We must take back control

Vijay Sudra[1]

Key points

- Future of NHS General Dental Services.
- Erosion of GDP standing.
- Patients deserve better.

Abstract

General dental practitioners are the backbone of the NHS dental system but have seen the regard for their services eroded over recent years. It is time for the profession to reassert itself and the values in which it believes in order to provide fitting care for patients. Many aspects of the current state of affairs need urgent attention.

Abridged from an after dinner speech by the author as Chair of the LDC Conference 2019 held on Thursday 6 June 2019 at Birmingham Town Hall.

People often ask me why I still provide a full NHS dental service to all my patients. I do not have an answer that makes sense, and certainly not financial sense anymore. Perhaps I am foolhardy, but one thing I have learnt in life is it is best to be yourself, and not to change, do what you think is correct. I come from modest roots having arrived from Uganda in October 1972 wearing shorts and in shirt sleeves but otherwise coming to this country with nothing. I do a job which is rewarding and where most of our patients live on the same side of the railway tracks that I grew up on. I can relate to my patients and I genuinely have a passion for real wet-fingered dentistry. In the sort of practice where I work, alleviating dental pain is a very significant feature of my day-to-day work; many of my patients can be irregular attenders and despite this, it is satisfying to get them out of pain. Any pain is awful, acute dental pain can be insufferable: we are in a privileged positon. There is no other branch of medicine or surgery where immediate pain relief is provided on a daily basis.

I therefore resent being told, I am, or will be a 'tier 1 practitioner'. I am a general dentist and I am very proud of it! There is no need for the ability tiering nonsense that is being foisted upon our profession: we should all be able to deliver satisfactory dental care for our patients. This is what the BDS prepared me for and should prepare us all for. I have never refused to see new patients; they are the lifeblood of my practice. I am proud to work within the NHS despite all the issues – yes, I make an operating loss on some of these patients, but I look at the bigger end of year picture. The NHS has become part of this country's DNA. The nation is proud of what the NHS represents, and patients find comfort in knowing that they are being treated by the NHS for their dental needs and are respectful to my team for offering such a service.

It is a shame then, that successive governments have treated our profession with contempt and failed to recognise what we do for patients on the NHS. Patients used to get subsidised dental treatment on the NHS before April 2006, and, like a lot of things before that date, it made sense. The current patient charge revenue system is morally wrong.

I now speak for so many colleagues who work in practices like mine but have no interest in dental politics and who are simply happy to get on with the business of treating their patients. They are sick and tired, and fed up that the great and the good (and I include Chief Dental Officers [CDOs], Deputy CDOs current and past, the thinkers, movers and shakers, the academics, including those of us who ostensibly represent them as LDCs) who have never had to work in the UDA world, let alone in the general practice world. Yet these same people come up with ideas and variations on what is good for the profession and patients but have no idea what the reality is like at the enamel face, no idea at all. NHS practices are struggling. The system is broken. To all leaders of our profession, my message is simple: do not tell us what will work for us and our patients until you have experienced our world yourself.

The past decade

My final year at university studying for the BDS was 1992, HM the Queen referred to this same year as her *annus horribilis*. We, as a profession, have had a *decennium horribilis*, a decade of misery. We all know what's wrong: we get to hear this from colleagues all the time. Low morale, overregulation, fear of the regulator – a crisis point has been reached, unquestionably. Look at the data: average incomes continue to plummet. Spend on NHS dentistry in GDS/PDS [general dental service/public dental service] continues to come down year on year over the past decade. During this same period, the average taxable income of general dental practitioners (GDPs) has nearly halved from £99k to £55k. This is hardly going to fund the glamorous lifestyles we

[1]General Dental Practitioner, Shard End Dental Practice, 221 Heathway, Shard End, Birmingham B34 6QU
Correspondence to: Vijay Sudra
Email: vijaysudra1@gmail.com

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are all purported to have. During this decrepit decade, oppressive regulation and the expense of running practices has skyrocketed. More time than ever is spent on doing non-clinical work. Colleagues are doing more for less, often failing to make legitimate claims so that they do not become 'outliers' and face the AT stormtroopers. This is wrong. Surveys demonstrate time and again that increasingly more colleagues are looking to get out at the earliest opportunity. The mental and physical stress of this has an impact on our health physiologically and psychologically. It has become a dangerous vocation.

The unfortunate patients are totally oblivious to all of this, we continue to treat them in the same professional manner we always have. I would argue that the service that they get now, though not necessarily due to a fault of the profession, is poorer than ever for a multitude of reasons. Another concern over the past decade has been how younger colleagues fearing the wrath of the regulator are now content to refer anything remotely challenging, leaving the patients on ever increasing waiting lists being passed from pillar to post as the electronic referral management systems bounces them forth like yo-yos. How does this, 'Protect the Public' Dr Bill Moyes?

Fear of dental litigation has changed the landscape of our service too, across all sectors, and it is symptomatic of wider changes in society. The legal profession lost the gravy train that was legal aid and thereafter, the medical and dental professions have become easy prey. Regrettably, our own profession has done little to offer resistance to demands made by law firms when they go raking through patient record cards. I am sorry, but the indemnity organisations have a lot to answer for here. They have been too willing for too long to sign blank cheques fearing escalation and the associated costs if the cases end up at the GDC (General Dental Council). Allow me to give you an example of what I mean: I was recently at a lecture given by one of the indemnity organisations on the subject of record keeping. The audience was advised that to simply write OHI (oral health instruction) given to a patient was deemed inadequate, more detailed information on precisely what this OHI entailed is needed for a case to be defended – this is utter nonsense. More resistance has been needed rather than placating the parasitic lawyers and the GDC.

The reality is that the vast majority of us do an exceptional job for our patients. Sometimes things do go wrong, we are human, and nobody except the ambulance chasing lawyers and the GDC seek perfection in an imperfect but functioning world. The GDC and these lawyers are far from perfect themselves. The problem is simply that we have lost sight of common sense in all matters related to the provision and delivery of dental care.

As a young associate, I have had the privilege of working for some very highly skilled dental surgeons, their clinical work was good, but they were modest and did not necessarily seek recognition with additional medals, the BDS was sufficient. There was never any need identified for 'tiering', and the only patients we referred were those needing general anaesthetic and occasional denture patients that were difficult to satisfy: we just did the work. The hand written notes though brief had a human feel and the trained eye could decipher exactly what had been done. Today, we are forced to type ludicrous amounts of rubbish in the patient notes. The pursuit of defensive dentistry is madness and has nothing to do with the quality of care provided to our patients.

Somebody please, please tell me why we were wrong before and our current culture is the way forwards? Simple. Linked to this, there is nothing wrong with being a generalist, why do the powers that be assume we all want to, and indeed need to specialise? Our patients need GDPs. The BDS degree has become devalued. There are a number of reasons for this, some would be deemed politically incorrect. The world has changed, but the BDS remains a tough degree and the stress comes with the job is immense, there is nothing wrong with GDPs therefore earning a fair income for the work we have trained hard for. Nobody said dentistry was easy.

Also, we are losing the characters in our profession: consummate professionals, yet proud and good sports. Regrettably, too many coming into our profession these days seem to come from the same mould. Some are robotic in nature, having been spoon fed at the best schools; this is not what the profession, and more importantly, what our patients, need. I hear that some dental schools are offering 'resilience training' to BDS undergraduates – this should be a worry to all of society and relates to far more serious social and mental wellbeing issues affecting our younger people. Developments in communication have had an impact on society, good and bad. Abuse of, and obsession with, social media and the extremes in confidence that this creates has no place in any healthcare profession.

The old guard were great company to be with, they had a sense of humour and their lives were somewhat colourful (nothing wrong with that), they were good as clinicians, competent and safe, and their patients liked them. Best of all, they did dentistry.

The future

So, what of the future? How can we stop this rot? Solutions can and must be found; a common theme of mine is simplicity, do not go looking for complex answers to simple problems. If anyone is in doubt about where we are heading as a profession, then I would direct them to the outcomes of the national orthodontic procurement. Good, respected clinicians are losing their contracts overnight, often to faceless corporates, these corporates have teams of personnel who it is impossible to compete against in winning tenders by wet-fingered dental clinicians. When are NHS England and the Department of Health and Social Care (DHSC) going to understand the real meaning of value for money? It is not about the cheapest UOA or UDA, and that's before we consider the cost of these wretched procurements.

We have a despicable contract: it is unfair to the profession and to our patients. Its proposed replacement is no better, in fact, in my opinion, it is worse. It is unwieldly, it is a paper exercise in ticking boxes (just in case we don't have enough to tick already), it is fraught with potential abuse with misinterpretation of data (especially at transition), it only works in mixed practices, there are far too many unknowns (and this after how many years of piloting?). Not least, it brings into question, the employment status of associates (over 80% of our profession). HMRC are already looking at this.

Let's just step back and look at the bigger picture. At the inception of the NHS, the whole service cost £9 billion in today's money. The current budget for NHS England alone is over £122 billion. The cost has practically doubled since 2000 and the reasons for this are clear for all: an increasing ageing population and advances in medical and surgical care. Additional spend on NHS dentistry since 2000, however, has not doubled, it has dropped. We cannot go on like this. There are significant challenges on the horizon for the NHS, the recent epidemic in childhood obesity and the links to type 2 diabetes is a time bomb

ticking. Sugar is now known to be a killer. What message could be stronger? Any public education campaign should include the harm that these same refined carbohydrates are having on the dentition of our children.

Perhaps it is time to start pressing the government to force manufacturers to show pictures of decayed teeth on soft drinks and confectionery packaging in the same way cigarette packets now show the harm cigarettes cause. Extreme, I totally agree, but the number of children having GAs for extraction of teeth is a national disgrace. The likes of Coca-Cola and McDonalds have been allowed to get away for too long. Such a campaign of linking tooth decay and sugar consumption with obesity and diabetes will do far more than any wishy-washy campaigns to get babies to the dentist in preventing dental disease. The momentum is there; obesity is killing people, putting massive strains on the NHS, Public Health England need to educate, it is really very simple.

Which brings me onto the whole prevention agenda. We all extoll the virtues of preventative care, there is nothing wrong with that, but we must all be capable of fixing problems too. Treatment is also prevention, please do not lose sight of this when we are in discussions with the Department and equally, we need to be paid appropriately, for both. Painting fluoride varnish is no substitute for being able to carry out root canal therapy, and this, in the vast majority of cases, should be deliverable by a GDP to an acceptable standard, free of the shackles of which tier the work or the practitioner fall into. We must not allow any further deskilling of the profession. Prevention is part of our armamentarium, not the panacea that many would have you believe.

We have too willingly accepted the language which sucks us into the Department's dangerous web. Why do we speak of tiering without challenging the need for such a dangerous and blunt tool? We must stop the forced erosion of our abilities. We must stop accepting in our lexicon the language that allows the further diminishing of both the BDS and the GDP: I want tiering out, common entry out, UDA out, silly window dressing gimmicks in the name of prevention out, grey areas in the contract out, non-evidenced based directives (HTM0105, use of amalgam fillings in under 15-year-olds etc) out. Incidentally, the harm our profession is doing to the environment as a result of HTM0105 needs addressing, urgently. The world is looking to use less plastic, we are going in the opposite direction: where's the common sense in that?

With the new language have come new structures taken from the medical world: the MCNs (medical clinical networks) and the LPNs (local professional networks). They may work there, but in my experience, neither of these are working for us, and if they do, they will come at a cost to the GDP. Global warming is aided by the vast amounts of hot air produced by these MCNs and LPNs.

Something else that needs addressing is the issue of inter-colleague assessments and professional relationships. Those that represent the profession (LDCs, GDPC) and those that judge us (DPAs, expert witnesses) must understand the circumstances under which our colleagues work. And, they must be able to demonstrate that these same representatives and adjudicators, can equally do clinical work themselves under the same conditions as the rest of us, before passing judgement or directives. I have heard stories of shockingly poor expert witness testimonies at fitness-to-practise hearings. Those people who purport to be better than the rest of us should all be accountable for their actions and mechanisms must be in place to challenge their experience of the real world. The usual adage applies – do not compare a Ford Fiesta with a Rolls Royce, they both do one basic job, but they are different: the poor associate under investigation may be working under pressure to deliver a molar endodontic treatment for £30 while the specialist expert witness may be charging 30 times more to deliver a perfect result. Do not judge a man until you have walked a mile in his shoes.

Linked to this matter is the disturbingly high number of inter colleague referrals to the GDC for non-patient safety matters because professional relationships have broken down. This is unprofessional behaviour and, again, symptomatic of wider social changes related to the demise, sadly, of professional values. It is also disappointing that a past CDO and two past Deputy CDOs have no ethical concerns about sitting on boards of dental corporates once they have left office – what message does this send to the profession and the DHSC?

I believe in a no-nonsense approach to tackling our problems: keep things simple and there can be solutions found. There is no point talking about skills mix usage until there is a contract that can deliver it. Equally, there is no point in pretending that we have a truly NHS dental service anymore, we do not. And this is coming from me, one of those practitioners who still ardently works completely in that system. Let us have an adult conversation about this. Perhaps the time has finally come to say those that need the treatment most receive it paid for by the state, this could be on based on inability to pay by the patient or based on what they need: pain relief must be available to all on the NHS, this is essential for any first world nation. Let's be clear about what we can and what we cannot prescribe on the NHS and get this is black and white. The prototype nonsense is an agonising charade that needs to stop. It is only working for those that are making it work and in mixed practices where private income is holding the thing together. Treatment is prevention, please do not lose sight of this while chanting the prevention mantra, and most importantly, both need to be paid for appropriately.

As the dental budget is reduced year on year, with ever increasing clawback, the longer we delay a replacement to our current contract, the less money there will be left to start the reformed contract with. There is now desperate need to stop and reverse the clawback of monies from NHS dental services. Otherwise, it really will be game over.

The GPs have an access problem, so we are told: billions of pounds found from down the back of the sofa to help and on top of that they get they get crown indemnity too, plus costs to help recruit more staff to ensure GDPR compliance. Where is the parity? So, this is my message as Chair of the LDC Conference 2019; we must stop being led up garden paths that suit the Department. We must stop dancing to their every tune. If we collectively say no, no, no, who will deliver the work: fix broken teeth, not just paint fluoride varnish? We are dentists! We must get our patients onside, we must educate them on why they deserve a better deal. The time has come to stop nailing pretty framed pictures to the surgery walls encouraging babies to attend the practice, when the building around us is falling apart.

We are the most resilient of all primary care providers, and there is no reason to be modest about this. We should be proud of what we have achieved for the nation's dental wellbeing. We have so much to offer, far more than any government will give us credit us for. GDPs must remain head of the dental team, not just part of the team. We still have some power, it is time to use it. For our patients, for our younger colleagues, for the sake of our profession, it is time to take back control. We can, we must, and with the right attitude, we will!