British Dental Association

Supplementary evidence to

The Doctors' and Dentists' Review Body

For its thirty-ninth report

November 2009

Summary

The BDA's supplementary evidence this year is limited to responding to questions posed by DDRB secretariat and giving our views on the submissions of the UK Health Departments and NHS Employers.

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1. Questions posed by DDRB

1.1 NHS Employers' evidence

1.1.1 ***Comment please on the proposal for a flat rate pay uplift.*** (Paragraph 3.20 - 3.23)

1.1.2 We do not believe that a flat rate pay uplift is appropriate to the salaried primary dental care services (SPDCS). The problem faced by the NHS in providing SPDCS is the recruitment and retention of staff in the career grades Bands A and B and not in the lower trainee grades, for which a flat-rate uplift would work.

1.1.3 We do not agree with NHS Employers' contention that the recruitment situation may be improving for salaried dentists as a consequence of the new contract (paragraph 11.8) and believe that their view may be based on returns from trusts that do not in fact provide this service. Both the BDA and NHS Benchmarking have demonstrated an acute recruitment problem, as explained in our main evidence. Evidence from the NHS Benchmarking salaried services report is that 76 per cent of providers of salaried dental services were experiencing difficulties in recruiting to Band A posts and 66 per cent have difficulties recruiting to Band B. Overall, salaried dentist posts had a high (14 per cent) vacancy rate. Given that 40 per cent of the salaried dental workforce are in Band A posts, this represents a serious situation for the provision of services for patients.

1.2 BDA's evidence

1.2.1 ***Why do you continue to consider it necessary for DDRB to make any recommendation on gross contract values (in England and Wales)? Now that full commissioning is in place, is it not reasonable for PCTs to agree an uplift to each contract with the providers, taking into account local circumstances, including the position on dental expenses?*** (paragraph 1.3.1)

1.2.2 We believe that the Review Body has a key role in providing an efficient way of determining increases in gross contract values in England and Wales. Passing responsibility to Primary Care Organisations (PCOs) would result in significant duplication of effort on the part of both PCOs and contractors. With PCO resources increasingly stretched, having a central process makes financial sense.

1.2.3 There is precedent from pre-2006 Personal Dental Services to lead us to believe that PCOs, with their superior bargaining position, would, perhaps understandably, prefer to spend on short-term NHS priorities, rather than on annual rises in dental contract values. This would lead to long-term deterioration in the availability of service, inhibit continuous improvement and would have a detrimental effect on the NHS dental workforce. DDRB can provide a balanced view and promote equity for dentistry in the health service.

1.2.4 DDRB's important role in determining pay for dentists in Scotland and Northern Ireland has not changed.

1.2.5 ***Can you explain what you mean by a 'timings exercise'?*** (paragraph 3.5.1)

1.2.6 The purpose of a timings exercise is to determine how long it takes, on average, to undertake specific items of treatment, with the intention, in the past, of determining an hourly rate for general dental practice. There have been a number of similar exercises over the years, some undertaken jointly with DH. The results of the exercise were last taken into account when determining the fee scale in 1988, which means that the remuneration systems in all four countries are based on a pattern of dental care that is twenty years out of date. For this reason it is important to go back to basics.

1.2.7 The contention is that many factors have influenced the time it takes to deliver dental treatment in the last twenty years. Huge technological advances have completely changed the complexity of the offering: there are many more options available to patients and dentists, requiring much more time to be spent on explanation and obtaining consent and then on the more sophisticated procedures themselves. Examples include endodontic treatment, the use of composite restorative materials, rubber dam and advanced restorative treatments. Other factors influence the time taken and infrastructure required to provide care, such as modern decontamination methods, the improved quality of service and the contractual requirements in today's NHS.

1.2.8 To explain the process in more detail: a panel of dentists measured the absolute time taken to carry out 21 key treatments. The relative times of related treatments were then estimated. The panel also came to consensus about the variables to construct the hourly rate model. The absolute timings exercise was applied to the hourly rate model in order to draw some conclusions about the average earnings of a full-time dentist committed to the NHS.

1.2.9 ***Can you explain how such "additional funding" to compensate dentists for their massive investments might work in practice. How would the additional funding be applied?*** (Paragraph 6.1.1.3)

1.2.10 We envisage practice owners receiving compensation when their NHS practice is closed or sold without an NHS contract being continued from the same address in circumstances where the PCO does not re-contract with a proposed purchaser who is otherwise qualified to take on an NHS contract. The amount of the allowance might be calculated on the basis of a percentage of the NHS contract value aggregated over say the previous five years.

1.2.11 ***I believe we said that the current formula had delivered an increase in fees to Northern Ireland of around 0.7 per cent over what have been awarded in the absence of the current formula (actually 0.732 per cent).*** (Paragraph 6.2.6.1)

1.2.12 Yes we agree; we recorded the figure incorrectly. It must be noted that, in applying a percentage rise across a fee scale of over 400 items, supported by multiple small value fees for continuing care and capitation payments for patient registration, the true value of the award is diluted. The April 2009 pay award of 0.21 per cent is reduced to 0.126 per cent when this effect is taken into consideration.

1.2.13 ***For 20 per cent of total GDS income to be derived from allowances, the NHS fees: allowances ratio would be 4:1. Please clarify.*** (Paragraph 6.3.4.2)

1.2.14 This relates to Scotland. Yes we agree: the ratio should have been expressed as 4:1. Our point is that allowances, such as practice improvement grants, remote areas allowance and recruitment allowances are an important element of dental practice funding and an increase only in fees and other payments leaves a significant proportion of funding unchanged.

1.2.15 ***You are seeking a recommendation for salaried dentists of 3.6 per cent, based on the increase in average earnings in the public sector. However, the 3.6 per cent increase in average earnings in the public sector also includes the effect of increments. The salaried dentist pay scale includes increments (according to NHS Employers evidence at paragraph 11.9) of between 2 and 11 per cent. Comments please.*** (Paragraph 7.12.1)

1.2.16 The reference to increments of between 2 and 11 per cent is misleading. The largest incremental increases in both Bands A and B occur between entry point and the achievement of a ‘gateway’ performance pay point set at the third pay point in both Bands A and B. The gateway pay point represents *the standard expected for the grade*

by achievement of a set of core competencies that *must* be achieved before any further progression can occur.

1.2.17 These early, accelerated Increments up to and including the gateway pay point are much higher than standard increments because they reflect a strong performance pay element designed to attract dentists into the SPDCS and hence ensure that they quickly reach an acceptable level of quality and performance.

1.2.18 Away from this performance-related element, standard increments in Band A are typically between 4 and 6 per cent, and in band B, between 2 and 4 per cent.

1.2.19 The numbers of SPDCS dentists benefiting from an incremental pay increase is, however, relatively very low, where the overwhelming majority of SPDCS dentists are already at their pay maximums. Data collected in 2006 during the negotiations for the SPDCS contract showed that, from a total of 779 whole-time equivalent (WTE) staff, in Band A 481.4 (61.8 per cent) were at pay points 5, 6 or 7 moving in to the new contract. All will now be at their pay band maximums with no incremental increase due. In Band B, the same statistics showed that 358.5 WTE staff from a total of 574 (62.8 per cent) were at pay points 11, 12 or 13 at that stage and, again, all will now be at their pay band maximums with no incremental increase due.

1.2.20 We would also draw attention to the failure of even the relatively high valued increments at the entry points of the SPDCS pay system successfully to attract staff into the service.

1.2.21 While we understand that the 3.6 per cent across the wider public service may include increases due to staff from incremental pay systems, we reiterate the dual need within SPDCS to tackle serious issues of recruitment at lower pay levels, and retention of experienced dentists at the higher end of their pay bands.

1.2.22 Finally, the SPDCS contract implemented from June 2007 was fully funded with a 10 per cent increase in the pay envelope made available to NHS Trusts to fund the in incremental pay increases due. There were no additional cost pressures on Trusts as a result of the pay restructure.

2. Efficiency savings and the effect on net pay

2.1 In its evidence (paragraph 6.9), the Department of Health contended that it should be possible for dentists to make efficiency savings on expenses of 1.0 per cent, which would result in an increase in net income before tax of 0.6 per cent. DHSSPS and SGHD also thought that efficiency savings were possible. NHS Employers said that a 0.2 per cent award would deliver a 1.0 per cent rise in net pay (paragraph

12.7). We were interested to note that they were concerned about the effect on morale of a nil rise and we share this concern since we believe, as we say in our main evidence, that morale among NHS dentists is a significant problem (paragraph 12.8). NHS Employers also reported PCTs as not seeing any significant improvement in recruitment in the GDS (paragraph 11.8).

2.2 We do not understand how DH, DHSSPS and SGHD have calculated that these efficiency savings are possible and how they will necessarily be achieved equally in the four countries where the systems are so different. We find no attempt to explain their conclusion.

2.3 We are also concerned that these submissions assume that savings can be made in the future. DDRB has frequently reminded us that it makes its recommendations based on a retrospective view of actual earnings and expenses patterns, not prospectively based on an unproven assumption.

2.4 As small businesses, most dental practices have very little scope to achieve real efficiency savings, particularly at a time where NHS regulatory and contractual requirements are increasing. For example, new information governance requirements are being introduced in April 2010 that will mean new protocols and procedures that will increase costs and management time; and PCTs will require demonstrable continuous improvement in service. Workforce costs are the most significant expense in dental practice and, for a business with say three staff members, it is not normally possible to reduce numbers of posts without affecting service and quality significantly. Most practices are being forced to increase, rather than contract, management and administrative staff to enable them to function in today's NHS.

2.5 We explained at length in our main evidence that costs overall had in fact risen due in large part to the effect of the fall in the value of Sterling and rising staff costs (section 5.4). We do not accept that it is possible for dentists to make savings in the current climate and fully expect costs to increase significantly in the coming year as they make necessary adjustments to their practices to comply with decontamination requirements and, in England, to comply with dental access contracts and prepare for Care Quality Commission registration. In a fee-per-item system, it is not possible to work harder and reduce costs at the same time.

2.6 NHS Employers also say that a large award would create little incentive to improve quality or increase the range of services since dentists would receive increased funding for existing services regardless of improved efficiency, quality or access. We do not follow this logic. All businesses need to generate profit to grow and to improve; if dentists do not have the funds available, they will be unable to make improvements to practice services and infrastructure. It is precisely this inability that has historically held NHS dentistry back.

2.7 Compliance with NICE dental recall guidelines will result in increased expenses. Some patients will be seen more frequently and others less frequently. Where capacity is increased by lengthening recall intervals, new patients will be seen, many of whom will have high dental needs. Providing a proper standard of care for these new patients will not yield efficiency gains, but will be hungry in time and resources.

2.8 We repeat the point that if, in England and Wales, some courses of treatment have become simpler, dentists have still been providing care that incurs costs. There is no evidence that there has been a further reduction in advanced treatments in England and Wales since last year. If a formula approach is to be used by DDRB, it should only look at changes year on year. The figures in table 6.22 are experimental and cannot be relied on this year, particularly because not all contractors provide this information.

2.9 Morris & Co, accountants to many dental practices and a major contributor to NASDA, publish statistics showing the breakdown of total practice expenses. These show that the average percentage for all practices reduced from 6.9 per cent in 2006 to 6.1 per cent in 2008. In cost terms, this equates to £28,535 and £28,748 respectively. So if laboratory work has decreased, the costs have remained constant. Dentists in Northern Ireland and Scotland are paid for laboratory work solely through item-of-service fees.

2.10 DDRB is concerned with a fair return for dentists, although this might be arrived at by determining a gross uplift to contract values or fees. We do not believe that the Department's statement that *decisions on NHS earnings growth should be focused on explicit incentive to increase productivity and efficiency* (paragraph 6.6) is relevant to net pay.

3. Effect on practices of contract values

3.1 It was evident for many years that dentists' productivity and efficiency were driven by the 'treadmill' of an underfunded item-of-service fee scale system that resulted in a service that undermined the sustainability of practices and so was not fit for purpose. We have demonstrated repeatedly, and have been supported by the Health Select Committee and the Steele Review, that the contract value based on UDA targets which replaced it in England and Wales has been detrimental to dentists' businesses and to the delivery of patient care. Contrary to the Department of Health's claims, this system has not delivered stability and security: security is much more fragile than in the previous system, since dentists work under the constant threat of clawback, and for many, particularly those with PDS agreements, there is no security of tenure. This is borne out by NHS Employers when they explain in their evidence (paragraph 12.12) their wish to enable

PCTs renegotiate *existing* contract values to ensure that efficiency savings are made and that quality is driven up at the same time.

3.2 We demonstrated through the Business Trends Survey in our main evidence that morale of fully-committed NHS dentists is lower than that for mainly private dentists. Although GDS contracts have no end date, they can be terminated after two breach or remedial notices have been issued by a PCO. Fixed-term PDS agreements are becoming more common given that most new contracts are being awarded on the basis of a PDS agreement.

4 The uneven availability of grants and loans

4.1 Some PCTs/LHBs have assisted practices with grants and loans for the purchase of specialist equipment, but this is by no means universal and cannot be relied upon as an element of a pay award. We have demonstrated elsewhere (BDA Independent Local Commissioning Working Group report) that in England and Wales PCTs' performance is extremely variable. The availability for some of financial support for exceptional outlay cannot affect the overall award for the many. And while some capital grants have been made, revenue costs have not been met.

5 Expenses study

5.1 We note that the Department wants to work with the BDA and NHS Employers to examine expenses factors in more detail for next year and on a joint survey of motivation and morale and look forward to receiving details of their proposals.

5.2 We also note that NHS Employers want to work with the Review Body, the Department of Health and the BDA to examine and assess the components of a formula approach, in particular to investigate the possibility of taking into account other factors such as expected efficiencies. Again, we look forward to receiving further information.

6 Submissions for the award

6.1 We are concerned that both DH and NHS Employers maintain that making a lower award means that PCTs have money to commission new services, so improving access, and go on to assert that dentists can increase their earnings through new services. As we say above in paragraph 2.10, DDRB is concerned with determining a fair return for dentists for the delivery of dental services. Although offering new services gives practices the opportunity for more work and greater turnover, this will certainly not represent an increase in personal earnings because of the costs of contract compliance and the much

higher level of expenses incurred. If returns are driven down, access will be reduced as dentists look for alternative means of supplementing their income.

6.2 The BDA supports properly funded and designed initiatives to improve access to NHS dentistry particularly to people in deprived and excluded communities. But we see it as a false economy to expect the workforce to pay for greater access. At a time of rising expenses, freezing contract values will reduce net pay. PCOs have the budget to commission additional services in 2010-11 and there is normally a considerable amount of uncommissioned dental budget because of the lengthy and complex process required to procure new services coupled with a lack of PCO administrative capacity.

7 Northern Ireland

7.1 Key points

- All of the payments made to dentists are either laid out in the Statement of Dental Remuneration or linked back to the dentist's gross earnings (which come mainly from fees for treatment and patient registration).
- GDS practitioners are asked to make 1 per cent efficiency savings to gain 0.6 per cent to net pay. No evidence has been offered as to how this can be achieved.
- 8.27 per cent of the total monies in the Northern Ireland General Dental Services is attributed to payment of the practice allowance.
- The practice allowance is the only payment in the general dental services which is directly aimed at addressing increasing overheads costs.

7.2 Practice allowance

7.2.1 The practice allowance in 2008-09 accounted for a £7.522 million spend in the dental budget. At April 2008 there were 357 GDS practices in Northern Ireland, accounting for a typical practice allowance per practice in the range of £21,070 per annum. DHSSPS evidence at paragraph12.41 describes health service committed practices as receiving in excess of £30,000 in practice allowance payments.

7.2.2 The level of the practice allowance payment is directly related both to the volume of treatment items delivered and the number of patients registered. More items delivered and greater number of patients registered will generate increased turnover and consequently the practice allowance value will rise in line with this.

7.2.3 DDRB has asked specifically how expenses should be accounted for. In the light of the direct correlation between volume of work and number of patients registered, with the value of the practice allowance, BDA suggests that DDRB should continue to make a percentage award in the same way as previous years as the award to fees is automatically reflected in the practice allowance. The same correlation can be applied to superannuation, seniority payments, maternity, paternity, adoption pay, commitment payments and long term sick pay. Details of the aim of the practice allowance is given at paragraph 6.2.8.2 of BDA's main evidence. In order to meet the current requirements of health and safety, additional staff training needs, the expanding requirement for IT support at practices and the provision and upkeep of premises, practices are finding that the practice allowance goes some way to meeting an ever increasing agenda of continuing expenses.

7.3 The effect of allowances

7.3.1 We describe the dental payment system in Northern Ireland at paragraph 6.2.1.1 of our main evidence. Considering the overall payments made to dentists in 2008-09, with the exception of superannuation and VT allowances, item-of-service fees and payments for registered patients account for 87.04 per cent of dentists' gross turnover. Some allowances cover areas of work which are non-clinical, such as clinical audit and peer review and continuing professional development allowances. This is described at 6.2.1.6 and in annex 2 of our main evidence.

7.3.2 DHSSPS NI evidence at paragraph 12.43 describes the dental payment system as being made up of items of service, capitation and continuing care payments (for patient registration) and 'block payments'.

7.3.3 It is important to understand that in the DHSSPS description, the term 'block payments' is used as an overarching term and includes superannuation, seniority pay, session payments to dentists for participating in locally organised hospital-based out of hours rotas, payments in respect of vocational training, payments to dentists undertaking a set amount of clinical audit and/or peer review, maternity, paternity and adoptive leave payments, compensation for dentists who are forced to retire early, commitment payments, reimbursement of non domestic rates, long-term sickness pay, postgraduate education payments and the practice allowance. Also included are payments made on behalf of Health and Social Services Boards for quality assurance and the payment of a centrally-administered contract for the collection of controlled waste from dental practices. These latter two payments are administered through the dental payments system, but fall outside the remit of DDRB.

7.3.4 Out of this grouping of payments, the practice allowance is the only payment which is designed to assist practices in meeting overheads/expenses costs. The aim and nature of the remainder of the payments are described below.

7.3.5 Superannuation is a percentage deduction of gross fees earned going towards future pension costs. The deduction is proportionate to the level of income generated through item-of-service and patient registration payments.

7.3.6 Seniority pay, out-of-hours rota payments, clinical audit and peer review payments, maternity, paternity and adoptive leave payments, early retirement compensation, long-term sick pay and postgraduate education payments are all payments which compensate dentists when they are undertaking additional non-clinical work or are unable to work at the dental chairside and so to treat patients and earn item-of-service fees.

7.3.7 Out-of-hours payment is a sessional fee laid out in the Statement of Dental Remuneration and is paid to dentists who undertake additional clinical sessions, outside their practice, in out-of-hours rotas.

7.3.8 Clinical audit and peer review payments are claimable up to a maximum per every three years and payment is abated in accordance with the volume by percentage of health service work undertaken.

7.3.9 Postgraduate education payments are claimable to a maximum level per year and payment is abated in accordance with the volume by percentage of health service work undertaken.

7.3.10 Seniority pay, maternity, paternity and adoptive leave payments, early retirement compensation, and long-term sick pay are all claimable up to maximum levels set out in the Statement of Dental Remuneration. In turn, these payments are linked to previous gross earnings and the level of income generated through item-of-service treatments and patient registrations.

7.3.11 Vocational training payments are specific to the group of dentists participating in vocational training and include payments to recognise the resources involved in training a new graduate dentist, as well as reimbursement of the trainee dentist’s salary.

7.3.12 Commitment payments provide a reward to individual dentists with over five years’ service in recognition of their commitment to the health service.

7.3.13 Reimbursement of rates is a direct reimbursement of a cost incurred by dental practices. The payment is abated in accordance with the volume by percentage of health service work undertaken.

7.3.14 The practice allowance is a payment made to a designated dentist where the practice meets the definition of 'committed health service practice' and is to help address the increasing requirements in relation to the provision of premises, health and safety, staffing support and information collection and provision. The practice allowance, when considered against the total payments administered by BSO in respect of general dental services in 2008-09, including all of the payments listed above, accounts for 8.27 per cent of the total. When VT payments and superannuation are excluded, the practice allowance accounts for 8.97 per cent of the total. In 2007-08, the practice allowance, when considered against the total payments administered by BSO, accounted for 7.94 per cent of the total. When VT payments and superannuation are excluded, the practice allowance accounts for 8.25 per cent of the total. The value of the practice allowance to a practice is directly proportionate to the value of the historic item-of-service claims and the number of patients registered. So a percentage rise to fees will automatically increase the practice allowance in Northern Ireland.

7.3.15 The remainder of the items covered under the DHSSPS term 'block payment', superannuation, seniority pay, maternity, paternity and adoptive leave payments, compensation for dentists who are forced to retire early, commitment payments, and long- term sickness pay will increase in line with percentage rises to the fee scale. Payments in respect of postgraduate education, session payments to dentists for participating in locally-organised hospital-based out-of-hours rotas, payments in respect of vocational training and payments to those undertaking a set amount of clinical audit and/or peer review are set out in the Statement of Dental Remuneration and rise with the percentage rise from DDRB.

7.3.16 Reimbursement of non-domestic rates is not affected by DDRB.

7.3.17 All figures are available at Annex 1.

7.4 Commitment payments

7.4.1 DHSSPS evidence at paragraph12.42 states that some dentists may receive up to £8,000 in commitment payments. Figures from BSO show that in 2007-08 there were ten contractors out of a total of 920 who had gross earnings sufficient to achieve a level 10 commitment payment, which now has a value of almost £8,000 per year. In 2007-08, 827 contractors out of 920 (almost 90 per cent) had gross health service earnings of less than £100,000 and are more likely to achieve a commitment payment in the order of levels 1-5. So a more typical value of an increased commitment payment would be in the order of less than £1500 per annum. (See annex 2 - Gross earnings band data Northern Ireland 2007-08).

7.5 Item-of-service fees

7.5.1 The bulk of a dentist's time is spent treating patients and remuneration for clinical work is based on fees per item of service and registration payments for the number of patients registered. It is essential that the fees for items and patient registration reflect the time spent with patients and the costs incurred in production. In turn, as is demonstrated above, payments in respect of superannuation, seniority pay, maternity, paternity and adoptive leave payments, compensation for dentists who are forced to retire early, commitment payments, long-term sickness pay and the practice allowance are directly linked to prior earning fees for treatment and patient registrations.

7.6 The effect of decontamination guidance

7.6.1 Decontamination guidance for Northern Ireland sets out standards that practices should achieve by November 2010. This guidance goes further than that for England and is specific and detailed, as well as more onerous. The practical reality means that practices will have to change working practices and provide additional staff to meet the requirements. For example, practices in Northern Ireland must use instruments that have been sterilised that working day. To meet this demand will require staff to be in the premises processing instruments in advance of the clinical session. This has a negative impact on practice resources, working hours, use of disposables and all of these represent additional costs, without the ability to generate additional turnover in the practice. The additional costs must be met through the pay package available.

7.7 DHSSPS submission

7.7.1 The pay conclusion in the DHSSPS evidence asserted that self-employed GDS practitioners, in order to produce a 0.6 per cent increase in net payments would make 'reasonable efficiency savings' of 1.0 per cent. DHSSPS did not offer any evidence as to how this can be achieved.

7.7.2 DDRB is asked to note that the pilot for a new contract for dental services in Northern Ireland is delayed. This will have a consequential delay on implementation of a new dental contract for Northern Ireland

8 Scotland

8.1 Implementation of last year's award

8.1.1 We were disappointed that the Scottish Government Health Directorates (SGHD) did not explain the reasoning for the way in which they implemented last year's award when it was clear that the DDRB award could not be applied as a straight percentage on fees in order to arrive at an appropriate increase in net pay.

8.2 Workforce

8.2.1 SGHD gives figures showing an apparent increase in the numbers of dentists. While the headcount is greater, the working patterns of dentists today are very varied and greater numbers do not necessarily equate to significantly more hours.

8.3 Expenses and allowances

8.3.1 We note that SGHD does not provide evidence on dental practice expenses. We therefore refer the DDRB to our own evidence in relation to materials and laboratory costs.

8.3.2 SGHD explains a number of allowances available to dentists in Scotland and these do make an important contribution to practice funding. Once again, however, we note that increases to item-of-service fees and other payments leave allowances as a significant proportion of funding unchanged.