that the rate they pay reflects a substantial risk premium. This is particularly problematic for dentists due to the large start-up costs of a dental practice which mean that a bank loan must be taken. The inability to borrow, or the ability only to borrow at higher rates, effectively increases dentists' costs and constrains their ability to deliver high quality NHS care and inhibits further investment. The problems are the more acute for those with time-limited contracts.

2.2.2 Dental practices employ numerous staff, including dental therapists, hygienists, nurses, practice managers and receptionists. They are an important part of the local economy and landscape in many areas, particularly rural areas. As well as providing an essential service, they provide employment opportunities and, along with other small businesses, are central to helping local communities to thrive.

2.2.3 General dental practitioners, unlike most NHS health professionals, are particularly vulnerable to the state of the economy because patients have to make financial contributions to the cost of their care. As small businesses, they are taking on the responsibility as well as bearing the risks of providing dental care, so economic shocks have the potential to threaten the viability of high quality NHS care. This can have long-term consequences, as once an NHS practice is lost it is difficult and very expensive for it to re-emerge.

2.3 Inflation and health inflation

2.3.1 Inflation as measured by the Consumer Price Index (CPI) stood at 3.3 per cent in the year ending 30 November 2010, above the Bank of England's inflation target of 2 per cent. RPI is currently at 4.7 per cent. This has been blamed on a number of factors, including the restoration of VAT to 17.5 per cent, higher oil prices (see chart below) and the past depreciation of Sterling. Retail Prices Index (RPI) inflation, which includes housing costs, was higher at 4.6 per cent.

Crude oil price rise in 2010



Source *ThisisMoney* 25 November 2010

2.3.2 Inflation is likely to remain above target for a prolonged period. Next year's VAT rise from 17.5 per cent to 20 per cent will again push inflation up and the Bank forecasts that it is not likely to fall back to target until some time in 2012. Practices will face a rise in equipment and consumables costs because of the rise in VAT.

2.3.3 We continue to argue that broad measures of inflation are not an accurate reflection of the rates of inflation faced by dental practitioners. For example, the cost of providing dental care is particularly sensitive to fluctuations in the value of Sterling. This is because a significant proportion of dental materials

and equipment is imported and because precious metal prices are denominated in US Dollars. While it is true that Sterling has strengthened somewhat since the new coalition government announced its ambitious programme of spending cuts, it is still far weaker against the Dollar and the Euro than it was before 2008.

2.3.4 Precious and base metals prices continue to rise strongly, with gold prices up over 28 per cent in the past year; silver saw a 22 per cent increase; platinum a 20 per cent increase and palladium a 76 per cent increase in the same period.

2.3.5 Dentistry is a fast-moving industry with rapid technological change. This means that in order for dentists to continue to provide high quality patient care with technological change and innovation in dental equipment and to keep up with the increasing expectations of patients, equipment and machinery need regular updating and can quickly become out of date and in need of replacement. Although most dental surgeries will need re-equipping every seven years, the speed of changing requirements mean that often equipment and instruments need to be upgraded more frequently. Clearly, this high level of depreciation is a substantial cost to dental practitioners.

2.4 The impact on patients

2.4.1 The recent recession and its effect on household income and employment have meant that this has been a testing time for many NHS patients. Households have to cut back on their expenditure and the worry is that due to increased deprivation the need for NHS care is now greater than ever. Additionally fail-to-attend rates amongst exempt patients are higher so that dentists lose even more time with missed appointments, which impacts on efficiency.

Fail to attends

2.4.2 Some patients continue to miss and cancel appointments and this is a prevailing problem reported to us by members. Not only does this mean that patients are not getting the care they need on time, but it also represents a real and significant cost to dentists, who lose time which could be spent treating others, and it makes it difficult for them to achieve their UDA targets. Recent BDA research showed that an average 75%+ committed NHS dentist lost 91 hours in failed appointments in 2009-10. In mid-December we asked members to send us copies of the FTA reports from their software systems and this was the result from 48 responses. An average heavily-committed NHS dentist works a 37.7 hour week which means, in total, practitioners have lost 2.41 weeks each. The economic uncertainty is likely to make this worse as patients become more cautious in their spending as well as reluctant to make long-term plans or invest in preventive dental procedures.

2.4.3 **Organising practices to cope and prevent DNAs represents an efficiency gain of at least $2.41/48 = 5.02$ per cent.**

2.5 **Increasing regulation and administration**

2.5.1 The burden of regulation on dental practitioners is becoming intolerable. In England, the following new requirements have come into force for NHS practitioners since last September. These requirements bring a need for further additional work and more staff.

- Information governance requirements

This involves additional training for the dental team and new policies and procedures to evidence that patient information is secure. The process of registration is complex and time consuming for practitioners and we have received a lot of enquiries from practices who are finding the process very difficult. For small practices, compliance will have a significant impact on staff time. There are also extensive hardware and structural requirements, such as the introduction of bars on ground floor windows, a requirement that practices in listed buildings may find impossible to meet. Assuming that it takes a dentist an average of **two additional days** to implement the procedures and ensure ongoing compliance and registration, **compliance with these requirements is an efficiency gain of 0.83 per cent.**

- NHS Choices

NHS Choices has added dental practices to its remit in November 2010. This is not strictly regulation, but the opportunity for dental practices to be rated equates to the same thing. If NHS Choices is not robust in its screening process, there is a chance for professional reputations to be damaged, a concern that has also been raised by the BMA and RCGP. This *ad hoc* rating system can have a significant negative impact on morale and, when negative postings are made, practices have to investigate and respond which takes added management time.

- Compliance with HTM 01 05

Decontamination guidance has been a source of much concern for the profession. The capital costs are exceedingly high and many BDA members have reported that yearly running costs are the same as the initial start-up cost. Not only are the costs prohibitive (see paragraph 3.6 below), but its imposition is one of the major causes of low morale among practice owners in the focus groups set up by the BDA. This year dentists have had to spend time conducting an audit of their performance against

the essential standards and then taking the appropriate management action.

- NHS contract administration

Dentists are spending increasing amounts of time dealing with PCTs who are requiring additional information as part of the contract management process. This is exacerbated by the turnover in PCT staff due to the uncertainties about the future. Members are having to justify their claims and present a lot of data and information to PCTs who are attempting to introduce clawback.

2.6 Care Quality Commission

- 2.6.1 The present consultation on CQC registration fees suggests that they will be a minimum of £1,500 per practice, which is in our view completely unjustifiable since the requirements are in large part duplicative and inappropriate. For all practices, expenses will increase by a minimum of £1500 if the present level of fees contained in the CQC fees consultation is imposed. The increasing compliance activities required for CQC registration will add significantly to practice costs this year and in the future, particularly where new equipment and services need to be purchased and there is a steep rise in VAT. The additional work for the same contract value means an automatic efficiency gain. We estimate that dentists are having to spend an average of 2.5 days setting up systems to evidence CQC compliance and prepare all of the paperwork plus operating the checking procedures necessary to maintain compliance. **For a full-time NHS committed practitioner working a 48 week year this represents an ongoing efficiency gain of 1.04 per cent (0.5/48 per cent).**

3. Dental practice expenses

“Financial pressures on practices are just ... they are squeezing the pips out, there is nothing more to give. Very soon the service is going to stop and collapse.” (Practice Owner, England. BDA Focus Group research summer 2010)

- 3.1 Rises in practice expenses remain the most significant concern. This section puts forward evidence of rising expenses that are affecting practice profitability, particularly for highly-committed NHS practices. The DDRB formula (which is considered in detail in section 5) contains components for staff costs, premises costs as well as the costs of laboratory items, equipment and materials. This section will provide evidence that practice costs have increased this year. This must be taken into account in a pay settlement

because DDRB worked on the basis of catching up with rises in expenses in the financial year three years prior to the year the rise came into effect.

3.2 Staff costs

3.2.1 Most staff employed by dental practitioners typically fall under the protected category of those public sector employees who will receive a pay award of £250. In order to remain competitive with NHS pay for dental care professionals, dental practice owners will be under pressure to award their staff at least £250. These costs will have to be met from practice income. If these additional costs are not funded, then effectively dentists will see their taxable incomes fall not just in real terms but in cash terms too.

*Table 1: Percentage of DCPs earning a full-time-equivalent annual salary of under £21,000**

	% earning £21,000 or over	% earning under £21,000	Total	
	Row %	%	Count	Unweighted Count
Dental nurses	4.6%	95.4%	2341	1823
Receptionists	5.9%	94.1%	647	647
Practice managers	63.6%	36.4%	321	250

*Based on a 35 hour working week

Source: BDA Dental Care Professionals pay survey 2010

3.2.2 Staff costs remain the highest proportion of practice expenses and are the biggest factor in dental inflation. In our evidence to DDRB this year, we have already described the problems faced by many practice owners in recruiting appropriately-trained dental care professional staff. Most family dental practices are small businesses, with the average practice comprising 3.0 dentists and 7.8 support staff². Pay is determined by practice owners by a variety of means that reflect the close relationships that exist within dental teams and the local recruitment and retention situation for the staff group. In the past year, all groups of dental care professionals across the UK received, on average, an hourly pay award well in excess of the 0 per cent awarded to NHS dentists in 2010-11. For example, in the BDA Dental Business Trends Survey 2010 (DBT 2010), practice owners reported that they had had to award their dental nurses a mean hourly pay rise of 3.3 per cent in England. Table 3 gives the uplifts for all staff groups in practice. A pay freeze is just not practical in a small, clinically-based business employing skilled professionals who have the choice of other similar employers in the area.

² BDA Dental Business trends 2010

Table 2: Mean percentage rises in hourly pay by staff group in 2009-10

	Mean	Count	Unweighted count
Dental nurses	3.30	493	379
Receptionists	2.83	413	318
Practice Managers	3.24	263	202
Employed hygienists	2.29	239	184
Employed therapists	1.48	114	88

Source: BDA DBT 2010

3.2.3 In 2010 the BDA undertook a survey of pay for dental care professionals. This repeated a survey done in 2007. The increase in average hourly pay for each of the staff groups is shown in Table 3.

Table 3 percentage staff pay rise from 2007 – 2010 (total)

Trainee Dental Nurses	22.2%
Trained Dental Nurses	9.3%
Receptionists	6.9%
Practice Managers	10.6%
Employed Hygienists	21.1%

Source DCP Pay Survey 2007 and 2010

3.2.4 The survey gives an average percentage rise over the three-year period of 14 per cent. The staffing element of the DDRB formula over the last three years has been uplifted by 13 per cent, so we are running at a loss of at least 1 per cent on staffing costs.

3.2.5 Now that the whole clinical dental team is registered and has compulsory CPD, additional training costs have fallen on practices. For employed clinical staff, there is a reasonable expectation that the employer will pay for necessary training and personal development. All dental nursing staff must be registered or in training and the costs of NVQ courses for dental nurses are considerable, normally between £1,000 and £1,800 per year for a two-year NVQ in Dental Nursing. Practices must also pay for temporary cover whilst clinical staff are away in training because performance against UDA targets cannot be allowed to fall.

Table 4: Percentage of practices paying for DCP registration, CPD, and other training

	In full	In part	None	Count
Registration	66.7%	6.3%	27.0%	126
Verifiable CPD	68.2%	27.3%	4.5%	132
Other Training	69.7%	22.1%	8.2%	132

Source: BDA Omnibus Survey October 2010

- 3.2.6 The Government has decided that staff paid less than £21,000 will receive a rise of at least £250 in 2011-12. This means that, to stay competitive, general dental practice staff must receive at least this uplift. The British Association of Dental Nurses recommends that full-time registered dental nurses are paid at least £20,000 per year. This is creating wage demands well in excess of the £250. Registration has also reduced the pool of applicants which is another factor driving up wage demands: the Dental Business Trends Survey 2010 showed that 65 per cent of those that tried to recruit for dental nurses in the last 12 months had difficulty.

“Registration and compulsory formal training are deterring potential trainees. Lack of experienced applicants also. Those with experience are demanding higher salaries as applicants become scarce.” (Practice owner, England. BDA Focus Group research summer 2010)

- 3.2.7 The £250 increase means that, if staff costs represent 29 per cent of practice expenses from the latest Dentists Earnings and Expenses report, and average practice owner expenses for 2008-9 were £235,500, with an average practice having seven staff, **the current average wage bill is £68,295: an increase of £1750 (7 times £250) or 2.6 per cent.**

3.3 NHS work – quantity

- 3.3.1 The amount of laboratory-based dental care has continued to rise in 2009-10 in England, as the contractual arrangements introduced in 2006 have settled down. Latest figures from the NHS Information Centre on the distribution of Band 3 laboratory-based treatment items in England are shown in table 4. There was a 12.2 per cent increase in band 3 courses of treatment from 2008/09 to 2009/10, compared with a 2.7 per cent increase in band 1 treatments. This will mean an increased proportion of practice expenses being taken up by laboratory costs and overall practice expenses will rise.
- 3.3.2 It is also important to recognise that dentists are providing a range of laboratory and other items on the NHS. In the *Clinical Dental Report, England and Wales Q3, Q4 2008-9* produced by the NHS Information Centre, data showed that, in Quarter 4, where permanent fillings or sealant restorations

were provided within a course of treatment for adults, the average number of treatments was 1.5. The figure for endodontic treatment was 1.1 and number of bridge units 2.

3.4 Materials and equipment costs

3.4.1 The price of gold continues to rise, affecting the price of laboratory items.



3.4.2 Over the last two years we have monitored the catalogue price of some items of dental equipment and materials. Following a rise of 19 per cent last year, which we reported in our DDRB evidence for 2010-11, the items have risen by a further one per cent this year. Practice owners responding to the DBT 2010 reported substantial rises in materials and equipment costs.

Table 5: Percentage of practices reporting the following increases to materials costs in 2009/10 compared with the previous year

	% increase in materials costs					Total	
	0-4%	5-9%	10-19%	20-29%	30% or greater	Count	Unweighted Count
	Row %	Row %	Row %	Row %	Row %		
All England	10.2%	32.5%	31.0%	20.1%	4.0%	356	274
NHS practice							
0-24% NHS	14.5%	32.3%	28.2%	16.9%	3.2%	161	124
25-74% NHS	7.4%	31.5%	37.0%	20.4%	3.7%	70	54
75-100%	6.3%	33.3%	31.3%	24.0%	5.2%	125	96

Source: BDA DBT 2010

3.4.3 A reasonable estimated average rise for materials costs as reported by dentists would be 10 per cent.

3.5 Laboratory costs

3.5.1 We asked practice owners in our Dental Business Trends report to give us the price paid for some typical laboratory items in 2009 and 2010. Table 6 gives the median values. All show an increase.

Table 6: Costs of laboratory items 2009 and 2010

	Median		
	2009	2010	% change
S Porcelain bonded crown with precious metal	45.00	47.75	6.1%
Full acrylic dentures	90.00	95.00	5.6%
Two tooth partial skeleton chrome cobalt denture	126.25	140.00	10.9%
Two tooth acrylic partial	46.45	50.00	7.6%

- 3.5.2 The average increase of the items in Table 5 was 7.6 per cent. In its 39th report for 2010-11, the DDRB formula gave an uplift of 2.8 per cent for the cost of laboratory and materials elements. So assuming that approximately the same amount is spent on laboratory items and materials (which tallies with NASDA information), on average these elements rose by 8.8 per cent. **So there is a shortfall of 6.0 per cent in the amount awarded by DDRB and the amount that laboratory and materials costs actually rose.**

3.6 Decontamination costs

- 3.6.1 The Dental Business Trends survey showed that costs incurred by practices in meeting the new decontamination standards ranged widely, from a few thousand pounds for a new work surface, to over £100,000 to build a new room from scratch. Some practice owners are considering closing their practices because of the requirements and a number have had to decommission a surgery to make way for a decontamination unit. In many cases, practices have to recruit additional staff and purchase additional equipment in order to meet the requirements. The initial outlay and ongoing utility, materials, and staffing costs are placing considerable financial pressure on many practices. This is particularly true for more committed NHS practices. This has been time consuming and represents on average a cost in dentist time to carry out the audit, change working practices and take part in essential training of at least 2.5 working days. **This represents an efficiency gain this year of 1.04 per cent which will be repeated next year as practices work towards best practice requirements.**

3.7 Turnover and profitability

- 3.7.1 This year we will use two main sources of information on dentists' earnings and profitability: the DBT 2010 survey and the NHS Information Centre's *Dentists Earnings and Expenses England and Wales* report for 2008-9. The 2008-9 *Dental Earnings and Expenses* report revealed that average taxable income for dentists spending 75 per cent or more of their time on NHS work was £94,100, up from £93,891 in 2007/8. **This was a rise of only 0.22 per cent when the intended effect of the rise in fees for that year was 2.2 per cent. So the actual rise in income achieved was ten per cent of that intended.**
- 3.7.2 We asked practice owners in England to tell us how their turnover and profitability had changed since the last financial year. Twenty-seven per cent reported turnover increasing somewhat or substantially and 26 per cent reported it had decreased somewhat or substantially. So, for just less than half the respondents, turnover had stayed the same. Expenses showed a different trend, with 90 per cent of respondents saying they had increased substantially or somewhat, with ten per cent saying they had stayed the same

and no respondents saying they had decreased. As a result, profitability was generally down. Eleven per cent of respondents said it had gone up somewhat or substantially, 20 per cent reported it had stayed the same, with 69 per cent stating profits had decreased somewhat or substantially.

3.7.3 The 2008-9 *Dental Earnings and Expenses* report revealed that average expenses for dentists spending 75 per cent or more of their time on NHS work was £100,000, up from £99,589 in 2007/8. This was an increase of 0.44 per cent. For practice owners in 2008-9, expenses had risen by 7.6 per cent.

3.7.4 As last year, it was practice owners with higher NHS commitments who were more likely to report a decrease in practice profits than their highly-committed private colleagues. This trend continues and ultimately will detract from NHS practice as a career option for dental professionals.

Table 7: Percentage of practice owners reporting that their practice turnover and/or practice profitability has decreased over the last financial year (2009-10) by NHS commitment

	Turnover decreased	Profit decreased	Count	Unweighted count
All England	27.7%	68.3%	554	426
NHS practice				
0-24% NHS	27.5%	58.9%	205	158
25-74% NHS	36.5%	71.7%	120	92
75-100%	19.0%	77.5%	156	120

Source: BDA DBT 2010

3.7.5 This year we asked practice owners whether the business costs they had sustained in the 2009-10 financial year had met their expectations. Fifty-five per cent in England reported they had exceeded their expectations, 41 per cent reported that they were in line with expectations, 1 per cent said they were below expectations and 4 per cent didn't know. This shows dramatically how difficult it has been in the past year for practice owners to plan and budget due to rising costs.

4. Efficiency gains in general dental practice

“Dental practices are already extremely efficient as profit depends on it. Impossible to decrease costs and implement HTM 01-05. Impossible.”
(Practice Owner, England. BDA Focus Group research summer 2010)

4.1 As small businesses, general dental practices run as efficiently as possible. In our focus groups, which were held around the UK, the consistent message was that it has always been in practice owners' best interests to run their business with as little loss and waste as possible. Efficiency gains cannot be made except by reducing the incomes of the owner and the self-employed dentists and DCPs who are key members of the dental team. Employment law prevents cuts being made to the pay of existing members of staff without their consent.

4.2 Efficiency gains cannot be assumed when making pay awards. Dental practices were forced to cover efficiency gains of 1 per cent in 2010-11. The DBT 2010 survey asked practice owners what plans they had to implement the savings and what impact they would have on their practices and all respondents expressed the view that it would be very hard to absorb the one per cent requirement in the light of rising expenses.

4.3 Within this document we have identified efficiency gains that practices have to make because of the pay freeze and increasingly regulatory burden. These are as follows:

Pay freeze on dentists' income	1 per cent
CQC registration and ongoing compliance	1.04 per cent
Information governance requirements	0.83 per cent
Time lost for DNAs	5.02 per cent
HTM 01-05	1.04 per cent

4.4. **This achieves an efficiency gain of 8.93 per cent without anything else being imposed.**

5 The formula

5.1 GDPC supports the retention of the DDRB system and was very disappointed at the Department's decision to suspend it for this year and next. We believe that a modified version of the formula used in the 39th report should be used again to give a minimum rise for general dental practice contract values. Although we are taking this view, using the formula will not rectify the situation identified in this paper that previous DDRB rises have not covered the rise in practice expenses where we have **a shortfall of 1 per cent on staff pay and 6 per cent on materials and laboratory costs**. We therefore think it is fair to adopt a two stage approach to the formula this year.

Stage one

5.2 Using the DDRB formula and the latest quarterly figures for RPI and RPIX, an expenses-to-earnings ratio of 54 per cent (as suggested by the Department in

its evidence to the DDRB 2010), 29 per cent for staff costs and 19 per cent for laboratories and materials costs (from the same report), with other costs being 52 per cent, **the uplift according to the formula is 2.302 per cent.** We do not accept CPI as an accurate index for rises in practice costs.

$$\text{Uplift}_{2011-12} = 0.460 * x + 0.157 * \text{HRPSASHE} + 0.103 * \text{RPIX} + 0.28 * \text{RPI}$$

where

x = 0 per cent income uplift
 HRPSASHE = 3.2 per cent
 RPIX Q3 = 4.7 per cent
 RPI Q3 = 4.7 per cent

$$\text{Uplift}_{2011-12} = 0 + 0.502 + 0.484 + 1.316$$

$$= 2.302 \text{ per cent.}$$

Stage two

- 5.3 It is reasonable to add amounts into the formula to account for the cost pressures already identified, plus the £250 minimum rise for low-paid staff announced by the Government. We believe that this is the minimum necessary to ensure that dentists do not receive a cut in their net taxable income this year.
- 5.4 So, as we calculated in paragraph 3.2.7, for an average practice owner a £250 rise for each member of staff earning under £21,000 would mean an average 2.6 per cent on the pay bill which, when added to the formula, gives an additional 0.408 per cent on the required uplift, giving a total of 2.71 per cent.
- 5.5 In paragraph 3.5.2 we identified a shortfall of 6.0 per cent in the amount awarded by DDRB in 2009-10 for rises in laboratories and materials costs. Adding this additional element to the formula gives an additional 0.618 per cent.
- 5.6 **This brings the uplift to 3.32 per cent but still takes no account of the efficiency savings we have identified that dentists have already made.**
- 5.7 These figures do not include the CQC registration fee and the planned rise in VAT in January to 20 per cent.

6 Conclusions

6.1 We believe that in order to retain the services of general dental practitioners there needs to be a minimum contract value rise. Using the basic DDRB formula plus a £250 rise for practice staff, an uplift of 2.71 per cent is indicated, and this rises to 3.32 per cent when previous shortfalls in rises in laboratories and materials costs are taken into account.

Efficiency gains of 8.93 per cent are already being made and need also to be taken into account. These are described in paragraph 4.3 and relate to CQC, HTM 01-05, information governance, missed appointments and the pay freeze for practitioners.

John Milne
Chair
General Dental Practice Committee