

Articles of Interest



BDA response to NHS White Paper

The BDA supports many of the principles in the White Paper but has raised questions on others.



Party conferences

Delegates at the three major political parties' annual conferences heard about the importance of remembering vulnerable patient groups as the reform.



Dental commissioning survey

A survey of dental commissioners shows commissioning priorities and workforce issues in Primary Care Trusts in England.



Student debt

BDA research shows student debt has more than doubled in the last ten years.



Prison dentist survey

A recent survey of prison dentists raises awareness a number of problems relating to providing dental care in prisons.



Data page

Recently released data in Northern Ireland looks at dentists' commitment to health service dentistry by age and gender.

BDA responds to Equity and Excellence White Paper

The BDA has responded fully to the Government's White Paper Equity and Excellence: Liberating the NHS. The consultation sets out proposals for major structural reform of the NHS in England and a new contract for general dental practice to be piloted. The main elements of the proposed reforms are:

- Primary care trusts and strategic health authorities to be abolished by 2013
- Commissioning of most aspects of NHS care to be done by consortia of GPs
- Contracts for doctors, dentists, pharmacists and optometrists to be held by a central NHS Board
- Monitor to take on the role of NHS economic regulator
- Patient choice to be key
- Health and wellbeing boards will be established within local authorities
- The outcomes of care will be monitored as well as patient experience
- The Care Quality Commission will have a strengthened role
- Local authorities to be responsible for public health and to undertake joint strategic needs assessments for health and social care.

While welcoming many of the principles in the White Paper such as the removal of targets and micro-management and the introduction of a national dental contract, the BDA has raised questions on others and asked for much more detail. We are anxious that the gaps are filled in full dialogue with the profession.

We have stressed the importance of the costs of the re-organisation not being taken from service budgets and that transitional

arrangements must protect practices to ensure continuity of patient care.

Consultants in Dental Public Health will take on a new importance in the new system as will Oral Health Advisory Groups and Local Dental Committees. Dentists will be working closely with other primary care professionals in order to ensure that local dental services are appropriate. Local health and wellbeing boards must engage with clinicians in influencing the commissioning of care.

The BDA's response is available at www.bda.org/nhsreforms



Reforms must not forget vulnerable, party conferences hear

BDA co-hosted events at the three major political parties' annual conferences this year stressed to delegates the importance of remembering vulnerable patient groups as the reform of NHS dentistry continues. Fringe events at the Liberal Democrat, Labour and Conservative conferences heard BDA speakers emphasise the need to remember patients including the prison population, those with learning disabilities and older people in nursing and care homes as the NHS undergoes reform and proposals for new arrangements for dentistry in England are developed.

Speaking at the event at the Conservative Party event in Birmingham, Minister Earl Howe reiterated the Government's position that the current arrangements for dentistry had failed, pledging to create a new system built on elements including quality and capitation. Patient registration, he said, is particularly valuable and must be reinstated. The success of the changes in dentistry would, he added, depend on information technology. He also promised that, while dentistry was his responsibility, it would no longer be an "also-ran" in the NHS.

Criticism of the Labour Government's record on dentistry was also a theme of the fringe event at the Liberal Democrat conference, where Lord Clement-Jones, a member of the Liberal Democrat

Backbench Committee on Health and Social Care, targeted the reduction in the number of patients able to access care after the introduction of the current contract. He also attacked the previous administration's record on health inequalities, arguing that economic fairness must be addressed by the Coalition Government if it is to make progress in this area.

At the Labour Party conference, this year held in Manchester, then former Shadow Public Health Minister Mary Creagh MP acknowledged there had been a problem with preventive dental care, but defended the previous administration's record on health, citing the achievements of its 13 years in power. She also expressed concerns that vulnerable patients who are



currently on the edges of care will fall into the abyss as the new arrangements outlined in the health white paper are developed.

BDA speakers Susie Sanderson, Peter Bateman and John Milne were profiling the initial stages of research being carried out by the BDA under the 'unheard voices' banner.

GDPIC Chair John Milne alongside Margot James MP and Earl Howe at the fringe event at the Conservative Party Conference (Courtesy: Acumen Images)

Student debt doubled in ten years

In 2000, the average debt held by a final year dental student was just over £11,000. Ten years later, it has more than doubled and final year dental students owe on average in excess of £25,000.

The BDA has conducted regular surveys into the levels of dental student debt upon graduation since 1997. The latest report released in August this year has shown that student debt is still on the rise and affecting the future career choices of students.

Eighty-nine per cent of final year students were in debt, an increase from 83 per cent in 2008. The average student owed £25,545

(excluding those with no debt). This represents a one per cent increase since 2008, and a 128 per cent increase since 2000.

With an increase in tuition fees in 2006 it is likely that the average level of debt will rise dramatically again. In a report by the British Medical Association (BMA) in 2009, final year medical students left with an average of £19,000. The BMA estimates that those who began

their degree in 2006 could expect to face debt of up to £37,000.

Eighty-one per cent of students received a contribution from their parents or another family member that they were not expected to pay back. The average amount was £20,841, with 12 per cent receiving over £30,000 from their parents. This reliance on family contribution could be limiting the ability of those from lower socio-economic backgrounds to access the profession. In 2008¹, 18 per cent of successful applicants came from the lower socio-economic backgrounds 4 to 7² compared to 23 per cent on all courses.

NHS bursaries are available to dental students, although there are some significant differences in accessibility across the devolved nations. With the exception of Scotland, bursaries are only available in students' final year with four in five students accessing one. However, a bursary reduces the level of student loan available. As a result, over half found that their total level of funding had decreased in their final year compared to the previous year. This caused a greater reliance on overdrafts and

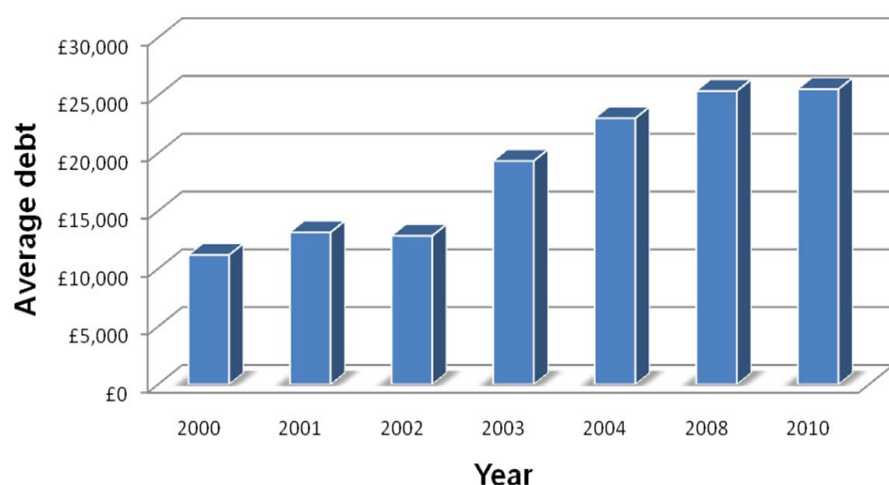


credit cards and resulted in financial difficulties for almost three-quarters of these students at one of the most crucial times in their course.

Over a third of the students thought that their level of debt would influence their career. It was widely commented that due to financial constraints they would have to delay or not undertake postgraduate courses and further training. Many also suggested that they desired to work in hospital dentistry but this would not be possible because of fiscal responsibilities.

If you would like to read the report in full it is available on the BDA website www.bda.org/studentdebt.

Figure 1: Average final year student debt excluding those with no debt, 2000-2010



¹ UCAS application data.

² National Statistics Socio-economic Classification: 1-3 = Higher managerial occupations and higher professional occupations; Lower managerial and Professional occupations; Intermediate occupations. 4-7 = Small employers and own account workers; lower supervisory and technical occupations; Semi-routine occupations; Routine occupations.

Access still high on commissioning agenda

The most recent BDA survey of Dental Commissioners has shown that improving access to NHS dentistry is still high on the agenda for Primary Care Trusts in England. The workforce issues highlighted in the survey now have a greater significance as the Equity and Excellence White Paper proposes that responsibility for dental commissioning will transfer from PCTs to the National Commissioning Board by 2013.

Commissioning priorities

Nine out of ten respondents stated that improving access was one of their top three commissioning priorities in 2010/11. Access was the clear leader, with the next most popular priority, 'improving quality', cited as a top three priority for just over a quarter (28 per cent) of respondents. Other commissioning priorities included improving oral health, reducing inequalities, and achieving value for money.

This focus on improving access was also evident through increased use of PDS Plus agreements. While 70 per cent of PCTs held no PDS Plus agreements at the time of the survey, most planned to use at least some aspects of the agreement when commissioning new and replacement services. Over a third (37 per cent) plan to use the PDS Plus template agreement as it is, with a further

40 per cent using contracts or agreements that include elements of PDS Plus.

Budgets

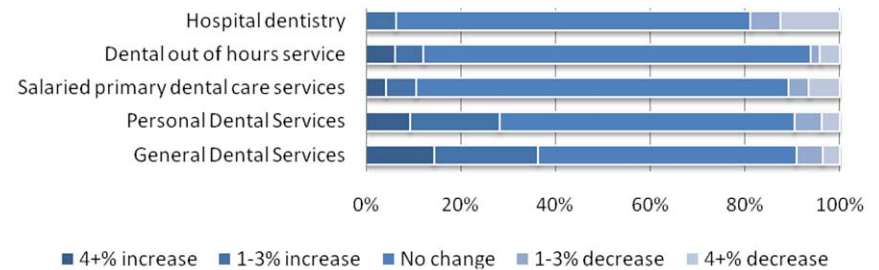
The majority of PCTs have seen no change, or moderate increases to most dental budgets in 2010/11. Over one in five PCTs (22 per cent) experienced a one to three per cent increase in GDS budget, while 15 per cent had an increase of four per cent or more. Similarly, nineteen per cent experienced a one to three per cent increase in PDS budget, with 9 per cent had an increase of four per cent or more. The largest decrease was in hospital dental budgets with almost one-in-five of the PCTs (19 per cent) experiencing a decrease in their hospital dentistry budget.

One worrying finding highlighted by the survey was that 20 per cent of PCTs had spent less than 95

per cent of their ring-fenced dental budgets in 2009/10. One PCT spent less than 60 per cent of this budget. It is, however, not clear from the survey whether or not the remaining funds were simply unspent, or had been diverted outside of the dentistry budget.

access to Consultants in Dental Public Health with a quarter of the PCTs (26 per cent) having no Consultants in Public Health. Almost three-quarters (74 per cent) of the dental leads felt that they needed additional support in their dental commissioning team, commonly within the areas of

Figure 2: Percentage change in budget from 2009/10 to 2010/11



Workforce

Just under half of the Dental Commissioning Leads (48 per cent) were responsible for dentistry exclusively, with the leads spending an average of 81 per cent of their time devoted to dentistry. One in five spend less than half of their time devoted to dentistry, commonly holding additional responsibility for areas like optometry, pharmacy, or general medical practice.

The survey showed variable levels of commissioning support provided by Strategic Health Authorities, with six per cent saying that they received no support from their SHA in this area. It also showed a disappointing level of

administration, contract management, and consultants in dental public health.

“We need more contract manager time if we are to introduce more effective management of contracts, that is, more emphasis on prevention, access and quality in addition to activity”.

It is clear that the commissioning teams face major challenges in the wake of the Equity and Excellence White Paper. We hope that the expertise that has been built up since the introduction of the new GDS contract in 2006 will not be lost in the transition.

Prison dentists face challenging work environments

A recent survey of BDA members working in the field of prison dentistry has highlighted a number of problems in the provision of dentistry in prisons.

Around a third of respondents were salaried, working on behalf of a Primary Care Trust or Health Board. The remaining dentists had contracts with the Trust or Health Board, and the prisons, including GDS and PDS contracts.

Contracted dentists were less likely to be happy with their contractual arrangements than the salaried services (48 per cent were happy with their arrangement, compared to 75 per cent of the salaried dentists). UDA targets were a source of frustration for many dentists, often due to unrealistically high targets relative to the number of sessions contracted.

“UDA target does not work and is not fair in delivering dental services in a prison situation.”

“The sessions I do under UDA target are putting me under a lot of



stress, to fulfil the UDA target and lower the waiting list at the same time is very difficult to do.”

“Not enough clinical sessions to fulfil the terms of the contract and provide adequate care for patients.”

There was a general perception that commissioners do not understand or appreciate the unique circumstances and complexities of prison dentistry. In addition to the security and other prison-specific constraints, the dentists are dealing with patients who have very high treatment needs and can be highly litigious. The mobility of remand prisoners in particular causes problems in treatment planning and in completing longer courses of treatment.

“Unrealistic expectations, both of commissioners, managers, and prisoners, as there is often a lot of movement and also the high level of dental need in the prison population making it almost impossible in some prisons to ever achieve what is expected with the level of resources allocated.”

Another problem encountered by many prison dentists stemmed from the reliance on prison personnel to deliver patients to appointments. Failure to do so placed additional pressure on the dentists to meet targets.

“Sometimes no cooperation from prison staff, no admin/staff support to collect patients, though we are held ‘responsible’ via UDAs if no patient arrives etc.”

“The efficiency or otherwise of clinical time is dependent on discipline routine and staff providing me with patients. You are up against the demands of other clinics, other prison activities, staff shortages which affect escorting arrangements.”

Somewhat alarmingly, a large number of the dentists reported that they have had no specialist prison or security training at all. Others received no training initially but have since received some.

“Nil. Did not even receive any training from the prison with regard to security...”

“I started the job without any training! I have asked on numerous occasions for some prison-based training re breakaway techniques etc but so far no luck.”

This research forms part of a larger policy initiative seeking to improve the working lives of dentists delivering care in secure settings such as prisons and, subsequently, the oral health of the prison population.

Consultations

The BDA has recently been involved in the following consultations.

UK

- General Dental Council: Principles of ethical advertising
- General Dental Council: Constitution of committees rules
- Scientific Committee on Health and Environment Risks: Critical review of any new evidence on the hazard profile, health effects, and human exposure to fluoride and the fluoridating agents of drinking water

England

- Care Quality Commission: Enforcement policy
- Department of Health: White Paper - Equity and Excellence: Liberating the NHS
- Department of Health: HTM 07-01 Safe management of healthcare waste

Northern Ireland

- Health and Personal Social Services: Disciplinary Proceedings Regulations 2010

Scotland

- Recommendations for future tobacco control strategy in Scotland (ASH Scotland)
- Scottish Government Health Directorates: Tobacco & Primary Medical Services (Scotland) Act 2010 - Amendment Regulations
- Scottish Government Health Directorates: Tobacco & Primary Medical Services (Scotland) Act 2010 - Amendment Regulations
- Scottish Prison Service: Dental quality assurance framework for Scottish prisons



Economic Data

Figure A:
Average proportion of time devoted to Health Service dentistry in Northern Ireland 2009/10¹

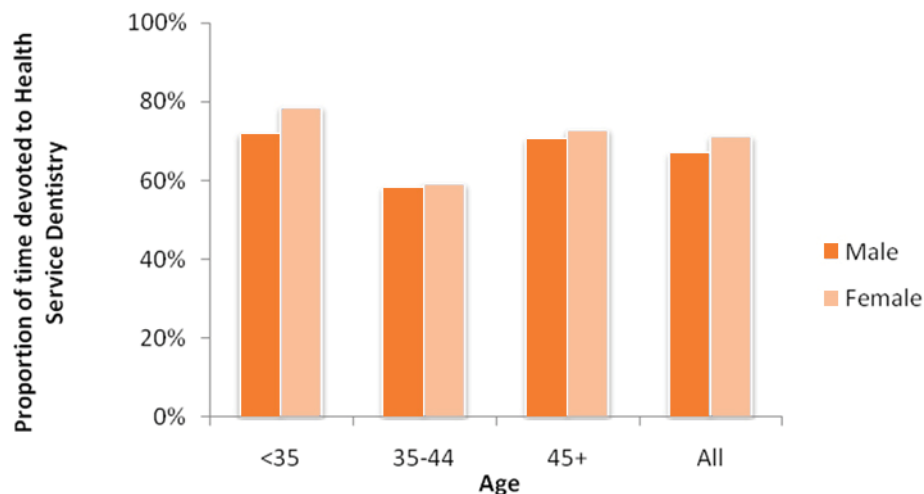


Table B:
UK inflation, earnings, housing and unemployment indicators³

	DEC 2009	JAN 2010	FEB 2010	MAR 2010	APR 2010	MAY 2010	JUN 2010	JUL 2010	AUG 2010
RPI - CZBH	2.4	3.7	3.7	4.4	5.3	5.1	5.0	4.8	4.7
RPIX - CDKQ	3.8	4.6	4.2	4.8	5.4	5.1	5.0	4.8	4.7
CPI - D7G7	2.9	3.5	3.0	3.4	3.7	3.4	3.2	3.1	3.1

Note: All figures represent year on year growth rates, unless specifically stated otherwise

Table A:
UK base interest rates²

BOE rate (%)	
2006 Aug 3	4.75
Nov 9	5.00
2007 Jan 11	5.25
May 10	5.50
July 5	5.75
Dec 6	5.50
2008 Feb 7	5.25
Apr 10	5.00
Oct 8	4.50
Nov 6	3.00
Dec 4	2.00
2009 Jan 8	1.50
Feb 5	1.00
Mar 5	0.50

Sources

- 1 Dental Working Hours, Northern Ireland, 2008/09 and 2009/10, Experimental Statistics
- 2 Bank of England
- 3 Source: HM Treasury Pocket Databank 29 Sept 2010