



Woburn House, 20 Tavistock Square, LONDON, WC1H 9HD
Tel: +44 (0)20 7419 5494 Fax: +44 (0)20 7380 1482
Email: admin@dentalschoolscouncil.ac.uk

Dental Schools Council response to the DDRB Review of Clinical Excellence Awards November 2010

As the authoritative voice of all eighteen UK Dental Schools, the Dental Schools Council aims to be the principal source of informed opinion and advice on all matters concerning dental education and research in dental schools in the United Kingdom, on relations between dental schools, medical schools, the National Health Service and other clinical care providers, and on relations with university dental schools and faculties in other countries.

In putting together this submission, all 18 Schools were canvassed for their views which were then consolidated.

The Dental Schools Council considers the CEA scheme critical to the retention of senior clinical academic staff in dental academic institutions. The scheme is cardinal to the arrangements whereby senior clinical academic staff pursue excellence in both their clinical service and academic endeavours and thereby are better able to fulfil their various roles and responsibilities. The White Paper *Equity and Excellence, Liberating the NHS*, emphasises the importance of research to the NHS. The clinical excellence scheme forms a fundamental part of the research architecture, rewarding as it does, the long term commitment of clinical academics.

There are, unfortunately, powerful disincentives to embarking upon a clinical academic career: CEAs have been a useful counter-balance which provides the necessary incentive for younger clinical academics to sustain their academic pursuits in research and teaching despite the concomitant financial disadvantages – it takes longer for an academic to train in order to achieve the required additional higher qualifications.

With dental schools in the US and Australasia having numerous vacancies and many new dental schools opening in various parts of the world with “buying power”, there is a strong possibility of clinical academics moving away from the UK if the salary enhancing effects of CEAs are reduced, let alone lost.

Chair:

Professor WP Saunders BDS PhD FDS RCS Edin
FDS RCPS Glas FDS RCS Eng MRD FHEA FHKAM
Dean of Dentistry, University of Dundee

Executive Secretary and Treasurer:

Professor F Fortune CBE, BDS MBBS MRCP, FRCP, FDS
RCSeng, FGDP, PhD, DipEd teachers Med/Dent
Director, Institute of Dentistry, Queen Mary University of London

Without the CEA scheme it is possible that clinical academics of the future who could negotiate incentive schemes with their employing university might have little, if any, interest in honorary consultant appointments and, as a consequence, in contributing to the National Health Service. The rift which could therefore develop between NHS and academic colleagues in dental clinical academic centres would be detrimental to present and future dental health care and to the oral health of the UK population.

The activities of clinical academics significantly enhance the NHS in all its aspects. Within the UK only 18% of dental clinical academic posts are funded by the NHS (*cf* 40% of clinical academic posts in medicine). Hence despite funding not coming from the NHS **and** the majority of clinical academics undertaking 5 PAs of clinically-related activity, almost all senior dental positions allied to clinical research, training, governance etc within the NHS are held by clinical academics.

Summary key points that support the importance of clinical academic dentistry include:

1. Clinical academics have held, and hold, the majority of senior positions within NHS groups/committees allied to dental training
2. Clinical academics provide the vast majority of leadership within dental schools and thus drive the training of university undergraduates, postgraduates and NHS-funded trainees
3. In some schools clinical academics hold Directorship of both the HEFCE and NHS elements
4. The theme leads of the 2 AHSCs (KHP and UCLP) with an oral/dental theme are clinical academics
5. Almost all innovation within UK NHS Dentistry has arisen from clinical academics and/or their science collaborators. We are not aware of any instances when an NHS dental consultant has contributed to this sphere
6. Clinical Academics lead in teaching, for both the University and the Trust. They tend to be the teaching leads for the Schools of Dentistry
7. The job plans of clinical academics in dentistry do not make significant adjustment for the many additional local, national and international roles that they undertake – *i.e* there is no NHS funding for these NHS-allied activities to which they commit a great deal of their time
8. Clinical academics are extremely talented clinicians and as a consequence of their research and innovation are likely to have a greater awareness of contemporary clinical care than their NHS colleagues. They are thus likely to be able to have a highly successful private clinical practice, hence any loss of the CEAs will drive them out of the Universities (and adversely affect education and research) *and* lessen their impact upon NHS care provision. Similarly loss of the CEAs would place an additional financial burden upon the universities to retain such

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staff (despite already funding the vast majority of clinical academics who are contributing 50% of their time to NHS-allied activities)

9. Dental academia is not notably attractive in view of the demands of HEFCE and the NHS. Any substantial changes to the CEA scheme have the potential significantly to damage dental training/research and hence the oral health of the present and future populations

A review of the criteria for CEAs reinforces the evidence that clinical academic dentists contribute significantly to the NHS:

- *Demonstrate sustained commitment to patient care and wellbeing or improving public health;*

Clinical academics have taken national leadership roles in developing and advising the NHS – for example the Clinical Advisory Group for ‘Options for Change’ and the recent review of NHS Dentistry (Steele).

Clinical academic dentists provide local leadership as clinical leads of services (e.g. oral surgery, restorative dentistry, paediatric dentistry, endodontics, orthodontics, oral medicine, oral pathology).

They have led the development of services and guidelines – e.g. establishment of sedation services, dental trauma in childhood, established referral pathways for disease (e.g. dental trauma, endodontics, orthodontics, bisphosphonate-related osteonecrosis of the jaw, aggressive periodontitis in children and adults, epidermolysis bullosa).

They have led the establishment of multidisciplinary clinical teams (e.g. craniofacial anomalies in children and young adults, hypodontia).

- *Sustain high standards of both technical and clinical aspects of service whilst providing patient-focused care;*

Clinical academics in dentistry have led the establishment of patient-focused care in craniofacial anomalies and the establishment of patient-centred focus groups for clinical research

- *In their day-to-day practice demonstrate a sustained commitment to the values and goals of the NHS by participating actively in annual job planning, observing the private practice Code of Conduct and showing a commitment to achieving agreed service objectives;*

All clinical academics contribute to the achievement of the agreed service targets (that are always met) and ensure that undergraduates and particularly postgraduates contribute to this achievement as well as maintaining high standards of clinical governance.

- *Through active participation in clinical governance contribute to continuous improvement in service organisation and delivery;*

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There is a sustained and strong commitment to audit via design, implementation *and publication* of national and international audits and to the promotion of all aspects of clinical governance.

- *Embrace the principles of evidence-based practice;*

Clinical academics are the principal (and usually sole) drivers of evidence-based practice by virtue of:

- Research allied to outcomes and patient reported outcome measures
- Design and delivery of systematic reviews (e.g. allied to the Cochrane Collaboration e.g. periodontology, paediatric dentistry, orthodontics, oral medicine)
- Evaluation of interventions and of clinical trials

- *Contribute to knowledge base through research and participate actively in research governance;*

The majority of HEFCE-funded clinical academics contributes to research (as evidenced by the RAE 2008 report and the DSC document on staffing levels), much of which is allied to NHS patient care. Almost all research-active clinical academics were returned in RAE 2008. The majority of research is of national and international excellence – as reported in RAE 2008. Dentistry has been able to recruit NIHR Clinical lecturers and academic fellows to centres of excellence.

Clinical and translational research is almost exclusively undertaken by clinical academics (in contrast to the minority of such activity undertaken by NHS staff (despite having research Programmed Activities)). Similarly it is the academics who secure the funding for research that will benefit patients (and be allied to portfolio-related NHS income – examples are NIHR RISC, NIHR Research for Patient Benefit, Diabetes UK, Comprehensive Biomedical Research Centres).

Dissemination of knowledge/knowledge transfer via editorship of journals & editorial board membership.

- *Recognised as excellent teachers and/or trainers and/or managers;*

Outwith university-allied roles 100% of senior clinical academics are recognised trainers of SpRs and SHOs. Additionally at least 70% of clinical academics hold or have held senior roles in local and national NHS-related training e.g.

- Chairman of local STCs
- Educational supervisors and training programme directors (i.e. orthodontics, oral medicine, oral surgery, paediatric dentistry, restorative dentistry)
- Chairmanship and membership of SACs (i.e. orthodontics, paediatric dentistry)
- President of Specialist Societies, national and international (i.e. endodontics, oral medicine, orthodontics, paedodontics, periodontology, restorative dentistry)
- Council membership of Specialist Societies (Association of Consultants and Specialists in Restorative Dentistry, British Orthodontics Society, British Paediatric Dentistry Society, British Society for Oral Medicine, British Society for Periodontology, European Association of Oral Medicine, British Endodontic Society)
- Other leadership roles within Specialist Societies

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- *Contribute to policy-making and planning in health and health care;*

Clinical academic dentists are members of various groups such as NICE.

Dental clinical academics commit considerable additional hours (evenings & weekends) and skills to the NHS and indeed may contribute to up to 80% of some NHS Trust services through direct & indirect patient care, research and teaching instead of undertaking any private practice. This has been **sustained**, as recognised through clinical excellence awards against the highest national competition by critical and objective peer review.

Academics sacrifice higher incomes compared to their non-academic peers who often work in both NHS and private sectors. Thus the “lost income” over the career of a senior clinical academic is considerable. The choice of entering clinical academia has often been based upon the belief that in due course efforts might eventually be recognised through the CEA process. Pension plans and investment decisions have been predicated on this process.

There is no doubt that the national CEA system is critically important to develop, incentivise and most importantly retain the best staff for the NHS. The Dental Schools Council agrees that a review is timely but that any new system must specifically recognise the contribution made over and above the normal contract. Losing such a system will lose the goodwill which drives much of what happens in the NHS. Genuine commitment to the NHS, its leadership and impact upon present and future patient well being must be at the heart of any new system.

Whilst the DSC would support the review and possible abolition of local awards, to focus on excellence of true national significance, it is absolutely vital that the national scheme be maintained. ACCEA has worked hard to ensure that the current scheme is both fair and entirely transparent. Going forward, a national scheme could provide a bench-marked, quality assured and independent process which ensures that only the most deserving receive awards in a way that is externally moderated and refereed.

ANNEX: List of acronyms

AHSC	Academic Health Science Centre
KHP	King’s Health Partners
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
PA	Programmed Activity
RAE	Research Assessment Exercise
RISC	Research for Innovation, Speculation and Creativity (NIHR)
SAC	Specialist Advisory Committee
SHO	Senior House Officer
SpR	Specialist Registrar
STC	Specialist Training Committee
UCLP	UCL Partners

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