

Written evidence from Mr Martin Kelleher

Q 1. What is the state of the relationship between the NHS and dentistry?

1.1 It is highly dysfunctional.

1.2 Confidence in the NHS has completely collapsed within the UK dental profession. The imposed and widely discredited 2006 contract, which is based on Units of Dental Activity (UDAs) is target driven with dental care being commissioned to meet the basic dental needs of only around half of the population.

1.3 Two frequently peddled lies to the public include “that dentistry in England is the envy of the world” and that “it is free at the point of delivery”. Neither statement is true.

1.4 Dentistry has **not** been free since the 1950’s .The introduction of patient charges for dentistry caused Nye Bevan, who founded the NHS, to resign. The present patients charges (which are additional to the tax and national insurance most patients will have already paid) now contribute about £650 million to the overall spend on NHS dentistry. The state’s nominal expenditure is about £2200 million.

1.5 England has chosen to substitute increased patient charges for state investment. Since 2010 patients have been contributing an ever increasing share of the NHS spend on dentistry with these rising from just over 20% to nearly 30% of the budget.

1.6 In 2006, the Health Minister in England set aside roughly £35 per head for dental care. Twelve years later, England now allocates only £36 per capita, with Scotland investing about £53 per head and Northern Ireland allocating £57 per head

1.7 Factoring in inflation, spending in England has fallen by £12 per head in real terms since 2010.

1.8 In practical terms, Government contributions in England have fallen by over £500 million since 2010 with the increased patient charges plugging part of that gap.

1.9 NHS dentists' contracts specify that they have to collect those state imposed patient charges and account for them –unlike doctors.

1.10 To control overall state spending on dentistry, the fees allocated for dental treatments have been set at unsustainably low levels. That has resulted in many dentists refusing to treat “high needs” patients -or those with complex medical or dental problems - because they would go broke if they did so frequently.

1.11 Once the commissioned and agreed UDA targets are met then many patients are unable to access NHS care from their local dentist for the rest of that year.

1.12 NHS dental practices are closing across England, including three recent high profile closures in Portsmouth, previously owned by Colosseum, and one in the Suffolk constituency of Health Secretary Matt Hancock.

1.13 Dental corporates, an ever increasing presence in NHS, are arguably a Ponzi scheme, a form of pyramid selling. Some are largely reliant on venture capitalists' short term investments .Practices have been acquired and packaged together usually with some increased clinical activity (such as providing Botox, dermal fillers , ceramic veneers ,short term orthodontics and/or dental implants) coupled with some creative accountancy before being sold on to the next buyer with the increased debts.

1.14 Last year Integrated Dental Holdings (IDH), better known as Mydentist, which has now bought 600 practices, reported a doubling of pre-tax losses to £144 million. Those acquisitions were fuelled by more than £1 billion of debt (including loans from its private equity partners).

1.15 IDH has said it will not be buying any more dental surgeries for the time being as it is having great difficulties in retaining and recruiting staff to work under the current NHS contractual regulations.

Summary: NHS dentistry faces a range of existential challenges – a recruitment and retention crisis and a failed contract which is devastating morale in the profession.

2, How satisfactory are the arrangements for the provision of dental services by the NHS?

2.1 They are most unsatisfactory from the perspectives of most dentists and very many patients. Since 2006, when the fee per item of service was replaced by Units of Dental Activity (UDAs) which were commissioned at a very low value, dentists have had to adapt to those imposed changes by doing very different types of dentistry.

2.2 In practical terms, the limitations of the UDA contract system means that many dental professionals are now unable to spend enough time on helping patients to implement effective preventive strategies. Many feel that they cannot afford to treat patients with high amounts of tooth decay, or to provide difficult root fillings, or deliver high quality dentures, or manage tooth wear appropriately for many in the population because they are, in effect, penalised financially if they try to do so.

2.3 One interesting question is: "Was this done deliberately to force dentists into the private sector or in to the corporate sector - or was it a perverse outcome because it hadn't been thought through?"

3, Are current arrangements contributing to the widening of health inequality?

3.1. Yes, they definitely are.

In England, the Department of Health allocates about £36 per head (as previously stated) which is grossly inadequate to fund decent levels of care for people with significant tooth decay or serious gum problems. These are referred to as "high needs", and most of them are in social groups 4 & 5.

3. 2.The UDA fee structure does not encourage dentists to undertake effective preventive approaches and discourages them financially from undertaking time consuming, technically difficult- but possible- dental treatments. When patients receive a lot of time consuming, extensive treatment, it comes at the expense of the providing dentist – and there is a limit to how much altruism

they are prepared to give. For instance, if a dentist were to provide all levels of dentistry possibly required for about £70-the rough value of three UDAs- they would probably be better off giving the patient about £500 out of their own pocket, or asking them to get somebody else to do it, or possibly by inappropriately referring them to a hospital.

3.3 People who can afford to go to private dentists do so and get their desired result. Those who cannot – those on very limited incomes – do not. Dentists do not usually provide the most complex treatments under the current NHS fee system because they want to stay solvent. Dental practices are businesses and if they do not get enough income from doing complex treatments to match their outgoings, they go bust – and they are not willing to do that.

3.4 Many people on very low incomes are exempt from paying dental charges. This would be OK if the fees payable to the providing dentist for delivering these high volumes of treatment were reasonable- or reflected the time, equipment and skills involved in undertaking many technically difficult treatments.

3.5 Realistically, people who are exempt on income grounds can only go to NHS dentists.

3.6 Sadly, most tooth decay is still found in social groups 4 & 5. Most dental problems are due to poor diets, inadequate dental cleaning, frequency of sugar intake and smoking. The more obese they are, the more tooth decay they are likely to have- partly because of the frequency of eating hidden sugars often present in cheap processed foods.

4 How could access to NHS dentistry be improved?

4.1 Increase the resources available and possibly adopt some sort of attractive salaried service for some priority groups. If enough dentists were adequately salaried and able to work in a satisfactory environment then the present problems of access for effective prevention and appropriate treatment would not be such an issue. It is because dentists have to make their income out of these units of dental activity (UDA) contracts that the situation has become problematic.

4.2. For the sake of argument, supposing a dentist was to spend about five hours undertaking direct resin composite bonding to deal with extensive wear on an individual patient. They would be paid for all that experience, skill and

time with just three UDAs (circa £70) .Not only would they have they lost substantially on providing that proven protective resin treatment but they would have also lost the opportunity to see other patients during those five hours to help to fulfil their UDA contract obligations.

4.3 Great pressure now exists because each NHS dentist has a total number of UDAs stipulated by their contract. If they fail to meet that agreed target, they have to pay back the balance -or if they are an associate they may well be fired by that practice.

4.4 The Department of Health imposed this contract in 2006. Just before that happened, many dentists were terrified that if they didn't get a contract to fund their existing practices they would lose their business. This resulted in them carrying out lots of necessary dentistry on a "fee per item of service" in order to get a soon- to-be –imposed UDA based contract.

4.5 The general idea of the UDA based contract was to deliver to NHS dentists roughly the same income that they had received previously under the old contract, which was based on a piecemeal fee- per- item -of -service.

4.6 However, the actual value of the Units of Dental Activity then got revised downwards over the years, usually by the NHS negotiating lower prices .The corporates then muscled in to sign high volumes of UDAs which they promised they could deliver at much lower UDA values than the much smaller individual dental practices. However, in the end they could not and did not. Hence the huge losses reported (£144million in the case of Mydentist) and some practice closures -which have already been mentioned above.

4.7 Dentists have to fulfil the agreed minimum specified under their NHS contracts .In private practice there is much more freedom to do what the individual patient actually wants and would benefit from. That is partly because much more clinical time is available from more experienced (and perhaps better qualified) dentists. In addition, better materials, modern techniques and more skilful technical laboratory support are much more readily available in the private sector.

4.8 All dentists have to pay VAT on materials and equipment as well as items such as dental implants .They also usually pay 40-45 % income tax on whatever they have left after their expenses have been paid - as well as making national insurance contributions and pension contributions for their employees.

4.9 So why do politicians still support dentistry under the NHS?

It would be political suicide if they did not. Politicians need to keep up the pretences of this thin veneer of easy availability of NHS dentistry “which is free at the point of delivery” –although it has not been true since the 1950’s.

4.10 Complex, time-consuming treatments are only available under the NHS system if dentists are willing to take a financial hit to provide them and incur the possible complaints and /or regulatory and legal issues that go with providing these. They could be doing dentistry for very little but that does not stop patients complaining if they are “not totally happy” with the outcome - with all the potential regulatory and legal risks and worries that follow.

4.11 Complaints by patients, most of whom have caused their own problems by frequent use of sugar and/or poor cleaning and /or smoking have led to some dentists becoming very risk averse and therefore to practise “defensive dentistry”. This involves making copious notes but not actually providing some moderately difficult treatments themselves- but instead referring the patient to dental or other hospitals.

4.12 That “defensive dentistry” approach is partly to protect themselves from possible future complaints. That is because there is now a widespread perception that the General Dental Council usually assumes that if the patient complains about anything that the patient is always right and the dentist is usually wrong.

4.15 Many of the more experienced dentists have moved out of the NHS system, either partially or completely .Those that can will do so increasingly in the future -or they will emigrate .

4.16 Many surveys show that new dental graduates do not see any future in working in NHS dentistry.

5. Are there inequalities in access to dentistry services?

5.1 Of course there are. However, the Government has NHS dentistry in its control and it appears they have no intention of changing things as long as they can get some dentists to carry on doing NHS dentistry with all its flaws.

5.2 Corporates have also become a significant part of the NHS mix and this hasn't helped in terms of effectively improving patient access for comprehensive treatment. Many conglomerates - who now make up close to a quarter of all dental practices treating NHS patients cannot retain dentists- not even those they have recruited from abroad. The reason is that these associate dentists work on commission – often based on 40-50% of the value of any negotiated UDA – and they soon become aware they cannot make a living. That's why quite a number of corporates have run into serious trouble with staff retention when trying to run their businesses on retail lines.

5.3 The SpecSavers model simply doesn't work in dentistry because, unlike providing eyewear, skilled customised and irreversible dentistry on individual patients cannot be outsourced to a low- cost factory facility.

5.4 Corporates, as mentioned in 2.2, and 5.2 are seen by some as little better than Ponzi schemes. Small corporates nominally increase turnover and then sell out to a bigger corporate body that do superficial improvements –different signage, more advertising etc. They add non- purely -dental services such as Botox and dermal fillers, which is more lucrative to provide than general dentistry. When it comes to complex treatments such as root canal treatments or implants, they bring in specialists and charge privately for this. So the patient who couldn't afford to go private in the first place, which is why he went to the NHS, ends up being offered specialist treatments with the possible consequential bills for a specialist.

5.5 The complex issues exposed in the current English NHS contract has had many unintended knock-on effects. Contracts may vary throughout the country but they have all agreed certain target UDA figures. Where there are situations where dentists are being paid the same for doing one filling as for doing 20 fillings, dentists start to look for people needing just with one filling and try to pass on the other more time consuming or difficult cases to someone else, often on the grounds that it is beyond their "level of competence". As a result, patients with extensive decay or gum problems, or other complex needs, start being bounced around, because no one really wants to treat them on the NHS on time and cost grounds.

5.6 Some eventually arrive at hospitals where consultants work out an appropriate treatment plan but then they often have to find a dentist in general practice who is prepared to take them on – and that usually means

going private to get the actual treatment done at some mutually agreed appropriate fee reflecting the actual time and technical difficulties involved .

5.7 The bottom line is the patient who cannot afford to go private for some complex treatments is left with little or no choice. That is the real issue in terms of inequalities in access to dental services.

6 What could be done to address the inequalities?

6.1 Have a new contract that is fair to both patients and dentists to make it a properly functioning service. Various pilot schemes have been trialled and reported on- but none have been adopted- probably because the present system suits the Treasury.

6.2 The unfairness of the current contract means that patients cannot get an appropriate or fair level of care. Government keeps going on about “more access” to some sort of less qualified dental professional .The flaw is that if you have more access to some system or dental professional who then doesn’t solve your actual problems, what is the point? – you are no better off. If the problems do get not sorted out effectively, you are left with the problem.

6.3 The Government is not prepared to say openly that having taken peoples’ taxes and national insurance, it can’t- or won’t - provide the possible crowns, complex molar root fillings, high quality dentures or other treatments for all potential patients – and that these will have to be done privately after negotiations with dentists .

6.4 Understandably, many patients hate the inherent untruthfulness of having paid NI and income tax , which was based on various government promises that they can then access modern dentistry “free at the point of delivery” when they need it, then find out that they cannot get what they believe is their fair due .

6.5 The Government has to decide what to do about this. They are now spreading the budget resources so thinly with UDAs that NHS dentist are forced to do the bare minimum. The wealthier in society, who want to look

good and who do not want to see teeth being lost as a natural part of growing old can afford to pay what they need to obtain their chosen types of dentistry.

6.6 As any experienced businessperson soon realises, it is impossible to have “good, quick and cheap” all provided in the same deal. Two out of three is the business rule. In other words, if it is good and quick -it will not be cheap. If it is cheap and quick- it will not be good long-term.

6.7 An “Iron Triangle” exists in healthcare. That expression means that out of the same financial resources it is possible to get excellent and quick healthcare results -but only for a limited number of people. Alternatively, out of the same financial resources, one can get slower and reasonable results for many more people. Two out of three of “quick, good, cheap” remains the rule.

6.7 Government has to decide what it wants out of it’s limited resources and to stop lying to people that it is possible to have excellent, cheap, and quick dental services out of the very limited resources that they have chosen to allocate for the provision of dentistry.

6.7The health committee hearing is probably just another delaying talking shop. True ,there will be recommendations written in civil service double speak ,as we have had before, but then it will all get kicked into the long grass . The sad truth is this present system works very well for the Government with their limited resources and they can continue to blame dentists for any perceived deficiencies or problems experienced by patients .

6.8 Various new pilot schemes have been commissioned to replace the current system but these have resulted in no concrete action.

7, Where does dentistry fit in within the NHS primary care services?

It is largely separate in terms of NHS provision of healthcare. The mouth now seems to be regarded as a separate territory and not as part of the whole body medical model.

For instance, doctors do not charge patients but they get practice allowances and various payments, contributions for staff salaries etc. that dentists don’t get. Instead, NHS dentists have to make a modest living by operating under significant pressure by working within a seriously flawed NHS contract.

8 What opportunities are presented by the development of primary care networks?

8.1 Training practices and schemes exist but these seem to be there largely to shore up marginal NHS dental practice's profitability.

8.2 It is highly questionable what new dental graduates really learn that is of lasting value for the benefits of patients during their first year after graduation in their "Vocational Training" (VT) year. This is in spite of the huge costs involved in providing these schemes for Vocational Trainees.

8.3 In many experienced dentist's eyes some VT training practices perpetuate existing NHS suboptimal standards, treatments, or techniques which can then quickly become normalised in those new graduates.

8.4 Dental Core Training ("DCT") can help filling gaps in experience but the undergraduate curriculum now involves so little actual clinical training that new graduates need very close supervision for much longer in order to become adept in solving moderately complex dental problems.

8.5 Some training and education schemes exist to improve the technical root filling skills of a small number of dentists -but these have had only limited impact.

8.5 Sadly, the UDA system offers new graduates -or even experienced practitioners - very few incentives to encourage them to acquire and develop sophisticated dental skills -largely because they will not be paid adequately to use them under the current NHS system.

9 What issues are affecting the wider dental workforce?

9.1 Perceived loss of professional autonomy, loss of security and loss of status.

9.2 Overwhelming bureaucracy and having to keep copious "defensive notes" in case of possible complaints.

9.3 Perceived fears about falling foul of perceived antagonistic regulators such as the General Dental Council and the CQC

9.4 Increased demands and complaints from patients if they are not "completely happy" with some aspect of their treatment that they have been

led to believe is their absolute right by some government disinformation and misinformation –but which is also spread by GDC propaganda.

9.5 Early retirement by many experienced dentists, now disillusioned with the NHS system, will have unpredictable consequences for training and mentoring in many NHS practices.

9.6 An increasing number of females in the dental work force might well be altering the number of “available dental treatment hours”. It needs to be emphasised that many women dentists do work a similar number of hours to many men and in doing so contribute hugely to patient care.

However, a significant proportion of younger dentists now want to work part time –often because of various family responsibilities -and many of these are female. As an understandable result, the previously expected 40 to 50 hour week of patient treatment hours being available from each dentist on the register, might be now as low be much lower e.g. 10-15hours per week .

9.6 Any general dentist, of any gender, working only 10-15 hours a week will be unlikely to acquire the many new skills now needed to treat an ageing population with their increasingly complex medical and dental needs.

10 What steps need to be taken to address them?

10.1 Any new system needs to provide some security and status and instil in dentists a desire to partake enthusiastically in a public run service. At present, there is no reason for any dentist to see his or her preferred future being in the NHS long term. The Government is currently calling all the shots and many experienced NHS dentists feel undervalued, frustrated, demotivated and largely powerless within the present system. This why many surveys show young dentists wanting to get out of the NHS as soon as possible.

10.3 The frustration in patients about not receiving the dental treatment that they feel entitled to is often vented on dentists .That is understandable but NHS dentists are the wrong target. Citizens who have paid compulsory income tax and national insurance (with the majority of patients then having to pay contributions to state imposed dental fees out of their income that has already been taxed) are entitled to feel aggrieved- but they should address the proper target . That is the UK Treasury and that part of the complicit Department of Health which are jointly responsible for the current mess.

10.3 The Treasury is laughing because of being able to raise the income from taxes while simultaneously neglecting to pay for comprehensive dentistry out of it.

10.4 Government propaganda involving disinformation and misinformation abound about NHS dentistry .Lies follow lies. “Free at the point of delivery” – it isn’t. “Treatment is based on need” -, which it isn’t.” The NHS service is the envy of the world” – which it sure as hell isn’t. Politicians trot out these three lies all the time and they do not challenged frequently enough.

10.5 Any time a dentist tries to speak out about the real problems in NHS dentistry, the Government mounts a PR campaign in some tame newspaper such as by saying, “Look at that rich greedy bastard dentist demanding money from the poor widowed pensioner”. However, when they do this they are just destroying mutual trust on which people have to rely in order for society to function. Little wonder that most dentists now do not trust government.

11 Is sufficient data available on the workforce and if not how should it be improved?

11.1 There is sufficient data on registered numbers of dentists but the real problem is these do not show how many hours each registered dentist is working.

11.2 One can look at how many people there are on the GDC register and where they qualified - as well as possibly their genders .However, no one can tell for sure how many hours they are working clinically- or whether this time is spent on clinical NHS dentistry or on working privately.

11.3 What the data need to show is if a dentist is undertaking any treatment at all... or is it 5,20 or 30 or perhaps any number up to 50 hours a week of clinical activity. At the moment, there are no reliable or accurate figures available as to the number of actual treatment hours being worked .Neither is there any solid information available on the hours that are theoretically available from the workforce to treat the complicated dental needs of an ageing and increasingly medically and dentally compromised population.

12 What are issues in commissioning and payment systems for NHS dental services and how can they be improved?

12.1 The main issue is that the present contract does not give an outcome that is good for either patients or dentists. It is quite satisfactory from the

Government's point of view as they are getting significant sums of money and able to control their overall spend. Hence, the measly current £37 a head per year allocated for NHS dental patients in England.

12.2 Does anyone seriously think that one can get comprehensive dentistry for a year for less than the price of one good meal in a half-decent restaurant or for the price of half a tank of petrol?

13 How can they be improved?

13.1 Be more specific as to what is included and what is not in NHS dental provision. The Government needs to stop saying it is a comprehensive all-inclusive modern service – mainly because it isn't and it won't be in the future.

13.2 The truth is that the government is cheating patients. If a private insurance company took agreed premiums for anything and then refused to pay out as they had promised they would, they would be sued all the time.

14, What needs to be included in or removed from the current NHS dental contract?

14.1 Get rid of UDAs and come up with a fairer reward system which means that younger and experienced dentists can afford to – and genuinely want to – work for the NHS – or there won't be one in the future.

15 Is there enough focus on prevention in dentistry and what are the avoidable forms that could be addressed?

15.1 No. There are multiple powerful disincentives such as lack of available time to communicate the correct preventive messages effectively. There is a lack of available time for follow-up appointments to help check that patients have understood the right messages – such as reducing their sugar frequency and improving the cleaning between their teeth and are acting effectively on those messages.

Little clinical contact time as is allowed for smoking cessation advice which needs to be very effective because smoking increases the risk factors of developing gum diseases by between 400% and 700% – all depending on the number of cigarettes smoked and the number of years of smoking etc.

15.2 A hypothecated tax based on sugary drinks and hidden sugars in processed fast foods could help – but only if the resources raised were to be allocated for better dental treatment, which is highly unlikely.

15.5 However, it needs to be noted **sugar free** fizzy drinks are still **very dangerous for teeth** and that fact seems to have escaped those promoting sugar taxes. There is an emerging epidemic of tooth surface loss particularly in young people's teeth which is being caused by the multiple erosive acids (carbonic acid, citric acid, phosphoric acids etc.) which are contained within these heavily advertised drinks

These fizzy drinks are now heavily promoted as being "calorie free and sugar free" and they account for about half of fizzy drinks sales and profits .However far from them being beneficial they damage the teeth **badly by dissolving them** in the acids so that large amounts of sound teeth disappear- rather than rotting them with the frequent sugar contact.

15.3 There is a need to advise the use of appropriate sized tapering Inter dental brushes (not the ones in the store) which have much better compliance with their use than dental floss.

15.4 Dietary advice provision and supervised cleaning with appropriate fluoride toothpaste should be obligatory from an early age in schools, especially for children from disadvantaged backgrounds.

15.5 Prescription of triple strength fluoride toothpaste should be encouraged for elderly medically compromised patients with teeth because their protective saliva is grossly reduced as a bad side - effect of the drugs keeping them alive. The intensely uncomfortable dry mouth -which is due to the reduction in their saliva -often leads to frequent sipping of sweet things and thereby allows new decay to develop around their already filled, crowned or otherwise compromised teeth.

15.6 There is a need to tackle the dental consequences of bulimia with direct resin composite bonding being used early to protect the unfortunate patient's teeth from the hydrochloric acid in vomit which swiftly removes the vulnerable outer enamel from the inside of the top teeth

16, What can be learned from best practice in other parts of the UK or EU?

16.1 Water fluoridation in Birmingham has helped to reduce tooth decay in the most vulnerable groups. Sadly that is only true if people drink the water from the tap rather than some young people drinking, cheap, heavily promoted addictive sugary "cool" drinks over extended periods.

16.2 There is strong evidence for the effectiveness from fluoridating water- but only provided that it is tap water people actually drink -rather than using single use, disposable, environmentally polluting, plastic bottles for carrying non fluoridated water around all day with them.

16.3 There is a lack of political will to impose water fluoridation on populations. Some political activists persuade politicians to see water fluoridation as “mass medication”, so they keep kicking the issue into the long grass.

16.4 Fluoride in toothpaste has gone a long way to help where it is used consistently and appropriately.

16.5 If people could be persuaded to stop eating sugar so frequently, used triple strength fluoride toothpaste (when appropriate in high caries risk situations) and cleaned their teeth properly including using tapering interdental brushes regularly, that would reduce oral health problems- and their associated costs- quite dramatically.

16.6 Smoking is a major risk for developing gum diseases with the increased risks ranging from 400% to 700%-all depending on the amount of cigarettes smoked by individuals and the number of years of smoking.

Smoking cessation needs to be encouraged – **but not by substituting vaping instead**. Vaping is being quietly and corruptly encouraged by the tobacco industry as their new “cash cow”. Nicotine and other toxins in vaping still hit the mouth first and will probably have the same bad effects on the gums as smoking cigarettes.

Summary:

1. The reality is that Government could do a lot more to make the main issues and problems go away. However, that is only if it has the determination to do so and a real desire to deploy the necessary resources to achieve better outcomes for patients.
2. The relevant government departments and their various regulatory agents should not encourage ever more unrealistic expectations among patients unless the Treasury puts an awful lot more money in to helping to achieving those ambitions.
3. Dentists cannot control other people’s genetic susceptibility to their dental diseases, nor control the sugars in their diets, nor their smoking habits nor the effectiveness of their dental cleaning.

- 4 Dental professionals can advise on how to reduce or mitigate dental disease risks and treat the consequences of many of these -but only if there is a fairer system to allow them to do so.
- 5 Dentists cannot force patients to comply with good advice and therefore they should not be blamed for patients largely causing their own problems.
- 6 The perception of fear among dentists that various regulators (such as the GDC and CQC)will not treat them fairly if there are spurious complaints needs to be addressed urgently if it is considered desirable for dentists to re-engage with solving technically difficult dental problems.
- 7 Having lost the hearts and minds of so many NHS dentists the government now needs to do some meaningful things soon to mend fences within the majority of the dental profession that has largely lost faith in it.
- 8 It is in everybody interests that they should do this quickly because they still need the dental profession's engagement and goodwill for whatever limited future dentistry might now have within the NHS.

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