Written evidence submitted by Mr Philip Martin (DTY0008)

I have practised as a dentist for 40 years, almost exclusively within the NHS as I have always believed in its guiding principles, but I greatly fear that the system is now broken, and unless urgent action is taken NHS dentistry will cease to exist.

The significant variability of UDA rates, coupled with the rigidity of the commissioning system is starving many potentially excellent practices of funds and the ability to accept new patients. Practice contracts were fixed in 2006 and based on activity in 2004. Since that time many practices have changed hands, what was a good practice in 2006 may well have deteriorated, patients no longer want to attend that practice, but it will retain its original contract which will be far larger than required. Meanwhile a nearby practice may have improved significantly so that patients wish to attend there, but its original small contract does not provide it with the capacity to accept more patients. This limits access, prevents good practices expanding and potentially directs patients to poorer practices. In theory, NHS England's area team can reduce the size of underperforming contracts and recommission elsewhere, but this never seems to happen, as they are too afraid of legal challenge. Greater flexibility needs to be created within the system.

UDA rates, again these are based on activity from 2006, changes in practice profiles have rendered them obsolete, resulting in some practices being significantly underfunded for the work they undertake, and others overpaid. The new minimum UDA rate will help a bit but is not sufficient in and off itself.

Until recently I owned two dental practices in the same general area, both NHS. One I had initially started in 1990, the second around the time of the 2006 contract. In the first practice I had built up a loyal patient base. By acting ethically and providing quality care, by the time of the 2006 contract most of my patients had stable, well maintained dentitions so they did not require lots of treatment. As a result, I ended up with a very low UDA rate. Potentially this was starving me of funds to invest in that practice to improve services. Fortunately, I had taken on the second practice where, in 2006 many of the patients had high needs and required considerable work; consequently, in that practice I ended up with a high UDA rate. Over time as I have improved the dental health of patients in this second practice, the higher UDA rate has yielded surplus funds, which have enabled me to keep my original practice viable. I have been fortunate, not everyone has been so lucky and many practices with lower UDA rates have reached the point where they can no longer continue to provide NHS treatment whilst remaining solvent, essentially forcing them to go private.

This situation needs to be addressed; UDA rates in an area should be roughly equivalent, the current significant disparities should be addressed, otherwise practices with lower UDA rates will be forced out of the NHS, further reducing access.

Neither of these measures will be popular in some parts of the profession but unless we revert to a system where contracts are unlimited it is the only option. Otherwise, practitioners will continue to vote with their feet and leave the NHS, access will decline further and eventually NHS dentistry will implode.

A further issue with the current commissioning system is that on the rare occasion when NHS England commissions activity, it is directed by needs assessments. Experience would suggest these needs assessments are expensive to undertake, seldom accurately reflect local need and are constantly being updated. Essentially this is a planned command economy. Whilst I understand there is a need for government to retain some control over NHS dental spending, this type of system does not respond well to market forces or patient demand, particularly when trying to decide where new practices should be situated.

My suggestion would be to establish a fund for new practices. Dentists wishing to set up a new practice could apply for an NHS contract, which the ICB could award at its discretion, for a maximum period of two years. After that time, based on a series of metrics the ICB could decide whether to continue that contract. Dentists are shrewd businessmen, they will carry out market research before setting up a new practice and will only do so if this is viable. This proposal would bring market forces back in to play and increase provision in areas where there is a need for more NHS dentistry.

The system of foundation training has long been recognised as an excellent introduction to NHS practice for newly qualified dental graduates, with many foreign graduates who aspire to work in the UK seeking to obtain places on the scheme. Unfortunately, places on foundation training schemes are limited, with UK graduates quite properly given first preference. Many foreign dentists wishing to work in the UK have no option but to apply for a PLVE scheme. In many respects PLVE mirrors foundation training but it is self-funded and does not provide the same element of peer support that is found in FD. This can leave the foreign graduates participating in such schemes, isolated and at risk of exploitation.

Whilst it would be expensive to fully or even partially fund PLVE schemes, an element of peer support could be introduced at little or no cost. As already noted, PLVE largely mirrors the foundation schemes; the FD schemes already include small tutorial mentoring groups, why not add one or two places to each of these groups for PLVE placements? Since the tutorial groups are already fully funded, this should have little or no financial impact, it would provide the peer support and independent mentoring, which is currently missing from PLVE, it would potentially reduce issues arising further down the line and make participation more attractive for foreign dentists seeking to work in the UK, thereby helping to increase the size of the workforce.

Jan 2023