



Review Body on Doctors' and Dentists' Remuneration

Supplement to the
Thirty-Second Report 2003

Chairman: Michael Blair, QC



Review Body on Doctors' and Dentists' Remuneration

Supplement to the
Thirty-Second Report 2003

Chairman: Michael Blair, QC

**Presented to Parliament by the
Prime Minister and the Secretary of State for Health**

**Presented to the Scottish Parliament by the
First Minister and the Minister for Health and Community Care**

**Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services**

**by Command of Her Majesty
June 2003**

© Crown Copyright 2003

The text in this document (excluding the Royal Arms and departmental logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the document specified.

Any enquiries relating to the copyright in this document should be addressed to
The Licensing Division, HMSO, St Clements House, 2-16 Colegate, Norwich, NR3 1BQ.

Fax: 01603 723000 or e-mail: licensing@cabinet-office.x.gsi.gov.uk

Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the Secretary of State for Scotland and the Secretary of State for Wales on the remuneration of doctors and dentists taking any part in the National Health Service.

The members of the Review Body are:

Michael Blair, QC (*Chairman*)
Hugh Donaldson, Esq¹
Alan Hawksworth, Esq TD, DL²
Richard Malone, Esq

Professor Frank Burchill
Professor Alexander Dow
Dr Gareth Jones
Mrs Deborah Page³

The Secretariat is provided by the Office of Manpower Economics.

¹ Mr Donaldson was appointed to the Review Body by the Secretary of State for Health from April 2002.

² Mr Hawksworth resigned from the Review Body in November 2002.

³ Mrs Page was appointed to the Review Body by the Secretary of State for Health from April 2002. Mrs Page subsequently resigned in October 2002.

Contents

	Summary of recommendations and main conclusions	v
<i>Chapter</i>	1: Economic and General Considerations	1
	2: General Dental Practitioners	3
	3: Salaried Primary Dental Care Services	34
	4: GMP Registrars	38
	5: Salaried GMPs Employed by a Primary Care Organisation	43
<i>Appendix</i>	A: Detailed recommendations on remuneration	45
	B: Letters from the parties on the agreement for Salaried Primary Dental Care Services Staff	49
	C: Research on Salaried Primary Dental Care Services Staff – report by Mercer Human Resource Consulting	54

Summary of recommendations and main conclusions

Our recommendations are for implementation with effect from 1 April 2003. This report deals only with general dental practitioners, Salaried Primary Dental Care Services, GMP registrars and salaried general medical practitioners employed by a primary care organisation. We continue to await further developments on the proposed new contract for general medical practitioners and the recently launched ballot.

Chapter 1 – Economic and General Considerations

- Our aim this year has been not to delay the pay timetable any longer than has been made necessary by the various pay negotiations, but it is unfortunately inevitable that none of our remit groups will have received a pay uplift on 1 April, as they would normally expect. This is a very unfortunate delay and we hope that the next review can revert to the usual timeframe (paragraph 1.3).

Chapter 2 – General dental practitioners (GDPs)

- We were disappointed to hear that agreement on a three-year deal for GDPs could not be reached between the Department and the BDA. We do not wish to make, or even imply, any comment on the merits or otherwise of the deal which was tabled. We would only observe that although the Department clearly described its offer in terms of the overall investment (23.8 per cent) it would provide over the three-year period, we consider, for the sake of clarity, that this figure should also be accompanied by a year-by-year account of the pay increase being offered to the profession (paragraph 2.8).
- Our concern is that there should be no ill-feeling between the two sides following the BDA's rejection of the offer, and that the parties should continue to work constructively together to move the agenda for the General Dental Services (GDS) forward (paragraph 2.9).
- We warmly welcome the demonstration that the reform process is moving forward through the Bill now going through Parliament which will, subject to Parliament, provide the legislative framework for the reforms envisaged under *Options for Change*. The way forward must now be for the parties to continue to work together. We note the development of *Options for Change* field sites and look forward to receiving evidence for our next review on the effectiveness of the models which are being tested at these sites (paragraph 2.25).
- We also note the profession's point that the *Options for Change* process will not become substantive until at least 2005, and so there will be no changes during the current review period. Although we accept that reform of the current system must be the way forward in the medium term, we are tasked with considering the issues as they stand now for 2003-04 (paragraph 2.26).
- We would welcome evidence from the Health Departments on the size of the workforce needed to produce the level of dental care they feel appropriate. It does seem to be agreed amongst the parties that retention is a problem. The one to two per cent annual drift out of NHS dentistry, which has been estimated by the Department of Health, seems to bear this out. There can be no doubt that the Department's figures point to an adverse trend and we have taken this into account in making our recommendations (paragraph 2.43).

- In view of the need for clarity about the resources required to support NHS dentistry, we welcome the reviews of the dental workforce which have been carried out across all three countries. We would ask to receive regularly updated evidence for the forthcoming review rounds (paragraph 2.44).
- We would ask the Health Departments to provide us with evidence on the numbers joining the GDS over recent years for our next review so that we can assess the trends here (paragraph 2.45).
- We would very much welcome evidence from the Scottish Executive Health Department on the impact of changes that it has made to help recruit and retain dentists in the GDS in Scotland (paragraph 2.46).
- We continue to regard it as essential to encourage GDPs' retention in the GDS while the parties work towards reforming the service, and we have taken this into account in making our recommendations (paragraph 2.48).
- The evidence presented to us clearly suggests that morale is low amongst GDPs. While we welcome the work being taken forward under *Options for Change*, and hope that it will provide solutions to address the problems with the current remuneration structure for GDPs, which is the main driver of the 'treadmill effect', clearly the morale of GDPs in general is unlikely to be improved during 2003-04 by any outcomes from *Options for Change*, and we have taken that into account in considering our recommendations (paragraph 2.56).
- The remuneration of GDPs remains broadly in line with that of the comparator groups, although it is difficult to draw any detailed conclusions because of the lack of agreed data on whole-time equivalent (WTE) remuneration of GDPs fully committed to the GDS (paragraph 2.63).
- We have sought to establish an acceptable and agreed estimate of total remuneration for WTE GDPs for some time now, as we feel the information would be an important addition to our deliberations on this group. We are concerned that we still do not have this information, and must rely on separately derived figures. We would therefore ask the parties to ensure that their work on reforming the GDS takes the need for this important information into account, so that a reliable and agreed baseline for the remuneration of WTE GDPs fully committed to the GDS can be established for the reformed GDS, which can then be updated for each round (paragraph 2.64).
- As the parties have not provided any definitive evidence on the overall effectiveness of the Commitment Payments scheme, we propose to undertake our own research which we hope will be available for the next review. We hope that the research will help inform final decisions about the role of the scheme in the wider work which aims, under *Options for Change*, to reform current remuneration arrangements in the GDS (paragraphs 2.74 and 2.75).
- The Department has estimated the drift from NHS dentistry to be around one to two per cent per year, and it seems to us that this drift could become a serious issue if it continues over the next few years until *Options for Change* is implemented. We therefore feel that the potential retention problem is serious enough to warrant action in the short-term. We have looked at the various options open to us to provide support to retention in the GDS, bearing in mind the need to minimise the extent to which any extra funding we recommend can be used to support private practice. Although the parties have been unable to provide

definitive evidence on the effectiveness of the Commitment Payments scheme, we consider that it is currently the best way to provide the extra support we feel is needed for retention. We reached this conclusion because the scheme both offers financial support to a significant majority of GDPs working in the GDS and also provides a means of targeting those doing the most for the NHS. In addition, the BDA support the scheme. We therefore **recommend** that the current scheme is increased by a third, which we believe will amount to additional funding of just over £9 million in the coming year. We are also fortified in our decision by the knowledge that there are other costs in the system which might not be adequately covered at the moment (paragraph 2.75).

- If any further improvements are needed to any aspect of the remuneration for assistants, we would ask the parties to negotiate directly. We have noted the decision by the Scottish Executive Health Department to raise the accumulated earnings threshold for seniority payments and would welcome further evidence, both on the effectiveness of this measure at retaining GDPs within the GDS, and whether it has increased the overall delivery of NHS dentistry in Scotland (paragraph 2.81).
- We have considered carefully the BDA's request that we should recommend additional funding for seniority payments and that the thresholds for seniority payments should be aligned with those for Commitment Payments. On the first point, we do not consider that it would be right to make a large change to the scheme this year, as changes to seniority payments will not offer sufficiently widespread retention benefits within the GDS. As we have explained, we feel that a change to Commitment Payments is the right focus for this year. On the latter, we would agree with the Department of Health that the two schemes have different purposes. Therefore, for now, we do not consider that we should recommend extending the seniority payments scheme in England and Wales (paragraph 2.82).
- We welcome the extension of the Continuing Professional Development allowance to assistants. We would ask the parties to continue to monitor the practical application of the allowance in each country and if any further improvements seem necessary, to negotiate on them directly (paragraph 2.88).
- The detailed feescale issues raised by the profession only serve to highlight the need for a fundamental review of the feescale system, and we do not intend making arbitrary changes to the existing feescale. We expect the forthcoming reform of the GDS and the development of new methods of remuneration to address these various issues, but in the meantime, the parties should negotiate directly on any pressing and specific issues (paragraph 2.92).
- We remain of the view that the Modernisation Fund is not strictly a remuneration issue and is therefore not within our remit, but it is for the Health Departments to decide the extent to which they wish to provide continuing support for capital investment. We do, of course, very much welcome any funding that the Health Departments put towards modernisation of practices, as it should help improve morale, and we would ask them to continue to bear in mind the retention, morale and motivation effects of any schemes to provide capital support. We hope that the reform programme for NHS dentistry will take these points into account as it goes forward and we would ask for further evidence on this for the next review (paragraph 2.103).

- We welcome the Department's confirmation that the £59 million of modernisation funding (£23 million in 2003-04 and £36 million in 2004-05, less whatever the parties agree will be set aside under the three-year pay offer agreed for the salaried services) will still be available to support the GDS. We hope that the parties will work effectively together to target this money where it can be used most effectively. We would expect to see the funding fully spent over the period. We welcome and accept the Department's proposal that we should monitor the spending of this funding and look forward to receiving evidence on progress here for our next review (paragraph 2.104).
- We would be grateful for evidence on the average level of return on capital received by GDPs for our next review. We would not wish to complicate further the GDS feescala by making a specific recommendation on return on capital, but we consider it very important that *Options for Change* does move this issue forward (paragraph 2.106).
- We expect the development of new arrangements for remunerating GDPs, which will be trialled under *Options for Change*, to take account of the various cost pressures which have been raised by the profession and would ask the parties for further evidence for our next review (paragraph 2.118).
- A fundamental review of the feescala is needed to address issues such as unremunerated time, London Weighting and the variability of costs across the country, and administration costs. As the feescala seems likely to continue in some form following *Options for Change*, we therefore would ask the parties to take forward a fundamental review of the feescala as part of the reform process (paragraph 2.119).
- We do not consider it appropriate to recommend the national introduction of a practice allowance, but would ask the parties to accelerate their work on a basic practice allowance and to set up urgently a number of pilot sites at which an allowance can be tested. We would further ask the parties to consider whether the arrangements for the Scottish Practice Costs Allowance would provide a useful broad model for testing out a basic practice allowance in England. We would ask the National Assembly for Wales to consider testing such an allowance in Wales. We would ask the parties to report back to us on progress in time for our next review (paragraph 2.120).
- It must be for the parties to develop a mechanism which allows for the separation of pay from expenses, if they agree that it would be appropriate. We would therefore ask the parties to address the question of expenses as part of the work to develop new methods of remuneration. The current situation makes it impossible for us to recommend a pay uplift net of expenses (paragraph 2.121).
- We would ask the Health Departments to consider the impact on recruitment, retention and morale if any substantive changes to the NHS Pension Scheme should be considered at any time in the future, which might be viewed by the profession as a deterioration in their current levels of benefits (paragraph 2.126).
- Our role is to make recommendations which are, in our view, fair in relation to our terms of reference. To this end, we consider that, in totality, the evidence suggests an award for GDPs which should be a little ahead of three per cent. We have viewed this conclusion in the light of a number of factors – the events leading up to the round, the understanding that the GDS, in England at least, is now in a transitional period until the programme of reform under *Options for Change* and

the current Parliamentary Bill take effect, our recommendation to target support for retention specifically on the Commitment Payments scheme, and also the Department of Health's commitment to press ahead and deploy the modernisation funding from the original pay offer within the GDS over the next two years. Our final conclusion is that we should therefore **recommend** that gross fees for items of service and capitation payments should be increased by 3.225 per cent for 2003-04 for GDPs. We also **recommend** that sessional fees for taking part in Emergency Dental Services be increased by 3.225 per cent. This figure is incidentally also available to other NHS staff (paragraphs 2.135 and 2.136).

Chapter 3 – Salaried Primary Dental Care Services (SPDCS)

- We understand that the Department of Health and the BDA have now agreed a position on a three-year pay deal for the SPDCS, and that, though there is no joint statement, they are content that we should publish their exchange of letters in which the Chairman of the Management Side and the Chairman of the Staff Side set out their jointly agreed positions (Appendix B). We note that the parties have agreed a 3.225 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2003-04. We agree with this and have calculated 2003-04 salaries on this basis and reproduce these in Appendix A. We very much welcome the agreement that has been reached by the two sides, particularly on the planned review of the salaried services, and hope that the outcome of the review will enable pay and grading considerations to be thoroughly considered in due course. We look forward to receiving further evidence regarding the situation in Scotland and Wales for our next review, as well as receiving evidence on the progress the review has made in England (paragraphs 3.4 and 3.5).
- We look forward to receiving further evidence on developments within the salaried services in Scotland for our next round. We would also hope to receive more detailed evidence for our next review from the National Assembly for Wales regarding developments within the SPDCS in Wales (paragraph 3.9).
- The research carried out by Mercer Human Resource Consulting (Mercer) into the SPDCS on our behalf clearly highlighted for us that the problem facing the SPDCS is mainly linked to recruitment rather than retention, particularly recruitment at the dental officer (payband one) level, where Mercer believed the research suggested that pay levels did not reflect the market rates. This is very much in line with our recommendation last year that the bottom point of payband one should be removed and that an extra point be added to the top. We also recommended that a wider review of the payscales for the SPDCS was needed. Mercer's conclusions support this view with the proposal that a full-scale review of the payscale is undertaken. We are therefore pleased to see that linked with the three-year pay deal which has now been agreed between the parties, there will be a review of the SPDCS. We consider that the research commissioned from Mercer on our behalf, and the report Mercer have produced, have provided an important backdrop to the review of the SPDCS, and we hope that the parties can take forward Mercer's findings in a productive fashion. We feel it is important for the morale of this important group of dentists that the review gets underway quickly and that any quick wins which can be identified can be put in place as soon as possible (paragraph 3.15).

Chapter 4 – GMP registrars

- It is not possible for us to make a judgement on whether GMP registrars and specialist registrars are equivalent in terms of responsibility, as we have received no evidence on the relative job weight of either grade. We therefore note that GMP registrars will continue to be aligned with the senior house officer (SHO) payscale, as at present. We made recommendations on the pay of SHOs in our thirty-second report. We are aware that the Departments are taking forward their proposals for the reform of postgraduate medical education and we would expect any pay issues which emerge for GMP registrars to be addressed in the light of any decisions about changes to specialist training. We will await evidence from the parties for our next review on how this is progressing (paragraph 4.8).
- In view of the strong recruitment figures for GMP registrars, we accept the joint recommendation from the Health Departments and the NHS Confederation and we **recommend** that the out-of-hours supplement for GMP registrars should rise from 1 April 2003 from 50 per cent of their basic salary to 65 per cent. We would wish to review the level of the out-of-hours supplement payable to GMP registrars in the next round in the light of both further progress in reducing the hours of doctors and dentists in training in the hospital sector, and further evidence on the recruitment of GMP registrars (paragraph 4.10).
- As we would expect, at some future time, there will be a need to consider reducing the supplement payable to GMP registrars, we would wish at that time to consider the position of those doctors who were then receiving the higher level of supplement. Fairness suggests that such individuals should mark time rather than see their pay supplement reduced (paragraph 4.11).
- We were very disappointed to learn that the pay anomalies which were first brought to our attention for our thirtieth report remain unresolved. Whilst we welcome the Health Departments' statement that they are committed to ensuring the relevant amendments are made to the General Practitioner Registrar Directions as soon as was practicable, we would ask the Departments to see this commitment through as quickly as possible (paragraph 4.15).
- We would further ask the Health Departments to give consideration to the position of those doctors who were formerly in one of the groups affected by these pay anomalies and who are now GMP registrars. Fairness would suggest that, at least for the remaining part of their time as a GMP registrar, the salaries of these doctors should be adjusted to reflect their final salary prior to becoming a GMP registrar (paragraph 4.16).
- We would ask the Health Departments to consider carefully how their commitment to promoting flexible working arrangements and the need to minimise retention difficulties apply to GMP registrars. The arrangements for flexible GMP registrars will be an increasingly important part of any retention strategy for the primary care sector given the changing demography of the medical school intake (paragraph 4.19).
- We welcome the statement from the Health Departments that they will be seeking an early resolution to the issues raised by the BMA regarding the excess rent allowance rules, in view of the possibly adverse impact that the current anomaly may be having on GMP registrar recruitment and morale (paragraph 4.24).

- We welcome the assurances offered by the Health Departments and the NHS Confederation about the current support offered to GMP registrars on childcare provision. However, we would also ask them to bear in mind the childcare issues faced by GMP registrars when developing and implementing childcare policy within NHS Primary Care Trusts (paragraph 4.25).

Chapter 5 – Salaried GMPs employed by a Primary Care Organisation (PCO)

- We very much welcome the submission of joint evidence from the parties and welcome the agreement by the parties on their proposals for this group of doctors. We **recommend** that the position stated by the parties in their joint evidence be adopted and that the proposed salary range for the employment of salaried GMPs by a PCO should be sufficiently wide to take account of the spectrum of roles to be accommodated in the light of the parties' joint evidence (paragraph 5.9).
- We support the parties' proposals and therefore **recommend** that an initial salary range of £45,000 to £68,500 is appropriate. We also welcome and support the parties' expectation that the salary range would serve as a benchmark for practice-employed GMP-qualified doctors and that this should be reflected in PCO contracts with General Medical Services (GMS) practices. We note that the salary ranges for the comparator groups have been uprated by 3.225 per cent, following our recommendations in our main report for 2003-04 for associate specialists and consultants. We therefore **recommend** that the salary range for salaried GMPs employed by PCOs suggested by the parties is uplifted by 3.225 per cent, giving a salary range of £46,455 to £70,710 for 2003-04. As the parties request, we also **recommend** that progression and review should be determined locally. We would ask the parties to ensure that monitoring of salaries paid to these GMPs is carried out, in order to allow the parties and ourselves to monitor the use of the salary range. We would welcome regular evidence on this, starting in time for our next review, if that would be possible. We would also welcome evidence from the parties for our next review on the recruitment and retention situation for salaried GMPs employed by PCOs (paragraph 5.10).

Our main recommendations on pay levels are:

General dental practitioners

The gross fee for each item of service and capitation payment should be increased by 3.225 per cent¹.

The current Commitment Payments scheme should be increased by a third².

General medical practitioner registrars

The supplement payable to GMP registrars for out-of-hours duties should be increased³ from 50 per cent to 65 per cent of basic salary.

Salaried general medical practitioners

The salary range for salaried GMPs⁴ employed by PCOs should be £46,455 to £70,710 for 2003-04.

MICHAEL BLAIR QC (*Chairman*)
PROFESSOR FRANK BURCHILL
HUGH DONALDSON
PROFESSOR ALEXANDER DOW
DR GARETH JONES
RICHARD MALONE

OFFICE OF MANPOWER ECONOMICS
9 June 2003

¹ See paragraph 2.136 of this report.

² See paragraph 2.75 of this report.

³ See paragraph 4.10 of this report.

⁴ See paragraph 5.11 of this report.

CHAPTER 1: ECONOMIC AND GENERAL CONSIDERATIONS

Conduct of the 2003 review

- 1.1 *Our review was conducted under the terms of reference introduced in 1998 and which are reproduced at the beginning of the thirty-second report¹. The outcome of the last review is set out at Appendix C of the thirty-second report.*
- 1.2 *This supplement to the thirty-second report deals with general dental practitioners (GDPs), Salaried Primary Dental Care Services (SPDCS), general medical practitioner (GMP) registrars, and salaried GMPs employed by a Primary Care Organisation (PCO). The thirty-second report considered career grade hospital doctors and dentists, doctors and dentists in training, and ophthalmic medical practitioners. The situation regarding GMPs remains very unclear for now and we are awaiting further developments regarding the current contract negotiations and the recently launched ballot. As we said in the thirty-second report, the unusual situation this round has arisen because of the contract negotiations for consultants and for GMPs working within General Medical Services (GMS). Similarly, there has been a delay in starting our consideration of dentistry issues while we awaited the outcome of the discussions between the Department of Health and the British Dental Association (BDA) on a three-year pay deal. GMP registrars have been considered separately in this report, at the request of the British Medical Association (BMA), the three Health Departments of England, Scotland and Wales and the NHS Confederation. The report also covers salaried GMPs employed by a PCO, as the parties have submitted joint evidence on this group ahead of any developments on the main GMS contract.*
- 1.3 *As we said in the thirty-second report, our separate consideration of the different remit groups this round has been for the purely pragmatic reason of ensuring that we make recommendations on each remit group as soon as possible, given that we are already reporting after the usual pay implementation date of 1 April. Our aim has been not to delay the pay timetable any longer than has been made necessary by the various pay negotiations, but it is unfortunately inevitable that none of our remit groups will have received a pay uplift on 1 April, as they would normally expect. This is a very unfortunate delay and we hope that the next review can revert to the usual timeframe.*
- 1.4 *We have received written and oral evidence on GDPs and the SPDCS from the BDA; the Department of Health in England; and the General Dental Practitioners' Association (GDPA). We have also received written evidence covering NHS dentistry from the Scottish Executive Health Department and the NHS Confederation. The National Assembly for Wales supported the main recommendations submitted by the other Health Departments and we were advised that it would be considering the details of its own strategy for NHS dentistry in the light of the rejection of the three-year pay deal by the BDA. We were disappointed not to receive any detailed evidence from the Assembly, but hope that it will be in a position to provide more detailed evidence on how it is taking forward dentistry issues for our next review.*
- 1.5 *Written evidence was received from the BMA on GMP registrars, while joint written evidence was very recently received from the Health Departments and the NHS Confederation on this group. Evidence was received from the Health Departments, the NHS Confederation and the General Practitioners Committee of the BMA covering salaried GMPs employed by a PCO.*

¹ Review Body on Doctors' and Dentists' Remuneration, Thirty-Second Report 2003, Command paper 5721

- 1.6 *As we noted in our thirty-second report, as part of our preparation for this review, we continued our programme of visits to NHS Trusts, Primary Care Trusts (PCTs), and medical and dental practices in England, Scotland and Wales. We found these visits and meetings to be valuable and would like to thank all those who helped to arrange the programme and who gave their time to participate in it.*

Output targets for the delivery of services, the funds available to the Health Departments, economic considerations and the Government's inflation target

- 1.7 *The evidence submitted by the Health Departments and the BMA on these areas of our remit, along with our comments, are set out in detail in our thirty-second report. Relevant evidence from the BDA on these areas is set out in chapter two of this report.*

CHAPTER 2: GENERAL DENTAL PRACTITIONERS

Three year pay offer

- 2.1 The **Department of Health** told us that it had opened discussions with the British Dental Association (BDA) on a three-year pay deal last summer, to provide a “background of financial stability and reassurance...whilst we work together to get the local commissioning arrangements and underpinning infrastructure for NHS dentistry right”. The Department said it had been keen to take the opportunity to focus energies over the next few years more on the reform agenda than on the detailed maintenance of the existing General Dental Services (GDS) pay system. This system had been widely criticised by the BDA, dentists and a variety of expert commentators as no longer relevant to the needs of the NHS, patients or dentists. It had proved increasingly difficult to maintain to the mutual satisfaction of dentists and the NHS and was incapable of adapting to the changed oral health needs of the population. The BDA had indicated to the Department in December that it wished to explore the pay offer and negotiations continued until the end of February.
- 2.2 The Department considered that it and the BDA had worked hard to agree an affordable package to address what the BDA said was needed by GDS dentists to maintain their commitment and stay with the NHS, whilst paving the way for reform. The Department considered that a fair pay offer, together with a significant package of investment for reform, had been finalised, on top of a number of significant improvements in the existing arrangements which it had agreed to make for GDS dentists. The Department said that reform would have covered the “end[ing] of the treadmill” which the BDA had always claimed was the major problem rather than pay *per se*. The offer, the Department said:
- was above inflation at 3.225 per cent per annum for three years (subject to safeguards on inflation);
 - was supported by £59 million of modernisation funding over the first two years (£50 million for a capital modernisation fund and £9 million for a support team for the hardest pressed dentists and Primary Care Trusts (PCTs)). This funding would have been equivalent to an additional 3.1 per cent on expenses over the first two years; and
 - in total amounted to a significant investment in NHS dentistry of 23.8 per cent of current annual GDS spend over three years.
- 2.3 In addition, the Department reported that the deal included an offer to develop a new system for assessing movements in expenses, negotiation of call-off contracts for purchase of practice consumables and working with Workforce Development Confederations to encourage the spread of best practice in expanding training for dental nurses and professionals complementary to dentistry (PCD) in the run-up to their registration with the General Dental Council (GDC).
- 2.4 The Department said it very much regretted that the General Dental Practice Committee (GDPC) of the BDA had rejected the detailed final offer by 47 votes to 1. Agreement over a three-year pay deal would have been valuable from the Department’s perspective, providing financial stability and reassurance for dentists during a period of transition between the now outmoded and entirely nationally-led remuneration system and the new system, which would be able to accommodate variations in oral health at PCT level.

- 2.5 The **British Dental Association** said in oral evidence that the three-year pay offer had been considered by its members in the light of the very attractive offer to general medical practitioners (GMPs) of an extra 33 per cent and to consultants of an extra 20 per cent, whilst for general dental practitioners (GDPs), a ten per cent pay offer over three years had been coupled with an offer of modernisation money worth less than three per cent over two years. The BDA said that the calculation that the pay offer was worth 23.8 per cent involved triple counting of the 3.225 per cent per year. It said that it had rejected the three-year pay offer for the following reasons:
- the ten per cent over three years was considered insufficient and for many GDPs was tantamount to a pay cut;
 - the pay offer did not address the long-term chronic under-funding within the GDS;
 - the issue of expenses was not properly addressed and tentative promises on it had no credibility with GDS dentists; and
 - the omission of supply chain repercussions.
- 2.6 In reply to those points, the **Department of Health** noted that the BDA considered that for many GDPs the offer was tantamount to a pay cut, but it felt it was difficult to understand how this could be so. The Department commented that the GDS operated within a non-cash limited budget and the inability of the NHS to commission more dentistry from practices in line with other NHS services was a key reason for reform. It also noted that the BDA negotiated the position which was reached on expenses within the three-year offer and the final position was entirely within its own hands, and that the BDA's comment on the omission of supply chain repercussions was unclear. In oral evidence, the Department told us that the 23.8 per cent figure was on an investment basis and therefore included 3.225 in year one, 3.225 in year two plus the 3.225 from year one, and 3.225 in year three plus the 3.225 from years one and two, which amounted to 20 per cent. The remaining 3.8 per cent was the £59 million modernisation and access funding. It said that this had been made clear to the BDA, and that it was "normal Departmental practice" to describe such offers in terms of overall investment.
- 2.7 The **General Dental Practitioners Association (GDPA)** told us in oral evidence that other NHS groups had been offered far more than GDPs, even though GDPs had the added pressure of running their own businesses and paying their own costs.

Comment

- 2.8 *We were disappointed to hear that agreement on a three-year deal for GDPs could not be reached between the Department and the BDA. We do not wish to make, or even imply, any comment on the merits or otherwise of the deal which was tabled. That is for those most closely involved, the parties, to judge. We would only observe that although the Department described its offer in terms of the overall investment (23.8 per cent) it would provide over the three-year period, we consider, for the sake of clarity, that this figure should also be accompanied by a year-by-year account of the pay increase being offered to the profession.*
- 2.9 *Looking ahead, our concern is that there should be no ill-feeling between the two sides following the BDA's rejection of the offer, and that the parties should continue to work constructively together to move the agenda for the GDS forward. As we note in chapter one, the main area of regret for us around these negotiations is that, due to the length of time that such discussions naturally take, GDPs did not receive a feescal rise on 1 April. For our part, whilst still giving full consideration to all issues, we have carried out the review as swiftly as possible in order not to delay any further the feescal uplift for 2003-04.*

The way ahead

- 2.10 The **Department of Health** told us that it saw the rejection of the three-year deal as a crossroads. The Department did not consider it to be a good use of scarce organisational resources to continue to fine-tune the GDS as it now stood. A succession of reports and studies¹ had underlined that the GDS fee-for-service system was now neither relevant to oral health needs, nor a rational way of remunerating dentists.
- 2.11 The Department described to us what it saw as some of the limitations with the existing GDS pay system – a system which it said had been widely criticised by the BDA, dentists and a variety of expert commentators as no longer relevant to the needs of the NHS, patients or dentists:
- The GDS had proved increasingly difficult to maintain to the mutual satisfaction of dentists and the NHS and incapable of adapting to the changed oral health needs of the population.
 - The NHS locally had at present no means of targeting problems through harnessing a notional share of GDS resources, nor was this balanced by the arrangements for the GDS, in that they did not fix the amount of dentistry which a dentist would deliver for the NHS in a given area.
 - If an individual dentist reduced their commitment, or chose to ‘walk away from the NHS’, they could do so with impunity, giving only very little notice to the NHS. Any resulting resources were lost to the local health economy. Responding to the BDA’s evidence, regarding dentists moving on, and its statement that former associates could not open “just down the road”, creating an alternative NHS and attracting away “all the patients”, the Department said that it was not the entirely reasonable limitations which protected practice owners, but the aggregate effect across the entirety of the GDS which was unsatisfactory.
 - The movement of dentists into an area took place in the context of the wider economy and was not therefore evenly spread across the country, and the situation was further complicated by the extent of private practice in some areas, so the areas where the level of dentists *per capita* was highest, might also be the areas where NHS leverage was weakest.
 - The current contractual and remuneration arrangements did not enable the NHS to secure medium to longer-term access to dentistry in a given locality and it was, for example, impossible at present to develop coherent local approaches to recruitment and retention.
 - There was no scope for recognising geographic variations in expenses.
- 2.12 The limitations on securing access to NHS dentistry demonstrated to the Department that more of the same was almost certain to be ineffective. The Department said that the BDA had argued for years that the problem was not pay of itself, but the old item-of-service contract. The Department agreed with that. Given the broad agreement that fee-for-service payments were an unsatisfactory way of incentivising and rewarding dentists, the Department said that rather than continued tinkering with the existing system, what was needed was the radical reform to deliver local commissioning as envisaged in *Options for Change* and provided for in the legislation currently before

¹ The Department said that these included over the last two years those from the Health Select Committee and the Audit Commission, as well as *NHS Dentistry: Options for Change*.

Parliament. The Department felt that a great deal of progress with the reform of NHS dentistry had been made since autumn 2001, underlined with the introduction of the Health and Social Care (Community Health and Standards) Bill into Parliament on 12 March 2003, to provide the legislative framework for reform, following the publication of *NHS Dentistry: Options for Change*², produced by a working group which had included the BDA. The Department considered that it was difficult to imagine what more solid evidence could be required of the intent to change. It said that the BDA's argument in evidence appeared to be that 'more of the same' would deliver improved support for GPs in a changing environment, but the Department felt that this would simply enable dentists to switch comfortably to private practice. 'More of the same' had been shown not to deliver any certainty for the NHS, which, in the Department's view, must now take priority. The track record of the current system demonstrated that additional investment within an entirely national framework did not address the NHS's needs for local certainty.

- 2.13 The Department told us that the Government fully recognised the need to support NHS dentistry and was committed to addressing the issues raised by the profession within the context of a reformed system. The Department said it had worked hard to attempt to address the issues of concern to GPs raised by the BDA, and gave us details of issues on which progress had been made (for example, reflecting Commitment Payments in the dynamising factor for superannuation, extension of the Occupational Health Service to dentists and their staff, and extension of paid maternity leave to 26 weeks). However, the Government had accepted the BDA's arguments that it was time to reform rather than to continue to operate indefinitely within the current remuneration system. The Department therefore proposed to make only the minimum essential changes to the existing system in order to concentrate on developing the new models. We were told that the *Options for Change* field sites involved the BDA directly and should produce models for development and application in the new contractual framework which would be enabled by the Bill now in Parliament. *Options for Change* field sites would be important in contributing to the reform process, but they were not the end of reform in themselves. The Department intended that actions taken to support GDS dentists should henceforth be on the basis of a clear link to PCT commissioning. This would be a part of a process of normalising dentistry's relationship with the NHS.
- 2.14 The Department said it now proposed to focus on the needs of the NHS at a more local level, using available funds through PCTs, rather than through the national contract. The channels which would be created for this would be geared to a future system and would be linked directly to dentists' willingness to contract with the NHS for longer-term stability. The Department noted that whilst the legal framework to replace the GDS did not yet exist, the provisions for Personal Dental Services (PDS) allowed the NHS to introduce longer-term certainty into the working lives of dentists who were heavily committed to the NHS and an urgent programme to do this was currently being developed. The Department said that the BDA referred to the reforms not becoming substantive until 2005, but it felt that this reference must have been in error.
- 2.15 The Department felt that the experience of implementing the Prime Minister's pledge on dentistry, which, in its view, had been delivered, showed that it was possible to improve relations and build capacity at local level when national systems were not delivering. It was through such local relationships, rather than through changes at a national level, that the NHS would expect to enhance the extent of support it could offer to dentists during the transitional period. Subject to Parliament, funding would in future be allocated to the PCT to secure dental service provision. PCTs would also be able to target resources and increase spend in the light of local circumstances. On the

² *NHS Dentistry: Options for Change*, NHS, August 2002

basis of the general rate of increase in NHS spending over recent years, this rate of future increase in primary dental service spend was unlikely to be less than the current GDS trend rate, and PCTs would be able to commit additional funding from the extra resources being made available to them. This increased local leverage would begin over time to balance the wider effect of the relative movement of dentists between areas. There would be the opportunity for funding levels for NHS dentistry to grow in parallel with the long-run growth in funding for other NHS activity. In oral evidence, the Department asked us to urge the BDA to continue working with the Department on the reform agenda.

- 2.16 The Department noted that in general medical practice during the 1990s, practices grew both in physical size and in diversity in staffing, enabling family doctors to become leaders of teams. Comparable changes in infrastructure to support the development of team working were envisaged in *Options for Change* and PCTs would contract with practices rather than individuals, in order to overcome the pay issues which were a barrier to change at present.
- 2.17 The **Scottish Executive Health Department** (SEHD) told us that much progress had been seen on a number of issues, in which it had worked in conjunction with the other Health Departments and the profession to effect real change. There remained, however, a number of specific issues, which required a separate approach in order to address particular Scottish circumstances. Its *Action Plan for Dental Services in Scotland*³ aimed to identify and address the specific needs of Scotland and targets and initiatives had been developed. Within the policy framework set out in the *Action Plan*, it had implemented several new initiatives designed to address concerns peculiar to, or more pronounced in Scotland, while maintaining a consistent line with overall UK policy. The SEHD told us it was committed to maintaining and improving NHS dental provision within Scotland, through strategy, partnership and delivery.
- 2.18 One of the main priorities highlighted in the *Action Plan*, was the need to focus attention and action on the strengthening of preventative measures, particularly for children and in areas of high deprivation. The introduction of a caries prevention scheme (open to six and seven year olds) in October 2001 provided the dentists with an enhanced monthly fee according to deprivation. Many of the responses to *Towards Better Oral Health for Children; a Consultation Document on Children's Oral Health in Scotland*⁴ made reference to the need for improved NHS dental service provision. The SEHD had also commissioned research to review existing dental charges in Scotland and emergency dental service provision in Scotland was currently under review. In supplementary evidence, the SEHD also said that in the coalition agreement which had just been published, there had been agreement to introduce systematically free eye and dental checks for all before 2007.
- 2.19 We were told that the **National Assembly for Wales** would be considering the details of its own strategy in the light of the rejection of the three-year pay deal by the BDA.
- 2.20 The **BDA** told us that it had been closely involved with the *Options for Change* initiative in England and had agreed to enter into talks with the Department of Health on modernisation arising from the initiative. The BDA mentioned the Parliamentary Bill, which would devolve the commissioning of services and funding locally to PCTs in England. The BDA said that there would, however, not be any changes within the review period (2003-04) and such changes would not apply to Scotland.

³ *Action Plan for Dental Services in Scotland*, Scottish Executive, August 2000

⁴ *Towards Better Oral Health for Children; A Consultation Document on Children's Oral Health in Scotland*, Scottish Executive, September 2002

- 2.21 Although the BDA felt that *Options for Change* might well go some distance towards alleviating some aspects of the present problems, the schemes, which were untried, untested and had not even been piloted, would not become substantive until 2005. The BDA noted that there were whispers of slippage due to the delay in implementing the initial phases of the trials coupled with IT difficulties. It felt that “the future [was] a promise; the present [was] uncertainty”.
- 2.22 The BDA noted that the Department felt that dentists could move whilst giving little notice of their intentions. It informed us that the rules stated that GDPs must give three months’ notice, or they could go earlier if they ensured that patients were being cared for. The BDA felt that this time span was within the accepted ‘norms’ of most industries and merely reflected the pressures that most practice owners suffered when related to employee or associate work stability.
- 2.23 The **NHS Confederation** said it was aware that a major review of the whole GDS contract had been mooted for some time and that it was probably fair to say that developments with the GMP contract were being watched with interest for possible pointers as to the way forward. The Confederation’s general view on the key issues in dentistry had not changed from those it had set out in its evidence for the previous round. Because the vast majority of dentists were independent contractors, many of whom provided no or very few NHS services, issues around remuneration of dentists had not been a concern for NHS organisations and in a strict sense that remained true. However with the publication of the Government’s dental strategy *Modernising NHS Dentistry*⁵ and the closer interest taken by PCTs in dentistry, the Confederation thought that the issue was moving up the agenda for primary care organisations.
- 2.24 The **GDPA** commented that the feescala was outdated and could no longer deliver what was intended. It thought that our thirty-first report relied heavily on *Options for Change*, but the GDPA noted that there would be no quick or short-term solutions, with pilots and evaluations taking many years. It felt that it was right that the proposals should be piloted, but felt that we now needed to re-address the concerns from the last round which it felt we had shelved to await the *Options for Change* report.

Comment

- 2.25 *The evidence from the parties refers to the problems with the current method of remunerating GDPs. We agree with the parties that this current system has indeed many problems. We commented in our last report that there was an urgent need to bring the remuneration system up to date. We also expressed considerable hopes for improvements through the Options for Change developments. Progress has been made. The Options for Change report was published in summer 2002 and following on from that, we hear from both the BDA and the Department that a Bill is now going through Parliament which will, subject to Parliament, provide the legislative framework for the reforms envisaged under Options for Change. The Bill will place a duty on PCTs and Local Health Boards to provide, or secure the provision of, primary dental services. This is a very important development, and demonstrates to us that the reform process is moving forward. We warmly welcome that. The way forward must now be for the parties to continue to work together on the Options for Change process and to take forward this work while the Bill continues its passage through Parliament. We note here the development of Options for Change field sites and look forward to receiving evidence for our next review on the effectiveness of the models which are being tested at these sites.*

⁵ *Modernising NHS Dentistry: Implementing the NHS Plan*, Department of Health, September 2000

- 2.26 *However, we also note that the profession's point that the Options for Change process will not become substantive until at least 2005, and so there will be no changes during the current review period. Although the Department has told us that an urgent work programme is being developed to use PDS to introduce longer-term certainty, the point made by the profession nevertheless seems valid. Although we accept that reform of the current system must be the way forward in the medium term, we are tasked with considering the issues as they stand now for 2003-04. We shall return to this later in the chapter.*
- 2.27 *We note the various developments in Scotland and welcome hearing that the Scottish Executive Health Department has been able to work with the profession to effect, as it sees it, real change. This process has necessarily led to separate developments in Scotland to England and Wales, and we return to these later in this chapter.*

Recruitment and retention

- 2.28 As far as overall supply was concerned, the **Department of Health** told us that there was no shortage of applicants for dental training places and that the supply of dentists was robust. What the Department needed to do was create a system in which sufficient of them were encouraged to join and remain in the NHS. The Department reported that the review of the primary care dental workforce in England (addressing the supply of dentistry as a whole, not solely the NHS) had continued, but it was hopeful of being able to publish the review later this year, together with workforce planning assumptions. The review would be regularly updated. The main findings of the review to date were in respect of supply:
- the change in GDC regulations would have an impact on supply of non-UK qualified dentists;
 - as dentists changed the balance of their work from NHS to private dentistry, the total time available for dentistry was affected, though the exact effect was not clear; and
 - the increased number/proportion of women dentists, together with new working patterns for men, was affecting the whole-time equivalents (WTEs) available.
- 2.29 The review had not highlighted particular problems of declining numbers joining the workforce or of imminent bulges in retirements. However, past changes in the numbers of training places for dentists meant that the workforce was ageing and that numbers coming up for retirement were increasing. GDS numbers were now fairly stable after steady increases for many years, although the current GDS system provided no method of securing any overall increase in the volume of NHS treatment provided by an increase in workforce and this underlined the need to move to a new contracting framework. The Department did not accept the "bare analysis" offered by the BDA in its evidence on the 'failure to retain'. The assumptions behind the calculation of NHS WTE were not shown and there appeared to be no acknowledgement of over 1,000 dentists now working in PDS, of whom 700 did not work in the GDS. The change in work patterns over the period shown suggested that comparisons over the last decade may not be valid given that the percentage of advanced work had fallen.
- 2.30 From 2005-06 onwards, the NHS would establish patterns for new relationships between dental practices and local populations and this experience would feed directly into NHS workforce planning both locally and nationally. The NHS would then be able to commission education and training in the light of a reformed dental service. The Department considered that the NHS was in general able to offer its wider workforce a positive package, when training and development opportunities were taken into

account. The Government had acknowledged that there was some way to go on this as regards dentistry. However, the middle-term aspiration would be much clearer delineation between private and NHS dentistry, to make contracting with the NHS more attractive to dentists and a good business proposition equivalent, for most, to a commitment to private dentistry.

- 2.31 The Department felt that there was some evidence that, as with the General Medical Services, new workforce cohorts entering the dentistry profession were unwilling to enter the same commitment to independent practice as did their predecessors. Whilst there were clearly risks at present as to workforce participation, the plans for reform must to a high degree be geared to the aspirations of those new cohorts, as well as to those which were established and had an interest in building largely on the status quo.
- 2.32 The Department reported that it had agreed with the profession to extend maternity payments to 26 weeks, as well as introducing paternity leave and extending entitlement to adoptive parents from 2003-04. Those new entitlements could generate additional benefits worth up to £3.5 million per annum. The **Scottish Executive Health Department** also noted that it had introduced from 1 April 2003 the same maternity payments entitlement, plus two weeks paternity payments, and maternity and paternity payments for adoptive parents.
- 2.33 With regard to retention issues more generally, the **Department of Health** noted that under the existing system, gross and net GDS spend had been increasing in real terms measured against the Gross Domestic Product deflator in recent years, while GDS activity had hardly changed. Over the past ten years, dentists' pay had always run ahead of inflation. However, despite very significant efforts in recent years, for example in the introduction of Commitment Payments for NHS practitioners and "incessant" tinkering with the feescale to try to make it more workable, the Department said it had not managed to retain dentists in the NHS. On the contrary, it said, some dentists had been able to rely on the NHS underpinning to build up their private practice, going on to increase the proportion of private practice as soon as they were able. The Department said that it was clear that there was a continued small drift from GDS work to private work by dentists. Together with a continued small rise in the number of dentists in the workforce, this had led to a reduction in the amount of NHS dentistry carried out per dentist. The Department said that business behaviour which involved moving between the private and the NHS markets for service, according to the needs of the business at a particular point, appeared to be common.
- 2.34 In oral evidence, the Department told us that it considered that the BDA's evidence on the Trent region was only providing a "snapshot", but that national figures supported the Department's claim of a small drift from the GDS to private work. It said that there was a change in GDS activity of between zero and minus one per cent per year, combined with an increase of around half a per cent in the number of GDPs, and the Department therefore considered that the drift out of NHS dentistry was around one to two per cent a year. However, there were local variations. The withdrawal from NHS dentistry was said to be a slow shift out of certain sectors, rather than a complete departure.
- 2.35 The **Scottish Executive Health Department** told us that in April 2002, a package of measures to recruit and retain dentists within GDS had been announced, which included:
- the offer of a training place to all graduates of Scottish Dental Schools;

- an allowance of £3,000 to each newly qualified dentist taking up their vocational training (VT) in a designated area;
- an allowance of £5,040 over two years to dentists who joined a PCT or Island Health Board (IHB) within three months of completing training, with an additional allowance of £5,040 over the two-year period when joining a PCT or IHB within a designated area; and
- grants of up to £10,000 to dentists wishing to establish a new VT practice.

- 2.36 The SEHD said that the incentives had received the backing of the profession. The package had represented the first phase of a series of measures on recruitment and retention which were being developed, with the second phase announced on 12 February 2003 and, in addition to measures to help practitioners address increased practice requirements, it included items designed to aid recruitment and retention within the GDS, such as raising the earnings ceilings for seniority payments, Commitment Payments for assistants, widening from 200 to 450 the number of NHS sessions per year a returner could undertake in the Return to Work scheme, and a doubling of the remote areas allowance to £3,000 per year. The SEHD also told us that there were VT places for all Scottish graduates and General Professional Training (GPT) for 50 per cent of Scottish graduates, with an increase in dental graduates from 2005 onwards, with at least 120 dental graduates annually.
- 2.37 In its evidence, the **BDA** said that it believed that there was a serious shortage of dental personnel in the UK. It noted that the dental workforce had been considered in all three countries of Great Britain, although the review in England was not complete. In Scotland, a shortage had been identified and the output of dental graduates would be increased to 120 per annum, with 35 qualified dental hygienists and/or therapists a year planned. The BDA said that the Welsh Assembly Government had also identified a shortage of dentists and proposed to recruit an additional 44 dentists and to increase the output of graduates from 55 to 76 a year. In oral evidence, the BDA told us that the approach taken by Scotland was very different to the rest of the country, and that the approach was more pragmatic and not cost driven.
- 2.38 The BDA considered that fees and allowances were too low to keep dentists in the GDS and they were leaving in “ever increasing numbers”. The shift to private practice had continued and the professional, bureaucratic and financial demands being made on dentists providing GDS care had increased. The BDA said that the “small drift” away from the NHS referred to by the Department was a substantial understatement. The profession was poised on a knife edge regarding moving away from the NHS with considerable improvements in pay and conditions required now to stem the outward flow.
- 2.39 There was a failure to retain dentists in the GDS, with the number of WTEs falling over the last decade. Changes to the gender mix of the workforce, more part-time working and the continued shift towards private dentistry had, the BDA said, resulted in a reduction in the absolute number of NHS WTEs working within the GDS. The BDA calculated that in 2000-01 there were 12,900 WTEs in the GDS, compared with 11,468 in 1996-97 and 13,679 in 1992-93. The BDA gave us a snapshot for the Trent region, which in the last year it said had seen 15 practices close, and in addition, there were 73 vacant surgeries in the remaining practices. In August 2002 it carried out a survey of availability of dental services within England and found that 40 per cent of practices were not taking on new NHS patients, a figure which the BDA said was in line with those found by the Audit Commission and other surveys.

- 2.40 The BDA commented that there were also difficulties of recruitment into the GDS. The BDA gave the following examples:
- the *BDA Young Dentist Survey 2001* reported that fewer than one in five young dentists had confidence in the economic future of the NHS. However, over nine in ten had confidence in the economic future of private dentistry;
 - the number of vocational dental practitioners (VDPs) enrolled on VDP schemes in England and Wales fell in 2002;
 - a 2001 survey by the Dental Vocational Training Authority in England, showed that 135 dentists who had just completed their vocational training did not then go on to apply for a VT number; and
 - information from the Dental Council of Ireland showed that for the first time ever, Ireland was a net importer of dentists from the UK.
- 2.41 The BDA considered that the evidence suggested that the GDS was appearing less and less attractive as a career pathway for dentists. Nevertheless, the BDA believed that the incentives offered by the NHS, such as the Commitment Payments, self-funded seniority and superannuation schemes, were acting as a brake on departures from the NHS and were a reason why those benefits must be strengthened. Allowing GDPs, and their staff, to have access to the same family-friendly benefits as other NHS workers would provide a strong incentive to their retention in the GDS. This should include 18 weeks' paid maternity leave, adoption and paternity leave and allowances for childcare. The BDA noted that from April 2003 paid maternity leave in the rest of the NHS would be increased to 26 weeks and asked us to recommend that dentists may claim maternity payments for up to 26 weeks from April 2003.
- 2.42 The **GDPA** felt that the crises in dentistry, in manpower and delivery of service were obvious to all, and that the need for the Department of Health's current workforce review was evidence of that. The GDPA said that there was renewed momentum to move out of the NHS. The GDPA considered that we, the Review Body, had failed to accurately advise on remuneration and thus retain the commitment of the workforce. It said there were clear indications of workforce difficulties developing in NHS dentistry, with a survey of vocational trainees last year showing that 70 per cent did not see their future in the GDS. The GDPA reported that only about 300 foreign dentists joined the 2002 dental register compared with 800 in the year before. The GDPA had undertaken a survey of its members to gauge the effectiveness of pay incentives in retaining GDPs' commitment. It felt that the results hardly endorsed using pay incentives made outside the feescala to pay dentists for NHS work, and asked us to take careful note of the survey's findings.

Comment

- 2.43 *We said in our last report that we would welcome greater clarity about the resources needed for NHS dentistry as a basis for assessing recruitment and retention. We repeat that call now, and in particular, would welcome evidence from the Departments on the size of the workforce needed to produce the level of dental care they feel appropriate. It does seem to be agreed amongst the parties that retention is a problem. The one to two per cent annual drift out of NHS dentistry, which has been estimated by the Department, seems to bear this out. There can be no doubt that the Department's figures point to an adverse trend and we have taken this into account in making our recommendations. We would like to thank the BDA for the*

evidence provided from the Trent region on practice closures and vacant surgeries. This is the only substantiated evidence we have received on the retention problems. We accept that Trent is only one region and that it may not be typical of the national picture, but if the Department of Health is to resist this evidence on the grounds that Trent is atypical, we need to have detailed evidence.

- 2.44 *In view of the need for clarity about the resources required to support NHS dentistry, we welcome the reviews of the dental workforce which have been carried out across all three countries. The BDA tells us that the Scottish Executive Health Department and the National Assembly for Wales plan changes to deal with the shortages identified in those countries. In England, we note that the Department of Health hopes to publish its review of the primary dental care workforce later this year, together with workforce planning assumptions. We hope these will be available in time for our next review and welcome the confirmation that the review will be regularly updated. We would ask to receive regularly updated evidence for forthcoming review rounds.*
- 2.45 *In our last report, we commented that recruitment challenges could be in the pipeline. We would like to thank the Departments for their evidence on the number of applicants to dental schools, and we note the Department's evidence that there is no shortage of applicants for dental training places. We would ask the parties to keep the situation under review and report back to us for the next round. Recruitment into dental schools may not be an urgent issue at the moment, but the Department of Health acknowledges that it needs to create a system in which sufficient dental graduates are encouraged to join and then remain in the NHS. We would ask the Health Departments to provide us with evidence on the numbers joining the GDS over recent years for our next review so that we can assess the trends here. Ideally, we would prefer to receive data on the WTE number joining the GDS, but we recognise that headcount data is more readily available.*
- 2.46 *We note the changes that have been made in Scotland which the Scottish Executive Health Department hopes will help recruit and retain dentists in the GDS in Scotland. We would very much welcome evidence for the next round on the impact of these measures on the recruitment and retention situation in Scotland.*
- 2.47 *The BDA asked us to recommend that dentists may claim maternity payments for up to 26 weeks from April 2003. We note that the Departments have now agreed this with the profession, as well as introducing paternity leave and extending entitlement to adoptive parents.*
- 2.48 *We welcome the various measures which have been introduced by the Departments in order to support recruitment and retention within the GDS. We also note here the Department of Health's view that despite "incessant tinkering" with the feescall, and making other changes, such as the introduction of Commitment Payments, it has not managed to stem the loss of dentists from the NHS. The Department argues that the only answer is to reform the system. As we stated earlier in this chapter, we agree that in the medium term, reform is the only way forward. However, we are asked to make recommendations for 2003-04. All parties agree that there is a drift away from the NHS towards private practice, although they disagree on the size of that drift. What seems clear is that retention is acknowledged by both sides to be a problem for the GDS at the present time. We have said in previous reports that we regard it as essential that as many doctors and dentists as possible are retained in, and, if possible, attracted back to the NHS. We continue to regard it as essential to encourage GPs' retention in the GDS while the parties work towards reforming the service, and we have taken this into account in making our recommendations.*

Morale and motivation

- 2.49 The BDA reported that GDPs' morale was very low. Committed practitioners were said to be in despair, stemming from excessive workloads, a lack of training support, an inability to deploy the latest equipment, unsuitable premises, failure to keep treatment modalities up-to-date, inadequate information technology infrastructure, lack of Government progress on our previous recommendations, and difficulties in recruiting dentists and staff to 'NHS' practices. This sentiment of low morale was exacerbated by the realisation that *Options for Change*, which was only for England, would take some years to even begin to address those problems. The *BDA Morale Survey 2002* indicated that there had been a downward trend in morale over the last five years. The extremely low morale of the profession was causing much serious consideration being given, from previously very committed GDPs, to the prospect of moving away from the NHS.
- 2.50 There was, the BDA considered, an ever-growing burden of bureaucracy for NHS GDPs, but despite our recommendation that the Department should refer bureaucracy for GDPs to the Cabinet Office, this had not moved forward. In its response to the *Office of Fair Trading Enquiry 2002*, the BDA had reported that two in three GDPs who had increased their proportion of private work did so to reduce NHS bureaucracy. Ever increasing bureaucracy continually resulted in poor morale and raised stress, as well as higher costs and reduced clinical time with patients.
- 2.51 The **Department of Health** noted that the BDA had made a number of references to the low state of morale of GDS dentists and the major factors accounting for that. The Department felt that the issues were being addressed directly by the reform plans and several were specifically covered in the documentation issued in connection with the new Parliamentary Bill. Some points raised by the BDA were directly related to the item-of-service method of remunerating dentists in particular and would change when that system changed. Treatment modalities, for example, would not in future be an issue for the method of remuneration, but for clinical governance. The need to make workload more manageable was understood by the Department and was a key part of the reform programme.
- 2.52 With regard to the BDA's claim of lack of progress on our previous recommendations, the Department reminded us that all the Health Departments had worked hard to address the issues which the BDA had raised. The Government had accepted the BDA's arguments that it was time to reform, rather than to continue to operate indefinitely within the current remuneration system.
- 2.53 The Department told us that it would continue to work with the profession to minimise bureaucracy as far as possible, and that the replacement of item-of-service work with other forms of contracting offered considerable potential for this. In the meantime, from 1 April 2002, the Department had increased the prior approval limit for treatment plans from £265 to £375, which generated an immediate 40 per cent reduction in the number of applications dentists had to submit to the Dental Practice Board (DPB) before commencing more complex courses of treatment.
- 2.54 The Department also noted that the BDA had referred to difficulties in recruiting dentists and staff to 'NHS' practices. It felt that the reform arguments were directly relevant to that point. *Modernising NHS Dentistry* had signalled the beginnings of a process for the GDC to arrange for all groups of PCD to be trained, qualified and statutorily registered. There was increased scope for other members of the dental team to offer clinical care in the GDS. This would create opportunities in future for dentists, as leaders of the team, to concentrate on more complex items of clinical treatment and further develop their role as Team Leader.

2.55 The **Scottish Executive Health Department** told us that following the publication of its *Workforce Planning for Dentistry in Scotland* report in September 2000, it remained committed to an integrated approach on workforce issues. In 2001-02, it had invested £1.6 million over three years in an education and training strategy for PCD, which would potentially address workload and morale issues in dental practice. With the recent expansion of dental therapists into GDS, the SEHD viewed their enhanced role, and that of hygienists, as a constructive means of addressing workload, motivation and morale issues in dentistry. Whilst accepting that PCD were not strictly within our remit, the SEHD said that we might wish to consider ways of incentivising the use of PCD in GDS, thereby potentially alleviating the burden of work on GDPs.

Comment

2.56 *The BDA considers that GDPs' morale is very low, and informs us of its Morale Survey which indicates that there had been a downward trend in morale over the last five years. The Department of Health does not challenge this view, but sees the solution to the major factors accounting for low morale lying in its plans for reform. The BDA points out that low morale is being exacerbated by the fact that Options for Change will take some years to even begin to address the problems. The evidence presented to us clearly suggests that morale is low amongst GDPs. We acknowledge the Department's point that only major reform of the system can get to the heart of the matters which are causing low morale – namely, as we have noted in previous reports, the belief amongst GDPs that their work is too intensive, which is often referred to as the 'treadmill effect'. We would repeat the point we made in our last report that we would hope a reduction in the 'treadmill effect' would also help to improve retention and morale. While we welcome the work being taken forward under Options for Change, and hope that it will provide solutions to address the problems with the current remuneration structure for GDPs, which is the main driver of the 'treadmill effect', clearly the morale of GDPs in general is unlikely to be improved during 2003-04 by any outcomes from Options for Change, and we have taken that into account in considering our recommendations.*

2.57 *The Department of Health and the Scottish Executive Health Department both point to developments with PCD, either as allowing dentists to develop roles and to concentrate on more complex items of treatment in England, or, in Scotland, helping to address workload and therefore motivation and morale issues. The Scottish Executive Health Department asks us to consider ways of incentivising PCD in the GDS and thereby potentially alleviating the burden of work on GDPs. It also notes that this is not strictly within our remit. We agree that this issue is not within our remit, but we do of course recognise that skill mix is an important part of the solution to any workforce shortage which may exist in dentistry. However, we would not wish to go beyond encouraging the parties to work together to continue to develop the role of PCD, which as the Scottish Executive Health Department notes, could alleviate the burden of work on GDPs.*

Remuneration

2.58 The **BDA** said that GDS dentists' earnings were £3,591 less (or 4.4 per cent less) than the actual average reported gross fee earnings. It considered that the Health Departments' data on "average GDS earnings" appeared significantly higher than the actual earnings because of the inclusion of the earnings of specialists. There were, for example, approximately 400 specialist GDPs carrying out orthodontics in the GDS in 2001. The BDA therefore asked for non-orthodontic fees to be increased by 4.4 per cent at the 2002-03 rate, and then for all fees to be increased by any inflation-linked increase for 2003-04. The **GDPA** commented in oral evidence that orthodontic fees had skewed analysis of income unfavourably, resulting in non-orthodontic fees being four per cent below their proper level.

- 2.59 The **Department of Health** considered that the mix of specialists and non-specialists in the primary care dentistry field was far more complex than the simple distinction implied by the BDA's suggestion that non-orthodontic fees received a specially weighted increase. It had been a long-standing feature of practice that some GDPs specialised and many GDPs had undertaken some orthodontic treatments. A number of factors could also be affecting the pattern and mix of earnings. For example, the movement by some dentists to withdraw from offering NHS treatments to adults might have contributed to a situation where the volume of orthodontic treatment, which was overwhelmingly delivered to children, had assumed a greater statistical impact on average NHS earnings. This would distort any analysis of specialist or non-specialist earnings. Average earnings data had been taken for many years as a measure of movement across a necessarily diverse primary sector, and the Department felt that it would be premature to "weight" any pay award without more careful analysis of the justification and possible consequences.
- 2.60 The Department told us in an Annex to its evidence that average GDS net income of dentists in England and Wales with a reasonable commitment to the GDS, excluding those on the lowest earnings, was about £62,600 in 2001-02. Excluding the highest earners, the average would be about £57,000 in 2001-02. The Department noted that earnings of a full-time dentist would be higher. The Department suggested that the levels of net pay achieved by dentists under the present system had been acknowledged by us (in our thirty-first report) as fair in relation to comparator groups.

Comment

- 2.61 *The BDA has asked us to recommend that the non-orthodontic feescale is uprated by 4.4 per cent before any inflation linked increase for 2003-04. It has based the need for this upon an analysis of earnings and says that data on "average GDS earnings" appeared significantly higher than the actual earnings because of the inclusion of the earnings of specialists. The Department rejects this analysis, saying the situation is far more complex, and that a number of factors could also be affecting the pattern and mix of earnings. For our part, we consider that the BDA has removed some of the higher earners from its analysis, but, as far as we can see, it has not removed any of the low earners. If that is so, it does not seem to us to be the right way to construct an average of all GDPs. We also note here that the concept of the earnings of the "average" GDP no longer formally exists following the abandonment of Target Average Net Income for GDPs in 1994.*
- 2.62 *In our thirty-first report, using data from the Survey of GDPs' Workload⁶, agreement between the Office of Manpower Economics (OME), Department of Health and the BDA on the time that a GDP fully committed to the GDS would work each year, and data from the DPB, the OME estimated that the average total remuneration⁷ for a WTE GDP fully committed to the GDS in 2000-01 was £54,800. We noted that although the BDA accepted the supporting methodology, the Department of Health had raised a number of issues, and had continued to provide its own evidence on GDPs' net earnings. The Department's evidence for this round has estimated that the average GDS net income of GDPs in England and Wales with a reasonable commitment to the GDS⁸, excluding the highest and lowest earners, would have been about £57,000 in 2001-02. The Department also noted that the earnings of a full-time GDP would have been higher. We would like to thank the Department for providing these estimates, and note that the BDA has provided no estimates of GDP remuneration for this*

⁶ Survey of general dental practitioners' workload, BMRB Social Research, 2001

⁷ Net earnings from the feescale added to other remuneration, such as Commitment and seniority payments.

⁸ Defined as those with gross fee earnings of £53,700 or more.

round, although it has provided figures for average GDP gross earnings. OME has rolled forward its 2000-01 estimate, using the uplifts we recommended in our last two reports, including the changes recommended to the Commitment Payments scheme in our reports. This gives an estimate for average total NHS remuneration for WTE GDPs fully committed to the GDS of around £57,200 in 2001-02 and around £59,700 in 2002-03. We note that OME's estimate for 2001-02 is similar to that of the Department of Health.

- 2.63 We explained in our thirty-second report the basis on which we consider pay comparability for our remit groups against other professions, both in terms of pay movements over recent years and of pay levels. We have considered GDPs on this basis, as usual. Our conclusion is that the remuneration of GDPs remains broadly in line with that of the comparator groups, although it is difficult to draw any detailed conclusions because of the lack of agreed data on WTE remuneration of GDPs fully committed to the GDS.
- 2.64 We would therefore remind the parties again that we have sought to establish an acceptable and agreed estimate of total remuneration for WTE GDPs for some time now, as we feel the information would be an important addition to our deliberations on this group. We are concerned that we still do not have this information, and must rely instead on separately derived figures. We would therefore ask the parties to ensure that their work on reforming the GDS takes the need for this important information into account, so that a reliable and agreed baseline for the remuneration of WTE GDPs fully committed to the GDS can be established for the reformed GDS, which can then be updated for each round.

Fees and allowances

Commitment Payments and additional registrable qualifications

- 2.65 The BDA said that its analysis⁹ of Commitment Payments showed that, even at such an early stage, they had helped to slow the move to private practice and it believed that Commitment Payments must be strengthened. In oral evidence, it noted that dentists did appreciate receiving the payments. That overall pay was too poor was, in the BDA's view, recognised by the Department's statement that even with Commitment Payments, there was still a drift away. The BDA reported that it had managed to negotiate two, limited improvements to the current scheme. From April 2003, assistants would receive Commitment Payments and that there would be adjustments made to the bandings between income levels, to take account of a "lag effect" in the full introduction of new fees.
- 2.66 The BDA said it had discussed with the Health Departments the recognition of those with an additional registrable qualification (ARQ). It had suggested a further development of the Commitment Payments scheme that would have rewarded those who had ARQs in proportion to their commitment to the GDS and their ongoing attendance at approved Postgraduate Courses. This was, the BDA reported, rejected by the Health Departments. The BDA said that it was understood that any ARQ recognised by the GDC had a relevance to dentistry. The BDA argued that salaried GDPs currently received financial benefits (at appointment, an additional incremental point was allowed provided that the dentist was not appointed above the fifth point on the scale) for acquiring an ARQ. The BDA estimated that approximately 2,500 GDPs (or 12 per cent)

⁹ Following its oral evidence session, the BDA provided a copy of its paper *The Impact of the GDS Commitment Payments Scheme*. The paper concludes that the scheme has contributed, in part, to retaining existing levels of commitment in the GDS for those GDPs receiving Commitment Payments, but acknowledges that the available data set did not allow for the examination of GDS commitment and the Commitment Payments scheme in isolation, keeping all other factors constant.

were in possession of ARQs, but said it was unable to provide definitive data. It was clear to the BDA that currently there was little to encourage dentists to acquire such qualifications, despite the obvious benefit to patients. The BDA said it could infer from research articles that better qualified dentists would save the NHS money by making fewer unnecessary referrals to secondary care and by achieving quantitatively more accurate rates of diagnosis. The BDA therefore asked us to recommend that the Commitment Payment scheme was strengthened by an additional £8 million to increase payments to GDS practitioners with an ARQ.

- 2.67 The **GDPA** noted that the way Commitment Payments were awarded encouraged dentists not achieving maximum payments to work harder or faster and therefore quality suffered. It deduced from its membership survey that Commitment Payments had failed to increase the commitment of the profession by any significant amount. In oral evidence, it told us it would rather see the seniority payments scheme improved. The GDPA felt that Commitment Payments discriminated against those who were fully committed to the GDS, but who only worked part time. The GDPA was also concerned about the potential difficulties experienced by assistants with non-payment of Commitment Payments.
- 2.68 The **Department of Health** told us that, in line with our last recommendation, it had extended the Commitment Payment scheme to begin after five years' service. In doing so, it made a further provision by including the VT year (costing an additional £1 million) and had made changes to ensure that dentists were not disadvantaged during maternity leave. The profession had told the Department that the annual uprating of the Commitment Payment earnings bands had led to an underpayment. To address this, it had agreed to uprate the earnings levels for Commitment Payments by 50 per cent of our 2003-04 uprating figure as a one-off measure. The Department also said that it had agreed to standardise thresholds and enable part-time dentists who were highly committed to the GDS to apply for exemption from the current minimum earnings threshold.
- 2.69 The Department considered that the Commitment Payments scheme had increased GPs' pay, but had had little or no effect on the NHS's ability to secure dentistry. Evidence for the effectiveness of Commitment Payments was limited, and in oral evidence, the Department told us it had examined levels of payments and trends in working, and the trend of a slow drift away from the NHS had continued. The Department would not expect commitment to be enhanced significantly by any further extensions to the existing scheme, and nor would it now be appropriate to modify the scheme further.
- 2.70 With regard to ARQs, the Department told us that it had discussed the case for recognising ARQs with the profession and had explained that it felt that any additional payments needed to be justified by evidence that such qualifications were linked with and contributed to improvements in patient care. In oral evidence, it told us that its mind was not closed to recognising those qualifications, but it did not want to see blanket payments made to dentists for achieving any ARQ. It also considered that the profession had not brought forward substantive evidence to that effect, and that payment for ARQs would not necessarily increase commitment. The Department proposed to tackle the issue, not through the changes the BDA had suggested, but through fundamental reform. The proposals embodied in the Bill now in Parliament would allow PCTs to commission more specialist dentistry through dedicated contracts, which would provide the opportunity to value those skills in an appropriate way, amongst the criteria for contract bidding and as part of contract value. In oral evidence,

the Department said that financial recognition for salaried dentists with an ARQ was justified because service managers had more control over the qualifications chosen for study by dentists and would agree with the individual in advance how the particular ARQ would benefit service delivery.

- 2.71 The **Health Departments** said that they had agreed to extend Commitment Payments to assistants with effect from 1 April 2003.

Comment

- 2.72 *We welcome the changes agreed between the parties to extend Commitment Payments to assistants (including those who will only be spending short periods in the GDS) and to ensure that dentists are not disadvantaged during maternity leave, and we also welcome the further provision made by the Department to include the VT year in assessing eligibility for Commitment Payments. We also note that adjustments are to be made to the bandings between income levels for Commitment Payments and that part-time dentists who are highly committed to the GDS would be able to apply for exemption from the current minimum earnings threshold.*
- 2.73 *We commented earlier in the chapter that the parties seemed to be agreed that retention was a problem for the GDS, although their evidence disagrees about how severe and urgent a problem the GDS is facing. The Department estimated this drift from NHS dentistry to be around one to two per cent per year, while the BDA said the Department's description of a "small drift" was a substantial understatement, with dentists leaving in "ever increasing numbers". The BDA believes the profession to be poised on a knife edge regarding moving away from the NHS.*
- 2.74 *We also said earlier that we fully agree with the Department's view that reform of the GDS is the way forward in addressing recruitment and retention within the GDS. Nor do the BDA dissent from this. However, this is necessarily a medium-term objective, and we must make a judgement for the current year on what measures might best support retention across the wider GDS. We said in our thirtieth report that we considered it was important to encourage GPs' retention in the GDS, and introduce measures to increase their motivation. This remains our view and we have considered this against the evidence from the Department of an adverse downward trend in retention across the service. The Commitment Payments scheme was introduced in 2000 following our recommendation that £20 million should be set aside for a scheme specifically to encourage retention of GPs within the NHS, and to improve their motivation. We asked the parties in our last report to produce joint evidence for this review on the most effective reinforcement of the scheme and for evidence on the effectiveness of the scheme. We regret that the parties have not provided any joint evidence, but are grateful to the BDA for its evidence on the effectiveness of the scheme, while noting the acknowledged shortcomings of the evidence. As the parties have not provided any definitive evidence on the overall effectiveness of the scheme, we propose to undertake our own research which we hope will be available for the next review.*
- 2.75 *We have considered the parties' evidence carefully. The Department has estimated the drift from NHS dentistry to be around one to two per cent per year, and it seems to us that this drift could become a serious issue if it continues over the next few years until Options for Change is implemented. We therefore feel that the potential retention problem is serious enough to warrant action in the short-term. We have looked at the various options open to us to provide support to retention in the GDS, bearing in mind the need to minimise the extent to which any extra funding we recommend can be used to support private practice. Although the parties have been unable to provide definitive evidence on the effectiveness of the Commitment Payments scheme, we consider that it is currently the best way to provide the extra support we feel is needed for retention. We reached this conclusion because the*

*scheme both offers financial support to a significant majority of GPs working in the GDS and also provides a means of targeting those doing the most for the NHS. In addition, the BDA support the scheme. We therefore **recommend** that the current scheme is increased by a third, which we believe will amount to additional funding of just over £9 million in the coming year, making a total of nearly £37 million. The top level of payment would therefore be £3,900 (or £5,850 for those GPs aged 45 or over). Further, we believe that the effect of our recommendation would be to increase the average annual payment from an estimated £780 in 2002-03 to around £1,040 in 2003-04. We are also fortified in our decision by the knowledge that there are other costs in the system which might not be adequately covered at the moment. We do recognise that better quality evidence about the effects of Commitment Payments is desirable and we are putting that in hand. That, we hope, will help inform final decisions about the role of the scheme in the wider work which aims, under Options for Change, to reform current remuneration arrangements in the GDS.*

Seniority payments

- 2.76 The **BDA** was concerned about retaining dentists over 55 years of age in the GDS. Whilst it welcomed the recent announcement by the Health Minister in England that from April 2003 dentists up to age 70 may continue as GDS principals, the BDA said this would have no real impact if dentists had already left the GDS. It did not understand why self-funded seniority payments ceased for dentists who received their pension, but continued working in the GDS. The BDA considered that the self-funded seniority payments scheme could aid retention in the GDS, by allowing dentists who took age-related retirement, and subsequently returned to the GDS, either as principals or assistants, to be eligible to claim seniority payments. The BDA asked us to recommend that assistants should be eligible for seniority payments and that they should be available to dentists returning to the GDS after age-related retirement.
- 2.77 Currently seniority payments were, the BDA reported, capped at a level of gross earnings (£68,287) below the average. Those self-funded payments were made to compensate older GPs for lower earnings as they slowed down because they had become less able to manage the physical demands of working in the GDS. The BDA asked us to recommend that the maximum gross earnings limit on which seniority payments were based was increased to match the maximum top level of Commitment Payments. In oral evidence, it confirmed that it did not want the funding for seniority payments to be “top-sliced”, but for new funding to be provided, as in Scotland. The aim of seniority payments was to provide some financial compensation which allowed older dentists to reduce their NHS workload, and this would be an improvement because older practitioners would stay in the service rather than leaving altogether.
- 2.78 The **Department of Health** said that seniority payments were paid to principals aged 55 and over and covered ten per cent of gross fees – payments in 2002-03 could therefore reach £6,829. In addition, those dentists would qualify for Commitment Payments, and so dentists whose earnings reached the qualifying maximum were already receiving incentive payments of £11,215. The Department calculated that the BDA’s proposal would give an additional £6,071, or a total of £17,286, and did not consider that the BDA had justified why those incentives needed to be increased further. The Department also felt it would be inappropriate to try to standardise individual elements of a complex pay system, other than to address any obvious anomalies, when attention needed to be focussed on system reform. The system of seniority payments and Commitment Payments had evolved to address different needs, and, as seniority payments were designed to compensate those more mature dentists whose earnings rate might be reduced by factors such as some loss of manual dexterity, it was not surprising that

payments were focussed on lower earning levels than Commitment Payments, which were designed to recognise absolute levels of commitment to the NHS. In oral evidence, the Department also noted that, in its view, it was also more likely that younger dentists would make the switch to private practice. Commenting on the increase in seniority payments in Scotland, the Department said that it would be more rational to consider what was best for particular parts of the country with any increases made at a local level, as foreseen under *Options for Change*, and it did not see a major advantage of going down the Scottish route as Scotland had particular problems which were different to England.

- 2.79 The Department noted that the BDA argued that assistants and dentists returning after age-related retirement should be eligible for seniority payments. Assistants were not in a direct, contractual relationship with the NHS and their individual remuneration arrangements with practice principals might be very varied. The Department reported that from April 2003, principals could continue practising until the April after their 70th birthday and therefore principals who had been continuing to do dental work after age 65 as assistants could now continue as principals and would be eligible for seniority payments. Dentists who were spending short periods in the GDS as assistants would, from 1 April, become eligible for Commitment Payments up to £4,386. The Department did not think that a case had been made for further, piecemeal amendment to the seniority payment system.
- 2.80 The **Scottish Executive Health Department** reported that to encourage the more senior dentists to continue to undertake NHS dentistry, it had agreed with the profession that the accumulated gross fee ceiling would be raised. Currently, a maximum of around £7,000 might be earned through seniority payments. By raising the accumulated earnings threshold, a dentist would have the potential to earn £12,500.

Comment

- 2.81 *We were pleased to note that the Department of Health has agreed to allow principals to continue to practise as principals until the April after their 70th birthday, and that this will allow them to remain eligible for seniority payments. We welcome the Department's evidence that dentists who spend short periods of time in the GDS as assistants are also eligible for Commitment Payments, up to £4,386. If any further improvements are needed to any aspect of the remuneration for assistants, as we have said in previous reports, we would ask the parties to negotiate directly. We have noted the decision by the Scottish Executive Health Department to raise the accumulated earnings threshold for seniority payments and would welcome further evidence, both on the effectiveness of this measure at retaining GDPs within the GDS, and whether it has increased the overall delivery of NHS dentistry in Scotland.*
- 2.82 *We have considered carefully the BDA's request that we should recommend additional funding for seniority payments and that the thresholds for seniority payments should be aligned with those for Commitment Payments. On the first point, we do not consider that it would be right to make a large change to the scheme this year, as changes to seniority payments will not offer sufficiently widespread retention benefits within the GDS. As we have explained earlier in this chapter, we feel that a change to Commitment Payments is the right focus for this year. On the latter, we would agree with the Department of Health that the two schemes have different purposes. We have asked for evidence from the Scottish Executive Health Department on the effectiveness with regard to retention of extending seniority payments in Scotland, and we hope this can be provided for the next round. Therefore, for now, we do not consider that we should recommend the same approach for England and Wales.*

Training and Continuing Professional Development

- 2.83 The **BDA** felt that the simplification of the system for claiming Continuing Professional Development (CPD) allowances in England and Wales was a positive step, and the increased course attendance by practitioners had positive patient gain. The BDA also welcomed the Minister of Health's announcement that those allowances would be claimable by assistants from April 2003.
- 2.84 The **GDPA** commented that part-time workers who earned less than £22,000 were not entitled to CPD allowances, although they had to undertake the same mandatory requirement of CPD. It also commented that the rights of assistants should be clearly established in relation to CPD allowances.
- 2.85 The **Department of Health** told us that in response to representations from the profession about the complexity of the scheme for claiming the CPD allowance, it had overhauled the system from 1 April 2002 and replaced it with a version similar to that applying in Scotland. It had retained some features of the previous system (payment on an hourly rate and distinguishing between CPD and travelling time) which it felt were helpful. It had also extended the scheme to assistants.
- 2.86 The **Scottish Executive Health Department** told us that an additional allowance had been made available for dentists in remote areas for undertaking CPD, in recognition of the long journeys (and travelling time) involved. From 1 April 2002, a dentist practising in such a remote area was entitled to claim an additional £94.33 for each half-session of education time of more than one hour and up to two hours and £188.65 for each session of education time of more than two hours and up to three and a half hours. The SEHD said it was committed to an education and training strategy that supported a high quality system in Scotland. In acknowledgement of the work involved in the new assessment of VTs, an interim payment of £2,000 had been made to current VT trainers in Scotland from 1 August 2002. That interim payment would be repeated in 2003-04 and further discussions would take place with the profession to arrive at an appropriate level of remuneration, to recognise their increased workload.
- 2.87 The SEHD said that it had introduced new salary grades in the existing VT grade (first year) and GPT grade (second year). The training grades would initially be used in the GDS and the Community Dental Services, but it hoped to further extend the grade to include hospital posts in future.

Comment

- 2.88 *We are pleased to hear that the parties have agreed a simplification of the CPD allowance for England and Wales, and we welcome the extension of this important allowance to assistants. We also note the developments in Scotland in recognition of long journeys and travelling time from remote areas. We would ask the parties to continue to monitor the practical application of the allowance in each country and if any further improvements seem necessary, to negotiate on them directly.*

Clinical audit, peer review and clinical governance

- 2.89 The **BDA** commented that considerable demands were starting to be placed on GDS dentists over and above the clinical governance requirements described to us by the Health Departments in the last round. This activity had to be undertaken within working time because it was essentially team-based and there was no allowance to cover this

activity. The BDA estimated that dentists were spending a non-remunerated average of four hours a month on clinical governance activity. In oral evidence, it confirmed that it only had anecdotal evidence to show that dentists were spending around four hours a month on clinical governance, but said that clinical governance was a professional requirement. The GDC, for example, had suggested 50 hours per year should be set aside for practice development. The BDA asked us to recommend a payment of a new Clinical Governance allowance of up to 48 hours per annum at the CPD allowance rate, currently set at £54 per hour.

- 2.90 The **Department of Health** felt that many of the principles underlying clinical governance reflected long standing features of good clinical practice and practice management, and the professional standards required by the GDC. The recent introduction of CPD and Clinical Audit allowances had substantially reinforced the maintenance and development of good clinical governance. In the Department's view, the effectiveness and take up of those measures needed to be evaluated before the case for any further financial support could be judged. However, the issue illustrated the concern that under an item-of-service system, any activity not directly linked with a remunerable item of treatment risked a potential loss of earnings. The Department said that in PDS and under the proposals being taken forward from *Options for Change*, contract pricing could better take into account activities which underpinned clinical practice.
- 2.91 The **Scottish Executive Health Department** reported that from 1 April 2002, as we had recommended in our last report, it had instigated a mandatory requirement that all dentists in Scotland who provided GDS, must take part in at least 15 hours of clinical audit during each three-year period. An allowance, payable for undertaking approved projects in the relevant period, had been introduced and was calculated at an hourly rate of £54. Before moving to implementation of a Quality Assurance System, the SEHD had agreed with the profession that it should ensure that certain essential building blocks, and associated funding, were in place to underpin a fully strategic approach to measuring and achieving the standards it wished to see in primary care dentistry across Scotland. The SEHD was working to develop an integrated approach to standards for dentistry in Scotland.

Comment

- 2.92 *We note the BDA's evidence in support of the introduction of a new allowance for clinical governance. We said in our thirtieth report that we believed GPs should not be expected to absorb new quality requirements which impinge significantly on the time available for them to undertake their NHS work without financial recompense in exchange as, in our view, NHS fees are not at a level to support such activities. The evidence presented by the BDA in support of its case appears to be anecdotal, but we would be concerned if the developing quality agenda was shown to be impacting significantly on GPs' time. However, we remain of the view we expressed in our last report that detailed feescale issues raised by the profession only serve to highlight the need for a fundamental review of the feescale system, and we do not intend making arbitrary changes to the existing feescale. We expect the forthcoming reform of the GDS and the development of new methods of remuneration to address these various issues, but in the meantime, the parties should negotiate directly on any pressing and specific issues.*

Practice investment and return on capital

- 2.93 The BDA reported that financial uncertainty had left many NHS practitioners unable to form a business plan and to make long-term sustainable decisions concerning their practices. Provision of a substantial increase in funds would enable dentists to embark on the road towards improvement in facilities and patient care, and the BDA felt that similar standards as were available in Dental Access Centres (DACs) should be applicable to all GDPs with regard to the case load and the income levels coupled with the high standards of equipment and IT. The BDA noted that previously there was a promise that the 'Local Improvement Finance Trust (LIFT)' schemes would address the modernisation issues, but this would not be in the next few years because those projects were not yet off the ground. In oral evidence, the BDA told us that dentists received no return on the capital they had invested in practices.
- 2.94 The BDA said that its own surveys pointed strongly to a positive link between the level of private work undertaken in a practice, the level of profitability achieved and the consequent level of investment undertaken. It said that in reality, private income was subsidising NHS provision. The BDA reported that almost two thirds of practices had received Modernisation Funds in 2001-02, which was a very welcome capital injection, but it was nowhere near enough to bring practices up to an acceptable standard and it needed to be sustained. The BDA said it was therefore disappointed that the Minister had ruled out modernisation funding for GDS practices in England for 2002-03. In Scotland, the BDA reported that £3 million had been allocated as practice improvement funds in 2002-03. For Wales, there was approximately £900,000 earmarked as refurbishment money in 2002-03, although the money came from an under-spend on previous initiatives. As capital expenditure was derived from profits, it was directly linked to remuneration and it was therefore, the BDA considered, part of our remit to ensure that there was sufficient funding for investment for practices. The BDA therefore asked us to recommend that Modernisation Funding, at an appropriate level of £56 million per year, was paid for five years across Great Britain.
- 2.95 In oral evidence, the BDA noted that the three-year pay offer had included £50 million for capital investment over two years, but said that it had no idea how that money would have been distributed and it only amounted to £2,200 per practice in England. It confirmed that it would work with PCTs to ensure that maximum benefit of the funding was given to the GDS and suggested that joint BDA/Department of Health guidance should be issued.
- 2.96 The BDA commented that very few practices across Great Britain were in a position to comply with requirements for the Disability Discrimination Act, which would come into full force in October 2004. It had made proposals to the Health Departments for funding from health authorities for audits of practices, to identify the scale of the work needed for practices to comply. The BDA asked us to recommend that a survey of practice premises was carried out, and that the funding required for compliance with the Act was identified.
- 2.97 The GDPA commented that *Options for Change* pointed out that fair reward for capital investment in the NHS was an important issue. It said that industry sought between a ten and 15 per cent return on investment, and that dentists were entitled to a return of at least ten per cent before any other income calculations. The GDPA said that this had been acknowledged by the Department of Health, and that it was now time for us to act. In oral evidence, it noted that things had greatly changed since the feescale had been set up, with equipment being much more expensive, and it said the feescale no longer provided an adequate return.

- 2.98 The **Department of Health** said it had proposed that a reformed dental service would provide a better framework for more sensitive and targeted assistance to meet variations in practice expenses and to help with the modernisation of practices and surgery premises. The proposed reforms would lead to much greater clarity about what was being supported and what was sought in exchange, on a contractual basis. Such a contractual basis was largely lacking at present and it did not believe that general “add-ons” to the present pay system represented a good or cost-effective means of supporting practice expenses. In the meantime, the Department reported that additional funding, which it proposed to make available via the NHS, would enable a variety of methods of supporting dentists to be taken forward. Among those, scaling up of PDS contracting should enable the NHS to take a more flexible and local approach to expenses.
- 2.99 In oral evidence, the Department noted that the £59 million would be ring-fenced for dentistry, although some of the modernisation funding would be set aside for the agreed deal with the salaried side (possibly ten per cent, though this was yet to be agreed). The intention would be to use the money to help the GDS in the most effective way. In supplementary evidence the Department informed us that the £59 million available for modernisation and access was split between 2003-04 (£23 million) and 2004-05 (£36 million). Under the new legislation, PCTs would have powers to support practices through capital allowances in any way they thought was appropriate. Available capital funding, which it proposed to deploy through the NHS, would enable modernisation issues to be addressed on a local basis, not dissimilar to the approach being adopted in Scotland. In oral evidence, the Department asked for us to give encouraging words for the Access and Support team that would advise on distributing the modernisation funding, and asked for a recommendation for the Department to target the modernisation money where it would be most effective, and for us to monitor this spending. It also commented that five per cent of expenses were treated by the Inland Revenue as capital allowances, and that if a particular new piece of equipment was required across the GDS, the usual approach would be for the BDA to seek to negotiate a specific fee to cover the cost. If additions or amendments needed to be made to the feescale, then it was for BDA to approach the Department to negotiate them.
- 2.100 The Department felt that the BDA’s evidence on DACs appeared to recognise that they had a different role from the GDS, but then compared them, disregarding their being part of the salaried service. The need for investment in GDPs’ services was understood and agreed, but in itself required a reform programme, as the Department had set out. The inability of the NHS to use the existing system to help patients who were unable to obtain dentistry from GDPs was one of the key reasons for setting up DACs.
- 2.101 The Department told us it had provided £1 million to PCTs to survey dental practices to assess what action might be necessary to ensure that disabled people had adequate access to NHS dental services. In most areas those surveys were not yet complete. It would be premature to assume that every dental practice required substantial investment to comply with the Disability Discrimination Act, and many adjustments might entail little or no cost. The NHS’s responsibility was to ensure that within any given area, the option of accessible NHS dental services was available to people of all disabilities. It noted that a number of LIFT projects were underway and some were likely to involve dentistry. However, the way in which GDPs were paid was indeed a substantial impediment and this was among the reasons for reform.

2.102 The **Scottish Executive Health Department** told us that it recognised the profession's concerns in relation to infrastructure and it had made available £3 million in 2002-03 to enable eligible dentists to upgrade their practices, particularly in respect of improving patient safety and access, addressing the requirements of the Disability Discrimination Act and introducing new environmental measures. A further tranche of funding (£3 million) would be allocated in 2003-04. In consultation with the profession locally, each Trust was able to decide on how best to spend the allocated funding, subject to certain criteria. The modernisation of primary care premises was a high priority and in the third tranche of funds (£15 million), announced in December 2001, the Primary and Community Care Premises Modernisation Programme included specific emphasis on improving access to NHS dentistry. Under the Scottish Dental Access Initiative, it continued to offer grants to dentists proposing to establish new or expand existing NHS practices in areas of unmet patient demand or high oral health need. Since its inception in 1997, grants had been awarded amounting to over £1 million.

Comment

2.103 *The BDA has asked us to recommend Modernisation Funding of £56 million per year, for five years, across Great Britain, as it considers it is part of our remit to ensure that there is sufficient funding for investment in practices. We remain of the view, expressed in our thirty-first report, that the Modernisation Fund is not strictly a remuneration issue and is therefore not within our remit, but it is for the Health Departments to decide the extent to which they wish to provide continuing support for capital investment. We do, of course, very much welcome any funding that the Health Departments put towards modernisation of practices, as it should help improve morale, and we would ask them to continue to bear in mind the retention, morale and motivation effects of any schemes to provide capital support. We hope that the reform programme for NHS dentistry will take these points into account as it goes forward and we would ask for further evidence on this for the next review.*

2.104 *We note that the Scottish Executive Health Department made available £3 million in 2002-03 to enable eligible dentists to upgrade their practices, and that a further tranche of funding (£3 million) would be allocated in 2003-04. We also note that the Department of Health offered £59 million of modernisation funding over the first two years of the now rejected three-year deal. Despite the rejection, the Department intends to use this funding (though through PCTs, rather than through the national contract) and specifically confirmed this to us in oral evidence. We welcome the Department's confirmation that the £59 million of modernisation funding (£23 million in 2003-04 and £36 million in 2004-05, less whatever the parties agree will be set aside under the three-year pay offer agreed for the salaried services) will still be available to support the GDS. We note that the BDA has confirmed that it will work with PCTs to ensure that maximum benefit of the funding was given to the GDS and we hope that the parties will work effectively together to target this money where it can be used most effectively. We would expect to see the funding fully spent over the period. We welcome and accept the Department's proposal that we should monitor the spending of this funding and look forward to receiving evidence on progress here for our next review.*

2.105 *The BDA also asked us to recommend that a survey of practice premises be carried out to identify the scale of work needed for practices to comply with the Disability Discrimination Act, and that the necessary funding for compliance be then identified. We note that the Department of Health has provided £1 million to PCTs to survey dental practices to assess what action may be necessary. We do not consider this issue to fall within our remit, although we would again ask the Health Departments to take into account, when they are taking forward their policies for implementation of the Act, how these policies might impact on the recruitment, retention and morale of this remit group.*

2.106 *The GDPA raised again with us the issue of return on capital. In our last report, we noted the Department of Health's evidence that, under the averaging system, the level of return was likely to vary between practices. We would be grateful for evidence on the average level of return on capital received by GDPs for our next review. We would also like to remind the parties of our comments last year, which still stand, that we would not wish to complicate further the GDS feescale by making a specific recommendation on return on capital, but that we consider it very important that Options for Change does move this issue forward. The framework agreement on Options for Change noted that one of the changes it wanted to deliver was "fair reward for capital investment in the NHS". We will await evidence on progress here for our next review.*

GDPs' expenses

- 2.107 Increasingly often, the **BDA** considered, practice owners had to meet the costs of legislative change which, taken collectively, added up to significant sums. Those items included additional National Insurance contributions, which would affect all practices, but particularly those employing full-time staff. It was worth underlining, the BDA felt, that in addition to the one per cent employers' increase, there would also be additional pressure to cover the one per cent employees' increase. Other costs included increased payroll costs associated with Working Families Tax Credit, statutory maternity leave for staff and training costs. Those were not currently accounted for within the feescale, but they further eroded practice profitability and therefore affected income and morale. The BDA asked us to recommend the introduction of a new Practice Costs Allowance, payable to the practice, to represent an extra three per cent of the earned fees of the practice.
- 2.108 The BDA reported that the Department of Health had agreed in December 2002 to distribute the newly modified BDA Infection Control advice sheet to all practitioners in England, and the Department confirmed to the BDA that it would be using the recommendations within the booklet as the definitive advice to dentists on this matter. The BDA expected the Welsh Assembly Government to follow likewise. Nevertheless, the BDA said, there had been no commitment by the Health Departments to underwrite the costs of implementing the new guidelines. The increased costs associated with the new requirements were estimated to be a ten per cent reduction in output by the dental team (holding all other factors constant) and was equivalent to a 25 per cent reduction in net income. The ten per cent reduction in output would also be accompanied by a 20 to 25 per cent increase in dental nurse staff time. The BDA emphasised that for certain GDPs, following the advice might make their practices financially non-viable. Many practices would either need to reorganise their current workforce responsibilities, or to employ, at additional cost, additional personnel.
- 2.109 The BDA reported that its *Dental Business Trends Survey (2002)* showed that overall waste disposal costs for practice owners had risen over the last two years, and the main contributors to the rise had been the increased costs for the disposal of clinical and special waste. The average percentage increase in the cost of disposal for special waste over the last two years was 51 per cent and for clinical waste was 44 per cent. The introduction of new legislation over the past two years had resulted in an increase in waste disposal costs. The BDA reported that the costs for palladium based crowns had remained high, despite a fall in the actual cost of the metal over recent months.
- 2.110 In oral evidence, the BDA noted that city costs – not just London – needed to be taken into account when considering reimbursement of expenses. Expense ratio differences which were particular to rural and urban areas should also be looked at. Variability of costs was the problem and the BDA wanted the Department to address this.

- 2.111 In supplementary evidence, the BDA said that the Department referred to “cost pressures” being recognised in the future, but that the ‘jam tomorrow’ syndrome did not deal with the needs of today. The Department’s evidence mentioned the intention ‘in principle’ to address the expenses issues, but there were no solid proposals. There was a strong belief by dentists that the Department’s promises were “worthless”. In oral evidence, it noted that the opportunity to separate pay from expenses (part of the three-year deal) was therefore sadly missed. The BDA still wanted to pursue the separation of the expenses element of the pay offer and make the analysis prospective rather than retrospective, and it hoped we could recommend this work going ahead. It also hoped that we would make a recommendation that pay should be kept separate from expenses, and it wanted a reasonable pay uplift net of expenses.
- 2.112 The **GDPA** felt that there was an urgent need to accept the financial pressures building within dental practice. It reported that dentists were experiencing some difficulties in finding suitable staff because of the low feescall and this would be exacerbated by the compulsory registration of dental nurses proposed by the GDC, unless funding was made available for attracting, training and retaining dental nurses. National Insurance would increase in April, adding two per cent to the wage bill, and the GDC Annual Retention Fee would be more than doubled by the end of the year. The GDPA also mentioned the increasing cost of indemnity insurance and practice insurance. In oral evidence, it told us that more needed to be done for practice owners who bore all the costs (unlike associates and assistants), and commented that our recommendations at present unfairly impacted upon practice owners.
- 2.113 The GDPA commented that infection control was a rapidly increasing cost and that it supported representations that would be made by the BDA on the issue. The GDPA felt that there should be no treatment on, or work carried out for, patients that was unremunerated. It told us that if patients were examined and reassured, that there was no fee and that time spent with patients discussing treatment plans was not built into the feescall. It also mentioned that referral letters and searches for the shortest waiting list were all carried out free of charge.
- 2.114 The GDPA commented that because *Options for Change* was going to be a slow process, it sought fairness in the interim period for the greatly increased costs of maintaining a dental surgery in London. The GDPA requested an urgent review of funding for London dentists because of the cost of employing staff and the cost of premises. It noted that other essential services in London paid London Weighting, including salaried doctors and dentists and that the cost of living and housing in London meant the level of earnings were less in real terms. It also drew our attention to the 2002 report by the Greater London Authority into London Weighting. It commented that similar problems to those in London were being experienced by dentists working in many other areas of the country. The GDPA felt that an alternative to London Weighting would be to have direct reimbursement of fixed cost expenses. The GDPA also suggested a new method of calculating the percentage entitlement to allowances based on a target figure of gross earnings or patient numbers.
- 2.115 The **Department of Health** reported that dentists’ income to expenses ratio was stable and that it had been for some time. As part of the three-year pay offer, it had offered to develop a new system for responding to cost pressures within the current pay round at arm’s length from the Department, acknowledging the BDA’s position that there might be exceptional changes in expenses which should be addressed prospectively. A mechanism to address this had been proposed by the BDA and, in principle, accepted by the Department. The Department said the BDA had been repeatedly pressed to deliver proposals, but that it had failed to do so. The BDA rejected the pay offer, of which this mechanism was to have been a part. At a point when there was a clear pathway to

a reformed contractual framework for dentists (which would, the Department said, of course include expenses aspects), the Department said it would propose to focus resources on a mechanism to address prospectively exceptional changes in expenses. What it felt was needed in the longer term was a mechanism which could recognise local variations in expenses, as changes in costs were rarely uniform across the country. This was a goal for a new contractual framework. Exceptional cost pressures would in future be recognised at PCT level through some form of supplementary assistance, rather than dealt with, as hitherto, entirely within a centrally-run system based on gross average fees. The Department did not believe that general “add-ons” to the present pay system represented a good or cost-effective means of supporting practice expenses. In oral evidence, it said that London Weighting should be looked at on a local level, as envisaged by *Options for Change*.

- 2.116 The Department noted that palladium prices had dropped, but the profession had maintained that to date there was no evidence that the laboratory costs charged to dentists had reduced. The Department wished to keep the situation under review. To avoid any risk of placing undue pressure on dentists and the service to patients, it had therefore not sought an early reversal of the original increase in dental fees.
- 2.117 The **Scottish Executive Health Department** told us it had introduced a Practice Allowance from April 2003 to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, clinical standards, practice staff training and support, information collection and provision of high quality patient information. Such an allowance should, it felt, also contribute to the retention of dental practitioners within the NHS. The practice allowance would be calculated by reference to NHS earnings and the number of principal dentists working at the practice. The maximum allowance per principal dentist was £3,000. The SEHD also told us that a Sedation Practice allowance (up to a maximum of £2,000) was available to practices offering conscious sedation treatments to agreed conditions and standards which would be developed with the profession.

Comment

- 2.118 *The BDA has requested that we recommend the introduction of a new Practice Costs Allowance, payable to the practice, to cover a variety of costs arising from legislative changes which are not accounted for in the feescale. Both the BDA and GDPA have also drawn our attention to a variety of other cost pressures, for example, increasing waste disposal costs and the variability of expenses in different parts of the country. We expect the development of new arrangements for remunerating GDPs, which will be trialled under Options for Change, to take into account the various issues which have been raised by the profession and would ask the parties for further evidence of progress for our next review.*
- 2.119 *There was no suggestion in the Options for Change framework document that the feescale (in some form) would become redundant under the reformed GDS. We therefore note here that the evidence put forward by the profession leads us to conclude once again that a fundamental review of the feescale is needed to address issues such as unremunerated time, London Weighting and the variability of costs across the country, and administration costs. As the feescale seems likely to continue in some form following Options for Change, we therefore would ask the parties to take forward a fundamental review of the feescale as part of the reform process.*
- 2.120 *We noted with interest that the Scottish Executive Health Department has introduced a Practice Costs Allowance from April 2003 to help address increasing practice requirements in relation to the provision of high quality premises, health and safety, clinical standards, practice staff training and support, information collection, and provision of high quality*

information. We are also aware that the Options for Change framework document said that a key theme for early exploration would be the option of testing a basic practice allowance to offset some of the fixed costs of running a dental practice. The BDA has, of course, given its support to the need to test out the ideas in Options for Change before any national introduction. In keeping with this approach, we do not consider it appropriate to recommend the national introduction of a practice allowance, but would ask the parties to accelerate their work on a basic practice allowance and to set up urgently a number of pilot sites at which an allowance can be tested. We would further ask the parties to consider whether the arrangements for the Scottish Practice Costs Allowance would provide a useful broad model for testing out a basic practice allowance in England. We do not make the assumption that circumstances affecting NHS dentistry are the same in England as Scotland, as, for example, we know that the density of private practice is likely to be higher in some areas of England than in Scotland, but we would be surprised if some of the relevant factors were not broadly similar. We would also ask the National Assembly for Wales to consider testing such an allowance in Wales. We would ask the parties to report back to us on progress in time for our next review.

2.121 The BDA have asked us to recommend that pay should be kept separate from expenses. We are concerned that a lack of detailed evidence on the prospective trends in the NHS expenses of GDPs (as opposed to their total private and NHS expenses), means that we necessarily cannot keep our recommendations on pay separate from expenses. This, however, has been the case since 1994 when, for excellent reasons, our predecessors on DDRB decided not to make recommendations on Target Average Net Income (TANI). At that time, the parties were urged in the twenty-third report to give the utmost priority to the development and implementation of a new remuneration system for GDPs. This accords with our own view, and it must be for the parties to develop a mechanism which allows for the separation of pay from expenses, if they agree that it would be appropriate. We would therefore ask the parties to address the question of expenses as part of the work to develop new methods of remuneration. The BDA also ask us to recommend a pay uplift net of expenses. As we have already explained, the current situation means it is impossible to make such a recommendation at the moment.

Pensions

2.122 The BDA reported that the introduction of Commitment Payments, combined with an operational error by the Health Departments, had resulted in a shortfall of the dynamisation factor used for the purpose of providing NHS pensions on retirement. However, the BDA said that after over 12 months of pressure, the Health Departments had agreed in November 2002 to rectify the error.

2.123 The GDPA sought our assurance that the 'final salary' type of pension currently enjoyed by practitioners would not be eroded in the future, although in oral evidence it noted that there was no specific threat at the moment. It also sought our assurance that we would look into methods of 'dynamising and improving' the scheme in line with the improvements for GMPs in their renegotiated contract. It was also concerned that added years could not be purchased by those dentists who were over 60, and urged us to question the Department of Health on all issues relating to pensions with a view to removing any barriers to dentists over 60 or 65 who wished to continue to provide a service to the NHS. The GDPA also felt that the rights of assistants should be clearly established in relation to pension contributions.

2.124 The **Department of Health** reported that the profession had approached it last year suggesting that the dynamising factor had not reflected the full value of the annual pay award when Commitment Payments were introduced in 2000. It had since agreed and secured agreement across Government to make retrospective adjustments to the dynamising factor, correcting the awards for 2000-01, 2001-02 and 2002-03. Interest would be paid on any arrears due.

Comment

2.125 *We were pleased to note that the parties have agreed changes to the dynamising factor to ensure it reflected the full value of our award in 2000.*

2.126 *The GDPA has asked for an assurance from us about the current NHS Pension Scheme which it is not within our power to give. We would however ask the Health Departments to consider the impact on recruitment, retention and morale if any substantive changes to the Scheme should be considered at any time in the future, which might be viewed by the profession as a deterioration in their current level of benefits. We review the pensions situation of our remit groups every five years and the next such review is timetabled for 2005. We would also ask the Departments to note the requests by the GDPA on added years and the rights of assistants and to respond positively, if possible.*

Feescale uplift for 2003-04

2.127 The **BDA** reported that there had been an estimated £18 million of savings within the GDS during the last twelve months, from measures to counter patient fraud (£10 million); withdrawal of general anaesthetic fees from the NHS feescale (£2.4 million); and because of, it felt, the complexity of the system, there was an under-spend of CPD allowances in England in 2001-02 (£5.5 million). The BDA believed that those savings should be re-applied to improve patient care and to restore the morale of dentists who worked in the service.

2.128 In supplementary evidence, the BDA said that in order to retain the present workforce, there had to be a great improvement in both pay and conditions. It noted that the Department felt that dentists' pay had always run ahead of RPI, but told us that related to gross fees and there needed to be substantive recognition that expenses were usually considerably higher than RPI. The BDA felt there was an acceptance that GDS dentistry had seriously and consistently fallen behind the general spend on the NHS and the resulting very poor profitability of dental practices had led to excessive workloads, leading dentists to move away from the NHS. There was also the exacerbating factor that patient demand for treatments which were not available in the NHS was rising with the growth in cosmetic services. If there was not a very substantial increase in pay coupled with a reduction in patient workload, there would be a greater migration away from the NHS and the *Options for Change* experiment would be wasted as there would be no substantive workforce to re-organise. In oral evidence, the BDA urged us to make a sensible recommendation and leave it to the Government to reject it, if it felt it needed to, and asked for a reasonable pay uplift net of expenses.

2.129 The **GDPA** felt that the level of NHS fees were now so far behind the level in the private sector that even the 50 per cent enhancement it had previously requested would fail to attract many GDPs back into the NHS, but it might stall the rush of dentists away from the NHS, while going some way in correcting the workload and lifestyle of those who did stay. It considered that NHS dentistry could not survive if recent pay award levels were repeated this year. In oral evidence, the GDPA told us that if dentists did slow

down and carry out less work following a large increase in fees, there would be a problem in covering the existing workload. However, it also felt that dentists would be able to take longer over their work and provide better quality work as a result, which would reduce the dentistry demand in the future.

- 2.130 The **Department of Health** told us that it remained committed to supporting and reforming NHS dentistry as an integral part of the NHS. The *Options for Change* programme and the new legislation currently before Parliament paved the way for that. In the meantime, it had to work out how to support NHS dentists between now and when the reforms began to come on stream in 2005-06. It submitted that increasing fees above the current rate of underlying inflation would not be the best way of doing that. The BDA's bid for "very substantial increase in pay" was not based on evidence, and in fact was against it. For example the significant increase already provided through the Commitment Payments scheme appeared to have had little effect on the continuing dilution of dentists' NHS practice by private dentistry.
- 2.131 The Department noted that the BDA maintained there had been significant savings, but commented that dentists remained free to maintain their income by undertaking other GDS work to fill time formerly devoted to – for example – general anaesthesia. It considered, however, that the fee-for-service system encouraged a fruitless dialogue on such matters. The Department's commitment to increasing resources for the NHS was demonstrated by its overall funding plans and giving PCTs commissioning responsibility for dentistry would give greater security to the funding for dentistry.
- 2.132 The **Health Departments** noted that we had already seen some broader economic evidence from them¹⁰. Taking into account that evidence and the other factors set out in their evidence, they suggested that our recommendation should:
- seek to reflect the broad trend in inflation, as measured by RPI; and
 - be consistent with the awards already made in this round for the other review body groups (in the range 2.25 per cent to 2.9 per cent).
- 2.133 That approach would be preferable to initiating further system or structural changes to the present, outmoded remuneration arrangements and would support the Government's drive to focus energies for the future on reform rather than on pay negotiations.
- 2.134 The **NHS Confederation** told us that it recommended that the annual general pay award for dentists should be ten per cent over the three years from 2003-04 to 2005-06, with equal increases of 3.225 per cent in each of those years. The Confederation considered that all our remit groups should receive this same award, as a different award for different groups would cause greater problems for NHS employers than it would solve. It also felt that 3.225 per cent was probably not far removed from the sort of recommendation that it would have been considering in any event.

Comment

- 2.135 *The late start to this round and the offer of 3.225 per cent for 2003-04 as part of a three-year pay deal for GPs have both made this round very unusual and also formed the background to our deliberations. We have listened carefully to all the evidence from the parties. With the exception of the NHS Confederation, the parties have essentially urged us*

¹⁰ Written Evidence from the Health Departments for Great Britain submitted in January 2003 for the Review for 2003 of the Review Body on Doctors' and Dentists' Remuneration.

towards very different conclusions on the pay recommendations for 2003-04 from that proposed under the three-year pay offer. Our role is to make recommendations which are, in our view, fair in relation to our terms of reference. To this end, we consider that, in totality, the evidence on recruitment, retention and motivation, along with the general economic conditions which existed at 1 April, when our recommendations would normally take effect, and the other evidence we have been asked to take into account, all suggest an award for GPs which should be a little ahead of three per cent. The BDA have asked for a reasonable pay uplift net of expenses. We discussed the difficulties with net pay uplifts earlier in this chapter.

- 2.136 We have viewed this conclusion in the light of a number of factors – the events leading up to the round, the understanding that the GDS, in England at least, is now in a transitional period until the programme of reform under Options for Change and the current Parliamentary Bill take effect, our recommendation to target support for retention specifically on the Commitment Payments scheme, and also the Department of Health's commitment to press ahead and deploy the modernisation funding from the original pay offer within the GDS over the next two years. Our final conclusion is that we should therefore **recommend** that gross fees for items of service and capitation payments should be increased by 3.225 per cent for 2003-04 for GPs. We also **recommend** that sessional fees for taking part in Emergency Dental Services be increased by 3.225 per cent. This figure is incidentally also available to other NHS staff.

CHAPTER 3: SALARIED PRIMARY DENTAL CARE SERVICES

Three-year pay deal

- 3.1 The **Department of Health** told us that it had opened discussions with the British Dental Association (BDA) on a three-year pay deal last summer, to provide a “background of financial stability and reassurance for dentists, practices and the NHS ... [whilst they worked] together to get the local commissioning arrangements and underpinning infrastructure for NHS dentistry right”. The Department said that negotiations had continued until the end of February, with the relevant committees of the BDA voting on the detailed final offer on 26 and 27 March 2003. The representatives of the salaried primary dental service voted by 25 to 3 to take up the offer.
- 3.2 The Department of Health, in consultation with the other Health Departments, accepted in principle the BDA’s proposal that an agreement should be made in respect of staff in the salaried primary dental services. The Department of Health said it expected to write to us jointly with the BDA to set out what had been agreed.
- 3.3 In oral evidence, the **British Dental Association** said that the review of the salaried services had been crucial to the agreement of the three-year deal. The **Department of Health** said in oral evidence that the main aims of the review would be to give salaried dentists proper recognition of their role and to provide a career structure. The review would aim to have made substantive progress by summer 2004.

Comment

- 3.4 *We understand that the Department of Health and the BDA have now agreed a position on this, and that, though there is no joint statement, they are content that we should publish their exchange of letters in which the Chairman of the Management Side and the Chairman of the Staff Side set out their jointly agreed positions on the terms of the three-year pay deal for salaried dentists (Appendix B). We note that the parties have agreed a 3.225 per cent uplift on salaries and allowances for all dentists in the Salaried Primary Dental Care Services (SPDCS) to be applied across the board in 2003-04. We agree with this and have calculated 2003-04 salaries on this basis and reproduce these in Appendix A. We very much welcome the agreement that has been reached between the two sides, particularly on the planned review of the salaried services. In our last report, we said we hoped to receive evidence for this round which clarified the service context across Great Britain and the remuneration implications for salaried dentists. We therefore very much welcome the planned review and hope that the outcome will enable pay and grading considerations to be thoroughly considered in due course.*
- 3.5 *We look forward to receiving further evidence regarding the situation in Scotland and Wales for our next review, as well as receiving evidence on the progress the review has made in England.*

Developments in Scotland

- 3.6 The **Scottish Executive Health Department** (SEHD) described various initiatives underway in Scotland concerning the salaried services. The SEHD said that in order to achieve greater integration of training grades in dental services, new salary grades had been introduced in the existing Vocational Training grade (first year) and General Professional Training grade (second year). This latter grade now formed the basis for training across the three major disciplines in dentistry, i.e. Hospital, Community and General Dental Services. Such training was now offered to 50 per cent of all Scottish

dental graduates. The training grades would initially be used in the General Dental Services (salaried and independent) and the Community Dental Services (CDS), but it was hoped to extend the grade to include hospital posts in the future. The SEHD had also initiated specialist training in community-based settings in paediatric dentistry and it would be exploring further with the profession how it could develop community-based training pathways (and training grades) for both specialists and generalists in primary care.

- 3.7 The SEHD told us that CDS specialist training posts had been established, and it planned to expand the number of places over the next three years. However, it said consideration was required as to how to reward generalists, especially in remote areas, where they often provided a comprehensive service with reduced availability of specialist support. It said that a specific training pathway for adult special needs was in development.
- 3.8 The SEHD said it saw the salaried service as an essential and continuing element in the provision of services across Scotland, particularly in remote and rural areas, where independent General Dental Services practice was not always economically viable, and that new salaried dentist posts were therefore regularly approved. It described a new grading structure introduced in April 2002 for the salaried service to maintain equivalence with the CDS grading structure. It also said that it was in discussion with the profession on the possible extension of the General Dental Services recruitment and retention package, announced in April 2002, to the salaried service. Further work was required, it said, on how to prepare and reward dentists for comprehensive dental care, especially in remoter areas where specialist support services were not easily accessible. Support through tele-dentistry links was also being explored.

Comment

- 3.9 *We were grateful for the Scottish Executive Health Department's evidence describing developments within the SPDCS in Scotland and look forward to receiving further evidence on developments within the salaried services in Scotland for the next round. We would also hope to receive more detailed evidence for our next review from the National Assembly for Wales regarding developments within the SPDCS in Wales.*

Research on Salaried Primary Dental Care Services

- 3.10 *In our report last year we noted both that recruitment was a particular problem in the CDS and also the evidence from the profession suggesting that pay rates were not competitive. We concluded that the evidence established a case for re-evaluating the pay structure for CDS dentists, and that there was a need for a fundamental assessment of the relative demands of CDS work in relation to other areas of NHS dentistry. With that principle in mind, we asked for evidence from the parties on the service context, the job demands relative to other dental and medical jobs in the NHS, and the remuneration implications. The parties did not, however, feel that research on job demands would be appropriate at this stage. We therefore asked our secretariat to carry out research on the SPDCS, focussing on recruitment and retention and to investigate relevant career and pay progression issues. Mercer Human Resource Consulting (Mercer) was commissioned to carry out the research.*
- 3.11 *Mercer carried out a postal survey of all SPDCS dentists, collecting information on career progression, the use of the payscale and impact on individual commitment to the NHS. The questionnaire (for self-completion) also collected information about individual career progress and intentions, including past action to seek other posts or jobs outside the SPDCS, and some information on qualifications. The survey achieved a response of 46 per cent (which we feel was reasonable given the timing of the research over the summer months and problems*

with contact details). Mercer also interviewed eleven SPDCS managers, aiming to identify the extent of any recruitment and retention problems for the service along with the management response to past and present recruitment and retention problems through pay (e.g. the rates of starting pay for new appointments). The interviews also collected information on whether and how the pay structure could be improved to support recruitment and retention and hence service delivery. Mercer also drew on results from the BDA's annual survey of SPDCS clinical directors.

3.12 More detail on the research and the findings are in Mercer's report *Research on Salaried Primary Dental Care Services*, included at Appendix C.

3.13 The key results from the study were:

- Recruitment, particularly of those in less senior roles, was problematic for the service. The main reasons for recruitment problems were the unpopular locations of the vacancies (particularly those remote locations where more on-call work was required) and a general shortage of dentists. Uncertainty about the future of the SPDCS was also a factor.
- In a response to recruitment problems, new entrants were being brought in towards the top of payband one (the dental officer (DO) payscale), particularly in the Personal Dental Services (PDS). The study did not find any evidence that paybands two and three (for senior dental officers (SDOs) and assistant clinical directors/clinical directors) created any recruitment problems.
- Due to the recruitment problems, less experienced DOs in the PDS were generally being paid more than those in the CDS. Although there were some other minor differences, in general, there were no other major discrepancies between PDS and CDS pay when comparing those with similar levels of experience and responsibility.
- Retention was not seen as a problem. However, Mercer did find clear evidence of career ceilings operating within the salary bands, mainly at the DO and SDO level, and reported that frustration with career progression and the associated lack of salary progression were the main factors motivating dentists to leave the SPDCS.
- DO and SDO dentists were clustered at the top of their paybands. In payband one, 62 per cent of dentists were on the top two points, while in payband two (for SDOs), 53 per cent were on the top two scale points.

3.14 Mercer also gave advice, in a letter to the Chairman, on whether changes to pay or paycales would improve recruitment and retention, and if not, what else might. We passed Mercer's recommendations to the parties for their consideration. In response to the recruitment problems, Mercer recommended in the letter a review of pay strategy and grading structure, in order to provide scope for progression to reward greater skill and experience. Mercer considered that the review should result in agreed pay principles which stated where SPDCS pay should be positioned in relation to market competitors, with a clear policy on the rationale which underpinned pay relativities between the services and across the grades. Mercer also considered that the review should lead to more scope for rewarding greater skill and experience. If a total review was not felt to be appropriate, Mercer recommended that variable payments could be used to attract staff to posts involving working on-call, in remote locations, and to recognise those on a specialist list or with specific post-graduate qualifications. Mercer also made a number of detailed recommendations on issues that needed to be addressed either by the Government and the profession or Strategic Health Authorities. These included developing a clear vision for the future of the SPDCS. There were also recommendations for improvements which could be made at Trust level.

3.15 *The research clearly highlighted for us that the problem facing the SPDCS is mainly linked to recruitment rather than retention, particularly recruitment at the DO (payband one) level, where Mercer believed the research suggested that pay levels did not reflect market rates. This is very much in line with our recommendation last year that the bottom point of payband one should be removed and that an extra point be added to the top. We also recommended that a wider review of the payscales for the SPDCS was needed. Mercer's conclusions support this view, with the proposal that a full-scale review of the payscale is undertaken. We are therefore pleased to see that linked with the three-year pay deal which has now been agreed between the parties, there will be a review of the SPDCS. We consider that the research commissioned from Mercer on our behalf, and the report Mercer have produced, have provided an important backdrop to the review of the SPDCS, and we hope that the parties can take forward Mercer's findings in a productive fashion. We feel it is important for the morale of this important group of dentists that the review gets underway quickly and that any quick wins which can be identified can be put in place as soon as possible.*

CHAPTER 4: GMP REGISTRARS

Salary scale for GMP registrars and the GMP registrar pay supplement

- 4.1 The **British Medical Association** (BMA) said in its evidence that at present, senior house officers (SHOs) promoted to the GMP registrar grade retained their salary and progressed incrementally up the SHO salary scale. However, the BMA believed that the minimum basic salary for GMP registrars should instead be set at the level payable to specialist registrar (SpR) hospital doctors, arguing that the GMP registrar grade was at least equivalent in terms of responsibility to that of the SpR grade. GMP registrars learnt to practise independently as a GMP and experienced the responsibilities and workload of GMP principals. The BMA referred to evidence showing that the competencies and skills tested by, and required to pass, summative assessment also demonstrated that the level of responsibility required of a GMP registrar was akin to that of an SpR. In addition, the Joint Committee on Postgraduate Training for General Practice's certificate of prescribed/equivalent experience was equivalent to the Certificate of Completion of Specialist Training (CCST), since both were proof of a doctor's fitness to work as an independent qualified professional. Indeed, the BMA said, the Health Departments' policy statement on the Postgraduate Medical Education and Training Board had proposed that a single Certificate of Completion of Training should replace both the CCST and the Vocational Training Certificate.
- 4.2 The BMA also said that SHOs who transferred to the GMP registrar grade, rather than the SpR grade, were further financially penalised because on appointment to the SpR grade, those with two or more years' experience as an SHO would automatically go up to the second SpR point. If this was lower than their previous salary, their new salary was set at the point in the scale next above that previous rate. However, SHOs who transferred to the GMP registrar grade did not benefit from this promotional increase, as they retained their previous pay and only increased incrementally along the SHO payscale. This anomaly needed to be addressed urgently to encourage more non-vocationally trained SHOs to consider vocational training. To rectify this and to recognise the responsibility and skills required of a GMP registrar, the BMA sought a recommendation from us that the basic salary of SHOs taking up GMP registrar posts should be increased to that of an SpR and set at a point which was higher than their previous salary.
- 4.3 The BMA also asked us to recommend a further increase in the supplement for GMP registrars this year to ensure that they were not financially disadvantaged in relation to their junior hospital counterparts. Our previous recommendation to increase the GMP registrars' supplement to 50 per cent of their basic salary had gone some way to addressing the pay differential between GMP registrars and junior hospital doctors. However, from 1 December 2002, junior hospital doctors had received a further increase to their supplement to 80 per cent for those in Band 2A and to 100 per cent for those in Band 3. As the majority (75.8 per cent) of junior hospital doctors were currently in Bands 2A and 3, the BMA said it was essential that a similar increase should apply to GMP registrars to ensure greater pay parity between the two groups of junior doctors.
- 4.4 The BMA considered that without a substantial increase to the GMP registrars' supplement, there would be an even larger financial incentive to remaining in a hospital post. This meant that doctors would not be encouraged into vocational training and so would not see the benefits of a career in general medical practice. The BMA reported that its current cohort study of doctors who graduated in 1995 showed that, to date, only 34 per cent of those graduates had indicated general practice as their career

choice, compared to the required 55 per cent (as determined by the Royal College of General Practitioners). Given the overall shortage of new GMPs, particularly in relation to the Government's targets set out in the NHS Plans, the BMA considered that any financial disincentive to becoming a GMP registrar had to be rectified.

- 4.5 The **Health Departments** and the **NHS Confederation** said in a joint letter that GMP registrar pay was linked to that of hospital doctors, and they said they remained committed to the principle that the pay differential between GMP registrars and hospital doctors should not widen further. The Departments and the NHS Confederation reminded us that Ministers had consistently said in evidence to us that they did not wish the pay arrangements for hospital doctors to have an adverse impact on the recruitment of GMP registrars, and that they had made a commitment to retain the pay relativities between the two. In Scotland, beyond 2003-04, the Departments and the NHS Confederation said that the application of that principle would need to be kept under review in the light of initiatives to modernise medical careers. Against that background, the Departments and the NHS Confederation said that as the number of GMP registrars continued to rise year on year – as at 31 March 2002, there were 1,910 GMP registrars (in England), the highest number ever recorded – there appeared little disincentive to the recruitment of GMP registrars. On that basis, the Health Departments and the NHS Confederation were therefore seeking only a basic pay rise linked to inflation, in line with the evidence previously submitted by them in respect of our other remit groups.
- 4.6 The joint letter noted that the BMA was recommending that the minimum basic salary for GMP registrars should be set at the level payable to SpR hospital doctors. The Health Departments and the NHS Confederation said that they considered the comparison invalid, given the differing training requirements of GMP registrars and hospital specialties.
- 4.7 The Health Departments and the NHS Confederation said, however, that a further increase in the supplement for GMP registrars was recommended. Based on the latest available figures on the pay of hospital doctors, the joint letter advised that to maintain the previous relativity, GMP registrars' earnings needed to increase by ten per cent over 2002-03 levels. They said that to achieve an increase in overall earnings of ten per cent for 2002-03, the supplement therefore had to rise from 50 per cent to 65 per cent from April 2003, before taking account of any basic pay award.

Comment

- 4.8 *The BMA has set out its case for the payscale of SHOs who become GMP registrars to be aligned to the SpR payscale, rather than the SHO payscale, as at present. In noting the BMA's evidence, we must make clear that it is not possible for us to make a judgement on whether GMP registrars and SpRs are equivalent in terms of responsibility, as we have received no evidence on the relative job weight of either grade. We therefore note that GMP registrars will continue to be aligned with the SHO payscale, as at present. We made recommendations on the pay of SHOs in our thirty-second report. We are aware that the Departments are taking forward their proposals for the reform of postgraduate medical education, following the publication of *Modernising Medical Careers*, and we would expect any pay issues which emerge for GMP registrars to be addressed in the light of any decisions about changes to specialist training. We will await further evidence from the parties for our next review on how this is progressing.*

- 4.9 *The joint evidence from the Health Departments and the NHS Confederation reminded us of Ministers' previous statements that they did not wish the pay arrangements for hospital doctors to have an adverse impact on the recruitment of GMP registrars. We welcome this, though we would also note that there is an oddity in trying to retain the pay relativities between two groups whose workloads may be very different. We note that recruitment of GMP registrars is good at the present time, with the figure of 1,910 GMP registrars (in England) as at 31 March 2002 said to be the highest ever recorded. We are also aware that the latest available figures for Great Britain showed that between September 2000 and September 2001, the whole-time equivalent and headcount figures for GMP registrars in both General Medical Services and Personal Medical Services had increased by around 12 per cent. This compares favourably with the increase between 1999 and 2000 of around seven per cent (headcount) and around six per cent (whole-time equivalent).*
- 4.10 *In view of the strong recruitment figures, we therefore accept the joint recommendation from the Health Departments and the NHS Confederation and we **recommend** that the out-of-hours supplement for GMP registrars should rise from 1 April 2003 from 50 per cent of their basic salary to 65 per cent. As we said in our last report, we would wish to review the level of the out-of-hours supplement payable to GMP registrars in the next round in the light of both further progress in reducing the hours of doctors and dentists in training in the hospital sector, and further evidence on the recruitment of GMP registrars.*
- 4.11 *We would repeat the comment made in our last report that as we would expect, at some future time, there will be a need to consider reducing the supplement payable to GMP registrars, we would wish at that time to consider the position of those doctors who were then receiving the higher level of supplement. We remain of the view that fairness suggests that such individuals should mark time rather than see their pay supplement reduced.*

Pay anomalies affecting certain GMP registrars

- 4.12 The **BMA** pointed out that the recommendation in our twenty-ninth report¹ to remove the current anomaly whereby certain groups of doctors faced a substantial drop in salary on transfer to GMP training had not been implemented, despite repeated and continuing representations to the Health Departments. The groups affected included non-consultant career grade doctors, doctors in military posts, those in public health posts, university employees, Medical Research Council employees, doctors in other *bona fide* research posts, doctors working for the NHS in "other" capacities, for example those employed by deaneries, and doctors transferring from community grades.
- 4.13 To protect those doctors against a drop in salary and to remove the current disincentive to entering general practice, the BMA said their previous salary needed to be protected and uplifted in line with the annual increases recommended by us, in the same way as for junior hospital doctors who transferred to GMP registrar posts. Although the BMA was working with the Health Departments to resolve this issue, the BMA said it would welcome a strong intervention by us to ensure that the necessary amendments were made and backdated as a matter of urgency.
- 4.14 In their joint letter, the **Health Departments** and the **NHS Confederation** said that the BMA had notified us of delays in implementing the recommendation to address the anomaly whereby certain groups of doctors, such as non-consultant career grades, faced a drop in salary when they became a GMP registrar. The Health Departments and the NHS Confederation acknowledged the anomaly and said they were committed to ensuring the relevant amendments were made to the General Practitioner Registrar Directions as soon as practicable.

¹ Although the BMA cited our twenty-ninth report in its evidence, this issue was in fact raised in our thirtieth report (Cm 4998).

Comment

- 4.15 *We were very disappointed to learn that the pay anomalies which were first brought to our attention for our thirtieth report remain unresolved. While we welcome the Health Departments' statement that they are committed to ensuring the relevant amendments are made to the General Practitioner Registrar Directions as soon as was practicable, we would ask the Departments to see this commitment through as quickly as possible. We hope that the evidence we receive for the next review will confirm that these pay anomalies have now been resolved.*
- 4.16 *We would further ask the Health Departments to give consideration to the position of those doctors who were formerly in one of the groups affected by these pay anomalies and who are now GMP registrars. Fairness would suggest that, at least for the remaining part of their time as a GMP registrar, the salaries of these doctors should be adjusted to reflect their final salary prior to becoming a GMP registrar. This would at least allow such doctors to complete the rest of their training without the ongoing financial penalty.*

Flexible GMP registrars

- 4.17 The **BMA** commented that flexible GMP registrars currently received a *pro rata* portion of basic full-time pay (said to be typically 60 per cent) and a *pro rata* payment of the 50 per cent supplement. This was in contrast to flexible hospital trainees for whom the majority (said to be 84 per cent) received full-time basic salary, plus an additional five per cent or 25 per cent supplement or more. The BMA said that the majority of flexible hospital trainees therefore earned significantly more than flexible GMP registrars. This lack of pay parity was a major disincentive to moving into general practice flexible training. It also further disadvantaged those who wished to, or who could only, work part-time. The need for this to be remedied was particularly acute, the BMA said, given the changing demography of the medical school intake (57 per cent of the intake was female in 2001²). To correct this, we were asked to recommend that the total salary of flexible GMP registrars was substantially increased to between 105 per cent and 125 per cent of basic full-time salary.
- 4.18 In their joint letter, the **Health Departments** and the **NHS Confederation** noted that the BMA had pointed out a disparity between the treatment of flexible GMP registrars and flexible hospital trainees in the pro-rating of salaries and supplements. The Health Departments and the NHS Confederation proposed that this should be dealt with through further consideration of the contract for flexible trainees.

Comment

- 4.19 *We said in our thirty-second report that we could not comment on the original agreement to include flexible trainees in the new contractual arrangements for junior doctors and similarly, we cannot comment on what has been agreed between the parties in respect of flexible GMP registrars. However, in the same way as we asked the Health Departments in the thirty-second report to consider carefully how they could ensure that their commitment to promoting flexible working arrangements and the need to minimise retention difficulties were both supported by the flexible trainee scheme, the same considerations should apply to the arrangements for GMP registrars. Like the flexible trainee scheme for hospital doctors, the arrangements for flexible GMP registrars will be an increasingly important part of any retention strategy for the primary care sector, given, as the BMA notes, the changing demography of the medical school intake.*

² UCAS, October 2001

Excess rent allowance and childcare costs

- 4.20 The **BMA** raised what it saw as the current discrimination in the rules on excess rent allowance against single GMP registrars and cohabiting couples and asked for our support in remedying the anomaly.
- 4.21 The BMA also commented that childcare costs were a very significant disincentive to returning to work following maternity leave, as there was no subsidy towards childcare for GMP registrars or qualified GMPs. The BMA considered this was a deterrent to working in general practice. Childcare vouchers or other subsidies would aid recruitment into general practice while also helping to retain current GMP registrars and would remove a current disparity between GMP registrars and their hospital colleagues, since a number of NHS Trusts provided subsidised crèche facilities. The BMA therefore proposed that reimbursement towards childcare expenses or access to NHS childcare facilities should be available for GMP registrars and other GMPs.
- 4.22 The **Health Departments** and the **NHS Confederation** said in their joint letter that they were actively considering the BMA's proposals for excess rent allowances rules and would be seeking an early resolution.
- 4.23 The joint letter also noted that the BMA had signalled the disincentive to returning to work following maternity leave where no childcare provision existed. The Health Departments and the NHS Confederation said they were committed to the new General Medical Services contract, which made clear that GMPs and their staff should have equal access to NHS childcare facilities, as was the case for other NHS staff. They said that all NHS staff, including GMPs and GMP registrars, would have access to an NHS childcare co-ordinator from April 2003. They did not believe that any special arrangements should be made for one particular group of NHS professionals, nor did they favour additional arrangements such as direct reimbursements or vouchers, as such arrangements did little to increase the overall number of NHS nursery scheme placements.

Comment

- 4.24 *These two areas are not ones in which we usually make specific recommendations. However, we welcome the statement from the Health Departments that they will be seeking an early resolution to the issues raised by the BMA regarding the excess rent allowance rules, in view of any possibly adverse impact that the current anomaly may be having on GMP registrar recruitment and morale.*
- 4.25 *Our interest in childcare provision also lies in the adverse impact that lack of childcare provision may be having on the recruitment, retention and morale of our remit groups. We welcome the assurances offered by the Health Departments and the NHS Confederation about the current support offered to GMP registrars. However, we would also ask them to bear in mind the childcare issues faced by GMP registrars when developing and implementing childcare policy within NHS Primary Care Trusts.*

CHAPTER 5: SALARIED GMPs EMPLOYED BY A PRIMARY CARE ORGANISATION

- 5.1 The **Health Departments, NHS Confederation** and the **British Medical Association (BMA)** said in joint evidence that as part of the new General Medical Services (GMS) contract negotiations, the BMA's General Practitioners Committee (GPC) and the NHS Confederation negotiators had produced separate model offer letters and terms and conditions of service for Primary Care Organisation (PCO)-employed GMPs and GMS practice-employed GMPs, which set out the nationally agreed minimum terms and conditions which PCOs and practices would use as the basis for their employment of GMPs. PCOs and GMS practice employers would have the flexibility to offer enhanced, but not diminished, terms and conditions.
- 5.2 The parties all agreed that we should be asked to recommend a salary range for GMPs employed by PCOs on such terms and conditions which was wide enough to cover the whole range of possible roles encompassing the equivalent of GMS or any part thereof. The range should bear in mind job weight relative to hospital doctors, in particular levels of responsibility and training. The parties said that the most relevant comparator groups were associate specialists and consultants. In 2002-03, the associate specialist range was £31,210 to £56,105, increasing to £64,525 with discretionary points, and the consultant range (excluding discretionary points) was £52,640 to £68,505.
- 5.3 In the absence of a formal job evaluation of salaried GMP posts, the parties said that it was not possible at this stage to identify where precisely salaried GMPs should fit. Their judgement was that the range should be nearer that of consultants than associate specialists and so they suggested a salary range of £45,000 to £68,500, noting that £45,000 was the mid-point on the associate specialist range. Although the range was intended for salaried GMPs employed by PCOs, the parties said they would expect it to serve as the benchmark for practice-employed GMP-qualified doctors and that this would be reflected in PCO contracts with GMS practices. The parties said that the salary range should be sufficiently wide to bear variances in the level of responsibilities, qualifications and workload of PCO-employed GMPs, and also to take account of the need to recruit and retain PCO-employed salaried GMPs in the future.
- 5.4 The parties also agreed that local job evaluation should be the basis for assigning to an appropriate point on the pay range. They also said that, as was agreed between the parties in the national minimum terms and conditions of service, employers should in addition use their discretion to determine an appropriate salary by taking into account equivalent service, service in HM Forces or in a developing country, special experience, local job market requirements, time working as a GMP principal whether in GMS or Personal Medical Services, geographical considerations and the requirement for the practitioner to work out of hours, in particular where such services could not otherwise be provided.
- 5.5 The parties said that no further recommendation was sought, for example on progression or review, beyond support for this to be determined locally.
- 5.6 The Health Departments, NHS Confederation and the BMA therefore asked us to recommend a salary range which was sufficiently wide to allow for the spectrum of roles to be accommodated in the light of their joint evidence.

- 5.7 In supplementary written evidence, the **BMA** said that given the need to recruit into general practice, to encourage those who had left to return and to retain existing GMPs, it was essential that all GMPs, including salaried GMPs, were financially incentivised. For that reason, the BMA asked us to increase the basic salary range for salaried GMPs in line with the year one uplift under the new GMS contract (approximately 11 per cent) for 2003-04. It said that we must not allow salaried GMPs' incomes to fall relative to their self-employed colleagues. It said that the present workforce crisis, the failure to meet the Government's modest targets for additional GMPs and the ever-increasing demands being placed on general practice all justified its argument that such an increase should be made at this stage.
- 5.8 In supplementary written evidence, the **Health Departments** and the **NHS Confederation** said that as the proposed salary range given in the original joint evidence used 2002-03 figures, they would expect us to consider uprating the salary range in line with the pay uplift for hospital doctors.

Comment

- 5.9 *We very much welcome the submission of joint evidence from the parties on the employment of salaried GMPs by a PCO and welcome the agreement by the parties on their proposals for this group of doctors. We **recommend** that the position stated by the parties in their joint evidence be adopted and that the proposed salary range for the employment of salaried GMPs by a PCO should be sufficiently wide to take account of the spectrum of roles to be accommodated in the light of the parties' joint evidence.*
- 5.10 *We support the parties' proposals and therefore **recommend** that an initial salary range of £45,000 to £68,500 is appropriate. We also welcome and support the parties' expectation that the salary range would serve as a benchmark for practice-employed GMP-qualified doctors and that this should be reflected in PCO contracts with GMS practices.*
- 5.11 *For 2003-04, the BMA has asked for a substantial uplift largely on the basis of the need to recruit and retain doctors within general practice overall. However, at present, we do not have any specific evidence on salaried GMPs employed by a PCO, and further, we have not seen any evidence which demonstrates the need for a substantial uplift for this group. In the absence of specific evidence for this group, we note for this round that the salary ranges for the agreed comparator groups have been uprated by 3.225 per cent, following our recommendations in our main report for 2003-04 for associate specialists and consultants. We therefore **recommend** that the salary range for salaried GMPs employed by PCOs suggested by the parties is uplifted by 3.225 per cent, giving a salary range of £46,455 to £70,710 for 2003-04. The recommended salary range for 2003-04 for salaried GMPs employed by a PCO is also set out at Appendix A. As the parties request, we also **recommend** that progression and review should be determined locally. We would ask the parties to ensure that monitoring of salaries paid to these GMPs is carried out, in order to allow the parties and ourselves to monitor the use of the salary range. We would welcome regular evidence on this, starting in time for our next review, if that would be possible. We would also welcome evidence from the parties for our next review on the recruitment and retention situation for salaried GMPs employed by PCOs.*

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time salaried primary dental care staff are set out below; rates of payment for part-time staff should be *pro rata* that of equivalent whole-time staff.

Salaried primary dental care staff¹

	Current scales £	Recommended scales payable from 1 April 2003 £
	<i>(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
<i>Band 1: Community dental officer</i>	28,445	29,365
	30,815	31,815
	33,185	34,265
	35,555	36,715
	37,925	39,165
	40,295	41,615
	42,665 ²	44,065 ²
	45,035 ²	46,515 ²
<i>Band 2: Senior dental officer</i>	41,030	42,355
	44,345	45,780
	47,660	49,205
	50,975	52,630
	54,290	56,055
	55,025 ³	56,810 ³
	55,760 ³	57,565 ³
<i>Band 3: Assistant clinical director</i>	54,815	56,585
	55,675	57,475
	56,535	58,365
	57,395	59,255
	58,255 ³	60,145 ³
	59,115 ³	61,035 ³
<i>Band 3: Clinical director</i>	54,815	56,585
	55,675	57,475
	56,535	58,365
	57,395	59,255
	58,255	60,145
	59,115	61,035
	59,975	61,925
	60,865	62,830
	61,725 ³	63,720 ³
	62,585 ³	64,610 ³

¹ These payscales also apply to salaried dentists working in Personal Dental Services.

² Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the thirty-first report. See also twenty-eighth report, paragraph 8.9 (community dental officers) and twenty-ninth report, paragraph 7.61 (salaried general dental practitioners).

³ Performance based increment, see paragraphs 4.21 and 4.38 of the thirty-first report. See also thirtieth report, paragraph 8.15.

	Current scales £	Recommended scales payable from 1 April 2003 £
Regional dental officer Band B (Region with population under 3.5 million)	60,775 61,595 62,415 63,235	62,735 63,585 64,435 65,285
Regional dental officer Band A (Region with population of 3.5 million or over)	62,040 62,860 63,680 64,500	64,045 64,895 65,745 66,595
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	48,035 51,075 54,115 57,155 60,865 61,725 ⁴ 62,585 ⁴	49,585 52,725 55,865 59,005 62,830 63,720 ⁴ 64,610 ⁴
Part-time dental surgeon:	<i>Sessional fee (per hour)</i>	
Dental surgeon	23.55	24.35
Dental surgeon holding higher registrable qualifications	31.25	32.30
Dental surgeon employed as a consultant	38.95	40.25

Details of the supplements payable to community dental staff are set out in Part II of this Appendix.

⁴ Performance based increment, see paragraph 4.48 of the thirty-first report.

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES¹

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2003. The previous levels quoted are those currently in force.

General medical practitioners

2. The supplement payable to GMP registrars for out-of-hours duties should be increased² from 50 per cent to 65 per cent of basic salary.
3. The salary range for salaried GMPs³ employed by Primary Care Organisations should be £46,455 to £70,710 for 2003-04.

General dental practitioners

4. The gross fee for each item of service and capitation payment should be increased by 3.225 per cent from 1 April 2003.
5. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £99.00 to £102.20.
6. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £70.05 to £72.35.
7. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £54.00 to £55.75.
8. The quarterly payments under the Commitment Payments scheme⁴ should be increased as follows:

Level 1 payment	from £27 to £36 a quarter
Level 2 payment	from £235 to £314 a quarter
Level 3 payment	from £305 to £407 a quarter
Level 4 payment	from £366 to £488 a quarter
Level 5 payment	from £427 to £570 a quarter
Level 6 payment	from £487 to £650 a quarter
Level 7 payment	from £549 to £732 a quarter
Level 8 payment	from £610 to £814 a quarter
Level 9 payment	from £671 to £895 a quarter
Level 10 payment	from £731 to £975 a quarter

¹ Note that established rounding practices mean that the final uprating for some fees and allowances is different to the exact recommended uprating.

² See paragraph 4.10 of this report.

³ See paragraph 5.11 of this report.

⁴ See paragraph 2.75 of this report.

Community health and community dental staff

9. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,020 to £2,090 a year.
10. The teaching supplement payable to clinical directors in the CDS should be increased from £2,285 to £2,360 a year.
11. The supplement for clinical directors covering two districts should be increased from £1,475 to £1,525 a year and the supplement for those covering three or more districts should be increased from £2,355 to £2,435 a year.
12. The allowance for dental officers acting as trainers should be increased from £1,615 to £1,670 a year.
13. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

APPENDIX B

LETTERS FROM THE PARTIES ON THE AGREEMENT FOR SALARIED PRIMARY DENTAL CARE SERVICES STAFF

This appendix reproduces an exchange of letters, copied to us by the Department of Health and the British Dental Association, in which the Chairman of the Management Side and the Chairman of the Staff Side set out their jointly agreed position on the terms of the three-year pay deal for salaried dentists.

06 May 2003

Janet Clarke
Chair, Staff Side
JNF/CCCPHD
British Dental Association
64 Wimpole Street
London W1M 8AL
Wimpole Street LONDON W1

Wellington House
133-155 Waterloo Road
LONDON
SE1 8UG

Dear Janet

3 Year Pay Deal - Communicating with DDRB – Salaried Services

Following the interchange of letters between John Renshaw and David Hewlett concerning the headline issues relating to a possible three year pay deal for dentists I am writing to confirm the details of our terms of agreement to such a deal for salaried primary dental care staff, linked to reform.

We recognise four elements to the proposed deal, all linked to reform:

1. An uplift of 3.225% on salaries and allowances for all dentists of the salaried primary dental care service for each of the three years 2003/4, 2004/5 and 2005/6. At your request and with our agreement the uplift is to be applied across the board in 2003/4 rather than differentially targeted. The 3.225% each year is to be re-visited if RPI(X) in any year to October falls outside the range 1.725 – 4.725%, when the deal would be renegotiated or put to the Review Body. We are agreed that we do not otherwise envisage any role for DDRB in this process.
2. A review of the role of the salaried service and staff therein to be led by the CDO (England) to be undertaken in the context of *Shifting the Balance of Power*, the planned future for NHS dentistry in England as set out in the Bill currently before Parliament, and the wider modernisation of the NHS and medical workforce. It is intended that the review be undertaken in two phases. We have already discussed a timetable in which the first phase be completed by November 2003 and the second phase by April 2004. After this consideration would be given to any pay and grading considerations which might emerge, for possible implementation, subject to agreement and affordability, from April 2005. We are in discussion with you about the Terms of Reference (ToR) for that review. We will also need to discuss the implications further with the Health Departments involved. Bearing in mind your desire that other countries play a part in the review process, and the recent elections in Wales and Scotland, it may be some weeks yet before we can finalise the ToR. We should therefore probably be prepared to look again at the review timetable, as suggested at the last JNF. We are agreed that there

is potential for a DDRB role in this process after April 2004 if pay or grading issues arise from the review.

3. Related to the first phase of the review we have noted that this may throw up pay issues around the margins where it would be practical and desirable to make progress for the pay year 2004/5, over and above the standard 3.225%. We confirm in principle our willingness to make that progress where the changes are affordable, are desirable to enable changes which will support the future agenda, and are consistent with the general principles under which the CDO-led review is being undertaken. Should the review identify such a pay issue then we would expect to be able to agree the detailed action directly with the BDA, through the JNF, and report the agreement on to the DDRB for information. We do not at this stage envisage any other role for the DDRB in that process.
4. During discussion with the BDA collectively about a possible three year pay deal we discussed the potential role for a primary dental care modernisation fund to be made available over the two years 2003/04 and 2004/05. We agreed with a BDA request that should such a fund be made available then a part would be available to support the modernisation of salaried services, especially those which had modernised without significant central financial support. With the rejection of the three year deal by the GDPC this offer falls as regards the GDS but we agree that a proportion of the funding can stand as part of the deal with the salaried service representatives. We shall need to discuss the principle through which the funds are applied but see some kind of benchmarking as likely to be required in this. There will need to be separate discussions with the other Health Departments about the applicability of such funds in other parts of the UK. This is not a pay matter and we see no role for the DDRB in relation to these funds.

I hope that this adequately sets out our jointly agreed position on the terms of a three year deal for salaried dentists which is linked to tangible reform. Subject to your views, I propose that we use this text as the basis of a joint statement to DDRB.

I look forward to hearing from you shortly and am of course happy to discuss.

Yours sincerely

(pp John Langford)

John Langford
Management Side Chairman
Joint Negotiating Forum.

Copy: Mrs Sue Martin, BDA



*64 Wimpole Street
LONDON
W1G 8YS*

08 May 2003

John Langford
Management Side Chairman
JNF
Department of Health
Wellington House
133-155 Waterloo Road
LONDON
SE1 8UG

Dear John

3 YEAR PAY DEAL; COMMUNICATING WITH DDRB – SALARIED SERVICES

Thank you for your letter dated 06 May 2003, confirming the details of the terms of agreement for a possible 3 year pay deal for salaried primary dental care staff.

2. I am pleased to confirm that your letter reflects the BDA's understanding of the proposed deal as it affects salaried primary dental care staff.
3. Your agreement to the BDA's request for application of the 2003/04 uplift across the board is welcome, and we would propose separate discussions, via JNF channels, on the application of the awards for 2004/05 and 2005/06, closer to the respective implementation dates.
4. The clarification you provide of the process for the CDO (England) review is helpful, and I agree that, given the political timetables in devolved governments, and the importance attached by the BDA to their involvement, we should be ready to revisit the review timetable. The BDA looks forward to considering the redrawn TOR in due course.

5. Your confirmation of willingness to make progress, in pay year 2004/05, on pay issues over and above the standard 3.225% uplift, is welcome also, and we agree the proposed mechanism for progressing such changes.

6. We are pleased also to receive your confirmation of the offer of modernisation fund money for the salaried services, and look forward in due course to further discussions of the principles of application. The BDA agrees that, not being a pay matter, there would be no DDRB role in this.

7. I confirm the BDA's acceptance of your letter as a statement of our jointly agreed position on the terms of the proposed three year deal, and that the text may form the basis of a joint statement to the Review Body.

8. The BDA looks forward to confirming the details of an advance letter promulgating the above agreements, at the earliest opportunity, and would hope that this can be done in time for payment in June salaries. I should be grateful if you could liaise with the Industrial Relations team at Wimpole Street on this.

Yours sincerely

(pp Janet Clarke)

Janet Clarke
Chairman
Staff Side JNF/
Central Committee for Community & Public Health Dentistry

CC: Ms Almas Mithani, Ms Pam Scoular, Mr Andy Taylor, Mr Tim Brown, DoH
Mr John Renshaw, Chairman, BDA Executive Board
Mr Ian Wylie, Chief Executive, BDA

APPENDIX C

REPORT BY MERCER HUMAN RESOURCE CONSULTING:

RESEARCH ON SALARIED PRIMARY DENTAL CARE SERVICES STAFF

This appendix reproduces Mercer's report *Research on Salaried Primary Dental Care Services Staff* which was commissioned on our behalf by the Office of Manpower Economics.

23rd October 2002

Research on Salaried Primary Dental Care Services Staff

Research study on career progression, current use of the payscale, recruitment and retention in the Salaried Primary Dental Care Services

for the

Review Body on Doctors' and Dentists' Remuneration

MERCER

Human Resource Consulting

Contents

1. Executive Summary	1
2. Introduction and Methodology	3
▪ 2.1 Objectives	3
▪ 2.2 Research Methods	4
3. Characteristics of the SPDCS	7
▪ 3.1 Demographics	7
▪ 3.2 Use of the payscale	14
4. Recruitment.....	16
▪ 4.1 The Number and Duration of Unfilled Posts	16
▪ 4.2 Barriers to Recruitment.....	16
▪ 4.3 Factors Attracting Dentists to the SPDCS	18
▪ 4.4 Flexible Working Arrangements.....	21
5. Retention.....	22
▪ 5.1 The Extent of the Retention Problem.....	22
▪ 5.2 Factors Influencing Retention.....	23
▪ 5.3 Satisfaction with the SPDCS	27
6. Career Progression.....	29
▪ 6.1 Aspirations and Expectations.....	29
▪ 6.2 Promotion.....	30
▪ 6.3 Movement Through the Payscale.....	32
7. Comparison of Pay in the CDS and PDS.....	33
▪ 7.1 Band 1 Salaries	33
▪ 7.2 Band 2 Salaries	37
8. Summary of Findings.....	40

Appendices

Appendix 1: Interview report

Appendix 2: Staff survey questionnaire

Executive Summary

This report presents the main findings of a research study to investigate career progression, current use of the payscale, recruitment and retention in the Salaried Primary Dental Care Services (SPDCS).

The research was conducted by means of interviews (with 11 managers of Primary Care Organisations (PCOs) and Clinical Directors within the SPDCS) and a postal staff survey of all SPDCS employees. The survey achieved a response rate of 46%, very reasonable for this kind of research.

Overall the research found that retention is not a major problem within the SPDCS, but that recruitment of dentists to the services is problematic.

The key factors attracting dentists to the SPDCS are the vocational desire to provide a good service to patients and to serve the community. The security of a salaried income is also important. In the management interviews, the opportunity for flexible working arrangements was reported to be important, as well as having opportunities for on-the-job coaching from experienced dentists.

The factors that appear to inhibit recruitment are:

- Location of vacancies – dentists are often unwilling to move from their home or area where they trained. In remote locations dentists also have more on-call commitments and may work in smaller teams with few experienced dentists to provide coaching and support.
- An overall shortage of dentists.
- Uncertainty about the future of the SPDCS - for those potential recruits looking for long-term, stable employment this may be an inhibiting factor.
- Lack of co-ordinated structure and process for recruitment of overseas dentists.

The level of salary offered is reported by dentists currently within the services to have been a relatively less important factor in attracting them to the SPDCS. What the current research has not been able to determine is whether salary levels have been a major factor in deterring other dentists from joining the SPDCS. It has been found that among those who are thinking of leaving the SPDCS, the desire to improve their salary/financial reward is an important factor.

Clustering of dentists at the top of the salary bands is evidence of career ceilings. This is occurring at the Dental Officer (DO) and Senior Dental Officer (SDO) levels but not with Clinical Directors and Assistant Clinical Directors. Frustration regarding a lack of career progression is another factor motivating dentists to leave the SPDCS. There is also frustration with the quality and style of management in the SPDCS which may need further investigation.

The research has found that dentists in the Personal Dental Services (PDS) and Community Dental Service (CDS) are generally within the same pay bands for similar levels of experience (length of service since qualifying).

Closer examination of the payscales within band 1 shows a difference in pay for dentists with less than five years post-qualifying experience. Within the CDS only 3% are paid at the top two scale points and 58% are paid at the bottom three points, whereas in the PDS 30% are paid at the two points and 43% are paid at the bottom three points. This indicates that the band 1 salary scale may not be perceived as market competitive in that some PDS dentists and occasionally CDS dentists are being recruited at the higher points on the band 1 scale. The finding that more PDS dentists are contracted to work unsociable hours may also partly explain differences in band 1 salaries between the PDS and the CDS.

Among those paid band 2 salaries, there is evidence that dentists with similar levels of experience tend to be paid at higher salaries in the CDS than the PDS. This may be due to CDS dentists having different responsibilities that were not identified by this research.

Introduction and Methodology

2.1 Objectives

Mercer Human Resource Consulting (Mercer) was appointed by the Office of Manpower Economics (OME) on behalf of the Review Body on Doctors' and Dentists' Remuneration (DDRB) to conduct a research project within the Salaried Primary Dental Care Services (SPDCS) in Great Britain with the following objectives:

- Advise on the recruitment and retention situation, career progression and the use of the payscale;
- Uncover where pay, and other factors, fit into the picture of any recruitment and retention difficulties in the SPDCS;
- Address the particular issue of whether dentists in the Personal Dental Services (PDS) are paid more than dentists in the Community Dental Service (CDS) with similar levels of responsibility and experience.

The research was conducted in three stages:

Stage 1 of the project involved structured interviews with managers of Primary Care Organisations (PCOs) and Clinical Directors within the SPDCS.

Stage 2 involved a staff survey of all SPDCS dentists, conducted by postal questionnaire.

Stage 3 involved final qualitative interviews to validate the survey results.

This report incorporates findings from all three stages. Appendix 1 presents a separate report on Stage 1. Results tables from the staff survey are available from the DDRB secretariat upon request.

This report also draws on the findings of a recent study conducted by the British Dental Association (BDA) of 'Recruitment and Retention in Salaried Primary Dental Care 2002'. The BDA study comprised a survey of Clinical Directors within the SPDCS.

2.2 Research Methods

2.2.1 Interviews

Structured interviews were conducted with 11 managers within Primary Care Organisations (PCOs) and Clinical Directors within the SPDCS. Interviewees were recruited from nominations made by the BDA, the NHS Confederation and Department of Health (DoH). Interviewees were not selected randomly, rather the aim was to interview managers that were geographically spread throughout Great Britain. Nine interviews were conducted in stage 1 with a final two interviews conducted in stage 3.

The aim of the interviews was to identify the extent of any recruitment and retention problems for the service along with the management response to past and present recruitment and retention problems. Interviews in stage 3 were also used to validate research findings.

2.2.2 Staff Survey

Questionnaire Design

The questionnaire was designed by Mercer in conjunction with the OME. A draft was circulated to the DoH, the NHS Confederation, the Scottish Executive, the Welsh Assembly and the British Dental Association for their review and feedback. A revised version was pilot-tested with four dentists. Their suggested amendments were reviewed with the OME prior to finalisation.

A copy of the questionnaire is included in Appendix 2.

Questionnaire Content

The questionnaire collected a mix of data types. Descriptive measures of job role, qualifications, type of work, career history, career development and pay were collected alongside attitudinal measures. The latter were derived from questions about attraction and commitment to the SPDCS as well as measures of satisfaction with pay, career opportunities, training, work activities and management of the SPDCS.

Data for a number of the subjective measures have been benchmarked against Mercer's UK national normative database. The normative data is the intellectual property of Mercer Human Resource Consulting and therefore the data itself has not been reproduced in this report.

The normative database has been created following a national survey on employee perceptions about their work environment. The database is built from a statistically valid sample of the workforce in Britain and of major industrial sectors including the NHS.

Fieldwork

The SPDCS staff survey was administered between 19th August and 13th September 2002, with a reminder letter sent to all non-respondents on 30th August. In England and Scotland the questionnaire was posted to individual dentists at their clinic address (for salaried GPs and those working in PDS pilots) or at their trust address (for those in the CDS) and returned directly to Mercer. In Wales, questionnaires were sent to Trusts for onward distribution to dentists.

Apart from in Wales, each questionnaire was marked with a unique code number that was matched to the name and address of individual dentists. This enabled return questionnaires to be tracked so that the reminder letter was only sent to those who had not replied, and to allow more detailed analysis of response rates. Mercer guarantees the confidentiality of survey responses.

Survey Population and Response Rate

The questionnaire was sent to all salaried dentists in England, Scotland and Wales. In total 2,104 questionnaires were distributed¹. A total of 962 questionnaires were returned which gives a response rate of 46%. In addition 56 questionnaires were returned in the three weeks after the end of the fieldwork.

Although a response of 46% is reasonable, a higher response might have been achieved if the survey had been undertaken outside the holiday season as some dentists may not have been at work during the fieldwork period. In addition:

- An unknown number of questionnaires were sent to PDS dentists, who are self-employed rather than salaried, as the sample frame available from the DoH did not distinguish between the two. Where these dentists did not notify the project team, they could not be excluded from the survey population.
- The sample frame provided was mainly for September 2001, and therefore some address information was out of date, so not all questionnaires reached the intended target.

It is also possible that a number of dentists may have had concerns about confidentiality given the sensitive nature of the information requested. This was despite reassurances given concerning this matter.

¹ This excludes 14 questionnaires that were sent to a Welsh Healthcare Trust, which it seems were not further distributed.

The questionnaires sent to the CDS in England were sent to generic trust addresses, rather than to individual clinics. Because of concerns about the accuracy of this address information, the returns from the CDS in England were analysed by Trust. Some 164 questionnaires were sent to Trusts from which no responses were received. The number of CDS dentists working in these Trusts clearly varies; however, when there are more than three dentists in a Trust and none replied, it seems likely to us that there were problems with the address information.

In total, 125 questionnaires were sent to Trusts with more than three dentists, where no responses were made. Similar calculations are not possible in Scotland, or for the PDS and salaried GDPs in England, as their questionnaires were sent directly to clinics, not to Trusts.

The impact on the response rate of the information discussed above is summarised in table 2.1 below. This shows that a revised response rate of 51% can be calculated, which perhaps more accurately reflects dentists' participation in the survey.

Table 2.1 Participation in the Survey

Out going questionnaires	Returned questionnaires	Response Rate
Absolute no. of outgoing questionnaires = 2,104	Questionnaires returned in fieldwork period = 962	46%
Adjusted no. of outgoing questionnaires, excluding 125 sent to Trusts from which no returns were made = 1,979	Total number of questionnaires returned, including late returns = 1,018	51%

Results Analysis: Tests of Statistical Significance

Throughout this report, the results of various groups or sub-groups within the SPDCS have been compared. These comparisons have been subject to statistical tests to determine if the differences could have occurred by chance or whether they signify a meaningful difference in the characteristics of the groups. The tests have been conducted at the 95% confidence level ($p < 0.05$). This means that, if there was actually no difference between the comparison groups, we would only obtain an incorrect indication of a significantly different result 5 times out of 100 (i.e. 5% of the time) if the measure were repeated. The use of the word “significant” in this report indicates that the result has been tested on this basis.

3

Characteristics of the SPDCS

In this section the characteristics of the SPDCS as identified by the staff survey are summarised.

Firstly, the demographic characteristics of the sample are examined and some of the survey findings are compared to data held by the Health Departments (HDs). This helps establish that the survey sample is adequately representative of the SPDCS.

3.1 Demographics

3.1.1 Gender and Age

Tables 3.1 and 3.2 show that, with regard to gender, the survey population is a good match with the expected distribution indicated by the HDs' data.

Table 3.1 Gender: Overall and in the CDS

Gender	% of all respondents (n=960)	% of CDS respondents (n=593)	HD data for CDS in Great Britain - %
Male	40.0	35.4	34.2
Female	60.0	64.6	65.8
Total	100%	100%	100%

Table 3.2 Gender: PDS and Salaried GDPs

Gender	% of PDS respondents (n=271)	HD data for PDS - %	% of Salaried GDPs respondents (n=49)	HD data for Salaried GDPs in Great Britain - %
Male	45.8	46.6	53.1	52.2
Female	54.2	53.4	46.9	47.8
Total	100%	100%	100%	100%

Unfortunately we have not been able to compare the age of respondents with the age of the whole population.

Table 3.3 Age

Age ranges	% of all respondents
Less than 35 years	20.2
36 – 40 years	16.6
41 – 45 years	20.7
46 – 50 years	18.1
More than 50 years	24.5
Total (n=912)	100%

3.1.2 Geographical Distribution and Type of Community Served

Table 3.4 Work Location of Respondents - former Health Region

Former Health Region	% of all respondents (n=918)	% of CDS respondents in GB (n=561)	HD data – CDS in GB %
English Regions			
Northern and Yorkshire	9.2	10.2	8.9
North West	15.3	17.3	13.0
West Midlands	9.8	7.0	8.3
Trent	6.1	8.6	5.8
Eastern	3.3	2.1	5.3
South Eastern	11.4	8.6	14.4
London	9.0	11.6	13.5
South West	13.4	7.0	7.8
Scotland and Wales			
Scotland	17.3	20.0	17.0
Wales	5.2	7.8	6.1
Total	100%	100%	100%

Comparison of the regional distribution of the CDS survey respondents and the expected distribution indicated by the HDs' data shows a higher than expected return in Scotland and the former North-West and Trent regions. In the Eastern and South-Eastern region the number of respondents is lower than expected.

These differences may have been due to problems with address information in the Eastern and South-Eastern regions, however, precise comparison of the data is problematic since the HDs' data counts twice any dentists that work in two regions.

Overall, whilst the match does not seem precise it is felt that the regional distribution of survey respondents provides a reasonable basis from which to draw research conclusions.

Table 3.5 Type of Community Served

Type of community	% of all respondents
Rural community	10.6
Urban community - inner city	25.1
Urban community - suburban	16.2
Urban community - other (e.g. market town)	17.3
Mixture of communities	30.9
Total (n=946)	100%

3.1.3 Service

Table 3.6 shows the percentage of dentists whose main job in the SPDCS is in the services identified.

Table 3.6 Service in Main Job

Service	% of all respondents
CDS	62.4
PDS: Dental Access Centre (DAC)	18.2
PDS: Other Pilot Project	10.3
Salaried GDP	5.1
Combined CDS/GDS dentists (Scotland only)	1.8
Other	2.2
Total (n=953)	100%

The remainder of this report examines the PDS as a whole since the sample sizes are too small to allow Dental Access Centres to be compared to ‘Other Pilot Projects’.

Table 3.7 looks within the CDS and shows the percentage of dentists at each grade. The respondents’ reported salary point was used to determine their grade.

Table 3.7 CDS Dentists: Distribution of Grades

Grade in main job (from salary point response)	% of CDS respondents (n=558)	HD data for CDS in Great Britain %
Dental Officer	49.5	64.4
Senior Dental Officer	38.5	30.0
Assistant Clinical Director	3.8	1.9
Clinical Director	8.2	4.5
Total	100%	100%

There is a relative over-representation of senior grades in the respondent population. This may be partly attributable to the fact that a greater proportion of DOs may have been on leave at the time the staff survey was distributed. It may also be the case the CDS questionnaires were sent to trusts in the expectation that they would be forwarded on: the names of more senior staff would have been more recognisable and therefore the questionnaire was more likely to reach them. When reading the remainder of this report it should borne in mind that there are 14.9% fewer DOs in the sample than expected, although we do not feel this would have a major effect on the representativeness of the results.

3.1.4 Work Profile

Table 3.8 shows the percentage of dentists reporting that they carry out particular types of dental work. Paediatric and Special Needs work are each carried out by 71% of respondents with Adult Restorative and Geriatrics each being carried out by just over half of respondents

Table 3.8 Nature of Dental Work Carried Out

Note: Dentists could choose more than one type of dental work

Type of dental work	% of all respondents conducting this type of dental work (n=962)
a. Adult Restorative	56.3
b. Clinical Generalist	45.8
c. Clinical Manager	18.4
d. Epidemiology	27.0
e. General Anaesthesia	33.2
f. Geriatrics	53.1
g. Orthodontic	29.5
h. Paediatric	71.2
i. Special Needs	71.2
j. Other	20.6

Table 3.9 shows the proportion of time dentists spend at a range of work activities. Due to the higher than normal proportion of non-response to question 22² in the staff survey it has been assumed that non-respondents spend none of their time on the activity specified.

Table 3.9 Percentage of Time in Main SPDCS Job Spent on Work Activities

Rows total 100%

Activities	% of all respondents spending the defined % of their time on each activity (n=962) note: in this table a ‘-’ indicates a percentage less than 0.5% and greater than 0				
	None/ No response	1-25% of time	26-50% of time	51-75% of time	Over 75% of time
a. Adult Restorative	27	47	10	8	8
b. Epidemiology	68	31	2	-	-
c. General Anaesthesia	64	34	3	-	-
d. Geriatric	34	54	11	2	-
e. Orthodontic	58	34	4	1	4
f. Oral Health Promotion	59	37	2	2	1
g. Paediatric	19	38	21	13	9
h. Screening	47	48	5	-	1
i. Special Needs Care	21	46	19	9	6
j. Safety Net for GDS Care	43	41	6	2	7
k. Management/Administration	40	48	8	3	2
l. Professional Development/Training	23	74	2	-	-
m. Other Activities	67	30	2	0.6	0.9

Table 3.9 shows that SPDCS dentists tend to have a varied workload. There are relatively small proportions that spend over half of their time on any one type of activity.

² Question 22: ‘Approximately, what percentage of your time, in your main SPDCS job is spent on the following activities’. The activities are those listed in table 3.9.

3.2 Use of the payscale

Table 3.10 shows the percentage of dentists at each of the main salary bands across the whole of the SPDCS.

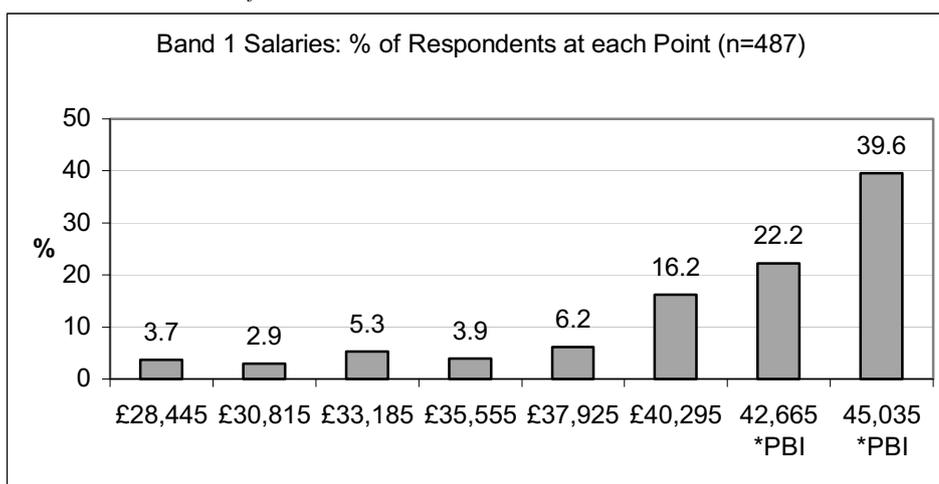
Table 3.10 Percentage of dentists paid using each salary band

SPDCS Salary Bands	% of respondents paid using each salary band
<i>Band 1:</i> Community dental officer or Salaried GDP	55
<i>Band 2:</i> Senior dental officer or Senior Salaried GDP	34
<i>Band 3:</i> Assistant clinical director or Specialist Salaried GDP and Clinical director	11
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	0.1
Total (n=886)	100%

Chart 3.11 shows, within each band, the percentage of dentists at each salary point.

Chart 3.11 Percentage of dentists paid using each salary point, within bands

Note: PBI indicates a Performance Based Increment.



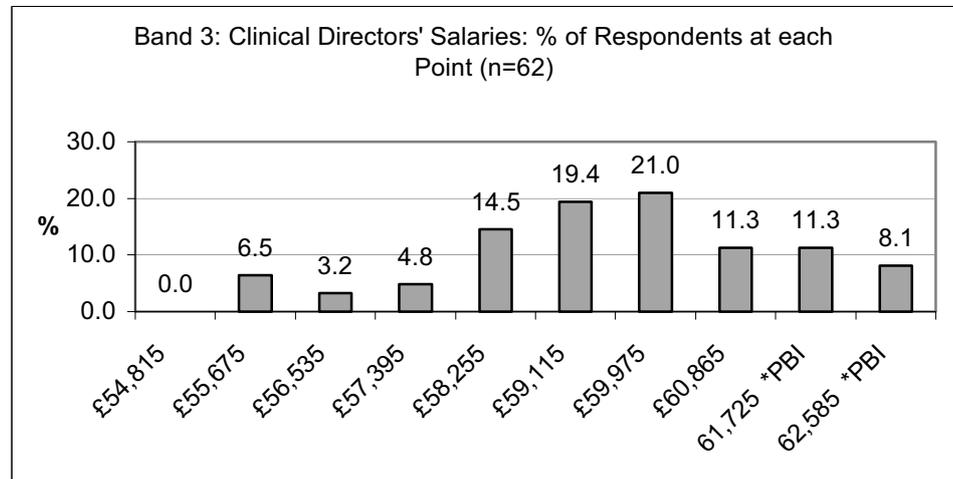
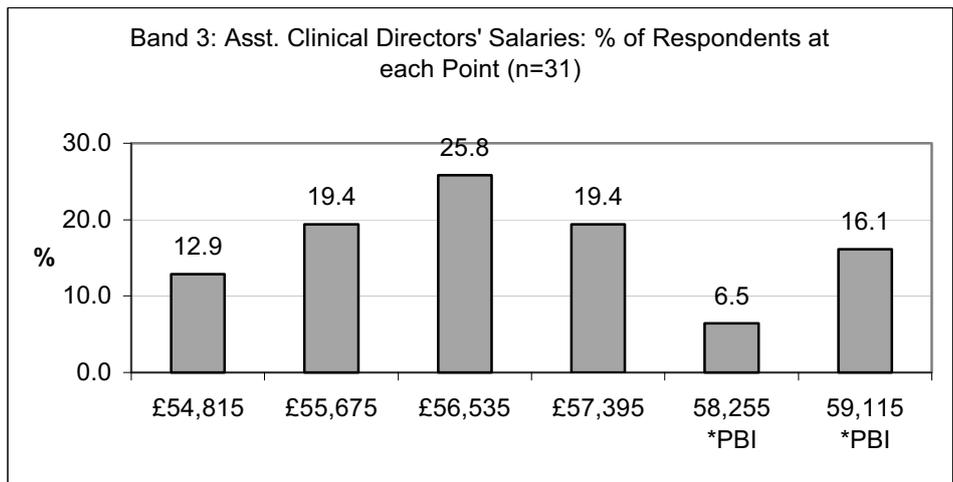
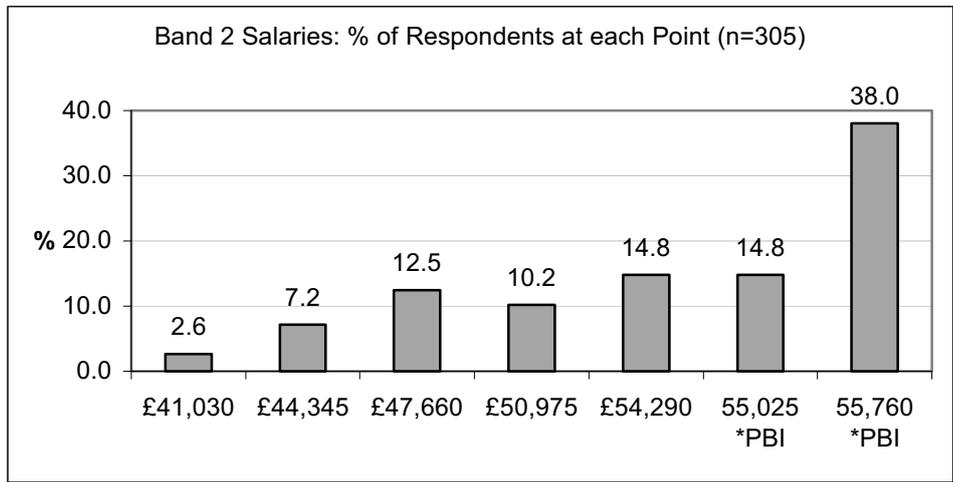


Chart 3.11 shows that in bands 1 and 2 dentists are clustered at the top salary points. Specifically, in band 1, 62% of dentists are paid using the top two scale points and in band 2, 53% of dentists paid using the top two scale points.

In band 3 there is a much greater spread of salaries across the scale points.



4

Recruitment

The interviews conducted in this research reveal that recruitment of dentists to the SPDCS is regarded as a far greater problem than retention of dentists within the services.

The recruitment problems exist at the DO and SDO levels. No recruitment problems were reported in the management interviews or the BDA research for Clinical Directors and Assistant Clinical Directors.

4.1 The Number and Duration of Unfilled Posts

The interviews identified the recruitment problem as being most acute at DO level, with posts remaining vacant for between 6 - 18 months. The BDA research provides further detail to support this finding, reporting that the average length of time that a DO post has been vacant is 12 months and that 10% of all DO posts are vacant. Vacant SDO posts are unfilled for an average of 9 months.

4.2 Barriers to Recruitment

The BDA research found a lack of suitable applicants to be the primary barrier to recruitment. In addition, the location of vacancies and salary levels, competition for applicants with the private sector, as well as between the PDS and CDS were also cited as barriers. This is consistent with the findings reported from the interviews we carried out.

In the Mercer research the majority of those interviewed cited the location of vacancies and a shortage of skilled dentists in the marketplace as the key barriers to recruitment.

4.2.1 Location

The management interviews revealed that potential SPDCS recruits are often unwilling to move far from their home or the area in which they studied to find work. Posts in remote areas are even harder to recruit into as dentists working in these areas are expected to be 'on-call' more often as they will often be the only NHS dentist in an area. The staff survey confirmed that a greater proportion of dentists working in rural communities work on-call (53% of dentists in rural communities work some on-call, compared to 29% of other dentists, a significant difference).

4.2.2 Pay and recruitment

Management interviewees stated that the general perception within the profession is that SPDCS dentistry is poorly paid which makes it hard to attract applicants to vacancies. Within the SPDCS the perception is that CDS dentists are paid less than PDS dentists. Interviewees view this to be a further obstacle to recruitment for the CDS. The survey data presented in Section 7 of this report show that whilst, in general, PDS dentists are not paid more than CDS dentists, recently qualified dentists (paid at band 1 salaries) are paid more by the PDS.

4.2.3 Competition for applicants

Management interviewees cited examples where the shortage of dentists drives competition for applicants between the PDS and the CDS and also with the private sector on the basis of pay. This leads to an upward spiral in the salaries offered. Neighbouring services within the SPDCS will also compete with each other, using pay to attract applicants. This can create recruitment difficulties even in locations where there is a supply of applicants.

4.2.4 Difficulties in overseas recruiting

The staff survey found that 3% of dentists have been recruited to the SPDCS from overseas. A third of the interviewees have tried recruiting dentists from overseas. Most saw this as a good potential solution to addressing staff shortages. However, interviewees currently find the process around securing work permits particularly obstructive, and there is little structure or process to ensure the staff with the right skills and qualifications can be easily sourced and hired from overseas.

4.2.5 The need for guidance on the future of the SPDCS

The BDA research found that the factor most likely to improve recruitment is “the provision of definitive guidance on the future role of the CDS”, with 63% of Clinical Directors reporting this. The staff survey found that only 24% of dentists believe that “Senior management communicates a clear vision of the future direction of the SPDCS”.

This is significantly below the Mercer norm for Britain and the norm for the NHS.

An organisation without a clear picture of the future is likely to be less attractive to potential employees than one where a compelling vision exists. The findings suggest that the SPDCS is currently at a competitive disadvantage in this respect.

4.2.6 The Impact of on-the-job Training

Whilst a lack of available on-the-job training was not cited as an obstacle to recruitment, one trust which did have a reputation for good training reported receiving a relatively high proportion of applications per vacancy. The good reputation for training was, in part, due to having a high ratio of senior staff to facilitate coaching for less experienced dentists. It can be hypothesised that small services in remote locations are not able to offer this kind of support and are therefore less attractive to recently qualified dentists.

4.3 Factors Attracting Dentists to the SPDCS

In the staff survey, dentists were presented with a list of 11 factors that could have attracted them to the SPDCS.

The analysis of their responses reveals that the ‘level of salary offered’ is rated as the least important factor among the 11 listed. This finding is difficult to interpret on its own, but management interviewees reported a common perception that SPDCS salaries are low, (see Section 4.2.2) and SPDCS dentists have somewhat negative views about the fairness of their salary (see Table 5.4). In combination these findings indicate that serving dentists were attracted to the SPDCS by factors other than money and are willing to tolerate a salary they consider low.

In considering this finding it must be borne in mind that the survey was conducted only among dentists who have already joined the SPDCS and remain there. Dentists outside the SPDCS may have a different perception of the importance of pay.

- The three most important reasons for joining the SPDCS were:
 - ❖ The desire to work in an environment where you can provide good service to patients
 - ❖ The security of a salaried income
 - ❖ The desire to serve the community and disadvantaged groups of patients
- Only 20% of all respondents rated the level of salary offered as ‘extremely’ or ‘very’ important in attracting them to the SPDCS. This figure is even lower for CDS dentists (13%: a significant difference).
- Of those dentists who have recently joined the SPDCS, pay is a more important factor: 33% (n=59) of those with less than 3 years service in the SPDCS rated pay as ‘extremely’ or ‘very’ important – significantly more than for respondents as a whole.
- Dentists aged under 35 did not rate the factors differently, except that 40% rate the opportunity for post-graduate studies as ‘extremely’ or ‘very’ important, compared to 29% for the overall survey population (a significant difference).

Table 4.1 Importance Rating of Factors Attracting Dentists to the SPDCS

Rows total 100%

Factors: ranked in order by the combined % of dentists rating the factor as 'extremely' or 'very' important	% of all respondents					
	Total extremely or very important	Extremely important	Very important	Important	Of little importance	Not important at all
Desire to work in an environment where you can provide good service to patients (n=921)	72	34	38	24	2	2
Security of a salaried income (n=933)	55	23	32	36	8	2
Desire to serve the community and disadvantaged groups of patients (n=936)	53	22	30	36	8	3
Availability of a job in a preferred location (n=921)	38	11	27	35	19	8
NHS Pension (n=919)	36	11	25	46	15	4
Not interested in doing general practice work (n=911)	32	12	20	24	27	18
Opportunity to study for a registerable post-grad. qualification (n=908)	29	8	21	29	29	14
Preference for more flexible working (n=906)	28	7	21	29	30	12
Long-term career potential (n=911)	26	6	20	45	23	7
Interest in pursuing a dental specialism (n=899)	24	8	17	31	35	10
Level of salary offered (n=912)	20	5	15	51	24	6

4.4 Flexible Working Arrangements

In the manager interviews it was found that flexible working arrangements were offered by all the PCOs to varying degrees in order to attempt to attract staff. Practices include family friendly policies, job shares, out of hours working, evening surgeries, flexible weekly hours to fit around childcare arrangements and term-time working. Where relevant some also had retired staff returning to practise for one or two days a week. Interviewees generally felt that of all the recruitment and retention strategies at a PCO's disposal, offering flexibility was amongst the most effective.

The preference for flexible working arrangements did not emerge from the staff survey as a critically important factor (although table 4.3 shows that almost two-thirds of dentists prefer to have the option of working on a flexible basis). This is surprising, however the impact of this factor may have been reduced in the minds of dentists already in the service due to the fact that flexible work is widely available in the SPDCS.

Table 4.2 shows that 44% of dentists work less than 35 hours per week and Table 4.3 shows that only 17% of all SPDCS dentists have a preference for flexible working hours, but do not have the opportunity for this in their current job.

Table 4.2 Contracted Hours per Week in Main SPDCS Job

Contracted Hours Per Week	% all respondents
15 hours and less	13.0
16 to 34 hours	31.1
35 or more hours	55.9
Total (n=937)	100%

Table 4.3 Preference for Flexible Working (e.g. job sharing, part-time working)

Which of the following best describes your views on flexible working?	% of all respondents
a. I do not have a strong desire to work flexible hours	35.2

My preference is to have the option of working flexible hours:

b. and I HAVE the opportunity for this in my current job	33.5
c. but I DO NOT have the opportunity for this in my current job	17.0
d. but I have not ASKED about the opportunity for this in my current job	14.2
Total (n=948)	100%

Retention

5.1 The Extent of the Retention Problem

The interviews found that managers do not consider retention of dentists within the SPDCS to be a priority issue. Overall, this view is reinforced by the results of the staff survey. Some of the relevant findings upon which this assessment is based are:

- The average length of service for all dentists in the SPDCS is 13.0 years. In the CDS the average length of service is 15.8 years. This illustrates that historically there has been a high degree of commitment to the service.
- 19% of respondents say that they are currently seriously thinking of leaving the SPDCS. This is at a comparable level to Mercer norms for all employees in Britain and for NHS employees. Thus, 'intention to leave' in the SPDCS is in line with the normal level. If those aged over 55, who are planning to retire, are excluded from the analysis, then only 17% are considering leaving the SPDCS.
- Only 8% of respondents state that it is not their preference to remain with the SPDCS for the foreseeable future (excludes those aged over 55 considering retirement³).
- 17% of respondents have applied for posts outside of the SPDCS in the past two years, which is consistent with the proportion currently considering leaving.

³ This means that most of those considering retirement in the normal way are excluded, hence allowing comparison between groups of staff with different age ranges.

- Among Assistant Clinical Directors 17% are considering leaving (excludes those aged over 55 considering retirement), and the comparable proportion for Clinical Directors is 19%. It is normal for management grades to report results for this question that are similar to the results for the whole population. It should be noted that fewer Clinical Directors and Assistant Clinical Directors gave the 'Don't Know' response to the question about 'intention to leave' and a slightly higher percentage more gave a positive affirmation that they intend to stay with the SPDCS than for respondents as a whole.
- Among the following sub-groups the percentage who are considering leaving is higher than the average across the SPDCS (excluding those aged over 55 considering retirement):
 - ❖ Males – 20.5% are considering leaving, significantly higher than the proportion of females of 14.4%. Mercer's normative database shows that it is normal for a greater proportion of males to be considering leaving their organisation.
 - ❖ Those aged less than 35 – 22.2% are considering leaving, but this is not significantly different from the average across the SPDCS. Again Mercer's normative database indicates that this age group are more likely to consider leaving.
- The proportion considering leaving in the CDS is not significantly different from the comparable proportion in the PDS.

5.2 Factors Influencing Retention

The survey asked respondents to rate how important they considered a number of factors to be in influencing their commitment to the SPDCS. The most important factors that were found to influence commitment were the same three factors that had attracted dentists to the SPDCS in the first place:

- The desire to work in an environment where you can provide good service to patients
- The security of a salaried income
- The desire to serve the community and disadvantaged groups of patients.

The consistency of this with the earlier finding indicates the strength of these factors in driving dentists' interest in, and commitment to, the SPDCS. Traditionally, these have been integral elements of the working experience that the SPDCS provides which partly explains the lack of a retention problem.

To understand further the factors influencing retention the views of respondents considering leaving have been compared to those not considering leaving.

5.2.1 Continuing Commitment to the SPDCS

Table 5.1 compares the views of respondents considering leaving to those not considering leaving with regard to the set of factors listed in the questionnaire which may influence commitment

Table 5.1 Comparison of Commitment Factors for those Seriously Considering Leaving the SPDCS and those Not Considering Leaving

Factors influencing commitment to SPDCS	% of respondents rating the factor as 'extremely' or 'very important'		
	Respondents seriously considering leaving the SPDCS	Respondents <u>not</u> considering leaving the SPDCS	Difference between groups
Quality of colleagues you work with	75 (n=143)	58 (n=626)	17
Security of a salaried income	50 (n=139)	65 (n=633)	-15
NHS Pension	42 (n=143)	53 (n=627)	-11
Level of salary offered	53 (n=141)	43 (n= 622)	10
The opportunity to serve the community and disadvantaged groups	54 (n=144)	64 (n=634)	-10

The differences that are noted in Table 5.1 are all statistically significant.

This analysis shows that among those thinking of leaving, the level of salary is a comparatively important issue, whereas the security of having a salaried income and the NHS pension are less important. Further, there is less of a sense of vocation to serve disadvantaged groups among those thinking of leaving.

Respondents were also asked whether they agreed or disagreed with a series of attitudinal statements relating to working life in the SPDCS. Table 5.2 compares the attitudes of those considering leaving with those not considering leaving.

The data in Table 5.2 suggest that the following factors contribute to dentists leaving:

- frustrations regarding career progression and also salary progression
- the inability to make full use of one's skills and abilities in the job
- dissatisfaction with pay relative to performance.

Free-form comments made in the staff survey shed further light on frustrations regarding monetary reward. Several dentists spoke of the lack of recognition associated with being on a specialist list, having specific post-graduate qualifications or having relevant experience in other services.

It is also clear that among dentists thinking of leaving there is a gap between their expectations prior to joining and their experience of working for the SPDCS.

Table 5.2 Comparison of Work-Related Attitudes for those Seriously Considering Leaving the SPDCS and those Not Considering Leaving

Attitudinal Statement	% of respondents giving the 'strongly agree' and agree' response		
	Respondents seriously considering leaving the SPDCS	Respondents <u>not</u> considering leaving the SPDCS	Difference between groups
Overall, I am confident that I will be able to achieve my long-term career objectives in the SPDCS	16 (n=148)	59 (n=641)	-43
The overall experience of working in the SPDCS matches my expectations prior to joining	23 (n=148)	62 (n=634)	-39
My job makes good use of my skills and abilities	49 (n=147)	80 (n=643)	-31
I am paid fairly for my performance and contributions to the SPDCS	23 (n=149)	54 (n=642)	-27
I am satisfied with the career progress I have achieved in the SPDCS	24 (n=148)	50 (n=640)	-26
I am satisfied with the rate of salary progression I have achieved in the SPDCS	20 (n=149)	46 (n=643)	-26

The differences that are noted in Table 5.2 are all statistically significant.

5.2.2 Motivations to Seek a New Post Outside of the SPDCS

Those dentists who are considering leaving or who had considered leaving in the recent past, were asked to rate the importance of a series of factors in motivating them to seek a new post.

Table 5.3 Factors Motivating Respondents to Seek a New Post

Factors: ranked in order by the combined % of dentists rating the factor as ‘extremely’ or ‘very’ important	% of all respondents considering leaving the SPDCS					
	Total extremely & very important	Extremely important	Very important	Important	Of little Importance	Not important at all
Desire to improve salary/financial reward (n= 366)	66	43	24	18	11	5
Career progression opportunities (n=351)	58	30	29	22	14	5
Quality and style of management in SPDCS (n= 358)	56	27	29	26	11	7
Uncertainty about the future of the SPDCS (n= 354)	44	20	24	28	20	9
Challenge of doing a different type of work (n= 355)	43	17	27	35	15	7
Changes in the type of work being carried out in the SPDCS (n= 346)	36	14	22	30	23	11
Availability of a job in a preferred location (n= 354)	36	13	23	37	18	9
Preference for more flexible working hours arrangements (n= 348)	24	9	15	31	29	15
Preference to work fewer evenings & weekends (n= 326)	18	7	11	16	34	33

Of those people seriously considering leaving the SPDCS the highest proportion of respondents rated a desire to improve salary / financial reward and career progression as the two most important factors influencing their decision to leave. This is consistent with the findings in section 5.2.1.

It is also worthy of note that 56% rate ‘the quality and style of management in the SPDCS’ as ‘extremely or very important’ in motivating them to seek a post outside of the SPDCS. The survey does not provide sufficient detail on the nature of the management issues affecting retention, therefore this could require further investigation.

5.3 Satisfaction with the SPDCS

In the staff survey, respondents were presented with attitudinal statements about working life in the SPDCS. In Table 5.4 the percentage of respondents who agree with the statements ('Strongly Agree' or 'Agree' response) is shown and compared with the Mercer normative data for Britain as a whole and for the NHS in Britain.⁴

Table 5.4 Attitudes to Working-Life in the SPDCS

Attitudinal Statements	SPDCS 'Strongly Agree' & 'Agree' Response		Statistically significant positive (+) or negative (-) difference in SPDCS score compared to the Mercer norm scores	
	% of Respondents	Number of Respondents	Difference to NHS norm	Difference to National norm
40 Promotions are generally given to the most qualified employees in the SPDCS	41	417	+	+
41 Overall, I am confident that I will be able to achieve my long-term career objectives in the SPDCS	48	489	—	
42 I believe that the SPDCS as a whole is well managed	34	346	—	—
43 Senior management communicates a clear vision of the future direction of the SPDCS	24	224	—	—
44 My job gives me the chance to do challenging and interesting work	77	784	—	
45 My job makes good use of my skills and abilities	73	743	—	
46 I am paid fairly given my performance and contributions to the SPDCS	46	468		
47 I feel I am paid fairly compared to other people performing similar jobs in the SPDCS	45	458	—	—
48 I believe that the pay in the SPDCS is as good as or better than the pay offered elsewhere in NHS dentistry	19	193	—	—
49 I feel a strong sense of commitment to the SPDCS	66	672		+
	'Very Good' & 'Good' Response			
55 How do you rate your non-pay benefits (e.g. NHS Pension)?	74	753	+	+

⁴ The normative data were collected by asking a stratified sample of respondents working in Britain about their organisation. For question 48, these respondents were asked to compare pay in their organisation to pay in their 'industry' as a whole. Normative data are not available for questions 50-54.

Compared to both norms, SPDCS staff are more positive about:

- Their benefits (e.g. NHS pension)
- Promotions being given to the most qualified employees.

Compared to both norms SPDCS staff have more negative views about these topics:

- Belief that the SPDCS is well managed
- Communication of a clear vision of the future direction of the SPDCS
- Being paid fairly compared to others doing similar jobs in the SPDCS
- Belief that pay in the SPDCS is as good as or better than the pay offered elsewhere in the NHS.

In summary, the evidence from the staff survey indicates that retention is not a major issue for the SPDCS. Nevertheless, the analysis presented in this section does point out that among those thinking of leaving, concerns about salary and career progression are important drivers.

In the absence of trend data relating to staff turnover, creating awareness of these findings may be helpful. It is also worth noting that among those thinking of leaving, concerns about the quality and style of management are prevalent. Confidence that the SPDCS is well managed is below the normative levels and therefore this issue could require further investigation.

6

Career Progression

This section looks at the aspirations and expectations of SPDCS staff in relation to career progression and compares this with movement through the payscale and banding structure.

Career progression can either be achieved by promotion to a higher band or grade or through an incremental progression through the payscale. An initial point to note is that the free-form comments from the questionnaires indicated that there is confusion among dentists about whether they need a post-graduate qualification to achieve promotion to Senior Dental Officer.

6.1 Aspirations and Expectations

Longer-term career potential is cited by over a quarter of respondents (26%) as an extremely or very important reason for joining the SPDCS (Table 4.1). This is not among the most important reasons for joining the SPDCS, however, once in the service, 46% of respondents would like to move to a more senior level (Table 6.1). If Clinical Directors, who have reached the most senior level are excluded, the proportion is 50%.

Table 6.1 Desire to Move to a More Senior Level in the SPDCS

Do you wish to move to a more senior level in the SPDCS?	% of all respondents (n=955)	% of respondents, excluding Clinical Directors (n=819)
Yes	46.1	49.8
No	25.9	23.9
Don't know	19.1	21.1
Not applicable	9.0	5.1
Total	100%	100%

Table 6.2 shows that only 19% are confident of making career progress.

Table 6.2 Confidence Regarding Promotion in the SPDCS

Are you confident that you will reach a more senior level in the SPDCS?	% of all respondents (n=939)	% of respondents, excluding Clinical Directors (n=806)
Yes	19.2	20.6
No	35.5	37.7
Don't know	24.3	26.2
Not applicable	21.1	15.5
Total	100%	100%

6.2 Promotion

The average length of service in the SPDCS is 13 years and the data indicate that a significant proportion of dentists may spend most of that period without being promoted. As Table 6.3 shows, 38% of respondents have spent more than 8 years at the same grade. In the CDS the comparable proportion is 49%.

In the PDS 59% have been in their current grade for two years or less. This reflects the fact that dentists in the PDS will have only recently joined the SPDCS or might have been promoted on transferring into the PDS.

Table 6.3 Years in Current Grade

	% of all respondents (n=931)	% of CDS (n=577)	% of PDS (n=261)	% of all other respondents (n=85)
Up to 2 years	33	21	59	37
More than 2 years – 4 years	13	13	8	24
More than 4 years – 8 years	17	18	13	19
More than 8 years	38	49	20	21
Total	100%	100%	100%	100%

Table 6.4 shows that 50% of SPDCS staff expect to spend a total of over 12 years at their current grade (including service to date) and for Dental Officers, the grade with the greatest scope for promotion there are 47% of dentists with this expectation.

Table 6.4 Anticipated Total Years in Current Grade – Overall and for Dental Officers and Senior Dental Officers

Note: to create the data presented in table 6.4 the responses to question 8 (years in grade to date) were added to those from question 31 (number of future years respondent expects to work in current grade).

Anticipated Total Years in Current Grade	% of all respondents (n=670)	% of all DOs and other dentists on Band 1 salaries (n=362)	% of all SDOs and other dentists on Band 2 salaries (n=229)
Up to 3 years	11.0	13.0	9.6
More than 3 years – 6 years	16.4	18.8	11.4
More than 6 years – 12 years	22.5	21.0	24.9
More than 12 years	50.2	47.2	54.1
Total	100%	100%	100%

Both the structured interviews and the free form responses in the staff survey raised the issue of career ceilings. Many expressed a sense of frustration with the lack of scope for promotion without taking on a managerial/ administrative role. Two Clinical Directors strongly stated that they joined dentistry to practise and want an option to progress their career as a practitioner. At present it is felt that there is no scope to do this.

6.3 Movement Through the Payscale

Incremental career progression can be achieved by movement through the payscale. Practically, this would not be an issue if the payscale enabled DOs and SDOs to secure recognition and career progression through pay increments. However, the clustering of employees at the top of the payscale in these bands (Table 3.11) shows this is not the case. As mentioned by the interviewees this could have a number of damaging effects including:

- Placing managers into a position where they feel forced to promote staff just so that they can award them a salary increase.
- Demotivating staff as they may not feel recognised or rewarded for good quality work.
- Losing staff as managers feel constrained by the current structure and do not award justifiable pay increases as a dentist may already be at the top of their payscale for their band.

Comparison of Pay in the CDS and PDS

One key aim of the research was to determine whether dentists in the PDS are paid more than those in the CDS with similar levels of responsibility and experience. A comparison of salaries has been made for bands 1 and 2 as these are used for 89% of SPDCS dentists, thereby providing sufficient data for detailed analysis.

Pay in the CDS has been compared to pay in the PDS as a whole since the sample sizes are too small to separately analyse Dental Access Centres and Other PDS Pilot Projects.

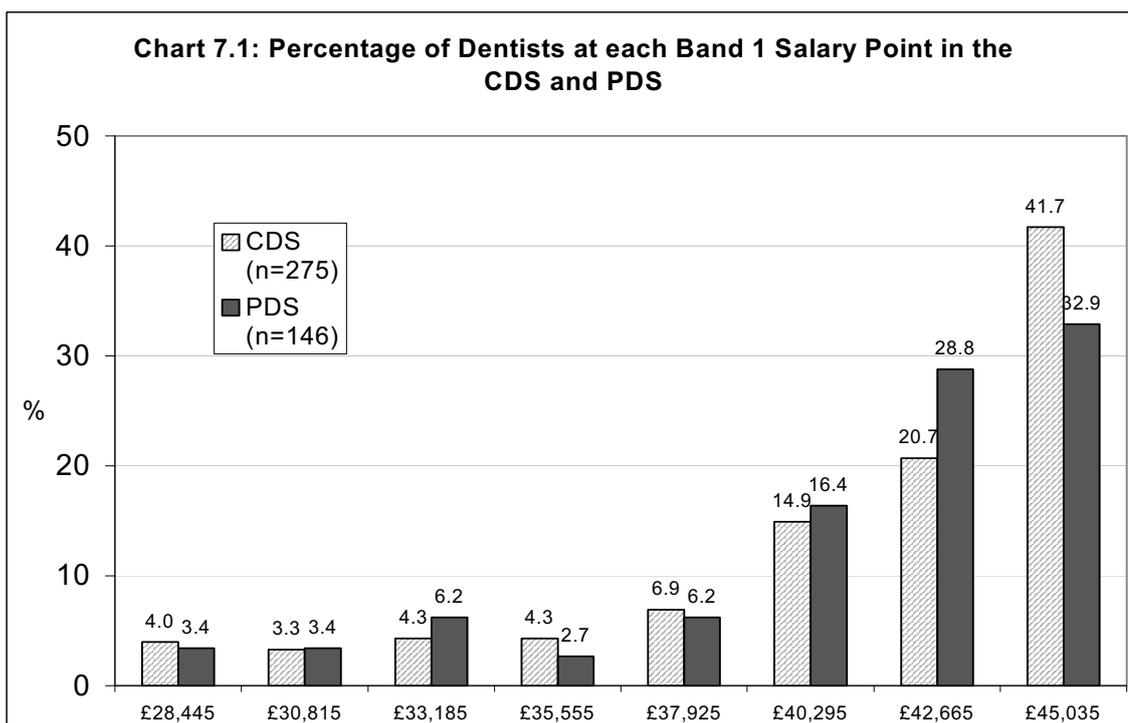
7.1 Band 1 Salaries

Chart 7.1 compares the distribution of band 1 salaries within the CDS and the PDS. The percentage of dentists in each service at the eight salary points in band 1 is shown.

The comparison of band 1 salaries in the CDS and the PDS reveals that the distribution of dentists across the band 1 salary points is similar. The average (mean) salary in the CDS – band 1 is £41,286, in the PDS it is £41,090. There is no statistically significant difference in the mean salaries.

- In total, 62% of CDS dentists are paid at the highest two salary points, which is the same as the proportion of PDS dentists, also 62%.
- A greater proportion of CDS dentists are paid at the highest band 1 salary point (42% in the CDS compared to 33% in the PDS), and more PDS dentists are paid at the second highest salary point (29% in the PDS compared to 21% in the CDS). These differences are not significant.

Chart 7.1 Distribution of Band 1 Salaries – CDS and PDS Compared



To investigate the relationship between salary levels and experience in dentistry, the experience level of dentists at each salary point has been examined. The experience levels reported in Tables 7.2 and 7.3, refer to the total number of years in dentistry since each dentist completed vocational training or since qualification, if vocational training was not undertaken.

Dentists have been clustered into three experience levels for this analysis. The clusters cover broad ranges of experience levels, but this is necessary to create groups with sufficient numbers of dentists to examine statistically significant differences in the data.

Table 7.2 Experience Levels of Band 1 Dentists in the CDS and PDS

Experience level in dentistry	% of band 1 respondents at each experience level		Mean number of years of experience within the defined experience level	
	CDS (n=273)	PDS (n=145)	CDS (n=273)	PDS (n=145)
5 years or less	14	21	3.1 years	2.9 years
More than 5 years to less than 15 years	17	27	10.0 years	9.4 years
15 years or more	69	52	24.0 years	25.0 years
Total/Mean years of experience	100%	100%	18.6 years	16.2 years

Table 7.2 shows that overall, the CDS employs a greater proportion of dentists with higher levels of experience, whereas the PDS tends to employ a greater proportion of less experienced dentists.

Among the populations of dentists within each experience level the average years of experience differs little. Because the experience bands are quite broad, there could have been variations within the bands.

Table 7.3 Percentage of Dentists with Specified Experience Levels at each Salary Point

Band 1 Salary Points	5 years or less experience		More than 5 years to less than 15 years experience		15 years or more experience	
	CDS (n=38)	PDS (n=30)	CDS (n=46)	PDS (n=39)	CDS (n=188)	PDS (n=76)
£28,445	18.4	10.0	2.2	2.6	1.6	1.3
£30,815	13.2	13.3	2.2	0.0	1.1	1.3
£33,185	26.3	20.0	2.2	5.1	0.0	1.3
£35,555	10.5	6.7	4.3	2.6	3.2	1.3
£37,925	15.8	6.7	8.7	12.8	4.8	2.6
£40,295	13.2	13.3	19.6	25.6	14.4	13.2
£42,665	0.0	23.3	26.1	28.2	23.4	31.6
£45,035	2.6	6.7	34.8	23.1	51.6	47.4
Total	100%	100%	100%	100%	100%	100%
Mean Salaries	£34,183	£36,819	£41,531	£40,963	£42,741	£42,790

Examination of the band 1 salaries of dentists with different levels of experience reveals:

- Among the most experienced dentists, with 15 or more years of experience:
 - ❖ The distribution of salaries and mean salaries of dentists in the CDS and PDS are similar (no significant difference).
 - ❖ The majority are paid at the top two salary points: 75% in the CDS and 79% in the PDS. Given that CDS dentists generally have long-service records within the SPDCS, these data reflect the movement of CDS dentists through the payscale over time (see also Table 6.4, which examines length of time in post). PDS dentists, working in a new service, but nevertheless with considerable experience, have moved into the PDS at the higher salary points.
- The distribution of salaries for those dentists with 5 to 15 years experience is similar, though a higher proportion of CDS dentists are paid at the highest salary point. The

mean salaries for this experience level are not significantly different, nor are the mean experience levels.

- Among the dentists with less than five years of experience, there are different distributions across the salary points in the CDS and the PDS. In the CDS only 3% of less experienced dentists are paid at the top two scale points, whereas 58% are paid at the bottom three points. In the PDS, 30% of less experienced dentists are paid at the top two points and 43% at the bottom three points (both are significant differences). On average a PDS dentist with less than 5 years experience is paid £2,636 more than a CDS dentist; a significant difference.

In the interviews with PCO management it was found that difficulties in the recruitment of dental officers into the SPDCS has required payment of salaries high up the payscale. This tactic may have been used more extensively in the PDS than the CDS.

Comparison of Band 1 Salaries: Summary

- The distribution of dentists across the band 1 salary points is similar in the CDS and the PDS, but more dentists in the CDS have 15 or more years experience in dentistry (Table 7.2).
- The majority of dentists in both services have considerable length of experience in dentistry and for the most experienced dentists, there is no difference in salary for those in the CDS and the PDS (Table 7.3).
- There are a relatively small number of dentists in the PDS, with less than five years experience who are paid at higher salaries than their counterparts in the CDS (Table 7.3).

This section has examined salary levels in relation to dentists' level of experience. It has not been possible to look at dentists' level of responsibility in detail, but it has been assumed that dentists paid at band 1 salaries have broadly similar responsibilities, which are different for those on band 2 salaries. Therefore, by examining separately, the distribution of band 1 and band 2 salaries there has been some recognition of responsibility levels.

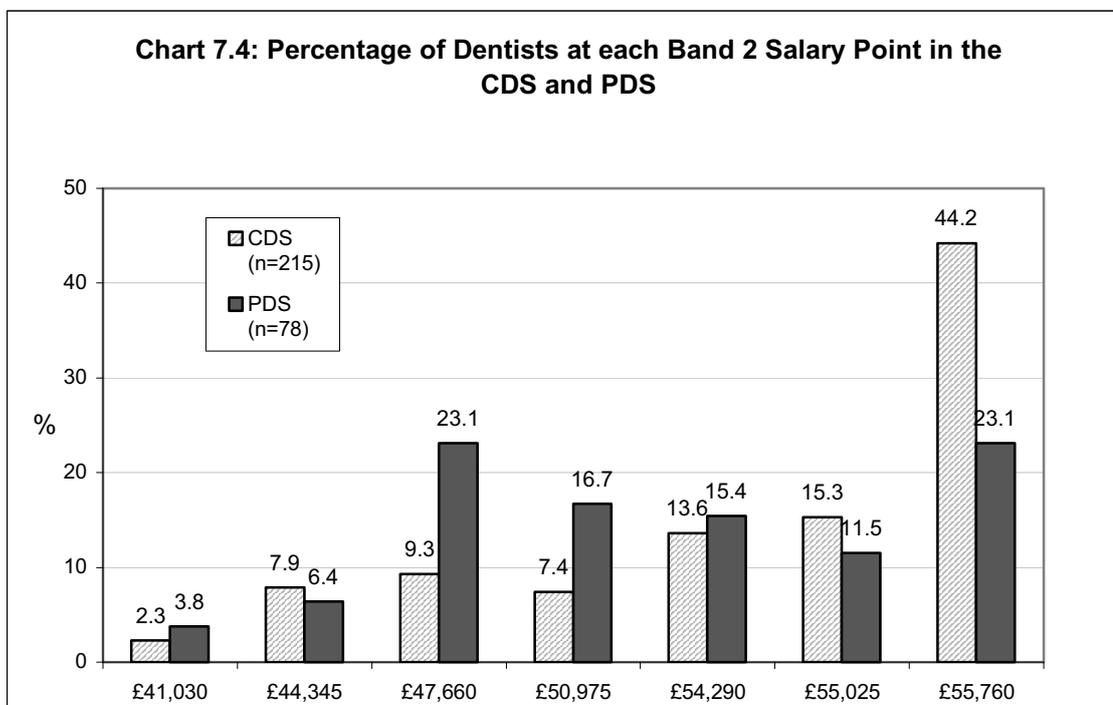
One aspect of job responsibility that does vary between the services is unsociable hours working. In the PDS, 26% of dentists work some contracted unsociable hours, whereas in the CDS it is only 4%: a significant difference. Of PDS dentists (band 1) with 5 years experience or less, 40% are contracted to work unsociable hours. This may help explain why, in some circumstances, the PDS are paid more.

As a footnote to this analysis it has been found that only 3% of CDS dentists would consider a career move to the PDS, though 22% of CDS dentists have applied for a new post in the SPDCS in the past two years. This indicates that movement into the PDS is not a widely sought option. Movement in the other direction, from the PDS to the CDS is more sought after, with 17% of PDS dentists interested in a move into an SDO role in the CDS.

7.2 Band 2 Salaries

The chart below shows the distribution of band 2 salaries within the CDS and the PDS. The percentage of dentists in each service at the seven salary points is shown.

Chart 7.4 Distribution of Band 2 Salaries – CDS and PDS Compared



The data show that:

- The proportion of band 2 dentists paid at both of the top two salary points in the CDS significantly exceeds the proportion in the PDS.
- Regarding the cumulative percentage of dentists at the top three salary points, 73% of CDS dentists are at these points, compared to 50% of PDS dentists (a significant difference).
- The average band 2 salary in the CDS is £53,082, which is significantly greater than that in the PDS of £51,484.

To investigate whether the CDS is simply paying extra for more experienced staff, the experience level of dentists at each salary point has been examined. The experience levels reported in Tables 7.5 and 7.6 refer to the total number of years in dentistry since each dentist completed vocational training or since qualification, if vocational training was not undertaken. The experience levels are different from those used in the analysis of band 1 salaries to reflect the greater experience levels of dentists paid using band 2 salaries.

Table 7.5 Experience Levels of Band 2 Dentists in the Two Services

Experience level in dentistry	% of band 2 respondents at each experience level		Mean years of experience within the defined experience level	
	CDS (n=213)	PDS (n=78)	CDS (n=213)	PDS (n=78)
10 years or less	9	19	7.5 years	6.8 years
More than 10 years to 20 years	39	44	16.0 years	16.8 years
More than 20 years	53	37	27.2 years	27.1 years
Total/Mean years of experience	100%	100%	21.2 years	18.7 years

The data show that the majority of band 2 dentists in both services are highly experienced, though there is a significantly greater proportion of the most experienced dentists in the CDS (with over 20 years of experience in dentistry).

Table 7.6 Percentage of Dentists with Specified Experience Levels at each Salary Point

Band 2 Salary Points	10 years or less experience		More than 10 years to 20 years experience		More than 20 years experience	
	CDS (n=18)	PDS (n=15)	CDS (n=82)	PDS (n=34)	CDS (n=112)	PDS (n=29)
£41,030	5.6	0.0	0.0	5.9	3.6	3.4
£44,345	22.2	20.0	11.0	2.9	3.6	3.4
£47,660	16.7	26.7	11.0	26.5	7.1	17.2
£50,975	5.6	40.0	7.3	8.8	8.0	13.8
£54,290	27.8	6.7	17.1	20.6	8.9	13.8
£55,025	5.6	6.7	11.0	11.8	19.6	13.8
£55,760	16.7	0.0	42.7	23.5	49.1	34.5
Total	100%	100%	100%	100%	100%	100%
Mean Salaries	£50,340	£49,256	£52,936	£51,602	£53,588	£52,498

Examination of the band 2 salaries of dentists with different levels of experience reveals:

- Among the most experienced dentists (more than 20 years experience), there are significantly more dentists at the top two salary points in the CDS (68.7%) in comparison with the PDS (48.3%). The average salaries for dentists with this level of experience are not significantly different.
- Among the dentists with between 10 and 20 years of experience:
 - ❖ The average salaries in the two services are similar (not significantly different).
 - ❖ There are more dentists at the top two salary points in the CDS (53.7%) in comparison with the PDS (35.3%), but this difference is not significant (due to the small sample size involved).
- Among the dentists with 10 years or less experience there are significantly more dentists at the top three salary points in the CDS (50.1%) in comparison with the PDS (13.4%).

Comparison of Band 2 Salaries: Summary

- Experience levels in the CDS are greater than the PDS (Table 7.5) which in part explains why the average band 2 salary is greater in the CDS (Chart 7.4)
- The average salary levels in the CDS are slightly, but not significantly higher than those in the PDS within the three levels of experience defined, which indicates that the overall difference between the CDS and PDS average salaries is related to the level of experience (Table 7.6).
- There are more CDS dentists than PDS dentists paid at points at the top of the scale at each experience level – the differences are significant for the most and least experienced dentists. It is not clear why this occurs – it may relate to different levels of responsibility in the two services, which have not been identified in this research (Table 7.6).
- PDS dentists are not paid more than CDS dentists for similar levels of experience (Table 7.6). Focusing on the most experienced dentists reveals that the reverse is true, which as noted, may relate to different responsibilities in the CDS.

Summary of Findings

8.1 Advise on the recruitment and retention situation, career progression and the use of the payscale

8.1.1 Recruitment and Retention

The research has found that the retention situation is not currently problematic for the SPDCS. The number of staff considering leaving is at the same level as Mercer's normative data for Britain and the NHS. In contrast, managers feel that there is a recruitment problem, which is also identified by the BDA research.

8.1.2 Career Progression

Long-term career potential is not a major factor attracting dentists to the SPDCS. However, there is clear evidence of career ceilings operating within the salary bands. Frustrations regarding a lack of career progression and associated salary progression are the main reasons cited by dentists for seeking another post outside of the SPDCS.

8.1.3 Use of the Payscale

The distribution of dentists across the payscale has been documented by this research. Dental Officers and Senior Dental Officers are clustered at the top of the pay band, which is indicative of the career ceilings discussed above. Salaries at the top of band 1 are being offered to those in the Dental Officer pay band, particularly by the PDS, to attract applicants.

8.2 Uncover where pay, and other factors, fit into the picture of any recruitment and retention difficulties in the SPDCS

8.2.1 Pay and Recruitment Difficulties

The study revealed a recruitment difficulty, particularly at the DO level, with the key issues cited being the unpopular locations of some of the vacancies and a general shortage of available dentists. The BDA research has found recruitment difficulties at SDO level, though there is no evidence of this for Assistant Clinical Directors and Clinical Directors. The existence of career ‘ceilings’ at DO and SDO level implies that there is a supply of dentists available for management positions.

Only 20% of all SPDCS respondents and 13% of CDS respondents said that salary level was the most important factor attracting them to the services. This finding is difficult to interpret on its own, but management interviewees reported a common perception that SPDCS salaries are low, and SPDCS dentists have somewhat negative views about the fairness of their salary. In combination these findings indicate that serving dentists were attracted to the SPDCS by factors other than money and are willing to tolerate a salary they consider low.

What is not known is how many dentists do not apply for roles in the SPDCS due to current salary levels. The recent use of the payscales within the service may indicate that the payscales do not reflect prevailing market rates. In this respect, it should be noted that only 19% of SPDCS dentists believe their pay is ‘as good as or better than’ the pay offered elsewhere in NHS dentistry. New entrants are being brought in towards the top of the scale leading to the view that the higher levels of pay are needed to attract higher numbers of suitable applicants for DO positions. This study has revealed no evidence that the payscales for SDOs, Assistant Clinical Directors and Clinical Directors create recruitment problems, but if the need to appoint DOs higher up the payscale continues then this will impact on the attractiveness of salaries for more senior grades.

8.2.2 Other Factors and Recruitment Difficulties

The key factors attracting dentists to the SPDCS are the vocational desire to provide a good service to patients and to serve the community. The security of a salaried income is also important. In the management interviews, the opportunity for flexible working arrangements was reported to be important as well as having opportunities for on-the-job coaching from experienced dentists.

The factors that appear to inhibit recruitment are:

- Location of vacancies – dentists are often unwilling to move from their home or area where they trained. In remote locations dentists also have more on-call commitments and may work in smaller teams with few experienced dentists to provide coaching and support.
- An overall shortage of dentists.
- Uncertainty about the future of the SPDCS - for those potential recruits looking for long-term, stable employment this may be an inhibiting factor.
- Lack of a co-ordinated structure and process for recruitment of overseas dentists.

8.2.3 Pay and Retention Difficulties

The study did not reveal significant retention problems within the SPDCS and 'intention to leave' matches normative data. However, trend data is not available to determine whether this level of commitment is stable over time.

For those who are seriously considering leaving the SPDCS a desire to improve salary/financial reward is the most important factor.

8.2.4 Other Factors and Retention Difficulties

Evident sources of frustration which motivate SPDCS dentists to seek other posts are a lack of career progression opportunities, the quality and style of management in the SPDCS and the inability to make use of one's skills and abilities in the job.

8.3 Address the particular issue of whether those in PDS are paid more than those in the CDS with similar levels of responsibility and experience

The data show in general that the PDS and CDS dentists are within the same pay bands for similar levels of experience (length of service since qualifying). The CDS employs a greater proportion of dentists with higher levels of experience, however for dentists paid at band 1 salaries this may be a reflection of the length of time that both services have been in existence and that over time this is likely to equalise.

Closer examination of the payscales within band 1 shows a difference in pay for dentists with less than five years post-qualifying experience. Within the CDS only 3% are paid at the top two scale points and 58% are paid at the bottom three points, whereas in the PDS 30% are paid at the top two point points and 43% are paid at the bottom three points. This shows that the PDS is paying its less experienced dentists significantly more than the CDS. This may in part be due to the fact that more PDS dentists than CDS dentists are contracted to work unsociable hours. It could also be a result of the PDS needing to attract a number of band 1 dentists within a short timescale, so a higher payscale point has been used to match prevailing market rates. A number of managers stated that they currently need to use the top points in band 1 to recruit dental officers.

Examination of the payscales within band 2 shows that dentists in the PDS are not paid more than those in the CDS with similar levels of experience. The evidence suggests the opposite might be the case, which may be due to dentists in the two services having different responsibilities.

The analysis presented in this report examined salary levels in relation to dentists' level of experience. It has not been possible to look at dentists' level of responsibility in detail, but it has been assumed that dentists paid at band 1 salaries have broadly similar responsibilities, which are different for those on band 2 salaries. By examining separately the distribution of band 1 and band 2 salaries there has been some recognition of responsibility levels, but as noted in the previous paragraph, more detailed investigation of responsibility levels may be required to explain possible differences in salaries, particularly for those paid within band 2.

MERCER
Human Resource Consulting

Dexter House, 2 Royal Mint Court
London EC3N 4NA
020 7488 4949

Mercer Human Resource Consulting Limited is regulated by the Financial Services Authority
and is a member of the General Insurance Standards Council

Registered in England No. 984275 Registered Office: Telford House, 14 Tothill Street, London
SW1H 9NB

Mercer Human Resource Consulting



INVESTOR IN PEOPLE

Appendix 1

9 September 2002

Structured Interview Report

Review Body on Doctors' and Dentists' Remuneration

MERCER

Human Resource Consulting

Contents

1. Executive summary.....	1
2. Introduction and methodology.....	3
▪ 2.1 Objectives	3
3. Recruitment.....	5
▪ 3.1 The issues.....	5
▪ 3.2 Current practices to address recruitment issues	6
▪ 3.3 Interviewees' views on what more can be done to address recruitment issues ..	7
4. Retention	10
▪ 4.1 The issues.....	10
▪ 4.2 Current practices to address retention issues	10
▪ 4.3 Interviewees' views on what more can be done to address retention issues ...	11
5. Use of the payscale	13
▪ 5.1 The issues.....	13
▪ 5.2 Current practices to address issues around use of the payscale	14
▪ 5.3 Interviewees' views on what more can be done to address these issues	14
6. Career progression	15
▪ 6.1 The issues.....	15
▪ 6.2 Current practices to address issues around career progression.....	15
▪ 6.3 Interviewees' views on what more can be done to address these issues	15
Appendix A	
7. Interview questionnaire.....	16
Appendix B	
8. Other topics.....	18

Executive summary

This section provides an overview of the key themes from the nine structured interviews with senior managers. Mercer used a structured interview template, for consistency of delivery and to avoid leading the interviewee (see Appendix A). This was performed by Mercer consultants experienced in structured interview techniques.

Recruitment

- interviewees believe recruitment to be the most critical issue of the four areas in this research.
- there is a perceived shortage of all types of dentist throughout the GB market.
- the SPDCS competes with the rest of the National Health Service (NHS), dental bodies corporate and private practice to source dentists.
- all these other areas are perceived to offer a better pay and benefits package than the SPDCS.
- suggested solutions to alleviate recruitment concerns included:
 - more localised dental schools
 - enhancing regional networks to support and co-ordinate recruitment efforts
 - paying the perceived market value for SPDCS roles
 - being able to source skilled dentists from overseas.

Retention

- retention is not perceived to be a significant cause for concern for the SPDCS overall. Where there are issues, these are mainly to do with increasing pressure due to workloads and poor pay and recognition.

Use of the payscale

- pay levels are not deemed market competitive and as a result are believed to fail to attract applicants for vacancies.
- there are pockets of demand for performance-related rewards. However, there is concern that the chosen criteria against which performance is assessed may compromise quality of patient care in favour of speed of throughput.
- no clear vision as to what the solution to the issues of pay and reward should be.

Career progression

- career progression and promotion opportunities are perceived to be limited due to the flat grading structure and lack of available SDO vacancies.
- interviewees felt SPDCS staff sought more scope to progress as practitioners rather than having to take on people and administrative management responsibilities to develop their careers.
- some interviewees expressed a desire to develop a technical career path for those dentists who want to stay in practice.

2

Introduction and methodology

2.1 Objectives

Mercer Human Resource Consulting (Mercer) has been appointed by the Office of Manpower Economics (OME) on behalf of the Review Body on Doctors' and Dentists' Remuneration (DDRB) to conduct a research project within the Salaried Primary Dental Care Services (SPDCS) in Great Britain with the following objectives:

- Advise on the recruitment and retention situation, career progression and the use of the payscale;
- Uncover where pay, and other factors, fit into the picture of any recruitment and retention difficulties in the SPDCS;
- Address the particular issue of whether those in the Personal Dental Services (PDS) are paid more than those in the Community Dental Service (CDS) with similar levels of responsibility and experience.

The research was conducted in three stages:

Stage 1 of the project involved structured interviews with managers of Primary Care Organisations (PCOs) and Clinical Directors within the SPDCS.

Stage 2 involved a staff survey of all SPDCS dentists, conducted by postal questionnaire.

Stage 3 involved final qualitative interviews to validate the survey results.

This report documents a summary of our findings for **Stages 1 and 3**. These findings are grouped into broad themes to maintain the anonymity of interviewees. A full list of interviewees is held by the DDRB secretariat.

The project team selected interviewees based on the recommendations of the NHS Confederation, the British Dental Association (BDA) and Department of Health (DoH). In addition interviewees were selected in accordance to geographical location some geographical spread throughout England and Scotland (although no respondents were

available in Wales for Stage One) and availability. Primary Care Managers were selected where possible instead of Clinical Directors, as data from these participants had already been collated by the BDA as part of a separate survey.



3

Recruitment

3.1 The issues

A variety of factors in combination make recruiting into SPDCS roles difficult and it was reported that posts are remaining vacant for between 6-18 months before suitable applicants are found. Interviewees attributed this to a combination of the following factors:

Location

Location is the most frequently cited obstacle to recruitment. The lack of proximity to a dental school invariably proves problematic for PCOs. Potential recruits are often unwilling to move far from their home or the area in which they studied to find work. Posts in remote or isolated areas are even harder to recruit into as working in these areas often means dentists are on-call all year round as they will each be the only NHS dentist in an area.

Location is also an issue for PCOs positioned near more ‘desirable’ areas (e.g. cities). They feel their recruitment situation is particularly challenging. An issue raised by a large number of our interviewees is that they feel the current framework forces PCOs to compete for staff with neighbouring regions. They feel this competition between NHS bodies hinders the service’s ability to work efficiently and effectively.

Competition

Competition with other “easier and better paid” work in the private sector has been a long standing factor which impacts on the recruiting success of the SPDCS. Most PCOs advertise their vacancies in a range of media including professional journals, through universities, at open days and by word of mouth, but all with limited success. One interviewee spoke of advertising SPDCS roles in journals as being virtually pointless

because adverts for SPDCS roles are placed next to adverts for dentists in other sectors of the industry, with the former appearing less favourable for two reasons:

- they are judged in terms of remuneration alone.
- the sheer volume of adverts that are placed for SPDCS roles reflects badly as this presents an unsettling picture to potential new recruits showing many shortages.

A more recent trend in this area is the rise of the ‘dental bodies corporate’ (e.g. Boots). ‘Corporates’ provide an alternative salaried role for those who are looking for the financial security of salaried work. In one region a corporate was aggressively recruiting by sending mailshots to SPDCS dentists’ home addresses in an attempt to ‘poach’ PCO staff.

Pay

Almost all PCO budgets are under pressure to reduce costs, which in turn impacts upon what can be done to recruit and retain staff. The salaries being offered to potential recruits are seen as being “derisory” for Dental Officer (DO) roles, and “less than a dental hygienist gets in the private sector”. In one area “Dental Officer posts are no longer being offered as they will not be filled” due to the pay levels.

3.2 Current practices to address recruitment issues

Recruitment strategies vary between PCOs but all those interviewed stated they offered dentists flexibility in the way they work. The following strategies are used to a lesser extent at some of the PCOs with their use dependent on the skills, resources and contacts at a PCOs disposal.

Flexibility

Flexible working arrangements are offered by all PCOs to varying degrees in order to attempt to attract staff. Practices including family friendly policies, job shares, out of hours working, evening surgeries, flexible weekly hours to fit around childcare arrangements and term time working. Where relevant some also had retired staff returning to practise for one or two days a week. Interviewees generally felt that of all the recruitment and retention strategies at a PCO’s disposal, offering flexibility was amongst the most effective.

Pay

The majority of interviewees paid their dentists at the top end of the payscale to attract staff at every level. One interviewee stated that “this is the only way to get people to even consider joining” their practice. Where relevant, additional allowances are also paid to

encourage applicants to join, including temporary accommodation support, lease car schemes and relocation allowances.

Recruitment advertising

A small number of PCOs where we carried out interviews have focused their efforts in this area. Advertisements have sold the benefits of a particular geographic location. The effectiveness of advertising has not been measured so although no definite conclusions can be drawn, recruiters feel that overall this approach has had some success. One PCO held a recruitment open day event that proved to be successful as three vacancies were filled as a direct result of the day.

Training

Training is seen as one solution to recruiting SPDCS dentists, and is being actively used to recruit Vocational Dental Practitioners (VDPs). The ability to use this approach depends on the financial and other resources available to the PCO. Where the ratio of Senior Dental Officers (SDOs) to VDPs is high and the skill base of SDOs is strong, this approach has proved to work most effectively. PCOs with a strong reputation for training feel they have little problem in attracting staff (the number of applications for vacant posts is relatively high).

Recruiting overseas dentists

A third of those interviewed have tried recruiting dentists from overseas. Most saw this as a good potential solution to addressing staff shortages. However, interviewees currently find the process around securing work permits particularly obstructive, and there is little structure or process to ensure the staff with the right skills and qualifications can be easily sourced and hired from overseas.

Despite the variety of strategies employed to address recruitment problems for SPDCS staff, the interviewees viewed recruitment as a continuing challenge. None of the strategies, either alone or in combination, had made sufficient impact on the recruitment situation.

3.3 Interviewees' views on what more can be done to address recruitment issues

Interviewees were asked their views on how best their recruitment problems could be addressed. These are detailed below (with the most commonly cited recommendations listed first):

Local dental schools

In the longer term, having a greater number of dental schools with a more even geographical spread could be a solution to overcome the problem of graduates being reluctant to move away from the area in which they studied.

Regional networks

Creating regional networks to share information and informally agree recruitment conditions could reduce competition for staff. PCOs competing with one another in neighbouring regions can result in a 'wage spiral' and undermines the extent to which NHS provision can work effectively for the interests of its patients.

Reward and recognition

Most interviewees quoted remuneration as one of the major factors that would ease the recruitment situation. Exactly what form this reward should take varied from one PCO to another. The most significant themes are:

- offering a market competitive salary, although no definition of what the comparison market might be was given.
- recognising community dentistry as a speciality and rewarding for that speciality.
- supporting graduates through their studies in return for a contractually agreed period of work within the sponsoring PCO, post qualification.

Raising awareness

CDS and PDS roles are only well perceived by those who have had experience of the nature of work. Many interviewees felt that others have a low appreciation of the work. Raising awareness about the specialised (and often unique) work and benefits that they provide to the community could be more actively used to help attract more dentists to this area of work.

Recruiting overseas dentists

Interviewees thought recruiting abroad is an option that needed exploring further. The experience of PCOs to date suggests that some countries are harder to recruit from than others, both in terms of valid qualifications and immigration bureaucracy. Providing a clear process and structure to ease the difficulty of recruiting good overseas people was identified by a third of those interviewed as being a potential solution to the current recruitment situation.

Supporting relocation

The financial and administrative burden of relocation could be eased for potential new employees to encourage them to move to a new area. Although no respondent said that the relocation allowance was too low, assisting new employees with more than just the financial support i.e. for travel arrangements, accommodation, finances and contact information, would make relocation more of an attractive option for applicants.

4

Retention

4.1 The issues

Although exit interview data was not gathered by most, managers did however feel they had a good understanding of why people left. Some reasons fell outside the sphere of a manager's control e.g. staff leaving as their spouse's job required them to move from the area. Other reasons for staff turnover included:

- the lack of promotion opportunities. The small number of Clinical Director (CD) roles and the lack of staff turnover result in little promotion opportunity within the same workplace. The highest level of turnover is amongst those looking to move into CD roles.
- the lack of up-to-date technology and equipment.
- the completion of a training period (VDPs).
- the lack of market competitive pay has meant some dentists have moved into better paid areas of dentistry.

Although the above may provide some idea about contributors to staff turnover, it is important to re-iterate that retention was not seen to be a major issue for interviewees.

4.2 Current practices to address retention issues

At the highest level, the variety and type of work (particularly in the CDS) promotes job satisfaction which in turn leads to retaining staff. However in addition to the above, the following are utilised:-

Quality focus

Retention is strong as there is felt to be less focus on “time taken per patient” as a performance measure for SPDCS staff compared with other areas of dentistry. This results in less time pressure on dentists and enables them to focus on quality, and work at a rate that meets the needs of patients.

Flexible working arrangements

Flexible working arrangements (see previous section 3.2) were also seen to be a significant contributor to staff retention as they enable staff to secure a better work-life balance.

Team working

One interviewee felt the growth of the PCO into a larger service has brought “the buzz of working in larger teams” with it. This PCO manager saw a positive team working environment as a direct contributor to staff retention.

Investors in People (IiP)

Where PCOs are working within the IiP framework, a small number of interviewees felt strong people management practices were contributing to staff retention. No further detail was provided to support this point.

4.3 Interviewees’ views on what more can be done to address retention issues

A range of ideas were put forward by interviewees. Responses varied according to interviewees’ local context and personal interests/ motivations. Feedback included the following themes:

Clarifying roles

The need for greater clarity from governing bodies was seen as a solution to addressing retention issues. Narrowing the definition and/or confirming the scope of the CDS, PDS and General Dental Services (GDS) services is required “so that the work of PDS dentists is not seen as a catch all safety net service for when other areas cannot/ will not pick up the pieces”. Clarifying roles could enable PCOs to plan resources more effectively and reduce the pressure of workloads on existing staff - a pressure seen as “a risk with the potential to negatively impact staff turnover”.

Tying in graduates

A proportion of interviewees felt that tying in graduates post qualification would be the best way to retain newly qualified dentists - this would also ensure that PCOs could secure a degree of return on their training investment.

Reward and recognition

A small number mentioned performance-related reward as a solution to retain SPDCS staff. While interviewees agreed that this was a good idea in principle there were serious concerns about how this can be effectively addressed. Interviewees questioned the kind of performance measures to be used to recognise the right kind of performance, i.e. performance that would benefit patients and provide them with a quality service. All who expressed an interest in performance pay were firmly against a “patients per hour” measure for SPDCS work.

It was also felt that further efforts need to be made to encourage part-time working with “good” pay, and training posts for those who are returning to work.

In addition to the above interviewees feel that in order to continue to retain staff, PCOs should continue to offer good pension provisions, flexible working arrangements and maternity/paternity leave.



5

Use of the payscale

5.1 The issues

Uncompetitive payscale

There was a perception that CDS pay does not reflect the market position and is insufficient to attract dentists. The DO payscale was deemed to be so low that one interviewee expressed that they will no longer recruit at this level.

Inflexible payscale

Post qualification pay for newly qualified staff is not sufficient to meet their pay expectations. This is added to by competition between PCOs for this group of staff. The solution for one PCO was to offer two spine point increments upon qualification.

Similarly, as the formal application of the payscale is inflexible, there is no way to target pay and reward for exceptional recruits or, if there is a post in a remote or isolated location, offer an attractive level of reward.

Lack of recognition for performance

Historically promotion is driven by length of service. In practice this has resulted in anomalies as there is potential for staff with long service (but lesser skills) to be further up the payscale.

With the incorporation of discretionary pay points into the payscale there is no way to motivate and reward higher performance and higher levels of skills/competence or speciality.

One respondent commented that the re-introduction of discretionary pay points would be demotivating for those categorised as poor performers and not awarded the points.

Inconsistent reward practices

The inconsistent use of allowances and bringing in some new recruits higher up the payscale than their skills and competence may justify, distorts the consistency, transparency and equity of the pay structure. The *ad hoc* awarding of allowances (also used to attract staff) distorts the pay structure further.

Two respondents mentioned a perceived pay disparity between the PDS (who they felt were paid more) and the CDS. The position of PDS dentists on the scale is also perceived as closer to the market position than the CDS. One interviewee commented how it “seems outrageous that the PDS get more money than the CDS for a less skilled job”.

5.2 Current practices to address issues around use of the payscale

Some PCOs have worked within the confines of the payscale across regions to prevent a ‘wage war’, forcing the regions to offer a *de facto* maximum payscale, operating their own ‘cartel’ to prevent wages spiralling upwards.

5.3 Interviewees’ views on what more can be done to address these issues

Most interviewees thought that the current discretionary increments for continued effective performance worked well. However, some had strong feelings that an increment for exemplary performance would be beneficial.

Similarly it was thought that there is a greater need to reflect the particular circumstances of the role, for example by providing benefits such as an emergency allowance and out-of-hours allowance.



6

Career progression

6.1 The issues

Interviewees feel that there are not enough senior posts to move into. It is also perceived that PCOs have little scope to recognise people by awarding promotion. One interviewee said that this is “a Cinderella service that offers no status and no career progression”.

Some interviewees feel there is only one route for SPDCS dentists to further their careers which is by moving to a managerial role. In their view this does not suit dentists who want to remain as dental practitioners, as there was a desire for dentists to be able to progress within dentistry rather than having to move into administrative / managerial roles. Most interviewees were unaware that the need for a qualification to be promoted to SDO from DO had been removed.

6.2 Current practices to address issues around career progression

There were no specific responses as to how to address career progression.

6.3 Interviewees’ views on what more can be done to address these issues

Interviewees perceive a need to develop a technical career path for those dentists who want to stay in practice. At present the only route for promotion is to move up into a managerial / administrative role.

Appendix A

Interview questionnaire

Listed below are the interview questions approved by the OME.

Background

Can you briefly describe your role in the SPDCS?

Strategy

- 1 What are the Primary Care Organisation's (PCO's) key objectives with regard to primary dental case services?
- 2 What factors are critical to successfully achieving this PCO's current and future objectives. And why?
- 3 What are the main challenges for this PCO with regard to primary care dentistry over the next three years?

Recruiting dentists

- 1 Can you describe the recruitment problems you face with the SPDCS in your PCO. Why do you face these problems?
- 2 How do you think your recruitment situation for the SPDCS dentists compares with other PCOs and other service areas of your PCO?
- 3 What do you currently do to alleviate these recruitment problems in the SPDCS and how well have these measures worked?
- 4 In your opinion how can the SPDCS recruitment problems be effectively

addressed, both nationally and locally, in the longer term?

Retaining dentists

- 1 Can you describe some of the SPDCS problems you face in this PCO and why?
- 2 How do you think your experience of retaining SPDCS staff here compares with other SPDCS PCOs?
- 3 What do you currently do to alleviate the SPDCS retention problems and how well have these measures worked in your opinion?
- 4 In your opinion how can these retention problems be effectively addressed in the longer term?
- 5 Are there any other recruitment, retention or career progression issues which we have not discussed?

Other topics

A wider range of topics were raised that were not within the structured interview, and a brief précis of the main points are listed below.

- Most of the interviewees did not feel that they knew too much of what was going on in other PDS pilots, and one specifically mentioned the possibility of a PDS ‘link person’ as a forum to share information.
- The initial PDS pilots were established for three years, but this has been extended on a two year rolling basis so that the PDS could continue for 5, 7, or 9 years, and review of the situation is ongoing. Commitment from central authorities would help allay concerns and resolve the temporary basis of the service.
- One interviewee saw the role of the PDS as being at the forefront of developing best practice on “useful” information technology (IT), that can then be cascaded to private practice, thereby improving the standing of the service.
- Several interviewees mentioned that “the ‘Options for Change’ report does need to be acted upon”, though there was not time in the interviews to provide detail.
- The Clinical Directors are taking on expanded roles in contrast to regional CDS roles, and this “needs to be recognised”.
- Interviewees did not offer information regarding salaried GPs in isolation in the context of a PCO.
- Finally, although focusing on dentists there are other factors outside of the direct scope of the study that were mentioned:-

- “Nobody can get hygienists for love nor money”. Although not directly related it is seen as a contributing factor, as a hygienist may be able to remove some burden on the service.
- “If therapists are allowed to work in general practice then this could be a threat for the future”.
- “Due to the lack of GDS dentists there is now an increasing amount of emergency work as routine treatment is not available”.
- “We need quality support staff for everybody in the team to maximise efficiencies”.

MERCER

Human Resource Consulting

Dexter House, 2 Royal Mint Court
London EC3N 4NA
020 7488 4949

Mercer Human Resource Consulting Limited is regulated by the Financial Services Authority and is a member of the General Insurance Standards Council

Registered in England No. 984275 Registered Office: Telford House, 14 Tothill Street, London SW1H 9NB



Appendix 2

SALARIED PRIMARY DENTAL CARE SERVICES (SPDCS): STAFF SURVEY

Welcome

Welcome to the Staff Survey for the Salaried Primary Dental Care Services. This survey explores topics related to your job and career. Please respond candidly as the confidentiality of your responses is guaranteed by Mercer Human Resource Consulting Limited.

If you are a dentist working in more than one job, please consider your main job in the SPDCS when answering.

Salaried Primary Dental Care Services (SPDCS) - Definition

The salaried primary dental care services comprise the Community Dental Service, the Personal Dental Services - Pilots, and salaried General Dental Practitioners. The umbrella term for all these services is the SPDCS.

Instructions for completing the questionnaire

Most of the questions require you to select your response from options that are listed. Please mark your response by placing an 'X' in the appropriate box. Please use blue or black ink or a dark pencil.

Other questions require a written response. Please write clearly in capital letters.

Questions about You, Your Service and Location

1 What is your gender? Male Female

2 What is your age (in years) ? _____

3a In which service do you work, in your main SPDCS job? If you work in more than one service, please indicate in which you spend the majority of your time.

Community Dental Service (CDS)	<input type="checkbox"/>	Salaried General Dental Practitioner (GDP) (Including senior/specialist GDPs in Scotland)	<input type="checkbox"/>
Personal Dental Service (PDS) - Dental Access Centre	<input type="checkbox"/>	Joint CDS/GDS Dentist (Scotland & Wales only)	<input type="checkbox"/>
Personal Dental Service (PDS) - Other pilot project	<input type="checkbox"/>	None of the above (Please specify)	<input type="checkbox"/>

3b For PDS dentists only: are you self-employed or salaried? Self Employed Salaried

4 In which (former) health region do you work?

English Regions

Northern and Yorkshire	<input type="checkbox"/>	Eastern	<input type="checkbox"/>
North West	<input type="checkbox"/>	South Eastern	<input type="checkbox"/>
West Midlands	<input type="checkbox"/>	London	<input type="checkbox"/>
Trent	<input type="checkbox"/>	South West	<input type="checkbox"/>

Scotland and Wales

Scotland	<input type="checkbox"/>	Wales	<input type="checkbox"/>
----------	--------------------------	-------	--------------------------

5 Which type of community do you predominantly serve?

- | | | | |
|------------------------------|--------------------------|--|--------------------------|
| Rural community | <input type="checkbox"/> | Urban community - other (e.g. market town) | <input type="checkbox"/> |
| Urban community - inner city | <input type="checkbox"/> | Mixture of communities | <input type="checkbox"/> |
| Urban community - suburban | <input type="checkbox"/> | | |

Your Career History

In this section, for questions 6, 7, 8 and 13 please state number of years, rounded to the nearest half-year.

6 How many years have you spent in dentistry since completing vocational training, or since qualification if you did not undertake vocational training? _____

7 How many years have you worked in salaried primary care dentistry? _____

8 How many years have you been in your current grade? _____

9 Which of these dental qualifications do you hold in addition to BDS or LDS? Please state year acquired.

Qualification	'X' if held	Year Acquired
a. Diploma in Dental Public Health	<input type="checkbox"/>	_____
b. FDS (Fellowship in Dental Surgery)	<input type="checkbox"/>	_____
c. MFDS	<input type="checkbox"/>	_____
d. FDS (Specialism)	<input type="checkbox"/>	_____
e. MRD	<input type="checkbox"/>	_____
f. MSc	<input type="checkbox"/>	_____
g. MOrth	<input type="checkbox"/>	_____
h. FOrth	<input type="checkbox"/>	_____
i. M Clin Dent	<input type="checkbox"/>	_____
j. M Surg Dent	<input type="checkbox"/>	_____
k. MGDS/MCCD	<input type="checkbox"/>	_____
l. MFGDP (DGDP)	<input type="checkbox"/>	_____
m. MPaed Dent	<input type="checkbox"/>	_____
n. MCDH	<input type="checkbox"/>	_____
o. Management qualification (e.g. MBA, Dip HS Management)	<input type="checkbox"/>	_____
p. Other dental qualification	<input type="checkbox"/>	_____

- 10 Are you on a specialist list for Dental Public Health? Yes No
- 11 Are you on a specialist list for a clinical subject? Yes, on one list Yes, on 2 or more lists No
- 12 Are you currently studying for a registerable post-graduate dental qualification? Yes No
- 13 What previous posts have you held? Do not list your current post.

Type of Post	Previously held this post	No. of years in post (rounded to nearest half year)
<u>Vocational Training</u>		
a. VDP/GPT or other paid training post	<input type="checkbox"/>	_____
<u>SPDCS</u>		
b. Dental Officer	<input type="checkbox"/>	_____
c. Senior Dental Officer	<input type="checkbox"/>	_____
d. Assistant Clinical Director	<input type="checkbox"/>	_____
e. Clinical Director	<input type="checkbox"/>	_____
f. PDS Dentist	<input type="checkbox"/>	_____
g. Salaried GDP (including senior/specialist GDPs)	<input type="checkbox"/>	_____
<u>General Dental Service</u>		
If you have worked in the GDS <u>and</u> worked privately at the same practice, include this time here.		
h. GDS - Assistant	<input type="checkbox"/>	_____
i. GDS - Associate	<input type="checkbox"/>	_____
j. GDS - Practice Owner/Partner/expense sharer	<input type="checkbox"/>	_____
<u>Hospital Dentistry</u>		
k. House Officer	<input type="checkbox"/>	_____
l. Senior House Officer	<input type="checkbox"/>	_____
m. Specialist Registrar/Registrar/Senior Registrar	<input type="checkbox"/>	_____
n. Consultant	<input type="checkbox"/>	_____
o. Non-consultant career grade (staff grade, associate specialist)	<input type="checkbox"/>	_____
p. Clinical Assistant/Hospital Practitioner	<input type="checkbox"/>	_____
<u>Other Dentistry</u>		
q. Wholly Private Dentistry (Do not include here time spent in private practice whilst jointly working in the GDS)	<input type="checkbox"/>	_____
r. Other	<input type="checkbox"/>	_____

14 Were you recruited into the SPDCS from outside the United Kingdom? Yes No

15 How important were the following factors in attracting you to a career in the SPDCS? (Please try to only choose the rating 'extremely important' for the one or two most important factors). Note that Q. 17 asks about your perspective on these factors now that you work in the SPDCS.

	Extremely important	Very important	Important	Of little importance	Not important at all
a. Desire to serve the community and disadvantaged groups of patients	<input type="checkbox"/>				
b. Interest in pursuing a dental specialism	<input type="checkbox"/>				
c. Long-term career potential	<input type="checkbox"/>				
d. Security of a salaried income	<input type="checkbox"/>				
e. Level of salary offered	<input type="checkbox"/>				
f. NHS Pension	<input type="checkbox"/>				
g. Preference for more flexible working	<input type="checkbox"/>				
h. Opportunity to study for a registerable post-graduate qualification	<input type="checkbox"/>				
i. Availability of a job in a preferred location	<input type="checkbox"/>				
j. Not interested in doing general practice work	<input type="checkbox"/>				
k. Desire to work in an environment where you can provide good service to patients	<input type="checkbox"/>				
l. Other reason (Please specify)	<input type="checkbox"/>				

Your Current Main Job in the SPDCS

16 What is your current SPDCS grade or equivalent, in your main SPDCS job? If you hold more than one job, please also indicate other SPDCS posts you currently hold.

	Grade in main job	Other SPDCS Post
a. Dental Officer	<input type="checkbox"/>	<input type="checkbox"/>
b. Senior Dental Officer	<input type="checkbox"/>	<input type="checkbox"/>
c. Assistant Clinical Director	<input type="checkbox"/>	<input type="checkbox"/>
d. Clinical Director	<input type="checkbox"/>	<input type="checkbox"/>
e. Chief Administrative Dental Officer of Western Isles, Orkney and Shetland	<input type="checkbox"/>	<input type="checkbox"/>
f. PDS Dentist	<input type="checkbox"/>	<input type="checkbox"/>
g. Salaried GDP (including senior and specialist GDPs)	<input type="checkbox"/>	<input type="checkbox"/>

17 Thinking about your current job, how important are the following factors in influencing your continuing commitment to the SPDCS? (Please try to use the rating of 'extremely important' only for the one or two most important factors).

	Extremely important	Very important	Important	Of little importance	Not important at all
a. The opportunity to serve the community and disadvantaged groups of patients	<input type="checkbox"/>				
b. The opportunity to practise a dental specialism	<input type="checkbox"/>				
c. Long-term career potential	<input type="checkbox"/>				
d. Security of a salaried income	<input type="checkbox"/>				
e. Level of salary offered	<input type="checkbox"/>				
f. NHS Pension	<input type="checkbox"/>				
g. Having flexible working hours arrangements	<input type="checkbox"/>				
h. Opportunity to study for a registerable post-graduate qualification	<input type="checkbox"/>				
i. Having a job in a preferred location	<input type="checkbox"/>				
j. The quality of colleagues you work with	<input type="checkbox"/>				
k. Working in an environment where you can provide good service to patients	<input type="checkbox"/>				
l. Other reason (Please specify)	<input type="checkbox"/>				

18 What is your basic salary scale point? If you are not paid on the SPDCS scale, please go to question 19.

Note that PBI indicates a Performance Based Increment. All scale points shown are for full-time dentists. If you work part-time, please indicate the scale point against which you are paid pro-rata.

**Band 1
Dental Officer/Salaried GDP**

£28,445	<input type="checkbox"/>	£30,815	<input type="checkbox"/>	£33,185	<input type="checkbox"/>
£35,555	<input type="checkbox"/>	£37,925	<input type="checkbox"/>	£40,295	<input type="checkbox"/>
£42,665 PBI	<input type="checkbox"/>	£45,035 PBI	<input type="checkbox"/>		

Q18 continued

Band 2
Senior Dental Officer/Senior Salaried GDP

£41,030	<input type="checkbox"/>	£44,345	<input type="checkbox"/>	£47,660	<input type="checkbox"/>
£50,975	<input type="checkbox"/>	£54,290	<input type="checkbox"/>	£55,025 PBI	<input type="checkbox"/>
£55,760 PBI	<input type="checkbox"/>				

Band 3
Assistant Clinical Director/Specialist Salaried GDP

£54,815	<input type="checkbox"/>	£55,675	<input type="checkbox"/>	£56,535	<input type="checkbox"/>
£57,395	<input type="checkbox"/>	£58,225 PBI	<input type="checkbox"/>	£59,115 PBI	<input type="checkbox"/>

Band 3
Clinical Director

£54,815	<input type="checkbox"/>	£55,675	<input type="checkbox"/>	£56,535	<input type="checkbox"/>
£57,395	<input type="checkbox"/>	£58,255	<input type="checkbox"/>	£59,115	<input type="checkbox"/>
£59,975	<input type="checkbox"/>	£60,865	<input type="checkbox"/>	£61,725 PBI	<input type="checkbox"/>
£62,585 PBI	<input type="checkbox"/>				

Chief Administrative Dental
Officer of Western Isles, Orkney and Shetland Health Boards

£48,035	<input type="checkbox"/>	£51,075	<input type="checkbox"/>	£54,115	<input type="checkbox"/>
£57,155	<input type="checkbox"/>	£60,865	<input type="checkbox"/>	£61,725 PBI	<input type="checkbox"/>
£62,585 PBI	<input type="checkbox"/>				

If you have indicated your salary scale point in question 18, please go to question 20.

19 *If you are not paid using the SPDCS salary scales, what is your basic ANNUAL salary in your main SPDCS job?* £ _____

20 *In an average MONTH, what is your total salary (as it appears on your payslip) for your main SPDCS job, before deductions?* £ _____
This should take account of payments for additional hours, allowances etc. that you receive.

The Type of Work That You Do

21 What is the nature of your dental work? (Please 'X' all that apply).

- | | | | |
|------------------------|--------------------------|------------------|--------------------------|
| a. Adult Restorative | <input type="checkbox"/> | f. Geriatrics | <input type="checkbox"/> |
| b. Clinical Generalist | <input type="checkbox"/> | g. Orthodontic | <input type="checkbox"/> |
| c. Clinical Manager | <input type="checkbox"/> | h. Paediatric | <input type="checkbox"/> |
| d. Epidemiology | <input type="checkbox"/> | i. Special Needs | <input type="checkbox"/> |
| e. General Anaesthesia | <input type="checkbox"/> | j. Other | <input type="checkbox"/> |

22 Approximately, what percentage of your time in your main SPDCS job is spent on the following activities?

- | | None | 1 - 25% | 26 - 50% | 51- 75% | Over 75% |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Adult Restorative | <input type="checkbox"/> |
| b. Epidemiology | <input type="checkbox"/> |
| c. General Anaesthesia | <input type="checkbox"/> |
| d. Geriatric | <input type="checkbox"/> |
| e. Orthodontic | <input type="checkbox"/> |
| f. Oral Health Promotion | <input type="checkbox"/> |
| g. Paediatric | <input type="checkbox"/> |
| h. Screening | <input type="checkbox"/> |
| i. Special Needs Care | <input type="checkbox"/> |
| j. Safety Net for GDS Care | <input type="checkbox"/> |
| k. Management/Administration | <input type="checkbox"/> |
| l. Professional Development/Training | <input type="checkbox"/> |
| m. Other Activities | <input type="checkbox"/> |

Other Posts

23 Do you carry out any other NHS dentistry work, outside of the SPDCS? (Please 'X' all that apply).

General Dental Service

GDS - Assistant GDS - Associate GDS Practice Owner partner/expense sharer

Hospital Dentistry

House Officer Senior House Officer Specialist Registrar Registrar/Snr. Registrar

Consultant Non-Consultant career grade (staff grade, associate specialist) Clinical Assistant/ Hospital Practitioner

Other Dentistry

Private Dentistry Other

24 Given your qualifications and experience, what other jobs in the NHS do you consider yourself currently capable of taking on? Please 'X' all that apply, but do not list jobs at a lower grade than your current grade.

SPDCS Jobs

Dental Officer SDO Assistant Clinical Director

Clinical Director PDS Dentist Salaried GDP (inc. (senior/specialist GDPs)

General Dental Service

GDS - Assistant GDS - Associate GDS - Practice Owner partner/expense sharer

Hospital Dentistry

House Officer Senior House Officer Specialist Registrar Registrar/Snr. Registrar

Consultant Non-Consultant career grade (staff grade, associate specialist) Clinical Assistant/ Hospital Practitioner

Management Roles

Head of Primary Care Quality Manager Chief Executive of a primary care organisation

Other (Please specify)

Time at Work and Work Patterns

25 How many hours are you contracted to work per week in your main SPDCS job? _____

26 How many of these contracted hours are in the evenings and weekends on average (per week) ? _____

Less than once a month	About once or twice a month	About once a week	More than once a week
------------------------	-----------------------------	-------------------	-----------------------

27 How frequently do you work additional hours, in excess of contracted hours, in your main SPDCS job?

28 On average, how many additional hours do you work in a MONTH, above your contracted hours in your main SPDCS job? _____

Never	1-2 days per month	3-4 days per month	5 or more days per month
-------	--------------------	--------------------	--------------------------

29 How frequently are you required to work on-call in your main SPDCS job?

30 Please indicate your views on flexible working (e.g. job sharing, part-time working) by stating which of the following best describes you. Please select one option below.

a. I do not have a strong desire to work flexible hours

My preference is to have the option of working flexible hours:

b. and I HAVE the opportunity for this in my current job

c. but I DO NOT have the opportunity for this in my current job

d. but I have not ASKED about the opportunity for this in my current job

Career Development and Planning

31 For how many years, in the future, do you expect to work in your current grade? _____

Yes	No	Don't Know	Not Applicable
-----	----	------------	----------------

32 Do you wish to move to a more senior level in the SPDCS?

33 Are you confident that you will reach a more senior level in the SPDCS?

		Yes	No	Don't Know	
34	<i>Is your preference to remain in the SPDCS for the foreseeable future?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35	<i>Are you seriously considering leaving the SPDCS at the moment?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36	<i>In the past two years, have you actively sought a new post (by submitting a formal application?)</i>		Yes	No	
a.	Elsewhere in the SPDCS?		<input type="checkbox"/>	<input type="checkbox"/>	
b.	Outside of the SPDCS?		<input type="checkbox"/>	<input type="checkbox"/>	
37	<i>If you are likely to actively seek another post within the SPDCS in the next two years, what type of post and in which service will this be? Please 'X' all that apply.</i>				
PDS - Dental Access Centre	<input type="checkbox"/>	PDS - Other	<input type="checkbox"/>	CDS - DO Post	<input type="checkbox"/>
CDS - SDO Post	<input type="checkbox"/>	CDS - Assistant Clinical Director Post	<input type="checkbox"/>	CDS - Clinical Director Post	<input type="checkbox"/>
Become a salaried GDP	<input type="checkbox"/>	Senior Salaried GDP	<input type="checkbox"/>	Specialist Salaried GDP	<input type="checkbox"/>

Only answer questions 38 - 39 if you are thinking of leaving the SPDCS, or have considered doing so. Otherwise, go to question 40.

38 *If you are thinking of leaving the SPDCS, or have considered doing so, is (or was) this in order to move to: (Please 'X' all that apply).*

General Dental Service

GDS - Assistant GDS - Associate GDS Practice Owner partner/expense sharer

Hospital Dentistry

House Officer Senior House Officer Specialist Registrar Registrar/Snr. Registrar

Consultant Non-Consultant career grade (staff grade, associate specialist) Clinical Assistant/Hospital Practitioner

Other

Salaried Private Dentistry Non-Salaried Private Dentistry Salaried Dentistry Overseas

Other Dentistry Career break Retirement

A career outside of dentistry

39 Which of the following factors were or are important in motivating you to seek a new post? (Please try to only choose the rating 'extremely important' for the one or two most important factors).

	Extremely important	Very important	Important	Of little importance	Not important at all
a. Challenge of doing a different type of work	<input type="checkbox"/>				
b. Career progression opportunities	<input type="checkbox"/>				
c. Preference to work fewer evenings & weekends	<input type="checkbox"/>				
d. Desire to improve salary/financial reward	<input type="checkbox"/>				
e. Preference for more flexible working hours arrangements	<input type="checkbox"/>				
f. Availability of a job in a preferred location	<input type="checkbox"/>				
g. Changes in the type of work being carried out in the SPDCS	<input type="checkbox"/>				
h. Quality and style of management in SPDCS	<input type="checkbox"/>				
i. Uncertainty about the future of the SPDCS	<input type="checkbox"/>				
j. Other reason (Please specify)	<input type="checkbox"/>				

Your Attitudes to Work

This section consists of a series of statements, which you are asked to read and then indicate the extent to which you agree or disagree with each statement.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
40 Promotions are generally given to the most suitable candidates in the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41 Overall, I am confident that I will be able to achieve my long-term career objectives in the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42 I believe that the SPDCS as a whole is well managed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43 Senior management communicates a clear vision of the future direction of the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44 My job gives me the chance to do challenging and interesting work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
45	My job makes good use of my skills and abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
46	I am paid fairly for my performance and contributions to the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47	I feel I am paid fairly compared to other people performing similar jobs in the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48	I believe that the pay in the SPDCS is as good or better than the pay offered elsewhere in NHS dentistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49	I feel a strong sense of commitment to the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50	I am satisfied with the rate of salary progression I have achieved in the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51	I am satisfied with the career progress I have achieved in the SPDCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52	I have received training in the SPDCS that is appropriate to my needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
53	The overall experience of working in the SPDCS matches my expectations prior to joining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54	I accept working additional hours, at evenings and/or weekends as part of my job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Very Good	Good	Neither	Poor	Very Poor	Not Applicable
55	<i>How do you rate your non-pay benefits (e.g.NHS Pension?)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

56 If you would like to make any further comments relating to the issues raised in this questionnaire, please record them in the space below:

THANK YOU FOR COMPLETING THE QUESTIONNAIRE



Published by TSO (The Stationery Office) and available from:

Online

www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail

TSO

PO Box 29, Norwich, NR3 1GN

Telephone orders/General enquiries: 0870 600 5522

Order through the Parliamentary Hotline Lo-call 0845 7 023474

Fax orders: 0870 600 5533

E-mail: book.orders@tso.co.uk

Textphone 0870 240 3701

TSO Shops

123 Kingsway, London WC2B 6PQ

020 7242 6393 Fax 020 7242 6394

68-69 Bull Street, Birmingham B4 6AD

0121 236 9696 Fax 0121 236 9699

9-21 Princess Street, Manchester M60 8AS

0161 834 7201 Fax 0161 833 0634

16 Arthur Street, Belfast BT1 4GD

028 9023 8451 Fax 028 9023 5401

18-19 High Street, Cardiff CF10 1PT

029 2039 5548 Fax 029 2038 4347

71 Lothian Road, Edinburgh EH3 9AZ

0870 606 5566 Fax 0870 606 5588

TSO Accredited Agents

(see Yellow Pages)

and through good booksellers

ISBN 0-10-157222-0



9 780101 572224