British Dental Association

Evidence to

The Doctors' and Dentists' Review Body

For its thirty-ninth report

September 2009

Contents

Executive Summary

1. Dentists throughout the UK were very disappointed in the award given for 2009-10. They felt that it did not reflect the increase in expenses experienced across the board and in particular did not agree that the assumed reduction in laboratory costs reflected the true picture. (para 1.2.1)

2. As a result, we are asking the Review Body to revert this year to the old formula until such time as we have been able to agree an alternative, based on longer-term figures. We are also asking for retrospective correction for last year. (para 3.4)

3. The evidence that we have collected from members for this submission is showing that non-dental staff costs continue to rise at rates above inflation; equipment, material and laboratory costs have risen over the last year; and strengthened decontamination requirements are having an immediate or anticipated impact on practice costs. (para 2.3; 5.4)

4. The current economic environment is having a unique effect on dental practices as small businesses, due particularly to the fall in the value of Sterling. Rising standards of premises, service, equipment and treatment protocols are reflected in rising expenses. We believe that these two factors alone will have resulted in at least a 2.4 per cent rise in non-staff dental costs. (para 5.4.2; para 5.4.7)

5. Recession is also placing independently-operated dental practices at the mercy of economic forces. Dental practices provide important public services and it is vital that, as small businesses, they are supported through this difficult economic climate. The recession is changing patient behaviour which can lead to a greater number of missed or delayed appointments. Morale and motivation of dentists across the UK are flagging. (para 2.4; 5.1)

6. We think it is essential that a joint review of timings takes place this coming year: that is of length of time taken to undertake selected dental procedures. This has not been done for many years and we feel that changes in guidance and technology should be reflected in expenses. (para 3.5)

7. Recruitment in the salaried services is posing acute problems in providing adequate services, particularly for special needs groups. Both our own research and that published by NHS Benchmarking bears this out and it appears that it is a direct consequence of salary levels. (para 7.3)

8. We believe that DDRB should continue to make recommendations for changes to remuneration for all the current remit groups. We would welcome discussions on how to cater for the different contractual

systems and the different needs in the different countries in order to avoid a recurrence of the current year's difficulties and protect the viability of those delivering NHS dental care to the populations. (para 1.3.1)

BDA recommendations

1. We ask the Review Body to work with us to define an appropriate economic indicator to assess dental inflation. (para 2.3.2)

2. We ask that the Review Body works with us on developing a formula that is more suitable to the dental economic environment. (para 2.3.2)

3. We believe that it is essential that the flawed adjustment to the formula last year, which has caused a significant shortfall in remuneration, is corrected this year in order to safeguard the viability of practices. (para 3.4)

4. To correct last year's adjustment, we ask the Review Body to (para 3.4)

    - Agree with the Association that the old formula should be used for the award for all four countries of the UK until such time as the parties are able to agree a revised formula for the future, should that prove appropriate

    - Recalculate last year's award according to the old formula

    - Make a retrospective award for last year based on that recalculation. This would mean that the percentage uplift awarded for 2009-10 should have been 2.3 per cent, making the additional retrospective award 2.09 per cent

    - Compound the retrospective award in the award for this year.

    The correct formula would therefore be

    $$\text{Uplift}_{2009\text{-}10} = 0.45*x + 0.165*y + 0.385*z$$

    where:
    x= increase in GDP remuneration
    y = increase in staff costs
    z = increase in other costs

5. We seek a recommendation that the Health Departments and the British Dental Association undertake a comprehensive timings exercise to develop a more suitable method of determining the cost of providing dental services. (para 3.5.1)

6. For 2010-11, we ask the Review Body to (para 5.9.3)

- Make an award of 3.6 per cent on taxable income to reflect the pay awards made in the public sector

- continue to use the formula used for the 2008-09 pay award until such time as the parties are able to agree a revised and appropriate formula for the future. That formula is

  Uplift $_{YEAR}$ = 0.45*x + 0.165*y + 0.385*z

  where:
  x= increase in GDP remuneration
  y = increase in staff costs
  z = increase in other costs.

- make a retrospective recalculation using the previous formula for the 2009-10 pay award:

  For 2009-10, DDRB gave a net income award of 1.5 per cent and assumed that staff costs were to rise by 3.6 per cent and that all other costs were to rise by 2.7 per cent. Applying these to the original formula gives a revised 2009-10 uplift of 2.3 per cent for all four countries. Deducting the 0.21 per cent award last year, the retrospective award would be 2.09 per cent.

- Compound this retrospective award with a 2010-11 pay award, based on the original formula.

- Award a rise in taxable income of 3.6 per cent (public sector average earnings growth at July 2009)

- And a rise in staff costs of 3.6 per cent (public sector average earnings growth at July 2009)

- Apply RPI current at the time of the award.

- Current figures therefore would give a total award of 3.8 per cent on contract values, fee scales and other appropriate allowances, that is 2.09 plus 1.7 per cent.

7. For salaried dentists we ask for 3.6 per cent increase for all staff. We also ask for the addition of two incremental points to the top of the band A scale to address recruitment problems. (para 7.12)

1 Introduction

1.1 Parameters of the evidence

1.1.1 The British Dental Association (BDA) presents this written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for its thirty-ninth report for the year 2010-11. It is prepared under the terms of reference introduced in 1998 and all subsequent amendments. The evidence is submitted on behalf of dentists practising in the National Health Service (NHS) in all four countries of the United Kingdom (UK) and covers:

- Dentists in training
- General Dental Services and Personal Dental Services
- Salaried Primary Dental Care Services
- Dental Public Health
- Academic institutions (that is, clinical academic staff).

1.1.2 The British Medical Association (BMA) submits evidence on behalf of all hospital medical and dental staff. We ask the Review Body to note that the issues raised by the BMA are applicable to those working in the hospital dental service.

1.2 Response to the Review Body's thirty-eighth report

1.2.1 The award for 2009-10 was met with uniform disappointment in all spheres of practice and with particular dismay by general dental practitioners in Scotland and Northern Ireland, where it was felt that inappropriate extrapolations had been made from the English and Welsh situation. We pointed out that the award would do nothing to provide a much-needed boost for NHS dentistry and the Chair of the General Dental Practice Committee said '*Clearly economic prudence is essential for everyone. But it's also important to remember that high street dentists are running businesses that provide vital healthcare to millions of people. Those businesses must be properly funded so that they can invest in their premises and equipment to deliver the highest quality care to their patients'*.

1.2.2 At paragraph 3.4, we ask the Review Body to correct the anomalies that have occurred this year.

1.2.3 On the salaried side, representatives stressed that the award would not help staff and morale problems in their respective fields. Considerable problems have been demonstrated during the year in recruiting salaried

staff and we have been disappointed that the warnings in our last evidence went unheeded.

1.2.4 The texts of our press releases appear at annex 1.

1.2.5 In its last report, the Review Body asked the Departments of Health and the British Dental Association to work together with a view to submitting joint evidence on a number of areas where definitive evidence was difficult to find. We have met with the English Department to discuss how we might take this forward but have been unable to undertake this work in time for the current round. We shall meet again to discuss the matter in more detail.

1.3 Future role of the DDRB

1.3.1 We believe that DDRB should continue to make recommendations for changes to remuneration for all the current remit groups. We would welcome discussions on how to cater for the different contractual systems and the different needs in the different countries in order to avoid a recurrence of the current year's difficulties and protect the viability of those delivering NHS dental care to the populations.

2. The economic environment

Key points

- The current economic environment is having a unique effect on dental practices as small businesses, due particularly to the fall in the value of Sterling.
- Rising standards of premises, service, equipment and treatment protocols are reflected in rising expenses.
- The recession is having an effect on patient behaviour. Missed, delayed and cancelled appointments are affecting dentists' ability to meet their UDAs (England and Wales), and maintain their turnover (Scotland and Northern Ireland).
- We ask the Review Body to work with us to define an appropriate economic indicator to assess dental inflation and on developing a formula that is more suitable to the dental economic environment.

2.1 Investment in dental practice

2.1.1 High quality patient care requires highly-trained personnel who have the equipment and facilities necessary for first-class care. For patients to be at the centre of NHS dentistry, funding must be available to keep pace with the rising standards expected of premises, service, equipment and treatment protocols.

2.1.2 We recognise the unfavourable economic environment facing the country at the moment and the need for restraint. This environment is, however, having a unique effect on dental practices as they are meeting rising costs both in providing clinical services and as employers and small business people. This effect is explained in more detail in chapter 5.

2.1.3 We urge the Review Body to continue to acknowledge that general dental practitioners, more than any other NHS health professionals, are vulnerable to the state of the wider economy and that their small business status brings with it particular problems in a recession. Practices are unable to stand still in this environment: they must continue to improve and to comply with ever more demanding requirements.

2.1.4 Dental practices are built on the investment, borrowings and enterprise of dentists. The risk of delivering the vast majority of quality publicly-provided dental care is borne by dentists and not by the NHS. The loss of any dental practice providing NHS care can only restrict patient

choice and negatively impact access to care. The ongoing difficulties highlighted by the Treasury of small businesses securing borrowing remain a significant threat to the sustainable delivery of high quality NHS care.

2.1.5 Although affordability is of concern to the Review Body, the BDA urges it to consider the longer-term repercussions of their recommendations on recruitment, retention and morale as well as standards of service and premises.

2.2 Private and public sector pay rises

2.2.1 Average earnings in July 2009, excluding bonuses, are still showing an annual increase of 2.2 per cent. Public sector average earnings growth, excluding bonuses, stood at 3.6 per cent, with the private sector showing a lower annual increase of 1.8 per cent. The NHS Information Centre's report for 2007-8 demonstrates that general dental practitioners' taxable income is decreasing – see chapter 5.

2.3 Dental practice costs

2.3.1 In spite of the economic downturn, dental practice costs continue to rise:

- Materials and equipment costs have risen sharply as a consequence of the weakening of Sterling and the rise in precious and semi-precious metal prices.
- Practice owners are continuing to have to increase the pay of their dental care professionals (dental therapists, hygienists, nurses and technicians). They are experiencing considerable additional staffing costs due to supply and demand related to statutory regulation of dental nurses and the requirement for all dental care professionals to undertake continuing professional development.
- The introduction of greater decontamination requirements across the UK is increasing staffing, consumables and equipment costs as well as demanding more time in the surgery.

These are all directly impacting on practices' revenue and capital costs. We explain these in greater detail in chapter 5.

2.3.2 We have long maintained that for a number of reasons, described in subsequent chapters, dental inflation does not follow general inflation. The BDA asks the Review Body to work with us to define an appropriate economic indicator to assess dental inflation. We also ask

that the Review Body works with us on developing a formula that is more suitable to the dental economic environment.

2.4 Impact of the recession on patient behaviour – missed and delayed appointments

2.4.1 The recession is affecting both NHS and private dentists through changing patient behaviour. Results from the April 2009 BDA omnibus survey identified that over two in five dentists (41 per cent) reported increased cancelled appointments over the last 12 months, which they attributed to the economic recession.

2.4.2 Missed NHS dental appointments have a significant real cost. In England and Wales, dentists are unable to make a charge. The BDA's recent FOI request shows that over 41 per cent of dentists did not attain their UDA target in 2008-09 and it is highly likely that missed appointments will have played a part in this.

2.4.3 We have looked at the 2008-09 experience of two typical dental practices in different parts of the country that use sophisticated computer software to analyse missed appointments. In the year to 31 March 2009 (that is 365 calendar days), on average, each practice had around 440 missed appointments, which equated to a loss of 124 dentist hours (excluding lost hygienist time). If it is assumed that there are 9,500 dental practices in England and Wales and that this pattern is typical, then in 2008-09 there were around 4.2 million missed dental appointments – a loss of 1.2 million dentist hours. This cost, if it is assumed that the average UDA is £22 and that four UDAs are delivered per hour, is in 2008-09 conservatively estimated to be around £106 million, all of which is borne by dentists. The problem of missed appointments also seems to be getting worse; information from one of the practices showed that the number of missed appointments rose by 41 per cent between 2006-07 and 2008-09.

2.4.4 Another commonly reported effect of the recession is an increase in the number of patients delaying treatment or opting for cheaper treatment options. These findings are consistent with a BDA-commissioned survey earlier this year by YouGov of over 2,000 members of the public. This showed that around half of patients are likely to, or have already, cut back on checkups, whether NHS or private, as a result of the recession.

2.4.5 The change in patient behaviour as a consequence of the recession is proving to be a significant worry for dentists. More cancellations and the delaying of treatment make it ever more difficult for NHS practices to manage their appointment books efficiently and so there is increased difficulty in reaching UDA targets in England and Wales.

2.4.6 For the NHS, spaces in appointment books represent a waste of valuable clinical capacity. For dentists, they represent wasted time that can never be recovered. Given that overheads continue to accrue irrespective of activity, they are very costly to practitioners. Additionally, the lost opportunity to deliver UDA targets is now regularly impacting upon dentists in the shape of clawed back fees at the end of the financial year. In an effort to mitigate the effect of these lost hours, many practitioners are reporting that they are working extra hours in an effort to make up the shortfall. Thus the impact of failed appointments is threefold:

- Increased overheads
- Increased threat of clawback, and
- Increased workload.

Taken together, these factors have serious detrimental impacts on both morale and practice viability.

2.5 Small businesses

2.5.1 Overall, the recession is having a significant impact, as with so many other areas of the economy, on dentists and their businesses: this is set against a backdrop of rising need. Nonetheless, both the Secretary of State for Health, Andy Burnham (FN BBC Breakfast interview 10 June 2009), and Shadow Secretary of State, Andrew Lansley (FN HSJ article 10 June 2009), have said that they are committed to maintaining sustained investment in the NHS over the coming years, both perceiving investment in improving the quality and efficacy of services to be the long-term route to greater efficiency. It is, therefore, now more important than ever for dentists to be funded to continue to make the necessary investment in their practices and provide high quality dental care.

3 The uplift formula

Key points

- We believe that changing the formula in 2009-10 was premature and did not reflect the increase in expenses experienced across the board and was completely inappropriate for Northern Ireland and Scotland. In particular, the assumed reduction in laboratory costs did not reflect the true picture.
- We ask the Review Body to revert to the old formula and to recommend that a timings exercise takes place in preparation for the next round.

3.1 BDA view of the change to the formula for 2009-10

3.1.1 In our supplementary evidence last year, we strongly opposed any alteration of the formula used to derive the contract/fee uplift until such time as stable and robust information was available. We conceded that we would be happy to see future adjustments to the formula when all parties were agreed on an accurate dataset.

3.1.2 We reiterated the inconsistencies identified in the Information Centre's 2006-07 dental earnings and expenses information and stressed that our members did not feel that the new system in England and Wales had attained steady state, so that changes in treatment patterns, as demonstrated by the Information Centre, should be regarded as transitory. In our view, there was no strong evidence-based justification to adjust the formula.

3.1.3 Despite our misgivings, the Review Body opted to adjust the formula significantly for its 2009-10 recommendation with very detrimental results.

3.2 The detail of the BDA's concerns

3.2.1 We believe that the structure of the new formula and the underpinning assumptions are inconsistent and result in fragile conclusions. Our members in Scotland and Northern Ireland are angered that it has been applied to them. The inconsistencies include

- The formula weightings are derived from different sources of information – for example, the laboratory costs come from NASDA

information, whilst the expenses ratio comes from the Information Centre. Using different sources of information, which follow differing methodologies, can lead to unreliable conclusions.

- The derived weightings use information relating to dentists with differing NHS commitment across inconsistent time periods – for example, staff costs are based on 2006-07 information relating to mainly NHS dentists, yet materials costs information is based on 2004-05 data relating to the average dentist with an average NHS commitment.

- The formula uses inconsistent time periods across the assumptions that deliver the uplift – for example, dentists' taxable income, staff, materials and other practice costs have been assigned an annual growth assumption, but the assumption for laboratory costs is taken across two years (that is 2004-05 to 2006-07). This very significantly increased the effect of any apparent reduction in laboratory work.

- The formula inconsistently uses a weighting of 0.065 for laboratory costs (which is equivalent to 6.5 per cent) despite the Review Body stating that laboratory costs as a proportion of practice costs was 9.0 per cent, or 0.09, in 2006-07 (Review Body on Doctors' and Dentists' Remuneration, Thirty-Eighth Report 2009 – paragraph 4.82).

3.2.2 We also believe that available information has been applied incorrectly in constructing the formula:

- Despite our emphasising the Information Centre's warning about the robustness of the expenses information in the first year of the new dental contract, the expenses ratio was adjusted from 55 per cent to 50 per cent on an incorrect assumption that expenses had fallen in that way. For a practice with an average NHS commitment, the Review Body took the proportion of practice costs attributed to laboratory costs and from this understood that those costs as a proportion of practice costs fell from 13 per cent in 2004-05 to 9.0 per cent in 2006-07 – a reduction of 31 per cent. But, due to a number of NHS transitional arrangements, described next, almost all NHS dentists in England and Wales experienced a one-off increase in NHS turnover, causing what was only a mathematical reduction in the 2006-07 expenses ratio. The adjustment also took no account of rising laboratory prices and the fact that, if dentists were in fact undertaking less laboratory work, they were doing other treatments incurring other costs.

- As a result of the transitional arrangements in England and Wales, in 2006-07, nearly all practices received 13 months' worth of NHS payments because of the change from claims-based to regular monthly payments. Around one-third of the approximately 9,500 practices in England had higher contract values prior to April 2006

due to a transfer from GDS to PDS contracts to reflect new ways of working, and these tended to have high NHS commitment. Those PDS practices were assigned lower than average UDA targets, so incurring lower materials and laboratory costs (but not other expenses); and orthodontic payments were front-loaded on to contract values so boosting turnover. In the first year of the new contract, orthodontic dentists' turnover was twice that of non-orthodontic dentists (£397,000 compared with £198,000), but by the second year this turnover gap was lower (£350,000 compared with £188,000). The impact of all these factors is very significant indeed due to their scale and adversely affected GDS practices.

- Our contention therefore is that the use of the 50 per cent expenses ratio in the formula fails to take account of the complexities of the 2006-07 figures and so the consequent adjustment of the weightings in the formula to accommodate this change is incorrect.

- A closer examination of the medium and long-term trends in the price and quantity of laboratory work carried out in the NHS would also, we believe, have led to a different conclusion. A significant amount of dental treatment requiring laboratory work (for example, crowns) was cheaper to patients prior to the introduction of the new NHS contract in 2006. In order to avoid the increased cost, many patients completed required complex treatments prior to April 2006, thereby reducing their need for such treatment in 2006-7.

3.3 The consequences for Scotland and Northern Ireland

3.3.1 We also contend that the new formula was not appropriate for determining the uplift to fees in Scotland and Northern Ireland: no new NHS contract has been introduced in these countries, nor is there any evidence that laboratory work reduced. In fact, information from the Northern Ireland Central Services Agency and the Scottish Dental Practice Board shows that, between 2004-05 and 2006-07, the cost as a proportion of total NHS turnover for items with laboratory work rose from 32.1 per cent to 33.6 per cent in Northern Ireland, and remained stable at 33.5 per cent in Scotland. Our Business Trends Survey (BTS) reported below reports a significant increase in laboratory work in those countries.

3.3.2 Rather than applying the same formula because there appeared to be no evidence to do otherwise, we argue that the approach should have been to assume that laboratory costs in Scotland and Northern would have risen by 2.7 per cent (that is, RPI). This would have delivered an uplift in fees of 2.4 per cent.

3.4 BDA submissions to correct the position

3.4.1 We believe that it is essential that the flawed adjustment to the formula which has caused a significant shortfall in remuneration must be corrected this year in order to safeguard the viability of practices. We ask the Review Body to

- Agree with the Association that the old formula should be used for the award for all four countries of the UK until such time as the parties are able to agree a revised formula for the future, should that prove appropriate
- Recalculate last year's award according to the old formula
- Make a retrospective award for last year based on that recalculation. This would mean that the percentage uplift awarded for 2009-10 should have been 2.3 per cent, making the additional retrospective award 2.09 per cent
- Compound the retrospective award in the award for this year.

3.4.2 The correct formula would therefore be

$$\text{Uplift}_{2009\text{-}10} = 0.45*x + 0.165*y + 0.385*z$$

where:

x= increase in GDP remuneration
y = increase in staff costs
z = increase in other costs.

3.5 The use of the formula in future

3.5.1 Because of the fragility of the formula and of the best available data, the developments in patterns of clinical dentistry that have taken place over the last five years, and the manner in which dental contract values are now including quality, as well as quantity, measures, we ask the Review Body to recommend that the Health Departments and the British Dental Association undertake a comprehensive timings exercise to develop a more suitable method of determining the cost of providing dental services. In the meantime, we believe that the old formula should be used this year.

4. Dentistry in the UK – developments in 2008-09

Key points

- The Health Select Committee raised a number of concerns in its report on dental services in England. It painted a poor picture of the new dental contract and the way in which it had been introduced and implemented.
- We have expressed support for the report of the Steele review of dental services in England and look forward to working with the Department of Health and other stakeholders in developing the proposals.
- Changes to contracting are to be piloted in Wales.
- Discussions continue in Northern Ireland on a new remuneration system and pilots are beginning. There has also been an extension of patient registration to 24 months.
- In Scotland, the profession is very concerned at plans for lifelong registration of patients as it feels that it will be detrimental to patient care due to their lack of capacity to cope with the demand that will be created. The proposal follows an existing extension of registration to four years.
- There is significant instability in the salaried services caused by uncertainty over the future of many services and poor salaries which are causing recruitment and retention difficulties.

4.1 General

4.1.1 Dentistry has featured highly in the healthcare debate again in 2008-9, with patient access and, increasingly, initiatives looking at quality in commissioning, service delivery and clinical practice dominating the political agenda. Clearly, access to high quality NHS dental services remains a high priority for patients. This is reflected in the political priority being afforded to dentistry with significant work being undertaken on access and quality initiatives, service reviews, new contract negotiations and divestment of provider services across all four countries. If high quality NHS dentistry is important to the population of the UK, then ensuring that it is properly funded must also be a priority.

4.1.2 The GDS contract continues to have a profound impact on practitioners in England and Wales, which is explored in more detail in section 6. Following on from the 2008 Health Select Committee report into dental services, the Steele Review has now published its final report, making far-reaching recommendations for the reform of the provision of dental

services and the contractual arrangements in England; the Welsh Task and Finish Group has made a number of recommendations to change aspects of the contract (see paragraph 4.3.1).

4.1.3 In Scotland, the Scottish Government Health Department (SGHD) has introduced a four-year patient registration period and is proposing lifelong patient registration. The profession in Scotland has serious concerns about the implications of lifelong registration for the timely availability of care given the already severe workload and workforce problems.

4.1.4 In Northern Ireland, where the payment system also remains based on item-of-service fees, pilots are being developed for alternative remuneration systems following continuing discussions with the profession. These are, however, at a very early stage.

4.1.5 Salaried services in England are also in the midst of fundamental organisational change. The drive towards complete commissioner-provider split – leading to full divestment of salaried services into social enterprise or community foundation trust model organisations – is progressing with services in each PCT being required to decide on their future this autumn. Services are at greater risk than ever before as PCTs increasingly put former provider unit contracts out to tender. Discussions about opening contract negotiations for the new SDS contracts are progressing extremely slowly in both Scotland and Northern Ireland. We remain disappointed that comments made in paragraph 5.7 of the Thirty-Eighth Report appear not to have been acted upon by either the Scottish Government or Northern Assembly with any great degree of determination. It appears unlikely that either country will be in a position to implement any changes by April 2010. As is evident, however, arrangements for the provision of NHS dental services in the different countries across the UK are increasingly divergent, with each seeking to address its own oral health challenges. As a result, in addition to our general evidence, the Association believes that it is appropriate to explore the impact of these developments individually.

4.2 England

4.2.1 Health Select Committee report into dental services

4.2.1.1 The House of Commons Health Select Committee reported on NHS dental services in June 2008, to which the Association responded last autumn.

4.2.1.2 Overall, we welcomed the conclusions of the report, particularly its recognition of the shortcomings of the 2006 GDS contract arrangement and the subsequent detrimental impact on the profession. The Association believes that the fact that the Select Committee, on the weight of the evidence presented by a range of stakeholders, came

down significantly in favour of the arguments advanced by the BDA on behalf of the profession, is a compelling steer from an independent body on the real state of NHS dentistry.

4.2.1.3 The Select Committee raised a number of key concerns in its report, noting:

- That the negative impact of introducing an untried and untested, and unpopular, system of remuneration (UDAs) had been significant, particularly as UDA targets were often implemented too rigidly; (paras 175-77)
- That the 2006 contract had so far failed to improve access to NHS services; (para 74)
- That there was a lack of sufficient commissioning expertise within some PCTs, and that amongst most there was a need for improved professional input and engagement in commissioning; (para 211-2)
- That the 2006 contractual arrangements had not seemed to support or incentivise the provision of preventive care; (para 100)
- That the 2006 contractual arrangements had transferred financial risk from the NHS to dentists without sufficient security, eroding the traditional autonomy of providers to manage their business and creating disincentives towards investment on the part of the practitioner; (para 203)
- That the NHS had relied on the recruitment of overseas dentists to enable PCTs to replace much of the lost NHS capacity following 2006; (para 198)
- That there were concerns that dental school graduates would not choose to practise in the GDS following their graduation, recommending that the Department of Health take steps to ensure that it remains an attractive career option. (para 197)

4.2.1.4 The BDA also supported the Health Select Committee in welcoming the Department of Health's decision to establish a review of how dental services will develop over the next five years, including an analysis of service and workforce requirements (the Steele Review).

4.2.2 The Steele Review of NHS dental services in England

4.2.2.1 In response to the publication of the 2008 Health Select Committee report into dental services, the Government announced the Steele Review of NHS dental services in England (*An independent review of NHS dental services in England (2009)*. In recognition of the many criticisms and concerns the Select Committee had raised, the remit of the Steele Review team was framed to:

- identify ways the Government and local NHS can work together with dentists and other providers to increase access to dental services and improve the quality of services;
- suggest how the government can build on its work to reduce inequalities in oral health and ensure that dentists and other dental professionals can provide appropriate levels of preventive work;
- recommend how funding for dentistry should be allocated to Primary Care Trusts to support these aims and meet the needs of local populations;
- identify how over the next five years, developments in workforce planning, training and regulation can best support the provision of high quality NHS dental services and enhance the working lives of dental professionals;
- recommend how the Government can best address the issues raised in the Health Select Committee's 2008 report.

4.2.2.2 The BDA has welcomed the conclusions of the Steele Review team. We were pleased to see that it sought to address the clear flaws in the current GDS contract, recognising that the provision of high quality oral healthcare requires significant investment of time and resources on the part of the dentist – something which the current 'treadmill' does not adequately support.

4.2.2.3 There are several conclusions and recommendations of the report which we believe are particularly important to the Review Body's deliberations.

4.2.2.4 The report recognised (page 27) that the introduction of the current GDS contract in 2006 has had a serious impact on morale within the profession, summarising the experiences of the profession as:

- a sense of professional frustration about how they feel they are having to practise, and a perception that it adversely affects their patients
- the perceived uncertainty it creates, particularly in terms of business risk
- poor or inappropriate commissioning is frustrating
- a general suspicion of government motives and the lack of piloting
- growing bureaucracy.

4.2.2.5 As a consequence, the report stressed the need for government and the NHS to reaffirm their commitment to NHS dentistry, and in doing so recognise the importance of good oral health to good general health across a lifetime.

4.2.2.6 With regard to the transfer of business risk from the NHS to the individual practitioner, the Steele report endorsed the position of the BDA and the verdict of the Health Select Committee, agreeing that *"under the pre-2006 arrangements, the development growth and continuity of the NHS elements of a dental practice or business were largely in the control of the practice owner. Local commissioning changed that, shifting control to the local PCT."* (page 29)

4.2.2.7 The report also supported the findings of the Health Select Committee pertaining to the current GDS contract arrangements. Specifically, it highlighted that the use of the UDA, as the single unit of currency, is counterproductive and inappropriate, recognising that *"there is no single contract currency which is capable of reflecting the complex nature of the delivery of modern dental care"*. (page 64)

4.2.2.8 As a result, the report calls for fundamental reform in the way in which dentists are remunerated, and the delivery of primary dental care organised; recommending that dentistry be commissioned and delivered around a staged care pathway, allowing and supporting a continuity of care relationship for those patients who want it, while maintaining access to urgent and ad hoc care for those who do not.

4.2.2.9 The report envisages contracts and remuneration based upon payments for continuing care responsibility, blended with rewards for activity and quality. It suggests introducing specific payments related to taking on new patients, recognising that the level of activity may initially be higher, something which currently poses a significant financial risk to the provider which is unsupported in the existing GDS contract.

4.2.2.10 The Steele Review highlighted that, in order to support the provision of high quality dental care, there is a need for significant investment in the dental estate. In particular, it recommended that the NHS make a clear commitment to ensuring that all NHS dental practices are computerised by the end of 2011, enabling the easy transfer of data from chairside to the NHS Business Services Authority and other bodies to support information extraction on quality and outcomes. Yet, as the Review notes, dentists are currently responsible for ensuring investment in their practices.

4.2.3 NHS Next Stage Review

4.2.3.1 The NHS Next Stage Review published its final report '*High Quality Care for All'* in 2008, setting out a vision for the future of the NHS. Recognising the importance of training, education and workforce planning in achieving this vision, the Review also incorporated a work stream considering the future NHS workforce.

4.2.3.2 The report of this work stream, *'A High Quality Workforce'*, sets out ambitious guiding principles for the future development of the NHS workforce, including new arrangements for workforce planning centred on:

- focusing on quality
- delivering patient-centred care
- being clinically driven
- flexibility
- valuing people
- promoting lifelong learning.

4.2.3.3 The current GDS contractual arrangements do not support the realisation of these principles. Dentists still work within a system driven by achieving activity targets and not health outcomes or patient care and there is no provision for supporting the NHS independent contractor workforce. This has been recognised by the establishment in January 2009 of a Dental Programme Board within Medical Education England (MEE), a body responsible for the workforce planning and overseeing nationally of the education and training arrangements for doctors, dentists, pharmacists and healthcare scientists.

4.2.4 NHS Operating Framework and access initiatives

4.2.4.1 The NHS Operating Framework 2009/10 raised the profile and priority afforded to dentistry within the NHS. It identified as priorities for PCTs and SHAs the need to continue to develop NHS dental services, improve access and quality of care, and reduce oral health inequalities. In particular, the operating framework stressed the need for PCTs to improve dental commissioning, including reviewing their commissioning strategies and ensuring open and transparent procurement processes.

4.2.4.2 Alongside the Operating Framework, the Department of Health announced a welcome 8.5 per cent increase in the dental budget. This funding is allocated to PCTs by SHAs but is not necessarily spent on additional dental services.

4.2.4.3 The increased priority afforded to improving access to NHS dentistry is also reflected in the roll-out of the Department of Health's 2009 access initiatives. In England, the NHS has a significant target to ensure that by March 2011 anyone who wants NHS dentistry will be able to access it; the aim is to return to 1993 attendance levels.

4.2.4.4 The Department intends to procure new services in identified priority areas of England this autumn, but it intends to use radically different, commercially-focused contractual arrangements that would exclude the majority of general dental practitioners from tendering. At the time of writing we are in discussion with the Department of Health with a view to making the terms more appropriate and achievable.

4.2.5 Quality initiatives

4.2.5.1 The 2008 Health and Social Care Act brought the functions of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission into a single independent body to regulate the quality of all health and social care provision – the Care Quality Commission. From 2011 all dental practices will be required to register with this new body, and in doing so will have to demonstrate compliance with 16 significant new registration requirements. In Wales, practices providing any level of private work must register with Healthcare Inspectorate Wales.

4.2.5.2 The 2009 Health Bill also sets out legislation for the introduction of quality accounts, which from 2011 will require all dental practices to publish annual quality accounts, assessing their performance against a series of nationally and locally determined quality markers.

4.2.5.3 As a consequence of the introduction of both quality initiatives, the Association is currently very concerned that the profession is facing a large surge in the amount of bureaucracy and expense required of ordinary practitioners. There will be a significant cost involved in meeting the new requirements and for small practices this will mean a further extension of dentists' administrative working hours or employing additional administrative staff and the real ongoing costs of implementation. We shall return to this in the future.

4.3 Wales

4.3.1 Task and Finish Group

4.3.1.1 A sub-group of the Welsh Assembly Government Task and Finish group, which was established to examine the first year working of the 2006 contractual arrangements, reported its findings in 2008. As a result of the group's recommendations, the protection of the overall dental budget has been extended until 2012.

4.3.1.2 The Task and Finish group has also now established a number of sub-groups; of specific note is the group tasked with considering alternatives or variations to UDAs and a second looking at the orthodontic contract. These are due to report in 2009. The Welsh Minister has agreed in principle to pilots based on alternative commissioning methods and deprivation-based weighting. There will, however, be no extra funding available and the pilots must work within the existing financial envelope.

4.4 Northern Ireland

4.4.1 Developments in General Dental Services

4.4.1.1 The payment system used in Northern Ireland is unique to Northern Ireland and should be considered as such.

4.4.1.2 The pay award has been implemented later in Northern Ireland for the last two years. In 2008, the award of 3.4 per cent was announced in June and implemented in October, backdated to April. In 2009, the award of 0.21 per cent was accepted in April, implemented in October and again backdated.

4.4.1.3 Department of Health Social Services and Public Safety Northern Ireland, in its last evidence to DDRB supported a 2 per cent pay award to dentists in Northern Ireland for 2009-10.

4.4.1.4 As part of the 2009 pay round, the quarterly commitment payments to dentists have been increased by 75 per cent. Prior to April 2009, commitment payments represented 1.79 per cent of dentists' pay (Annex 2). With the increase, this now represents an estimated 3 per cent of the GDS pay pot. Commitment payments are a reward for commitment to Health Service general dental services and dentists become eligible for the payment when their name has been on the dental list for at least five years.

4.4.1.5 From 1 August 2009 any patient registering with a dentist will now be registered for 24 months, an increase from the previous registration period of 15 months. No additional spend will be incurred in the dental budget through this change until 15 months have elapsed (October 2010) from the date of implementation.

4.5 Scotland

4.5.1 Developments in the General Dental Services

4.5.1.1 Although there are plans for a number of significant changes to the way in which general dental services in Scotland will be delivered in the future, the timetable is uncertain. The proposals include the development of an oral health assessment, consolidation of the Statement of Dental Remuneration and a proposal to introduce continuous (lifelong) patient registration.

4.5.2 Continuous (lifelong) patient registration

4.5.2.1 The Scottish Government intends to introduce continuous (or lifelong) patient registration in April 2010. The Scottish Dental Practice Committee (SDPC) of the BDA has considerable concerns with this

development, as it believes that there will be insufficient capacity, with practices already managing substantial patient lists. There is therefore the danger that it will not be possible to meet patients' expectations in accessing care, whether they are regular patients who have always maintained registration or irregular patients who expect to be seen quickly. The SDPC has explained to SGHD that a time-limited registration period encourages a pattern of regular attendance and is therefore conducive to maintenance of oral health and that it is concerned that continuous (lifelong) registration would remove this emphasis. The Committee has consulted with the profession in Scotland and results are being analysed.

4.5.3 Funding

4.5.3.1 The Scottish Government has pledged continued funding for general dental services at the same level of the final year of the three-year dental action plan, implemented in March 2005. From a baseline of £200 million, funding was to have been raised by £45 million in the first year (year one total £245 million), by £100 million in the second year (year two total £300m) and by £150 million in 2007-08, resulting in a year three total of £350 million.

4.5.3.2 From figures provided to the BDA by SGHD, the actual amounts spent on general dental services in each of the three years were:

Year one	£241,001,898
Year two	£293,789,917
Year three	£317,497,107

4.5.3.3 These sums included non-salaried GDS spend, salaried GDS spend, education and training, dental bursary, clinical and special waste collections and the Scottish dental access initiative. Consequently, there appears to have been an underspend in each of the three years of the Dental Action Plan of £3,998,102, £6,210,083 and £32,502,893.

5. The coming year's award: general dental practice

Key points

- The BDA's Business Trends Survey demonstrates seriously low morale and motivation and that high NHS commitment equates with low morale.
- Recruitment of dental staff continues to be a problem.
- Few dentists are planning to increase their NHS practice.
- Workload and working hours are increasing, both in terms of clinical and administration commitment.
- Practice profitability is decreasing markedly.
- Costs are rising, with the fall in value of Sterling having a significant effect.
- Pensions contributions are increasing, while benefits reduce.
- The pensions dynamising factor has been misapplied.
- Young dentists leaving vocational training are continuing to find it difficult to find suitable posts. We are concerned that this situation will become acute in 2011 when new graduate output is set to increase**.**
- We recommend an uplift to taxable income of 3.6 per cent in line with public sector pay.

5.1 Morale and motivation

5.1.1 The Association has long contended that the morale and motivation of dentists has been suffering across the UK; the evidence from the BDA's 2009 Business Trends Survey (BTS) clearly shows that morale is indeed seriously low. Two-thirds of dentists in England reported their morale as being 'neither high nor low', 'low' or 'very low'. The picture in the other countries is similarly troubling, with the respective figures being six out of every ten dentists in Scotland and Northern Ireland and three-quarters of dentists in Wales.

Percentage of dentists reporting that their morale was 'high' or 'very high'; 'neither high nor low'; or 'low' or 'very low' by country

	England	Wales	Scotland	Northern Ireland
'Low' or 'very low'	28%	31%	21%	31%
'Neither high nor low'	38%	44%	39%	35%
'High' or 'very high'	34%	25%	40%	34%
BASE	907	126	246	107

Source: BDA BTS 2009, base figures in brackets

Percentage of dentists reporting that their morale was 'high' or 'very high' by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	22% (36)	23% (13)	25% (12)	0% (2)
75-99% NHS	26% (373)	20% (61)	31% (121)	26% (47)
50-74% NHS	25% (97)	21% (14)	45% (29)	24% (21)
25-49% NHS	31% (80)	18% (11)	46% (24)	39% (13)
1-24% NHS	40% (180)	35% (20)	57% (47)	55% (20)
0% NHS	61% (135)	57% (7)	64% (11)	100% (4)
ALL	32% (907)	25% (126)	40% (246)	34% (107)

Source: BDA BTS 2009, base figures in brackets

5.1.2 Morale is worse amongst those dentists with a high commitment to the NHS. Dentists with the least commitment to the NHS were more likely to report their morale as 'high' or 'very high', even in the current challenging economic market. Committed NHS dentists also report lower levels of job satisfaction and were less likely to 'agree' or 'strongly agree' with the statement *I am satisfied with my job as a dentist.* In England, for example, only one-third per cent of fully-committed NHS dentists reported that they 'agree' or 'strongly' agree with the statement, compared with over 80 per cent of fully private dentists.

Percentage of dentists reporting that they 'agree' or 'strongly agree' with the statement 'I am satisfied with my job as a dentist' by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	39% (36)	54% (13)	67% (12)	50% (2)
75-99% NHS	54% (372)	48% (61)	65% (121)	57%(47)
50-74% NHS	59% (97)	64% (14)	72% (29)	48% (21)
25-49% NHS	60% (80)	50% (12)	75% (24)	54% (13)
1-24% NHS	73% (180)	70% (20)	83% (47)	65% (20)
0% NHS	82% (135)	83% (6)	73% (11)	100% (4)
ALL	62% (905)	56% (126)	71% (246)	58% (107)

Source: BDA BTS 2009, base figures in brackets

5.1.3 In our survey, nearly half of the dentists in England reported that their morale had declined in the last 12 months. A similar picture is apparent in Wales. In Northern Ireland and Scotland, however, the picture is not quite as bad, but with over one-third of dentists also reporting a decline in morale in the past year.

Percentage of dentists reporting how their morale has changed over the last year by country

	England	Wales	Scotland	Northern Ireland
Improved morale	12%	5%	14%	14%
Stayed the same	44%	46%	50%	*42%*
Lower morale	44%	49%	36%	44%
BASE	904	126	245	107

Source: BDA BTS 2009

5.1.4 In terms of the causes of low morale, the costs and additional workload associated with decontamination and infection control are a serious source of anxiety for practitioners UK-wide, an issue we consider in greater detail elsewhere.

5.1.5 In England and Wales the continuing and well-documented problems dentists experience working within a flawed contract are having a persistent impact on morale. The effect of the "UDA treadmill" and working within a target-driven NHS cause pressure for practitioners with a large NHS commitment. Seventy-six per cent of dentists in Wales and 66 per cent in England reported that they 'agree' or 'strongly agree' with the statement *I feel under pressure to achieve targets*, compared with 49 per cent in Northern Ireland and 36 per cent in Scotland.

Percentage of dentists reporting that they 'agree' or 'strongly agree' with the statement 'I feel under pressure to achieve targets, by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	75% (36)	100% (13)	42% (12)	0% (2)
75-99% NHS	83% (372)	82% (61)	36% (121)	57% (47)
50-74% NHS	84% (97)	100% (4)	45% (29)	43% (21)
25-49% NHS	72% (80)	75% (12)	17% (24)	54% (13)
1-24% NHS	53% (180)	50% (20)	36% (47)	45% (20)
0% NHS	19% (134)	14% (7)	46% (11)	0% (4)
ALL	66% (904)	76% (127)	36% (246)	49% (107)

Source: BDA BDT 2009, base figures in brackets

5.1.6 In Scotland and Northern Ireland, a major factor contributing to low morale is the constantly increasing practice overheads, in particular the costs associated with decontamination/infection control. This is compounded by the ever-growing volume of dental administration required (which we explore in more depth below), the inadequate uplifts to the fee scale and increasing patient expectations. In Northern Ireland there are also real concerns about proposed new NHS contracts and their implementation.

5.2 Recruitment and retention

5.2.1 The problems that NHS dental practices face in recruiting high quality, qualified staff are also well documented within the 2009 Business Trends Survey; with 62 per cent of dentists in Northern Ireland, 42 per cent in Scotland, 30 per cent England and 42 per cent in Wales reporting that they 'disagree' or 'strongly disagree' that *the practice has no problem recruiting dentists to do NHS dentistry*.

5.2.2 Market forces appear to be exacerbating the difficulties of attracting well-qualified support staff to NHS practices. Seventy-four per cent of dentists in Northern Ireland, 60 per cent in Scotland, 53 per cent in England and 53 per cent in Wales 'disagree' or 'strongly disagree' with the statement that *the practice has no problem recruiting appropriately skilled dental nurses*. Committed NHS dentists are also less likely to 'agree' or 'strongly agree' that *the practice is able to reward DCPs with competitive rates of pay*. If practices with large NHS commitments are unable to attract well-qualified staff, their ability to continue to deliver high quality NHS patient care and meet essential requirements will be seriously jeopardised.

Percentage of dentists who 'agree' or 'strongly agree' with the statement 'the practice is able to reward DCPs with competitive rates of pay' by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	22% (36)	31% (13)	17% (12)	0% (2)
75-99% NHS	28% (363)	20% (60)	19% (119)	19% (47)
50-74% NHS	30% (95)	29% (14)	38% (29)	24% (21)
25-49% NHS	33% (80)	33% (12)	46% (24)	64% (11)
1-24% NHS	50% (180)	40% (20)	59% (46)	67% (18)
0% NHS	60% (131)	57% (7)	50% (10)	50% (4)
ALL	38% (890)	29% (126)	33% (242)	39% (103)

Source: BDA BTS 2009, base figures in brackets

5.2.3 Dentists' concerns are clearly reflected in the reported trends towards private practice, with very few planning to increase their NHS work over the next three years: most intend to increase private work. Despite the prevailing economic climate, it is apparent that a significant number of dentists do not currently consider expanding their NHS commitment as attractive or viable.

Percentage of dentists who 'agree' or 'strongly agree' with the statement 'I am planning to increase my amount of private dentistry within the next three years'; and 'I am planning to increase my amount of NHS dentistry within the next three years' by country

	England	Wales	Scotland	Northern Ireland
Increasing private	60%(882)	59% (126)	53% (243)	79% (107)
Increasing NHS	10% (885)	7% (126)	9% (244)	10% (107)

Source: BDA BDT 2009, base figures in brackets

5.3 Workload

5.3.1 Dentists across the UK are reporting increasing their hours and spending more time undertaking clinical dentistry. These results are consistent with an increase in the overall numbers of patients being seen by dentists.

Percentage of dentists reporting how the hours spent performing clinical dentistry per week has changed over the last financial year (2008-09)

	Increased	Decreased	Stayed the same	BASE
England	29%	17%	54%	913
Wales	31%	12%	57%	128
Scotland	24%	19%	57%	248
Northern Ireland	38%	15%	47%	109

Source: BDA BTS 2009

5.3.2 The numbers reporting more time spent on dental administration over the last year is even more noteworthy given that the burden of administration is only likely to continue to grow in 2009-10 and beyond, to comply with new government requirements to, for example, publish quality accounts and register with the Care Quality Commission.

Percentage of dentists reporting how the hours spent on dental administration per week has changed over the last financial year (2008-09)

	Increased	Decreased	Stayed the same	BASE
England	64%	5%	31%	897
Wales	57%	4%	39%	127
Scotland	60%	6%	34%	245
Northern Ireland	70%	5%	25%	107

Source: BDA BTS 2009

5.3.3 The opportunity cost for all dentists fulfilling burgeoning administration requirements is significant; and, although the results also show that the burden of dental administration tends to fall on practice owners, a significant proportion of associates/performers have seen their clinical administration rise in 2008-09.

Percentage of dentists reporting an increase in the hours spent on dental administration over the last financial year (2008-09) by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	75% (36)	38% (13)	39% (13)	100% (2)
75-99% NHS	70% (370)	57% (60)	63% (119)	85% (47)
50-74% NHS	72% (97)	64% (14)	66% (29)	72% (21)
25-49% NHS	63% (79)	67% (12)	38% (24)	50% (12)
1-24% NHS	62% (173)	52% (21)	61% (46)	57% (21)
0% NHS	41% (136)	71% (7)	67% (12)	0% (4)
ALL	64% (897)	57% (127)	60% (245)	70% (107)

Source: BDA BTS 2009, base figures in brackets

5.4 Profitability and expenses

5.4.1 Turnover and profitability

5.4.1.1 While many practice owners report increased practice turnover in 2008-09 (as well as working hours), it is extremely worrying to see that the proportion reporting rising practice profit is significantly lower. This suggests that the practice expense ratio has risen in 2008-09 and that the costs of running an NHS practice are rising faster than previously supposed and impacting on profitability. This must point to fragility in

the future sustainability of the service as practitioners turn away from the NHS and see more profitable business in the private sector.

5.4.1.2 This trend is reflected across the UK. In England, while 44 per cent of practice owners reported an increase in practice turnover, only 23 per cent reported a rise in practice profit; in Northern Ireland the respective responses were 53 per cent compared to 19 per cent; in Scotland 63 per cent compared to 28 per cent; and in Wales 30 per cent compared to 15 per cent.

5.4.1.3 As a consequence, practice profitability fell in 51 per cent of practices in England, 65 per cent in Wales, 54 per cent in Northern Ireland and 44 per cent in Scotland. It was practice owners with higher NHS commitments who were more likely to report a decrease in practice profits than their highly-committed private colleagues. These trends will impact adversely on the sustainability of delivering high quality NHS patient care.

Percentage of practice owners reporting that their practice turnover and/or practice profitability has decreased over the last financial year (2008-09) by country and NHS commitment

	England	Wales	Scotland	Northern Ireland
100% NHS	73% (15)	60% (5)	80% (5)	0% (0)
75-99% NHS	54% (170)	71% (31)	45% (64)	57% (23)
50-74% NHS	53% (59)	73% (11)	50% (18)	46% (13)
25-49% NHS	68% (50)	50% (8)	40% (15)	71% (7)
1-24% NHS	47% (129)	60% (15)	37% (30)	50% (14)
0% NHS	36% (98)	60% (5)	50% (10)	50% (2)
ALL	51% (524)	65% (75)	44% (144)	54% (59)

Source: BDA BTS 2009, base figures in brackets

5.4.2 The value of Sterling and its effects on practice costs

5.4.2.1 There is very little dental industry in the UK, so virtually all equipment, materials and consumables are imported. The decline in the value of Sterling has therefore had a significant impact on practice costs. In August 2008, 53 pence could buy one US dollar and 79 pence could buy one Euro – by August 2009 it cost 60 pence to buy one US dollar (a rise of 13 per cent) and 86 pence to buy one Euro (a rise of 9 per cent).

5.4.2.2 We compared catalogue prices of ten typical, essential items of equipment, materials and consumables in October 2008 and August 2009. All showed an annual increase in price, with the highest annual

increase being 74 per cent for composite resin. The annual increase in the price of a set of one of each of the ten items was 29 per cent.

5.4.3 Decontamination

5.4.3.1 We shall return in the future with evidence demonstrating the additional costs incurred in complying with the varying requirements in each country. In Scotland, many Health Boards have made capital grants for equipment, but dentists are experiencing significant increases in their running costs, including the need for more staff, taking more time, investing in more equipment (both for the sterilisation process itself and to augment clinical instrumentation necessary as a result of added cycles) and incurring significantly greater consumable costs. In England, the new decontamination requirements are very recent and for the most part dentists are waiting for further information on what funding may be available from their PCTs. In Northern Ireland, increased decontamination requirements came into place in November 2007. Dental practices are working towards achieving the standards by 2012, but with only limited additional funding available, it will be increasingly difficult for practitioners to meet them. In Wales, there have as yet been no changes in requirements.

5.4.3.2 Trials in Scotland, where strengthened decontamination requirements recommend the use of a local decontamination unit (LDU), show that the capital cost is in the range of £25,000 to £45,000 per practice (personal correspondence, 2008). The NHS Borders dental capital project found that equipping a unit in a six-surgery practice costs around £30,000. It is important to note that these estimates are based on practices for which a suitable room for decontamination already exists and does not include any increased revenue costs. Information from an independent decontamination engineering company (personal correspondence, 2008) indicates that the ongoing revenue cost of quarterly and annual periodic tests for a washer disinfector is in the region of £1,800 and for a vacuum autoclave is around £2,800. These costs do not include the validation/commissioning charges (which are one-off payments of around £1,200 per machine) nor the associated consumables costs (for example distilled water) and additional utility charges that these machines incur on a day-to-day basis. Dentists in Scotland and England are fearful that they may be unable to comply with a requirement for LDUs in their current premises.

5.4.4 Staff costs

5.4.4.1 As staff costs remain the highest proportion of practice expenses, they continue to be a major inflationary factor on practice costs. We have already described the problems faced by many practice owners in recruiting appropriately-trained dental care professional staff; the results of the Business Trends Survey demonstrate that some of those recruitment and retention issues are being reflected in staffing costs. In

the past year all groups of dental care professionals across the UK received, on average, an hourly pay award well in excess of the 1.5 per cent awarded to NHS dentists in 2009-10. For example, practice owners reported that they had had to award their dental nurses a mean hourly pay rise of between four times this amount in Northern Ireland, twice this amount in Wales, with rises awarded in England and Scotland coming in at three times that awarded to dentists.

5.4.4.2 We ask that the public sector pay increase of 3.6 per cent is applied to staff costs.

Mean increase (or decrease) in the hourly rate of pay for dental nurse, receptionists, and practice managers over the last year by country

	England	Wales	Scotland	Northern Ireland
Dental nurses	4.5% (516)	2.5% (76)	4.4% (140)	5.4% (59)
Receptionists	3.9% (487)	2.7% (74)	4.0% (136)	5.5% (58)
Practice managers	3.1% (382)	2.6% (60)	4.7% (104)	3.9% (38)

Source: BDA BTS 2009, base figures in brackets

5.4.5 Laboratory work – quantity and prices

5.4.5.1 With the introduction of the new contract in England and Wales it has been contended that the volume of clinical dentistry requiring laboratory work has decreased for all dentists. The Association has consistently argued that this is a misrepresentation of the prevailing trends, with the volume of laboratory work decreasing neither as quickly nor as significantly as suggested and that it was skewed by the challenges of the transitional period of the new contract. The 2009 BTS supports the argument, showing that in England and Wales respectively 65 per cent and 68 per cent of dentists reported that the amount of clinical dentistry where laboratory work is required has increased or stayed the same since 2006.

5.4.5.2 In Scotland and Northern Ireland, where the contractual arrangements have remained stable throughout this period, the percentage of dentists reporting that their laboratory work has increased since 2006 is significant at around a third.

Percentage of dentists reporting how the amount of clinical dentistry where laboratory work is required has changed since 2006 by country

	Increased	Decreased	Stayed the same	BASE
England	23%	35%	42%	892
Wales	15%	32%	53%	123
Scotland	37%	13%	50%	241
Northern Ireland	31%	17%	52%	105

Source: BDA BTS 2009

5.4.5.3 The Business Trends Survey examined six indicative laboratory items for use in NHS treatment to calculate the mean price paid by dentists and assess the change in price between 2007-08 and 2008-09. Eighty per cent of respondents said that the price of NHS laboratory work has risen between 2007-08 and 2008-09.

The (weighted) mean UK price paid for selected laboratory items for NHS treatment in 2008-09 and the percentage of practice owners reporting that the price of the item increased between 2007-08 and 2008-09

	Mean price paid	% dentists reporting an increase in price between 07-08 and 08-09
Porcelain bonded crown with precious metal	£51.54	83%
Gold shell crown (yellow)	£54.21	84%
Full acrylic dentures	£101.06	83%
Two tooth partial skeleton chrome cobalt denture	£136.64	85%
Two tooth acrylic partial	£52.99	84%
Porcelain jacket crown	£45.85	80%

Source: BDA BTS 2009

Note: The weighted UK-wide results have been calculated from BDA membership information on the proportion of practice owners in each of the four countries

5.4.6 NASDA information

5.4.6.1 The National Association of Specialist Dental Accountants (NASDA) has again shared some of their information on dental expenses with the Information Centre and this has been published as Annex D in its 2007-08 report.

5.4.6.2 Their information shows that for NHS practices non-clinical staff wage, laboratory and materials costs as a percentage of principals' (practice owners or providing-performers) total turnover (before any deductions) have all increased between 2006-07 and 2007-08.

5.4.6.3 Laboratory costs in NHS practices increased from 5.6 per cent to 6.1 per cent between 2006-07 and 2007-08 – a 8.9 per cent rise. Materials costs changed from 5.0 per cent in 2006-07 to 5.6 per cent in 2007-08 – a 12 per cent rise.

Non-dentist staff wages, laboratory costs and material costs as a percentage of principals' total turnover (before any deductions) for NHS practices, 2006-07 and 2007-08

	2006-07	2007-08	% change 06-07 to 07-08
Non-clinical staff wages	17.3%	17.9%	+ 3.5%
Laboratory costs	5.6%	6.1%	+ 8.9%
Materials costs	5.0%	5.6%	+ 12.0%

Source: NASDA, Information Centre, 2009.

Note: NHS practices are those practices performing at least 80 per cent NHS dental activity.

5.4.6.4 Finally, NASDA's information also shows that non-clinical staff wages for NHS practices increased by 3.5 per cent in 2007-08, from 17.3 per cent to 17.9 per cent.

5.4.7 Precious and semi-precious metal prices and exchange rates

5.4.7.1 Precious and semi-precious metals are vital dental consumables; gold, silver, platinum and palladium are potentially used in at least 12 per cent of all non-orthodontic treatment items carried out under the NHS.

5.4.7.2 The graph below shows that the price of gold per ounce has risen significantly in the last five years – from a low of £219 per ounce in early 2005, peaking at just under £700 per ounce in early 2009, to a current price of £596 per ounce (as of 10 September 2009). In the twelve months to 10 September 2009, the price rose from £441 per ounce to £596 per ounce – an annual rise of 35 per cent.

Five year price of gold in GBP per ounce

Source: www.goldprice.org

5.4.7.3 The price of silver per ounce has risen in the last year from £6.42 on 10 September 2008 to £9.70 on 10 September 2009 – a rise of 51 per cent; the price of palladium has risen by 33 per cent to £174 per ounce in the last year; and the price of platinum has increased by 11 per cent to £768 per ounce in the last 12 months.

5.4.7.4 The weakness of sterling over the last twelve months has also had a direct impact on the price paid by dentists for overseas laboratory work, materials and consumables.

5.4.7.5 The increase in the price of precious metals and the devaluation of Sterling has had a direct inflationary impact on the cost of dental laboratory work, materials and consumables. We believe that these two factors alone will have resulted in at least a 2.4 per cent rise in non-staff dental costs and this should be recognised in the recommended uplift.

5.5 Pensions

5.5.1 Dynamising factor

5.5.1.1 Over three years to April 2008 the Review Body has made a net award and then recommended a gross uplift to deliver it. In each of the three years the Health Departments have, however, applied the uplift inconsistently by using for dynamising purposes the lower of the awards given, net or gross. This has resulted in the dynamising factor used on two occasions being the net and on one occasion being the gross.

Year	DDRB gross uplift	Netuplift	Dynamising factor
2005	3.4%	3.225%	3.225%
2006	3.0%	3.4%	3.0%
2007	3.0%	2.0%	2.0%

5.5.1.2 The effect of the application of the lower rate is that the uplift was 8.225 per cent instead of the anticipated 9.4 per cent, a loss of 1.175 per cent in GDPs' pension.

5.5.1.3 From April 2008, inflation adjustment arrangements have been standardised across the NHS Pension Scheme for all occupational groups, at the rate of RPI plus 1.5 per cent.

5.5.2 Increased pension contributions

5.5.2.1 The new tiered contribution band arrangements, introduced in April 2008 as a result of the NHS Pension Review, have resulted in increased pension contributions for dentists with no addition to benefits. Prior to that, they made a contribution of 6.0 per cent of net income, but there are now four contribution rates (5.0 per cent, 6.5 per cent, 7.5 per cent, and 8.5 per cent).

5.5.2.2 Approximately 34 per cent of dentists are paying 5.0 per cent, 45 per cent are paying 6.5 per cent and 6.0 per cent are paying 8.5 per cent in superannuation costs. The most common rate is in income band 2 – that is dentists whose NHS income is between £20,710 and £68,392. Most in this band will qualify for higher-rate tax relief and so the average net effect on pay is 0.3 per cent. This affects GDPs and salaried dentists equally.

Number of principal dentists (and percentage of the total in each country) in each of the four NHS pension tiers in England, Wales, Scotland and Northern Ireland

	England as of June 2009	Wales as of June 2009	Scotland as of June 2009	Northern Ireland as of April 2009
Tier 1	7,197 (35%)	306 (27%)	556 (26%)	243 (26%)
Tier 2	8,712 (43%)	574 (50%)	1,057 (50%)	538 (58%)
Tier 3	3,077 (15%)	201 (18%)	391 (19%)	104 (11%)
Tier 4	1,354 (7%)	61 (5%)	101 (5%)	46 (5%)
TOTAL	20,340 (100%)	1,142 (100%)	2,105 (100%)	931 (100%)

Source: Various

5.5.2.3 We ask the Review Body to consider its impact on taxable income.

5.6 Associate recruitment and performer pay

5.6.2 We are conscious that the new arrangements in England and Wales appear to be having an effect on the pay and working conditions of associates/performers, although the data is difficult to interpret given the significant variability of associate working patterns.

5.6.3 The contractual and payment arrangements for associates are complex and by no means uniform, reflecting as they do different business needs, market rates and historical relationships, often according to whether the associate was working at the same practice prior to 2006.

5.6.4 We believe that in principle all dentists working in the NHS should receive the same DDRB uplift to net pay, but this will necessarily be applied to associates' turnover in different ways depending upon their payment mechanism and their historical percentage payment, if any.

5.6.5 We are undertaking a review of associates' career pathways, contractual arrangements and working conditions.

5.7 Vocational dental practitioners

5.7.2 The BDA remains seriously concerned about the future career prospects for current dental students and those in their VT year. The high incidence and size of student debt must impact on the attractiveness of dentistry as a career especially for those in lower socio-economic groups (*Unleashing Aspiration: The final report of the Panel on fair access to the professions, 2009*). There is now greater uncertainty in the dental market and, in 2011, not only will the ring-fenced funding for dentistry be removed but there will be even more dental students graduating from UK institutions entering the market and seeking employment.

5.7.3 The results of the 2009 BDA/COPDEND survey of UK vocational dental practitioners (VDPs) show that, as of July 2009, almost one in five VDPs had not yet been successful in securing post-VT dental employment and almost a quarter (24 per cent) of all VDPs found their experience of job hunting 'very difficult' or 'fairly difficult', with 21 per cent saying that their experience of job hunting was 'more difficult' than they had expected.

5.7.4 At a time when securing access to NHS dentistry is so high on the political agenda, it seems paradoxical that such a large proportion of VDPs are finding it so difficult to secure a post-VT dental career. The BDA believes that this situation will worsen significantly in 2011 when dental schools' output increases significantly. The figures are

Expected year of Graduation	***2013***	***2012***	***2011***	***2010***	***2009***
Total number of students graduating	926	905	923	851	712

5.7.5 Many VDPs also reported that practices now prefer to recruit dentists with between three and five years' experience, which effectively rules them out of securing certain employment opportunities.

5.7.6 Of those who had secured post-VT dental employment, the majority were working as an associate/performer in a GDS/PDS practice (62 per cent) with a further third (33 per cent) securing a hospital/senior house officer post.

5.7.7 Fifty-six per cent of those who had secured post-VDP dental employment in England and Wales were to be paid in full or part by units of dental activity. Their mean UDA value before expenses are deducted, was found to be £20.59. The mean UDA value being secured by VDPs has been falling over the last three years: for example in 2007 the mean was £21.00 which then fell to £20.91 in 2008.

5.7.8 So in real terms, newer dentists in the NHS have experienced a significant reduction in the mean UDA values that they are securing, which has a direct impact on their net remuneration. VDPs have also lost the flexibility of securing employment in their training practices and the terms and conditions of their employment contracts are now entirely market-driven – these factors are leading to the erosion of morale and motivation in the youngest cohort of NHS dentists.

5.8 VDP trainer workloads

5.8.1 As highlighted in our evidence last year, VT trainers have seen an increase in their workload. In England and Wales, the fact that VT trainers cannot guarantee keeping their VDPs on at the practice after a successful VT year has proved so frustrating that some have given up on being a VT trainer. We hope to undertake joint research on this for next year.

5.8.2 VT trainers find that they now have to spend much more time supervising VDPs, both clinically and with administrative work, and in some instances are responsible for more than one VDP at a time.

5.8.3 This increase in workload is reducing the attraction of being a trainer, which is likely to lead to a reduction in the number of future trainers. Worryingly, this is at a time when the VDP population is due to increase by a quarter.

5.9 Recommendations

5.9.1 The evidence that we have collected from members for this submission is showing that non-dental staff costs continue to rise at rates above inflation; material and laboratory costs have risen over the last year; and strengthened decontamination requirements are having an immediate or anticipated impact on practice costs.

5.9.2 Recession is also placing independently-operated dental practices at the mercy of economic forces. Dental practices provide important public services and it is vital that, as small businesses, they are supported through this difficult economic climate. The recession is changing patient behaviour which can lead to a greater number of missed appointments often leading to clawback. Morale and motivation of dentists across the UK are flagging.

5.9.3 We ask the Review Body to

- Make an award of 3.6 per cent on taxable income to reflect the pay awards made in the public sector
- Continue to use the formula used for the 2008-09 pay award until such time as the parties are able to agree a revised and appropriate formula for the future. That formula is

  Uplift $_{YEAR}$ = 0.45*x + 0.165*y + 0.385*z

  where:

  x= increase in GDP remuneration
  y = increase in staff costs
  z = increase in other costs.

- Make a retrospective recalculation using the previous formula for the 2009-10 pay award:

  For 2009-10, DDRB gave a net income award of 1.5 per cent and assumed that staff costs were to rise by 3.6 per cent and that all other costs were to rise by 2.7 per cent. Applying these to the original formula gives a revised 2009-10 uplift of 2.3 per cent for all four countries. Deducting the 0.21 per cent award last year, the retrospective award would be 2.09 per cent.

- Compound this retrospective award with a 2010-11 pay award, based on the original formula.

- Award a rise in taxable income of 3.6 per cent (public sector average earnings growth at July 2009)
- And a rise in staff costs of 3.6 per cent (public sector average earnings growth at July 2009)
- Apply RPI current at the time of the award.
- Current figures therefore would give a total award of 3.8 per cent on contract values, fee scales and other appropriate allowances, that is 2.09 plus 1.7 per cent.

6. General dental practice - country-specific issues

6.1 England and Wales

Key points

- There remain significant numbers of dentists in England and Wales who are still unable to meet their contracted UDA targets.
- The numbers experiencing clawback is steady.
- Some individuals are still experiencing difficulty in selling their practices as a result of PCT action. This represents serious loss of deferred income for some individuals.
- Access to NHS dentistry in England and Wales continue to be less than before April 2006.
- The average taxable income for dentists fell between 2006-07 and 2007-08. Providing-performers demonstrated a reduction in their average taxable income of 5.9 per cent, while performer-only dentists experienced a 5.4 per cent reduction.
- The average taxable income for mainly NHS dentists is lower than that of mixed or mainly private dentists.
- Between 2006-07 and 2007-08 the expenses ratio for all self-employed primary care dentists increased from 53.4 per cent to 54.0 per cent – an increase of 1.1 per cent. The expenses ratio for mainly NHS dentists saw a 1.4 per cent rise from 50.8 per cent to 51.5 per cent.

6.1.1 Contract issues

6.1.1.1 During the third year of the new contract, dental practitioners have become more accustomed to the new way of working and having to achieve their UDA targets, but there are still significant numbers of dentists not achieving their UDA targets. Headline statistics from NHSBSA Dental Services for England and Wales based on the entire dataset showed that 41 per cent (or 3,142) of NHS contracts did not achieve their 96 per cent UDA target in 2008-09 (2007-08: 44 per cent). Primary Care Trusts and Local Health Boards continued to struggle with contract management and frequently have not had the resources to work proactively and constructively with dental providers. There remain significant problems in the payment of maternity and sickness payments by some PCTs/LHBs because of lack of understanding of who is eligible for payment and the mechanisms involved.

6.1.1.2 The Dental Business Trends Survey indicates that, in England, the proportion of practice owners experiencing clawback has remained reasonably steady in the first three years of the new contract: 30 per cent of practice owners experienced clawback in 2006-07, 33 per cent in 2007-08 and 33 per cent in 2008-09. In Wales, the figures are 35 per cent in 2006-07, 40 per cent in 2007-08, and 31 per cent in 2008-09. Of those, 44 per cent in England and 42 per cent in Wales reported that it had caused financial difficulties to the practice.

6.1.1.3 Seven per cent of practice owners in England and 12 per cent in Wales have tried to sell their practices since 2006; 37 per cent of those in England found that the primary care organisation refused or made it difficult for them to transfer their NHS contract to the new owner. This has a significant impact on the value of their practices, which in most cases represents loss of deferred income. At a stroke, it completely destroys any residual goodwill value in the practice. Given that this element of practice finance is something that dentists will have relied upon throughout their careers and represents normal business custom and practice, its removal is a significant detriment. If this approach is to be adopted, the Review Body is asked to consider additional funding to dental remuneration in order to compensate for the massive investments made by dentists throughout their working lives.

6.1.1.4 Local health boards, whose number will reduce to seven on 1 October, continue to cause concern in some areas of Wales, the lack of consistency in their decision-making being the main problem. Based on FOI information in 2008-09 170 dentists' NHS contracts underachieved and 333 over-delivered on their allotted UDA quota. Some LHBs have paid contractors for their additional UDAs, usually up to a 5 per cent limit. Others will not do so, nor will they offset them against the following year's contract.

6.1.1.5 There also examples of LHBs trying to recover funds that were allocated as part of the VDP training budget. The nominal value of a VDP UDA may be higher than the practice UDA value and it has been the experience of practices that LHBs try to recover funds at the highest possible value.

6.1.2 Access to NHS services and treatment patterns under the new contract

6.1.2.1 The NHS Information Centre's report *NHS Dental Statistics for England: 2008-09* showed that in 2008-09 there were 37.4 million course of treatment delivered in England, an increase of 4.0 per cent on the previous year, and that this equated to 81.4 million UDAs – an increase of 5.7 per cent on the previous year.

6.1.2.2 Despite these increases, in 2008-09 improvement in access to NHS dentistry (as defined by the Government as the number of unique patients seen in a twenty-four month period) has been poor. The NHS

Information Centre, in the same report, showed that for England, in the twenty-four month period ending 31 March 2009, 27.5 million patients had seen an NHS dentist – a 2.3 per cent decrease as compared with 31 March 2006 when the new NHS dental contract was introduced.

6.1.2.3 The Information Centre's *Provisional Clinical Dental Report, England and Wales: Quarter 3, 31 December 2008 - Experimental Statistics* showed that treatment patterns in England and Wales had changed between 2003-04 and 2008-09. In 2008-09 there have been reductions in the volume of many of the more complex treatments compared with 2003-04. These changes are in line with the goals of the Government reforms of NHS dentistry which among other things aimed to reduce the amount of complex treatments being provided in favour of simpler courses of treatment.

6.1.2.4 The report does not show what has happened to NHS treatment volumes and patterns annually since 2006-07, but we believe that the volume of more complex treatments being carried out by NHS dentists rose in 2008-09 and will continue to rise. We anticipate that this will be demonstrated in next year's report.

6.1.3 Interest in tendering

6.1.3.1 In England and Wales, the only way for a dentist to establish a new practice or to increase the amount of NHS work they do is to win a competitive tender. These tendering opportunities are not frequent within any given area and so when a tender is announced bids are normally forthcoming. Our experience has been that younger associates who aspire to becoming practice owners will bid repeatedly but have little chance of success because of their lack of track record as business owners. This accounts for tenders receiving large numbers of bids.

6.1.3.2 Tendering is a time-consuming and expensive exercise and experience has shown that dental companies have a significant competitive advantage in winning contracts, which is yet another factor affecting the viability of small practices.

6.1.4 Dental earnings

6.1.4.1 The 2007-08 *Dental Earnings and Expenses Report, England and Wales*, provides information on the self-employed earnings and expenses of primary care dentists who carried out some NHS work in England and Wales during 2007-08. The results are based on anonymised tax data for dentists with an accounting year ending in the fourth quarter of 2007-08 and relate both to full-time and part-time dentists with varying levels of self-employment earnings from NHS and private dentistry. The report does not consider dentists who performed only private dentistry.

6.1.4.2 The report shows that the average taxable income for dentists fell between 2006-07 and 2007-08. Providing-performers demonstrated a reduction in their average taxable income of 5.9 per cent, while performer-only dentists experienced a 5.4 per cent reduction.

6.1.4.3 The key finding for non-orthodontic self-employed primary care dentists in England and Wales in 2007-08 was that the average taxable income for a non-orthodontic providing-performer dentist was £121,091, compared with £64,099 for non-orthodontic performer-only dentists. For all self-employed non-orthodontic primary care dentists (that is, providing-performer and performer-only dentists) this figure was £85,422.

6.1.4.4 The average taxable income for mainly NHS dentists is lower than that of mixed or mainly private dentists. The average taxable income for mainly NHS dentists in 2007-08 was £93,891 compared with £101,151 for a mixed dentist and £97,299 for a mainly private dentist. Mainly private dentists have larger average turnover (£252,882) and average expenses (£155,583) than mainly NHS dentists (£193,479 and £99,589).

6.1.5 Expenses

6.1.5.1 Between 2006-07 and 2007-08 the expenses ratio for all self-employed primary care dentists increased from 53.4 per cent to 54.0 per cent – an increase of 1.1 per cent. The expenses ratio for mainly NHS dentists saw a 1.4 per cent rise from 50.8 per cent to 51.5 per cent.

Expenses ratio by NHS commitment for all self-employed primary care dentists, England and Wales, 2006-07 and 2007-08

	ER (%) in 2006-07	ER (%) in 2007-08	% change in ER
Mainly private	60.6%	61.5%	+ 1.5%
Mixed	58.2%	57.0%	- 2.1 %
Mainly NHS	50.8%	51.5%	+ 1.4%
ALL	53.4%	54.0%	+ 1.1%

Source: Information Centre, 2009

6.1.5.2 Mainly NHS providing-performer dentists demonstrated a 3.6 per cent increase in their expenses ratio from 58.5 per cent to 60.6 per cent; the average rise for all providing-performer dentists was lower at 2.3 per cent.

6.2 Northern Ireland

Key points

- The provision of GDS and the payment system in Northern Ireland are explained.
- Access remains a priority for the NI Assembly.
- The NI population has an intractably high level of dental disease.
- Practitioners in Northern Ireland are highly committed to working in the health service.
- In Northern Ireland pay awards are applied across a large number of small fees. As a consequence the true value of the pay award is diluted and does not result in a corresponding increase in gross turnover.
- A high dental needs population presents a high cost to service in materials and laboratory items.

6.2.1 Overview of the provision of general dental services in Northern Ireland

6.2.1.1 Payment system for dentists in Northern Ireland

6.2.1.1.1 The patient-focused aspects of dental care in Northern Ireland are delivered through an item-of-service payment system, with patient registration. Dentists are paid individual fees, set by government, for items of dental care provided. Patients need to be registered with a dentist as a health service patient. A patient over 18 years of age is registered as a 'continuing care' patient and a patient under 18 years of age is registered as a 'capitation' patient. For registered patients, the dentist will provide the care and treatment that is necessary to secure and maintain oral health. Over 400 individual treatment items are available, providing an array of services including routine dental care and maintenance, fillings, crowns, bridges, orthodontics and oral surgery.

6.2.1.1.2 In tandem with the patient-facing aspects of dental care, delivered through continuing care, capitation and item-of-service, additional payments are delivered through a range of fees and allowances made available to dentists (details of these are available at annex 2).

6.2.1.1.3 In total the payment system for dentists in Northern Ireland can broadly be considered in five distinct categories (excluding payments in respect of vocational training)

- Fees for patient care, clinical treatment and registration
- Fees for defined non-clinical work
- Allowances for expenses (practice allowance)
- Reimbursement of costs
- Commitment payments

6.2.1.1.4 There are also payments for dentists in respect of undertaking the role of vocational trainer.

6.2.1.1.5 The five distinct areas of funding are described below and with additional detail at Annex 2. For the purposes of this exercise, we have excluded vocational training payments as, out of the 911 GDS dentists at April 2009, there were a total of 36 trainers in place. Trainers in vocational training and general professional training represent less than four per cent of the workforce. (Figures provided by the Business Services Organisation, 2 September 2009; and the Northern Ireland Medical and Dental Training Agency).

Patient care, clinical treatment and registration

6.2.1.1.6 The payment system provides a series of payment fees for the clinical care of patients and their ongoing registration. (Annex 3)

Fees for non-clinical work

6.2.1.1.7 The work of a general dental practitioner includes necessary areas of non-clinical work (on a defined and limited basis). Fees for non-clinical work provide recompense to dentists when they exchange clinical care of patients for certain types of non-clinical work, such as continuing professional development; recompense for reduced working speed for dentists over 55 years; and recompense for inability or excusal from work, for example due to maternity or sick leave.

Allowance for expenses

6.2.1.1.8 A practice allowance for practices meeting the definition of ‘committed health service practice’ is to help address the increasing requirements in relation to the provision of premises, health and safety, staffing support and information collection and provision.

Reimbursement of rates

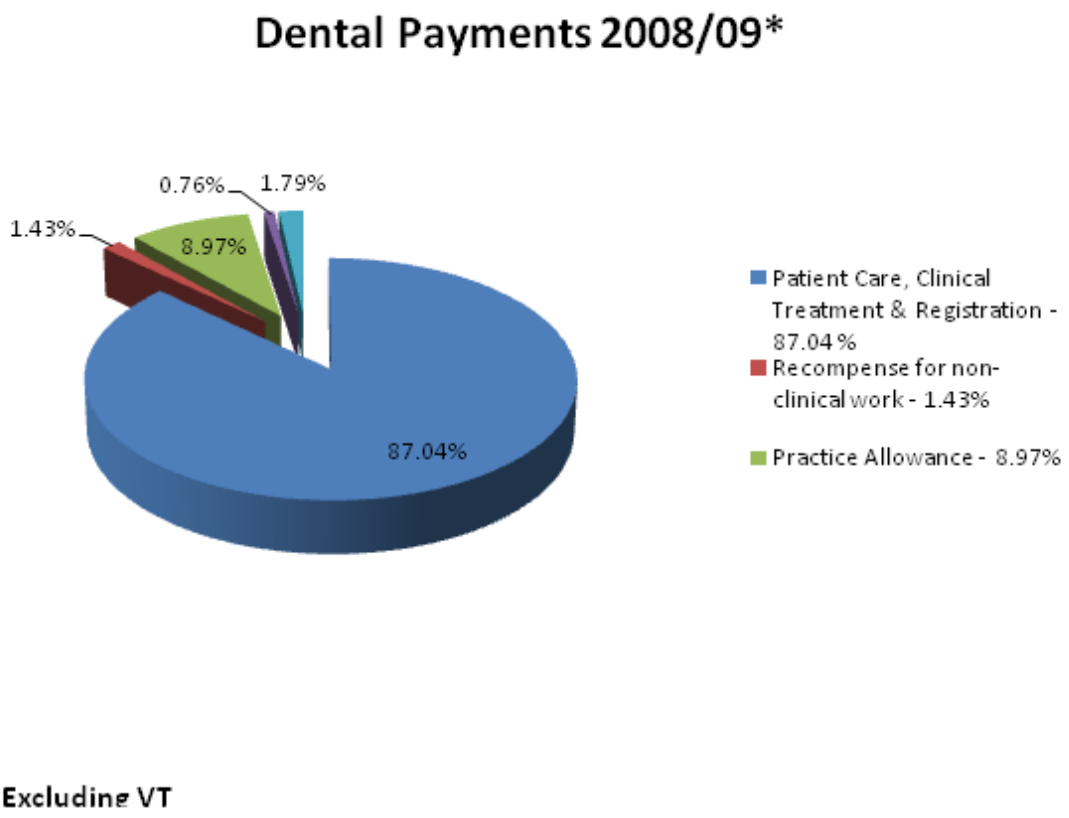
6.2.1.1.9 Reimbursement of the cost incurred through non-domestic rates, in proportion to their commitment to the health service.

Commitment payments

6.2.1.1.10 These provide a reward to individual dentists for commitment to the health service (over time) and volume of work carried out in the health service.

6.2.1.1.11 The ratio of the payment system in place for dentists in Northern Ireland demonstrates that allowances (practice allowance and re-imbursement for rates) account for almost ten per cent of gross turnover (not including payment for VT).

Dental Payments 2007/08 & 2008/09				
	2007/08	2008/09	2007/08	2008/09
Patient Care, Clinical Treatment and registration	£67,965,384.58	£72,960,269.62	87.32%	87.04%
Recompense for non-clinical work	£1,185,458.02	£1,201,917.31	1.52%	1.43%
Practice Allowance	£6,486,147.87	£7,521,751.07	8.33%	8.97%
Re-imbursement of rates	£656,778.65	£636,290.17	0.84%	0.76%
Commitment Scheme	£1,541,028.88	£1,501,192.13	1.98%	1.79%
Total	**£77,834,797.99**	**£83,821,420.29**	**100.00%**	**100.00%**



* Excluding VT

6.2.2 Policy drivers

6.2.2.1 The predominant policy drivers for dentistry in the period 2008/09 have been the Northern Ireland Assembly's desire to address issues of access to health service dental care for patients. Figures show that the number of patients registered over the period 2005 to 2009 has fluctuated (see table) and, in September 2008, the Health Minister stated that, during the past four years, 50,000 fewer patients received Health Service dental care. During the period described, patients were registered with a dentist for 15 months. This has now increased to 24 months with effect from August 2009.

Registration Figures for Northern Ireland				
Period	Children	Adults	Total	Change on June 2006
June 2006	272,415	640,695	913,110	-
June 2007	268,856	622,898	891,754	- 21,356
June 2008	267,136	591,968	859,104	- 54,006
June 2009	274,012	602,595	876,607	- 36,503

6.2.2.2 Northern Ireland dental professionals are working very hard to provide care for almost 900,000 patients on the health service. Northern Ireland's dentists are highly committed to the health service: two-thirds of all dentists spend the majority of their time on HS work and more than half do at least 75 per cent of their work in the health service. (Dental earnings and expenses, Northern Ireland, 2007-08 experimental statistics; the Information Centre 2009).

6.2.2.3 The context of dental care in Northern Ireland is one of a population with an intractably high level of dental disease (Oral Health Strategy for Northern Ireland. DHSSPS June 2007). This in turn places a stressor on the systems and workforce tasked with delivering HS dental care for the population where the costs of servicing a high-needs population will be high in respect of materials used and laboratory work generated. In turn, where individual patients have higher dental needs, fewer patients can be treated.

6.2.3 Dental earnings

6.2.3.1 This year the NHS Information Centre produced Experimental Statistics on Dental Earnings and Expenses for Northern Ireland. The figures showed that the average taxable income for all principal dentists was £121,174 compared to £66,134 for associate dentists. As this is the first time this data has been produced, there are no comparators and, given

that the Northern Ireland context for general dental services is unique, comparisons cannot be made,

6.2.4 Dental expenses

6.2.4.1 Dental expenses continue to rise in respect of staff costs, laboratory and materials costs and general overhead costs of meeting the continuing requirements of best practice. This is covered in Chapter 5 and decontamination is covered at 6.2.11

6.2.4.2 In addition, Northern Ireland operates in a unique context. Laboratory work volumes can be expressed as a cost, given that each item carries a specific cost. In 2006-07, laboratory items made up 33.6 per cent of the gross cost of patient care and treatment (excluding patient registration). In 2007-08 this figure was 33.5 per cent and in 2008/09 it was 32.9 per cent. So laboratory volumes in Northern Ireland are very stable. The costs of laboratory work are covered in 5.4.5.

6.2.5 Issues with the formula for 2009-10

6.2.5.1 The problems experienced by Northern Ireland dentists as a result of the application of a revised formula this year across the UK are described in paragraph 3.3.

6.2.6 Delivering a percentage pay award to Northern Ireland

6.2.6.1 Representatives of NI dental practitioners met with DDRB in June 2009. DDRB pointed out that it believed that the current formula had delivered an increase in fees to Northern Ireland in the region of an additional 0.9 per cent over what might have been awarded in the absence of the current formula.

6.2.6.2 Detail of the payments made to dentists in Northern Ireland is held in the Statement of Dental Remuneration. The bulk of the pay packet for all dentists comprises fees for patient care, clinical work and patient registration, and is made up of numerous small fee payments. These fees range from the lowest patient registration fee of £0.80 to the highest treatment fee at £337.65. (see BDA fees guide 2008-09 at annex 3).

6.2.6.3 When DHSSPS applies a percentage rise to the fee scale, the award is applied to each individual fee. No award is made if the fee does not rise by more than £0.05. In the application of a small percentage rise, such as 0.21 per cent for 2009/10, a large bulk of the fees does not rise and consequently a much reduced pay award may be delivered. For example, in 2009-10, due to the low percentage increase, none of the payments for patient registration will increase, nor do fees which are under £12.00. Of the gross cost of items of service in 2008-09, £13.6million out of a total of £53million did not attract a pay rise, due to

being under the threshold of £12.00. The £19.95 million in registration fees also does not attract a pay rise since these fees range from £0.80 to £4.55). So of the total of £72.9million paid out in 08/09 in respect of fees for patient care, clinical work and patient registration, £33.5million did not attract a pay rise. The overall effect of this is to dilute the pay award from 0.21 per cent to 0.126 per cent for Northern Ireland.

6.2.7 Fee-cost relationship

6.2.7.1 DDRB has asked for information about the fee-cost relationship in both Scotland and Northern Ireland (paragraph 4.67).

6.2.7.2 The Fundamental Review of Dental Remuneration (Report of Sir Kenneth Bloomfield, December 1992) described the remuneration system as being dependent upon the amount of work dentists do, the number of patients registered and the expenses incurred. Bloomfield described the fees fixed for items of service as factors in an equation, designed to produce a particular pre-determined average outcome. Until 1994, the then Dental Rates Study Group translated the DDRB's target average net award into a target average gross income.

6.2.7.3 So the fee scale determined by the former Dental Rates Study Group was originally intended not to reflect actual costs of providing individual items but to deliver, after expenses, an average net income (then determined by DDRB) for an average dentist undertaking an average amount of NHS care in average circumstances for patients with average dental needs. Over the years, however, some adjustments were made to a small number of fees to reflect increasing costs. In recent years DDRB has awarded percentage increases to the fee scale (or to contract values in England and Wales); the last target average net income was determined for 1993-94.

6.2.7.4 Whilst the mechanism of payment has not changed since that in place in 1992, other factors which influence it have changed, where the cost of provision of some items relative to their fee means that some items are not viable or remunerative to provide.

6.2.8 Effect of allowances

6.2.8.1 Northern Ireland has two practice-based allowances available to dental practices (annex 2). Non-domestic rates reimbursement is claimable in proportion to the percentage of health service work carried out in the premises. In the period 2008-09 the value of rates reimbursement was £636,290, which accounts for 0.76 per cent of the income stream for dentists (not including vocational training). It is important to note that this is the reimbursement of a direct cost, recognising the extent to which the premises is given over for use by the health service. There is no profit element to rates reimbursement.

6.2.8.2 The practice allowance for Northern Ireland delivers funding directly to practices with the intent of helping to address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision. The practice allowance is available on two levels. Level 1 is payable to all practices providing health service care and equates to 4.0 per cent of the accumulative gross earnings of all the dentists in the practice. Level 2 is payable to practices which meet the definition of 'health service committed practice' whereby the dentists have an average of at least 500 patients registered per dentist, of whom at least an average of 100 per dentist must be fee paying adults; and the dentists have average gross earnings of at least £50,000 or above per dentist in the last year. This additional payment equates to 7.0 per cent of the accumulative gross earnings of the dentists in the practice. In 2008-09 the practice allowance accounted for £7.5million or 8.9 per cent of the income stream for dentists (excluding vocational training).

Practice Allowance			
2007/08		2008/09	
£	%	£	%
£6,486,147.87	8.33%	£7,521,751.07	8.97%

6.2.8.3 Whilst the practice allowance is welcome, it needs to be improved to make it available to as many practices as possible. The calculation of the practice allowance is not sensitive to the varying circumstances in which dentists work; for example practices may be penalized where dentists work part-time or where they start or leave during the calculation period.

6.2.8.4 The practice allowance has enabled practices better to meet practice running costs, but the expense burden of practice continues to rise to meet governance, legislative and regulatory agendas.

6.2.9 Contract negotiations

6.2.9.1 Northern Ireland Dental Practice Committee (NIDPC) continues to be in negotiations with DHSSPS regarding a new contract for General Dental Services for Northern Ireland. There is agreement that any new arrangements will be piloted and NIDPC is currently focused on working with DHSSPS towards developing robust piloting to enable the delivery of a sustainable contract for Northern Ireland.

6.2.10 Growth in practices

6.2.10.1 There are also changes in the number of dental practices in Northern Ireland available to provide Health Service dental care. The number of

dental practices has not kept pace with the increase in the number required to meet the needs of the public dental service.

Number of Dental Practices - Northern Ireland					
Year	2005	2006	2007	2008	2009
Number of Practices	363	362	355	349	357

6.2.11 Decontamination

6.2.11.1 The detailed guidance for decontamination in dental practices in Northern Ireland was produced in November 2007, with the DHSSPS expectation that practices would achieve compliance over three to five years. The guidance is now being superseded by new, more onerous, guidance from June 2009 and the DHSSPS position is that it expects practices to have validated processes and procedures in place which go beyond those contained in HTM 01-05 in England. This in turn means that practices will have a significant capital expenditure to meet, together with ongoing revenue costs. Each practice must have a dedicated room for decontamination which meets the layout described in HTM 01-05, contains the relevant plant and achieves validated processes. In turn the practice needs to have enough instruments and additional staff to enable it to function. The DHSSPS expectation remains that practices should work to achieve best practice by November 2010 and, by November 2012, all dental practices must have achieved best practice.

6.2.11.2 So practices have already incurred significant spend over the 2008-09 period and again in 2009-10 in attempting to meet both ongoing and forthcoming decontamination requirements. DHSSPS has provided funding over the period 2002 to the present through a 'Quality Improvement Scheme' to support improvements in the delivery of General Dental Services. In 2008-09, this scheme provided approximately £1.1million to Northern Ireland's 357 practices, with the priority of requiring practices to purchase equipment for decontamination. This grant can assist with capital costs of equipment, but practices require additional staff to manage decontamination areas. The funding to improve the delivery of general dental services is a grant issued directly from DHSSPS and falls outside of the remit of the DDRB. Some of the costs of decontamination are outlined in 5.4.3.2.

Period	Funding to improve the delivery of GDS	No of practices at 1 April	Average funding per practice
2008-09	£1,105,965	349	£3,169
2009-10	£1,134,720	357	£3,178

6.3 Scotland

Key points

- Scottish dentists are also paid on an item-of-service basis and the system of allowances is explained.
- There is also a significant access problem in Scotland.
- This year's pay award had a particularly detrimental effect in Scotland. Increasing laboratory costs means that laboratory work will become more expensive regardless of volume.

6.3.1 Issues with the formula 2009-10

6.3.1.1 We explained in paragraph 3.3 our concern about the formula and the effect of applying it in Scotland. Where payment is largely based on item-of-service fees, the volume of laboratory work has a direct effect on turnover, so last year's award was particularly damaging. Increasing laboratory costs means that laboratory work will become more expensive regardless of volume.

6.3.2 The Scottish dental workforce

6.3.2.1 Data produced by the Information and Statistics Division in Scotland show an increase in non-salaried and salaried GDP numbers. The most up-to-date figures show a 5.5 per cent increase in non-salaried dentists and a 11.3 per cent increase in salaried dentists in the year to 30 September 2008. These figures should be regarded with caution, as they are headcount and not whole-time equivalent, and there may still be some instances of double-counting. No attempt has yet been made to calculate whole-time equivalents.

6.3.2.2 The Chief Dental Officer has established a workforce planning review group to assess whether Scotland is training sufficient numbers of dentists and other dental care professionals to meet patient needs. The BDA has been invited to participate in this review, completion of which is planned for December 2010.

6.3.3 Payments to NHS committed practices

6.3.3.1 As reported last year, SDPC successfully negotiated revised conditions for "partly-committed" practices. This has resulted in a further 104 practices now benefiting from additional funding through the General Dental Practice Allowance. These additional payments redress the

anomaly whereby these practices were penalised in the past despite the fact that they were providing care for NHS patients.

6.3.4 NHS allowances

6.3.4.1 The annual report of the Scottish Dental Practice Board shows a breakdown of payments of all allowances. For the period 2007-08, these were:

GDS allowances	**2007/08 (£)**
Seniority payments	1,624,236
Maternity payments	789,190
Paternity payments	94,333
Long-term sickness payments	57,564
Continuing professional development allowance	967,146
Reimbursement of non-domestic rates	1,660,597
Commitment payments	4,942,501
Practice improvement payments	839,713
Clinical audit allowance	118,151
Remote areas allowance	662,400
Recruitment and retention allowances	1,327,500
General dental practice allowance	22,832,491
Sedation practice allowance	127,000
Vocational training practice allowance	205,000
Reimbursement of practice rental costs	6,636,639
Total	42,884,460

6.3.4.2 We believe the NHS fees:allowances ratio to be 5:1. In other words, 20 per cent of total GDS income is derived from allowances. Despite the fact that the majority of these are superannuable, some of those that have implemented in recent years have not been up-rated since their introduction. These include the Vocational Training Allowance and Remote Areas allowance.

6.3.5 Dental earnings in Scotland

6.3.5.1 The following table shows the annual average gross earnings of non-salaried general dental practitioners in Scotland over the financial years 2004-05 to 2008-09. It also shows the DDRB uplift for each of those years and demonstrates the percentage change in earnings in relation to the DDRB uplift.

The earnings data relate to payments received for registering and treating patients. The sums do not include other GDS payments (allowances).

Financial year	Average earnings	% change	DDRB uplift
2004-05	£80,810	-	2.9 %
2005-06	£81,850	1.39%	3.4%
2006-07	£81,144	-0.86%	3%
2007-08	£81,214	0.09%	3%
2008-09	£84,848	4.47%	3.4%

Source: Information and Statistics Division, NHS National Services Scotland

6.3.6 Fee-cost relationship

6.3.6.1 This is covered in paragraph 6.2.7 above.

6.3.7 Access

6.3.7.1 Access is known to be problematic in certain areas in Scotland, notably in rural and remote areas. Child registrations have increased, but still under half of the adult population is registered with an NHS dentist. Overall, there has been an increase of 8.3 per cent and 16.2 per cent in the number of registrations for children and adults respectively from 31 March 2008 to 31 March 2009 (these are the most recently published figures). However, no patient registrations will lapse between 1 April 2009 and 31 March 2010 due to the fact that the registration period has been extended from 36 months to 48 months for all patients registered with a dentist on 1 April 2009.

6.3.8 Expenses

6.3.8.1 Profitability and expenses

6.3.8.1.1 Information from the Scottish Dental Practice Board shows that the total number of claimed fee items fell by 2.4 per cent from 2004-05 to 2007-08; also during this period the number of fee-per-item claims involving laboratory work fell by 6.2 per cent. Between 2004-05 and 2006-07 the respective declines are 2.6 per cent and 6.1 per cent. The slight fall in

the volume of claimed fees which involve laboratory work is nowhere near the 31 per cent reduction used by the Review Body in its calculation for the 2009-10 recommendation, and it also needs to be viewed in the light of an overall slight reduction in the total number of claimed fee items which automatically reduces gross turnover.

6.3.8.2 Laboratory volumes and costs

6.3.8.2.1 This is covered in section 5.4.5.

6.3.8.3 Decontamination

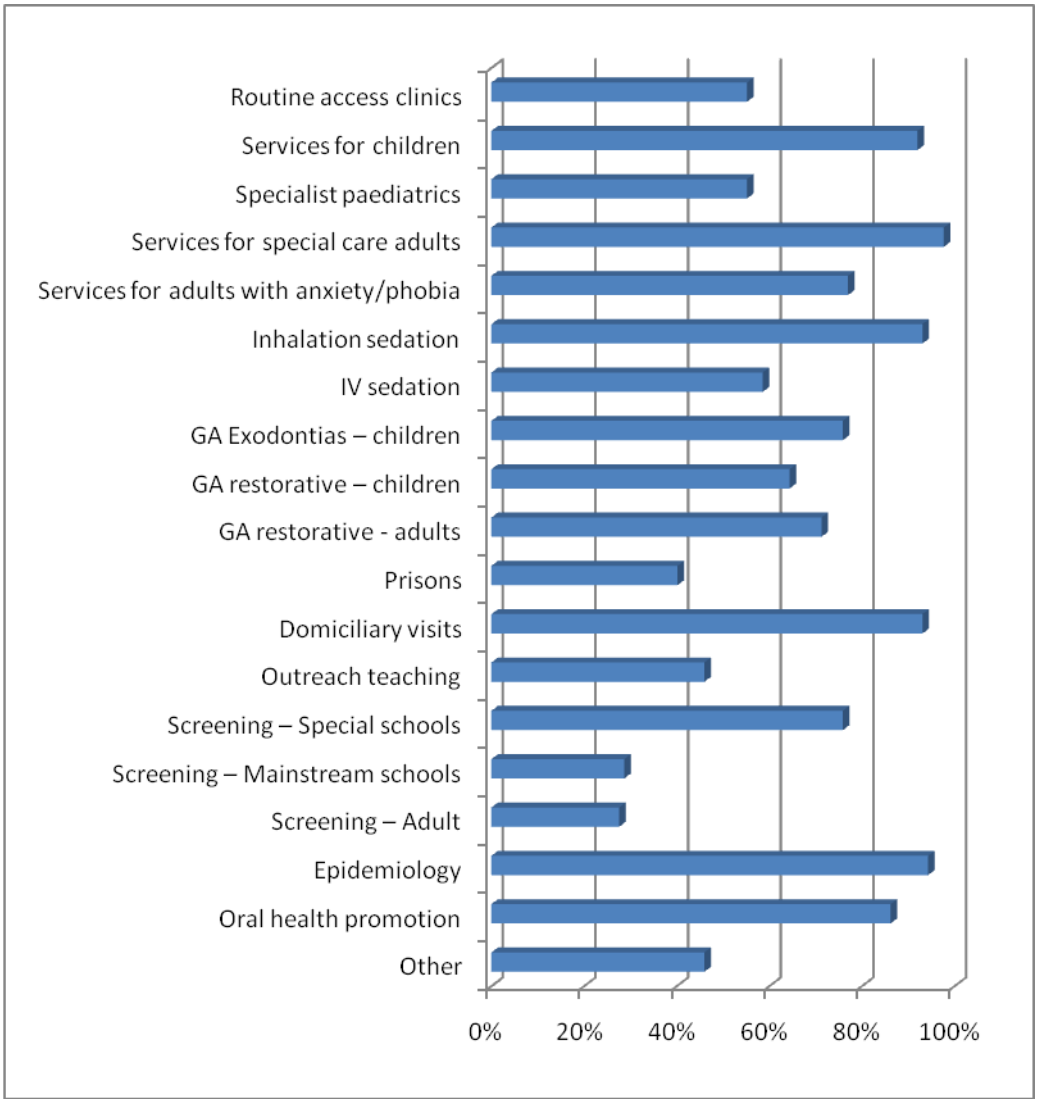
6.3.8.3.1 The effects of the decontamination costs are described in section 5.4.3.

7. Salaried Primary Dental Care Services

7.1 The role of the salaried primary dental care services

7.1.1 Dentists who work in the salaried primary dental care services fulfil a variety of roles and meet the needs of the most vulnerable groups in society. Treating patients with special needs is challenging, both physically and intellectually, and requires a high level of specialised knowledge and clinical skills, as well as a commitment to providing care for patients who often have higher than normal levels of dental disease. Figure 1 shows the spread of activities undertaken by the Service.

Percentage of services providing the following in the 2009 Clinical Directors Survey:



7.1.2 We believe that it is vital that the Review Body looks at the evidence on recruitment and retention difficulties that we are putting forward this year. Despite the benefits inherent in the new SPDCS contract, younger dentists are not choosing 'special needs' or other NHS salaried dental posts as readily as we had hoped. We will be looking to the DDRB this year to send a positive signal that the specialised nature of the SPDCS must be supported, by addressing the inability of the current pay structures to recruit.

7.2 Research evidence

7.2.1 This year our evidence includes findings from two studies into the salaried primary dental care services. We also visited a large and a small service. We believe that the evidence we have found is of a service beset by recruitment difficulties, rising workload and, in England, serious concerns about job and pension security.

7.2.1.1 Clinical Directors Survey 2009

7.2.1.1.1 In May 2009, we conducted our annual Clinical Directors survey that looked at recruitment, retention, referrals into the services, workload and service developments. All 156 Clinical Directors in the UK were sent a questionnaire in May 2009 with one email reminder in late May. 87 replies were received, giving a response rate of 56 per cent.

7.2.1.2 National Benchmarking Survey 2009

7.2.1.2.1 The national benchmarking survey was a survey of all PCTs in England undertaken by NHS Benchmarking on behalf of Primary Care Contracting looking at their salaried dental care services. Data was collected from 97 PCTs which represents 64 per cent of the total number of PCTs in England.

7.3 Recruitment

7.3.1 In its last report, the Review Body noted evidence from NHS Employers that dentistry had the highest vacancy rate of all medical and dental staff groups and this is an area where employers are citing pay as a factor in recruitment difficulties. The Review Body itself expressed concern about recruitment and retention and this concern was justified.

7.3.2 We have evidence from a number of sources that there are serious recruitment and retention difficulties for posts in the salaried primary dental care services. The BDA Clinical Directors Survey 2009 revealed that around two-thirds (69 per cent) of the services in the UK are experiencing difficulties recruiting dentists. This was an increase of seven per cent since last year. 93 per cent of those experiencing

recruitment difficulties cited low applicant numbers, 67 per cent low quality applicants and 75 per cent ineligible applicants.

7.3.3 The PCT benchmarking exercise in England showed that salaried primary dental care services have on average a 14 per cent vacancy rate or almost 1.0 WTE per service. Recruitment problems are most acute in the lower pay bands. Pay bands that have significant difficulties are

- Band C managerial – 31 per cent of respondents reported difficulties
- Band C Specialist – 43 per cent reported difficulties
- Band B Senior dentist – 66 per cent reported difficulties
- Band A dentist – 75 per cent reported difficulties.

7.3.4 These vacancy rates show significant recruitment problems, the origins of which, we would argue, are based on pay levels that do not reward salaried dentists for the work they do and are not attractive to young dentists with substantial student debts to repay. In their evidence for last year, NHS Employers identified that recruitment problems for salaried dentists were to do with pay levels (DDRB 38th Report, para 1.18). The Review Body also identified that there was a recruitment problem but noted that there was a new contract in place (para 1.21). We believe that our evidence this year shows that the introduction of the new salaried contract has not improved recruitment and that there is a serious problem for salaried dentists. When comparing salary scales with *average* figures for general practice associates, it is not difficult to see why.

Comparison of taxable income between performers/associates and salaried dentists

	Taxable income
Average associate in Northern Ireland (2007-08)	£66,134
Average performer in England and Wales (2007-08)	£65,697
Community Dental Officer (CDO) - MAXIMUM INCOME(2009-10)	£53,686
Median pay spine income for CDO (2009-10)	£43,980*
Senior Dental Officer (SDO) – MAXIMUM INCOME (2009-10)	£66,193
Median pay spine income for SDO (2009-10)	£60,608*

Source: DDRB (2009), NHS IC (2009)

*Note: * these figures are not the median income of CDO or SDO dentists but the income at the median point on the respective pay spines*

7.4 Retention

7.4.1 The benchmarking report identified retention as an issue, with a ten per cent turnover rate for salaried dentists in pay bands A to C. This is a high rate of turnover when compared with other NHS professional occupations.

7.5 Morale, motivation and workload

7.5.1 There has been a significant increase in workload this year with our Clinical Directors survey showing, for the third consecutive year, increases in many types of referrals as shown in the following table. (The list of referral types were not directly comparable across the here years but in each year the majority of Clinical Directors reported increases in all of the categories given).

	Percentage of Clinical Directors reporting that referrals have increased
Domiciliary visits	78
Children's services	71
Adults referred for sedation due to anxiety or phobia	71
Other services such as minor oral surgery and dental access centres	79

7.5.2 Of the Clinical Directors who have seen an increase in referrals since April 2008, eight out of ten felt that the referrals had caused increased waiting times for specialist services and a similar proportion felt that the increased referrals had caused increased numbers of patients overall.

7.5.3 So at a time of increased workload, service budgets have not kept pace and increasingly are being cut. A quarter of all services received no increase or a decrease in budget in the year 2008-09 compared with 2007-08 and between 2008-09 and 2009-10, four in ten budgets showed no increase or a decrease. The table below shows the overall picture.

Change in budget	2007/08-2008/09	2008/09 -2009/10
Zero increase or a cut in budget	25%	40%
Budget cut of more than five per cent	2%	15%
Budget increases of five to ten per cent	27%	8%

7.5.4 Increased workload and reducing budgets, in combination with recruitment/ retention issues, affects morale and motivation.

7.5.5 There are various reasons identified for increases in referrals to the salaried dental care services. The single-assessment process for older people has resulted in patients with oral health needs being identified for care by the salaried dental care services and greater resources being devoted to child protection results in increased referrals. Problems with access to NHS dentistry in general dental practice can mean greater demand on dental access centres run by the salaried services.

7.6 18-week pathway

7.6.1 Where services are required to meet the 18-week time limit for access to services, some salaried primary care dental services are not meeting the deadline. The national benchmarking survey for England showed average waiting times of 7.5 weeks for routine appointments (longest 42 weeks). Waits for general anaesthesia show even wider variation at an average of 18 weeks (longest 68 weeks) for adults and 11 weeks (longest 26 weeks) for children.

7.6.2 We believe that these missed targets show the pressure under which salaried dental care services dentists are being placed and are having a detrimental effect on morale.

7.7 Transforming Community Services

7.7.1 The DH in England published its *Transforming Community Services* report in January 2009, the focus of which is for PCTs to separate their commissioning and providing functions unless there is a clear reason for not doing so.

7.7.2 There is currently a great deal of uncertainty among salaried primary care dentists as the process of divestment unfolds threatening consequences for their terms and conditions. Coupled with the uncertainty of losing contracts, and therefore jobs, when PCTs put salaried services out to tender, these factors have an adverse effect on morale and concerns have been raised that there could be a great deal of flux within the workforce as some dentists may look for a position of greater security.

7.7.3 One of the options for PCTs is to create a social enterprise (non NHS body) to provide dental care. New staff members will not have access to existing NHS terms and conditions, including the NHS pension scheme, and, likewise, existing NHS employees will not be eligible for these if they accept a post in another social enterprise. It is quite possible that this retreat from guaranteeing NHS terms and conditions for all staff members may result in an increase in the average age of the workforce followed by the inevitable decline of staff numbers.

7.8 Implementation of the new pay system

7.8.1 As previously noted, the new contract has now been in place for almost two years. With the exception of a minority of locations where issues remain over the award of extended competency points and arrangements for training budgets, we are pleased to note that the contract is now fully implemented in most parts of the country. It has, however, not had the impact on recruitment and retention that had been hoped in spite of having been designed in part to attract new staff into the service.

7.9 Northern Ireland

7.9.1 From mid 2008, the BDA has been holding preliminary discussions with the Northern Ireland Department of Health Social Services and Public Safety (DHSSPS) to encourage them to open negotiations on a new contract for community dentists. This process has reached a conclusion and a business case outlining the benefits of the new contract for patients, employers and CDS dentists has been put to senior government officials, prior to ministerial decision whether or not to proceed with negotiations. If the go-ahead is given by Ministers, negotiations would take place to reach agreement on the details of the new contract, which would be based on those introduced in England and Wales. Unfortunately after managing to get DHSSPS to agree to put the case to ministers, the BDA has now been told that the process of considering whether or not to agree to open negotiations on a new contract for CDS staff has been put on hold whilst a major financial review of general NI finances takes place.

7.10 Scotland

7.10.1 A Project Board convened by the Chief Dental Officer for Scotland to develop the recommendations arising from the Review of the Primary Care Salaried Dental Services in Scotland reported to the SGHD in December 2007. Since then, the BDA's Scottish Salaried Dentists Committee has continued to press the Scottish Government on progress with the development of the integrated salaried service, which has been fraught with delay, with particular emphasis on the need to modernise terms and conditions as part of that development. The primary care salaried dental service in Scotland is the last group of healthcare professionals to undergo modernisation of its terms and conditions.

7.10.2 The BDA believes that, although modernisation does not exclusively relate to pay, there is benefit in addressing the differences in salary scales between the countries, and the effect this will have on recruitment to the service in Scotland. The differences in salary scales between England and Scotland are notable. The Band 1 range in

Scotland is £34,275 to £48,140 (with two discretionary points at £50,913 and £53,686). In comparison, the corresponding Band A in England ranges from £37,344 to £56,016. From findings of a BDA survey of Clinical Directors in the UK, the salaried services in Scotland are experiencing higher numbers of referrals, with difficulties in recruiting dentists and other dental staff. Out of those who responded, the majority of clinical directors in Scotland confirmed that they had problems in recruiting dentists, with low numbers of applicants, low quality applicants and ineligible applicants being the main types of problems encountered when recruiting.

7.10.3 Through the Scottish Joint Negotiating Forum, the Scottish Government has now set up a working group to discuss development of the new service and consider terms and conditions and membership of the group comprises SGHD, representatives of the NHS Boards, the BDA and Scottish Salaried Dentists Committee.

7.11 Wales

7.11.1 The factors affecting the evidence submitted for England apply equally for the service in Wales. The 2008 SPDCS contract was applied in England and Wales, with no variation to its main conditions. Implementation in Wales has been consistent with that in England, and has been welcomed by staff and NHS Trusts alike but where the same concerns about recruitment (particularly at the band A level) and retention are now prevalent. As a result we will wish to see the outcomes of this year's DDRB award for applied in both England **and** Wales in full.

7.12 Recommendations

7.12.1 We ask for 3.6 per cent increase for all staff, representing public sector pay rises.

7.12.2 Because of the difficulty in recruiting staff at this level, we also ask for the addition of two incremental points to the top of the band A scale. This would require the deletion of the two points at the bottom of the scale

8. Consultants in Dental Public Health

8.1 Recruitment and retention of high quality Consultants in Dental Public Health has never been more important. A locally-commissioned dental service in England depends upon the ability of PCTs to determine local oral health needs, which is a highly-skilled task requiring CDPH leadership. Many PCTs have no or very little CDPH support, which is highly detrimental to their work in commissioning care to improve oral health. Because the Consultants who are in post are over-stretched, morale is adversely affected. A sufficiently well-resourced CDPH has a major impact on the quality of commissioning and the delivery of a patient centred service.

8.2 The Steele Review in England gave particular emphasis to the role of Consultants in Dental Public saying that “ready access to advice from a consultant is essential in all PCTs”. We thoroughly endorse that point.

8.3 The main evidence for Consultants in Dental Public Health is provided by the British Medical Association.

9. Clinical academic staff

9.1 We are providing evidence on the recruitment and retention of clinical academic staff. Although this staff group is outside the formal remit of the Review Body, they have a profound influence on the quality of the education received by dental undergraduate students and so ultimately affect the recruitment of young people into the profession. Clinical academic staff play a key role within dental schools and exhibit very high levels of teaching, research, and clinical skills which should be rewarded. We thank the Review Body for considering our evidence on clinical academic staff in previous years and invite it to do so again this year.

9.2 This year there has been no improvement in the significant recruitment and retention problems for clinical academic posts that we reported last year. The rapid expansion of dental school places has led to a pressure on posts because the pay of clinical academic staff is insufficient to attract dentists to this work when compared to pay achievable in other spheres of the profession. Data published in May 2009 by the Dental Schools Council (DSC) on dental academic staffing levels to the end of 31 July 2008 show that the total number of Professors, Senior Lecturers and Lecturers in post has declined year on year since 2000, from 476 FTE to 373 FTE in 2008. Only the inclusion of Senior Clinical Teachers and Clinical Teachers in the 2007 and 2008 datasets have increased staffing levels to those similar to 2000. (Dental Schools Council, Staffing levels of dental clinical academics and dental clinical teachers in UK Dental Schools, 2009:p11)

9.3 The training pathway for clinical academic staff has increased, which has had an effect on recruitment. The closure of the Associate Specialist Grade to new entrants and its replacement by the Specialist Doctor grade (which has a lower maximum salary than the current maximum for non-consultant senior lecturer/reader posts) will also have a detrimental effect.

9.4 Many clinical academic staff are recruited from general dental practice and salaried primary dental care (SPDCS) and this is hugely beneficial to dental students. These personnel are often part-time and are able to bring real-life experience of practical dilemmas faced by dentists, which helps prepare students for life in practice. Although there has been a rise in the numbers of these posts (Clinical Teachers and Senior Clinical Teachers), there is a large turnover because the remuneration is not comparable to that achievable in general practice and the SPDCS. We believe there should be pay parity between these posts and those in the SPDCS to aid recruitment and retention. We intend pursuing this issue with the Universities and Colleges Employers Association (UCEA). It is also important to note that the Dental Schools Council itself has acknowledged that “efforts must be made to recruit to

(sic) and retain clinical academics…..in order to stem the decline of clinical academic numbers in dentistry". (page 16)

9.5 As in previous submissions, we reiterate the continued importance of pay parity being maintained with NHS dentistry to address the recruitment and retention issues and ensure that clinical academic dentistry remains a valid career choice for high-calibre dentists. This includes fair and equal access to additional Programmed Activities (PAs, the currency of the NHS consultant contract and academic contract) and the Clinical Excellence Awards scheme.

BDA press releases on the DDRB award for 2009-10

31 March 2009

Review Body award fails NHS family dentists, says BDA

Today's announcement that high street dentists are to be awarded a 0.21 per cent gross pay uplift does nothing to provide a much needed boost for NHS dentistry, according to the British Dental Association (BDA). The 0.21 per cent rise is based on a formula that, taking estimated decreased expenses into account, suggests GDPs will actually see a 1.5 per cent increase in net incomes.

John Milne, Chair of the BDA's General Dental Practice Committee (GDPC), said:

"We appreciate that a measure of financial restraint is necessary in the current economic climate. Clearly, economic prudence is essential for everyone. But it's also important to remember that high street dentists are running businesses that provide vital healthcare to millions of people. Those businesses must be properly funded so that they can invest in their premises and equipment to deliver the highest quality care to their patients.

"Sadly, the basis of the formula which suggests that the increase might amount to 1.5 per cent in real terms does not take account of the effect of the devaluation of sterling and its effect on the prices of equipment and materials that are largely manufactured overseas. These expenses, and dentists' ability to access the finance necessary to met them, are both adversely affected by the recession.

"The problems many patients have faced accessing NHS dentistry in recent years have been well documented. The solution to those problems is to build confidence in the future of NHS dentistry by properly supporting our current NHS practitioners, and sending a positive signal to newly qualifying dentists about the future of NHS dentistry. This settlement will do neither of those things."

Ends

Notes to editors

1. Details of the award are available at: http://www.ome.uk.com/review.cfm?body=5.
2. The British Dental Association (BDA) is the professional association for dentists in the UK. It represents over 23,000 dentists working in general practice, in community and hospital settings, in academia and research, and in the armed forces.
3. For further information, please contact the BDA's media team on 020 7563 4145/6.

PR16.09

01 April 2009

Scotland's dentists let down by pay award, says BDA

The British Dental Association (BDA) has slammed the announcement that NHS family dentists in Scotland have been awarded just a 0.21 per cent gross pay uplift for 2009/10. The award mirrors that given to NHS practitioners in England where, it is argued, changes to expenses incurred by NHS dentists as a result of a new contract implemented in 2006, mean that the uplift will produce a 1.5 per cent net award.

Colin Crawford, Chair of the BDA's Scottish Dental Practice Committee, said:

"This award is simply insulting. Dentists recognise that these are difficult financial times for everybody, but it also needs to be recognised that there are significant issues to be tackled with health service dentistry in Scotland. This award will not help to do that.

"The changes to the delivery of dental services in England that were made in 2006 have not been mirrored in Scotland, so calculations about changing expenses that the English uplift is based on don't apply here. If the intention was to award high street dentists in Scotland a 1.5 per cent uplift to match their English colleagues, this award will fail to achieve that.

"In fact, expenses in Scotland are increasing, with major changes to decontamination requirements due for implementation later this year likely to place a significant burden on many practitioners. For some dentists, this will damage practice viability and may act as a discouragement to treat NHS patients."

Ends

Notes to editors

1. Details of the award are available at: http://www.ome.uk.com/review.cfm?body=5.
2. The British Dental Association (BDA) is the professional association for dentists in the UK. It represents over 23,000 dentists working in general practice, in community and hospital settings, in academia and research, and in the armed forces.
3. For further information, please contact the BDA's media team on 020 7563 4145/6.

PR18.09

9 April 2009

Salaried dental services let down by pay award, says BDA

Representatives of England's salaried dentists have today said the pay uplift they have been awarded for 2009/10 will not help to address the problems their services are facing. Representatives of dentists working in salaried primary care dental services, hospitals and academia have all criticised the award, arguing it will not help staff and morale problems in their respective fields.

Peter Bateman, Chair of the BDA's Salaried Dentists Committee, said:

"While we appreciate the current economic situation in Britain and the need for restraint in determining pay uplifts, it is also important that the effect of these uplifts is properly considered. We know that almost two thirds of PCT-run salaried dental services across the UK are already struggling to recruit dentists. This uplift will do nothing to improve our ability to recruit, and could even exacerbate the problems we and the vulnerable patients we treat face."

Keith Altman, Chair of the BDA's Central Committee for Hospital Dental Services, was also critical of the award:

"Dental staff working in hospitals are very disappointed by this award which will do little for the morale of dedicated professionals working with very limited resources. Those in training grades in particular need reassuring that a career in hospital dentistry is valued in order to encourage entrants to this branch of dentistry."

Professor Paul Wright, Chair of the BDA's Central Committee for Dental Academic Staff, also expressed concern:

"The future of the dental profession depends on the education of the dental workforce of the future. The Dental Schools Council Clinical Academic Staff Survey published in June 2008 showed that dental academic staff levels are unchanged since 2000, despite a huge increase in the number of undergraduate dental students and dental care professionals in training.

"While senior academics receive parity with their senior colleagues in the NHS, the training paths and career progression for academic staff are much more challenging and there is a financial penalty to be paid in lifetime earnings. Assuming the award is translated to dental academic staff, the relative incentives for various careers within Dentistry remain unchanged and this will do nothing to encourage recruitment."

Ends

Notes to editors

1. Details of the award are available at: http://www.ome.uk.com/review.cfm?body=5.
2. The British Dental Association (BDA) is the professional association for dentists in the UK. It represents over 23,000 dentists working in general practice, in community and hospital settings, in academia and research, and in the armed forces.
3. For further information, please contact the BDA's media team on 020 7563 4145/6.

Payment system for dentists in Northern Ireland

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

The information is separated into those payments made to individual dentists and those made to practices.

Individual payments

- Item-of-service fees for treatment items
- Sessional payments for provision of emergency dental services
- Seniority payments
- Vocational training allowances
- Commitment payments
- Maternity/paternity/adoption leave
- Long-term sickness pay
- Continuing professional development allowances
- Clinical audit allowances
- Practice payments
- Reimbursement of non-domestic rates
- Practice allowance

Item-of-service fees for treatment

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

Sessional payments for provision of emergency dental services

Dentists in Northern Ireland participate in Health and Social Services Board-run emergency clinics for out-of-hours emergencies. The fee paid for each three hour session is £119.68

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

Seniority payments

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

Vocational training allowances

Vocational training allowances cover

Reimbursement of the trainee dentist's salary

This is a direct reimbursement of an incurred cost.

A trainer grant of £753 per month

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

Trainer quality assurance grant

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

Charter Mark allowance

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

Commitment payments

Commitment payments are a payment to dentists in recognition of their individual commitment to the health service. The maximum payment per quarter up to April 09 is £1,104 per quarter. Commitment payments have been increased by 80 per cent with effect from 1 April 09.

The total expenditure on commitment payments in 08/09 was £1.501 million. The increase from April 09 will bring the spend on commitment payments to approximately £2.62 million for 09/10.

Maternity, paternity, adoptive leave

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

Long-term sick pay

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

Continuing professional development allowance

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

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

Clinical audit allowance

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

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

Reimbursement of non-domestic rates

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

Practice allowance

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