BRITISH DENTAL ASSOCIATION

Evidence to the Doctors' and Dentists' Review Body

October 2007

For the Thirty-Seventh Report 2008

TABLE OF CONTENTS

Executive Summary ....
Page 3

General Evidence ....
Page 5

General Dental Services ....
Page 13

Salaried Primary Dental Care Services ....
Page 43

Dental Public Health ....
Page 51

Clinical Academic Staff ....
Page 54

EXECUTIVE SUMMARY

Summary

1.1 The last year has been a testing time for dentists providing NHS care across all services. Both the new NHS dental contract in England and Wales and some of the remedial initiatives for the General Dental Services in Scotland and Northern Ireland have created unfair pressures and uncertainty for dentists practising in their respective countries. The consequential uneasiness and anxiety has done little to encourage greater numbers of dentists to work for or devote more time to the NHS.

1.2 Alongside the challenges in the GDS, many salaried dentists have been experiencing additional demands with a steady rise in the number and complexity of referrals into their service. Salaried dentists in England hope to have new pay, terms and conditions before the end of 2007 but the other three administrations are behind in terms of their pay reform agendas.

1.3 The Government's own report, NHS Dental Reforms: one year on (2007), suggests that the controversial reforms to NHS dentistry in England have failed to increase access. The report accepts, too, that the NHS has lost around 500 dentists in the first year of the new system, although we believe that the true figure is significantly higher. Similarly, evidence from the other three countries is also showing that access is not improving, and that dentists are shifting towards private sources of income in an attempt to maintain the viability of their practices.

1.4 The British Dental Association's research is also suggesting that the intended benefits from the reforms, such as freeing up time for dentists to spend more time with their patients, reducing their workloads and removing them from the 'drill and fill' treadmill have simply not materialised. These disappointing outcomes are hardly indications of success. In Northern Ireland and Scotland too where changes to NHS dentistry are on-going, and have not so far been as radical as in England and Wales, much more needs to be done to improve the working lives for dentists.

1.5 In the light of the growing body of evidence indicating the many problems created by the rushed and untested reforms of NHS dentistry, the BDA has called on the Government, in England and Wales, to make three key changes which would improve NHS dentistry for patients and dentists:

- the removal of units of dental activity as the sole contract monitoring tool;

- paying the Primary Care Trusts directly the whole of their commissioning budget. This is to remove the unfair pressures on PCTs concerned about the liability of unpredictable patient charge revenue collection as it is their obligation to make up any patient charge revenue shortfall; and
- allowing long-term business stability by permitting dentists to transfer their NHS contract to new owners, thus maintaining the goodwill value of practices.

1.6 In Scotland the BDA has been unsuccessfully urging the Scottish Government to reassess the "all or nothing" approach to defining NHS commitment – which is restricting access to additional funding to support dental practices – and seriously to tackle the looming impact of strengthened decontamination requirements. In Northern Ireland, however, the BDA is encouraged that as part of the on-going negotiations for a new NHS dental contract, the Department of Health, Social Services and Public Safety (DHSSPS) has recognised that any new contract should not include the use of units of dental activity.

1.7 Each individual Government also has a responsibility to ensure that the appropriate level of funding is made available to deliver the highest quality NHS dental service for its respective populations.

1.8 Progress has, though, been frustratingly non-existent, and the Governments seem to have taken an inflexible position on what the BDA believes are sensible and constructive suggestions to improve the respective systems across the United Kingdom.

1.9 There has been, and there will continue to be in the medium term, considerable turmoil for NHS dentistry. Differing system reforms are taking place across the services and across the United Kingdom and we are in a period of significant and traumatic transition. It is essential, if the DDRB feels it is important to retain a substantial and well motivated NHS workforce providing high quality services to the public that it sends out a strong and encouraging message to all dentists.

Summary of recommendations

1.10 In the light of the issues raised in our evidence, we therefore ask the Review Body to recommend that for 2008–09 all NHS dentists receive a seven per cent increase to their net NHS earnings before tax.

GENERAL EVIDENCE

Key points

- *The 2007–08 DDRB recommendations were deemed to be inadequate by the profession, and compounding this disappointment the respective Governments in England and Northern Ireland implemented the award in stages, with Wales having yet to implement the award.*
- *The proportion of the NHS budget spent on dentistry in England is estimated to be 2.8 per cent in 2007–08; this is lower than it was in 2002–03 when a five-year period of sustained increased funding for the NHS began.*
- *The BDA has been continually warning that access to NHS dentistry has not been improving and recent research by Citizens Advice and Which? has now substantiated this view. Access remains a problem across the United Kingdom.*

Introduction

2.1 The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for their 37th Report covering the year 2008–09. It is written under the terms of reference introduced in 1998 and all subsequent amendments. The evidence is submitted on behalf of dentists practising in the National Health Service (NHS) in all four countries of the United Kingdom (UK) and covers those working in:

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

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

The economic environment

2.3 The UK has experienced a prolonged period of stable economic growth, stable inflation in pay and prices, low interest rates and low unemployment. This has provided a positive environment where small businesses, such as dental practices, could remain financially viable. However, rising interest rates and higher inflation are now likely to weaken their financial position.

2.4 The economy grew at an annual rate of 3.1 per cent in the second quarter of 2007 with forecasts indicating that this growth will slow over the next two years. Forecasts for the UK economy (HM Treasury, June 2007) report that growth (i.e. the average forecast growth in gross domestic product) is set to increase by 2.7 per cent in 2007 and 2.3 per cent in 2008.

2.5 The slowdown in the growth of the economy, which can lead to lower aggregate demand for all goods and services, is occurring at a time where general price inflation is above trend. Although recent UK inflation has been low, the Retail Price Index (RPI) stood at 4.1 per cent for the twelve months to August 2007. Higher rates of price inflation add to the input costs of running a dental surgery and therefore will result in higher overall practice expenses.

2.6 Whilst price inflation will include some elements of the premises cost of running a dental practice, house price inflation can also shed light on changes to the cost of premises to a business. The recent strength of the economy has resulted in continued strong house price growth across the UK and the latest survey from the Halifax bank showed that house prices across the UK rose by 10.7 per cent in the year to September 2007, with Northern Ireland showing even stronger growth of 29.1 per cent.

2.7 The continued strength of the housing market makes it extremely expensive to purchase property for the purposes of providing dental care. Furthermore, the buoyancy of the housing market and concerns over inflationary pressures in the economy has resulted in the Bank of England raising interest rates five times in the past year so that they are now 5.75 per cent. The Bank of England also believes that there remains an upside risk to inflation, with many analysts expecting interest rates to reach six per cent by the end of the year. This upward trend in interest rates will make it considerably more expensive for dental practices to borrow money or repay funds that have been used to invest in their surgeries.

2.8 Finally, the average earnings growth in the private sector is currently exceeding that in the public sector. The Office of National Statistics reports that in the three months to July 2007, average earnings growth in the whole economy (excluding bonuses) rose by 3.5 per cent; this represents growth of 3.7 per cent in the private sector and

2.7 per cent in the public sector. To attract and retain quality dental staff, including dental nurses, requires rates of pay that are competitive when compared with those commanded within the private sector. This also adds to the overall expenses for running a dental practice.

2.9 From the brief overview of the economy presented here it appears that the economic environment is worsening for small business such as dental practices. Rising house prices and interest rates (proxies for premises and investment costs) will mean that dental practices will find it more expensive to finance investment in their practice without affecting their profitability. As borrowing money from institutions becomes more expensive, the rapid introduction of innovation and new technology will be stifled. This may limit patient choice.

2.10 The impact of all this is likely to be disproportionately higher for NHS dental practice where normal market forces, which for example determine price and quantity supplied, are distorted by factors such as predetermined NHS contract values and fixed NHS item of service prices. Such distorting factors make it much more difficult to maintain an NHS practice's profitability.

2.11 This worsening environment, combined with the tight fiscal rein on public sector spending, is likely to jeopardise the financial viability of NHS dental practice as the cost of running the practice escalates without a corresponding rise in turnover from their NHS provision. Given the current system of delivering NHS dentistry in the UK, the only way that a committed NHS dentist can reduce the uncertainty facing their business and ensure its long-term financial viability is to exercise choice in their provision of dental services and shift towards providing more private dental care.

Response to the 36th Report of the Doctors' and Dentists' Review Body

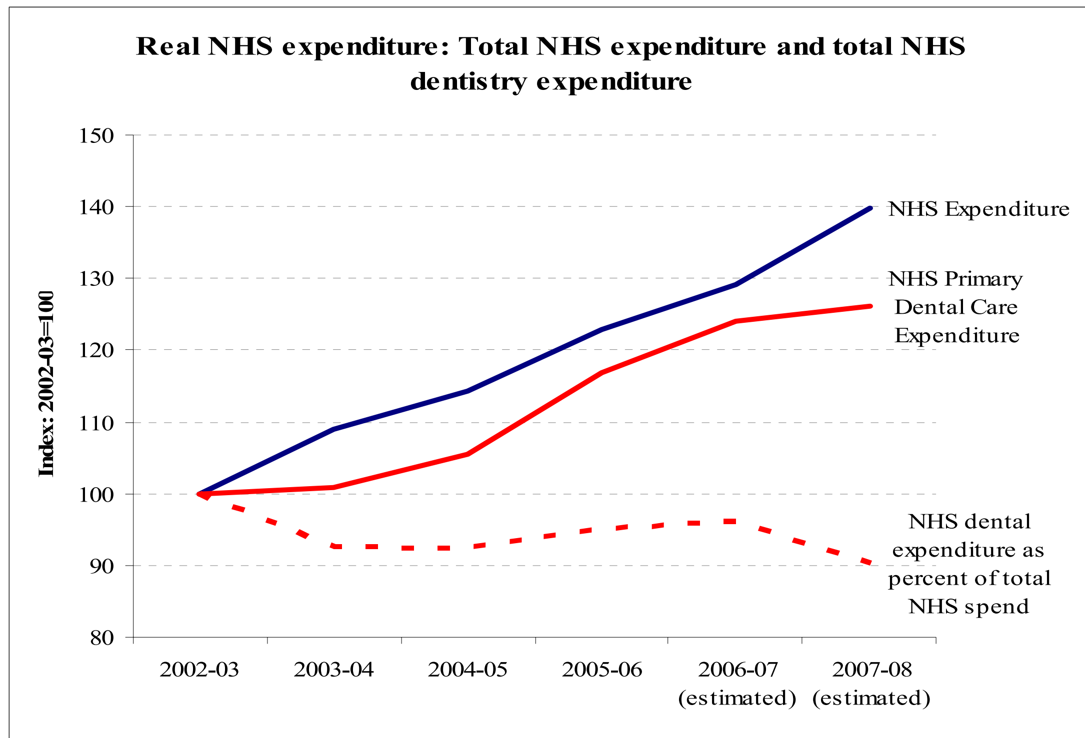
2.12 The BDA's view of the DDRB recommendations covering 2007–08 was that of "grave disappointment" and another "wasted opportunity". The uplift to high street dentists' gross earnings of only three per cent was considered to be "inadequate" by the profession, whilst the token fixed increase for dentists in salaried employment left many feeling "disillusioned and undervalued".

2.13 The implementation of these recommendations has served to further marginalise dentistry to the periphery of the NHS family and has once again contributed to the continuing underfunding of NHS dental services in the UK.

2.14 The BDA's analysis indicates that since 2002–03, when a five-year period of sustained increased funding for the NHS began, real expenditure in NHS primary dental care in England alone has risen by 26 per cent, compared with real NHS

expenditure growth of 40 per cent – see figure 1. Consequently, the proportion of the NHS budget spent on dentistry in England is now lower than it was in 2002–03 and currently stands at around 2.8 per cent.

Figure 1



Source: PESA, Hansard, The NHS in England: The operating framework for 2007-08

Notes: NHS expenditure data is from PESA, NHS Primary Dental Care expenditure data up to 2006-07 is from Hansard with the 2007-08 data from The Operating Framework

2.15 This analysis expands on the findings of the National Audit Office (2004) which noted that between 1990–91 and 2003–04 spending on NHS General Dental Services per capita increased by only nine per cent compared with a 75 per cent increase in the overall NHS funding per capita.

2.16 Once again, the BDA continues to be disappointed that the Review Body has neither accepted the need for the introduction of a practice allowance in England and Wales for practices providing NHS dentistry, nor has it countered convincingly our conviction that there would be a positive potential benefit in retaining and improving the morale of NHS dentists.

2.17 Not only were the 2007–08 recommendations deemed to be inadequate by the profession, the respective Governments in England and Northern Ireland implemented the award in stages, with Wales having yet to implement the award. The staging of the award incurs additional administration and software costs for both

the Northern Ireland Central Services Agency and its equivalent bodies in the other countries as well as the dental team as IT systems need to be updated twice in the year. Compounding this in Northern Ireland is the fact that the revised Statement of Dental Remuneration applicable from November 2007 had still not been circulated to dentists as of late October 2007.

2.18 Also, by staging the award, and without backdating it, the majority of dentists have not realised the anticipated financial value of the recommendation. The Government's decision to stage the award in England and Northern Ireland and not yet implement the award in Wales, during the most turbulent time in NHS dental history, is unacceptable and has only served to further demoralise the workforce and reinforce the widely held belief that the Government is committed to improving neither NHS dental services nor the working lives of the profession.

2.19 The DDRB intended to increase the net income before tax of NHS dentists working in the General Dental Services in 2007–08 by two per cent. By staging the award, however, net income before tax rises by only 1.75 per cent which is 12.5 per cent lower than the DDRB's intended two per cent increase on net earnings before tax.

2.20 Furthermore, the DDRB recommendation for GDS dentists implicitly incorporates underpinning assumptions on dental expense inflation in 2007–08. By staging the award, or in the case of Wales waiting indefinitely to implement the award, the full gross uplift is not passed on to the profession. This undermines the financial viability of dental practice as the staged uplift is insufficient to cover anticipated dental expense inflation, and dental expenses are therefore paid by borrowing or running down cash reserves.

2.21 In summary, last year the BDA urged the DDRB to recommend a package of essential recommendations which would have stabilised the dental workforce and retained NHS commitment levels. The DDRB did not respond positively to this recommendation and as a consequence the BDA believes that retaining NHS dentists, both now and in the future, will become increasingly more problematic.

Access to NHS dentistry

2.22 In 1999, the Prime Minister pledged to ensure everyone who wanted access to NHS dentistry got it, no matter where they lived, by September 2001. However, in Prime Minister's Questions on the 25 April 2007 the Prime Minister was forced to concede that "... we have not been able to fulfil that pledge".

2.23 The BDA has continually warned that access to NHS dentistry has not been improving since 1999 and this view has now been substantiated with recent research

from other organisations. It is now clear that access remains a problem across the UK.

2.24 A report published in March 2007 by Citizens Advice shows patients in England and Wales still face significant problems in finding a dentist. Their research found that there is still huge inequality in access to NHS dentistry, with some areas such as Hartlepool and Hornchurch spoilt for choice and others including Blackburn and Petersfield with very poor access.

2.25 Market research also published in March 2007 by Which? shows significant regional variation in the availability of NHS dental care in England, with over half of the practices surveyed reporting that they were not accepting any NHS patients. This was more likely to be the case for practices in the North West, Yorkshire and Humberside and South Central England.

2.26 In Scotland almost 35,000 people are on the waiting list for an NHS dentist in the Highlands and Argyll[1], with a further 25,000 on waiting lists in the Grampian region[2]. NHS registration information relating to the NHS Highland Board area also shows that in March 2006 only 26.7 per cent of one and two-year olds were registered, against a 2010 target figure of 55 per cent, and that only 25.7 per cent of under-65s were registered compared with a target figure of 65 per cent.

2.27 Research by the Southern Health & Social Services Council in May 2007 found that 47 out of 58 dental practices (i.e. 81 per cent) in the Southern Area of Northern Ireland were not registering new NHS patients.

2.28 The March 2007 BDA new NHS contract survey, covering England and Wales, found that 85 per cent of dentist respondents to the survey said that the new contract had not improved access to NHS dental services for patients.

2.29 The DDRB reiterated in its 36th Report that it believes that the problem of access to dentistry is widespread and not confined to particular areas, a view that the BDA firmly shares. However, the BDA has consistently stated that neither the new NHS arrangements in England and Wales, nor the level of the NHS fee scale and the various allowances in Scotland and Northern Ireland, provide appropriate incentives that will encourage greater numbers of dentists to work for or devote more time to the NHS. Unless significant action is taken, the problem of widespread poor access to NHS dentistry will continue into the future.

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1 http://www.pressandjournal.co.uk/displayNode.jsp?nodeId=149212&command=displayContent&sourceNode=232919&home=yes&more_nodeId1=149221&contentPK=17995261

2 http://www.pressandjournal.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNode=149218&contentPK=17998945&moduleName=InternalSearch&formname=sidebarsearch

Workforce

2.30 In 2003 the Department of Health stated that it believed that there was a shortage of some 1,850 whole time equivalent (WtE) dentists in England, although the BDA strongly disputed the figure and believed the true number to be at least double that stated.

2.31 Whilst the UK dental workforce has increased since 2003, thanks in part to a highly publicised overseas recruitment campaign, the BDA believes that the overall capacity to provide NHS work has at best stayed the same, although some parts of the United Kingdom have witnessed a significant reduction in their capacity as measured by NHS registrations. This is a consequence of the continued increasing propensity for dentists to provide private rather than NHS care, in tandem with a rapidly changing workforce profile.

2.32 Research looking at the attitudes of senior dental school students, published in the *British Dental Journal*[3], suggests that the future dental workforce may have work-life patterns that will reduce their clinical commitment. The research showed that only 20 per cent of respondents intended to continue working full-time after the age of 60 years, a large majority of both sexes thought that starting a family would interrupt their professional life, and only three per cent intended to work exclusively for the NHS.

2.33 Furthermore, the demographics of the profession are changing dramatically. The BDA's 2007 *Young Member Participation and Engagement: Exploring the Needs for Today and Tomorrow* research project, co-funded by the Department of Trade and Industry (DTI), found that 61 per cent of young BDA members (i.e. members aged up to 35) were women, 38 per cent were of white English origin, whilst 21 per cent were Asian/Asian British Indian.

2.34 These findings strongly indicate that the profession has been, and still is, moving away from full-time dental practice towards dentists that are more disposed to part-time practice with career breaks. There is a greater focus on work-life balance allied with large proportions choosing careers involving significant time devoted to private dentistry.

2.35 These trends indicate that not only will overall clinical output, at the level of the individual, be reduced in the future, but that NHS care is likely to be squeezed out in favour of private care. As a result, the assumed increased output of what may appear to be a larger NHS workforce will not be realised, suggesting that there will be a

[3] Stewart F, Drummond J, Carson L, Theaker E (2007) - Senior dental students' career intentions, work-life balance and retirement plans. London: BDJ

continued shortage of dentists providing NHS care, certainly in the short to medium term.

2.36 The dynamics operating within the dental workforce in the United Kingdom has become increasingly complex. In part, the combination of an increasing overall workforce, significant changes in working practices and uncertainty about future NHS capacity have contributed to this complexity. Consequently, the BDA believes that a more up-to-date Workforce Review should be undertaken and the findings of this disseminated to the profession and other stakeholders, such as Primary Care Trusts, quickly.

GENERAL DENTAL SERVICES

Key points

- *Solid progress in resolving the concerns of dentists across the differing NHS dental systems of the United Kingdom has not materialised as the BDA would have expected. Individual administrations seem to have taken an inflexible position on what the BDA believes are sensible suggestions on how to improve their respective systems.*
- *More than one year in to the new system in England and Wales the BDA remains unconvinced that the reform to NHS dentistry has achieved its goals, and there is real concern that the failure of the new system could compromise care to the most vulnerable in society.*
- *Across the United Kingdom the combination of weakening relative pay for dentists, uncertainty in securing NHS employment, high levels of student debt and senior dental school students not wishing to working solely in the NHS has the potential to seriously harm the ability to recruit the appropriate number of dentists required to deliver the Government's vision of high quality NHS dental care.*
- *The underlying issue that needs to be addressed in relation to the retention of NHS dentists in all four countries is the increasing inability that dentists have to run a viable NHS dental practice and the unreasonably high NHS workload.*
- *The move to single use items for endodontic treatment and the implementation of dental nurse registration alone is set to cost the profession at least £135 million in 2008–09. This equates to an estimated five per cent of practice turnover and does not even include the potential cost repercussions of complying with anticipated infection control and dental decontamination standards, increased downtime spent on general administration or general pay and price inflation.*
- *There is a negative relationship between the NHS commitment of a dentist and their level of morale. Generally speaking, those with lower commitment to the NHS are reporting lower levels of morale and job satisfaction. Furthermore, it is also clear that the morale for an NHS dentist is influenced by a range of factors, not only level of remuneration.*

Twelve months in NHS dentistry

England and Wales

3.1 On the 1 April 2006 a new NHS dental contract was introduced in England and Wales. This contract was introduced without support from the profession and, as warned by the BDA, it appears to have so far failed to deliver its intended benefits to both dentists and patients.

3.2 To monitor the effects of the new system the Government established an Implementation Review Group in 2006, which includes BDA representation. The Group has met regularly to discuss progress since its inception. In these meetings the BDA has been active in raising its concerns about the new system, including issues relating to goodwill, patient charges revenue, and vocational training.

3.3 On 28 March 2007 the BDA hosted a special conference to mark the first anniversary of the NHS dental reforms, and to announce the results of BDA research looking at the impact they have had on patients and dentists. The key note speech called on the Government to make three key reforms which would improve NHS dentistry for patients and dentists, these were:

- The removal of UDAs as the sole contract monitoring tool;
- Paying the Primary Care Trusts directly the whole of their commissioning budget, to avoid the liability of uncertainties in patient charge revenue collection; and
- Allowing long-term business stability by permitting dentists to transfer their NHS contract to new owners, thus maintaining the goodwill value of practices.

3.4 Progress in resolving the concerns of dentists emanating from the new dental contract has not materialised as the BDA would have expected. Indeed, the Government seems to have taken an inflexible position on what the BDA believes are sensible suggestions on how to improve the new system. The profession is assured by Ministers that the correct forum for addressing problems is the Implementation Review Group and its work is ongoing. The BDA hopes that over the coming months much more will be achieved in addressing the many concerns that dentists in England and Wales have expressed

Scotland

3.5 An *Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland* was published in 2005. Amongst its ten key principles for the way forward

was a commitment to simplify and improve the current remuneration system, to provide better support and incentives for practices demonstrating commitment to the NHS and to provide support to encourage recruitment and retention of all dental team members.

3.6 The publication of the Action Plan has resulted in on-going uncertainty about the consolidation and re-pricing of the Statement of Dental Remuneration in Scotland, although there has been the introduction of a raft of initiatives and allowances to support dentists in their working lives. These include the reimbursement of rents, assistance with clinical waste disposal costs and the introduction of a General Dental Practice Allowance. However, movement of funding away from item of service and its reintroduction through allowances has implications for superannuation. Because a dentist's pension is based almost exclusively on fees earned and not on allowances the reintroduction of funding through allowances acts to erodes the pensionable pay which they receive.

3.7 Although these all appear to be positive measures the "all or nothing" approach to defining NHS commitment has resulted in around one-third of practices that provide NHS care being ineligible to access much of the additional funding. The eligibility criteria requires a practice to have average gross GDS earning per dentist of at least £50,000, and to have an average 500 registered patients per dentist with at least 100 of them being fee paying adults.

3.8 The concern with such criteria is that there are committed NHS dentists who marginally fail to meet the strict conditions and are therefore unable to access these funds. These tend to be those practices that are providing significant amounts of NHS care for children and exempt patients. Worryingly, and as consequence of the flawed eligibility criteria, the BDA is now seeing some practices withdrawing NHS care to all their patients, including children and exempt patients.

3.9 The BDA has been urging the Scottish Government to reconsider the rules defining NHS commitment and has suggested that a sliding scale would be fairer, thereby ensuring that NHS dental care can still be received by some of the most vulnerable people in society. This suggestion has, however, been rejected by the Scottish Government.

3.10 Finally, strengthened decontamination requirements have recently been introduced in Scotland which will mean that dental practices incur significant capital and revenue costs and will have a reduced throughput of patients. Although funding of £5 million has been promised by the Scottish Government the BDA believes that further discussions will need to take place to ensure that more funding is available as the requirements for decontamination are developed.

3.11 Four years ago the BDA in Scotland, in responding to *Modernising Dental Services*, showed that Scotland required £120 to £130 per hour to run a dental surgery. This figure has now risen, and based on information relating to salaried dental services, is now around £160 per hour. This figure is based on the Scottish Government's own aspiration for dental practices to be modernised and fully compliant with current guidelines for disability access, decontamination and health and safety. On the basis of this, the fees in Scotland would need to increase by around 300 per cent to allow GDS dentists to afford similar practices from their NHS earnings. This conclusion also resonates with dentists in Northern Ireland, England and Wales.

Northern Ireland

3.12 The Department of Health, Social Services and Public Safety (DHSSPS) published its Primary Dental Care Strategy in 2006. Within its 17 recommendations was the development of a new Northern Ireland wide GDS primary dental care contract framework which is to provide the basis to commission services to meet local need.

3.13 Negotiations are ongoing in respect of the contracting arrangements for primary care dental services, with the suggestion that a new contract for dental services in Northern Ireland will be completed by 2010 at the earliest. With respect to these new arrangements, DHSSPS and the Minister have recognised that the new English contract is problematic and that the new Northern Ireland contract should not utilise "units of dental activity" as a performance measure.

3.14 In the interim, until the new arrangements are agreed, the DHSSPS has introduced a £2 million practice allowance in recognition of the drift of dentists away from the NHS. The practice allowance is designed to help address the financial burden of the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision. In September 2007, the Minister for Health Social Services and Public Safety recognised that the £2 million funding provided through the practice allowance was insufficient to address the increasing costs of running a dental practice.

3.15 In late September 2007, the Northern Ireland Health Minister announced a £4.4 million funding package to dentistry. This is not new funding, but has been made available through recycling existing funding from the GDS budget. The Ministerial statement announcing this funding recognised that the costs of running a dental practice were running at a rate, much higher than inflation and made a further £2 million available through the practice allowance.

3.16 The funding is a step in the right direction and BDA is encouraged that the Minister has engaged seriously with the profession in responding to concerns and hopes that further constructive progress can be made in the near future.

3.17 As also occurring in Scotland, the redistribution of funding away from item of service into additional allowances erodes the pensionable pay for dentists in Northern Ireland. This needs to be addressed through the payment system.

The new NHS contract in England and Wales

3.18 Since the BDA last submitted evidence there has been a full year of the new general dental services contract in England and Wales. This new contract introduced a target-driven system for measuring the performance of NHS dentists, based on previous activity, with units of dental activity (UDAs) being the sole measure of performance.

3.19 Last year in our evidence we drew to the DDRB's attention the rushed nature of the implementation of the new dental contract and the absence of a reasonable lead-in time for the profession. We also informed the DDRB that dentists felt that they had been poorly treated, unappreciated and offered a contract on a 'take-it-or-leave-it' basis.

3.20 Although the BDA was not negotiating with the Government on the new NHS dental contract, the BDA consistently warned that the reforms would be unsuccessful unless the Government engaged with, and listened to the concerns and fears of, the profession. This did not happen and as a consequence the new system is beset with uncertainty and serious flaws.

3.21 A major principle of the *Options for Change* report (2002) was that any new NHS dental system should be tested and evaluated before being rolled out across the country. However, the new UDA system for measuring the work conducted by NHS dentists was never tested. Neither was there an evaluation of the likely impact on patient behaviour from the introduction of a new three banded NHS patient charging system.

3.22 It is now clear that the BDA's concerns about the failings of the new NHS system have been justified. The Government's own report, *NHS Dental Reforms: one year on* (2007), suggests that the controversial reforms have failed universally to increase access in England. It also accepts that the NHS has lost around 500 dentists in the first year of the new system; the BDA believes the true figure to be at least 1,000 dentists with varying levels of NHS commitment, although reliable comparisons of the workforce pre and post the new contract are difficult to measure with accuracy. These outcomes are hardly indications of success.

3.23 The untested nature of the new system, and the radical departure from the Personal Dental Services (PDS) model of reform that had been piloted as part of *Options for Change*, has resulted in an unstable new system and an increasingly uncertain environment. One significant and worrying example of the unfair pressure which PCTs can bring to bear is that from 2009 the contract value guarantee for dentists expires. As a consequence, the move to private practice is, more than ever, the favoured choice for dentists to maintain job satisfaction and provide high quality dental services.

Disputed and unresolved contracts remain one year on

3.24 The continued existence of disputed and unresolved NHS contracts illustrates that dentists are still facing a range of problems stemming from the reforms. Government statistics show that in England, twelve months after the introduction of the new contract, 396 of the 2,726 contracts originally signed in dispute were yet to be resolved. This represents more than one in seven of the total number signed in dispute.

3.25 Large numbers of dentists continued to treat NHS patients over the last year even without an agreed NHS contract. However, this has been in face of significant uncertainty about future practice income, along with patients being unsure as to whether or not their dentist will continue to provide NHS care upon completion of the dispute process.

3.26 Despite the Government claiming that the majority of disputed contracts resulted in the dentist remaining within the NHS, the uncertainty to plan for the future and the ordeal of contract resolution has left many dentists feeling poorly treated, undervalued and disillusioned by the NHS. Very few contract disputes were awarded in favour of the dentist except for cases where the PCT had inserted an clause which did not comply with the new GDS regulations.

3.27 Many of those 2,726 dentists who signed in dispute remain unsatisfied with their NHS contract and only accepted it in the hope that their situation would improve and to ensure stability of the practice. It is a real possibility that many of these unhappy dentists may now be considering a move into private practice.

Inflated workloads and financial penalties

3.28 Last year we reported that the profession was left confused and suspicious of activity levels as dentists received inflated UDA workloads, despite the Department's claim of a minimum five per cent reduction in workload for all dentists.

3.29 The way in which many PDS practices had their UDA targets imposed inflated their workloads. Their UDA targets were based on local GDS trends which is an inappropriate comparator given that the vast majority of these practices had already, in adopting the philosophy and aims of patient focused dentistry in "the new way of working" of the pilot process, removed themselves from the 'drill and fill' treadmill and adopted a more preventive focus to their work.

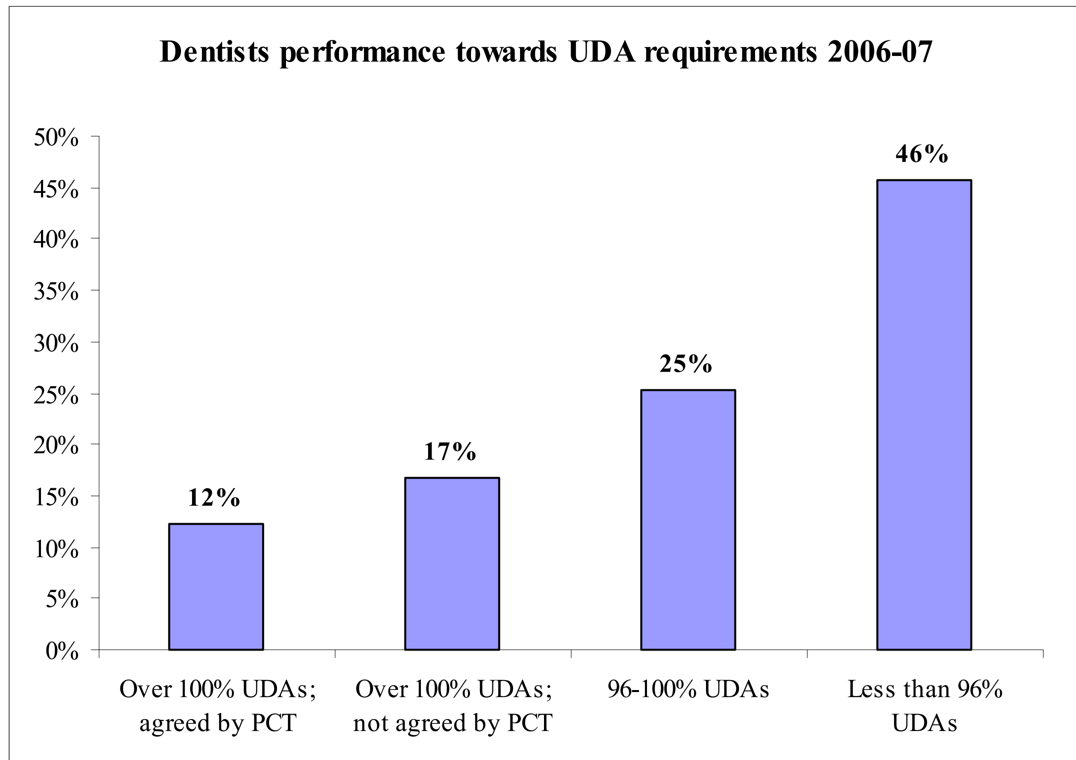
3.30 The impact of this was made worse in Wales by the decision of the Welsh Assembly Government to continue to encourage practices into PDS arrangements right up to the middle of March 2007 by using extra funding as an incentive.

3.31 As a consequence of these initially inflated and incorrectly calculated requirements, many dentists have not been able to achieve their UDA targets. BDA research (2007) indicated that around three in five NHS dentists believed that they would undershoot their UDA target, with three fifths of these anticipating that they would only be able to attain 90 per cent or less of their UDA requirement.

3.32 In an attempt to quantify this accurately, the BDA made a Freedom of Information (FOI) Act request to the NHS Business Services Authority (NHSBSA) at the beginning of July 2007. The request was rejected by the NHSBSA on the grounds that it fell under personal information and commercial interest exemption. The BDA does not agree with the decision and is currently pursuing the issue through the appropriate complaints procedure.

3.33 In response to the NHSBSA decision to reject the FOI request, the BDA liaised directly with a sample of Local Dental Committees and Primary Care Trusts in an attempt to establish up-to-date information on contract performance. This work suggests that around a quarter of dentists completed between 96 and 100 per cent of their UDA target. Around three in ten overshot their target, according to the research, with around 60 per cent of them not receiving additional funding for the extra work. Instead, the cost of the work was borne directly by the practice. Furthermore, around 46 per cent of dentists achieved less than 96 per cent of their UDA target, and of these 39 per cent faced financial penalties as a result – see figure 2.

Figure 2



Source: BDA

3.34 Many dentists are confused as to why they have missed their UDA target, given that their surgeries have been open as normal and their appointment books have been full. Many dentists will have worked longer and harder towards the end of the year in the hope of avoiding financial penalties as a consequence of a system that has, by inflating their workload, been working against them since its inception.

3.35 It is clear that Primary Care Trusts vary enormously in how they respond to those dentists that have not achieved their UDA requirements, and the variation is likely to emanate from the unfair pressures that they are subject to. Some are allowing dentists to carry over unmet UDAs into the next year, with others pursuing financial penalties for contract holders. This lack of uniformity is viewed by dentists as unfair and potentially divisive.

3.36 Both options are unsatisfactory as both carrying over UDAs into the next year and financial penalties undermine the financial viability of a dental practice in the subsequent period. Allowing unmet UDAs to be carried over involves delivering a greater number of UDAs for the same contract value – thus driving down the UDA value in the next year. Financial penalties, in essence, will require the delivery of the same number of UDAs in the subsequent year for a reduced income stream – thus driving down the UDA value in the next period.

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

3.38 To attempt to allay the fears of dentists who could not attain their UDA requirements the BDA wrote to the Chief Dental Officer (CDO) in August 2007 to ask for an amnesty for those dentists who had completed a significant amount, but not all, of their units of dental activity for 2006–07. However, this request was swiftly rejected.

3.39 The BDA has been lobbying hard to persuade the Government to remove UDAs as the sole contract monitoring tool. It is imperative that the Government and Primary Care Trusts acknowledge that the 'one size fits all' UDA approach to performance management does not take into account the complexities of individual practices. The longer these iniquitous and inappropriate units are in place, the more damage will be done.

3.40 The BDA urges the DDRB to support the BDA's call for the removal of UDAs as the sole performance management tool and for this to be replaced by a range of qualitative and quantitative performance indicators, which may or may not include a revised form of the UDA which is acceptable to the profession whilst providing flexibility for PCT commissioners.

Patient charge revenue demonstrates a shortfall

3.41 The decoupling of the NHS patient charge revenue from the overall spend on dentistry in England and Wales has created unfair pressures for Primary Care Trusts where the new patient charge system does not generate the expected amount of patient charge revenue.

3.42 The uncertainty around recouping the expected amount of patient charge revenue has led to instances of Primary Care Trusts failing to commission services in order to hold back funding to offset against a potential shortfall (a decision which will in itself reduce their patient charge revenue). This action puts a brake on any potential expansion of local NHS dental services.

3.43 Where Primary Care Trusts have major concerns of a patient charge revenue shortfall some have been requiring and/or encouraging dentists to see a greater proportion of fee-paying patients to ensure that a shortfall does not occur. The BDA understands that some individual PCTs have linked capital funding monies with a

commitment to see a certain amount of fee paying patients. This simply restricts NHS services to those patients with the greatest oral health needs.

3.44 In late 2006, the *Yorkshire Post*[4] reported that some "local health chiefs" in the region were predicting that their dental patient charge revenue would be, on average, 10-30 per cent for the year 2006–07 and that nationally, if the same pattern were to be repeated, the global dental charge deficit may be more than £100 million.

3.45 This proved to be an accurate forecast, as in 2006–07 NHS dental patient charge revenue in England amounted to only £475 million instead of the expected £634 million, thus resulting in a shortfall of £159 million in the dental budget[5]. The BDA is concerned that the massive 25 per cent shortfall in patient charge revenue is indicative of a system riddled with systematic flaws and also casts doubt on the underpinning calculations undertaken by the Government when designing the new system.

3.46 The Department of Health has now invested an additional £30 million as a measure to offset the patient charges shortfall for the current financial year. This simultaneously acknowledges the significant shortfall whilst implying that many of the causes of lower patient charge revenue collection were transitional only. This is, however, far from guaranteed.

3.47 In order to avoid the unfair pressures on Primary Care Trusts created by uncertainties in patient charge revenue collection, the BDA has been urging the Government to pay Primary Care Trusts directly the whole of their commissioning budget. This would allow Primary Care Trusts to undertake their commissioning responsibilities more efficiently. The BDA asks that the Review Body support this call for action.

Pay reforms and efficiency gains

3.48 Since coming to power the Labour government has implemented pay modernisation reform for most of the NHS workforce. Prior to implementing the new dental contract the Government introduced a new consultant and GP contract and implemented Agenda for Change.

3.49 It has now become apparent that the Government significantly underestimated the total cost of implementing Agenda for Change, the new consultant contract and the new GPs contract[6]. As a consequence of this mismanagement, the Government had

[4] http://www.yorkshirepost.co.uk/ViewArticle.aspx?SectionID=55&ArticleID=1945685
[5] The NHS Dental Statistics for England: 2006/7 and Hansard:25 Apr 2007: Column 1196
[6] House of Commons Health Committee: Workforce Planning [Fourth Report of Session 2006–07]

no choice but to tighten its fiscal controls, a factor which may have lead to the relatively poor deal for dentists.

3.50 Whilst other pay modernisation agendas resulted in large increases in remuneration, dentists' pay, on the other hand, was capped. A further, and perhaps more damaging, problem, was the introduction of UDAs. This created a defined unit of output and provided the Government with a blunt measure of efficiency or productivity, the UDA value.

3.51 The BDA has three main concerns about delivering efficiency gains under the new system. Firstly, delivering accurate efficiency gains requires a robust measure of productivity which should encapsulate the quality of the service and the value a patient places on that service. The UDA does not incorporate these important components of productivity.

3.52 Secondly, there has been no estimate of productivity prior to the new dental contract against which future efficiency gains can be assessed.

3.53 Finally, and most importantly, there remains scope for Primary Care Trusts to seek to improve value for money by driving down UDA values without the careful assessment on the impact on dental practice viability. It is important to note that driving down UDA values is not the same as delivering efficiency gains.

3.54 The BDA strongly supports using finite NHS resources in a manner which ensures that NHS dentistry is delivered as efficiently as possible. However, before any efficiency gain programme is implemented, there needs to be adequate funding already within the system and an agreed robust measure of productivity. Neither of these prerequisites, the BDA believes, currently exists.

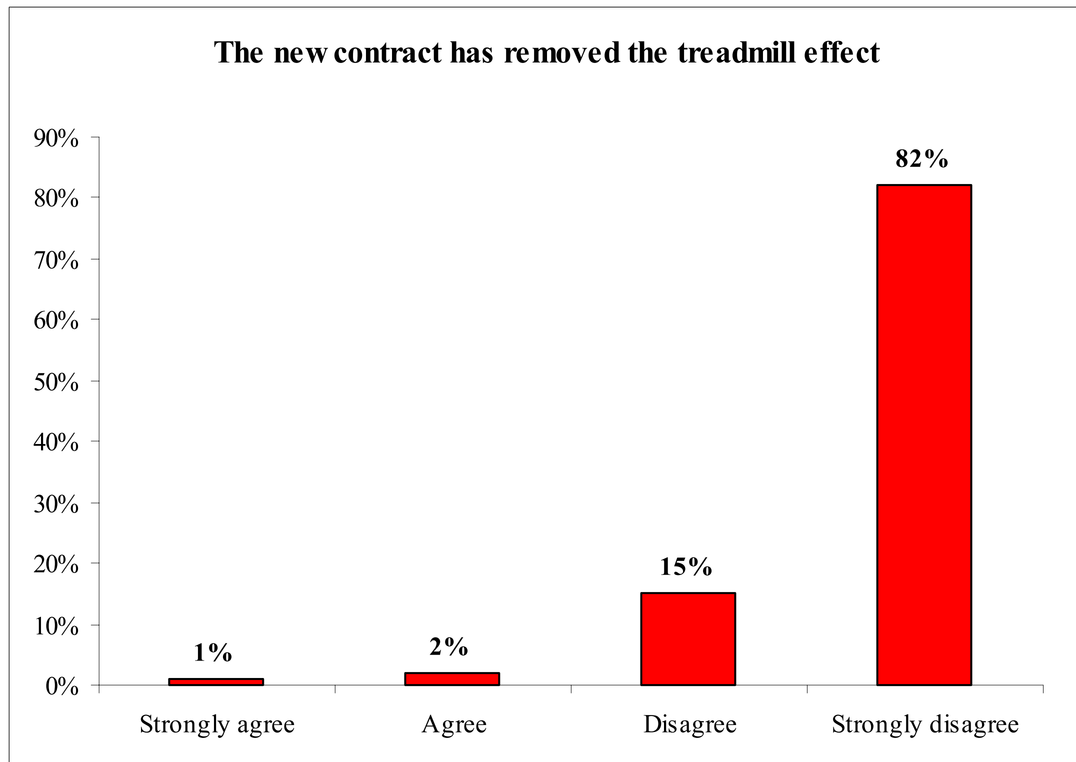
Reforms fail to deliver its intended benefits

3.55 The Government claimed that the new contract would free up time for dentists to spend more time with their patients, reduce their workloads, remove them from the 'drill and fill' treadmill and address the national problem of access to NHS dentistry. The BDA's research (2007) shows that dentists believe that the reforms have failed to deliver these promised benefits.

3.56 Thirty-six per cent of dentists reported that their working day had in fact become busier since the implementation of the new contract with 48 per cent stating that their working day had remained largely the same. Deconstructing the former figure paints an even more worrying picture for fully committed NHS dentists, as 70 per cent of them reported busier working days since the new contract was introduced.

3.57 Eighty-two per cent of dentists strongly disagreed with the statement that the new NHS contract has removed the treadmill effect and for fully committed NHS dentists this figure is higher at 88 per cent. Dentists are concerned that the old 'drill and fill' treadmill has simply been replaced by a target-driven UDA treadmill – see figure 3.

Figure 3



Source: BDA

3.58 Patients have also failed to benefit from the reforms as access to NHS dentistry remains a serious problem. 85 per cent of dentists do not believe that the new contract has improved access to NHS dental services for patients, with a similar percentage stating that it has not improved access to orthodontic treatment.

3.59 Only five per cent of dentists feel that the new contract has allowed them to spend more time with each patient, and only six per cent report that they can spend more time providing advice on prevention. Research by Cardiff University (2007) looking at the views of Welsh dentists and the new NHS dental contract notes that there is no longer an incentive to undertake preventative work.

3.60 Dentists are also concerned about the continuity and cost of the NHS care now being received by patients. Ninety-one per cent of dentists do not believe that the new contract has improved continuity of care, with 87 per cent feeling that on balance the affordability of NHS treatment has not improved. This is despite the maximum NHS patient charge declining by around a half – perhaps not such a surprising result as

simple procedures are now more expensive for the patient. Cardiff University (2007) research concurs with such a view by finding that some Welsh dentists believed that some patient charges in the new system were too high for some treatments.

3.61 More than one year in to the new system the BDA remains unconvinced that the reform to NHS dentistry has achieved its goals, and there is real concern that the failure of the new system could compromise care to the most vulnerable in society.

3.62 As a consequence, the BDA has been calling on the Government to re-examine the findings from the seven years of Personal Dental Services pilots with the BDA. These pilots were designed to explore different systems of delivery and remuneration and they paved the way for many subsequent PDS contractual arrangements between PCTs and dentists. The PDS model for delivering NHS dentistry was highly popular with the profession as it gave them the freedom to provide their patients with the treatment they needed. Having conducted these pilots, the government has a responsibility to evaluate them properly to see if there is a way of using this experience to establish a tested system that will work in the long-term interests of patients, practitioners and taxpayers.

Recruitment

3.63 The recruitment of dentists into the NHS is influenced by a range of factors including the attractiveness of working in the service and location. There are areas in all four countries of the UK where recruiting an NHS dentist can be difficult, and often these are more remote and deprived areas.

3.64 For example, anecdotal evidence suggests that dentists in Northern Ireland appear to prefer to work in the Greater Belfast area, with recruitment being more difficult in areas more than 30 miles away from the city. Often in remote and rural areas patient attendance patterns are more unpredictable and population catchment areas are too small to open a financially viable dental practice. Furthermore, many dentists also wish to be close to supporting dental infrastructures and their peers.

3.65 Scotland, unlike the other three countries, provides a Remote Areas Allowance and a Deprived Areas Allowance. However, despite these allowances there has been no Government evaluation of their impact and as yet it is unclear as to whether or not these are having an affect on improving the recruitment of NHS dentists in these areas and thus improving access for patients.

3.66 There is also concern that the continued unattractiveness of working in the NHS is likely to result in a gradual decline in the number of VT trainers, despite there being sufficient funding in the system to train a larger number of vocational dental practitioners.

3.67 The BDA is already seeing an indication that this problem is developing in Northern Ireland, where only 30 out of 40 VT places for which funding was available were taken up in period 2007-08. Although recycled funding of approximately £500,000 to encourage more dentists to become trainers was announced by the Northern Ireland Health Minister in late September 2007, it remains to be seen whether this will have the desired impact.

3.68 The situation in Scotland is such that there are simply not enough VT trainers to train all vocational dental practitioners. As a consequence VT trainers are now being asked to train more than one vocational dental trainee, with advertisements demonstrating ratios of 1 to 4 and 1 to 8, and when this does not deliver enough places some VT training is being provided in the salaried services.

3.69 Similarly in England and Wales there is a cohort of highly experienced VT trainers who have declared that this will be their last year as a VT trainer, stating that the increasing pressure of being a VT trainer has directly influenced their decision. Furthermore, there has also been a marked reduction in the number of applications from dentists wishing to become VT trainers.

3.70 These issues, if not immediately addressed, raise serious concerns about the pressures being placed upon the remaining VT trainers to maintain the high quality of VT training that vocational dental practitioners in the past have come to expect.

Continuing difficulties for vocational dental practitioners

3.71 The BDA's survey of vocational dental practitioners (2007) in England and Wales found that by summer 2007, 22 per cent of them had still not managed to secure post-VT employment for the coming year; this is three percentage points up on the same time twelve months ago. Those based in London were finding it significantly harder to find employment with 52 per cent reporting that they had not yet been able to secure a post-VT practice post.

3.72 Among those that had yet to secure a practice post, many reported that their lack of experience was a key factor hampering their search for employment. This is not surprising as the design of the new NHS system in England and Wales, with its UDA targets, strongly favours experience and productivity over youth.

3.73 Worryingly, only around a third of vocational dental practitioners are reporting that they have been fully able to pursue the post training career of their choice. Two thirds report that they either have not, or have only partially, been able to pursue their planned post training career.

3.74 Research by Cardiff University (2007) also found that there is a perception that Local Health Boards do not have the funding for vocational dental practitioners to continue on at their training practice, something also reported in the BDA's survey of vocational dental practitioners.

3.75 The BDA is therefore concerned that large numbers of vocational dental practitioners in England and Wales are now beginning their dental careers in posts that they did not envisage working in during their dental training. It cannot be in the interest of the public to have such highly motivated and skilled professionals not fulfilling their dental ambitions.

3.76 Furthermore, prior to the new NHS dental contract a dentist could provide NHS care whilst working under the NHS number of a principal dentist: for example, a graduate could choose to work as an assistant or locum to build their clinical experience. This has changed. Now, to provide NHS care a dentist needs their own performer number which can only be obtained by undertaking VT or demonstrating VT equivalence. As a consequence, where a graduate cannot secure an appropriate VT place – because for example they have commitments which tie them down to a particular area – they can no longer provide NHS care. They are, however, free to practice in the private sector unhindered.

3.77 The new system therefore creates unemployment in the dental workforce: although there are many dentists ready and willing to work in the NHS, some will not be able to because of the new regulations. This also affects overseas graduates who have passed the IQE/ORE exam set by the GDC as they are also not able to work in the NHS unless they have done VT or shown equivalence.

3.78 The BDA reiterates its view that it seems wasteful to neglect the proper deployment of the Government's own investment in domestically trained dentists, especially given the existence of unmet demand for dentistry and the problems of access across the country. Furthermore, the presence of such large numbers of vocational dental practitioners not being able to pursue their planned post training career will speed up their entry into the private dental market so as to fully realise their ambitions.

Relative pay comparability has weakened

3.79 It is recognised that the relative pay differential between jobs plays an important role in being able to recruit an appropriate dental workforce. Dental graduates have high academic entry grades[7] with most of them graduating with a large debt burden[8].

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[7] Research from 2002 found that the highest-scoring A-level candidates chose courses in pre-clinical dentistry http://news.bbc.co.uk/1/hi/education/1934771.stm

[8] BDA research from 2004 indicated that the average level of debt for a dental student in the UK in 2004 was around £18,000 (excluding outliers)

3.80 Although it is difficult to directly compare the changes in earnings across different professions, the evidence does seem to indicate that, as a consequence of the pay reforms across the National Health Service, dentists have fallen behind their NHS colleagues.

3.81 Analysis by the NHS Information Centre shows that the net earnings of a doctor has risen by 50 per cent between 2000–01 and 2004–05 to stand at around £96,000. Furthermore, research by the National Audit Office concludes that average consultant pay has increased by 41 per cent between 2000–01 and 2005–06 to stand at £110,000. These large rises are a direct consequence of the new GP and consultant contract introduced in April 2004 and October 2003 respectively. It is important to note that almost 100 per cent of the earnings of GPs and consultants come from providing NHS care.

3.82 In comparison, analysis by the NHS Information Centre shows that the average net income before tax and from all sources for a non-associate dentist (i.e. a dentist who does not have formal business links with other dentists) has risen by 43 per cent between 2000–01 and 2005–06 to stand at around £95,000, although the average net earnings before tax for all GDS dentists in 2005–06 is lower at around £84,000. However, the rise of non-associate earnings comprises of a 95 per cent increase in private income compared with only a four per cent increase in NHS income before tax. As a consequence, only around £40,000 of the £95,000 is derived from the NHS.

3.83 Furthermore, as 2005–06 incorporated the run up to the implementation of the new dental contract in England and Wales it is possible that NHS earnings were boosted for this year. The combination of a ‘rush’ to complete treatments before 1 April 2006 and some dentists working harder in the test period (which ended in September 2005) would both add a boost to average NHS income in this period.

3.84 Unlike the new GP and consultant contracts, the new dental contract in England and Wales has capped a dentist’s NHS income and, as a consequence of this, average NHS income levels for dentists in subsequent years will not demonstrate rises of the magnitude that have been experienced by doctors and consultants after introduction of their new contracts.

3.85 Many dentists in Scotland and Northern Ireland, meanwhile, will either work longer and harder to maintain their NHS earnings or shift towards providing more private work so as to maintain their overall earnings.

3.86 The positive impact of the pay modernisation is perhaps best demonstrated by the size of the respective workforces. Between 2004 and 2006 the number of doctors in the NHS rose by 1,568, while the number of consultants has risen by 2,224.

However, by the end of the first year of the new dental contract in England there were some 500 fewer NHS dentists than a year earlier[9].

3.87 Although the demand for university dental places remains robust with the ratio of applications to acceptance rising from 1.7 to 2.2 between 2001 and 2005, there has been stronger growth for university medical places with the ratio rising from 1.6 to 2.5. This perhaps suggests that the relative attractiveness of dentistry compared with medicine is already weakening.

3.88 It is therefore a possibility that one potential impact of the pay modernisation across the NHS is that A-Level students thinking about a career in the NHS are now more likely to consider a career as a doctor or consultant than as an NHS dentist.

Long term recruitment set to be compromised

3.89 The recent large increases to doctors' and consultants' incomes are a direct result of the pay modernisation for these groups. However, the design of the new dental contract in England and Wales is based on the principle of 'broadly the same amount of money for providing a broadly similar level of service'. The average NHS income for these dentists, therefore, will not rise under the new dental contract. The pay modernisation agenda across the NHS has resulted in the pay differential between doctors and consultants and dentists widening.

3.90 On 30 April 2007, in a speech to the King's Fund, the then Prime Minister Tony Blair concluded in relation to dentistry that "… you cannot force dentists to provide the NHS service so we tried to offer all sorts of inducements, we have increased the number of dentists … but there is a problem if they decide that they do not want to do the NHS treatment".

3.91 The increases in the number of doctors and consultants in the NHS after their respective pay modernisations contrasts starkly with the reduction in the number of NHS dentists in England after the first year of the new dental contract. This suggests that an appropriate pay modernisation framework with tangible incentives, as demonstrated in the case of doctors and consultants, can attract and encourage highly skilled dental professionals into the NHS.

3.92 Furthermore, increasing the volume of dentists in a cash limited system will lead to the unemployment of dentists. Such outcomes appear to be counterintuitive to the Government's policy of increasing the number of dental school places.

3.93 The combination of weakening relative pay for dentists, uncertainty in securing NHS employment, high levels of student debt and senior dental school students not

[9] NHS Dental Reforms: One year on, Department of Health, August 2007

wishing to working solely in the NHS has the potential to seriously harm the ability to recruit the appropriate number of dentists required to deliver the Government's vision of high quality NHS dental care. Given this, it is inconsistent and naive for the Government to continue to look unfavourably upon the shift to private practice as it is the only viable option for many dentists.

Retention

3.94 The retention of dentists in the NHS has been a problem since the early 90s when the Government took the ill-informed decision to impose a fee cut upon dentists. This critical moment in dental history scarred the profession and left the majority of them apprehensive and sceptical of the Government and its long-term ambitions for NHS dentistry. More than a decade later these sentiments still remain and, for dentists in England and Wales, the reforms have simply reinforced long-held beliefs.

3.95 The Government has long been in denial about the scale and underlying reasons for the problem of retaining NHS dentists across the UK, placing blame, unjustifiably, on the profession. However, recent evidence relating to GPs and consultants clearly show that NHS reforms can be structured and implemented in such as way so as to improve the retention of the workforce and stem the flow of manpower towards private options.

3.96 However, in all four countries of the United Kingdom not enough has been done to create a sustainable and viable NHS option for dentists to practice. Ominously, the rushed reforms implemented in England and Wales appear to have done little to improve the retention of dentists within the NHS.

3.97 Information from the NHS Information Centre highlights the extent of the shift towards private dentistry. Between 2004–05 and 2005–06 (i.e. the year prior to the implementation of the new dental contract in England and Wales) non-associates in Great Britain reduced their NHS commitment significantly. Although some of this decline may be explained by the migration to PDS over this period, NHS commitment had already been on the decline for many years.

3.98 NHS earnings as a percentage of total earnings fell from an average of 47.6 per cent in 2004–05 to 41.9 per cent in 2005–06, a fall of some 5.7 per cent. The reduction in NHS commitment was demonstrated across gender, age and location. The largest reduction in NHS commitment was for non-associate dentists aged under 35, whose NHS earnings as a percentage of total earnings fell by 20.7 per cent. This is worrying as it is this age cohort that has traditionally been more committed to the NHS and in the past has demonstrated increases in NHS commitment.

3.99 The NHS Information Centre information also indicates that the average net NHS income before tax for a non-associate dentist fell by 5.1 per cent between 2003–04 and 2005–06.

3.100 The underlying issue that needs to be addressed in relation to the retention of NHS dentists in all four countries is the increasing inability that dentists have to run a viable NHS dental practice and the unreasonably high NHS workload. Certainly in England and Wales, the reform to NHS dentistry appears not to have addressed either of these issues, with the evidence indicating that workload has not decreased for the majority of dentists and that the financial viability of the practice has not improved.

3.101 In England and Wales it has also been difficult to get Primary Care Trusts or Local Health Boards to set up new contracts for existing practices that wish to expand their NHS service, particularly when a vocational dental practitioner completes their VT year. This view was expressed by Welsh dentists in research undertaken by Cardiff University (2007). Often a new performer is added to an existing contract but the funding comes from within the original contract value with incumbent dentists reducing their NHS commitment (or increasing their private commitment) to accommodate the new performer.

3.102 The Scottish Executive has chosen a less radical path for reform, building upon the fee per item system by introducing various allowances aimed at improving NHS retention, e.g. General Dental Practice Allowance and Scottish Dental Access Initiative. However, the conditions for measuring NHS commitment and unrealistic tie-in periods appear to be significantly hindering the potential effectiveness of these allowances and in some instances are causing a reduction in NHS commitment.

3.103 A similar approach utilising allowances, e.g. a practice allowance, has also been adopted in Northern Ireland with the aim of improving retention. Although these have been welcomed by the profession, much more needs to be done. In particular, additional support focused at improving practice infrastructure and staff training is still needed.

3.104 A good example of the difficulties facing dentists is the financial repercussion to a dental practice from increasing regulations relating to cross infection control and clinical governance; e.g. the April 2007 advice to dentists that they must ensure endodontic reamers and files are treated as single use to avoid any potential transmission of vCJD.

3.105 In response, Scotland and Northern Ireland implemented a fee enhancement of £10 for endodontic treatments whilst dentists in England and Wales were left to address the financial cost from within their fixed contract values.

3.106 This is just one example, but several other challenges such as dental nurse registration, other cross infection control and clinical governance guidelines (e.g. decontamination requirements) and increasing downtime are combining to threaten the financial viability of NHS practice across the United Kingdom.

Practice expense ratios

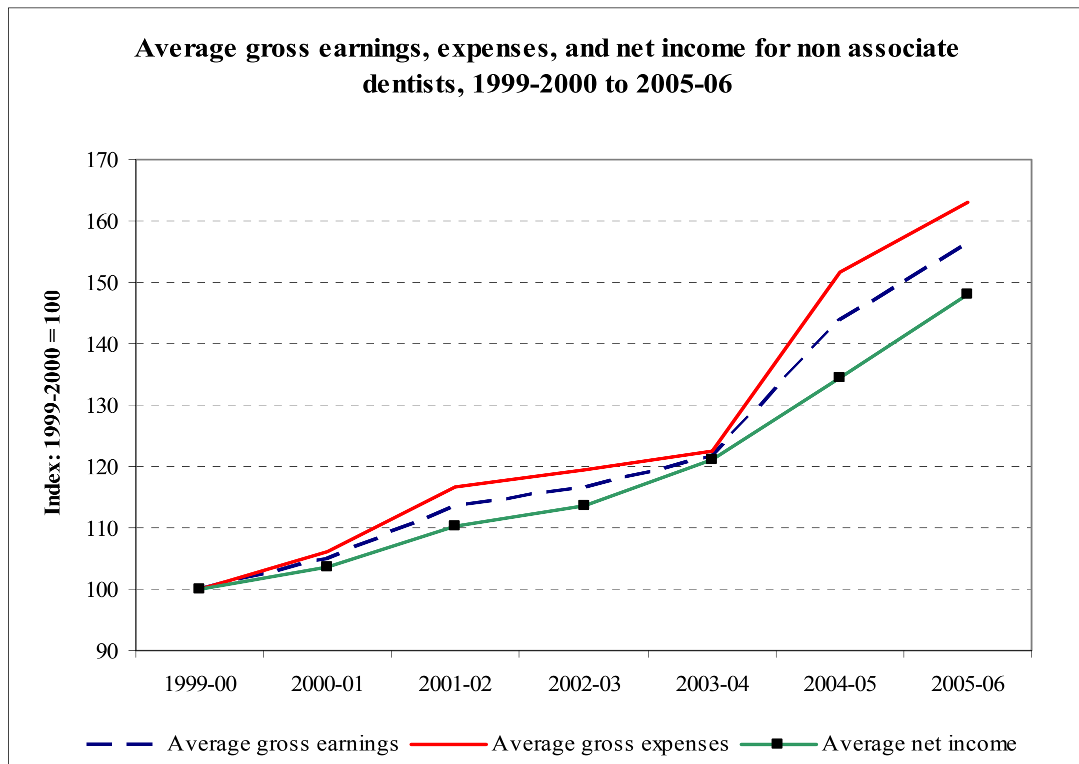
3.107 The BDA again urges the Review Body to adopt a more prospective view when assessing its uplift recommendation to ensure that dental expenses are met from current income streams and not through borrowing or the drawing down of cash reserves.

3.108 The Government's notion that under a fixed contract value, as exists in England and Wales, expenses can be driven down, is tantamount to telling the profession to compromise quality and innovation in the face of ever increasing patient expectations. This is an inconsistent approach and is likely to lead to dentists increasing their dependency on private dental income to ensure that quality and innovation can be delivered to all patients.

3.109 Research by the NHS Information Centre indicates that between 2003–04 and 2005–06 the expense ratio for all non-associate dentists has risen by four per cent, with the largest increases being demonstrated in the under 35 age group (a rise of 16.8 per cent) and for dentists based in London (a rise of 11.6 per cent).

3.110 Since 1999–2000 average gross earnings for non-associates have risen by 56.4 per cent, average gross expenses by 63.2 per cent and average net income before tax by a more modest 48 per cent. However, over the same period the compound GDS gross fee scale uplift was only 22.1 per cent. Since 1999–00 the expense ratio for all non-associate dentists has risen by 4.3 per cent – see figure 4.

Figure 4



Source: The Information Centre

3.111 Applying linear regression techniques to the expenses ratio since 1999–00 shows that the expense ratio for non-associate dentists in GB has been demonstrating an upward trend. This upward trend is demonstrated across gender, region and all age groups, except for the age group 45-54 which demonstrates a relatively flat trend.

3.112 Information from Nick Ledingham of Morris & Co. Chartered Accountants (specialist dental accountants) sheds light on more recent dental practice profitability. For sole principals without associates (i.e. a practice which is comparable with the NHS Information Centre's non-associate group) the average net profit per average number of half day sessions worked per week has fallen by four per cent between 2004–05 and 2005–06, despite an 18 per cent increase in the average number of sessions worked per week.

3.113 Further information from the National Association of Specialist Dental Accountants (NASDA) shows that between 2004–05 and 2005–06 that the average fee income for an NHS practice rose by 15 per cent with expenses rising by 11 per cent. This has resulted in an increase in the net profitability of an NHS practice during this period. However, NASDA stresses that this is an unintended consequence of implementing the new dental contract and is likely to be transitory in its nature.

3.114 They warn that the figures "… have been distorted by a huge amount of work dedicated to finishing treatments prior to 1 April 2006 … [and that] the greatest distortion comes from the impact of the early PDS contracts. Because Primary Care Trusts were under political pressure from the Department of Health to get practices signed up to PDS, some practices were overnight increasing profits by 50 per cent."

Specific practice expenses

3.115 The BDA notes that the DDRB considers that the (retrospective) median hourly pay for healthcare and related personal service (HRPS) is the appropriate proxy to measure changes in dental staff costs. However, the BDA once again urges the DDRB to use the available information to make prospective forecasts for dental staff cost inflation.

3.116 Between 2003 and 2006 the correlation coefficient between growth in the average earnings index and the median HRPS is 0.78. Although not perfect, this suggests that forecasts for the growth in average earnings can be used as a reasonably robust proxy for future dental staff cost inflation.

3.117 The June 2007 *Forecasts for the UK economy*, published by HM Treasury, report that the median forecast for average earnings growth in 2008 is 4.2 per cent. The BDA urges the DDRB to use this as a baseline in assessing the movement of dental staff costs in 2008–09.

3.118 Furthermore, the BDA estimates that the revenue cost of dental nurse registration will be in the region of £130 million in 2008–09. This includes the cost of registration and the cost of completing verifiable continuing professional development (CPD). The BDA believes that dental nurse registration will also add to wage inflation pressures as dental nurses demand higher wages in return for their additional qualifications and training. It is important that the DDRB include such costs when assessing dental staff cost inflation for 2008–09.

3.119 In April 2007 dentists were advised to ensure that endodontic reamers and files be treated as single use to avoid any potential transmission of vCJD. Based on Department of Health assumptions, the move to single use items for endodontic treatment will have revenue cost implications of at least £5 million in 2008–09 in England alone.

3.120 For England and Wales, the introduction of the Health Act 2006, new EN/ISO standards and the expected publication of the Department of Health's technical guidance on decontamination in early 2008, will demand higher standards in infection control and dental decontamination in order to ensure that patient safety is not compromised.

3.121 The purchasing, validation, routine testing and ongoing maintenance of new and improved dental decontamination equipment and facilities to meet these new and expected standards will therefore have to take place. The profession supports evidence based guidance, but it is concerned this will involve considerable capital costs and increased annual revenue costs in order to guarantee compliance within an area where standards are constantly being revised upwards.

3.122 As a prelude to this, strengthened decontamination requirements have already been introduced in Scotland. Local decontamination units are recommended and the trials that have taken place in the Lothian and Glasgow NHS Board area indicates that the capital costs may amount to between £25,000 and £45,000 per practice. This estimate concurs with findings from the NHS Borders Dental Capital project, which found that equipping a decontamination unit in a six surgery practice cost around £30,000. It is important to note that these estimates are based on practices for which a suitable room for decontamination exists; where space is not available significantly higher costs will be incurred, and in the worse case a practice may need to move premises to comply with the requirements. Furthermore, the additional increased revenue costs are yet to be assessed.

3.123 Although the £5 million additional funding announced in October 2007 aimed at offsetting the costs incurred by the decontamination requirements has been welcomed by the BDA, this only equates to around £6,000 per practice which is significantly lower than what the evidence suggests the actual costs would be.

3.124 Although there is some financial support for “NHS committed” practices in Scotland it is too early to say whether this increased financial support is enough. However, for the one in three practices in Scotland that are deemed not to be committed, but who are continuing to provide an NHS dental service to the most vulnerable patients including children and exempt adults, there is no support from the Scottish Government. Whilst all practices are bearing the financial repercussions of these requirements, committed NHS practices that do not qualify for financial support due to the technical definition of NHS commitment are likely to be the practices that are finding it the most difficult to absorb the costs.

3.125 Finally, according to dental accountants, dentists in England and Wales have had a significant increase in time spent on administration and preparing for meetings with Primary Care Trusts in 2007–08 as a consequence of the reforms. Much of this occurs during surgery time as it has not been possible for many Primary Care Trusts to deal with such matters outside of normal working hours. This is resulting in considerable downtime for dentists at a time when practice expenses are being incurred and thus also makes attaining UDA requirements more difficult. In some cases dentists have sought paid advice and help from an accountant, which has

added to their overall practice expenses. The BDA hopes to provide further evidence of this over the next year.

3.126 The move to single use items for endodontic treatment and the implementation of dental nurse registration alone is set to cost the profession at least £135 million in 2008–09. This equates to an estimated five per cent of practice turnover and does not even include the potential cost repercussions of other anticipated infection control and dental decontamination standards, increased downtime spent on general administration or general pay and price inflation.

Goodwill and practice viability

3.127 BDA research (2007) relating to NHS dentists in England and Wales showed that 53 per cent of dentists reported that their practice profit had decreased or stayed the same over the previous two years. However, 64 per cent of committed NHS dentists (i.e. those with 75 per cent or more of their income coming from the NHS) reported that their practice profit had decreased or stayed the same compared with 40 per cent for mixed or highly committed private dentists (i.e. those with 74 per cent or less of their income coming from the NHS).

3.128 Increasing practice profits are a key factor for introducing greater innovation in to dental practice through carefully developed investment plans. However, only 56 per cent of committed NHS dentists managed to maintain their planned two-year investment programmes in 2007 compared with 68 per cent of mixed or highly committed private dentists.

3.129 BDA research (2007) shows that 81 per cent of dentists disagree or strongly disagree with the statement that the new contract has improved the financial viability of the practice. It also reports that only six per cent of dentists agreed or strongly agreed with the statement that a consequence of the new contract has been that it has improved the long-term certainty of running their dental practice.

3.130 As a consequence of the new dental contract in England and Wales, dental practices now face much greater uncertainty about their NHS income. Although dentists have a three-year income guarantee, once there has been a variation to the original contract the guarantee is lost. This significantly higher level of uncertainty reduces the commercial value of the business.

3.131 The BDA is extremely concerned that, under the new dental contract, practices are now burdened with additional uncertainty and risk. Essentially, the new NHS dental contract is being viewed as a short-term contract between a practice and the Primary Care Trust, with many dentists apprehensive about 2009 when PCTs will have greater freedom in choosing who to commission.

3.132 The Scottish Dental Practice Allowance was introduced to provide financial support to practice owners towards the cost of running a practice and to encourage retention within the NHS. However, since the implementation of the new conditions for measuring NHS commitment there has been a decrease in the number of practices deemed as being committed. Whilst the sentiment of the allowance is welcomed, the precondition for support appears to be having an adverse effect on retention within the NHS.

3.133 Dental practices are therefore not able to plan their businesses with a long-term view. This will lead to practices shifting their commitment towards private sources of income in an attempt to ensure the long term financial stability of the practice which also ensures long term patient care.

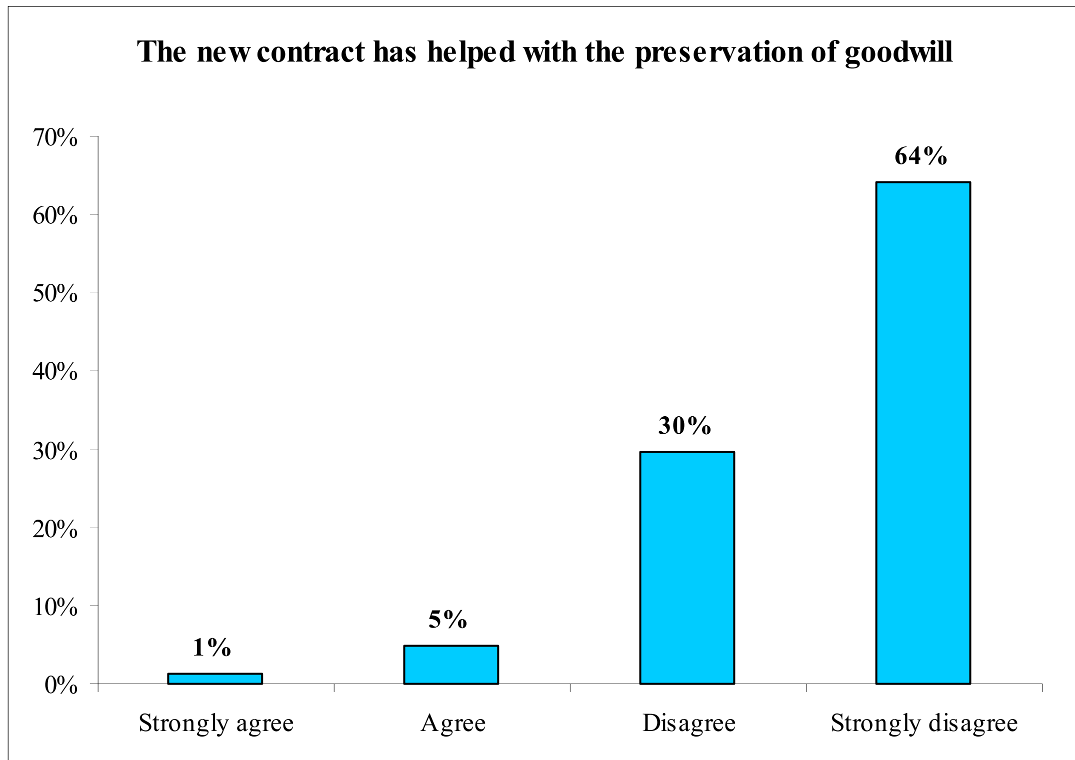
3.134 For dentists, the goodwill of their practice, which they have invested their time and money in, is viewed in part as retirement finances. However, due to the growing unattractiveness of NHS dental practice in general and the introduction of the new dental contract in England and Wales, the value of goodwill for an NHS practice has suffered.

3.135 There are two major concerns under the new contract in England and Wales. Firstly, there is no guarantee that a practice retains its NHS contract when it is sold. Additionally, even if the contract is retained by the practice when it is sold, there is no certainty that its financial value will be fully transferred.

3.136 Results from the BDA Retirement Survey (2007) show that 56 per cent of dentists planning to retire within the next five years feel that the value of their practice goodwill had decreased since the introduction of the new NHS contract. Furthermore, those with a larger commitment to the NHS were more likely to report that their practice goodwill is likely to have decreased.

3.137 This is further reinforced by BDA research (2007) which found that 94 per cent of dentists disagreed or strongly disagreed with the statement that the new NHS contract has helped with the preservation of goodwill – see figure 5.

Figure 5



Source: BDA

3.138 The BDA believes that the unattractiveness of owning a dental practice in partly due to a reduction in future levels of goodwill. BDA research (2007) indicates that 51 per cent of dentists have become less attracted to the idea of being a practice owner over the last two years, compared with a figure of 40 per cent in 2000. The indications also suggest that the increased desire for dentists to improve their work-life balance may also act as a deterrent to future practice ownership.

3.139 It is vital that appropriate incentives exist within the NHS that will foster a new generation of pioneering practice owners. This will require greater level of certainty within the profession, ensuring levels of goodwill are maintained, stabilising profitability and reducing the administrative burden placed upon NHS practices.

3.140 The preservation of goodwill is vital to ensure the continuity and certainty of patient care and to retain committed NHS dentists within the health service. To ensure that both these aims are realised the BDA has called on the Government to allow long term business stability by permitting dentists to transfer their NHS contracts in full to new owners, thus maintaining the goodwill value of practices and the long term care of those NHS patients that visit the practice.

Valuing the NHS pension

3.141 Membership of the NHS Pension Scheme is viewed as an important retention and reward mechanism in the NHS. At first glace the NHS pension seems to compare favourably with those operating in the private sector in which many final salary schemes are now closed to new entrants, closed to future accrual or replaced by defined contribution schemes.

3.142 The DDRB in its 36th Report requested that evidence be presented on the value of the NHS Pension Scheme as part of the overall package of remuneration for NHS dentists. In response to this, Hewitts, a firm of actuarial consultants and employee benefits consultants, were asked by the BMA and BDA to quantify the value of the scheme to groups of its members and compare it to the availability of benefits in the marketplace.

3.143 The NHS Pension scheme is a defined pension scheme which has two sections: Final Salary for employed dentists and Career Average Revalued Earnings for General Dental Practitioners as well as Medical Practitioners.

3.144 The findings indicate that for GDPs the Scheme represents the main perquisite of their commitment to the NHS. Although it compares favourably with other pension schemes which are available in the private sector, it does not compensate for the lack of other fringe benefits including company cars, bonus schemes and employee share schemes.

3.145 Furthermore, as a result of the NHS Pension Review, with effect from April 2008 the cost of membership of the NHS Pension scheme will increase substantially for most members. For the highest earning group, the contribution rate will rise from six per cent of pensionable earnings to 8.5 per cent, an increase in the rate of contribution of 42 per cent, while the employer contribution does not rise above its existing level of 14 per cent, except temporarily to 14.2 per cent.

3.146 The BDA's view of the NHS Pension scheme is that whilst it is a substantial benefit to general dental practitioners and other groups in the scheme, the absence of other fringe benefits acts as a disadvantage when compared with the range of fringe benefits available in the commercial sector.

Workload

3.147 Another important factor affecting the retention of dentists within the NHS is the constantly increasing workload facing dentists and their dental teams. Higher governance standards, increasing bureaucracy and decontamination issues have resulted in increased downtime and rising non-clinical workloads for dentists across

the UK, with some of these factors having financial repercussions on practice expenses.

3.148 Dentists in Scotland and Northern Ireland who are practising under the fee scale system are responding to higher governance standards and increasing practice expenses by exercising choice in their mix of provision towards a higher proportion of private care.

3.149 In England and Wales there are other factors increasing dentists' workloads. As discussed previously, the BDA believes that many dentists have received inflated workloads as a consequence of introducing the UDA as a measure of output – refer to figure 2 which highlights performance against UDA requirements. Additionally, the reforms have resulted in a direct increase in non-clinical administration. There has also been a significant increase in patient expectations as a result of the new NHS patient charging system.

3.150 The BDA research (2007) reports that 37 per cent of dentists in England and Wales have stated that the new NHS contract has made their working day busier, with 48 per cent stating that their working day remained unchanged. Among those considered to be committed NHS dentists, the effect was even more pronounced, with 48 reporting that their day had become busier and only ten per cent indicating that their working day was now less busy.

3.151 Of those dentists who have found that their working day is busier, the main ways that they are managing their time is by spending less time on preventive care, less time with each patient, treating fewer high needs patients and working longer hours.

Morale

3.152 Morale across NHS staff remains a serious challenge that the Government must address. Indeed, Alan Johnson, on launching a major health service review, admitted that morale was a problem[10] by stating that "The reality on the ground is there's a bit of a gloomy mood about the NHS that's among the public and among the staff". It is therefore of no surprise that the morale amongst NHS dentists is also generally low.

3.153 There is also a mood of distrust between the profession and the Government, with the profession left uncertain as to the future of NHS dentistry. This is also contributing to poor levels of morale. For example, the Government is claiming that the reform to NHS dentistry in England and Wales has been a success. The profession does not share this sentiment as it struggles through what has been a traumatic period post-reform. Devolved administrations also continue to paint a

[10] http://www.24dash.com/news/47/23568/index.htm

rosier picture of the state of NHS dentistry than the one recognised by their NHS dentists.

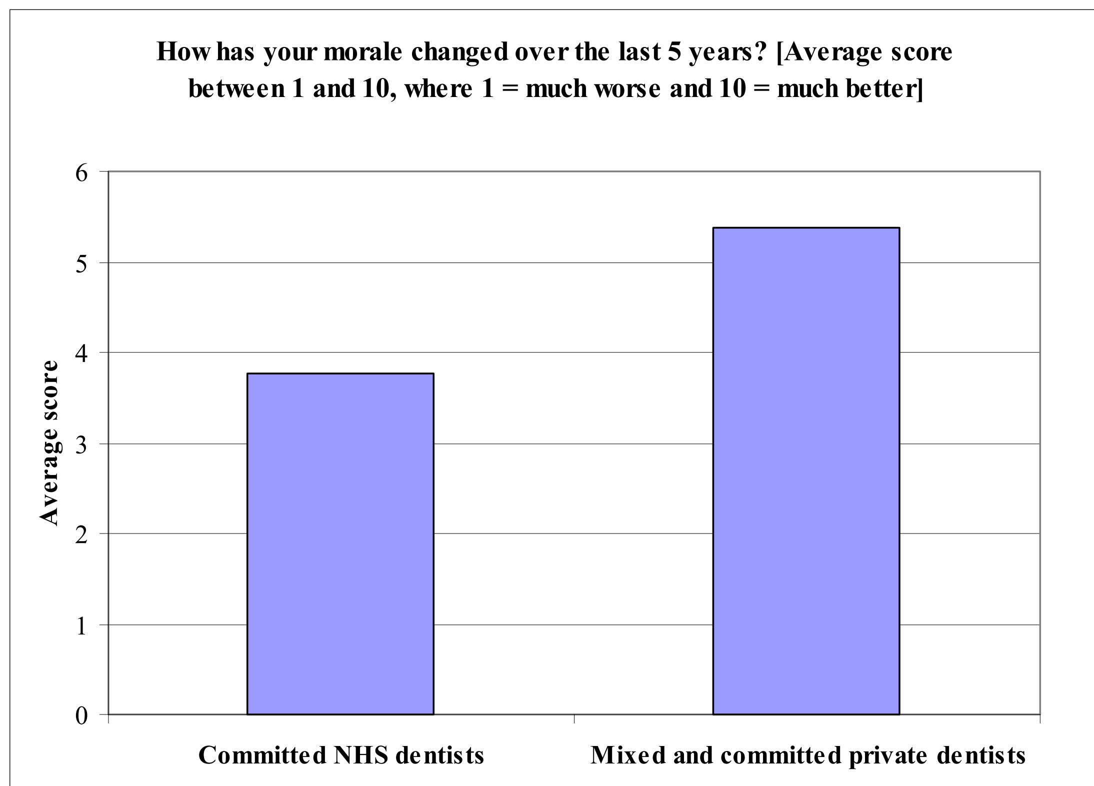
3.154 Because NHS decision makers are not acknowledging the serious problems that exist within the NHS dental services across the UK, NHS dentists have lost faith and confidence in them and are sceptical of the will to correct unfair pressures in the system. Recent BDA research among dentists in England and Wales (2007) illustrates the poor levels of morale among dentists. The research showed that:

- Ninety-five per cent of dentists feel less confident about the future of NHS general practice than they did two years ago;
- Seventy-one per cent of committed NHS dentists have lower levels of job satisfaction than two years ago, compared to 47 per cent of mixed or committed private dentists;
- On a scale of one to ten, with one representing ‘not happy’ and ten representing ‘very happy’, the mean score of how happy dentists were in their work environment was 5.7 for committed NHS dentists and 7.0 for mixed or committed private dentists;
- When dentists who had experienced significant change where they worked were asked to rate how well the change had been handled on a scale of one (not well) to ten (very well), the mean score for committed NHS dentists was 5.2. For mixed and committed private counterparts it was 6.4;
- Asked how happy they were with any changes that had occurred to their work environment on a scale of one (not happy) to ten (very happy), committed NHS dentists reported a mean score of 4.6. Mixed and private committed dentists reported a mean score of 6.3;
- Overall, when asked how well supported by the NHS dentists felt on a scale of one (not well) to ten (very well), the mean score was 2.6;
- Asked how valued they felt by their patients on a scale of one (not valued) to ten (very valued), dentists reported a mean score of 7.6. Asked how valued they felt by opinion makers, the mean score 3.4;
- When asked how satisfied they were working as a dentist on a scale of one (not satisfied) to ten (very satisfied), the mean score was 7.0 for a mixed or committed private dentists and 5.6 for a committed NHS dentists;
- Finally, when asked to rate how their level of morale had changed over the last five years on a scale of one (much worse) to ten (much better),

committed NHS dentists reported a mean score of 3.8 compared with a mean score of 5.4 for mixed or committed private dentists.

3.155 The results of the BDA's research indicate a clear relationship between the NHS commitment of a dentist and their level of morale and attitude towards their work – see figure 6. Generally speaking, those with lower commitment to the NHS are reporting lower mean scores for factors such as morale, happiness and job satisfaction. What is clear is that the level of morale for an NHS dentist is influenced by a range of factors, not only level of remuneration.

Figure 6



Source: BDA

3.156 The BDA believes that these findings also reflect the levels of morale for dentists working in Scotland and Northern Ireland, with many NHS dentists working in these countries also disillusioned by the fact that they cannot access what appears to be constructive financial support due to technical definitions of their levels of NHS commitment.

Recommendations

3.157 In the light of the issues raised in our evidence, we ask the Review Body to recommend that for 2008-09 all dentists receive a seven per cent increase to their net NHS earnings before tax.

SALARIED PRIMARY DENTAL CARE SERVICES

Key points

- *Many salaried dentists have been experiencing additional demands on their workload, with a steady rise in the number and complexity of referrals into their service. BDA research undertaken in 2007 found that between 1 April 2006 and 31 March 2007 73 per cent of Clinical Directors reported an increase in the number of referrals of children to their service; 65 per cent reported an increase in the number of referrals of patients with special needs; and 77 per cent reported an increase in the number of referrals of other groups of patients.*

- *The ability of the service to provide care for all of its patients is further stretched by primary care cost-cutting initiatives, and recruitment difficulties, which often reduce the clinical capacity of SPDCS/CDS.*

- *Salaried dentists in England hope to have new pay, terms and conditions before the end of 2007 but the other three administrations are behind in terms of their pay reform agendas. The policy position in the other three administrations appears to be one of 'watch and wait' of the outcomes in England. This uncertainty and absence of firm direction is causing considerable anxiety for CDS dentists in Scotland, Wales and Northern Ireland.*

Twelve months in NHS dentistry

England

4.1 In evidence to the DDRB last year the BDA reported that negotiations on new pay, terms and conditions for Salaried Primary Dental Care Service (SPDCS) dentists in England had commenced. The negotiations have been based on a funding envelope of 10 per cent over and above the 2006–07 pay bill for SPDCS dentists and are designed to reflect the proposals outlined in *Creating the Future – Modernising Careers for Salaried Dentists in Primary Care*. The new structure is intended to lead to an enhanced patient experience and to improve recruitment, retention and morale for SPDCS dentists.

4.2 Negotiations between the BDA and NHS Employers have concluded. The BDA received confirmation from NHS Employers that the Department of Health had ratified the new contract on 17 October 2007. The BDA will ballot all SPDCS

dentists in England in the latter half of November 2007 and based on the contract it has negotiated with NHS Employers will recommend a yes vote on the new contract.

4.3 Agreement has been reached with the Department of Health and NHS Employers that the new contract will be implemented as soon as it has been agreed by the profession, and the pay element will be backdated to 1 June 2007. The BDA would like DDRB to note that working with NHS Employers on these negotiations has been a positive process. All parties worked in partnership to ensure that the new contract is fit for purpose and meets the aims of all parties.

4.4 The BDA are currently discussing implementation issues with the Department of Health. It is vital that there is an initiative to cover training needs of SPDCS dentists to help to ensure appropriate implementation of all aspects of the contract especially appraisal and job planning, which are integral to its success. The BDA hope that Primary Care Contracting will be able to run events to communicate these new arrangements to PCTs.

4.5 While accepting that NHS Employers' role ceases with the conclusion of negotiations, the BDA has suggested to the Department of Health that collaborative work between the BDA and NHS Employers should be done with the aim of assessing progress and identifying any major inconsistencies. The Department's view is that the key focus should be on implementation and that it is premature to be considering a review. The BDA believes that an agreement in principle should be made.

Wales

4.6 Last year the BDA reported the intention of the Welsh Assembly Government to reorganise the Community Dental Service (CDS) in Wales following the consultation to *Bridges to the Future*. The aim of the re-organisation is to create three Community Dental Services in Wales from the current eight. This is in line with the Welsh Assembly Government's stated key objective of developing and commissioning NHS services through joint working by LHBs and NHS Trusts on the basis of three regions.

4.7 The merging of the Community Dental Services in Mid and West Wales has made minimal progress, though the planned merger has been delayed rather than shelved. The feasibility study examining the benefit of merging the two Trusts in South East Wales has not occurred as originally planned either. However, both proposals have now been superseded by the Health Minister's announcement of a consultation on proposals for a series of mergers of NHS trusts. The previously set timetable for the re-organisation of the Community Dental Service in Wales will now, therefore, be subject to this broader reconfiguration.

4.8 The Welsh Assembly Government has had observer status during the negotiations between the BDA and NHS Employers to develop new pay and terms and conditions for SPDCS dentists in England. Once the final agreement to implement the proposed new pay structure in England is reached, similar proposals will be submitted for consideration by the Welsh Assembly Government Minister for Health and Social Services. However, both the lack of formal commitment to implement change and the time it takes to introduce change in Wales combine to create an air of general uncertainty and frustration.

4.9 The large number of Local Health Boards (LHB) in Wales, currently 22, creates considerable problems for the Community Dental Services there. This is particularly true with respect to service development and expansion. For example, one CDS must contract with five LHBs who serve very diverse and contrasting populations. This creates conflicting contracting priorities.

Scotland

4.10 The summary and recommendations of the Review of the Salaried Primary Care Services in Scotland was published in late 2005, with the final report published in February 2007. The main recommendation from the Review was the integration of the salaried GDS and CDS into a single salaried primary care dental service.

4.11 The Review also recommended that, in order to provide the skills necessary to maximise the amount of care available in the new primary care setting, there needs to be a career structure for dentists that encourages advancement and provides the opportunity to develop appropriate skills. The Review went further and also recommended that career pathways should be developed for the wider dental team.

4.12 The BDA sees merit in combining the current CDS and salaried GDS in Scotland, although has concerns about workforce planning, achieving true flexibility in local delivery and the potential diminution of CDS specific roles (e.g. treating patients with 'special needs') if the new service was to become more generalist. The BDA also felt that the Review lacked specific details on how to take forward the recommendations – particularly those relating to the new career structures for dentists – and was unclear on the timeframe for implementation.

4.13 Since publication of the Review, a Project Board has been established to take the work forward. The BDA is now meeting regularly with members of the Project Board and any future negotiations on pay, terms and conditions is likely to take place via the Scottish Joint Negotiating Forum.

Northern Ireland

4.14 Policy development for the Community Dental Services in Northern Ireland has stemmed from the 2003 Review of the Community Dental Service, the 2006 Community Dental Service Corporate Plan and the September 2006 Primary Dental Care Strategy for Northern Ireland, which recommended greater integration of the GDS and the CDS in the future.

4.15 Although the work from the 2003 Review of the Community Dental Services in Northern Ireland has been ongoing for several years, progress has been very slow. A post of Project Manager, to consider implementing the recommendations of the five working groups under the main Steering Group, has been advertised, but has yet to be appointed. As a consequence, there is unlikely to be any significant progress in the near future.

4.16 The strategy of the Northern Ireland Assembly for moving forward with reforms to the CDS, such as new pay, terms and conditions for CDS dentists, appears to be to observe the outcome of the negotiations for SPDCS dentists in England. When these have been agreed by ballot and implemented the Assembly is then likely to consider the potential suitability of introducing something similar in Northern Ireland.

4.17 Across Northern Ireland a new salaried service is being introduced. This new service will be managed through the existing Community Dental Service. The management of an entirely new service has major implications for the CDS including recruitment of dentists, as well as the introduction of new financial and information systems This occurs at a time of major upheaval and restructuring of the HPSS with a 25 per cent reduction in management costs across all the trusts, directly impacting on CDS management structures.

More referrals and more complex case-mix driving workload pressures

4.18 England is clearly in a more advanced stage of reforming its SPDCS, with new pay, terms and conditions for SPDCS dentists likely to be agreed before the end of 2007. The policy position in the other three administrations appears to be one of ‘watch and wait’ before making any firm commitments for reform.

4.19 This uncertainty and absence of direction for CDS dentists in Scotland, Wales and Northern Ireland is causing considerable anxiety. In Wales, for example, there is great concern amongst those who manage the CDS that if the proposals for England are seen to offer a significantly enhanced career structure and remuneration, then recruitment and retention of younger dentists beginning their career in the CDS will become more difficult in Wales. This concern is also likely to resonate with managers of Community Dental Services in both Scotland and Northern Ireland.

4.20 As with their GDS colleagues, dentists in SPDCS/CDS are also seeing an increase in their workload due to increasing cross infection control and clinical governance standards. However, it is the continued rise in the amount of more complex work being referred to SPDCS/CDS dentists that is having the biggest impact on escalating workloads.

4.21 The 2007 BDA Survey of UK Clinical Directors found that between 1 April 2006 and 31 March 2007 73 per cent of respondents reported an increase in the number of referrals of children to their service; 65 per cent reported an increase in the number of referrals of patients with special needs; and 77 per cent reported an increase in the number of referrals of other groups of patients. The survey suggests that the number of referrals has increased by around a third. However, this figure is unweighted and is based on a small number of responses which demonstrate a wide statistical range so caution must be exercised when interpreting this finding.

4.22 Where respondents reported that that their service had witnessed a rise in the number of referrals, the majority of them said that this was increasing the waiting time to access specialist and general dental services, as well as increasing the overall patient numbers being treated in their service. There has also been an increase in the number of referrals that require domiciliary care and general anaesthetic or sedation, according to the survey.

4.23 SPDCS and CDS services in England and Wales are also now systematically charging non-exempt patients. The results from the survey indicates that almost all services (94 per cent of respondents) are now charging for non-exempt patients with 27 per cent reporting that they have a target for their patient charge revenue. This is a massive cultural shift for SPDCS/CDS dentists and the manifestation of this is borne out by 55 per cent of Clinical Directors stating that they had problems charging patients.

4.24 The major problem that SPDCS/CDS staff experience with charging their patients is that it is often very difficult to establish a patient's exemption status. These problems are accentuated when treating older patients, particularly those with dementia, patients with special needs, patients accompanied by a carer, and patients that are treated in an institutionalised setting, e.g. care homes, residential homes, and nursing homes. Consequently, the time spent establishing a patient's exemption status and/or explaining the charges has increased significantly, and can draw resources away from delivering clinical care.

4.25 The repercussions of the upswing in the number of referrals and growing complexity of work in SPDCS/CDS is further exacerbated, in England and Wales, by some PCTs using units of dental activity (UDAs) as an output measure for the service.

UDAs are a completely inappropriate measure to assess the output of SPDCS/CDS as they were constructed using historical GDS information only. Their design, therefore, does not incorporate the distinctly different patient/treatment profiles of the SPDCS/CDS, as compared with the GDS. The rapidly changing patient profile that is presenting itself to SPDCS/CDS is leading to higher workloads and this is directly compromising the ability for its dentists to be able to fulfil UDA targets.

4.26 Furthermore, in some instances PCTs have sought to begin disciplinary action against a SPDCS/CDS dentist who has not achieved a specified UDA target. The BDA is dismayed and astonished that some PCTs are not exercising their discretion and continue to use UDAs as the sole measure for measuring output. The BDA would like to see the complete removal of UDAs as a unit of output measure in SPDCS/CDS as it does not factor in the specialised nature of the care provided.

4.27 Increased average life expectancy means an increased demand for complex dental care from older patients. This demand has, in part, resulted in an increasing number of referrals to SPDCS/CDS dentists who provide the specialised care this patient group requires. The ability of the service to provide care for all of its patients is further stretched by primary care cost-cutting initiatives, which often reduce the clinical capacity of SPDCS/CDS.

Recruitment, retention and morale

4.28 The BDA Survey of UK Clinical Directors also indicates problems with recruitment and retention of dentists in SPDCS/CDS. Twenty eight per cent of respondents confirmed that posts had been frozen within their service. These posts inevitably include various dental grade positions, but also include administrative and dental nurse posts. The reason to freeze posts must, in part, be due to constraints on the financial resources available to individual services.

4.29 Although the freezing of posts is not taking place universally across all SPDCS/CDS, recruitment of advertised posts is proving to be problematic. Sixty eight per cent of Clinical Directors reported that their service had experienced difficulties when looking to recruit dentists. The major reason cited for this is the relatively poor pay for dentists in SPDCS/CDS compared with dentists in general practice, combined with a perception that this differential has been widening over time. As such, Clinical Directors are reporting that the choice of potential candidates is severely limited.

4.30 Supplementary survey work by the BDA looking at recruitment within the Salaried Primary Dental Care Services in Scotland shows that vacancies are not being filled within the Service, particularly for salaried GDP posts. Based on the responses of 12 NHS Boards, between 1 April 2006 and 31 March 2007, a total of 70 posts were

advertised with 14 remaining unfilled in the year to April 2007 – a vacancy rate of 20 per cent. The largest number of posts advertised was for salaried GDP positions (45 posts) followed by dental officer posts (9 posts), although the vacancy rate was similar across posts.

4.31 The survey also discovered that there were only 93 applications for the 70 posts advertised in Scotland, an average of 1.3 applications per position. This shortage of applicants compromises an employer's choice when recruiting. Employers in rural and remote areas reported frustrations with the large number of dentists, the vast majority of who were from overseas, who expressed an interest in working in these locations but were ineligible to work in the UK for one reason or another.

4.32 Another concern for SPDCS/CDS dentists is the increasing amount of time they are required to devote to tackling local access problems. Doing this reduces the amount of time they can spend treating patients with special needs, the very reason why many individuals chose this career path. The struggle to achieve a rewarding balance of work become increasingly difficult and job satisfaction is adversely affected.

4.33 Low job satisfaction and the increasing workloads facing SPDCS/CDS dentists both contribute to decreasing morale within the profession. The BDA's survey of clinical directors found that 66 per cent of services have undergone reconfiguration, with 35 per cent merging with other salaried dental services. This is undoubtedly having a negative impact on those affected by it.

4.34 The reconfigurations have, according to Clinical Directors, resulted in unnecessary and excessive tiers of management within the overall primary care structure in which they work. The majority of Clinical Directors report not to a Medical Director, Chief Executive or Director of Primary Care, but to a raft of other managers, many of who have limited or no experience of the specialised nature of the service. This is also occurring at a time when many services also have to meet rigorous performance management targets for example, waiting lists targets for GA services. The erosion of clinical leadership across SPDCS/CDS and in upper management position has also eroded the morale of dentists in the service.

4.35 Finally, morale is being further undermined by the commissioning process which is beginning to see traditional SPDCS/CDS services being put out to tender. The specialised nature of the care provided by SPDCS/CDS makes it inappropriate to tender these services solely on the grounds value for money principles. The process is resulting is greater uncertainty about the future and this is leading to the disillusionment of the workforce.

Recommendations

4.36 In the light of the issues raised in our evidence, we ask the Review Body to recommend that for 2008–09 all dentists receive a seven per cent increase to their net NHS earnings before tax.

DENTAL PUBLIC HEALTH

Key points

- *There is a serious inadequacy in the level of current availability of dental public health advice to Primary Care Trusts, with some Clinical Directors of Salaried Primary Dental Care Services expressing concerns that dental public health advice was being stretched too thinly across an SHA, or several Primary Care Trusts..*
- *A less than inflationary pay increase has, in part, contributed to the diminishing level of morale of CsDPH and put additional strain on loyal employees who are subject to ever increasing workloads.*

5.1 The BDA reported in evidence last year the national shortage of dental public health staff. Although never published, the Dental Public Health Workforce in England status report (January 2005), commissioned by the Chief Dental Officer, identified this shortage. It also concluded that although the number of Consultants in Dental Public Health (CsDPH) working in England has remained relatively stable over the last five years, it will fall in the near future.

5.2 The major administrative reorganisation identified by Chief Medical Officer Sir Liam Donaldson in his 2007 Annual Report means that Consultants in Dental Public Health, along with other public health colleagues, have faced difficult and uncertain times this year. That report also identifies the tendency that has existed in the past for public health budgets to be 'raided' in order to reduce hospital deficits or meet productivity targets. With the finances of the NHS in surplus, he argues, it is important that public health budgets are restored.

5.3 The BDA also believes that (excessive) reorganisation of the local NHS structure (i.e. Strategic Health Authorities and Primary Care Trusts) as part of 'Commissioning a Patient-led NHS' has the potential to worsen the situation facing CsDPH and their work. Indeed, we now know that during the last year a number of Consultants in Dental Public Health were either made compulsorily redundant or had their sessions reduced by their Primary Care Trusts.

5.4 Evidence collated by the BDA over the past year suggests that there is a serious inadequacy in the level of dental public health advice that is currently available to Primary Care Trusts. Some Clinical Directors of Salaried Primary Dental Care Services have expressed concerns that dental public health advice was being stretched too thinly across an SHA, or several Primary Care Trusts, for the advice to

be satisfactory. As a result, some Primary Care Trusts sought to receive, and have relied on, dental public health advice from a range of staff that are not trained or qualified in dental public health. Concerns have been expressed as to the appropriateness and quality of this advice.

5.5 Furthermore, the BDA is also aware that that some CsDPH have been either at risk of, or have actually faced, the threat of imminent redundancy, with cost savings as the main rationale. There have also been instances where CsDPH have retired and not been replaced.

5.6 All these factors, together with a less than inflationary pay increase, have contributed to the diminishing level of morale of CsDPH and put additional strain on loyal employees who are subject to ever increasing workloads. This needs to be considered in the context of Consultants in Dental Public Health being key strategic change leaders for the new dental commissioning arrangements over the past two years. CsDPH have played a key role in supporting PCTs in the process of commissioning dental services and assisting in the assessment and planning of local oral health strategies, and this has all been done in addition to their traditional dental public health roles.

5.7 There is undoubtedly a fear that the recent reconfiguration of Primary Care Trusts will result in further financial pressures, with consequent diminution of an already overstretched service. Indeed, since Primary Care Trusts have held complete responsibility for primary and secondary care commissioning, the range and volume of work has grown, increasing both workloads and the need for DPH advice and input. In many reconfigurations of PCTs and SHAs the Consultant in Dental Public Health has been the only person with the corporate memory for dentistry. This has resulted in them supporting and training new staff responsible for delivering the dental agenda within the organisations.

5.8 While the BDA welcomes the opportunity to raise the concerns of CsDPH afforded to it by membership of the Department of Health's Stakeholder Reference Group on the Dental Public Health Capacity and Capability Project, it is disappointing that the first meeting did not take place until June 2007. The BDA has also been asked by the Department to join with them in a survey of Salaried Primary Dental Care Services in England to identify the wider workforce engaged in dental public health services. The BDA welcomes this opportunity, but would hope that the project reports by the end of 2007, since we are aware of the strong likelihood of further posts being lost and the continued erosion of dental public health advice across the United Kingdom

5.9 The Chief Dental Officer is keen that PCTs embraces the new initiatives he has introduced for multi-agency working in regard to oral health such as "Practice-Based Prevention" and "Smoke Free and Smiling". These will require the input by Consultants in Dental Public Health for successful commissioning.

5.10 The BDA strongly backs the view of the Chief Medical Officer that public health budgets should be restored and urges the Chief Dental Officer to continue to promote public health so that Consultants in Dental Public Health can continue to provide an important NHS service at the local level.

CLINICAL ACADEMIC STAFF

Key points

- *There is great concern about the lack of apparent focus in strengthening and increasing the capacity of the UK's clinical academic workforce in the light of the Government policy to increase the number of domestically trained dentists; ultimately this may affect the quality of care delivered to patients. The BDA is worried at the implications of this lack of focus on staff morale and welfare.*

6.1 We continue to welcome the positive comments that the Review Body makes each year recognising the recruitment and retention issues facing Clinical Academic Staff (CAS) and their support for the principle of pay parity between Clinical Academic Staff (CAS) and NHS clinicians.

6.2 The BDA urges the Review Body to view our evidence in the context of the findings from the May 2007 *Clinical Academic Staffing Levels in UK Medical and Dental Schools* report. This report found that, as of July 2006, there were 435 full time equivalent (FTE) clinical dental academics in the UK and that this workforce has remained largely stable since 2004.

6.3 This is against the background of an anticipated 25 per cent increase in UK dental student numbers and the opening of two new dental schools. Consequently, this has, and will continue to, increase the burden and workload of the incumbent clinical academic workforce.

6.4 The pressures on CAS are not helped by the lack of transparency in the funding of dental schools and hospitals via Dental SIFT (Dental ACT in Scotland) and the Higher Education Funding Councils. Many institutions top slice dental undergraduate funding, making it more difficult to recruit new staff and appropriately reward existing staff.

6.5 Clinical academics also face being tasked with outreach teaching of dental undergraduates in a primary care setting, and this is on the increase, especially in the new dental schools where outreach will form a large part of the dental curriculum. Again, this adds to the already excessive workload of clinical academic staff.

6.6 Furthermore, the inconsistent implementation of the consultant contract, the Research Assessment Exercise and increasing demands in delivering patient care by

Primary Care Trusts are already beginning to take their toll on finite clinical academic resources.

6.7 The BDA's concern is that the consequence of a shortage of clinical academic staff and significant increases in workload may be that additional supervision and support are not available to students. Ultimately, this may affect the quality of care delivered to patients.

6.8 The clinical academic workforce has been operating at capacity for some time. Accommodating the larger cohort of dental students last year therefore caused real difficulties and emphasised the importance of retaining the current staff base. The weak incentives available to such staff do nothing to aid retention.

6.9 The allocation of a basic 10 Programmed Activities (PAs) for dental clinical academics in England (and 11 in Scotland) compared to their medical counterparts for whom allocations of up to 12 PAs are the norm, is clearly inequitable. The BDA believes that this inequity is a further disincentive for younger clinicians to consider a career as a dental clinical academic.

6.10 The *Clinical Academic Staffing Levels in UK Medical and Dental Schools* report also raises concerns about the diversity of the clinical academic workforce and notes that, as of the 31 July 2006, there were 12 female professors in the UK's dental schools, compared to 84 males. Although this is an increase of almost 18 per cent in the numbers of women in professional posts since 2004, it equates to the appointment of just 2.1 full time equivalent posts. This is clearly out of step with the profile of the profession, in particular new dental graduates. Although it is unclear as to the definitive underlying influences shaping the workforce, should this continue in the future there will be a critically acute shortage of clinical academic staff at a time when total UK dental student numbers peak.

6.11 Dental students need dedicated teachers as they routinely undertake irreversible procedures on the general public. The BDA believes that the ideal staff to student ratio should be a maximum of one to six, which cannot be achieved in many existing institutions due to a national shortage of clinical academic staff.

6.12 The BDA remains extremely concerned at the lack of apparent focus in strengthening and increasing the capacity of the UK's clinical academic workforce in the light of the Government policy to increase the number of domestically trained dentists. Furthermore, the BDA is worried at the implications of this lack of focus on staff morale and welfare.