Written evidence submitted by Derek Watson (DTY0102)

INTRODUCTION

i. I am pleased to submit written evidence to the House of Commons Health Committee on NHS dental services for the third (and probably final) time, building on my written and oral evidence in 1992 and 2007.

ii. I am a former Chief Executive of the Dental Practitioners Association (formerly General Dental Practitioners Association) which was formed in 1954 and was the largest body and Trade Union that represented dentists solely in general practice ('high street' dentists) and member of the British Dental Association's Representative Board. My full CV is attached.

iii. As a former NHS practitioner and current private practitioner, it should not be assumed that my experience of the NHS is limited. Private practitioners are in the best position to hear about the failings of the NHS and on many occasions have to remediate its worst aspects including failed and increasingly inappropriate treatment and providing a *pro-bono* service for NHS patients (including children) in severe pain.

iv. Where this document refers to contracting and commissioning bodies it includes Primary Care Trusts (PCTs), Local Health Boards and Clinical Commissioning Groups and their heirs and assigns in perpetuity.

v. The lack of any reference to patients' concerns should not be taken as a failure to acknowledge the distress caused by the collapse of NHS dentistry. I expect that the many organisations representing patients will make their case elsewhere with my full support.

1) I am disappointed to see that I will leave the oral health of the nation in a worse condition than when I found it in 1982, although not for want of trying. A particular financial injustice which occurred in my first year in the profession spurred me at an early age to investigate health treatment provision systems and it is a subject in which I have retained an interest throughout my career.

2) In 1981, approximately half the current number of dentists on the General Dental Council register treated substantially the same population with no NHS access problems. The current situation which has been described as an NHS 'dental desert' is the result of a failure of governance at all levels for reasons I will set out below.

3) Ken Weetch (Lab, Ipswich) commented that NHS dentistry was like a horse, where the farmer, in an attempt to save money, fed the horse very slightly less every day, a situation which worked very well—until the horse died. My contention is that the problem is not money but a concentration of power in the hands of a few people outside the democratic process, who doggedly pursued the wrong ideas until the service collapsed.

4) In this submission, which has been prepared at 5 days' notice, I intend to consider:

- the period from the inception of the NHS to the early 1990s when NHS dentistry was widely available.
- when NHS dentistry entered a decline and why.
- what might be done to remedy the situation (short of a collapse of provision and a market-based reset).

WHAT IS DENTISTRY?

5) Dentistry is a unique combination of academic, manual and business skills. I invite you to spend a few seconds trying to think of another job that requires all three.

6) Dentists are useful and scarce[1] which makes them valuable. The Review Body on Doctors and Dentists' Remuneration (RBDDR or DDRB if you are an insider) used to contain an analysis of dentists' pay which showed them to be consistently around the top decile.

7) The period when NHS dentistry was freely available coincided with the period when dentists were self-employed subcontractors to the NHS. They owned their own premises, employed their own staff, paid their own expenses and enforced

[1] By virtue of the cost of their training, the barriers erected through inspection, testing and compliance and a Government preference for corporate dental bodies (restricted in 1956 then

deregulated in 2005) that might bring about economies of scale.

their own high standards through a network of independent Dental Reference Officers. They were free to do as much or as little NHS work as they wished.

8) The financial arrangements which had worked so well up to that point consisted of a fee scale that was estimated to produce the desired income for the average dentist. After the close of the financial year, dentists' actual income was adjusted upwards or (more frequently) downwards so that the profession as a whole finished within budget although more treatment than expected had been carried out. Competition between individual dentists to achieve what would be the average output for that year and be a 'winner' rather than a 'loser' ratcheted up productivity, leading to a spectacular bust up and national strike in 1992 when the profession was penalised for exceeding output targets by a wide margin.

9) Fears that the dental budget might be out of control marked the start of a centralised, command-and-control approach to the provision of NHS dental services which can be likened to a 'nationalisation by stealth', since it gave Government control over what dentists could earn, where they could work, what they could do and who they could see while leaving them with the burden of the costs of a self-employed small business.

10) It is ironic that the period in which a patient could obtain NHS dentistry from any dentist was when they were self-employed subcontractors; and the period which has culminated in 'dental deserts' coincides with the period of central purchasing which began in 1992.

THE COCKCROFT YEARS

11) Undoubtedly the greatest collapse of NHS dentistry was coincident with the tenancy of Mr Barry Cockcroft as Deputy Chief Dental Officer (CDO) from 2002-06 and as CDO 2006-15 and subsequently Ms Sara Hurley as CDO from 2015 to date, who has made no substantive changes to the contract that Cockcroft introduced with senior civil servant Chris Audrey in 2006 and groups such as the Consumer's Association.

12) Due to a lack of dental expertise within the Department of Health and Social Care (DHSC), the CDO was co-opted and became the Government's representative to the profession rather than the profession's representative to the Government.

13) In 2006 a contract was introduced that rewarded dentists with Units of Dental Activity (UDAs), for carrying out one of three types of treatment course. Any UDAs earned in excess of the target would go unpaid. Abolishing patient charges for non-attendance (until then a model for the rest of the NHS) reduced surgery utilisation. Registration with a dentist ceased to confer any rights on a patient.

14) Critics of the system pointed out that, rather than rewarding improved productivity, this would encourage dentists to carry out the minimum treatment necessary in each band to earn the points.

15) Failure of policy to produce the desired results increased frustration with the dental profession. Dentists argued that they could not be blamed for working the system as designed, even if it was apparent that the designer had made a mistake.

16) Characteristics of the DHSC under Barry Cockcroft included:

- Failure to substantially alter policy in response to recommendations from the Health Select Committee.
- Lack of plurality in obtaining independent advice and feedback[2] and lip service to consultations. Private briefings at sporting events and removal of dissenting voices from DHSC mailing lists for business and social events.
- Reluctance to adopt ideas that are generally known to have originated from a third party, for example shared savings models or Grant-in-Aid (see below).
- Insistence in the face of criticism that their own ideas were automatically best-in-class and when they failed persisting with them, or moving forward to a worse system, rather than reverting to something that previously worked.
- A pervasive culture that leveraged the increased powers that were available to intimidate practitioners into not speaking freely for fear of arbitrarily losing their NHS contract.
- A presumption that the era of the small dental practice would be replaced by a few large dental corporate bodies[3].

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[2] Section 35 (Arrangements for General Dental Services) of the NHS Act 1977 states :…*it shall be the Secretary of State's duty, before he prescribes any circumstances for the purposes of paragraph (b)* (provision of services)*, to consult such organisations as appear to him to be representative of the dental profession*.

Regulation 19 of the National Health Service (General Dental Services (GDS)) Regulations 1992 imposes a requirement on the Secretary of State *to consult with an organisation that is most representative of dentists working within the GDS*.

The Secretary of State chooses to consult exclusively with the British Dental Association which is a closed membership group, not subject (as a Special Register Body) to legislation on election of the Chairman and President. It does not share the fruit of its discussions with the wider profession.

There is a conflict of interest insofar as the BDA will acquiesce to the wishes of the DHSC in order to avoid
losing 'most favoured' status. CDOs and other C-class appointments are generally drawn from the BDA gene pool.

[3] A ban was placed on any further Limited Companies carrying on the business of dentistry in 1955 to

stem the rise of ‘for-profit’ dental practices where the dentist was simply an employee. This was reversed in 2005 in order to encourage fewer NHS contracts with larger groups, that might produce economies of scale and undermine independent dentists. In fact dental corporates are highly motivated to maximise profit and see an NHS contract as a starting point to sell private treatments while in some cases leaving just a single dental nurse to be responsible to the General Dental Council for their conduct.

- A drift towards an unelected and therefore unaccountable executive (CDO Cockcroft, Earl Howe) that was impervious to argument.
- Dismantling of effective safeguards against contractual abuse (providing services privately that were available on the NHS) and over-reliance on the Care Quality Commission, leading to the biggest NHS patient recall in history (2014-17 D'Mello).

17) Current CDO Sara Hurley (formerly Royal Army Dental Corps) has made no substantive changes to the system since 2015 apart from to shut down all dental practices in response to Covid 19. When a legal opinion was obtained that the CDO did not have the power to make such a directive the profession was able to resume business as normal.

18) The decision by Sara Hurley to pay NHS dentists 100 per cent of their pre-CoViD income for 0 per cent NHS activity provided an ideal springboard for NHS dentists to go into the private sector to meet patient demand despite assurances that they would not take advantage of the supply-side shock.

UNITS OF DENTAL ACTIVITY

19) The UDA system has led to widespread distortion of dental treatment provision, where dentists are rewarded the same for one filling as they are for ten and where a dentist is paid the same for a quick extraction, as a time consuming and expensive root treatment that would save a tooth.

20) Treatment which generates the maximum UDAs for the least effort is overprescribed. For example, one filling takes a course from Band 1 into Band 2 although Band 2 is intended to cover much more than that. In NHS financial Q4 the entire nation suddenly needs bite raising appliances, which garner the maximum number of UDAs for five minutes' work. This coincides with a period where UDA targets must be met to prevent clawback of payments already made.

21) DHSC divides each new project into three parts:

- that which can be done easily.
- that which requires some work.
- that which is theoretically or practically impossible.

Having completed stages 1 and 2 of the NHS contract replacement, they are now stuck at stage 3 (what to do about the drop in patient charges under any new system, lack of funding due to Government running out of money, lack of experience at running profitable dental practices, etc.).

The failure of large corporates like Southern Cross illustrates the 'pass the hand grenade' venture

capitalist approach to healthcare where current profits are privatised in the knowledge that future losses will be borne by the state.

22) Dentists are blessed to be in a profession where the causes of tooth decay (poor diet) and tooth loss (poor brushing) are well-known. If prevention could be successfully implemented in dentistry then it could be rolled out across the NHS so I will spend a few paragraphs analysing why this is not the case.

23) The elements of a successful preventive service are

- Identifying a group of patients for whom a named provider agrees to be responsible.
- Categorising those patients individually according to need (risk).
- Agreeing with the provider a fixed monthly or annual fee to adopt the cohort.
- Having a system of risk-based additions/deletions to account for patient movement.
- Indemnifying the provider against *force majeure* (patient getting hit by a train, orthodontics, implants etc.)
- Sharing with the provider any savings as a result of delivering improved oral health / reducing treatment demand. **This reduces the dental budget by reducing need and drives dentists on to greater prevention creating a virtuous cycle.**

The DHSC is nowhere near this situation. Reliance on patient charges keeps the Treasury locked into a fee-based system. Any dentist who is effectively delivering prevention is seen as an ‘under-performer’ and will have his budget cut. Therefore, there is no incentive to deliver. As a monopsonist (sole) buyer of NHS services, the DHSC sets fees below market rate, leading to lack of uptake.

24) The type of prevention that is most effective for the first two decades is dietary control to effect decay reduction (specifically cakes, biscuits and sweets and carbonated drinks). However, the DHSC with sponsorship from major manufacturers continues to insist that distributing toothbrushes and (branded) toothpaste to children is appropriate. Even the tax on sugar was not motivated by the dental health of children but by the cost of diabetes to the NHS.

25) After the teenage years and having been delivered with a healthy set of teeth, advice should pivot to thorough brushing, which prevents loss of gum and bone support and consequently extractions in later life. However currently the main thrust of prevention is 'means-based’, consisting of unsupervised advice on the best toothbrush, number of times to brush, whether to use an electric toothbrush, interspace brushes, mouthwash, flossing etc.

26) It is not uncommon to see a patient with loose teeth and advanced gum disease, who has been to the dentist twice a year including visiting the hygienist, has never seen plaque, doesn’t know what it is, where it is or when it has gone, and is intermittently cutting their gums to shreds with floss to no avail. These

victims of dental dogma are dismayed to hear that little can be done to undo years of supervised neglect.

27) Instead, an 'ends-based' approach is required which focuses on the desired result (plaque removal) by educating patients on how to see dental plaque (using disclosing tablets) and how to remove it with a simple brush, at which point they will spontaneously develop brushing habits that are effective.

28) A system of 'shared savings' as described above would encourage adoption of this model as dentists would seek the most effective preventive routes.

FLUORIDE

29) After attempts to bring in a national fluoridation scheme failed, attention turned to local authorities on the basis that, surely, some would welcome the opportunity to follow first adopters like Birmingham and others would fall in line.

30) From 2009-14 a hotly-contested attempt to introduce fluoridation in Southampton resulted in failure and all further attempts were discontinued.

31) Proponents of fluoridation are again calling for national fluoridation scheme however it is unlikely to be implemented.

THE WORK OF ALLIED PROFESSIONS

32) It is DHSC's policy following the Nuffield Report to hand off insofar as possible the routine care of patients to allied professions. To this end registration and regulation of allied professions was completed by July 2008.

33) There has been an increase in the rôle of the allied professions in particular the hygienist/therapist which is the practitioner thought most likely to be able to assume the bulk of routine dental work currently carried out by highly trained and expensive dentists.

34) It is more efficient for dentists to be confined to those procedures for which only they are qualified however the rôle of dentists is as the leader of the clinical teams with ultimate responsibility for the patient's overall care.

NHS DENTISTS' WORKLOADS AND INCOMES

35) As lead dental practitioner I have given written and oral evidence to the DDRB on many occasions. As a result I am in a position to point out its obvious failings as a system for setting fair pay.

36) It is superficially correct to say that, having entered into the process, the parties have agreed to accept the result. People who make this argument are generally expecting the staff side to accept the result, while ignoring the fact that the employer side frequently does not accept the result. For example, the DDRB may make an award of 6 per cent but reduce it to 4 per cent on account of

economic factors. The Government will ‘accept’ the 4 per cent recommendation

but then reduce it to 2 per cent on the grounds of economic factors/affordability, causing the staff side to be put in double jeopardy.

37) Despite the heavy emphasis on the word ‘independent’, to use an initialism that has fallen out of favour, the Review Bodies are Quasi-Autonomous Non-Government Organisations or QUANGOs. These are organisations to which a government has devolved power, but which are still partly-controlled and/or financed by Government. There is ample opportunity on the Lords Terrace or the Commons Tea Room to set expectations. In a rare instance where Sir Trevor Holdsworth’s Report was (in the view of the Government) unduly favourable to the profession, the entire Review Body was dismissed.

38) While there may be some benefits to working under contract to the NHS (pension, unlimited demand) all the time there are no barriers to choice, DHSC is in competition for practitioners with the private sector.

39) A better system is **Pendulum Arbitration**. Both sides put an offer to an arbitrator who is free to reject both; or choose one or the other, in which case the process ends. The offers can only be accepted in their entirety and not varied. This means that a negotiator who pushes too hard is in danger of getting a more reasonable offer from his opponent accepted in full. It encourages both sides to put forward their best offer at an early stage.

VOUCHER SYSTEM

40) The Dental Practitioners Association was long associated with a system of healthcare known variously as Grant in Aid or the Voucher System.

41) In this system the state makes a core contribution leaving dentists free to set their fees based on the service they wish to provide. As now, some dentists would work for core fees (for patients who are fully remitted or exempt or who want a basic NHS service) and other practices where patients would need to make a larger co-payment if (for example) they wanted a better quality material or prosthesis approaching private standards.

42) The patients’ co-payment would consist of their NHS charge plus any optional costs agreed with the dentist for better quality materials or laboratory work.

43) This system works well in other countries that do not have our predilection for inefficient, collectivist healthcare. Exactly how it could work is covered in previous submissions that are available on request.

ORAL EVIDENCE

44) Having given oral evidence in the past, the author respectfully asks that he is called to give oral evidence on this occasion as a stakeholder and authoritative in the main area of this Inquiry.

INFORMATION

45) The author welcomes the opportunity to discuss this document with any interested party.

The lead practitioner on this document is:

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