BRITISH DENTAL ASSOCIATION

Evidence to the Doctors' and Dentists' Review Body

October 2004

For the Thirty-Fourth Report 2005

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GENERAL EVIDENCE

The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for their Thirty-fourth Report covering the year 2005/06. It is written under the terms of reference introduced in 1998 and all subsequent amendments. The evidence is submitted on behalf of dentists practicing in the National Health Service and covers those working in:

- General Dental Services
- Salaried Primary Dental Care Service – including the Community Dental Services and those in Dental Public Health
- Personal Dental Services
- Clinical Academic Staff

The British Medical Association will be submitting evidence on behalf of all hospital staff. We ask the Review Body to note that the issues raised by the BMA are applicable to those working in the Hospital Dental Service.

OVERVIEW

The BDA has continued to work towards a smooth transition from the current system of remuneration and delivery of NHS dentistry to the new system now beginning on the 1st October 2005 as the implementation of the Health and Social Care Act (England) comes into effect. The BDA has been working in conjunction with the Shadow Special Health Authority/Department of Health (DoH) on producing the details of the base contract for practitioners. It has to be emphasised that the BDA involvement has been one of being consulted and it has been made clear from the outset that we were not negotiating with the DoH. The BDA has represented the profession on the Department of Health's Dental NHS Patient Charges Working Group and the recommendations of this work were submitted to Ministers early in 2004.

WORKFORCE

The BDA reiterates that there is a serious shortage of dental personnel in the UK. The *Report of the Primary Care Dental Workforce Review* has finally been published and it supports this point. In the GDS alone we estimate that there is a workforce shortage of around 4,000 full time practitioners.

The BDA now presents to the Review Body its General Dental Services and Salaried Services evidence and subsequent recommendations which we believe need to be implemented in 2005/06 to ensure that NHS dental services of 'tomorrow' achieve the levels of patient care from a motivated and fully resourced NHS workforce.

GENERAL DENTAL SERVICES

1.1 The Doctors' and Dentists' Review Body (DDRB) recommendation of a 2.9 percent uplift on gross fees for 2004/05 did nothing to make the profession feel wanted by the National Health Service (NHS). This prompted two motions at LDC Conferences. In Scotland there was a unanimous vote to empower its Committee not to have any further part in talks with the DDRB on the grounds that their independent status is questionable. In England and Wales a motion of 'no confidence' in the DDRB and its independence was passed unanimously.

1.2 In addition to what was considered a derisory uplift, disappointment also focussed on the refusal by the DDRB to recommend a practice allowance (outwith Scotland) which takes steps towards appropriately reimbursing practitioners for the continuing and increasing administrative burden they bear and also the lack of action relating to dental expense inflation, coupled with there being no return on capital invested.

1.3 It is both disappointing and heartening to review some of the evidence that the BDA has provided in the past. Heartening to realise that in the main many of our predictions have been accurate and disappointing that the DDRB has chosen to believe the contrary evidence supplied by the DoH. For example the unpublicised *Report of the Primary Care Dental Workforce Review* finally accepts that there is a significant workforce shortage – recent BDA evidence to the DDRB indicated that the shortfall is in the region of 4,000 whole time equivalent (WTE) dentists and recent independent research by the University of Bath indicated a workforce shortage of 5,200 WTE dentists. Another example relates to our 2001 evidence that predicted that queues for private treatment were an impending phenomenon unless action was taken: within three years our prediction has come to fruition (see paragraph 1.27).

1.4 There is also a growing frustration at the lack of genuine evidence being submitted by the DoH, particularly on issues that are specifically requested for by the DDRB. For example, in last years Evidence to the DDRB the BDA provided estimates of WTE practitioners as well as prospective estimates for dental expense inflation. However, the DoH did not. We appreciate that a degree of agreement between both parties on such evidence is desirable: however it is not possible when one party simply does not submit evidence. In an attempt to resolve this, the DDRB secretariat, the DoH and the BDA formed a small Working Group. We hope that constructive joint working can be realised.

1.5 The GDS evidence submitted to the DDRB this year attempts to establish baseline data, e.g. on the number of WTE dentists in the GDS and dental expense inflation, to form the foundation for future rounds of evidence with the DDRB in the 'new world'.

NHS DENTISTRY FUNDING ANNOUNCMENTS

1.6 On 16th July 2004 the Government announced a range of measures relating to the upcoming reforms of NHS dentistry in England. This included a delay in the implementation date from April 2005 to October 2005 and a dental funding package. NHS Primary Care will receive an additional £250 million by 2005/06 (net of any patient charge revenue) with these monies

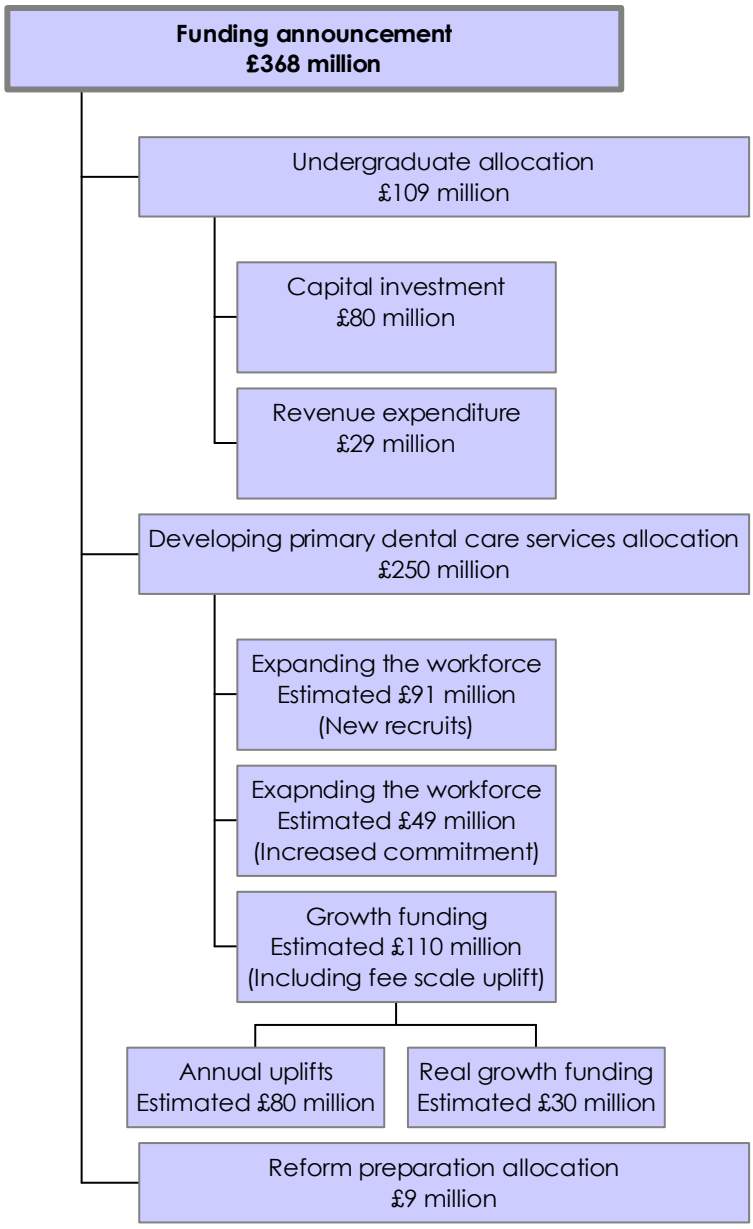
being devolved down to Primary Care Trusts (PCTs) – see figure 1 for a full breakdown of the funding allocation. In addition to the £250 million a further £9 million has been allocated to help GDS dental practices prepare for the new arrangements.

1.7 The Government also announced that 1,000 WTE dentists are to be recruited to the current workforce by October 2005. Of these, 650 are earmarked to be new foreign national recruits, with the remaining 350 WTE being obtained through increased NHS commitment from existing and returning dentists. It is envisaged that further support of schemes such as Keeping In Touch Scheme (KITS) will re-engage domestic dentists who are currently not an active part of the workforce. How successful this will be, remains to be seen, however a cursory glance at various national broad sheets shows full page advertisements encouraging dentists back to work.

1.8 Finally, from October 2005 there will be 170 extra dental undergraduate places available in England. As recruitment will not commence until 2005 there will be a minimum six-year time lag before the benefits of an increased domestic workforce can be realised. The Government has failed to indicate the number of GDPs that will retire over this time period and therefore the 'net gain' is unknown.

1.9 For many years now the BDA has submitted evidence on the national haemorrhaging of practitioners out of the NHS into the private sector. The BDA has continued to emphasise the difficulties in recruiting and retaining practitioners within the NHS and the DDRB, the DoH and the Government have largely ignored the recommendations that the BDA has proposed to stem this outflow. The DoH has consistently submitted evidence that speaks of a 'drift' away from the NHS. These initiatives smack of too little too late and the BDA remains unconvinced that 1,000 WTE practitioners will be recruited into the GDS by October 2005. Perhaps the failure of the Government to recruit these practitioners on time will indicate to the DDRB the more torrential nature of this 'drift'.

Figure 1: Breakdown of the July 2004 dental funding package



1.10 While the BDA welcomes the funding package and considers it a positive first step, we are keen to ensure that the additional funding goes to the 'frontline' of patient care, and not on administration at the PCT level. The BDA is aware that pay award recommendations, which may be made by the DDRB for this round of evidence, will be coming from the funding allocation announced in July 2004.

1.11 The BDA estimates that more than half of the funding (54 per cent) has been allocated for practitioners that are not yet part of the General Dental Service (GDS) workforce. This sends a strong signal to the current GDS workforce that historical commitment to the NHS is not to be appreciated or acknowledged by the Government. The funding package offers no return on capital deployed, or reward for the additional administrative burden facing practice owners to address ever increasing legislative requirements. In our Evidence to the DDRB last year we

highlighted the finding from the *BDA Dental Business Trends Survey (2002)* which showed that over 90 per cent of practitioners undertake up to ten hours administration a week. This finding is further corroborated in an article in the *Sunday Times* (dated 26th September 2004) where a spokesperson from the Federation of Small Businesses stated that the average small business spends 30 hours a month dealing with red tape.

1.12 As the recent MORI consultation (see paragraph 1.24) indicates practitioners, even before the funding announcements were made, had strong aspirations to reduce their NHS commitment over the next five years.

MOVING TOWARDS REFORM

1.13 Over the last 18 months the BDA and the DoH have met regularly to discuss and move forward with the programme for reform of NHS dentistry. In early 2004 the BDA undertook a consultation exercise with the profession on the DoH's Framework proposals for reform. In response to the feedback from the BDA consultation the implementation date for the reform of NHS dentistry was delayed by six months.

1.14 The Welsh Assembly Government has also announced that the dental services in Wales will now follow the same reforms and timetable as England. The Welsh Health Minister also announced extra funding amounting to £5.3 million to help the process of transition. To date none of this funding has come down to practices. Dental practitioners in Wales are also concerned that they have not had the opportunity to develop NHS practice through Personal Dental Services (PDS). No field sites were set up in Wales in general practice (although one Community Dental Service has a PDS site dealing with access problems).

1.15 In our ongoing discussions with the DoH, some key unresolved issues that remain include valuing NHS commitment, expectations on workload changes and dealing with new patients. The DoH's assertion is of an expected work reduction of 5 per cent. This reduction would be measured by courses of treatment, where the courses are weighted as per their complexity in line with the expected new NHS patient charges regime. The fact that this new charges regime has not yet been announced, even though recommendations were submitted to Ministers on 31st March 2004, has already undermined the professions confidence in the DoH and the Government. The current proposal would also feature a tolerance of two per cent in dentists' favour, allowing their productivity to fall to 93 per cent of pre-contract activity under certain conditions. It is difficult to envisage that this will truly free the dentists from the treadmill, though it may work some way towards relieving some of the pressures which dentists in the GDS experience.

1.16 The DoH has committed to review continually, jointly with the BDA, the reformed NHS dental system as data in the 'new world' becomes available. There is also a commitment to undertake independent research looking at, for example, the relative weightings for the courses if treatment and valuing non-clinical time.

1.17 Although these meetings have been highly constructive, allowing the BDA to comment and build upon DoH thinking for the base contract among other issues, it was in no way a

negotiation. In our last meeting on 24th September 2004, the BDA reiterated this to the DoH. At the time of writing, the BDA has written to the Minister requesting a formal meeting.

THE SIZE OF THE DENTAL WORKFORCE

1.18 In February 2004 the DoH finally published its long awaited *Report of the Primary Care Dental Workforce Review*. The Report reinforces the picture of dental care in England that the BDA has continued to highlight to the DDRB – that of an under supply of dental time required to meet demand.

1.19 The Report concludes that under-supply is projected to increase over the next two decades. Under supply in 2003 is estimated to be around nine per cent of demand; in the gravest scenario for 2021 under supply is projected to be 27 per cent of demand – representing around 6,500 WTE dentists. The BDA would also like to make the DDRB aware that this Report was written some two-and-a-half years ago and, as such, conclusions on the under-supply of WTE dentists are biased downwards.

1.20 The Report finally establishes a DoH estimate for the number of WTE dentists - under baseline assumptions (i.e. the most likely scenario) that the number of WTE dentists in England was 18,820 in 2001 and will be 18,570 in 2006. Extrapolation of this data indicates that there are 18,620 WTE dentists in 2004.

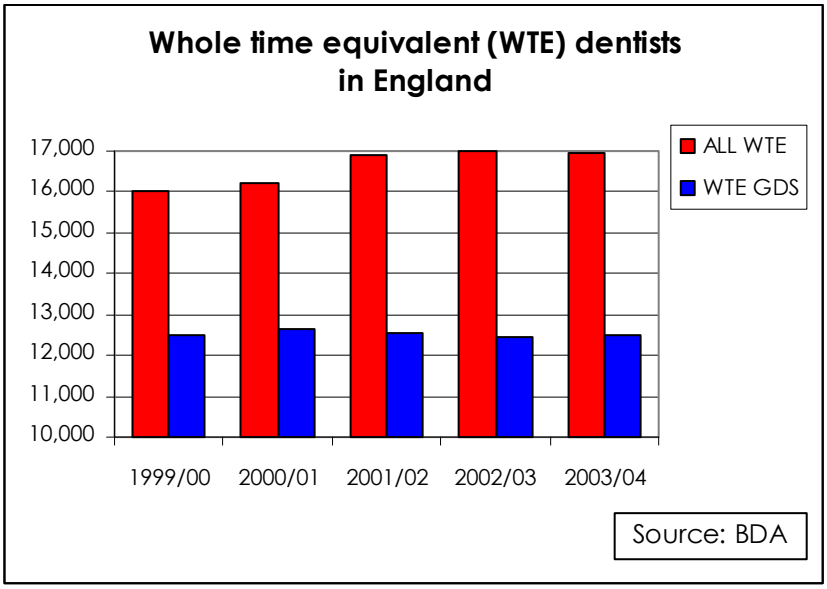
1.21 The DDRB has constantly been seeking to establish a baseline for the number of WTE dentists in England. The BDA has regularly provided the DDRB with up-to-date estimates in its Evidence – see figure 2. Our latest estimate shows that in 2003/04 there were 16,941 WTE dentists in England - 1,679 WTE dentists fewer than reported in the *Report of the Primary Care Dental Workforce Review.* However, the BDA estimate excludes therapists and hygienists[1].

1.22 Although the DoH has not provided an estimate for the number of GDS WTE dentists in England, the BDA estimates that, in 2003/04, the NHS component of the General Dental Services is comprised of around three-quarters of the total WTE workforce (74 per cent) – this equates to 12,487 WTE dentists for a population of 49.9 million people giving a population to NHS dentist ratio of almost 4,000 for England.

1.23 It is hoped that based upon the findings of the *Report of the Primary Care Dental Workforce Review* and BDA estimates, the DDRB will be able to establish a reasonably robust baseline for the number of WTE dentists in England in 2004/05.

[1] The baseline scenario in the *Report of the Primary Care Dental Workforce Review* indicates that therapists and hygienists will increase by the equivalent of 1,200 WTE dentists between 2001 and 2021.

Figure 2: WTE dentists in England



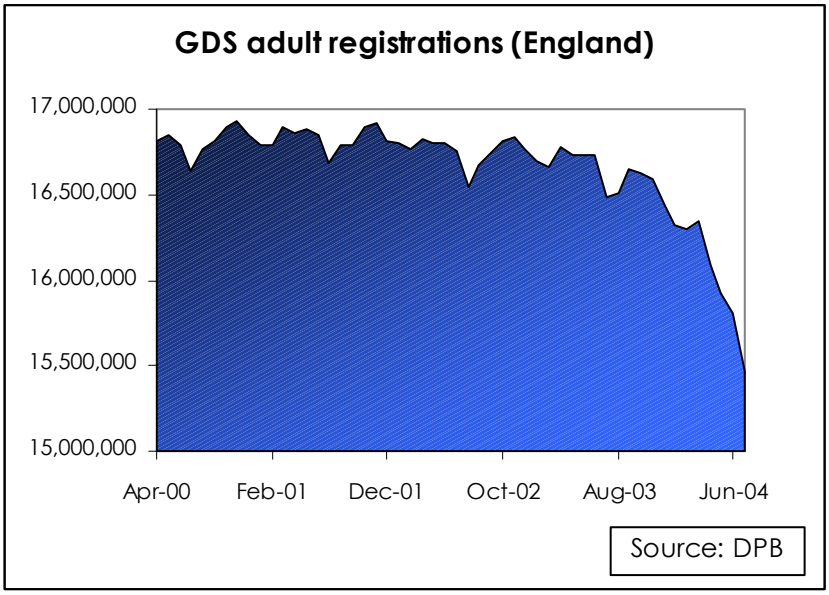
1.24 The MORI research *Proposals for Dentistry in England* (2004) found that in 2004, 60 per cent of dentists' income on average is derived from NHS work. The research also found that this is predicted to fall to 37 per cent in five years time. It is widely accepted that the proportion of income a practitioner derives from the NHS is lower than the proportion of time taken to undertake that NHS work. Hence, the 38 percent anticipated reduction in the proportion of NHS derived income would be accompanied by an even larger reduction in the time spent undertaking NHS work. This not only seriously compromises the quality and access of NHS patient care, but will also seriously undermine the ability of the DoH in being able to recruit and/or retain 1,000 WTE dentists into the GDS by October 2005.

1.25 It is clear from above that the effective size of the workforce providing NHS treatment is lagging behind the growth in the workforce as a whole. The NHS dental workforce model is characterised by both inflows and outflows of practitioners (and dental practices). In our Evidence to the DDRB last year we highlighted that organisations, such as Denplan, DPAS and Practice Plan, that assist in private practice conversion, converted around 260 dental practices to largely private practices in 2003. Further research, combined with the results of the MORI research, indicates that these trends have continued and accelerated in 2004.

1.26 Figure 3 shows the recent trend in adult registrations. Since January 2003 some 1.2 million adults (in England) are no longer registered with an NHS dentist. Denplan alone has converted some 300 dental practices in 2004 – this has involved the conversion of some 160,000 patients into the private sector. The information on practice conversions suggests that of the 1.2 million adults no longer registered at least 250,000 are now being seen privately; this implies that the remaining adults are either being seen through PDS or in many cases are now unable to access NHS dental care[2].

[2] The DoH estimates that in 2003/04 around 600,000 individual patients (i.e. both adults and children) were treated in a PDS environment in England.

Figure 3: GDS adult registrations



1.27 In our Evidence to the DDRB for its 31st Report (submitted in September 2001) the BDA presented evidence on the significant rise in the proportion of practitioners that were only taking new adult patients on privately. The BDA also warned that *"In some parts of the UK adult patients have now become used to the idea that they can only get dental care under private arrangements and there is a danger that this opinion will become more widespread."* This warning has now come to fruition, as reported in the 9th September 2004 *Daily Mail* article *"Now they're having to queue to register with private dentists".* The queue for private dental care occurred in Driffield, West Yorkshire, and was prompted when the local NHS dentist announced that as a consequence of insufficient state funding for the number of NHS patients on their books that the practice was forced into a private conversion.

1.28 The *Report of the Primary Care Dental Workforce Review* states that in 2003 the under supply of WTE dentists in England is 1,850. The challenge for the Government is to recruit 1,000 WTE dentists into the GDS over the next year. This is still at least 850 less than is needed to bridge the gap in the workforce. Additionally, the extra 170 undergraduate places, which will become available in England, will not enter the workforce for another six years.

1.29 There is a real risk that the measures announced by the Government to address the under-supply of the workforce will fall short, and the situation of under-supply will continue to be a prominent feature of dental services in England over at least the next two decades. The inflow of practitioners has continued to lag behind the outflow and our Evidence indicates that this will continue well beyond October 2005. In this final year before the reform of NHS dentistry, supplemental measures are still needed to stabilise and retain current levels of NHS commitment in time for the reforms to possibility arrest the decline of NHS dentistry and to ensure that the Government's vision for a modernised NHS dental service comes to fruition.

DENTAL EXPENSE INFLATION

1.30 In our Evidence to the DDRB last year the BDA outlined a pilot approach for prospectively looking at dental expense inflation. Unfortunately, last year our analysis was undermined by the DoH who stated *"… that the BDA's assertion that dental inflation was higher than general inflation was based on the results of the BDA's Professionals Complementary to Dentistry (PCD) Survey (2003) … PCDs were mainly therapists and hygienists and there were relatively few in the GDS"*[3]. This statement by the DoH is deliberately misleading, insulting and undervalues the central contribution made by the 35,000 plus dedicated professionals such as dental nurses, practice managers and receptionists that operate as frontline NHS dental staff.

1.31 Our approach built on the recommendations outlined in the Ernst & Young report *Review of the Dental Rates Study Group* (1991). The Review advocated the use of simple models to represent and forecast dental expenses, based primarily on expenses data, a price index such as the RPI and average earnings assumptions. At the time the review noted that *"… The RPI … and average earnings seem, to us, to provide a fully adequate basis for specifying the limits of plausible [dental expense] expenditure forecasts."*

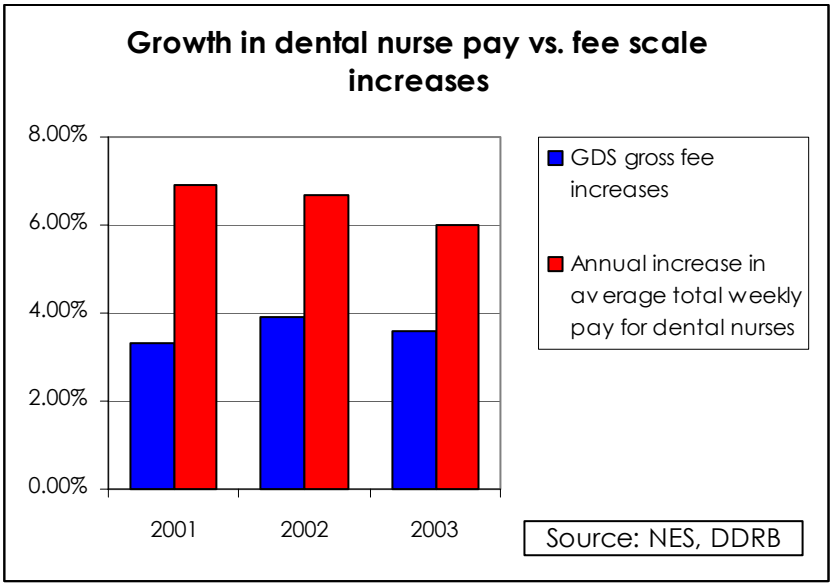
1.32 It is our assertion that RPI has become outmoded, as the shortage of available PCDs and the approaching necessity of registration of PCDs has meant that recruitment has had to tap into a pool of higher academically qualified people thus driving wages inflation at significantly above average rates. In addition, strict infection control guidelines and the resultant move toward single use items (i.e. disposables) are currently and will in the future drive up dental expenses inflation. The BDA considers the benefits of further research as an invaluable exercise in establishing a robust baseline for addressing dental expense inflation over the transition period and beyond. Issues including sub-regional analysis and the impact of age are factors that may draw out interesting new conclusions.

1.33 As a starting point for our analysis of dental expense inflation we note that salaries and wages of PCDs comprise, by and large, the largest component of dental practice expense. Our measure of the rate of dental expense inflation therefore utilises weights to forecast dental expense inflation. It also makes use of published forecasts for economic indicators (i.e. RPI) and other sources for the rate of average earnings growth for salaries and wages of PCDs. Where appropriate linear regression analysis is employed to produce future forecasts for model specific variables, e.g. growth in salaries and wages of PCDs.

1.34 Figure 4 shows information from the New Earnings Survey on dental nurse earnings for the period 2001-2003. It is clear that practitioners have been rewarding their dental staff with wage increases that are significantly higher than GDS gross fee increases. These findings are also supported by the results of the *BDA Professionals Complementary to Dentistry Survey* (2001 and 2003).

[3] Source: Review Body on Doctors' and Dentists' Remuneration (33rd Report 200), paragraph 3.64.

Figure 4: Growth in dental nurse pay vs. fee scale increases



1.35 The tightness of the labour market for PCDs is also driving the upward pressure on wages and salaries. Practices more committed to NHS care are finding it relatively more difficult to maintain PCD pay at levels that attract or retain staff as table 1 indicates.

Table 1: Recruitment of PCDs over the last two years

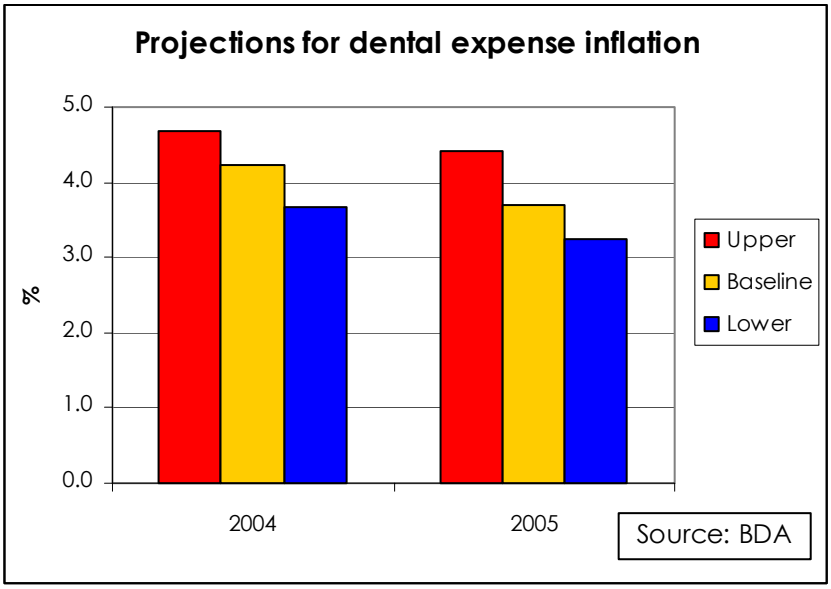
Difficulty in keeping PCD pay at a level that attracts and/or retains staff	**Hard (%) 2002**	**Easy (%) 2002**	**Hard (%) 2001**	**Easy (%) 2001**
Overall	73	14	61	23
NHS commitment: High	80	8	70	15
NHS commitment: Low	66	22	51	32

Source: Dental Business Trends Survey (BDA, 2002)

1.36 Taking a simple formula for dental expense inflation[4] we project that in 2004 dental expenses will rise by 4.2 per cent; looking further still it is forecast to rise by 3.7 per cent in 2005. Our upper forecast for dental expense inflation in 2004 is 4.7 per cent and our lower forecast is 3.7 per cent – see figure 5.

[4] The calculation of dental inflation, assumes that practices expenses are distributed according to the findings of the BDA Dental Business Trends Survey (2003) and builds on the recommendations outlined in the Ernst & Young report Review of the Dental Rates Study Group (1991). Wages and salaries account for 40 per cent of practice expenses, with upper and lower 95% confidence intervals of 43 per cent and 38 per cent respectively. Dental expense inflation is estimated using the following basic formula: 0.40*[forecast change in dental wages and salaries] + 0.60*[forecast change in RPI]. Upper and lower forecasts have also been produced using Forecasts for the UK Economy (No. 209) from the HM Treasury. Average earnings growth for salaries and wages of PCDs have utilised linear regression techniques based on data from the New Earnings Survey.

Figure 5: Projections for dental expense inflation



1.37 These forecasts do not take into account any additional factors that are likely to affect dental expense inflation in 2004 and 2005. For example, a 2004 BDA Survey of Dental Expenses has highlighted insurance costs, training costs, waste management costs and cross infection control costs as key factors that have contributed to rising practice expenses over the previous two years.

1.38 In addition, practice owners are unanimously concerned about step change increases in future salaries and wages of PCDs driving up practice expenses between 2005 and 2008. One of the most important (and pressing concerns) is that of dental nurse registration, due to be introduced in 2005. The cost of acquiring these qualifications is falling directly upon practitioners (as funding for this is limited and patchy across the UK). Additionally, and as indicated in the *BDA Professionals Complementary to Dentistry Survey (2003),* dental nurses that have qualifications are paid a premium which is on average £0.89 per hour more than those without qualifications. The consequence of this is that there will be a significant step change in the absolute level of PCD salaries and wages in the future, which will be borne entirely by practice owners. This implies that our projections underestimate dental expense inflation.

1.39 In paragraph 3.83 of the 33rd DDRB Report it stated *"… the Department of Health reported that the National Assembly for Wales has discussed practice allowances with the Welsh GDPC, and although no decisions had been made, negotiations would continue."* We are disappointed to report that to this date the Welsh Assembly has never made any contact with us to explore these issues.

1.40 Both the DDRB and DoH made reference to 'comparator' professions; our contention is that there are none insofar as our medical colleagues do not have to deploy their own capital in order to establish a practice nor do they run a commercial risk, which dentists do. For these criteria there is no reward offered by the DoH who have, since 1948, set the fees that can be

levied on the NHS patients and have had the use of the estate entirely free. In recent years the general profitability of practice has been severely eroded.

1.41 Information from Nick Ledingham of Morris & Co. Chartered Accountants (specialist dental accountants) sheds further light on dental practice profitability[5]. Between 2001 and 2003 total gross fees for NHS practices has risen by 5.5 per cent, whilst for private practices (i.e. those with 90 per cent of income generated from private sources) have seen total gross fees rise by 21 per cent over the same period. It is our contention that the ever-growing burden of practice expenses is eroding NHS practice profitability. More and more NHS practices and practitioners are moving out of the NHS. Action needs to be taken now to stem the haemorrhaging.

In the light of the issues raised in our Evidence, the following recommendations would have a positive impact on retaining commitment within the NHS workforce to deliver high quality NHS care to patients when the reforms are implemented in October 2005, we ask the Review Body to recommend that:

~ The fee scale increase for 2005/06 is at least 3.8 per cent

~ A practice allowance of up to £4,500 is introduced, pro rata, to GDS practitioners.

~ Independent research be undertaken to establish a robust baseline and understanding of dental expense inflation

~ A pilot impact assessment exercise be undertaken to establish the costs that would be faced by an average practitioner to provide the quality of care demanded to achieve the standards outlined by the DDA Act, cross infection control requirements, outreach training and placement of PCDs.

[5] Findings are based on actual audit accounts.

SALARIED PRIMARY DENTAL CARE

2.1 The Review Body will be aware that the BDA has been in participating with the Department of Health in a Review of Salaried Primary Dental Care Services in England, alongside similar, but separate reviews being conducted in Scotland, Wales and Northern Ireland. As part of this process the BDA agreed not to submit detailed evidence to the DDRB during the last round in order that our proposals could be considered as part of the Review as 'early implementer' proposals that could be agreed and submitted as joint evidence to this Review Body round.

2.2 The BDA has been disappointed that the Review was unable to keep to the agreed timescale in the Terms of Reference (as presented in Annex C in our evidence to the DDRB for the 33rd Report). The consultation document on the England Review was promised by "late summer", as of the date of submission we have yet to receive the proposals. This has caused considerable anxiety among staff working in the SPCDS and has further dented the morale within the Service.

2.3 The BDA put forward evidence to the Review covering Clinical Excellence Awards and Clinical Director Multi-PCT Allowances for consideration under the terms of an exchange with the DoH that they constituted "pay issues around the margins where it would be practical and desirable to make progress for the pay year 2004/5, over and above the standard 3.225 per cent"; and asked that the DoH's review of Salaried Primary Dental Care Services factored consideration of the potential for progress on these issues into its programme of work. Following consideration of our evidence in these areas, the Department turned down our proposals and the JNF held on the 25th May 2004.

2.4 The BDA is disappointed that the DoH did not consider our proposals sufficiently persuasive to be able to submit joint evidence to the DDRB. We await the consultation document following the Review with considerable interest and hope that our concerns will be addressed by the conclusions of the Review.

DENTAL PUBLIC HEALTH

3.1 The assimilation of Dental Public Health staff onto the terms and conditions of service for Hospital Medical and Dental and Public Health Medicine Staff has been completed. Staff are undertaking the process of either moving to the new consultant contract or remaining on their existing terms and conditions. In the case of the former we are monitoring its implication to ensure equity across the country. The BDA, together with the BMA, will be discussing with the new Employers' Organisation future joint mechanisms for negotiating for this group of staff.

CLINICAL ACADEMIC STAFF (CAS)

4.1 We welcome the comments made by the DDRB about recruitment and retention and their continued positive support of pay parity.

4.2 However, we are concerned about the implementation for the new consultant contract for clinical academics in England. We have been made aware that some dental schools are only granting additional Programmed Activities (PAs) if the staff member can demonstrate research excellence and others are simply offering 10 PAs with no flexibility for additional clinical or academic PAs, with the job planning process not necessarily having been taken into account. We are anxious that this differing interpretation may lead to even more recruitment and retention difficulties if it becomes apparent that some schools are simply not following the national guidance, leading to detriment for some clinical academics.