BDA response to DHSSPS Consultation on proposals to change the treatments that are available through General Dental Services

**Question 1:** Do you agree with the steps the Department proposes to reduce the pressure on the General Dental Services budget, so that the resources are directed on treatments which improve oral health? If not, then what alternative proposals would you suggest?

**Comment:**

No

The steps which are set out in the consultation document are an exercise aimed at reducing the spend through General Dental Services. The objective of spending less resource on General Dental Services needs to be addressed transparently so that the public are aware of what the general dental service is, what it provides for them and how much they contribute to the costs.

BDA believe the proposals outlined will not improve oral health. The oral health of the population in Northern Ireland is generally poor and the measures outlined will not change that. The Adult Dental Health Survey 2009 describes how 93 percent of adults at 2009 were dentate. 7 percent were classified as having excellent oral health and 64 percent of dentate adults had bleeding. Whilst these figures demonstrate improvements in oral health, there
continues to be unmet need in the population, coupled with a rising dentate population and the concomitant service requirements which accompany the population needs.

Improvements in oral health occur both as a result of dental awareness and treatment and as a result of patients receiving dental advice and preventative interventions. Dentists and their teams have a desire to take a patient centred approach to dental care, which addresses the main reason for dental care being sought and the wider oral health messages, which mutually agrees on management and enhances prevention and health promotion and secures the relationship between patient and dentist/dental team.

The service described in the consultation exercise presents a treatment focused service. It does not promote the strategic direction set out in Transforming Your Care which refers to reforming and modernising services so that they are focused on people rather than institutions. Instead, what this consultation sets out to do is to put in place a dental service which is defined by the treatment it offers and the Statutory Rules and Statements which govern the circumstances in which treatments can be provided and claimed and allowances claimed. The outcome will be that at the same time as the wider Health and Social Care agenda is developing in line with the 12 key principles underpinning the approach to Transforming Your Care, the General Dental Services will be developing in an alternate direction which is not in keeping with the direction of TYC. The results will be that patients will suffer as individuals, the oral health experience of the population will deteriorate and oral health inequalities will be magnified as a result of DHSSPS policy on the General Dental Services.

**Improvements in oral health**

The introduction to the DHSSPS proposals describe how the proposals would ensure that treatment provided through the GDS is targeted at patients with the greatest need and provided for within the allocated budget. It is important at this juncture to set out that the population of Northern Ireland continues to have very considerable oral health needs as set out in publications including The Oral Health Strategy for Northern Ireland June 2007; the Primary Dental Care Strategy 2006 and the Adult Dental Health Survey 2009. So, whilst there are those in the population with greater need, it needs to be borne in mind that Northern Ireland has some of the worst oral health experience in the UK and just 7 percent of the dentate adult dental population demonstrated oral health which might be classified as ‘excellent’. The need across the population needs to be considered in an absolute, rather than a relative context and DHSSPS policy should accept that when it comes to matters of oral health according to the Adult Dental Health Survey 2009, Northern Ireland requires
investment to enable the benefits in oral health already experienced to be sustained across the whole population.

**Overview of the proposals**

The proposals set out to cut very significant sums from the funding for the GDS. These are described as £6.8m in the consultation document.

In considering the budget for GDS based in 2011/12 figures it demonstrates that

- 1.12 million persons are registered with 1049 dentists at 390 practice sites
- £112.9m was the gross cost of the service
- Patients paid £17.5m, leaving a net cost of £95.4m
- To save £6.8m from a net cost of £95.4m is a reduction of funding in the order of 7 percent.

BDA believes the proposals, as set out by DHSSPS, have the capacity to bring about a cocktail of interlinked changes and untried changes which would impact in ways that are potentially destructive to the ability of the General Dental Services to remain sustainable and continue to provide oral healthcare for the vast majority of the public in Northern Ireland.

The General Dental Service is a service which has been impacted by factors including government policy, public desires and the economy. Government policy is that the general public should have access to a health service dentist [http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-may-2009/news-dhssps-13052009-mcgimpsey-announces-17million.htm](http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-may-2009/news-dhssps-13052009-mcgimpsey-announces-17million.htm) Government policy also dictates that additional governance requirements mean that in order that dental practices may comply with best practice in decontamination, they need to spend significant sums in new capital and revenue costs associated with dental practice. A GDS budget which does not fully take account of the new capital and revenue costs and expenses to be met by practices in providing GDS dental care makes this difficult to achieve. According to figures produced by the Health and Social Care Information Centre the average gross earnings for dentists in Northern Ireland fell by 7.8 per cent in 2010/11 (the most recent year that figures have been published for) at the same time the average cost of expenses fell by 7 per cent. This highlights how difficult the business situation facing dentists in Northern Ireland is. BDA fully expect that the figures for 2011/12 will show this trend continuing. BDA evidence on expenses from 2011/12 and 21012/13 demonstrates that without these cuts they already face significant financial pressures over the next 12 months,
the measures set out in this consultation will only make that situation worse. BDA evidence on expenses to DHSSPS relating to the need for a pay uplift for 2011/12 and 2012/13 set out the growing gap between the funding of Health Service dentistry and the cost of provision of health Service dentistry. BDA noted that the funding of the profession is significantly below the cost of inflation (as measured by CPI) and that to rectify the gap between CPI and the pay awards of the last three years dentists would require an award of 8.87 per cent above CPI, i.e. 11.87 per cent based on CPI of 3.5 per cent in March 2012. This figure also does not factor any extra regulatory costs imposed such as those for meeting decontamination requirements or additional governance costs.

The result is that primary care dental services are being asked to take cuts to release funds to other services, to operate inside a funding system where the ability to make capital and revenue spends are not addressed in the government pay freeze, and to operate in a funding system which does not account for new areas of necessary spending activity.

The public appetite for healthcare including dental care has increased very significantly over the past few years to the extent where patient registrations have increased from 895,145 at end of 2009 to 1,142,053 at end of 2012. At the same time the economy has changed very significantly with Northern Ireland slipping behind the rest of the UK with the second highest level of unemployment and long term unemployment prospects being almost double that in the rest of the UK. [http://pwc.blogs.com/northern-ireland/2013/03/northern-ireland-slipping-behind-the-rest-of-the-uk-pwc.html](http://pwc.blogs.com/northern-ireland/2013/03/northern-ireland-slipping-behind-the-rest-of-the-uk-pwc.html)

When these factors are considered and put into the context of the GDS, it can be concluded that the cut to funding in the GDS will impact the public and their experience of oral health, which will in turn lead to a long term legacy which BDA believes is likely to include a reduction in access to HS dental care caused by loss of dentists and even dental practices from communities in Northern Ireland. BDA case studies [see annex 3] provide evidence including those in respect of patient oral health, morale in the workforce and workforce makeup and size.

**Alternative proposals:**

- The proposals set out at the consultation introduction detail that reducing the pressures on the GDS budget would release monies within the overall budget available to the Department to provide other Health and Social Care services. The BDA view is that any monies released should be utilised within dental services, to meet the expanding needs of an increasing dentate population.
- The capacity of the practice allowance to increase to meet necessary capital and revenue spend in respect of HSC practice is constrained by the fact that the value of the practice allowance is linked to fees. In general the practice allowance accounts for a value of approximately 10% of the gross costs of items of service and patient registration fees. However previous pay awards have not kept pace with CPI and so the practice allowance has become increasingly underfunded. Over time, as new and additional requirements become essential to HS dental practice, the Practice Allowance is expected meet more and costs. However a fund which is linked to fees which have increased at minimal levels over the past three years cannot meet the requirements it is expected to deliver. In 2012 practices will be expected to have attained HTM 01/05 best practice compliance and this adds very significant capital and ongoing revenue costs to the running of the practice. Practice expenditure on revenue items rises at a rate commensurate with Consumer Price Inflation. DHSSPS policy requires capital expenditure within practices. The practice allowance rises with fees. CPI far outstrips fee rises and the result is that the value of the practice allowance is falling in real terms. An alternative is for DHSSPS to recognise the importance of the practice allowance to HSC dental practice and consider the approach taken in Scotland in November 2012 where the practice allowance was safeguarded

- Currently GDS charges are set at 80 percent of the total fees, to a maximum of £384. Charges set at a rate higher than 80 percent would provide additional monies to the GDS from the patients who normally pay HS dental charges. For example, if £16m was raised in patient charges at 80 percent, then this figure would increase to £17.6m at 90 percent. Alternatively, if patient charges were uplifted by CPI, rather than being pegged to fees, a patient who paid £20 in HS fees in 2009 would now pay £20 uplifted for CPI or £22.13, thus amounting to a more realistic, but still subsidised payment in respect of HS dental care. As it stands £20 paid by a patient in respect of HS care in 2009 has now increased to £20.24. Patient charges must be linked to the reality of increases in consumer spending.

- The proposal from DHSSPS is to make item 0101 available only once every 9 months and 0201 available every 12 months. In reality this does not sit well with the expectation that patients have of dental services, which is historically one of dental visits at 6 monthly intervals. To safeguard oral health and for this reason, we would accept moving item 0101 to 6 monthly.
Question 2: Do you agree that funding for Health Service orthodontic treatment should be prioritised for patients with a clinical need for treatment and that the threshold is set at IOTN 3.6, as is the case in the rest of the United Kingdom?

Comment

Yes

The criteria for orthodontic treatment provided through the General Dental Services and using IOTN 3.6 creates clear parameters for when the GDS will provide the treatment and when it will not.

BDA acknowledges that this measure will bring Northern Ireland into line with the rest of the UK. It should be noted that the measure will not deliver the savings suggested for 24 months due to the length and nature of orthodontic treatment.

The same principle of clarity should be applied across the rest of the GDS. The RIA assessment of orthodontic proposals at point 15 describes how a requirement to apply for prior approval for orthodontic cases could in turn lead to confusion for practitioners and patients over whether or not treatment could be provided. The partial RIA for the other proposals requiring treatment to prior approval does not appear to accept that the confusion and anxiety referred to in the orthodontic RIA is replicated in the other treatment related proposals when a dentist is unable to advise the patient with any degree of clarity about what treatment would be provided by the HSC.
**Question 3:** Do you agree with the proposed move to a core of services that would be available to all registered Health Service patients but excluding veneers, large bridges or those at the back of the mouth, metal dentures and root canal treatment on molar teeth, except where these are considered clinically necessary?

**Comment**

No

The proposal affects the treatments the patient can receive routinely through the GDS, without prior approval. Patients tend not to think of their dental care as individual treatment items, but rather as a means to address a problem of oral health, function or appearance. This highlights the need for clear communication from DHSSPS to the public to describe the General Dental Services in a way that is understandable to the majority.

The proposal is described as providing treatments to patients where they are considered ‘clinically necessary’. The dental profession is clear that clinical decisions underpin the provision of dental care as part of the health service arrangements. BDA is clear that the proposal for DHSSPS to set out a policy where HSCB is involved in making decisions about which treatments a patient may receive is based on costs and not solely on clinical considerations. DHSSPS should set out clearly that financial considerations are at the heart of the proposal to provide a core service.

Patients require clarity about the dental service provided by the Health Service; what it offers and how much it costs. For example as part of the Minimum Standards for Dental Care and Treatment; Standard 5 Deciding and Agreeing your Care and Treatment at point three, patients are expected to receive information which allows them to be clear about the costs (in advance) and detail of which treatment is to be carried out on the health service and which is to be provided privately.

The proposals set out in the consultation mean that in the absence of clear guidance, the dentist would not be in a position to provide such information to the patient as the dentist would not be in a position to advise, in the absence of prior approval, which treatment the Health Service expected to provide. The proposals knowingly place dentists in a position where they absolutely cannot meet the minimum standards.

The matter then also arises to the view the patient may take when advised that a treatment is technically available, but is not available on the Health Service without prior approval being granted. This whole situation of a dentist not being able to advise a patient about their future care places the dentist in a position whereby the mutual trust on which the dentist/patient relationship is founded would be eroded. The result is that due to matters arising out of the Health Service, dentists would find themselves more likely to be the subject of patient complaints associated with the General Dental Council 'standards for dental professionals'.
The proposal to move to a core service is a policy decision for the Minister. It is clear that the policy direction set out by the Minister in respect of dental services is that the Health Service might be generally be responsible for dental care to include relief of pain and provision of the least complex and often the cheapest form of treatment available thereafter. Dental professionals see their role as promoting oral health and disease prevention whilst providing care for patients which meets the specific needs of patients’ and enable patients to benefit from the technological and educational advances in dentistry.

For the public the proposals as presented lack clarity. The result is that patients will be unclear about what care the health service will be responsible for and what care it will not. The result will be dissatisfaction for patients about dental services and an increase in complaints associated with matters such as delay in treatment (prior approval), lack of clarity about what treatment the health service will be responsible for and consequently lack of clarity about costs of treatment.

For dentists, the proposals as presented are devoid of sufficient clarity to inform patients. For example, a patient wears a partial plastic denture replacing a front tooth. The patient has been previously advised by the dentist that there are other means of replacing a missing tooth which can involve a fixed replacement such as by the provision of a bridge or implant. The patient has considered the matter for some time and has now decided that the time is right for them to have a fixed tooth replacement and the patient identifies the bridge as presenting the treatment of choice. At this point the dentist has to inform the patient that they are not able to advise whether the health service will be responsible for this treatment, but to meet the minimum standards of dental care and treatment they advise that the cost of the course of treatment to include the bridge under the health service arrangements.

The only further matter where they can advise clearly is that the course of treatment now has to go for prior approval and this will take a minimum of 8 weeks, during which none of the proposed other items in the course of treatment can be progressed, as they are also the subject of this approval process. Now take the situation where this approval is rejected after 8 weeks. The patient is likely to review the situation and conclude that the dentist should have been able to more reliably inform them of the likelihood that treatment would be approved or not.

A similar scenario can be drawn in the case of molar endodontics. Here a patient presents in pain with irreversible pulpitis in a molar tooth which is restorable and in occlusion. The patient is keen to retain the tooth. The dentist can advise that the tooth can be saved and restored. However, the dentist cannot indicate whether the health service will be responsible for this care or not and the course of treatment involving the proposed molar endo must become the subject of prior approval. The latter situation presents a host of practical issues for both dentist and patient.

Firstly, when prior approval is sought, it is generally extended to the course of treatment which is inclusive of the item(s) which have triggered the request for prior approval. The result is that the dentist is expected to carry out no further treatment until the course of treatment is approved. The profession requires clarity so that the narrative of the SDR will give sufficient detail as to the conditions where prior approval is likely to be granted.
Secondly, patients have an expectation that the Health service places the individual patient at the heart of their care and that care is focused on their individual needs. Instead, they will experience a system that is introducing new levels of bureaucracy and delay in order to minutely manage small transactions. There are 1.12 million Health Service patients and many thousands of them can expect to experience first hand the bureaucracy and delay which will become associated with health service dental care.

The health service does not permit mixing of health service and private care on the same tooth during the same course of treatment. The profession would welcome comment from DHSSPS on how communication to the patient, in the case of the painful molar, requiring root canal treatment and prior approval can be managed for a patient who pays HS fees in respect of their dental treatment. The profession is at a loss to conclude how they can communicate transparently the health service arrangements in such cases, where the dentist does not know whether the treatment is likely to be approved.

At page 31 of the consultation document the RIA on ortho describes how continuation of prior approval for ortho could lead to confusion for practitioners and patients over whether or not treatment could be provided. The DHSSPS own argument on prior approval should be applied equally to the confusion due to be caused in approving courses of treatment containing specific items of treatment.

**Clinical necessity**

The DHSSPS proposals refer repeatedly to clinical necessity for dental treatment items. The dental profession is clear that it is primary care practitioners, responsible for the patient diagnosis who discuss treatment choices with the patient and are ideally placed to inform and make decisions on clinical grounds. The proposals should be clear that decisions to limit treatment availability are primarily based on funding decisions and that whilst they may take clinical information into consideration in approval cases, the HSCB decision making process will centre on funding.

BDA is particularly concerned with the proposal apply prior approval to root canal treatment on molar teeth. This matter requires further discussion with the profession’s representatives.
**Question 4:** Do you agree with the proposal to increase the time period between single scale and polishes from 3 to 9 months, except for those patients with a clear clinical need for more regular treatment?

**Comment:**

No

There is no robust evidence for the proposal to increase the time period between single scale and polishes from three to nine months. What is notable is the evidence presented in the Adult Dental Health Survey 2009 which demonstrates that of the dentate population of Northern Ireland, fifteen per cent of dentate adults were classed as periodontally healthy (pocketing and loss of attachment less than 4mm) and had no calculus or bleeding; 41 per cent were periodontally healthy but had calculus and/or bleeding; and 44 per cent of dentate adults had loss of attachment and pocketing of 4mm or more. Thus the requirement to manage the periodontal condition of the majority of the adult population continues and visiting the dentist is an important part of an oral hygiene and professional cleaning regime for patients as they work with their dentist to manage their oral health experience. [http://www.nhs.uk/Conditions/Gum-disease/Pages/Treatment.aspx](http://www.nhs.uk/Conditions/Gum-disease/Pages/Treatment.aspx)

At the same time new research frequently appears linking periodontal health to coronary conditions. For example gum and heart disease share common risk factors and studies have found an association between the two diseases.

A 9 monthly interval between routine scalings is not an interval for oral health interventions that is recognised by patients or based in evidence as being appropriate to the majority of patients. BDA supports six monthly interval as being an appropriate interval between routine scaling and polishing.

Any interval longer than six months for item 0101 requires the practical reality that is presented as part of prior approval to be considered for both patients and dentists. Prior approval as it is constructed, is set out at Para 26 1993 Regs. Prior approval requires approval of a course of treatment, rather than approval for individual items of treatment. In the absence of prior approval being granted, the treatment outlined and planned in the estimate cannot proceed. If a course of treatment subsequently changes, it requires to be resubmitted for approval.

The result is that introducing prior approval for low value items of care will suffocate the approvals system and introduce such additional delay to routine dental care that patients will lose confidence in the general dental services.

If scaling and polishing at more frequent intervals is to be available as part of prior approval, then the narrative of the SDR should set out the conditions for approval as a means of enabling the dentist to advise the patient of the likelihood of approval being granted.

Any change arising to the narrative of the SDR must be agreed with the representatives of the profession.
Any narrative change to the SDR should apply a change prospectively so that the interval between item 0101 is counted not from the last 0101, but from the date of issue of the SDR.
**Question 5(a):** Do you agree with the changes to the proposed criteria for the practice allowance in order to prioritise resources to practices with the most significant health service commitment?

**Comment**

No

The practice allowance is an important source of turnover, dedicated to expenses for dental practice within the health service. BDA are aware that for many practices this allowance is highly valued and presents a means to remain committed to HS dental practice.

It is imperative that DHSSPS recognise that the narrative of the practice allowance is already a cause of much concern to dental practice in meeting the criteria to demonstrate commitment to the health service. Any change, however minimal would be detrimental and would have the effect of denying practices which are committed to the HS the ability to receive the allowance. The impacts would be devastating to the public in their ability to access HS dental care.

The practice allowance aims to recognise those practices that are committed to the Health Service.

Commitment is typically measured by asking the question ‘How much work do you do on the health service?’

Dentists are self-employed independent contractors. They do not necessarily work a dedicated 37-hour week, but can work any combination of hours or clinical sessions. Each of the 1049 contractors will have a different working pattern, and more importantly a unique cohort of patients, with individual needs, for whom they care. There are similarities too between dentists. In considering the period to end 2012 there has been an increase in the number of patients for whom the health service now provides health service dental care. There has been a concomitant increase in the number of dentists. The result is that over the period to end 2012, the ratio of dentists to patients has remained stable. A typical dentist over the period 2007 to the present day, when averaged against his peers has continued to care for an average list size of patients of around 1000 patients. Patient needs have not changed significantly.

**Table 1 Dentists and Patients – September 2011**

<table>
<thead>
<tr>
<th>Northern Ireland</th>
<th>Period ending end Sept 2011</th>
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</thead>
<tbody>
<tr>
<td>Total no of patients registered</td>
<td>1,097,744</td>
</tr>
<tr>
<td>No of patients aged up to 18 years</td>
<td>314,596</td>
</tr>
<tr>
<td>No of adult patients registered</td>
<td>783,148</td>
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</tbody>
</table>
When considered together, these factors demonstrate that an individual dentist has a base of patients for whom they can provide care. It follows that commitment should be measured as an absolute measure which takes into consideration the unique nature of the patient base and clinical sessions worked.

Take Scotland as an example. In Scotland the vital importance of the General Dental Practice Allowance was raised by BDA in discussion with Scottish Government and Chief Dental Officer and in the most recent round of negotiations the practice allowance was protected. For Northern Ireland, we cannot stress enough that the role of the Practice Allowance in assisting with overheads costs is vital to HS committed practices staying in business.

Any changes to the Practice Allowance to increase the thresholds would be so highly detrimental to practice that any saving would be minimised as the Minister presides over the public detailing local difficulty experienced as individuals seek access to health service dentistry.

BDA asserts that commitment to the health service in Northern Ireland is high, given that there are a large number of patients registered. At individual dentist level commitment cannot be increased given that the patient needs have not changed and dentists are able to care for patients in line with their individual needs and oral health experience.

BDA has already made it clear that we believe the current practice allowance criteria to be flawed. Requiring dentists to have a certain number of paying patients is outside of the dentists control, being associated with factors such as practice location and the prevailing economic situation in Northern Ireland. For example the Department of Trade and Industry report of 2012 at http://www.detini.gov.uk/deti_monthly_economic_update--_february_2013-2.pdf shows a region with the lowest employment rate and highest inactivity rate of any area of the UK. The number of the fee paying patients is reducing and is beyond the control of dentists.

Looking at the matter of fee paying patients separately. The figures for registered patients at end of the quarter ending Sept 2011 (the most up-to-date quarter when these proposals

<table>
<thead>
<tr>
<th>No of fee paying adults at 43%</th>
<th>336,754</th>
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<tbody>
<tr>
<td>No of dentists</td>
<td>1033</td>
</tr>
<tr>
<td>Average No of paying patients per dentist</td>
<td>325</td>
</tr>
<tr>
<td>Average No of patients per dentist not paying fees</td>
<td>432</td>
</tr>
<tr>
<td>Average No of patients under 18 years per dentist</td>
<td>304</td>
</tr>
<tr>
<td>Average no of patients per dentist</td>
<td>1061</td>
</tr>
</tbody>
</table>
were first set out by DHSSPS) there were 783,148 adult patients registered. DHSSPS in the consultation document on the proposals sets out that 43 percent of patients pay health service fees for their dental care. This equates to a population of 336,754 persons. If the fee paying population and the wider population accessing HS dental care was evenly distributed across the communities of Northern Ireland, then based on figures to the end of Sept 2011 a dentist demonstrating the average across Northern Ireland would have a patient base as set out in Table 1

The average number of patients per dentist is a number which over time has changed little. The makeup of the patient base is dependent on a series of factors which are linked to the characteristics of the profile of the community which is local to the practice. For example looking at Northern Ireland neighborhood information at [http://www.ninis2.nisra.gov.uk/InteractiveMaps/Census%202011/Population%2020Pyramids/LGD/NINIS_Pyramid_2013.html](http://www.ninis2.nisra.gov.uk/InteractiveMaps/Census%202011/Population%2020Pyramids/LGD/NINIS_Pyramid_2013.html) and comparing two populations such as North Down and Derry Londonderry it can be demonstrated that one of these populations has a makeup where 28.8 percent of the population are under 19 years. The other population has an under 19 years population of 23.1 percent. It follows that if the local population has a higher percentage of patients with a particular characteristic such as under 19 years, this characteristic will be replicated in dental lists.

Given that a dentist can cater for patients dependent on their needs and oral health experience, it follows that if registered places are taken up with a youthful population, then they are less available for other cohorts of the population such as adults.

BDA asks that the narrative be revisited to address measures of commitment and reward the committed practice as opposed to the most committed. This should be based on an absolute measure which takes into account the unique nature of the patient base and the clinical sessions worked.

To safeguard the viability of practices dedicated to the provision of mainly Health Service dentistry, it is essential that the value of the practice allowance be maintained, but that the requirement to have paying patients be removed across the narrative of the practice allowance. The requirement for fee paying adults is of particular concern to orthodontists who mainly treat children and therefore cannot meet such a criterion.

The narrative of the Practice Allowance, from its introduction to the present day, uses a range of measures to determine whether a practice is ‘committed’ to the Health Service. Over time, there has been an increase in both patient numbers using health service dental services and the number of dentists providing dental services. The relationship between patients and dentists when expressed as a ratio has remained relatively constant (see table). This is a factor of the treatment needs of patients, so whilst more patients may desire health service dental care that requires more dentists to provide the care as a single dentist can only realistically cater for the needs of a finite number of patients, dependent on their needs.

**Table 2 – Dentist to Health Service patient ratio 2007-2012**

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of</td>
<td>852</td>
<td>894</td>
<td>889</td>
<td>984</td>
<td>1033</td>
<td>1049</td>
</tr>
<tr>
<td>dentists</td>
<td>No of patients</td>
<td>Patients per dentist</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<tr>
<td></td>
<td>877,442</td>
<td>1029</td>
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<tr>
<td></td>
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<td>961</td>
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<td></td>
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<td>976</td>
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<td>884,871</td>
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<td></td>
<td>1,001,094</td>
<td>969</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1,119,449</td>
<td>1067</td>
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Given the constancy of the number of patients per dentist over time and the economic situation which means that there are fewer fee paying patients, and the need for practices to provide resources to costs such as the capital and revenue costs of decontamination facilities, it is difficult to comprehend the rationale behind the DHSSPS proposal to make the practice allowance criterion more difficult for practices to achieve.

Patient numbers for the practice allowance – the no of patients registered per dentist has remained constant. To make a change to this number would remove the practice allowance from practices which are very clearly committed to the HS, but because of counting dentists by head count the calculation of the practice allowance is insensitive to counting commitment of those dentists who may provide fewer clinical sessions.

Paying patient numbers – BDA has raised this in the past with DHSSPS that counting fee paying patients is not in the spirit of the practice allowance. A patient who is registered with a dentist through the health service has the same rights conferred on them irrespective of their ability to pay health service fees.

In considering this proposal consideration must be given to the very much changed economic situation. Practices have to deal with rising costs against a backdrop of a pay freeze where DHSSPS has taken the view that elements of dentist remuneration (excluding pay for their employed staff earning less than £21,000) should be subject to the pay freeze. BDA has set out our evidence on the expenses to be met through HSC dental practice for the periods 2011/12 and 2012/13. We continue to be concerned with the proportion of turnover being taken up with expenses and have already submitted evidence to DHSSPS for the need to increase resource to dentists including that through the practice allowance.

BDA believes that any change to the practice allowance criteria would directly exacerbate the difficulties currently experienced at dental practice level and could result in a reduction of dentists in the workforce and even in practice closures.

BDA is warning DHSSPS that is can expect to witness the out turn of further stress, both emotional and financial on the dental profession. No individual is well placed to suggest how the stress the profession is experiencing will manifest itself, but BDA is clear that cuts of this magnitude will result in loss of dentist jobs and possibly lead to further practice closures and manifestations of the emotional aspects of stress.
**Question 5(b):** Given that access to Health Service dentistry is no longer problematic, do you agree that the Commitment Allowance should cease?

**Comment**

No

BDA reject this proposal. Commitment payments were introduced in the 2000 DDRB report as part of the Doctors’ and Dentists’ Review Body (DDRB) recommendations on General Dental Practitioner pay. A scheme was introduced to reward the loyalty of GDPs to the health service and consequently to encourage retention and improve motivation and allow for an element of career progression.

This proposal put forward by DHSSPS penalises most those practitioners who have remained committed to the Health Service. As with the practice allowance the commitment payment is an extremely important source of health service turnover for practitioners, providing a source of investment for health service care and patient benefit.

The DHSSPS proposal asserts that because access to HS dentistry is no longer problematic to the public, that the Commitment payment should be ceased. Increased access to HS dentistry has arisen as a result of the market place, meeting the needs of the consumer and as a result of the commitment payment. It does not follow that ceasing the Commitment Payment will not affect access.

BDA also note that the larger part of the commitment payment is actually an adjustment made by DHSSPS to recognise that they had delivered an inadequate pay award in 2009. In 2009, when Northern Ireland was in receipt of a pay award that was linked to events in England, and consequently a recommended award of 1.44% was abated to 0.21 percent and applied to fees in Northern Ireland. Therefore, the uplift to commitment payments in 2009 was in lieu of an uplift to fees.

If commitment payments are to be considered in the light of access being no longer a problem, this does not address the need to provide a fee uplift in respect of 2009, which needs to be addressed separately through an uplift to fees or other negotiated settlement.

DHSSPS need to recognise and accept that cuts to the payment including the commitment allowance will have knock on effects on business viability, jobs and consequentially patient care and access.

BDA notes that DHSSPS, through the action of renewing the PDS contract does not believe that the access issue is resolved.
**Question 6:** Do you feel that the proposals set out in this consultation document are likely to have an adverse impact on any of the section 75 categories

Yes

The proposals set out in the consultation propose altered thresholds for the practice allowance. That is, they set new levels and an increased threshold to show commitment to the health service.

The practice allowance currently measures Health Service Commitment by asking practices that each dentist individually meet a series of thresholds of commitment. There is also the opportunity to attain the practice allowance by a dentist limiting their work to demonstrate at least 90 per cent of turnover is a result of Health Service dentistry.

Our evidence demonstrates that over a period of increasing patient and dentist numbers, the dentist to registered patient ratio has stayed constant. The commitment per dentist is therefore stable. The proposal to alter the thresholds is a means of penalising practices which are committed and this penalty may be passed to patients.

BDA proposes that the measure of commitment should be based only on the number of registered patients without any reference to the number of fee paying patients, or the turnover per dentist.

The equality implications are set out.

**Between men and women generally**

The Individual Income Series Bulletin 2008-2009 provides the most up to date estimates of the individual income of women and men across the region and provides a means by which men’s and women’s incomes can be compared either directly or in their own right. The report is available at [http://www.dsdni.gov.uk/iis_bulletin_0809.doc](http://www.dsdni.gov.uk/iis_bulletin_0809.doc) and demonstrates that

- Median values for men were higher than those for women.

- Total Individual Income for women was £206 per week, compared to £298 for men.

- 156,600 women had a total individual income of less than £100 per week; the comparative figure for men was 97,600.

- 48% of women had incomes in the bottom two quintiles of the income distribution, compared to 32% of men.
• 27% of males had total individual incomes within the top quintile; the comparative figure for females was 13%.

BDA concludes that as men have higher income than women, they are more likely to be in a position to pay health service fees in respect of dental care.

By attaching the practice allowance to numbers of fee paying patients per dentist, and given that a single dentist can in reality only have a finite number of patients registered, dependent on their needs, the DHSSPS policy therefore has the capacity to encourage registration of male adults at the expense of registration of other members of the population. There is nothing to suggest that this is happening, but an adverse impact is about the potential of the policy to have an adverse impact on any of the section 75 categories.

**Income deprivation related to community background**

BDA is aware that some dental practices in Northern Ireland, often operating in the most deprived areas of Northern Ireland, and which are highly committed to providing health service care for local patients, are unable to qualify for the higher rate of practice allowance. The inability to qualify centres on the fact that practices are operating in locations where the population is income deprived and this in turn impacts on the number of patients who make a contribution to the cost of their care in the form of health service patients charges.

BDA believes this presents issues of equality of opportunity whereby the Practice Allowance does not serve to promote equality of opportunity and good relations and does not improve equality of access to the HSC dental service for particular sections of the community. This adverse impact disproportionately affects persons living in areas where communities are income deprived and these areas and persons are more likely to have a Catholic community background.

Income within the general public of Northern Ireland is not uniformly spread across Northern Ireland, and evidence from Northern Ireland Statistics and Research Agency (NISRA) describes deprivation using a series of indicators including income.

Using income as a descriptor, and placing Northern Ireland’s electoral wards according to rank where the most income wards are described, we have considered the community makeup of the ten per cent most deprived ward in Northern Ireland.

Communities in the 57 most income deprived wards in Northern Ireland have a population makeup which is much more highly representative of population who have a Catholic community background (see appended table).
Dental practices serve the population which is local to the practice. The community background of the patients attending the practice will be reflected in the community background of the electoral ward in which the dental practice is situated.

Practices which are located in areas where the population is income deprived are much more likely to serve members of the public from a Catholic community background.

In turn, because of income deprivation, there will be a low numbers of the public/patients living in these areas who normally pay health service charges. It follows that practices in income deprived areas are less likely to be able to meet the criterion of the practice allowance at Determination XI 1 (1)(c) (i) ‘…of which an average of 100 per dentists must be fee paying adults….’

Accordingly this criterion indirectly discriminates against persons from a Catholic community background by making it less likely that a dental practice will locate in their area because of a lack of sufficient fee paying patients and inability to meet the criterion of the practice allowance to demonstrate ‘health service committed.’

This outcome means that members of the Catholic community are more likely to have a poorer experience of dental practice availability and/or of resources available at the dental practice than persons from a Protestant community background. This is outwith the Departmental objectives that all of its services be fully accessible to all sectors of the community without discrimination and should promote equality of opportunity and good relations.

**People of different ages**

The census population estimates for Northern Ireland set out detail of the population make up and how the population in different areas is changing. For example Dungannon area has a population of under 14s which accounts for 21.8 percent of the population whilst in North Down this figure is 17.2 per cent of the population. The 55-69 year age group showed a different pattern whereby 19 percent of the population of North Down are in this age group and 13.5 percent of the population of Dungannon are in this age group.

It follows that in Dungannon, for this example, the ability for the dental practice to register sufficient fee paying adults will be reduced in comparison to North Down.

By attaching the practice allowance to numbers of fee paying patients per dentist, and given that a single dentist can in reality only have a finite number of patients registered, dependent on their needs, the DHSSPS policy therefore has the capacity to discourage registration of under 18s at the expense of registration of other members of the population who are more likely to pay health service fees.
The BDA asks DHSSPS to review and amend the proposals to remove fee paying patients from the threshold at which commitment is demonstrated as a means to ensure equality of opportunity for the public as they access health service dental care.

90 per cent

The narrative of the practice allowance allows for a dentist to demonstrate commitment if 90 per cent or more of their income is derived from Health Service dentistry.

The proposals put forward by the Minister in respect of a move to a core service could significantly alter the dynamic between the mix of private and Health Service care provided.

This is untested and BDA would welcome the opportunity to work with DHSSPS to review this criteria if the practice allowance is to maintain its purpose.
**Question 7:** Are you aware of any indication or evidence – qualitative or quantitative – that the proposals in this document may have an adverse impact on good relations for any of the section 75 categories?

Yes

The proposals set out in the consultation propose altered thresholds for the practice allowance. That is, they set new levels and an increased threshold to show commitment to the health service.

The practice allowance currently measures Health Service Commitment by asking practices that each dentist individually meet a series of thresholds of commitment. There is also the opportunity to attain the practice allowance by a dentist limiting their work to demonstrate at least 90 per cent of turnover is a result of Health Service dentistry.

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This is untested and BDA would welcome the opportunity to work with DHSSPS to review this criteria if the practice allowance is to maintain its purpose.
Question 8: Are there any aspects of these proposals where potential adverse impacts on human rights may occur?

No
**Question 9:** Are there any impacts associated with the Department’s proposals which have not been identified in the Regulatory Impact Assessments?

**Comment**

Yes

The impact assessment is partial in nature and does not fully identify the impact of these proposals on patients. Every patient in Northern Ireland is likely to be affected by these proposals in some way:

- Through the core service
- Through the need for prior approval causing delay and uncertainty
- Making scale and polish available less frequently
- Restriction of orthodontics

The proposals would create extreme uncertainty for patients, which because of the lack of transparency could make patient delay dental visits due to concerns about unknown costs. The result could be a widening of the existing health inequalities which exist in Northern Ireland.

Patients may also present in secondary care with conditions which could have been treated sooner in primary care.

The impact assessment does not identify the impact of these proposals on dental business. BDA has repeatedly explained that the dental sector provides thousands of skilled jobs in communities across Northern Ireland and often these skilled jobs are in short supply in these communities.

The figures for loss of turnover to practices and practitioners is overly simplistic. No attempt is made to assess what this will mean in terms of jobs lost in dental business. It is the case that these proposals will threaten the jobs of many dental nurses, receptionists, hygienists and dental therapists as well as dental professionals. BDA is already aware of practice closures and we anticipate the proposals in this consultation with only exacerbate this situation.
**Question 10**: Do you foresee any unintended consequences as a result of the introduction of these proposals?

**Comment**

Yes

The proposals set out address the issues that DHSSPS have identified, from a financial viewpoint. They do not address the real needs of primary care dentistry and the 1.2 million patients who access the service. Dental business is suffering from a crisis of viability through increasing expenses and addressing governance through further expense against a backdrop of stagnant fees. BDA is asking DHSSPS to recognise and address that jeopardising dental businesses this way will surely impact upon patient care and oral health generally.

The issue of the well being of dental professionals and the staff at dental practices has also not been addressed.
Annex 1

Increases in Dental Practice Expenses 2011/12
Northern Ireland

Executive Summary

- Dentists require an uplift to the expenses elements of 7 per cent for 2011/12 to provide a zero uplift to net pay for the period
- Laboratory fabricated items have risen in cost to the extent where the cost outstrips the health service fee
- The costs of a pay award to DCP and practice staff and additional staff training and development costs must be met through an increase to the expenses elements of the pay equation for dentists
- Loss of Quality Improvement Scheme funding requires the timeline for the policy initiatives associated with decontamination in dental practice to be pushed back by a minimum of two years
- The monies saved by HSCB in the movement of practice inspections to being paid for by the private purse must be reinvested in the dental service
- The efficiencies with which the business of dental practice operates must be recognised
- Budgetary planning must take into consideration the number of dentists and their likely activity against all aspects of the Statement of Dental Remuneration

1. Introduction

The Health and Social Care Board is charged with commissioning Health and Social care including dental services for the population of Northern Ireland. This is a time of constraints in funding for all services, including health and social care and the Executive was briefed by HSCB to have a full understanding of the issues for HSCB prior to agreeing the budget.
Even in advance of defining how the HSCB budget will be spent, HSCB has set out that it has had to set aside planned service developments and workforce control measures in the light of funding constraints.

It is now the turn of the Health and Social Care Board (with Departmental approval as necessary) to define how it will spend the resources available to it. BDA is keen that in making decisions, there will be a clear understanding of the issues which impact on General Dental Services and the public as they access dental services. This paper sets out for both HSCB and DHSSPS the issues which face dental practitioners and dental practices as they strive on a daily basis to meet a continual rise in demand for dental services and the demands of policy imperatives placed upon them.

The rises in demand come through:

- an increased number of patients seeking dental care under the health services
- the wide range of pay and expenses costs which need to be met as part of running a dental business
- meeting new and additional governance requirements and introducing new technology to dental practice
- inflationary pressures on both pay and expenses

HSCB in its own evidence to the Executive attached a value of 5.7% per annum to inflationary demand and demographic pressures alone.

2. Dental Spend

The spending on dentistry is essentially ‘demand led’ which will have activity as its main driver. The spending on dentistry for the period 2009/10 is set out at Annex 1 (all figures supplied by BSO). Whilst the budget is demand led in how the spend is derived at HSCB level, when the funding reaches practice level the practice must pay for the practice overheads (building, heat, light, patient facilities, equipment); the costs incurred in patient treatment (laboratory and materials costs); and staff and other costs.

The figures for General Dental services costs for 09/10 show that the gross cost of the dental service was £93,132,978. £79,380,421 represents the gross monies paid to dentists in respect of treatments provided and the registration of patients for the period.

Dentists’ pay is part of a complex equation whereby practitioners are paid gross sums in respect of specific treatment items. The dentist meets the costs arising and retains the balance for reinvestment and net pay. It is accepted, for the purposes of superannuation calculations, that 56.1% of gross turnover is practice expenses. This is the figure we have used in illustrations of how changes to practice expenses affect the amount retained for reinvestment and pay.

Essentially this can be represented where gross turnover = 100%
The expenditure falling to the dentist = 56.1%
The net profit/pay before tax = 43.9%
Therefore for £100,000 of turnover £56,100 is expenses and £43,900 is retained for investment and pay.

Net pay must be maintained, as outlined by Doctors’ and Dentists’ Review Body (DDRB), then as expenditure rises, in order to keep net pay stable requires a corresponding uplift to be applied to gross turnover.

For example, if expenditure rises by the figure predicted by HSCB of 5.7%, then expenses this year of £56,100 will increase over the period to £59,297. To maintain pay at £43,900 requires gross turnover to rise by 3.2% from £100,000 to £103,197.

3. Practice Expenses

Practice expenses can largely be attributed to three main categories of expenditure. These are:

- Laboratory fees and materials
- Staff costs for directly employed staff excluding dentists
- Overhead costs (premises, direct costs and other overhead costs)

Using information prepared and collated through a Northern Ireland accountancy firm, relating to year end information during 08/09, BDA has collated the income and expenses data for 30 dental practices across Northern Ireland.

The local evidence on dental practice expenses shows that expenses costs of 56.1% of turnover are accounted for as follows:

- Laboratory fees and materials costs account for 19.34% of turnover
- Staff costs for directly employed staff excluding dentists account for 21.37% of turnover and
- Overhead costs account for 15.39% of turnover.

4. Determining a pay award

In determining a pay award for dental services, the Doctors’ and Dentists’ Review Body uses a recognised formula approach which takes into consideration the expense elements of practice and applies an uplift according to prevailing factors. These figures can be applied to the DDRB formula to give a value for the percentage by which gross payments to dentists should rise to meet changes in dental practice expenses. The outcome using the DDRB formula and the latest quarterly figures for RPI and RPIX, an expenses-to-earnings ratio of 56.1 per cent. 21.37 per cent for staff costs and 19.34 per cent for laboratories and materials costs, with other costs therefore being 59.39 per cent, the uplift according to the formula is 2.82 per cent.

Uplift2011-12 = 0.439 * x + 0.12 * HRPSASHE + 0.109 * RPIX + 0.33 * RPI

where
In 2010/11 the DDRB used the recognised formula-based approach to take into account the increases in operating costs for dentists, in order to make an informed pay award. The most recent report of DDRB recommended an increase of 1.44% in order to deliver a zero increase in net income for GDPs. DDRB recommended that DHSSPS Northern Ireland should increase fees by 1.44%, if they did not have sufficient evidence to enable them to make adjustments to the fee scales to account for expenses. DHSSPS did not take the approach recommended by DDRB and instead applied an uplift of 0.5049% (0.9% award x 56.1%) for GDPs in Northern Ireland. What DHSSPS did was apply an efficiency saving to the award, bringing it to 0.9% and then applied a further expenses to earnings ratio of 56.1%, leading to an uplift of 0.5049%. DDRB have written to Michael McGimpsey as part of the DDRB monitoring round to advise that DDRB does not think this approach appropriate as their recommendation already took account of an expenses to earnings ratio of 51.5%. The approach taken by DHSSPS will have had the effect of requiring GDPs in Northern Ireland to make greater efficiency savings in their expenses in order to maintain their levels of net income, than is the case in other parts of the UK. This situation is not acceptable for GDPs in Northern Ireland and needs to be addressed in the expenses element of the pay equation going forward into 2012.

The outcome of this is:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross cost of estimates 09/10</td>
<td>£79,380,421</td>
</tr>
<tr>
<td>expenses at 56.1%</td>
<td>£44,532,416</td>
</tr>
<tr>
<td>net after expenses</td>
<td>£34,848,005</td>
</tr>
</tbody>
</table>

The aim of the DDRB recommendation was an uplift of 1.44% on the HS fees to produce a zero uplift in net after expenses, maintaining it at a total of £34,848,005.

To keep net pay the same, whilst applying an uplift to the gross cost of estimates, means that DDRB must have assumed a 2.57% rise in expenditure during the period.

The DHSSPS decision to abate the award and pay 0.9% in expenses (0.5% on fees), means that if net pay after expenses is to remain stable, then expenses would have to reduce by (2.57 - 0.9) = 1.67%.

An additional uplift of 1.67% to expenses would be required to address the shortfall in the pay round for 2010/11.
6. Loss of Quality Improvement Scheme Funding 2010

During 2010/11 HSCB withdrew the Quality Improvement Scheme (QIS) funding which was previously available to practices. All of this funding package of £1.1 million for the year 08/09 would have gone directly to meeting practice capital expenditure to meet an increasing decontamination agenda. The loss of QIS funding to dental practices represents a very significant reduction in the ability of practices to meet expenses and in real terms, the loss of £1.1 million from the expenses side of the equation is a reduction of 2.47% in the ability of practices to meet expenses. For every pound lost through QIS monies, in order to recoup the funds, without affecting pay, the profession will have had to generate £1.96 in fee income. The alternative of continuing to meet expenses, without increasing fee income, presents a reduction in pay after expenses in the order of 2.47%.

<table>
<thead>
<tr>
<th>09/10 expenses at 56.1%</th>
<th>£44,532,416</th>
</tr>
</thead>
<tbody>
<tr>
<td>add QIS monies</td>
<td>£1,100,000</td>
</tr>
<tr>
<td>Out turn of loss of QIS monies %</td>
<td>2.47%</td>
</tr>
</tbody>
</table>

An additional uplift of 2.47% to expenses would be required to address the loss of QIS monies during the period 2010/11

Elements making up dental practice expenses for the period 2011/12

7. Laboratory costs

Laboratory costs are incurred in dental practice in the making of crowns, dentures and appliances.

The price of metals continues to rise, affecting the price of lab fabricated items. Dentists are reporting that some laboratory fabricated items are so costly in laboratory fees, when compared with the fee paid through the Statement of Dental Remuneration that they are simply not economic to produce (see Table1, median values for lab items and the lab fee expressed as a percentage of the item of service fee). 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. All show an increase.

The intent of the item of service fee must be to fully cover the cost to fabricate the item and the in-surgery costs and surgery time. In no way is it the intent that the practice allowance should subsidise laboratory items or surgery time.
Table 1: Median values for Lab fees expressed as % of item of service fee.

<table>
<thead>
<tr>
<th>Material</th>
<th>Median 2009</th>
<th>Median 2010</th>
<th>% change</th>
<th>Fee paid in SDR 2010</th>
<th>% of fee taken up by median lab costs 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porcelain bonded crown with precious metal</td>
<td>45.00</td>
<td>47.75</td>
<td>6.1%</td>
<td>127.45</td>
<td>37.5%</td>
</tr>
<tr>
<td>Full acrylic dentures</td>
<td>90.00</td>
<td>95.00</td>
<td>5.6%</td>
<td>174.70</td>
<td>54.4%</td>
</tr>
<tr>
<td>Two tooth partial skeleton chrome cobalt denture</td>
<td>126.25</td>
<td>140.00</td>
<td>10.9%</td>
<td>165.80</td>
<td>84.4%</td>
</tr>
<tr>
<td>Two tooth acrylic partial</td>
<td>46.45</td>
<td>50.00</td>
<td>7.6%</td>
<td>68.35</td>
<td>73.15%</td>
</tr>
</tbody>
</table>

Source Dental Business Trends 2010

The costs of fabricating laboratory items when compared against the fees paid for such items via the SDR presents the stark reality of the expenses associated with dental care. What the health service pays for the care in no way covers the cost to produce and provide the item, the professional time and overheads of providing the care. The expenses uplift needs to address the reality of the costs of lab fabricated items. The average increase of the items in Table 1 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. 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. We are therefore seeking an uplift in expenses to recognise the costs of providing patients with lab fabricated items.

8. Materials costs

Dental materials costs will increase at least in line with general inflation over the coming period. Generally many specialised dental materials are manufactured in the Eurozone and will be subject to cost pressures due to the value of euro versus sterling. This adds costs in excess of inflation to the costs of dental materials.

9. Staff costs
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 Trusts and other employers of dental care professionals (DCPs), dental practice owners will be under pressure to award their staff at least £250. These costs will have to be met from practice turnover. It is essential that these additional costs are funded through a rise to practice expenses.

Now that the whole clinical dental team is registered and has compulsory CPD requirements, there are additional staff training costs for practices. All dental nursing staff must be registered or in pre-registration training and the costs of pre-registration courses for dental nurses are considerable. Training requires time out of the surgery and away from revenue generating exercises, so comes at additional cost to dental practices.

The costs of a pay award to DCP staff and additional costs of staff training must be met through an increase to practice expenses.

10. Over head costs

There are a host of overhead costs associated with dental practice. There is the fabric of the building and the facilities. Equally important are the skills of the whole staff complement involved in the practice and the patient experience. Funding must reflect the resources necessary to manage the total overheads in health service dentistry.

Inflation as measured by the Consumer Price Index (CPI) stood at 4.4 per cent in the year ending 31 March 2011, above the Bank of England’s inflation target of 2 per cent. RPI is currently at 5.5 per cent. This is associated with a number of factors, including the restoration of VAT to 17.5 per cent and subsequent increase to 20%, higher oil prices and the past depreciation of Sterling. Retail Prices Index (RPI) inflation, which includes housing costs, is 5.5 per cent.

Inflation is likely to remain above target for a prolonged period. The VAT rise from 17.5 per cent to 20 per cent continues to 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.

There are additional factors which affect dental practice. 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.

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 level of depreciation is a substantial cost to dental practitioners.

11. Decontaminations costs
Dental practices are expected to meet the DHSSPS policy initiative on decontamination in dental practice, whereby by end of 2012 practices should reach compliance with the DHSSPS policies.

Decontamination requires both capital and revenue spend. Capital spend is required to enable the practice to put in place a suitably equipped facility and equipment and instrumentation. Revenue is required for staff and to provide consumables and meet other overhead costs associated with running the facility. The initial outlay and ongoing utility, materials and staffing costs are placing intense financial pressures on practices, which go well beyond the amount and scope of the current practice allowance. The situation is further exacerbated by the loss of QIS monies, which were utilised by practices solely for the purpose of working towards the decontamination requirements of HTM 01/05. Equipment in the decontamination unit has to be maintained and serviced in line with DHSSPS. As an example, the costs of initial set up a validation of a washer disinfector, with a local supplier is £700+ VAT. This is in addition to the purchase cost and would have to be carried out annually. There is simply no revenue stream within health service dentistry which can manage this type of additional annual cost burden.

The loss of QIS monies has placed practices at least 2 years behind on the timeline for working towards meeting HTM 01/05 requirements. We would therefore request that the timeline attached to meeting the policy initiative of HTM01/05 and Northern Ireland modifications be reconsidered and moved to a time in the future when resources can be secured to enable investment to meet the guidance.

12. Regulatory costs

April 2011 sees the introduction of Regulation by statutory rule which introduces regulation of private dental services, categorises dental practices as ‘independent hospitals’ and regulates dentistry as a ‘listed service’. The regulation is aimed at regulating the establishments, registered persons and services in respect of private dental care and will be carried out by the Regulation and Quality Improvement Authority (RQIA). All dental practices and dentists already listed with the HSCB all provide dental care via the health service as well as privately. Therefore, whilst RQIA regulates and inspects private care, in so doing its remit will extend to all of the practices carrying out health service care.

It is essential that the normal outlay of practice inspection by the HSCB is reinvested in the dental service in order to offset the costs which will be met by the private purse.

13. Small business environment

Dental practices by their nature and location are providing services to local communities and as a result are often located in converted dwellings or converted commercial premises. The result is that they are often small as they are constrained for space by the existing building, have expanded to capacity or are large enough the deal with the needs of the community they serve.

As small businesses, dental practices are run as efficiently as possible. In fact it is in the best interests of the business owner to operate efficiently without waste or inefficiencies and by securing downward pressure on containable costs.

Therefore, when DDRB indicated to Minister McGimpsey that GDPs in Northern Ireland will have had to make greater efficiency savings in their expenses in order to maintain levels of net income, than is the case in the rest of the UK, it is worth noting that in an already
efficiently run business of dental practice, there is little additional capacity to make savings of
the order of 1.67% (loss incurred in pay 2010/11 pay round) plus 2.47% (loss incurred
through QIS). Dental practices would have to reduce their expenses by 4.2% in the current
year to remain stable. There are few ways a reduction in expenses of this magnitude could
be achieved in a single year and it would require significant service changes such as
shelving of capital projects; not equipping already developed decontamination spaces; not
implementing a new decontamination regime in order to avoid the increased revenue costs
or some other move to reduce costs.

The outturn here is that the business of dental practice is already efficient and exists without
unnecessary waste or inefficiencies often associated with parts of the health service. What is
required is either additional dedicated funding to assist practices with the essential business
costs which are incurred in dental practice, or alteration of departmental policy on
decontamination to bring about cost savings.

14. **Complexity inherent to the dental service**

The total population of dentists in Northern Ireland is inclusive of a diverse group of dentists
and dental practices offering a range of general dentistry and more specialised services
including orthodontics. This is demonstrated through the example of consideration of the
health service activity of the population of dentists who carry out more than 30% of their item
of service value claims through orthodontic items and those do not (i.e. carry out general
dentistry).

Information available from Business Services Organisation shows that in 2008/09 the health
service spend on clinical care items of service and treatment was £53,000,499.25. The gross
cost of orthodontic items of treatment, provided by dentists who do more than 30% of their
treatment claims as orthodontic items, in 08/09 was £7,351,925.90. BSO record 48 dentists
as fitting the criteria whereby they do more than 30% of their treatment as orthodontics in
Northern Ireland in 2008/09 which equates to each of those 48 dentists claiming on average
£153,165.12 in item of service fees. The remaining dental spend on items of service
excluding patient registration payments during 08/09 of £45,648,573.35 was split between
the remaining 775 dentist contractors listed by BSO and equates to an average gross claim
on items of service of £58,901.38.

This demonstrates how the item of service spend associated with a particular aspect of
dental care, which is without patient charge, can lead to skewing of the overall picture
associated with the item of service spend on dental services.

In planning future calls on the budget for dental services during 2011/12, the budget must be
modelled against the number of dentists and their likely activity against all aspects of the
Statement of Dental Remuneration.

15. **The dental budget**

During the course of 2010/11, the budget for dental services moved from DHSSPS to the
HSCB. At the same time, the budget is now defined as a ‘cash limited’ budget. The concept
of a ‘cash limited’ budget in a service which is ‘demand led’ requires careful management
and modelling to inform commissioners about likely spending. It is essential that all the
factors set out are considered in informing the budget.
16. Conclusions

It is essential that the front line service of primary care dentistry, provided to the public through independent contractor dentists is protected. Growth in need for dental services is continuing as the population increases in size and in the number of older persons who remain dentate.

The dental service is such that

- The workforce is highly skilled
- The public demand the service locally
- Practices work efficiently, with little downtime, high productivity and effective use of clinical time.

Given the efficiencies that exist, there must be a realistic increase to funding to the sector to enable the increasing costs of dental practice, as set out in this paper, to be met.

The DDRB formula and taking into account the problems encountered in 10/11 point towards a need for an increase to dental practice expenses of 2.82% for 2011/12 + 1.67% to address the pay round 2010/11 + 2.47% to address the loss of QIS monies in 2010/11

Thus a minimum increase to expenses of 6.96% is required.

This assumes QIS monies will be available in 2011/12

Northern Ireland Dental Practice Committee
April 2011
Annex 1

Payment system for dentists in Northern Ireland

This information describes the elements of Statement of Dental Remuneration which make up the gross payments available to dental practitioners in Northern Ireland.

The information is separated into those payments made to individual dentists and those made to practices. (Excluding payments in respect of expenses associated with vocational training and superannuation payments for dentists).

Individual payments

- Item-of-service fees for treatment items
- Patient Registration (Capitation & Continuing Care)
- Sessional payments for provision of emergency dental services
- Seniority payments
- Vocational training allowances
- Commitment payments
- Maternity/paternity/adoption leave
- Long-term sickness pay
- Continuing professional development allowances
- Clinical audit allowances
- Superannuation

Practice payments

- Reimbursement of non-domestic rates
- Practice allowance

<table>
<thead>
<tr>
<th>Payment Detail 2009/10</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Payments</strong></td>
<td></td>
</tr>
<tr>
<td>Items of Service for treatment items</td>
<td>£61,028,348.00</td>
</tr>
<tr>
<td>Patient Registration (Continuing Care &amp; Capitation)</td>
<td>£18,352,073.00</td>
</tr>
<tr>
<td>Sessional Payments for provision of emergency dental services</td>
<td>£296,741.00</td>
</tr>
<tr>
<td>Seniority payments</td>
<td>£241,708.00</td>
</tr>
<tr>
<td>Commitment payments</td>
<td>£2,692,252.00</td>
</tr>
<tr>
<td>Maternity/paternity/adoption leave</td>
<td>£855,073.00</td>
</tr>
<tr>
<td>Long-term sickness pay</td>
<td>£15,408.00</td>
</tr>
<tr>
<td>Continuing professional development allowance</td>
<td>£483,641.00</td>
</tr>
<tr>
<td>Clinical Audit &amp; Peer Review Allowances</td>
<td>£12,484.00</td>
</tr>
<tr>
<td><strong>Practice Payments</strong></td>
<td></td>
</tr>
<tr>
<td>Re-imbursement of non-domestic rates</td>
<td>£673,782.00</td>
</tr>
<tr>
<td>Practice Allowance</td>
<td>£7,661,742.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£92,313,252.00</td>
</tr>
</tbody>
</table>

All figures provided by BSO, September 2010

1. **Item-of-service fees for treatment**
Dentists carry out clinical work in return for item-of-service fees. Fees for clinical treatment provide gross payment to dentists to provide the aspects of clinical care for patients as laid out in the Statement of Dental Remuneration.

2. **Sessional payments for provision of emergency dental services**
   Dentists in Northern Ireland participate in Health and Social Services Board-run emergency clinics for out-of-hours emergencies. The fee paid for each three hour session is £119.55.
   
   If a dentist is participating in an out-of-hours clinic, they forego the opportunity to be working in their practice.

3. **Seniority payments**
   A seniority payment is a payment made to a dentist over 55 years. The payment recognises that dentistry is a physically demanding job, and with age speed of working and hence turnover reduces. A seniority payment compensates an older dentist for work foregone through working at a slower rate.

4. **Vocational training expenses allowances**
   Vocational training allowances cover the expenses elements associated with practice-based training for UK graduate dentists, or other dentists who may enter the scheme.

   4.1. **Reimbursement of the trainee dentist’s salary**
   This is a direct reimbursement of an incurred cost.

   4.2. **A trainer grant of £753 per month**
   This grant is to support the trainer in providing surgery and staff to support the trainee during the course of their training. Each vocational trainee will require a fully-equipped dental surgery and a dedicated dental nurse.

   4.3. **Trainer quality assurance grant**
   This is a grant paid to trainers to enable them successfully to complete the assessment of the trainee through the training period, using set assessment tools. The grant is up to £10,373 per year. During the training period, the trainer will need to spend a significant amount of time with the trainee to complete the training. The grant compensates the trainer for work foregone during the training period, when the trainer is away from his surgery to engage in necessary activities associated with the trainee’s ongoing training needs.

   4.4. **Charter Mark allowance**
   Up to £1037 is available per year for training practices which have a recognised quality assurance charter mark, such as BDA Good Practice, Investors in People.

5. **Commitment payments**
Commitment payments are a payment to dentists in recognition of their individual commitment to the health service. The payment per quarter ranges from £27.00 to £1,999.00 dependant on turnover.

The spend on commitment payments is approximately £2.62 million for 09/10.

6. Maternity, paternity, adoptive leave

When a dentist is on maternity, paternity or adoptive leave, they forego the opportunity to do their usual clinical work in the surgery. Payments in respect of maternity, paternity and adoptive leave are time-limited and based on the individual’s historic earnings, up to a maximum of £1,399 per week (up to 26 weeks maternity, up to 2 weeks paternity).

7. Long-term sick pay

Long-term sick pay provides a weekly equivalent of 25 per cent of net earnings up to a maximum of £349 per week for up to 22 weeks for dentists who are out of the workplace due to illness. The allowance is not payable for the first four weeks of sickness.

8. Continuing professional development allowance

The Statement of Dental Remuneration provides dentists with payment when they undertake continuing professional development activities. The maximum payment available per year is £1,369.20 (less any abatement).

When a dentist is undertaking continuing professional development, they forego the opportunity to generate turnover and meet ongoing expenses through clinical work.

9. Clinical audit and peer review allowance

The statement of dental remuneration provides dentists with payment for undertaking a maximum of 15 hours clinical audit/peer review activity over a three year period. The payment is £65.21 per hour (up to a maximum of £978.15 over a three year period).

When a dentist is undertaking clinical audit/peer review, they forego the opportunity to generate turnover.

10. Reimbursement of non-domestic rates

Reimbursement of non-domestic rates is a direct reimbursement of a practice cost. The amount of reimbursement is in direct proportion to the percentage of gross earnings from the health service.

11. Practice allowance

The practice allowance is an allowance to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.
17. Executive Summary

Expenses incurred in the provision of dental care through the GDS have continued to increase through the period to end March 2012.

This paper sets out the requirement for an increase to the expense elements of the provision of Health Service dental care of 6.9% to address the increase in expenses and effect a pay freeze to the remuneration of HSC dentists.

18. Introduction

The Health and Social Care Board is charged with commissioning Health and Social care including dental services for the population of 1.8 million persons in Northern Ireland. Health and Social Care Dental Services, although commissioned by the Health and Social Care Board, are ‘demand led’ and available to the public on the basis of demand and availability and within the rules governing the provision of Health Service dentistry.

This paper sets out the increase in expenses experienced by dentists in the provision of health service dentistry over the twelve month period to end March 2012 and seeks an increase to the expenses elements of provision of health service dental care for the period commencing April 2012.

The expenses increases in the provision of HSC dental services arise through:

- The increasing operating expenses over the period and the prevailing price rises as measured by the Consumer Price Index
- the wide range of pay and expenses costs which need to be met as part of running a dental business within the health service arrangements
- meeting continuing and new governance requirements
- inflationary pressures on pay and expenses
• The effect of previous inadequate pay awards from DHSSPS and the impact on expenses arising through the loss of dedicated QIS funding

• The effect of the practice allowance value being pegged to fees and therefore not rising in line with increasing expenses

19. Pay Freeze

We note that there is a continuing two year public sector pay freeze through 2012/13 for the public sector workforce earning in excess of £21,000 per annum on a full-time equivalent basis. The ‘pay freeze’ has been interpreted by DHSSPS and applied to the General Dental Services as a freeze on all HS remuneration received by dentists (excepting 0.5% increase to item of service fees for 11/12 to meet the £250 pay award to directly employed staff earning less than £21,000).¹

BDA believes a pay freeze should be applied to elements of pay only as increases in expenses in a fixed fee system lead to a drop in net pay. This is not the intention of the Government pay freeze.

Remuneration for dentists through the General Dental Services is delivered through a package of which is inclusive of elements for pay and expenses.

In the situation where uplift to gross remuneration is restricted the result is that as expenses rise and net pay falls.

This results in a situation of considering dentists remuneration in this way, where an increase in expenses results in a drop in net pay that goes beyond the intent of a effecting a pay freeze.

We are seeking a

• An uplift to the expenses elements incurred through the GDS in Northern Ireland which delivers a freeze to net pay.
• Recognition that there is no room for further efficiency in the small business environment in which dentists operate, especially given the additional capital and revenue expenses to be met during the period.

20. Dental Spend

The spending on dentistry is essentially ‘demand led’ and has activity as its main driver. The most recent figures available to us relate to spending on dentistry for the period 2010/11 Annex 1 (all figures supplied by BSO/HSCB). Whilst the budget is demand led in how the spend is derived at HSCB level, when the funding reaches practice level the practice must pay for the HS portions of overheads (building, heat, light, patient facilities, equipment); the direct costs incurred in Health Service treatment (laboratory, consumables and materials costs); and staff and other capital and revenue resource costs.

¹ See Annex 5 for the 4 October 2010 letter from the Minister for DHSSPS to DDRB setting out the decision of DHSSPS to apply the public sector pay freeze within Northern Ireland.
Dentists’ pay is part of a complex equation whereby practitioners are paid gross sums in respect of specific treatment items. The dentist meets the costs arising and retains the balance for investment in the fabric and resources of the practice and net pay.

The UK is currently in a public sector pay freeze as set out by HM Treasury. We view this as an expectation that net pay after expenses must be maintained at the previous level. Therefore, as expenses change, in order to keep net pay stable requires a corresponding alteration to be applied to gross turnover to address the effect of increasing expenses.

21. Expenses

Practice expenses can largely be attributed to four main categories of expenditure. These are:

- Laboratory fees and materials costs
- Staff costs for directly employed staff excluding dentists
- Overhead costs (premises, direct costs and other overhead costs)
- Decontamination and governance including clinical governance

This paper describes each of these areas. In the most recent BDA Business Trends Survey, 82 per cent of respondents experienced an increase in expenses beyond their expectation while only 2 per cent had seen expenses costs below their expectations.

For a pay policy to achieve a freeze to net pay any increase in expenses must be matched by an increase in funding.

In its 40th Report DDRB stated that in the period 2008/09 to 2010/11 all expenses for practices in Northern Ireland had risen by 8.1 per cent.

The expense awards applied to Items of Service fees by DHSSPS have been 0.21 per cent in 2009/10, 0.5 per cent in 2010/11 and 0.5 per cent 2011/12.

To deliver a pay freeze the uplift to the expenses elements over the last three years would need to match the increase to expenses described by DDRB. However this has not been the case. The gap between the increased expenses costs of 8.1 per cent over the period 2008/09 through 2010/11 and the awards made by DHSSPS over the most recent three years of 1.21 per cent is in the order of 6.9 per cent.

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2 The BDA Dental Business Trends survey is a survey of general dental practitioners who are BDA members. The survey is conducted annually by the BDA providing a general source of information about workforce and practice issues in General Practice. In 2011 the BDA carried out its annual Business Trend survey. The survey covered income and expenses, morale and motivation and the dental workforce. The survey was sent to 3000 BDA members across the UK. The overall response rate in Northern Ireland was 40 per cent.

To maintain a pay freeze in real terms we would seek an uplift of 6.9 per cent that addresses this gap between uplifts awarded and increase in expenses.

While an award of 6.9 per cent would match the gap between the DHSSPS awards and the increased expenses described by DDRB to effect a pay freeze while maintaining the relationship between expenses and earnings would actually require a greater increase.

**Laboratory and materials costs**

The increased costs of materials and laboratory work have continued in the period to the end of March 2012. Practices have reported increased costs caused by inflationary pressures on both the prices of the materials they purchase and the laboratory work they require.

Rising costs for laboratory costs had been experienced by 81 per cent of practices in Northern Ireland, while 96 per cent of practices had experienced increases in their material costs.

One of the most significant factors is the continued increase in the costs of metals. The steady rise in prices has led to increases in the cost of providing basic dental treatments such as amalgam fillings and crowns. Since 2009 the cost of metals has risen steeply as illustrated in table 1.

<table>
<thead>
<tr>
<th>Metal</th>
<th>Price ($) January 2009</th>
<th>Price ($) January 2012</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td>875.00</td>
<td>1586.00</td>
<td>81.26%</td>
</tr>
<tr>
<td>Platinum</td>
<td>940.00</td>
<td>1407.00</td>
<td>49.68%</td>
</tr>
<tr>
<td>Palladium</td>
<td>191.00</td>
<td>654.00</td>
<td>242.41%</td>
</tr>
<tr>
<td>Silver</td>
<td>11.53</td>
<td>28.46</td>
<td>146.83%</td>
</tr>
</tbody>
</table>

Table 1 - Increases in the price of metals used in dentistry

**Staff costs**

Most staff employed by dental practitioners fall under the protected category of those public sector employees earning less than £21,000 and who can expect to receive a pay award of £250.

There are additional staff costs in pre and post registration training of staff who expect to be or are GDC registrants. The course fees for NEBDN Certificate in Dental Nursing are listed in Further Education College brochures as being ‘full cost recovery’ with course fees in the order of £878 (2011-12). Courses leading to City and Guilds or NVQ qualifications for job roles outside of dental nursing can be viewed as competing with the career of applicants to dental nursing. These courses are free or available at much lower costs of up to £328 (the exception being City and Guilds Level 3 Diploma in Children’s Care Learning and Development at £1,085).

This is a further example of the cost burden of increasing expenses like staff training being placed on the dental practice, but without the availability of dedicated resource to meet the increased expenses.

**Overheads and premises costs**
There are a host of expenses derived from overhead costs associated with delivering health service dentistry and these must be able to be met through the GDS payment system. There is the fabric of the building and the facilities, equipment and the costs of provision of HS dental care. Equally important are the skills of the whole staff complement involved in HS practice and the patient experience. Funding must reflect the resources necessary to manage the portion of the overhead expenses attributed to health service dentistry.

In the British Dental Association Dental Business Trends Survey Full Report May – June 2011 82 per cent of Northern Ireland practices reported expenses exceeding expectations\(^4\), with 96 per cent of responses from Northern Ireland reporting increases in the cost of materials and 98 per cent reporting a rise in the cost of consumables\(^5\). Northern Ireland practices also reported increases to the expense costs from utilities with an average 23 per cent increase in quarterly electricity bills and 35 per cent increase in quarterly water bills.\(^6\)

Inflation as measured by the Consumer Price Index (CPI) stood at 3.5 per cent at the end of March 2012\(^7\), above the Bank of England’s inflation target of 2 per cent. At the end of March 2011 CPI was 4.0 per cent. Throughout the last twelve months CPI has always been at least 2.9 per cent above the 0.5 per cent fees increase awarded for the year 2011-12.\(^8\)

**Decontamination costs**

Dental practices are expected to meet the expenses resultant from the DHSSPS policy initiative on decontamination in dental practice, whereby by end of November 2012 practices should reach compliance with the DHSSPS policies. DHSSPS policy on decontamination in Northern Ireland requires compliance with best practice by end November 2012.

Decontamination generates significant expenses costs as compliance requires both capital investment and revenue spend. Capital investment is required to enable the practice to put in place a suitably equipped facility and equipment and instrumentation. Revenue is required for staff and to provide consumables and meet other overhead cost expenses associated with running the facility.

The initial outlay is a substantial capital expenditure, however it is the expenses generated by the ongoing resources and staffing costs which are placing intense financial pressures on practices. These go well beyond the amount and scope of the current practice allowance. It is also the case that the affect of the ongoing limited fee uplifts is to reduce the ability of the practice allowance to meet the costs of dental practice. This is because the practice allowance is derived from the fee structure within the Statement of Dental Remuneration. It can only rise within the structure of any fee award. While-ever the fee awards are capped and the real costs associated with dental business are rising at a rate above that of inflation the practice allowance real value will decrease.

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\(^8\) CPI was 3.4 per cent in February 2012. See ibid. and figure 1 below.
22. Determining a pay award

In considering an appropriate award to cover the rising expenses of GDS dentistry in Northern Ireland there are a number of factors that must be considered. These include the approach taken by the Scottish Government, the mechanism used by DDRB to calculate appropriate pay recommendations and comparison of historic pay awards in Northern Ireland with the trends in inflation.

General Dental Practice Expenses in Scotland

The Scottish Government sought the recommendation of DDRB in relation to dental practice expenses of independent contractors in General Dental Services in Scotland, on the basis that the system of Primary Care Dentistry in Scotland is different from England and had not been considered by DDRB for some time.

BDA Northern Ireland, through Northern Ireland Dental Practice Committee has requested that DHSSPS make the same request of DDRB, with a view to having a detailed assessment of GDS earnings and expenses recommendations.

DDRB Formula

Outcome of previous pay rounds for General Dental Practitioners in Northern Ireland

Consideration of the past three pay rounds shows that health service fees have been uplifted by 0.21% in 2009/10, 0.5% in 2010/11 and 0.5% in 2011/12. The gap between the increases in fees and the prevailing rates of consumer inflation as measured by the Consumer Price index measured over the three year period presents a reduction in the ability of health service dental practice to meet expenses in the order of 12.3%.

Figure 1 – The growing disparity between CPI and the DHSSPS Pay Award

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9 The 2009/10 pay award saw a 0.21 per cent uplift applied to the Item of Service fees with a subsequent further award to commitment payments.
To rectify the gap between CPI and the pay awards of the last three years (not the even larger gap between the increase in dental business costs and the pay awards of the last three years) dentists would require an award of 8.87 per cent above CPI, i.e. 11.87 per cent based on CPI of 3.5 per cent in March 2012.

23. **Loss of Quality Improvement Scheme Funding 2010 onward**

During 2010/11 HSCB withdrew a stream of funding (Quality Improvement Scheme (QIS)) for HS dental practice, dedicated to support improvements in the delivery of General Dental Services. The thrust of the scheme was to improve working practices that, in turn would lead to service improvements and ultimately benefit patients. Quality Improvement Scheme (QIS) funding was first introduced in 2002/03 and was previously available to provide funding towards practice expenses. The fund provided approximately £1m to dedicated practice expenses each year, with an additional £1.5m made available in 2007/08.

The funding formerly used for QIS has been reallocated to the GDS budget and will now pay for items of service. The effect on practices is that they have lost funding towards expenses to the value of £1.16m from 2010/11 onwards.

Practice expenses are inclusive of capital and revenue costs and the QIS monies were generally used by practices to provide assistance towards capital costs. The loss of this funding has directly affected the ability of practices to meet those capital costs.
24. **Practice Allowance**

Practices which meet certain criterion may qualify for a practice allowance providing either 4% or 11% of the gross fees earned during the previous period to the practice in the form of a practice allowance.

The Practice Allowance was introduced in 2004/05 as a means of recognition of the additional administrative burden facing practice owners because of the regulatory and clinical governance requirements and the impacts of this on the effective management of practices. The aim of the Practice Allowance is set out by DHSSPS and is to assist with the costs of running a health service dental practice.

The practice allowance in 2010/11 provided £7.457m funding to 311 practices. For the capital and revenue costs which it is expected to meet, that it is not of sufficient value.

In general the practice allowance accounts for a value of approximately 10% of the gross costs of items of service and patient registration fees. However previous pay awards have not kept pace with CPI and so the practice allowance has become increasingly underfunded.

Over time, as new and additional requirements become essential to HS dental practice, the Practice Allowance is expected meet more and costs. However a fund which is linked to fees which have increased at minimal levels over the past three years cannot meet the requirements it is expected to deliver.

In 2012 practices will be expected to have attained HTM 01/05 best practice compliance and this adds very significant capital and ongoing revenue costs to the running of the practice.

25. **Patient Numbers**

In March 2011 the number of patients registered with a health service dentist in Northern Ireland was 1,001,063. By March 2012 this had risen to 1,119,329 an increase of 118,266. This equates to a 12 per cent increase over the year.

The figures show that the Health Service is the provider of dental care to the majority of the population of Northern Ireland.\(^\text{10}\)

The scale of this commitment demonstrates the demand for health service dental care from the public.

It should be noted in this period the DHSSPS PDS service had, as of June 2012, registered 47,361 health service patients.\(^\text{11}\)

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\(^\text{10}\) NISRA estimates show a population of 1.799 million people in Northern Ireland as of June 2010 http://www.nisra.gov.uk/publications/default.asp10.htm

\(^\text{11}\) This figure was provided in response to AQW 12576/11-15 on 8 June 2012 from John Dallat MLA see: http://aims.niassembly.gov.uk/questions/searchresults.aspx?qf=0&asb=21&tbm=0&anb=11&abp=0&sp=1&qfv=1&asbv=24&tbmv=1&anbv=82&abpv=0&spv=14&ss=kjuJVCeJ3RO=&tm=2&per=1&sus=0&qs=1&ans=0&ld=0&td=&pm=0&asbt=Dallat, John&anbt=the Minister of Health, Social Services and Public Safety&abpt=All Parties&spt=2011-2012
26. Dental Earnings and Expenses Northern Ireland 2009/10

DDRB will be aware of The Information Centre reports on dental earnings and expenses in Northern Ireland.

BDA continues to engage in feedback with The Information Centre on how the report can be improved, particularly in respect of the counting of earnings and expenses across tax returns, which The Information Centre acknowledge results in inflation of the values reported.

27. Small business environment

Dental practices by their nature and location are providing services to local communities and as a result are often located in converted dwellings or converted commercial premises. The result is that they are often small as they are constrained for space by the existing building, have expanded to capacity or are large enough the deal with the needs of the community they serve.

As small businesses, dental practices are run as efficiently as possible. In fact it is in the best interests of the business owner to operate efficiently without waste or inefficiencies and by securing downward pressure on containable costs.

There is therefore no capacity within dental practice for operating in a manner which introduces new efficiencies.

28. Conclusions

Provision of health service dental care continues to face increasing expenses, without receiving sufficient resources from the health service to enable those increasing costs to be met. The business of dental practice operating within the health service arrangements already operates as efficiently as it can. We are seeking an uplift that meets the stated aim of the public sector pay freeze that is a freeze to net pay only for the health service elements of dental care, whilst recognising the need to meet increasing expenses. We note that CPI is running far ahead of any awards to expenses or fees of recent years and, based on the formula devised by DDRB would seek an increase in the order of 6.9 per cent to be made for the year 2012/13.

Northern Ireland Dental Practice Committee

February 2012
**Payment system for dentists in Northern Ireland**

This information describes the elements of Statement of Dental Remuneration which make up the gross payments available to dental practitioners in Northern Ireland.

The information is separated into those payments made to individual dentists and those made to practices. (Excluding payments in respect of expenses associated with vocational training and superannuation payments for dentists).

### Individual payments

- Item-of-service fees for treatment items
- Patient Registration (Capitation & Continuing Care)
- Sessional payments for provision of emergency dental services
- Seniority payments
- Vocational training allowances
- Commitment payments
- Maternity/paternity/adoption leave
- Long-term sickness pay
- Continuing professional development allowances
- Clinical audit allowances
- Superannuation

### Practice payments

- Reimbursement of non-domestic rates
- Practice allowance

### Payment Detail 2010/11

<table>
<thead>
<tr>
<th>Individual Payments</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items of Service for treatment items</td>
<td>£62,319,790.92</td>
</tr>
<tr>
<td>Patient Registration (Continuing Care &amp; Capitation)</td>
<td>£19,013,255.15</td>
</tr>
<tr>
<td>Sessional Payments for provision of emergency dental services</td>
<td>£197,179.20</td>
</tr>
<tr>
<td>Seniority payments</td>
<td>£276,256.00</td>
</tr>
<tr>
<td>Commitment payments</td>
<td>£2,806,987.00</td>
</tr>
<tr>
<td>Maternity/paternity/adoption leave</td>
<td>£627,115.00</td>
</tr>
<tr>
<td>Long-term sickness pay</td>
<td>£15,931.00</td>
</tr>
<tr>
<td>Continuing professional development allowance</td>
<td>£436,407.47</td>
</tr>
<tr>
<td>Clinical Audit &amp; Peer Review Allowances</td>
<td>£33,256.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Payments</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-imbursement of non-domestic rates</td>
<td>£746,262.00</td>
</tr>
<tr>
<td>Practice Allowance</td>
<td>£7,457,107.00</td>
</tr>
</tbody>
</table>

| Total                                                        | £105,134,679.00 |
12. Item-of-service fees for treatment
Dentists carry out clinical work in return for item-of-service fees. Fees for clinical treatment provide gross payment to dentists to provide the aspects of clinical care for patients as laid out in the Statement of Dental Remuneration.

13. Sessional payments for provision of emergency dental services
Dentists in Northern Ireland participate in Health and Social Services Board-run emergency clinics for out-of-hours emergencies. The fee paid for each three hour session is £119.55.

If a dentist is participating in an out-of-hours clinic, they forego the opportunity to be working in their practice.

14. Seniority payments
A seniority payment is a payment made to a dentist over 55 years. The payment recognises that dentistry is a physically demanding job, and with age speed of working and hence turnover reduces. A seniority payment compensates an older dentist for work foregone through working at a slower rate.

15. Vocational training expenses allowances
Vocational training allowances cover the expenses elements associated with practice-based training for UK graduate dentists, or other dentists who may enter the scheme.

15.1. Reimbursement of the trainee dentist’s salary
This is a direct reimbursement of an incurred cost.

15.2. A trainer grant of £753 per month
This grant is to support the trainer in providing surgery and staff to support the trainee during the course of their training. Each vocational trainee will require a fully-equipped dental surgery and a dedicated dental nurse.

15.3. Trainer quality assurance grant
This is a grant paid to trainers to enable them successfully to complete the assessment of the trainee through the training period, using set assessment tools. The grant is up to £10,373 per year. During the training period, the trainer will need to spend a significant amount of time with the trainee to complete the training. The grant compensates the trainer for work foregone during the training period, when the trainer is away from his surgery to engage in necessary activities associated with the trainee’s ongoing training needs.

15.4. Charter Mark allowance
Up to £1037 is available per year for training practices which have a recognised quality assurance charter mark, such as BDA Good Practice, Investors in People.

16. Commitment payments
Commitment payments are a payment to dentists in recognition of their individual commitment to the health service. The payment per quarter ranges from £27.00 to £1,999.00 dependant on turnover.\textsuperscript{12}

In 2009/10 as part of the award from DHSSPS commitment payments were uplifted.

The spend on commitment payments is approximately £2.806 million for 10/11.

17. Maternity, paternity, adoptive leave
When a dentist is on maternity, paternity or adoptive leave, they forego the opportunity to do their usual clinical work in the surgery. Payments in respect of maternity, paternity and adoptive leave are time-limited and based on the individual’s historic earnings, up to a maximum of £1,399 per week (up to 26 weeks maternity, up to 2 weeks paternity).

18. Long-term sick pay
Long-term sick pay provides a weekly equivalent of 25 per cent of net earnings up to a maximum of £349 per week for up to 22 weeks for dentists who are out of the workplace due to illness. The allowance is not payable for the first four weeks of sickness.

19. Continuing professional development allowance
The Statement of Dental Remuneration provides dentists with payment when they undertake continuing professional development activities. The maximum payment available per year is £1,369.20 (less any abatement).

When a dentist is undertaking continuing professional development, they forego the opportunity to generate turnover and meet ongoing expenses through clinical work.

20. Clinical audit and peer review allowance
The statement of dental remuneration provides dentists with payment for undertaking a maximum of 15 hours clinical audit/peer review activity over a three year period. The payment is £65.21 per hour (up to a maximum of £978.15 over a three year period).

When a dentist is undertaking clinical audit/peer review, they forego the opportunity to generate turnover.

21. Reimbursement of non-domestic rates
Reimbursement of non-domestic rates is a direct reimbursement of a practice cost. The amount of reimbursement is in direct proportion to the percentage of gross earnings from the health service.

22. Practice allowance
The practice allowance is an allowance to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.

\textsuperscript{12} As part of the pay award for 2009/10 DHSSPS made a one off uplift to commitment payments.
Annex 3

Impact of DHSSPS proposed cuts to GDS funding 2012/13:

The impacts on health service dentistry in Northern Ireland as a whole and on individual dentists

British Dental Association
64 Wimpole Street
London W1G 8YS
March 2012
Executive summary

- In November 2011 the DHSSPS made proposals substantially to cut funding to the GDS budget in Northern Ireland to compensate for overspends. The proposals include ceasing the dedicated Quality Improvement Scheme (QIS) funding, changes to the statement of dental remuneration and restricting the claim conditions for some items. Such dramatic changes represent severe restrictions to the budget for health service dentistry and so could have fundamental impacts on the provision of health service dental care.

- The BDA has undertaken case studies to assess the potential effect of the proposals. These demonstrate that they are likely severely to impact on dentists' turnover and income after expenses and consequently on their ability to provide NHS services for the public.

- In significantly reducing the budget for dental services, there would be ramifications for patients, the service, practice viability, dentists and practice staff and these cannot be fully anticipated or quantified.

- Therefore, the proposals have the potential to impact severely upon the oral health of the population, current dental capacity and morale within the profession.

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Introduction

The Department of Health Social Services and Public Safety (DHSSPS) has proposed changes to how the Health and Social Care Board would spend the budget that it is making available for General Dental Services for 2012/13\(^\text{13}\). The proposed changes are attributed by DHSSPS as being due to significant pressure being placed on a capped budget for dental services as it provides a demand-led dental service.

The BDA through Northern Ireland Dental Practice Committee has expressed its deep concern regarding the DHSSPS proposals and the catastrophic effect they would have on the profession, the business of dental practice, and the service to patients\(^\text{14}\).

As part of enabling individual dentists better to understand the potential impacts of the DHSSPS proposals and contextualise them, BDA has conducted four case studies of differing dentists to assess the potential impacts on the profession and individual dentists and consequently on dental practices.

The aim of the case studies is to inform BDA members and enable an improved understanding of the financial and service implications that proposed changes might have on dental businesses. They seek to achieve these aims by assessing the individual effect of each of the proposed changes by using Northern Ireland-wide data on the whole GDS in conjunction with individual practitioner data on treatment profiles generated at practice level.

This report first describes the DHSSPS proposals and explains the rationale for carrying out the case study. This is followed by some assessment of the effects of the proposed changes at a Northern Ireland level, the methodology of the case studies and the four individual dentist case studies. Each study contains a dentist profile and practice information, the current treatment turnover and makeup for each dentist and the financial impact of changes to treatment profiles which might arise as part of the DHSSPS proposals.

The thanks of BDA are due to the practices that provided information in support of this report and we are grateful for the continuing assistance of BDA members in enabling this type of research.

\(^{13}\) Set out in DHSSPS letter of 7 November 2011
Background

Dental services

At April 2011 there were 1,010 individual dentists\textsuperscript{15} in Northern Ireland providing dental services within the Heath Service (HS) arrangements. In April 2011 there were 1,001,063 patients registered with the 1,010 dentists holding contracts to operate in the HS arrangements.

Dental finances

The General Dental Services budget can be broadly categorised into elements that are paid to individual dentists and payments towards expenses that are made on behalf of practices. (An explanation of the payment system for dentists in Northern Ireland with the 2010/11 GDS spend is set out in Appendix A).

Generally a contractor will generate the vast majority of their individual HS turnover through provision of care and treatment in return for patient registration and item-of-service fees. Other items, such as payments in respect of vocational training, maternity, paternity and adoption pay, sick pay and seniority pay, may be involved but, for the vast proportion of GDS contractors, the significant individual payments are item-of-service fees, registration fees and commitment payments (if applicable). These elements make up the gross turnover from which pay is delivered after expenses.

A practice may also receive reimbursement in respect of business rates and a practice allowance (to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision).

\textsuperscript{15} All figures provided by Business Services Organisation.
Table 1: The spend for the years 2009/10 and 2010/11 on aspects of the GDS in Northern Ireland.

Table 1: Payment detail GDS 09/10 10/11

<table>
<thead>
<tr>
<th>Individual payments</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay and expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item-of-service payments including patient charges for all treatments (inclusive of orthodontics)</td>
<td>£61,028,348</td>
<td>£62,319,790</td>
</tr>
<tr>
<td>(Orthodontic treatment items of service)</td>
<td>(£8,770,000)</td>
<td>(£9,850,000)</td>
</tr>
<tr>
<td>(Patient charges for the period (all treatment items))</td>
<td>(£17,361,832)</td>
<td>(£17,434,171)</td>
</tr>
<tr>
<td>Patient registration (continuing care and capitation)</td>
<td>£18,352,073</td>
<td>£19,013,255</td>
</tr>
<tr>
<td>Gross cost of estimates including orthodontic items</td>
<td>£79,380,421</td>
<td>£81,333,045</td>
</tr>
<tr>
<td>Sessional payments for provision of emergency dental services</td>
<td>£296,741</td>
<td>£197,179</td>
</tr>
<tr>
<td>Seniority payments</td>
<td>£241,708</td>
<td>£276,256</td>
</tr>
<tr>
<td>Commitment payments</td>
<td>£2,692,252</td>
<td>£2,806,987</td>
</tr>
<tr>
<td>Maternity/paternity/adoption leave</td>
<td>£855,073</td>
<td>£627,115</td>
</tr>
<tr>
<td>Long-term sickness pay</td>
<td>£15,408</td>
<td>£15,931</td>
</tr>
<tr>
<td>Continuing professional development allowance</td>
<td>£483,641</td>
<td>£436,407</td>
</tr>
<tr>
<td>Clinical audit and peer review allowances</td>
<td>£12,484</td>
<td>£33,256</td>
</tr>
<tr>
<td><strong>Total turnover for pay and expenses</strong></td>
<td>£83,977,728</td>
<td>£85,726,176</td>
</tr>
<tr>
<td>(Total without orthodontic items)</td>
<td>(£75,207,728)</td>
<td>(£75,876,176)</td>
</tr>
<tr>
<td><strong>Practice payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-imbursement of non-domestic rates</td>
<td>£673,782</td>
<td>£746,262</td>
</tr>
<tr>
<td>Practice allowance</td>
<td>£7,661,742</td>
<td>£7,457,107</td>
</tr>
<tr>
<td><strong>Total for practice payments</strong></td>
<td>£8,335,524</td>
<td>£8,203,369</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£92,313,252</td>
<td>93,929,545</td>
</tr>
</tbody>
</table>

The dental budget for the GDS has a ‘gross cost’ value attached to it. This represents the total spend on Health and Social Care Dental Services and is inclusive of superannuation costs as well as all salaried GDP contract costs in addition to any contract costs which may have occurred.

In 2010/11 the total gross cost of the service was £105,134,679.

In 2009/10 the total gross cost of the service was £92,675,127.96

The DHSSPS proposed changes
The DHSSPS proposes substantially to cut funding to the GDS and wrote to Northern Ireland Dental Practice Committee in November 2011 setting out its proposals for making significant cuts to the dental budget and dental provision for 2012/13.

The DHSSPS has further detailed the savings it expects to make by limiting spending on dental services for 2012-13 as:

1. Moving the QIS funding into the GDS budget. The DHSSPS reports an expected saving of approximately £1.16m.
2. Changes to the statement of dental remuneration (SDR) with the emphasis placed on limiting treatments available. DHSSPS reports an expected saving of approximately £2m.
3. Changing the claims condition on simple scaling (1001) from three months to one year. DHSSPS reports an expected saving of approximately £1m.
4. Introduce IOTN 4.0. DHSSPS reports an expected saving of £2m over 24 months
5. Changing the qualifying criteria for the practice allowance and removing the commitment payments. DHSSPS reports an expected saving of approximately £3m.

These proposals account for an immediate reduction (inside 12 months) in GDS spend of over £7million. The effect on the budget of introducing IOTN 4.0 would be seen after the first twelve months owing to the time taken for orthodontic care already under treatment or planned for treatment. This would add a further reduction to the dental budget spend which is estimated by DHSSPS as a further £2 million.

Specifically the items in the SDR which have been proposed by DHSSPS for amendments are:

1. Endodontic treatment (item code 1501) – All molar teeth to require mandatory prior approval. All other teeth to be dealt with as before.
2. Cobalt-chrome dentures (code 2734–2745) – Only acrylic dentures to be used; CoCr dentures by prior approval only.
3. Bridges (code1801–1852) - Smaller anterior bridges permitted without prior approval but larger bridges and/or those in the back of the mouth will require prior approval automatically.
4. Veneers (1601) – All veneers will only be available by prior approval.

**The effect of the DHSSPS proposals on GDS funding**

Dentists’ pay is part of a complex equation whereby practitioners are paid gross sums in respect of specific treatments or other services. The dentist meets the costs arising and retains the balance for remuneration and re-investment.

It is accepted, for the purposes of superannuation calculations, that 56.1 per cent of superannuable turnover is practice expenses with the remaining 43.9 per cent available for remuneration/investment. These are the apportionment figures that we have used in illustrations on how the changes to turnover affect the proportion available for remuneration.

It is also important to note that item-of-service costs for all orthodontic items are included in the item-of-service costs recorded for all treatments. For the period 2010/11 orthodontic items of service accounted for 16 per cent (£9.85m) of the item-of-service spend. When
considering non-orthodontic items we have excluded this amount and applied the premise that most contractors carrying out orthodontic treatments tend to do so almost exclusively.

Table 2: Treatment and patient registration cost excluding orthodontics 2010/11

| Item-of-service costs for all treatments | £63,319,790 |
| Patient registration (continuing care and capitation) | £19,013,255 |
| Item-of -Service costs in respect of orthodontics | (£9,850,000) |
| Sub total | £71,483,045 |

In 2010/11 £71,483,045 was the gross treatment and patient registration turnover costs of the non-orthodontic items-of-service and patient registration costs shared by the majority of GDS contractors in caring for one million patients registered by the Health Service.

1) QIS monies

**DHSSPS anticipates a saving of £1.16 million**

During 2010/11 HSCB withdrew the dedicated funding stream of Quality Improvement Scheme (QIS) funding which was previously available to practices to assist with decontamination capital costs. All of this funding package of £1.1 million would have gone directly to practice capital expenditure to meet an increasing decontamination agenda. The loss of QIS funding to dental practices represents a very significant reduction in the ability of practices to meet capital expenses and, in real terms, the loss of £1.1 million in 2009/10 from the expenses side of the equation is a reduction of 2.4 per cent in the ability of practices to meet expenses. For every £1 lost through QIS monies, in order to recoup the funds, without affecting remuneration, the profession will have had to generate £1.96 in fee income. This equates to £2.16m in fees. Continuing to meet expenses, without increasing fee income, represents a reduction in remuneration after expenses in the order of 2.4 per cent for 2009/10.

Table 3: QIS monies calculation 2009/10

<table>
<thead>
<tr>
<th></th>
<th>Expenses</th>
<th>Profit</th>
<th>Gross cost of estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous expense and profit</td>
<td>£44,532,416</td>
<td>£34,848,005</td>
<td>£79,380,421</td>
</tr>
<tr>
<td>Previous profit and expense percentage</td>
<td>56.1%</td>
<td>43.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Without QIS monies</td>
<td>£45,632,416</td>
<td>£33,748,005</td>
<td>£79,380,421</td>
</tr>
<tr>
<td>% Change</td>
<td>+2.4%</td>
<td>- 3.26%</td>
<td></td>
</tr>
</tbody>
</table>

Tables 3 and 4 show the outturn on profit and expenses as a result of removal of QIS monies from the expenses side GDS budget.

Table 4: QIS monies calculation 2010/11
2) Changes to the SDR

DHSSPS estimate the proposed changes to the SDR would save £2 million.

The spend in 2010/11 on the specific items which DHSSPS mentions (molar endodontics, cobalt-chrome dentures, bridges, veneers) is set out in Table 5 and accounts for £3,118,559. This is 5 per cent of the total item-of-service spend of £62,319.790 for 201/2011. We have applied assumptions on the volume of work which in future might be approved at 25, 50 and 75 per cent.

Table 5: Item spend in 2010/11 with assumed prior approval limitations

<table>
<thead>
<tr>
<th>Item</th>
<th>Spend 2010/11</th>
<th>Assume 25% done</th>
<th>Assume 50% done</th>
<th>Assume 75% done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molar endodontics</td>
<td>£1,524,352</td>
<td>£381,088</td>
<td>£762,176</td>
<td>£1,143,264</td>
</tr>
<tr>
<td>Cobalt-chrome dentures</td>
<td>£288,879</td>
<td>£72,220</td>
<td>£144,439</td>
<td>£216,659</td>
</tr>
<tr>
<td>Bridges</td>
<td>£983,385</td>
<td>£245,846</td>
<td>£491,692</td>
<td>£737,539</td>
</tr>
<tr>
<td>Veneers</td>
<td>£321,943</td>
<td>£80,486</td>
<td>£160,972</td>
<td>£241,458</td>
</tr>
<tr>
<td>Total</td>
<td>£3,118,559</td>
<td>£779,640</td>
<td>£1,559,279</td>
<td>£2,338,920</td>
</tr>
</tbody>
</table>

DHSSPS estimates that changes to these items of the SDR would reduce the spend by £2m. The total spend on these items currently stands at £3.118m. The assumption could therefore be applied that DHSSPS presumes that two-thirds of these items will not be approved in future.
Table 6: Item expenditure for affected items and the total expenditure 2010/11

<table>
<thead>
<tr>
<th>Item</th>
<th>Spend</th>
<th>Percentage of IoS spend</th>
<th>2/3 reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molar endodontics</td>
<td>£1,524,352</td>
<td>2.44%</td>
<td>£503,036</td>
</tr>
<tr>
<td>Cobalt-chrome dentures</td>
<td>£288,879</td>
<td>0.46%</td>
<td>£95,330</td>
</tr>
<tr>
<td>Bridges</td>
<td>£983,385</td>
<td>1.6%</td>
<td>£324,517</td>
</tr>
<tr>
<td>Veneers</td>
<td>£321,943</td>
<td>0.5%</td>
<td>£106,241</td>
</tr>
<tr>
<td>Total</td>
<td>£3,118,559</td>
<td>5%</td>
<td>£1,029,124</td>
</tr>
<tr>
<td>Item-of-service spend</td>
<td>£62,319,790</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

3) Change to scale and polish (100) time bar to one year

*DHSSPS indicates it believes that this will cut spending by £1 million.*

A scale and polish is currently claimable at Item 1001 on the GDS every three months. Based on figures provided by the Business Service Organisation (BSO), £7.2m was spent on item 1001 during 2010/11. This represents 566,074 scale and polish items. Based on the number of patients who had had 1, 2, 3, 4 1001 items carried out during 2010/11, BDA calculates that 25.3 per cent of scale-and-polish items would fall outside the DHSSPS proposed time bar of 12 months. On its own this would lead to a drop in spend on item 1001 of £1.8 million. This is a significant difference from the figure anticipated by DHSSPS.

Table 7: Item expenditure 1001 Scale and Polish

<table>
<thead>
<tr>
<th>Item Of Service</th>
<th>201/11</th>
<th>% of total Item of Service</th>
<th>25% reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale and Polish spend item 1001</td>
<td>£7,217,444</td>
<td>11.6%</td>
<td>£5,413,083</td>
</tr>
</tbody>
</table>

4) Introduce IOTN 4.0

*DHSSPS estimates this proposal would save £2 million over 24 months.*

The saving from the introduction of IOTN 4.0 is difficult to quantify in the absence of clear evidence on the IOTN of the current caseload of orthodontic cases in treatment in the GDS.

BDA estimates that little or no reduction in the GDS spend would be realised in the first year as orthodontic care is prolonged and the cohort of patients undergoing or about to commence active care would continue to be undergoing treatment for some months. Following that, a reduction in the spend on orthodontics would be created.

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16 See Assumptions section Appendix C
which would be dependent on the case load of orthodontic patients who exhibited IOTN 4.0 or 5.0.

In 2009/10 the orthodontic item-of-service payments to orthodontic contractors was £8.77m with 25,850 patients treated. In 2010/11 the orthodontic item-of-service payments to orthodontic contractors were £9.85m with 30,758 patients treated. We can make assumptions about how the caseload in orthodontics might be affected in the future.

Table 8: Orthodontic spend in 2010/11 with assumptions on caseload of IOTN 4.0.

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>Assume 25% done</th>
<th>Assume 50% done</th>
<th>Assume 75% done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic spend</td>
<td>£9,850,000</td>
<td>£2,462,500</td>
<td>£4,925,000</td>
<td>£7,387,500</td>
</tr>
<tr>
<td>Patients treated</td>
<td>30,758</td>
<td>7,690</td>
<td>15,379</td>
<td>23,069</td>
</tr>
</tbody>
</table>

5) **Commitment payments**

*Commitment payments currently account for £2.8m of the GDS spend.*

In 2000 as part of the Doctors and Dentists Review Body (DDRB) recommendations on GDP pay, a scheme was introduced to reward the loyalty of GDPs to the NHS and consequently to encourage retention and improve motivation and allow for a form of pay progression.

In 2009, DDRB awarded 0.21 per cent to the GDS as a pay award. In Northern Ireland the award was uplifted by applying a further sum to the GDS through the commitment scheme.

A loss of £2.8m to the funding available for the GDS would be a very significant loss to remuneration. This would result in a 7.2 per cent loss if it was assumed that commitment payments were available to all dentists. Since commitment payments have no element of expenses, the entire loss would come from net remuneration. For individual dentists in receipt of commitment payments, some will find the loss greater as commitment payments can account for in the region of £10 – £12,000 per annum.

6) **Practice allowance**

DHSSPS proposes to change the criteria to qualify for the higher level of the practice allowance. It estimates that together with commitment payments this reduces their spend by £3 million. Commitment payments in 2010/11 were £2.8 million so we estimate DHSSPS expects to cut the total value of the practice allowance in the order of £200,000.

The practice allowance payment is a payment that arises from individual dentists in a practice meeting set criteria and this is then applied to the practice. The criteria in the DHSSPS proposals would be set to increase.
At the same time, practices could be experiencing a fall in HS turnover in the order of £2m for SDR changes, £1.8m for the scale-and-polish time bar, £2.8m for commitment payments. Orthodontic changes are not included here as they would not be realised immediately. This is an in-year reduction of £6.6m on the 2010/11 GDS spend. It therefore follows that in the absence of any change to criteria, the practice allowance payments would fall by a percentage of the £6.6m which would no longer be available. We therefore estimate that the practice allowance would fall by a much greater margin than DHSSPS have estimated.

The practice allowance currently equates to 8.7 per cent of total turnover for remuneration and expenses. If £6.6 million of turnover is removed then the BDA estimates that practice allowance payments would fall by at least £0.57 million. Any change of criteria to the practice allowance would have the capacity further to affect the value and accessibility of the practice allowance.

**Cumulative position**

BDA has responded to the DHSSPS’s proposals setting out a clear position that these proposals are wholly unacceptable and would be catastrophic for practitioners’ capacity to provide Health Service care.

The cumulative position is represented by consideration of

- DHSSPS proposals for the GDS 2012/13
- The position in 2011/12 of practice expenses having risen by 7 per cent
- Previous lower-than-inflation increases to item-of-service fees and patient registration payments over the past three years
- Policy requirements of decontamination
- Continuing increases to expenses
- The prevailing economic conditions affecting patients as consumers.

These points are covered in the section on Discussion.

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Methodology

Aims and objectives

The case studies aim to set out the financial implications of the DHSSPS proposed changes on individual dentists. They attempt to quantify how turnover may be affected as a result of the proposals and therefore enable an enhanced consideration of the likely initial impacts on the business of dental practice.

Given time constraints, a comprehensive financial model cannot be devised. We have therefore carried out case studies of four dentists practising in either a provincial town location or an inner city (deprived) location and whose practice circumstances could be applied in different locations in Northern Ireland. Provincial town locations were thought to be representative of a majority of dental practice locations where patients are drawn from all sectors of the surrounding community. Inner city and deprived locations are more likely to have a profile with specific characteristics such as high need or different treatment profiles. While it is understood that inference cannot be made to the general population of dentists, the case studies do provide a good insight and information base to inform how an individual dentist may be affected by the proposed changes.

Case study selection

Individual anonymised dentist data on the treatment items provided by four dentists operating very largely within the health service was provided by two dental practices. The information was derived from the practice software reports detailing the treatments carried out over the period January to December 2011. Two dentists operated in typical provincial town practice locations and two in deprived city locations.

A participant selection criterion was enforced to allow the widest possible and least skewed case study possible. The selection criteria required participants to:

- have a high commitment to working in the Health Service
- work a week which is inclusive of at least nine clinical sessions
- not use the services of a hygienist and no significant orthodontic component
- have an annual turnover gross from treatment in the range £70K to £130K
- not be on extended leave during the period and display a working year with typical annual leave.
- work in a practice with other dentists.

All the data was anonymous and all commercially sensitive information has been excluded from any output created. Research and reporting was carried out by the BDA Research Unit.

Data collection

Data collection to support the case studies considered Northern Ireland-wide data from the Business Services Organisation and individual dentist data derived from practices. BDA requested data from the BSO on a range of financial information on the spend on dental services and including the spend by item of service for the financial year 2010/11 and the volume of scaling and polishing carried out for individual patients one, two, three and four
times per year. Information was also gathered from BSO and by practice on the incidence of endodontic treatment by tooth type.

**Data management**

Data provided from individual dentists was stored in BDA secure servers in accordance with data protection and used only for the purpose of this report and seen only by the authors of this report.

**Limitations**

There are a number of limitations to this case study. These can be found in *Limitations* in Appendix B.

Whilst the dentist data was drawn using the same practice software program, these programs are utilised by practices in different ways and this can lead to differences in reporting.

**Assumptions**

It has been necessary to make a number of assumptions in order to complete this case study. It is important to note the assumptions when considering this report as they may have financial implications, or may not apply to individual circumstances in the same way. These are explained in *Assumptions* in Appendix C.

The main assumptions to be aware of are

1. The introduction of a time bar to scaling and polishing at item 1001 would reduce the frequency of this item by 25 per cent

2. The frequency of endodontic treatment of molar teeth has been taken as 36 per cent of root treatments are on molar teeth. This has been equated as being equivalent to 50 per cent of the fees for item 1501.
Case studies

Profile

Four different dentists were used as case studies to explore a range of dentist characteristics and provide a range of differing experiences and possible effects. Table 9 provides the characteristics for each of the case study dentists\(^\text{19}\).

The dentists all worked in practices where there were other dentists with differing characteristics and treatment profiles.

Table 9: Dentist characteristics

<table>
<thead>
<tr>
<th>Dentist</th>
<th>Dentist 1 (D1)</th>
<th>Dentist 2 (D2)</th>
<th>Dentist 3 (D3)</th>
<th>Dentist 4 (D4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job role</td>
<td>GDP Associate</td>
<td>GDP Associate</td>
<td>GDP Associate</td>
<td>GDP Associate</td>
</tr>
<tr>
<td>Clinical Sessions worked per week</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Location</td>
<td>Provincial town</td>
<td>Provincial town</td>
<td>Deprived city area</td>
<td>Deprived city area</td>
</tr>
<tr>
<td>Health service contribution</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>Career stage</td>
<td>approximately 5 years qualified</td>
<td>approximately 5 years qualified</td>
<td>approximately 5 years qualified</td>
<td>approximately 5 years qualified</td>
</tr>
</tbody>
</table>

With the proposals being put forward by DHSSPS relating to the health service dental budget, only those with a high commitment of Health Service activity were considered.

While we understand that clinical working patterns vary in dental practice it was felt that the dentists selected must work at least eight sessions a week and would not have had an abnormal amount of time off during the year. We did not feel it appropriate to consider those with high commitment to a specialism or those engaging the services of a hygienist as the effect could be skewed. All those selected had an annual gross turnover generated from treatment in the range £70K to £130K. This must be taken into consideration when interpreting the results, or applying them to individual or practice circumstances.

Provincial town location was chosen as it is probably most representative of the demography across Northern Ireland. Inner city deprived areas were chosen as this may have high reliance on the health service but with a different treatment pattern to that of provincial towns.

We acknowledge that the demography and characteristics of dentists differ hugely on a range of variables. The report must be read and interpreted by readers in the context of the characteristics of the case study dentists.

\(^{19}\) Each of the dentists has been given identifiers (e.g. D1) to protect anonymity. They will be referred to by this identifier throughout the report.
Study 1: Dentist 1 (D1)

Profile

D1 is a GDP, qualified approximately five years, working in a provincial town. D1 works a typical week of nine clinical sessions per week, with reasonable time off and holidays. D1 has a high level of commitment to the health service, with private work being undertaken in line with patient desires. The practice where D1 works is inclusive of other dentists, who have differing profiles.

What the story is now

D1 in 2011 had a total gross turnover from treatment items of £126,292 including any private work. A total of 14,358 items were provided during that 12 month period.

Average cost per item D1 = £8.80.

Table 10 demonstrates the top five treatment items from which the D1 has received income. It is apparent that the top five items account for over two-thirds (68.8 per cent) of D1’s treatment turnover.

This is made up of a high volume of items such as scale and polish, examination and fillings. Almost a third of D1’s income comes from providing fillings (30.7 per cent), while almost 17 per cent of fee income is generated through scaling and polish. Such a reliance on a narrow range of items makes the income derived from them sensitive to any change in frequency of their delivery through the Statement of Dental Remuneration.

Table 10: D1’s top five items by charges received

<table>
<thead>
<tr>
<th>Top five</th>
<th>Item</th>
<th>Fees</th>
<th>% of fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All fillings (excluding root canal)</td>
<td>£38,765</td>
<td>30.7%</td>
</tr>
<tr>
<td>2</td>
<td>Scale and polish</td>
<td>£21,072</td>
<td>16.7%</td>
</tr>
<tr>
<td>3</td>
<td>Examination</td>
<td>£15,159</td>
<td>12.0%</td>
</tr>
<tr>
<td>4</td>
<td>Root canal filling</td>
<td>£6,139</td>
<td>4.9%</td>
</tr>
<tr>
<td>5</td>
<td>Bonded full or jacket crown non-precious</td>
<td>£5,716</td>
<td>4.5%</td>
</tr>
<tr>
<td>Total</td>
<td>Total for top 5</td>
<td>£86,851</td>
<td>68.8%</td>
</tr>
<tr>
<td>Total Treatment D1</td>
<td>Total treatment fees D1</td>
<td>£126,292</td>
<td>100%</td>
</tr>
</tbody>
</table>

Current items subject of proposed changes

- The highest individual fee-earning item that D1 administered in 2011 was scale and polish treatments of which 1,685 were provided. This equated to £21,072 of income which is 16.7 per cent of total fee income. (average S/P fee £12.50)
• Whilst not the highest fee earning treatment, the highest treatment incidence was for examinations. In 2011 D1 undertook 2,778 examinations receiving £15,159 for this work. This equates to 12.0 per cent of D1 total income. (Average fee £5.45).

• The ratio of examination to scale and polish treatments was 1:0.6.

• In 2011 D1 received £13,771 of income for work relating to crowns, bridges and veneers. This accounted for 10.9 per cent of D1 treatment turnover.

• Root fillings accounted for almost five per cent (4.9 per cent) of D1 fee income. In total D1 received £6,139 for providing root fillings. Based on the assumptions made, we estimate that 36 per cent were molar root fillings 20 and that 50 per cent of the endodontic fees were derived from molar treatments. This equates to £3,070 for molar root fillings.

• D1 received £665 for providing metal dentures in 2011. This equated to just half a per cent of their annual fee income.

Proposed changes

• Scale and polish

Using data provided by the BSO on the number and incidence of scaling and polishing, and the number of patients who receive 1, 2, 3, or 4 scalings per year, we have calculated that on a Northern Ireland-wide basis 25.3 per cent of scale and polish item 1001s would in future be timed-out by the introduction of a 12-month time bar on this treatment item. On a Northern Ireland-wide basis this equates to almost 150,000 scale and polish items that would fall outside the 12 month time bar.

In 2011 D1 had a total fee income from scale and polish item 1001s of over £21,000 (see table 11), which equated to over 16 per cent of their treatment fees earned. Under the proposed changes outlined this would mean that if D1 conforms to the Northern Ireland picture of scaling and polishing then D1 would lose over £5,000 of health service turnover, or four per cent of their treatment turnover.

Table 11: Effect of proposed changes to scale and polish 1001

<table>
<thead>
<tr>
<th>Scale and polish</th>
<th>Currently</th>
<th>25% reduction under DHSSPS proposals</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of items</td>
<td>1,685</td>
<td>1,259</td>
<td>426</td>
</tr>
<tr>
<td>Fees</td>
<td>£21,072</td>
<td>£15,741</td>
<td>£5,331</td>
</tr>
<tr>
<td>% fees</td>
<td>16.7%</td>
<td>12.5%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

20 The estimate of 36% of root fillings being molar root canal is derived data provide by the BSO. It is then assumed to equate to roughly 50% of the fees generated for the item.
- **Molar endodontic treatment**
  Using practice data we have estimated that 36 per cent or one in every three root filling treatments carried out by D1 is molar. Under DHSSPS proposals this would mean that £3,070 of D1’s health service turnover would in future become the subject to prior approval.

- **Cobalt-chrome dentures**
  Extracting from 2011 only, £665 of D1’s turnover would be under prior approval from providing metal dentures. This equated to half a per cent of their annual treatment turnover.

- **Bridges**
  In 2011, £1,973 of D1’s treatment turnover was generated for work performed including bridges. This accounted for almost two per cent of D1 treatment turnover in 2011.

- **Veneers**
  In 2011 D1 did not perform any veneer work that would be subject to changes under the new proposals

**Potential effect of the DHSSPS proposals on D1**

The effect of a 12-month bar on scale-and-polish treatment 1001 is a fixed effect. Table 11 considers this financial impact in conjunction with differing levels of prior approval treatments being approved.

**Table 11: Financial impact of the proposed changes to D1’s gross treatment turnover**

<table>
<thead>
<tr>
<th>Prior approval</th>
<th>Total fee under review</th>
<th>Turnover lost if …</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Two thirds of treatment not approved</td>
<td>50% of treatment not approved</td>
<td>30% of treatment not approved</td>
<td></td>
</tr>
<tr>
<td><strong>Molar endodontic treatment</strong></td>
<td>£3,070</td>
<td>£2,047</td>
<td>£1,535</td>
<td>£921</td>
<td></td>
</tr>
<tr>
<td><strong>Cobalt-chrome dentures</strong></td>
<td>£665</td>
<td>£439</td>
<td>£333</td>
<td>£200</td>
<td></td>
</tr>
<tr>
<td><strong>Bridges</strong></td>
<td>£1,973</td>
<td>£1,302</td>
<td>£987</td>
<td>£592</td>
<td></td>
</tr>
<tr>
<td><strong>Veneers</strong></td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,787</td>
<td>3,788</td>
<td>2,855</td>
<td>£1,713</td>
<td></td>
</tr>
<tr>
<td><strong>Scale and polish</strong></td>
<td>£21,072</td>
<td>£5,331</td>
<td>£5,331</td>
<td>£5,331</td>
<td></td>
</tr>
<tr>
<td><strong>D1 total treatment turnover</strong></td>
<td>£126,292</td>
<td>£126,292</td>
<td>£126,292</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total gross treatment lost</strong></td>
<td>£9,119</td>
<td>£8,186</td>
<td>£7,044</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If two-thirds of items to prior approval were not approved, together with the change to scaling and polishing, D1 would find HS treatment turnover reducing by over £9,000, equivalent to 7.2 per cent of their annual treatment turnover.

If 30 per cent of prior approval items were not approved D1 would find HS treatment turnover reducing by almost £7,000, equivalent to 5.6 per cent of their annual treatment turnover.

**Conclusion**

With such a delicate composition of D1’s income it is clear that changes to the SDR could have a profound financial impact.

In addition, these changes would also have other consequences, many of which may not be able to be fully anticipated or quantified. For example the molar tooth, which is not approved for root canal treatment, may not subsequently be restored. Other changes could range from changes to working patterns to changes to patient behaviours. Because these changes are not measurable within the confines of the data we have available, they are discussed in more depth in the *Discussion* section).
Study 2: Dentist 2 (D2)

Profile

D1 is a GDP who is approximately 5 years post qualification, working in a provincial town. D2 works a typical week of 9 sessions per week, with reasonable time off and holidays. D2 has a high level of commitment to the health service, with private work being undertaken in line with patient desires. D2 works in a practice where other dentists exhibit differing treatment profiles.

What the story is now

In 2011 D2 had a total gross treatment turnover of £109,815 on items if service, including any private work. A total of 13,079 items were provided during that 12 month period of 2011. Average cost per item D2 = £8.40.

Table 12 demonstrates the top five treatment items for which the D2 has received income. The top five items account for just short of two-thirds (62.8 per cent) of D2’s treatment turnover. This is made up of a high volume of items such as scale and polish, examination and fillings.

A quarter of D2’s treatment income comes from providing fillings (24.9 per cent), while almost 14 per cent of fee income is generated through scaling and polish. Such a reliance on a small number of items makes the income derived from them sensitive to any change in frequency of their delivery through the Statement of Dental Remuneration.

Table 12: D2’s top five items by charges received

<table>
<thead>
<tr>
<th>Top five</th>
<th>Item</th>
<th>Fees</th>
<th>% of fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All fillings (excluding root canal)</td>
<td>£27,298</td>
<td>24.9%</td>
</tr>
<tr>
<td>2</td>
<td>Examination</td>
<td>£15,370</td>
<td>14.0%</td>
</tr>
<tr>
<td>3</td>
<td>Scale &amp; Polish</td>
<td>£15,007</td>
<td>13.7%</td>
</tr>
<tr>
<td>4</td>
<td>Partial Denture Bearing</td>
<td>£6,350</td>
<td>5.8%</td>
</tr>
<tr>
<td>5</td>
<td>Root Canal Fillings</td>
<td>£6,235</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total</td>
<td>Total for top 5</td>
<td>£70,260</td>
<td>64.1%</td>
</tr>
<tr>
<td></td>
<td>Total treatment fees D2</td>
<td>£109,815</td>
<td>100%</td>
</tr>
</tbody>
</table>

Current items subject of DHSSPS proposals

- One of the highest individual fee earning items that D2 administered in 2011 were scale and polish treatments of which 1,258 were provided. This equated to £15,007 of income which is 13.7 per cent of total income. (Average fee £11.90).

- The highest fee earning activity and the highest number of treatment incidences was for examinations. In 2011 D2 undertook 2,470 examinations receiving £15,370 for this work. This equates to 14.0 per cent of D2 total income. (Average fee £6.20)
The ratio of examination to scale and polish treatments was 1/0.6

In 2011 D2 received £14,181 of income for work relating to crowns, bridges and veneers. This accounted for a significant proportion (12.9 per cent) of D2 treatment turnover.

Root fillings accounted for over five per cent (5.7 per cent) of D2 annual treatment turnover. In total D2 received £6,235 for providing root fillings. Of these we estimate that 36 per cent were molar root fillings and have attributed 50 per cent of the endo fees to molar teeth\(^{21}\). This equates to £3,118 for molar root fillings.

D2 received £1,318 for providing metal dentures in 2011. This equated to 1.2 per cent of their annual treatment turnover.

**Effect of changes Proposed by DHSSPS**

- **Scale and polish**

  Using data provided to us by the BSO on the number and incidence of scaling and polishing, and the number of patients who receive 1, 2, 3, or 4 scaling’s per year, we have calculated that on a Northern Ireland-wide basis 25.3% of scale and polish items at 1001 would in future be disallowed by the introduction of a 12 month time bar on this treatment item. On a Northern Ireland-wide basis this equates to almost 150,000 scale and polishes that would fall outside the 12 month time bar.

  In 2011 D2 had a total income from scale and polish treatments of over £15,000 (see table 13), which equated to over 13% of their treatment turnover. Under the proposed DHSSPS changes outlined this would meant that if D2 conforms to the Northern Ireland picture of scaling and polishing then D2 would lose over £3,500 of health service turnover, or four per cent of their treatment turnover.

**Table 13: Proposed changes to scale and polish income**

<table>
<thead>
<tr>
<th>Scale and polish</th>
<th>Currently</th>
<th>25% reduction under DHSSPS proposals</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of items</td>
<td>1,258</td>
<td>940</td>
<td>318</td>
</tr>
<tr>
<td>Fees</td>
<td>£15,007</td>
<td>£11,210</td>
<td>£3,797</td>
</tr>
<tr>
<td>% fees</td>
<td>13.7%</td>
<td>10.2%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

\(^{21}\) The estimate of 36% of root fillings being molar root canal is derived from data provide by the BSO. We then assumed that if 36% of the teeth treated were molars, then roughly half of the fees could be attributed to molar teeth.
- **Molar Endodontic treatment**
  We have estimated that one in every three root filling treatments undertaken by D2 is molar. Under DHSSPS proposals this would mean that £3,118 of D2’s health service turnover would in future be subject to prior approval.

- **Cobalt Chrome dentures**
  In 2011, £1,318 of D2’s turnover would be under prior approval from providing metal dentures.

- **Bridges**
  In 2011, £2,475 of D2’s treatment turnover was for work performed including bridges. This accounted for over two per cent of D2 total treatment turnover in 2011.

- **Veneers**
  In 2011 D2 provided treatment £125 of veneers.

**Potential effect of the DHSSPS proposals on D2**

The effect of a 12 month bar on scale and polish treatment is a fixed effect. Table 14 considers this financial impact in conjunction with differing levels of prior approval treatments being approved.

**Table 14: Financial impact of the proposed changes to D2’s gross income**

<table>
<thead>
<tr>
<th>Prior approval</th>
<th>Total fee under review</th>
<th>Turnover lost if...</th>
<th>50% of treatment not approved</th>
<th>30% of treatment not approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molar Endodontic treatment</td>
<td>£3,118</td>
<td>£2,079</td>
<td>£1,559</td>
<td>£935</td>
</tr>
<tr>
<td>Cobalt Chrome dentures</td>
<td>£1,318</td>
<td>£879</td>
<td>£659</td>
<td>£395</td>
</tr>
<tr>
<td>Bridges</td>
<td>£2,475</td>
<td>£1,650</td>
<td>£1,238</td>
<td>£743</td>
</tr>
<tr>
<td>Veneers</td>
<td>£125</td>
<td>£83</td>
<td>£63</td>
<td>£38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£7,036</strong></td>
<td><strong>£4,691</strong></td>
<td><strong>£3,519</strong></td>
<td><strong>£2,111</strong></td>
</tr>
<tr>
<td>Scale and polish</td>
<td>£15,007</td>
<td>£3,797</td>
<td>£3,797</td>
<td>£3,797</td>
</tr>
<tr>
<td>D1 total treatment turnover</td>
<td><strong>£109,815</strong></td>
<td><strong>£109,815</strong></td>
<td><strong>£109,815</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total treatment lost</strong></td>
<td><strong>£8,488</strong></td>
<td><strong>£7,316</strong></td>
<td><strong>£5,908</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of turnover lost</strong></td>
<td>7.8%</td>
<td>6.7%</td>
<td>5.4%</td>
<td></td>
</tr>
</tbody>
</table>
• If two thirds of items to prior approval were not approved, together with the change to scaling and polishing, D2 could find HS treatment turnover reducing by almost £8,500, equivalent to 7.8 per cent of their annual treatment turnover.

• If 30 per cent of prior approval items were not approved D2 could see a reduction of almost £6,000 of annual treatment turnover, equivalent to 5.4 per cent of their gross annual treatment turnover.

Conclusion

With such a delicate composition of D2’s income it is clear that small changes to the SDR could have a profound financial impact.

In addition, these changes that have been described above would also have other consequences, many of which may not be fully anticipated. These changes could range from changes to working patterns to changes to patient behaviours. Because these changes are not measurable within the confines of the data we have available, they are discussed in more depth at the back of this document (see Discussion).
Study 3: Dentist 3 (D3)

Profile

D3 is an associate GDP, qualified less than 5 years and practicing in an inner city location with high deprivation. D3 works a typical week of 10 clinical sessions per week, with reasonable time off and holidays. D3 has a high level of commitment to the health service, with private work being undertaken in line with patient desires. D3 works in a practice with other dentists who exhibit varied treatment profiles.

What the story is now

In 2011 D3 had a total gross treatment turnover of £103,843 on items of service, including any private work. A total of 12,687 items were provided during that 12 month period. Average cost per item D3 = £8.18

Table 15 demonstrates the top five items from which the D3 has received fee income for. It is apparent that the top five items account for almost two-thirds (63.1 per cent) of D3’s treatment turnover. This is made up of a high volume of items such as scale and polish, examination and fillings.

A quarter of D3’s treatment income comes from providing fillings (25.2 per cent), while almost 13 per cent of fee income is generated through scaling and polish. Such a reliance on a small number of items makes the income derived from them sensitive to any change in frequency of their delivery through the Statement of Dental Remuneration.

Table 15: D3's top five items by charges received

<table>
<thead>
<tr>
<th>Top five</th>
<th>Item</th>
<th>Fees</th>
<th>% of fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All fillings (excluding root fillings)</td>
<td>£26,162</td>
<td>25.2%</td>
</tr>
<tr>
<td>2</td>
<td>Scale &amp; Polish</td>
<td>£13,019</td>
<td>12.5%</td>
</tr>
<tr>
<td>3</td>
<td>Bonded Full or Jacket Crown - Precious</td>
<td>£10,008</td>
<td>9.6%</td>
</tr>
<tr>
<td>4</td>
<td>Examination</td>
<td>£9,085</td>
<td>8.7%</td>
</tr>
<tr>
<td>5</td>
<td>Partial Denture Bearing</td>
<td>£7,421</td>
<td>7.1%</td>
</tr>
<tr>
<td>Total</td>
<td>Total for top 5</td>
<td>£65,695</td>
<td>63.1%</td>
</tr>
<tr>
<td></td>
<td>Total treatment turnover</td>
<td>£103,843</td>
<td>100%</td>
</tr>
</tbody>
</table>

Current items subject to changes through DHSSPS proposals

- The highest individual fee earning item that D3 administered in 2011 were scale and polish treatment of which 1,043 were provided. This equated to £13,019 of income which is 12.5 per cent of total income. (Average fee £12.50)

- The highest number of treatment incidence was for examinations. In 2011 D3 undertook 2,093 examinations receiving £9,085 for this work. This equates to 8.7 per cent of D3 total treatment turnover (Average fee 5.50)
• The ratio of examination to scale and polish treatments was 1/0.5.

• In 2011 D3 received £17,940 of income for work relating to crowns, bridges and veneers. This accounted for a significant proportion (17.3 per cent) of D3 treatment turnover.

• Root fillings accounted for five per cent (5.0 per cent) of D3 treatment turnover. In total D3 received £5,232 for providing root fillings. Of these we have applied an assumption that 36% of teeth treated are molars and 50 per cent of fees generated come from molar treatments. This equates to £2,618 for molar root fillings.

Proposed changes

• Scale and polish

Using data provided to us by the BSO on the number and incidence of scaling and polishing (1001), and the number of patients who receive 1, 2, 3, or 4 scaling’s per year, we have calculated that on a Northern Ireland-wide basis 25.3% of scale and polish would in future be timed-out by the introduction of a 12 month time bar on this treatment item. On a Northern Ireland-wide basis this equates to almost 150,000 scale and polishes that would fall outside the 12 month time bar.

In 2011 D3 had a total income from sale and polish treatments of over £13,000 (see table 16), which equated to over 12% of their fees earned. Under the proposed changes outlined this would mean that if D3 conforms to the Northern Ireland picture of scaling and polishing then D3 would lose over £3,000 of health service turnover, or over three per cent of their total treatment turnover.

Table 16: Proposed changes to scale and polish income

<table>
<thead>
<tr>
<th>Scale and polish</th>
<th>Currently</th>
<th>25% reduction under DHSSPS proposals</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of items</td>
<td>1,043</td>
<td>779</td>
<td>264</td>
</tr>
<tr>
<td>Fees</td>
<td>£13,019</td>
<td>£9,725</td>
<td>£3,294</td>
</tr>
<tr>
<td>% fees</td>
<td>12.5%</td>
<td>9.4%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

• Molar endodontic treatment

We have estimated that 50 per cent of the fees earned by D3 for root filling are molar. Under DHSSPS proposals this would mean that £2,618 of D3’s treatment turnover would become the subject of prior approval.

• Cobalt-chrome dentures

22 The estimate of 36% of root fillings being molar root canal is derived from individual dentist data. We then assumed that if 36% of the teeth treated were molars, then roughly half of the fees could be attributed to molar teeth.
In 2011 D3 did not provide any cobalt chrome dentures that would be subject to changes under the DHSSPS proposals.

- **Bridges**
  In 2011, £612 of D3’s treatment turnover was generated for work performed including bridges. This accounted for almost 0.6 per cent of D3 treatment turnover in 2011.

- **Veneers**
  In 2011, £1,486 of D3’s income was generated by providing veneers, which would be subject to prior approval under current proposal. This equates to over 1.4 per cent of D3’s total income.

**Potential effects of the DHSSPS proposals on D3**

The effect of a 12 month bar on scale and polish treatment is a fixed effect. Table 17 considers this financial impact in conjunction with differing levels of prior approval treatments being approved.

**Table 17: Financial impact of the proposed changes to D3’s treatment turnover**

<table>
<thead>
<tr>
<th>Prior approval</th>
<th>Total fee under review</th>
<th>Turnover lost if...</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Two thirds of treatment not approved</td>
<td>50% of treatment not approved</td>
<td>30% of treatment not approved</td>
</tr>
<tr>
<td>Molar Endodontic treatment</td>
<td>£2,618</td>
<td>£1,745</td>
<td>£1,309</td>
<td>£785</td>
</tr>
<tr>
<td>Cobalt Chrome dentures</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Bridges</td>
<td>£612</td>
<td>£408</td>
<td>£306</td>
<td>£184</td>
</tr>
<tr>
<td>Veneers</td>
<td>£1,486</td>
<td>£991</td>
<td>£743</td>
<td>£446</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£4,716</td>
<td>£3,144</td>
<td>£2,358</td>
<td>£1,415</td>
</tr>
<tr>
<td>Scale and polish</td>
<td>£13,019</td>
<td>£3,294</td>
<td>£3,294</td>
<td>£3,294</td>
</tr>
<tr>
<td>Total treatment turnover</td>
<td>£103,843</td>
<td>£103,843</td>
<td>£103,843</td>
<td></td>
</tr>
<tr>
<td>Total treatment lost</td>
<td>£6,438</td>
<td>£5,652</td>
<td>£4,709</td>
<td></td>
</tr>
<tr>
<td>Percentage of treatment turnover lost</td>
<td>6.2%</td>
<td>5.4%</td>
<td>4.5%</td>
<td></td>
</tr>
</tbody>
</table>

- If two thirds of items to prior approval were not approved, then together with the change to scaling and polishing, D3 would find HS treatment turnover reducing by
almost £6,500 equivalent to 6.2 per cent of their annual treatment turnover.

- If 30 per cent of prior approval items were not approved D3 would experience a reduction of over £4,700 of annual treatment income, equivalent to 4.5 per cent of their gross annual treatment turnover.

**Conclusion**

With such a delicate composition of D3’s treatment turnover it is clear that small changes to the SDR could have a profound financial impact.

In addition, these changes that have been described above would also have other consequences, many of which may not be fully anticipated. These changes could range from changes to working patterns to changes to patient behaviours. Because these changes are not measurable within the confines of the data we have available, they are discussed in more depth at the back of this document (see Discussion).
Study 4: Dentist 4 (D4)

Profile

D4 is an associate GDP qualified less than 5 years and practising in an inner city location with high deprivation. D4 works a typical week of 10 clinical sessions per week, with reasonable time off and holidays. D4 has a high level of commitment to the health service, with private work being undertaken in line with patient desires. D4 works in a practice where there are other dentists exhibiting differing treatment profiles.

What the story is now

D4 in 2011 had a total gross annual treatment turnover of £79,526 on treatment items of service, including any private work. A total of 11,589 items were provided during that 12 month period.

Average cost per item D4 = £6.86.

Table 18 demonstrates the top five items from which the D4 has received income. The top five items account for over half (52.4 per cent) of D4’s treatment turnover.

This is made up of a high volume of items such as scale and polish, examination and fillings. A fifth of D4’s income comes from providing fillings (20.1 per cent), while almost 10 per cent of fee income is generated through scaling and polish. Such a reliance on a small number of items makes the income derived from them sensitive to any change in frequency of their delivery through the Statement of Dental Remuneration.

Table 18: D4’s top five items by charges received

<table>
<thead>
<tr>
<th>Top five</th>
<th>Item</th>
<th>Fees</th>
<th>% of fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Filling (excluding root fillings)</td>
<td>£15,981</td>
<td>20.1%</td>
</tr>
<tr>
<td>2</td>
<td>Partial Denture Bearing</td>
<td>£7,637</td>
<td>9.6%</td>
</tr>
<tr>
<td>3</td>
<td>Scale &amp; Polish</td>
<td>£6,649</td>
<td>8.4%</td>
</tr>
<tr>
<td>4</td>
<td>Examination</td>
<td>£8,156</td>
<td>7.9%</td>
</tr>
<tr>
<td>5</td>
<td>Bonded Full or Jacket Crown - Precious</td>
<td>£5,083</td>
<td>6.4%</td>
</tr>
<tr>
<td>Total</td>
<td>Total for top 5</td>
<td>£43,506</td>
<td>52.4%</td>
</tr>
<tr>
<td></td>
<td>Total treatment turnover</td>
<td>£79,526</td>
<td>100%</td>
</tr>
</tbody>
</table>

Current items subject of DHSSPS proposed changes

- In 2011 D4 administered 522 scale and polish treatment items. This equated to £6,649 of income which is 8.4 per cent of total income. (Average fee £12.74)

- The highest number of treatment incidence was for examinations. In 2011 D4 undertook 1,465 examinations receiving £8,156 for this work. This equates to 7.9 per cent of D4 total income. (Average fee £5.56)
• The ratio of examination to scale and polish treatments was 1/0.4

• In 2011 D4 received £8,665 of income for work relating to crowns, bridges and veneers. This accounted for a significant proportion (10.9 per cent) of D4 treatment turnover.

• Root fillings accounted for five per cent (5.0 per cent) of D4 treatment. In total D4 received £4,012 for providing root fillings. We estimate that 50 per cent of these fees relate to molar root fillings. This equates to £2,006 for molar root fillings or 2.5 per cent of D4 treatment turnover.

• D4 received £665 for providing metal dentures in 2010/11.

Effect of changes proposed by DHSSPS

• Scale and polish
Using data provided to us by the BSO on the number and incidence of scaling and polishing, and the number of patients who receive 1, 2, 3, or 4 scale and polish items per year, we have made calculated that on a Northern Ireland-wide basis 25.3% of scale and polish would in future be disallowed by the introduction of a 12 month time bar on this treatment item. On a Northern Ireland-wide basis this equates to almost 150,000 scale and polishes that would fall outside the 12 month time bar.

In 2011 D4 had a total income from sale and polish treatments of over £6,500 (see table 19), which equated to over 8 per cent of their fees earned. Under the DHSSPS proposed changes outlined this would meant that if D4 conforms to the Northern Ireland picture of scaling and polishing then D4 would lose over £1,500 of health service turnover, or two per cent of their total from treatment turnover.

Table 19: Proposed changes to scale and polish income

<table>
<thead>
<tr>
<th>Scale and polish</th>
<th>Currently</th>
<th>Under new proposals</th>
<th>Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of items</td>
<td>522</td>
<td>390</td>
<td>132</td>
</tr>
<tr>
<td>Fees</td>
<td>£6,649</td>
<td>£4,967</td>
<td>£1,682</td>
</tr>
<tr>
<td>% fees</td>
<td>8.4%</td>
<td>6.2%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

• Molar endodontic treatment
We have estimated that 50 per cent of the fees generated for root filling treatments carried out by D4 were molar. Under DHSSPS proposals this would mean that £2,006 of D4’s health service turnover would be the subject of prior approval.

• Cobalt-chrome dentures

23 The estimate of 36% of root fillings being molar root canal is derived from BSO data. We then assumed that if 36% of the teeth treated were molars, then roughly half of the fees could be attributed to molar treatments.
In 2011, £173 of D4’s turnover would be under prior approval from providing metal dentures.

- **Bridges**
  In 2011, £938 of D4’s income was generated for work performed including bridges. This accounted for 1.2 per cent of D4 total treatment turnover in 2011.

- **Veneers**
  In 2011, £221 of D4’s income was generated by providing veneers, which would be subject to prior approval under current proposal.

**Potential effect of the proposals**

The effect of a 12 month bar on scale and polish treatment is a fixed effect. Table 20 considers this financial impact in conjunction with differing levels of prior approval treatments being approved.

**Table 20: Financial impact of the proposed changes to D4’s gross income**

<table>
<thead>
<tr>
<th>Prior approval</th>
<th>Total fee under review</th>
<th>Turnover lost if...</th>
<th>Two thirds of treatment not approved</th>
<th>50% of treatment not approved</th>
<th>30% of treatment not approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molar Endodontic treatment</td>
<td>£2,006</td>
<td>£1337</td>
<td>£1003</td>
<td>£602</td>
<td></td>
</tr>
<tr>
<td>Cobalt Chrome dentures</td>
<td>£173</td>
<td>£115</td>
<td>£87</td>
<td>£52</td>
<td></td>
</tr>
<tr>
<td>Bridges</td>
<td>£938</td>
<td>£625</td>
<td>£469</td>
<td>£281</td>
<td></td>
</tr>
<tr>
<td>Veneers</td>
<td>£221</td>
<td>£147</td>
<td>£111</td>
<td>£66</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£3,338</td>
<td>£2,224</td>
<td>£1,670</td>
<td>£1,001</td>
<td></td>
</tr>
<tr>
<td>Scale and polish</td>
<td>£6,649</td>
<td>£1,682</td>
<td>£1,682</td>
<td>£1,682</td>
<td></td>
</tr>
<tr>
<td>D4 Total treatment turnover</td>
<td>£79,526</td>
<td>£79,526</td>
<td>£79,526</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total treatment lost</td>
<td>£3,906</td>
<td>£3,352</td>
<td>£2,683</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of treatment turnover lost</td>
<td>5.0%</td>
<td>4.2%</td>
<td>3.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- D4 could experience a reduction in treatment turnover of almost £4,000 under DHSSPS proposals, equivalent to 5 per cent of their annual treatment.
turnover if at their current level of activity two thirds of approval items were sanctioned for treatment.

- If 30 per cent of prior approval items were approved D4 could experience reduction in treatment turnover of over almost £2,700 of annual income, equivalent to 3.4 per cent of their annual treatment turnover.

**Conclusion**

With such a delicate composition of D4’s treatment turnover it is clear that small changes to the SDR could have a profound financial impact.

In addition, these changes that have been described above would also have other consequences, many of which may not be fully anticipated. These changes could range from changes to working patterns to changes to patient behaviours. Because these changes are not measurable within the confines of the data we have available, they are discussed in more depth later (see *Discussion*).
Discussion

The proposed changes from DHSSPS address the primary problem as it presents to DHSSPS, which is a predictable problem of funding created by having in place a fixed budget to meet an open-ended commitment to dental services which are available to the public on demand and without delay.

The proposals compound the issues which the profession needs to have addressed, which are those of insufficient funding to meet the expenses elements of dental practice whilst providing support for the business providing health service care through dental practice.

While the full ramifications of any changes may not be known currently, we are clear that the DHSSPS proposals have the potential to impact on every aspect of dental practice in primary and secondary ways.

Northern Ireland funding for the GDS

The amount payable to GDS dentists in 2010/11 through items of service (excluding orthodontics), and including patient registration fees and commitment payments, was £74,290,032. The figure rises to £84,140,032 when orthodontic item of service payments are included.

Table 21 details the amounts by which funding through item of service, registration fees and commitment payments would be reduced to GDS contractors and orthodontic contractors through loss of QIS, item 1001 changes, core service, IOTN change and commitment payments to the GDS.

The percentage reduction in the GDS funding as a percentage of item of service fees and patient registration fees is in the order of 9.23%
Table 21: GDS funding changes brought about by loss of QIS funding, Item 1001 changes and commitment payment changes.

<table>
<thead>
<tr>
<th>Item of service spend</th>
<th>GDS (excluding ortho) 2010/11</th>
<th>GDS Ortho spend 2010/11</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item of service spend</td>
<td>52,469,790</td>
<td>9,850,000</td>
<td>62,319,790</td>
</tr>
<tr>
<td>Patient registration fees</td>
<td>19,013,255</td>
<td></td>
<td>19,013,255</td>
</tr>
<tr>
<td>Commitment Payments</td>
<td>2,363,483</td>
<td>444,503</td>
<td>2,807,987</td>
</tr>
<tr>
<td>QIS funding</td>
<td>(976,720)</td>
<td>(183,280)</td>
<td>(1,160,000)</td>
</tr>
<tr>
<td>Item 1001 reduce by 25%</td>
<td>(1,800,000)</td>
<td></td>
<td>(1,800,000)</td>
</tr>
<tr>
<td>Core service</td>
<td>(2,000,000)</td>
<td></td>
<td>(2,000,000)</td>
</tr>
<tr>
<td>Commitment Payments</td>
<td>(2,363,483)</td>
<td>(444,503)</td>
<td>(2,807,987)</td>
</tr>
<tr>
<td>Ortho IOTN 4.0</td>
<td></td>
<td>Estimate no change in first 12 months</td>
<td></td>
</tr>
<tr>
<td>Total following proposed cuts</td>
<td>68,326,325</td>
<td>9,222,217</td>
<td>76,373,045</td>
</tr>
<tr>
<td>% reduction to 2010/11 IoS and patient registration and commitment payment fees</td>
<td>7.48%</td>
<td>10.4%</td>
<td>9.23%</td>
</tr>
</tbody>
</table>

**Clinical time**

With a purported change in the time bar for item 1001 (scaling and polishing and simple periodontal treatment) as well as the other proposed SDR changes favouring simple forms of treatments, there would be consequences at dentist level leading to availability of dentist time as some items may have reduced volume or may no longer be delivered by the health service.

It is likely that the number of scale and polish items at 1001 and the proposed increase in items going to prior approval would lead to a decrease in the number of those specific items delivered. This has an impact on clinical time. For example, if a scale and polish is given 10 minutes of clinical time by Case Study D1, and 25% of the items were no longer carried out on the health service, then D1 has an annual accumulation of 9.5 days (or 71 hours) of clinical activity no longer taken up by this activity.

Carried across Northern Ireland, a loss of 25% of item 1001 would lead to a reduction of approximately 143,000 of these items. Giving each item a figure of 10 minutes would account for 24,000 hours of clinical activity. If this volume of clinical time is shared evenly across the population of dentists, then each of Northern Ireland’s 1010 dentists would have 24 hours of clinical time available. Put another way the change to item 1001 alone would account for 14 dentists working full time.
While it is evident that there will be an increase in clinical time available, it is difficult to quantify fully how much time would be available or how it might be utilised. For example, some treatment items previously carried out on the health service will move to the private sector, some will not be done at all and some will be replaced with alternative treatments either privately or on the health service. Any of these solutions will have a different impact on clinical time as well as patient throughput.

**Patient load/List size**

Patient load or list size is another important factor which would be subject to change in the DHSSPS proposals. A reduction in clinical work may be translated into less work per patient and therefore more patients might be sought to fill the same volume of clinical time.

There are currently 1,109,489 patients registered with a dentist on the health service at January 2012. This figure has increased on a quarterly basis over the period since end 2008 in both adult and child registrations. Some of this increase is associated with the increase in patient registration period, where at August 09 registration period went from 15 months to 24 months. The result is an increase starting 15 months after August 09, which would be expected to level 24 months after its start.

The wider economic situation will have an impact on how patient registrations develop in future.

**Figure 2: Patient registrations 2008-2011**

![Patient registrations 2008-2011](image)

**Private treatment**

Considering the purported changes to health service provision, patients wishing to receive items no longer available, not approved or delayed by the prior approval process may be inclined to seek private treatment as an option. In each circumstance, the outcome relies on
the demand for private services. BDA research\textsuperscript{24} showed that patient behaviour was changing in light of the economic down turn. If there is reduced likelihood that patients may seek private treatment that will in turn have financial consequences for practitioners and implications for dental businesses.

**Increase in HS treatments**

While an increase in private treatments may be one consequence, an increase in HS activity is another.

**Current position exacerbated**

The position in 2011/12 is one where the increase in expenses incurred by practices has been 7%. This increase to operating expenses has not been met by DHSSPS, other than with a pay offer of 0.5% (aimed at providing practice staff earning less than £21,000 with an award of £250). This presents dentists with a straight pay cut at a minimum level of 7% for the period 2011/12.

Looking then at the previous 2 years and comparing the pay awards provided through fees with the prevailing rate of the Consumer Price Index (CPI). Dentists have seen increases to fees of 0.21% in 2009 and 0.5% in 2010. At the same time CPI has been 2.3% in April 2009 and 3.7% in April 2010. The gap between fee rises and CPI for those 2 years presents an existing lag of 5.3%.

Cumulatively, up to April 2012, over the previous 3 years, dentists will have experienced a reduction in their ability to meet expenses of the order of 12.3%.

**Figure 1: Consumer Price Index and DHSSPS Pay Uplifts April 2009 - December 2011**

\textsuperscript{24} Omnibus survey 2010
Patient oral health

Patient oral health is the priority of dentists and dentists are deeply concerned that their efforts in caring for patients would be thwarted rather than supported by the health service. This is particularly the case where the dentist feels the patient is either denied treatment by the health service or is provided with some form of pain relief and asked to wait for approval. The evidence on the subject of routine scale and polish for periodontal health in adults has been considered as part of a Cochrane Review 2008, which concluded that

*The effects on periodontal health of a routine scale and polish and of providing this intervention at different time intervals are unclear.*

Many dentists and hygienists regularly provide scaling and polishing for patients, even if those patients are considered to be at low risk of developing periodontal (gum) disease. The trials included in this review were judged to be of poor quality. The research evidence was of insufficient quality to reach any conclusions regarding the beneficial and adverse effects of routine scaling and polishing for periodontal health and regarding the effects of providing this intervention at different time intervals.

Morale

Workplace and professional morale is a major aspect for any individual dentist in their workplace and caring role. Dentists and their staff are not immune to the pressures of the workplace and this is added to by factors including the job demands of dentistry, difficult patient contacts, business management, time pressures, government policies, compliance and financial matters.

Northern Ireland based research considering burnout and engagement in relation with job demands and resources among dental staff in Northern Ireland concluded that a high proportion of dentists in the study were suffering from psychological distress, whilst on the positive side high levels of engagement were found.

Practice Allowance

The Practice Allowance is a practice based payment made to dental practices. It is calculated based on qualifying factors including average number of patients per dentists, average number of paying patients per dentist and average gross earnings per dentist by practice.

DHSSPS propose to change the criteria for eligibility for the practice allowance. The proposal would increase the threshold from an average of 500 Health Service patients per dentist, of whom 100 must be fee paying to an average of 750 Health Service patients of whom 200 must be fee paying.

Each practice will need to consider whether the practice allowance, with these criteria is accessible.

BDA will be carrying out further work on this area.

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25 Burnout and engagement in relation with job demands and resources among dental staff in Northern Ireland, Ronald C Gorter and Ruth Freeman. Community Dentistry and Oral Epidemiology 2010
Workforce
The dentist workforce in Northern Ireland is 1010 individual dentists, working in around 370 practice locations across Northern Ireland. The DHSSPS proposals would dictate how dentists would use their clinical time on health service work.

It is difficult to describe the impact on the dentist workforce fully as changes on their own have impacts, but when a cocktail of changes is proposed, there could be consequences which may be cumulative or unpredictable, or only become apparent at a later point. For example change to item 1001 on its own would have the capacity to eliminate 25% of item 1001 treatments from the health service. But consideration must be given to how this may in turn impact on patient recall intervals.

Looking at the matter of workforce impact, a simple consideration is to consider the values at Table 21 and equate these back to the Case studies. The Northern Ireland wide reduction in item of service spend, and commitment payments brought about by the DHSSPS proposals would take a headline spend of £65,127,777 on these areas in 2010/11 down by £7,767,987 in the first 12 months. Using the Case Study dentists as example, the effects are shown at Table 22.

Table 22: The clinical activity by Case Study dentist represented by £7.77m

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Annual Treatment turnover</th>
<th>Number required to generate £7.77m</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>£126,292</td>
<td>62</td>
</tr>
<tr>
<td>D2</td>
<td>£109,815</td>
<td>71</td>
</tr>
<tr>
<td>D3</td>
<td>£103,843</td>
<td>75</td>
</tr>
<tr>
<td>D4</td>
<td>£79,526</td>
<td>98</td>
</tr>
</tbody>
</table>

Conclusions
There are multiple areas for discussion on the matter of DHSSPS proposing to cut the budget for dental services. This document and case study serves as a tool to assist BDA members in considering the initial impacts.

DHSSPS has responded to lobbying from BDA and there is due to be a public consultation on the public facing aspects of the proposals commencing March 2012.

BDA will continue to lobby on behalf of the profession and the service the public receive and we welcome all feedback to c.christie@bda.org
Appendix A: Payment system for dentists in Northern Ireland

This information describes the elements of Statement of Dental Remuneration which make up the gross payments available to dental practitioners in Northern Ireland.

The information is separated into those payments made to individual dentists and those made to practices. (Excluding payments in respect of expenses associated with vocational training and superannuation payments for dentists).

**Individual payments**

- Item-of-service fees for treatment items
- Patient Registration (Capitation & Continuing Care)
- Sessional payments for provision of emergency dental services
- Seniority payments
- Vocational training allowances
- Commitment payments
- Maternity/paternity/adoption leave
- Long-term sickness pay
- Continuing professional development allowances
- Clinical audit allowances
- Superannuation

**Practice payments**

- Reimbursement of non-domestic rates
- Practice allowance
### Table 1: Payment Detail GDS 10/11

| Item of service payments including patient charges for all treatments (inclusive of ortho) | £62,319,790 |
| (Orthodontic treatment items of service) | (£9,850,000) |
| (Patient charges for the period (all treatment items) | (£17,434,171) |
| Patient Registration (Continuing Care & Capitation) | £19,013,255 |
| Gross cost of estimates (including orthodontic items) | £81,333,045 |
| Sessional Payments for provision of emergency dental services | £197,179 |
| Seniority payments | £276,256 |
| Commitment payments | £2,806,987 |
| Maternity/paternity/adoption leave | £627,115 |
| Long-term sickness pay | £15,931 |
| Continuing professional development allowance | £436,407 |
| Clinical Audit & Peer Review Allowances | £33,256 |
| **Total turnover for pay and expenses** | **85,726,176** |
| **(Total without ortho items)** | **(£75,876,176)** |
| **Practice Payments** |  |
| Re-imbursement of non-domestic rates | £746,262 |
| Practice Allowance | £7,457,107 |
| **Total payment to practice payments** | **£8,203,369** |
| **Total** | **93,929,545** |

All figures provided by BSO

#### 23. Item-of-service fees for treatment

Dentists carry out clinical work in return for item-of-service fees. Fees for clinical treatment provide gross payment to dentists to provide the aspects of clinical care for patients as laid out in the Statement of Dental Remuneration.

#### 24. Sessional payments for provision of emergency dental services

Dentists in Northern Ireland participate in Health and Social Services Board-run emergency clinics for out-of-hours emergencies. The fee paid for each three hour session is £119.55.

If a dentist is participating in an out-of-hours clinic, they forego the opportunity to be working in their practice.
25. Seniority payments

A seniority payment is a payment made to a dentist over 55 years. The payment recognises that dentistry is a physically demanding job, and with age speed of working and hence turnover reduces. A seniority payment compensates an older dentist for work foregone through working at a slower rate.

26. Vocational training expenses allowances

Vocational training allowances cover the expenses elements associated with practice-based training for UK graduate dentists, or other dentists who may enter the scheme.

26.1. Reimbursement of the trainee dentist’s salary

This is a direct reimbursement of an incurred cost.

26.2. A trainer grant of £753 per month

This grant is to support the trainer in providing surgery and staff to support the trainee during the course of their training. Each vocational trainee will require a fully-equipped dental surgery and a dedicated dental nurse.

26.3. Trainer quality assurance grant

This is a grant paid to trainers to enable them successfully to complete the assessment of the trainee through the training period, using set assessment tools. The grant is up to £10,373 per year. During the training period, the trainer will need to spend a significant amount of time with the trainee to complete the training. The grant compensates the trainer for work foregone during the training period, when the trainer is away from his surgery to engage in necessary activities associated with the trainee’s on-going training needs.

26.4. Charter Mark allowance

Up to £1037 is available per year for training practices which have a recognised quality assurance charter mark, such as BDA Good Practice, Investors in People.

27. Commitment payments

Commitment payments are a payment to dentists in recognition of their individual commitment to the health service. The payment per quarter ranges from £27.00 to £1,999.00 dependant on turnover.

The spend on commitment payments is approximately £2.62 million for 09/10.

28. Maternity, paternity, adoptive leave

When a dentist is on maternity, paternity or adoptive leave, they forego the opportunity to do their usual clinical work in the surgery. Payments in respect of maternity, paternity and adoptive leave are time-limited and based on the individual’s historic earnings, up to a maximum of £1,399 per week (up to 26 weeks maternity, up to 2 weeks paternity).
29. Long-term sick pay

Long-term sick pay provides a weekly equivalent of 25 per cent of net earnings up to a maximum of £349 per week for up to 22 weeks for dentists who are out of the workplace due to illness. The allowance is not payable for the first four weeks of sickness.

30. Continuing professional development allowance

The Statement of Dental Remuneration provides dentists with payment when they undertake continuing professional development activities. The maximum payment available per year is £1,369.20 (less any abatement).

When a dentist is undertaking continuing professional development, they forego the opportunity to generate turnover and meet on-going expenses through clinical work.

31. Clinical audit and peer review allowance

The statement of dental remuneration provides dentists with payment for undertaking a maximum of 15 hours clinical audit/peer review activity over a three year period. The payment is £65.21 per hour (up to a maximum of £978.15 over a three year period).

When a dentist is undertaking clinical audit/peer review, they forego the opportunity to generate turnover.

32. Reimbursement of non-domestic rates

Reimbursement of non-domestic rates is a direct reimbursement of a practice cost. The amount of reimbursement is in direct proportion to the percentage of gross earnings from the health service.

33. Practice allowance

The practice allowance is an allowance to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.
Appendix B: Limitations

This section highlights some of the limitations of this case study. It provides specific limitations in the nature of the case study. Please take all limitations into consideration when reading the main case studies.

Selection of cases

Individual anonymised dentist data on the treatment items provided by four dentists operating largely within the health service was provided by two dental practices. The information was derived from the practice software reports detailing the treatments carried out over the period January to December 2011. Two dentists operated in a typical provincial town location and two dentists operated in a deprived city locations.

A participant selection criterion was enforced to allow the widest possible and least skewed case study possible. The selection criteria required participants to be:

- highly committed to working in the Health Service
- working a week which is inclusive of at least 8 clinical sessions
- not using the services of a hygienist and no significant orthodontic specialism
- having an annual gross turnover in the range £70K to £130K
- not be on extended leave during the period and displaying a typical working year
- whilst there was a mix of some private treatment, that it was predominantly health service

All the data was anonymous and all commercially sensitive information has been excluded from any output created. Research and reporting was carried out by the BDA Research Unit.

Data limitations

The case study that has been produced relies on the data that has been provided for it. In this case the dentist data has been provided by individual practice. Readers are asked to note that individual practices may utilise their software in different ways and record similar information differently. For example fillings can be recorded under a wide variety of headings. Treatment elements were grouped to provide the true value of each of the items examined.

With the data being generated from remuneration software, it can be assumed that the data is robust in its accuracy and is a true representation of the actual work which each dentist has performed.

Inclusions of private data

The datasets provided included all treatment provided by the dentist including private treatment. It has not been possible to separate private treatment form the health service treatment, however due to proportion of private work perform we do not consider that it will impact on the case study with undue affect however it should be considered.
Coding

To calculate the true value of various treatment (as mentioned above) it has been necessary to code differing items together. This was completed by those with clinical expertise in the knowledge of the coding framework which underpins the Statement of Dental Remuneration.

Clinical Time

One aspect that could not be fully explored was the time taken up by the treatments that have been explored. While data provided by practices did include a time field. This is utilised and recorded in different ways by practices and therefore significant inferences cannot be drawn.

Clinical time realised is an important factor in considering case study information in the context of your own practice situation. Based on the Northern Ireland data, approx. 25% of simple scaling and polishing treatments would be lost, together with the turnover generated from the HS. For some dentists where the ration of exam: scale and polish is high, the percentage may be greater. Each dentist can measure or estimate the time allocated to a scale and polish.

Patient list makeup

Each dentist will have a mix of patients on their list. In this case study, we have not considered the make up of the list in relation to adults and under 18’s.

Inferences

It is important to note that inference from these case studies cannot be made on to the general dental population. They are a representation of individual dentist and their situation, including: demography, working patterns and location. The complexity of variables which make a dental practice mean that generalisations can not be made from the data presented. Readers must be aware of the characteristics of each individual when considering any conclusions and not generalise the results.

Assumptions

Two assumptions have been made regarding the proportions multiple Scale and polishes and proportion of root canal fillings. Please read the Assumptions sect89h (Appendix C) for further details
Appendix C: Assumptions

This section should be read in conjunction with the main report. Calculations made in the main report must be considered within light of the assumptions made in this document. The document makes two main assumptions. The rationale and limitation for each assumption is explained in each section.

Assumption 1: Scale and polish (1001) assumptions

The following assumption has been made in relation to the provision of multiple scale and polishes that a GDP would administer over the course of a 12 month period and would therefore under the DHSSPS proposals be no longer permitted to individual patients under the GDS.

Assumption 1: 25.3% of scale and polish items are delivered the same patient more than once in 12 months and will not be delivered under the DHSSPS proposals.

Rationale

The BDA requested data from the BSO in relation to the number of patients for whom multiple 1001 item claims were made (table 1) over the course of a 12 month period.

Using this data the number of actual scale and polish items that had been delivered was derived (i.e. (1 1001 item) + (2*2 1001 items) + (3*3 1001 items) + (4*4 1001 items)). From this figure we could calculate the proportion of single and multiple scale and polish items (table 2 and table 3). A single scale and polish would be completed for each of the multiple items in additional to the single items, from which we make our assumption.

Table 1: Number of patients for whom multiple 1001 item claims were made

<table>
<thead>
<tr>
<th></th>
<th>1 1001 item</th>
<th>2 1001 items</th>
<th>3 1001 items</th>
<th>4 1001 items</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>293,925</td>
<td>116,989</td>
<td>9,953</td>
<td>2,078</td>
<td>422,945</td>
</tr>
</tbody>
</table>

Table 2: Calculation of equivalent scale and polish data

<table>
<thead>
<tr>
<th></th>
<th>1 1001 item</th>
<th>2 1001 items</th>
<th>3 1001 items</th>
<th>4 1001 items</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equivalent number of</td>
<td>293,925</td>
<td>233,978</td>
<td>29,859</td>
<td>8,312</td>
<td>566,074</td>
</tr>
<tr>
<td>scale and polishes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>items delivered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees earn for scale</td>
<td>£3,747,54</td>
<td>£2,983,22</td>
<td>£380,702</td>
<td>£105,978</td>
<td>£7,217,44</td>
</tr>
<tr>
<td>and polishes</td>
<td>4</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of scale</td>
<td>51.9%</td>
<td>41.3%</td>
<td>5.3%</td>
<td>1.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>and polishes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26 Based on £12.75, Fees scale 2010/11
Table 3: Calculation of single and multiple scale and polishes

|                               | Single 1001 item | Multiple 1001 items | Total  
|-------------------------------|-----------------|--------------------|-------
| Equivalent number of scale and polishes items delivered | 422,945         | 143,129             | 566,074  
| Percentage of scale and polishes delivered                | 74.7%           | 25.3%               | 100.0%  
| Fees earn for scale and polishes[^27]                      | £5,392,549      | £1,824,895          | £7,217,444 

Limitations

This data was received from the BSO and we believe it to be accurate. The data has been provided for a full year and for the whole of Northern Ireland.

There are several issues to be aware of when extrapolating this assumption to the dentists used in the case studies. Firstly, each dentist will perform differing levels of multiple scale and polishes dependent on a variety of factors. These include health service commitment, proportion of adult: child patients, size of practice, location and the oral health requirement of population.

[^27] ibid
Assumption 2: Molar endodontic treatment (RCT 6, 7 or 8) assumptions

The following assumption has been made in relation to the proportion of the proportion of endodontics treatment which is molar, and therefore be subject to prior approval.

Assumption 2: 51% of all fees received for root fillings carried out under HS are for molar root fillings.

Rationale

BSO provided data for the total number of items claimed under 1501 including the number of teeth treated under each of the four fees (i.e. tooth treated). This allowed us to calculate the proportion of molar 1501 treatments which had been claimed as a proportion from the total and the proportion of fees received for each of the item types. Table 4 demonstrates that while 36 per cent of root filling were for molar endodontic treatment this equated to 51 per cent of all fees received.

Table 4: The Northern Ireland incidence levels and fee received for root fillings by tooth type, 2011

<table>
<thead>
<tr>
<th>Root filling</th>
<th>Incidence</th>
<th>Incidence Cost</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incisor or canine tooth</td>
<td>10803</td>
<td>27.8%</td>
<td>£496,288.10</td>
</tr>
<tr>
<td>Upper premolar tooth</td>
<td>8701</td>
<td>22.4%</td>
<td>£546,320.80</td>
</tr>
<tr>
<td>Lower premolar tooth</td>
<td>5243</td>
<td>13.5%</td>
<td>£284,120.60</td>
</tr>
<tr>
<td>Molar tooth</td>
<td>14153</td>
<td>36.4%</td>
<td>£1,368,356.10</td>
</tr>
<tr>
<td>Total</td>
<td>38900</td>
<td>100.0%</td>
<td>£2,695,085.60</td>
</tr>
</tbody>
</table>

Limitations

This data was received from the BSO and we believe it to be accurate. The data has been provided for a full year and for the whole of Northern Ireland.

There are several issues to be aware of when extrapolating this assumption to the dentists used in the case studies. The data is taken from claims data and was provided with several caveats. The counts in table 4 do not add up to the total figure due to certain exclusions being made to the data (as stated above).

We do feel however for the purposes of this case study the estimate is within an acceptable limit to make an assumption, as long as care is taken when interpreting any effects. We recommend that this limitation is considered throughout the case study.

For further information on the limitations of the main document you can refer to Appendix B and the Limitations section.