Neutral Citation Number: [2023] EWCA Civ 481

Case No: CA-2022-001260

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE KINGS BENCH DIVISION
ADMINISTRATIVE COURT
Mr Justice Ritchie
[2022] EWHC 1380 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 5 May 2023

Before:

LADY JUSTICE KING
LORD JUSTICE COULSON
and
LADY JUSTICE NICOLA DAVIES

- -

Between:

The General Dental Council	**Appellant**
- and -	
Lucy Jane Williams	**Respondent**

- -
- -

Ms Z Johnson KC (instructed by **GDC Legal Advisory Service**) for the **Appellant**
Mr Robert Kellar KC (instructed by **Hempsons Solicitors**) for the **Respondent**
Mark Vinall as **Advocate to the Court**

Hearing Date: 30 March 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 5 May 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives

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LORD JUSTICE COULSON:

1. Introduction

1. This appeal arises out of a decision of the appellant's Professional Conduct Committee ("PCC") in which various charges were found to be proved against the respondent. On her appeal to the High Court, Ritchie J ("the judge") allowed that appeal in part, in particular relating to the "top-up" payments and related findings of dishonesty concerning three patients, T, U and V. A central feature of the judge's conclusion was his view that, contrary to the agreed position of the parties before him, the relevant Regulations did not prohibit the conduct complained of. Unusually, therefore, the appellant appeals against the judge's decision with at least some support from the respondent.

2. As I demonstrate below, the relevant Regulations are not at all straightforward. It appears that they have been accepted for many years as having a particular effect, but until the judgment below, no-one has troubled to analyse the actual words they use. The judge concluded that they did not mean what the appellant had always assumed they meant. To aid our task of interpreting them, we have been considerably assisted by Ms Z Johnson KC for the appellant (who did not appear below) and Mr Kellar KC (who did), and by Mr Mark Vinall of counsel, who was appointed as advocate to the court in the circumstances noted below.

2. The PCC Determination

3. The PCC Determination was dated 19 January 2022. It ran to over 70 pages. It covered numerous charges relating to 15 different patients.

4. The part of the Determination with which this appeal is concerned related to patients T, U and V, and is addressed at pages 65-72. These were all patients seen by the respondent for crown treatment in 2018. In each case, the patient was offered a porcelain bonded crown on the NHS. However, the patients were advised by the respondent that a better-looking ceramic crown could be provided for an additional fee, to be paid privately. The amount of the additional fee was modest: it varied between £30 and £65. This was to cover the additional laboratory costs of a ceramic crown.[1] It was described by the judge at [68] as "the difference in price between the porcelain bonded crowns and the wholly ceramic crowns".

5. The Determination proceeded on the basis that it was impermissible to mix the payment structure of the NHS and private payments in this way. It was accepted by the respondent that her conduct was "inappropriate", but she maintained that she did not know that what the appellant called "top-up fees" were not permitted. Dishonesty was firmly denied. In each case, however, the PCC went on to find that dishonesty had been proved and erased the respondent's name from the appellant's register.

3. The Proceedings

[1] Laboratory costs were deducted from the monthly payments the respondent's practice received from the NHS. Thus, without the additional payment, the practice was financially worse off if it offered ceramic as opposed to porcelain crowns.

6. On 15 February 2022, the respondent appealed to the High Court. Her appeal concerned, not only the findings in respect of patients T, U and V, but also patient S and other charges (not related to the ceramic crown treatment) in respect of patient T. There was no appeal in respect of the remainder of the Determination.

7. The matter came before Ritchie J on 18 and 19 May 2022. In his judgment dated 7 June 2022 ([2022] EWHC 1380 (Admin)), the judge dismissed the appeal in respect of patient S and the other charges involving T. However, the judge allowed the respondent's appeal in respect of the top-up fees charged to patients T, U and V, and quashed the findings of dishonesty in relation to those patients. He changed the sanction from erasure to one of suspension for 9 months.

8. The relevant parts of the judgment are set out between [66]-[111], with a further relevant finding at [137]. It is unnecessary to set those paragraphs out in detail. The essential elements were:

   (a) The relevant facts were summarised at [66] – [68]: the three patients accepted the appellant's offer to have ceramic crowns, part funded by the NHS and part by the patient paying privately. It was not the case that ceramic crowns were deemed medically necessary for these patients such that they would be automatically covered by the NHS: [68];

   (b) The judge recognised that both the experts who gave evidence to the PCC were agreed that the relevant Regulations prohibited top-up fees but rejected their evidence on the basis of the Regulations themselves: [69], [73];

   (c) The judge looked at the specific contract between the respondent's practice and the NHS which he noted reflected the terms of Regulation 22 and Schedule 3, paragraph 10 [74-76];

   (d) Having set out these matters, the judge concluded that the respondent "would have been entitled to conclude that she could charge top-up fees for the crowns she offered if the patients agreed to that route and she provided proper all round advice and so long as her clinical judgment was that ceramic crowns were not necessary for their 'oral health' and hence not available on the NHS": [79];

   (e) The judge said that he could not support the finding of the PCC, whatever the experts said or agreed, that voluntary mixing was banned by the Regulations. It was on that flawed basis that they had rejected the respondent's defence of genuine belief [96];

   (g) In all the circumstances of the case, the judge quashed the dishonesty findings in relation to Patients T, U and V. His detailed findings on this issue run from [95]-[111]. I address this aspect of the judgment in greater detail in Section 8 below.

9. On 28 June 2022, the appellants filed a notice of appeal. Doubtless in order to be helpful, the parties submitted an agreed consent order, allowing the appeal by consent, because they were agreed that the judge's interpretation of the relevant Regulations was wrong. However there were difficulties with that course, not least because, although the appeal was being allowed, it was proposed that the order that the judge made remained unchanged. Furthermore, and perhaps more significantly, there were

concerns about the making of a declaration that the judge's interpretation of the relevant Regulations was wrong, in circumstances where there would be no oral argument.

10. In the end, these difficulties were addressed by Dingemans LJ at a hearing on 15 December 2022 ([2022] EWCA Civ 1899). Dingemans LJ pointed out the problems with both the original consent order and the parties' subsequent proposal (which he described as a private agreement between the parties not to rely on the dishonesty findings). Having heard submissions, he concluded, not only that there was a real prospect of the appellant successfully showing that the judge's interpretation of the relevant Regulations was incorrect, but that the appellant also had a real prospect of showing that the findings made by the judge in relation to dishonesty should be set aside. Furthermore, given the Press interest in the case and its potential consequences for dentists' disciplinary hearings, Dingemans LJ found that there were also other compelling reasons to grant permission to appeal. However, Dingemans LJ sought, and obtained, an undertaking from the appellant that, whatever the outcome of the appeal, it would not seek to modify the lesser sanction imposed by the judge (namely the 9 months' suspension).

11. Dingemans LJ directed that the parties should write jointly to the Government Legal Department to seek an advocate to the court to address the point as to the proper interpretation of the Regulations. It was in consequence of that direction that this court has received the written and oral submissions of Mr Vinall.

4. Issues on Appeal

12. There are, I think, three issues arising on this appeal. Putting them into a more logical sequence, they are:

(a) Was the judge entitled to determine the proper interpretation of the relevant Regulations despite the fact that the parties before him were agreed on another interpretation (Ground 2 of the Appeal)?

(b) Was the judge's interpretation of the relevant Regulations correct (Ground 1 of the Appeal)?

(c) Regardless of the correct interpretation of the relevant Regulations, was the judge wrong to quash the findings of dishonesty in respect of patients T, U and V (Ground 3 of the Appeal)?

13. Before addressing those issues in turn, I set out the relevant Regulations.

5. The Relevant Regulations

14. Section 1 of the National Health Service Act 1977 provided as follows:

> "Secretary of State's duty as to health service.
>
> (1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement—

> (a)in the physical and mental health of the people of those countries and
>
> (b)in the prevention, diagnosis and treatment of illness,
>
> and for that purpose to provide or secure the effective provision of services in accordance with this Act.
>
> (2) The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed."

The Regulations relevant to this appeal were made pursuant to those powers.

15. The National Health Service (General Dental Services Contracts) Regulations 2005 ("*the Contracts Regulations*") provide at Regulation 14(2) that:

> "(2) A contractor must provide to its patients, during the period specified in paragraph (3), all proper and necessary dental care and treatment which includes—
>
> (a) the care which a dental practitioner usually undertakes for a patient and which the patient is willing to undergo;
> (b) treatment, including urgent treatment; and
> (c) where appropriate, the referral of the patient for advanced mandatory services, domiciliary services, sedation services or other relevant services provided under Part 1 of the Act."

16. Regulation 22 provides that:

> "**Fees, charges and financial interests of the contractor**
>
> 22.(1) The contract must contain terms relating to fee, charges and financial interests which have the same effect as those set out in paragraphs (2) to (4).
>
> (2) The contractor shall not, either itself or through any other person, demand or accept a fee or other remuneration for its own or another's benefit from—
>
> (a) any patient of its for the provision of any treatment under the contract, except as otherwise provided in the NHS Charges Regulations; or
>
> (b) any person who has requested services under the contract for himself or a family member, as a prerequisite to providing services under the contract to that person or his family member.
>
> (3) The contract must contain a term that—
>
> (a) only permits the contractor to collect from any patient of its any charge that that patient is required to pay by virtue of the NHS Charges Regulations, in accordance with the requirements of those Regulations; and
>
> (b) provides for obligations imposed on the contractor by virtue of the NHS Charges Regulations to be terms of the contract.
>
> (4) The contract must contain a term that requires the contractor in making a decision—

(a) as to what services to recommend or provide to a patient who has sought services under the contract; or

(b) to refer a patient for other services by another contractor, hospital or other relevant service provider under Part 1 of the Act, to do so without regard to its own financial interests."

17. Also relevant is Schedule 3, Part 2 of the *Contracts Regulations* concerned with the provision of services. Paragraph 10 of Schedule 3 provides as follows:

"**Mixing of services provided under the contract with private services**

10. (1) Subject to sub-paragraph (2) and the requirements in paragraphs 2 (referral services) and 6 (orthodontic treatment plans) of Schedule 1 and paragraph 7(1)(g) of this Schedule, a contractor may, with the consent of the patient, provide privately any part of a course of treatment or orthodontic course of treatment for that patient, including in circumstances where that patient has been referred to the contractor for a referral service.

(2) A contractor may—

(a) not provide privately or under the contract treatment that involves the administration of general anaesthesia or the provision of sedation; and

(b) in the case of an orthodontic course of treatment provide—

(i) the case assessment wholly privately or wholly under the contract; and

(ii) the orthodontic treatment wholly privately or wholly under the contract.

(3) A contractor shall not, with a view to obtaining the agreement of a patient to undergo services privately—

(a) advise a patient that the services which are necessary in his case are not available from the contractor under the contract; or

(b) seek to mislead the patient about the quality of the services available under the contract."

18. A "course of treatment", as referred to in paragraph 10(1), is defined in the Schedule as follows:

" 'course of treatment' means—
(a) an examination of a patient, an assessment of that patient's oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and

(b) the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient up to the date on which—

(i) each and every component of the planned treatment has been provided to the patient, or

(ii) the patient either voluntarily withdraws from, or is withdrawn by the provider from, treatment, by, unless the context otherwise requires, one or

more providers of primary dental services, except that it does not include the provision of orthodontic services or dental public health services …"

19. It is unnecessary to set out in detail the National Health Service (Dental Charges) Regulations, referred to in Regulation 22(2)(a) as the *NHS Charges Regulations*. However it should be noted that Schedule 3 of the *NHS Charges Regulations* sets out the crowns available on the NHS which attract a Band 3 charge:

> (a) "Laboratory fabricated porcelain to composite veneers, including acid etch retention.
> (b) Inlays, pinlays, onlays and palatal veneers, in alloys containing 60% or more fine gold, porcelain, composite resin and ceramics.
> (c) Full or three quarter crown cast in alloys containing not less that 33 % fine gold or platinum or palladium.
> (d) Full or jacket crown cast in alloys containing stainless steel or cobalt chromium or nickel chromium.
> (e) Crown in porcelain, synthetic resin and other non-metallic crowns.
> (f) Full or jacket crowns in alloys containing not less that 33 % fine gold or platinum or palladium, or alloys containing stainless steel or cobalt or nickel chromium, with thermally bonded porcelain.
> (g) Jacket crown thermally bonded to wrought platinum coping.
> (h) Prefabricated full or jacket crown, including any pin or post retention.
> (i) [Deleted]
> (j) Bridges in alloys containing 60% or more fine gold with or without bonded facings.
> (k) Bridges cast in alloys containing stainless steel, cobalt chromium or nickel chromium, with or without thermally bonded facings.
> (l) Acid etch retaining bridges.
> (m) Bridges on other [non-metallic] materials.
> (n) Provision of full (complete) or partial dentures, overdentures and obturators in synthetic resin or metal or both synthetic resin and metal, including any cast or wrought metal components or aids to retention.
> (o) Orthodontic treatment and appliances.
> (p) Other custom made appliances excluding sports guards."

6. Ceramic Crowns

20. This case is all about additional fees for ceramic crowns. It was agreed before the judge that ceramic crowns were covered by Schedule 3 of the *NHS Charges Regulations*, although they are not expressly referred to there, and there was no analysis that identified the relevant sub-paragraph. On appeal, there was a potential dispute as to whether ceramic crowns were included within Schedule 3. Ms Johnson's skeleton argument set out the provisions above and then, without more, asserted that "as is clear in Schedule 3, a full ceramic crown was available on the NHS". I did not read Mr Vinall's written submissions as making the same assumption, although I accept his observation that he did not intend to suggest that ceramic crowns were not covered by Schedule 3. In any event, it seems sensible to address the point.

21. It appears that, prior to 2006, there were different fees payable under the *NHS Charges Regulations*, depending on the type of crown fitted. That was done away

with, and under the new regime, all crowns were covered by the same fee. That sort of 'swings and roundabouts' arrangement is not uncommon in public funding for essential services (it is similar to the fixed fee regime for some types of civil litigation) but it presents the usual difficulties where, as here, the precise service in question, namely the provision of a ceramic crown, costs more than the alternatives. Ceramic crowns are not expressly referred to in Schedule 3 of the *NHS Charges Regulations*, and the most likely catch-all which would have covered them, namely sub-paragraph 9(i) (which referred to "crowns in other materials"), has been deleted.[2]

22. However, I have concluded that, despite the lack of an express reference, ceramic crowns are covered by Schedule 3. I consider that they fall within sub-paragraph (e) which refers to "other non-metallic crowns". This conclusion is supported by a simple Google search. The NHS website lists ceramic crowns under the heading of "What are NHS fillings and crowns made of?": see https://www.nhs.uk/common-health-questions/dental-health/what-are-nhs-fillings-and-crowns-made-of/. In addition, I also note that the word 'ceramic' expressly appears at paragraph (b) of Schedule 3, referring to inlays, pinlays, onlays and palatal veneers. I understand that inlays, pinlays and onlays are a type of partial crown. Again, that seems consistent with the finding that Schedule 3 does provide for ceramic crowns under sub-paragraph (e).

23. Accordingly, I conclude that ceramic crowns are covered by Schedule 3. But the fact that this was an agreed assumption (without explanation) before the judge, and the fact that ceramic crowns are not expressly referred to in Schedule 3, so that the answer is provided by a catch-all rather than clear words, suggests that the *NHS Charges Regulations* may need to be made clearer on this point.

7. Was the Judge Entitled to Provide an Interpretation Which Was Different to that of the Parties (Ground 2)?

24. The proper interpretation of the *Contracts Regulations* was a matter of law, and therefore a matter for the judge. As a general proposition, a judge is not bound to decide an issue of law in a particular way, even if the parties are agreed, between themselves, as to the answer: see *Zuckerman on Civil Procedure*, 4th Edition paragraph 7.7.

25. In my view, a judge would be acting contrary to his or her judicial oath if they decided a matter of law in the way that the parties had agreed, if they thought the parties were mistaken. That is particularly so where the issue of law has wider implications. Here, the judge's concern about the possible error of law was linked to the PCC's Determination that, because the respondent had acted contrary to what they called "a fundamental tenet" of NHS charging, she must have been dishonest. On that view of the Determination, if there was no such fundamental tenet, there could be no dishonesty.

26. A judge's broad room for manoeuvre in such a situation is, however, subject to one important caveat. The judge must indicate to the parties that he or she has formed a preliminary view to the effect that the parties may be wrong on the law, and invite them to address, not only the underlying proposition, but also the consequences

[2] Revoked by National Health Service (Dental Charges) Amendment Regulations 2006/1837 reg. 2 (August 10, 2006)

should the law be different to that on which the case had previously been conducted: see *Pantorno v R* (1989) 166 CLR 466 at 473.

27. At root, this is a requirement of natural justice. The giving of a warning, and the invitation of submissions on the point, is a necessary step for all courts and decision makers, so as to ensure that no-one is left with a result which they did not expect and had not been given the chance to address. The cases on adjudication enforcement are discretely analogous: an adjudicator who has come up with his or her own solution must share that view with the parties and seek their submissions on it, particularly if it is at odds with their agreed position: see, for example, *Shimizu Europe Limited v LBJ Fabrications Limited* [2003] BLR 381; *SLG Carbon Fibres Limited v RBG Limited* [2011] CSOH 62; 2011 SLT 417; and *Carillion Utilities Services Limited v SP Power Systems Limited* [2011] CSOH 139; 2012 SLT 119; [2012] BLR 186.

28. In the present case, the judge warned the parties that his interpretation of the *Contracts Regulations* might be different to theirs. He asked for further assistance on the point. In consequence, following the conclusion of the oral hearing, the parties provided a Joint Supplementary Note dated 24 May 2022, in which they set out their agreed interpretation of the relevant Regulations. The judge plainly considered that Note before producing his judgment, but he remained of the view that the parties were wrong in their shared interpretation.

29. Ms Johnson submitted that it would have been better if the point had either arisen earlier, or if the judge had invited Counsel back to make oral submissions on the law. She suggested that expert evidence might have been appropriate on the issue.

30. I accept that there are often better ways in which, with hindsight, things might have been done. But I am conscious that it was unlikely that the judge could have raised the point well in advance of the trial, because he probably did not know that he was trying the case at all until a day or two before it started. And whilst inviting the parties back to make oral submissions was an option, it is difficult to see how any prejudice could have been suffered because the judge asked them to provide their submissions in writing instead. I reject outright the suggestion that expert evidence would have been required: this was a point of law arising from the construction of the relevant Regulations. Expert evidence as to their proper interpretation would have been inadmissible. Indeed, as I note in Section 9 below, the PCC's reliance on expert evidence as to what the relevant Regulations meant, rather than giving any consideration to the Regulations themselves, is a root cause of the problems in this case.

31. I conclude, therefore, that the judge was quite entitled to set out his own interpretation of the relevant Regulations, even though it differed from that of the parties. Furthermore, the judge was alive to the importance of giving the parties an opportunity to address the point. He gave them that opportunity and they took it. Accordingly, there was no procedural unfairness. I would therefore dismiss Ground 2 of the Appeal.

8. Was the Judge's Interpretation of the Relevant Regulations Correct (Ground 1)?

8.1 The Parties' Submissions

32. The appellant's submissions as to the interpretation of the relevant Regulations are encapsulated at paragraphs 31 and 32 of Ms Johnson's helpful skeleton argument:

> "31. Regulation 22 forbids a private fee for "any treatment under the contract" (emphasis added). Paragraph 10(1) allows a private fee for "any part of the course of treatment". Paragraph 10(1) omits, one must assume deliberately, any reference to the contract. A reasonable and logical interpretation of these sections is that a dentist can charge a private fee for a part of the treatment which is removed, or is out with, the treatment provided "under the contract" but cannot receive an additional or top up fee for treatment provided on the NHS. It is of note that under the contract the dentist can only make one charge for a course of treatment. If any of the components of the course of treatment are listed in Schedule 3 of the Charges Regulations then the dentist can claim a band 3 charge from the patient. By charging the patient a band 3 amount the dentist is providing the crown on the NHS "under the contract" and therefore is forbidden by Regulation 22 from demanding a further private fee.
>
> 32. The ordinary meaning of paragraph 10(1) is that a dentist is permitted to take part of a course of treatment and charge a private fee but is not entitled to take any part of a course of treatment provided under the contract and charge a private fee. Once the course of treatment is complete the dentist is entitled to make a single claim on the NHS for whichever component provided on the NHS attracts the highest band."

33. On behalf of the respondent, Mr Kellar broadly supported that interpretation. It is said that that was why it was admitted at the PCC hearing that it was "inappropriate" to charge an additional fee to patients T, U and V (see paragraph 26(a) of Mr Kellar's skeleton argument).

8.2 The Submissions of the Advocate to the Court

34. Mr Vinall took issue with the judge's conclusion that paragraph 10 of Schedule 3 "clearly" provides "that mixed private and NHS is permitted for 'any part' of dental treatment". However, when moving on to consider the precise scope and limitations of the words "any part of a course of treatment", in paragraph 10 of his written submissions, Mr Vinall made a number of points in support of the judge's reasoning and result. He also went on at paragraph 17 to indicate a number of policy reasons which might be said to support the judge's interpretation. Mr Vinall's oral submissions also made plain that, far from advancing a maverick interpretation of the *Contract Regulations*, the judge reached a conclusion that was at least arguably correct.

8.3 Analysis

35. The starting point must be Regulation 22 of the *Contracts Regulations*. On the face of Regulation 22(2), a dentist must not demand or accept a fee from any patient for the provision of any treatment under the contract, a reference to the contract between the NHS and the particular dentist's practice in question. For the reasons set out in paragraphs 22-23 above, I have concluded that ceramic crowns were covered by

Schedule 3 of the *NHS Charges Regulations*. In isolation, therefore, Regulation 22(2) would suggest that an additional fee for a ceramic crown was not permitted.

36. That prohibition is subject to just one exception, by reference to the *NHS Charges Regulations* themselves. It is not suggested in this case that any part of the *NHS Charges Regulations* operated as an exception to Regulation 22(2). Importantly, the prohibition in Regulation 22(2) is not said to be subject to any alleged exception included in paragraph 10(1) of Schedule 3 to the *Contract Regulations* (the "mixing of services" provision). Paragraph 10(1) cannot therefore operate as an exception to the prohibition; instead it must inform it and be read with it. To the extent that the judge suggested otherwise, I consider that he was wrong to do so.

37. On the other hand, it must be acknowledged that paragraph 10(1) of Schedule 3 expressly allows for the private provision of "any part of a course of treatment". So there is the first potential difficulty: Regulation 22 offers a wide, express prohibition which is then qualified, perhaps significantly, by paragraph 10(1) of Schedule 3, which is not referred to in Regulation 22 at all. As a matter of statutory interpretation, therefore, the court must do its best to read these provisions together.

38. The second potential difficulty is that, whilst Regulation 22(2) talks about a prohibition on fees and other remuneration, paragraph 10(1) of Schedule 3 is rather more coy. It does not refer to fees expressly. Instead it is concerned with the provision of "private services". These are not defined. The implication must be that patients will pay additional fees for these private services. But it does not help with the clarity of the Regulations in general when the prohibition is concerned with fees, but the qualification is about the provision of "private services".

39. The third potential difficulty is perhaps the most significant. On the face of it, because there may be a contradiction between Regulation 22(2) and paragraph 10 of Schedule 3, it would have been helpful to have a clear division between, on the one hand, the provision of treatment under the contract in Regulation 22(2), and on the other, the provision of "any part of a course of treatment" which can be provided privately. But no such clear division is identified in the *Contracts Regulations*, or anywhere else.

40. Ms Johnson rightly recognised these potential difficulties. As noted above, her submission was that, in order to reconcile these provisions, a dentist could charge a private fee only where the part of the treatment for which the fee is being charged is (to use her words) "removed from or out with" the treatment provided under the contract. So, translating that to this case, she said that the provision of a ceramic crown was treatment under the contract, entitling the respondent to claim a Band 3 charge, such that the respondent was forbidden by Regulation 22(2) from demanding a further fee.

41. But in my view, that analysis begs the real question, because if the provision of a ceramic crown (as opposed to another type of crown) was part of the course of treatment and it was removed or otherwise out with the contract (by agreement) pursuant to paragraph 10(1) of Schedule 3, then the prohibition in Regulation 22 no longer applied. So what matters in every case is what work can be regarded as having been carried out under the NHS contract, and what work, if any, was provided as a private service (and thereby attracted an additional fee).

42. The answer to that seems to me to depend upon the agreement reached between the dentist and the patient. Schedule 3 paragraph 7(2) provides as follows:

> "(2) If the patient, having considered the treatment plan provided pursuant to sub-paragraph (1), decides to accept the provision of private services in place of all or part of services under the contract, the contractor shall ensure that the patient signs the treatment plan in the appropriate place to indicate that he has understood the nature of private services to be provided and his acceptance of those services."

Thus, what is performed under the contract with the NHS and what is, as Ms Johnson had it, "removed" from that contract, is a matter of agreement between the dentist and the patient. I consider that to be the only proper answer to the question, given the clear words of Regulation 7(2) and the importance of the principle of patient autonomy. On that latter issue, the decision in *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [87] is, I think, directly in point: an adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor (or in this case dentist) is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

43. In a typical case, the patient will agree to a course of treatment. He or she may agree that some component part or parts of that course of treatment will be provided under the NHS contract and that they will pay privately for another part or parts of that same course of treatment. That is permitted by paragraph 10 of Schedule 3: indeed, that is Ms Johnson's case. So where does the boundary lie? There are a number of potential options.

44. At its broadest, the appellant appeared at times to suggest that, because a ceramic crown was capable of being provided under the *NHS Charges Regulations*, Regulation 22(2) of the *Contracts Regulations* prevented the respondent and the patient from agreeing that the additional costs of such a crown, over and above another type of crown, could be the subject of an additional fee. But on the face of it, that would be contrary to paragraph 10 of Schedule 3, and its express permission to mix services. Moreover, if the fact that a service was capable of being provided under the contract meant that it could not be provided privately, mixing would not work at all. That is because almost all ordinary dental services are capable of being provided under the contract.

45. So some lesser or halfway-house position had to be adopted. Mr Vinall postulated that the position of the appellant might be that "a single, indivisible part of a course of treatment" could not be funded by a mix of NHS and private funding. That was not how it was put by the appellant, possibly because it begs the question of quite how a test of "indivisibility" could be applied. The closest to this argument that Ms Johnson came was when she said that the provision of a crown was "a package which would not sub-divide down". But it might be said that here the provision of ceramic crowns to T, U and V was a part of the course of treatment that was not only capable of being divided down, but it was in fact divided down in a rational way: hence the charging of the *additional* fee only for the ceramic crown, not the full cost of it.

46. The halfway-house position that was adopted by the appellant, both before the judge and on appeal, was different. It relied on the so-called "fundamental tenet", identified by the PCC in their Determination, namely that work on a single tooth could not be split between the contract with the NHS and an agreement to pay privately. This dividing line was the means by which the appellant said that some mixing of services under paragraph 10(1) of Schedule 3 could happen, but limited to easily definable parts of a course of treatment. So a crown in the lower jaw could be carried out and charged for under the contract, whilst a root canal in a back tooth in the upper mouth could be paid for privately.

47. But the problem with that potential solution is that it is simply not a part of the *Contracts Regulations*. There is nothing in Regulation 22(2), or paragraph 10(1) of Schedule 3, which refers to "work on a single tooth", or which seeks to limit the mixing of services by reference to individual teeth. It is therefore a distinction without any basis in the *Contracts Regulations*.

48. Indeed, I consider this alleged distinction to be contrary to the wide words of paragraph 10(1) of Schedule 3, which expressly allows the patient to agree with the dentist and pay privately for "any part of a course of treatment". Furthermore, the width of those words is confirmed by the definition in the *Contracts Regulations* of "a course of treatment" as "each and every component of the planned treatment". Whilst I agree with Ms Johnson that a division down to "a part of each and every component of the planned treatment" might, in some circumstances, become difficult to police, that is what the words of the *Contracts Regulations* say. On any view, it is plain that, with no qualification on the words "any part", significant granularity is inevitable. It points away from an unexpressed division by reference to work on a single tooth.

49. I therefore conclude that, on any view of the *Contracts Regulations*, there is no rule that two different parts of a course of treatment (as defined) cannot be carried out to a single tooth. Say the same tooth requires a filling and then a crown. Those are two parts of a course of treatment. By agreement with the patient, paragraph 10(1) of Schedule 3 provides that one can be provided under the contract, and the other can be paid for privately. That seems to me to be a perfect example of what Ms Johnson described as "the dentist's ability to isolate part of a course of treatment" in accordance with paragraph 10(1) of Schedule 3.

50. For those reasons, I reject the appellant's primary contention, that work on a single tooth could not be the subject of mixed services under paragraph 10(1) of Schedule 3.

51. As to other possible dividing lines, Mr Vinall suggested that it was possible to differentiate between what might be called 'parts' and what might be called 'labour'. He argued correctly, in my view - that it was no answer to say, as Ms Johnson submitted, that the patient would not know which was which. The detail would have had to have been explained to the patient in order that the patient could give informed consent as to which part was being provided under the contract and which part was a private service. Paragraph 10(3) of Schedule 3 requires a dentist to explain carefully to a patient which services are necessary and not to seek to mislead the patient into agreeing "to undergo services privately".

52. Whether such a division can be made will obviously depend on the facts of each case. I can see that in some cases, one particular procedure may not be capable of further

division, although as my lady, Lady Justice Nicola Davies, pointed out during argument, that may also depend on the precise formulation of the treatment plan agreed with the patient. This potential division would provide some further support for the respondent's conduct in the present case: it must again be stressed that this case is only concerned with the additional (laboratory) costs of 'the part', namely a ceramic crown over and above a porcelain crown; it is not the cost of the entire crown, much less the fixing of that crown.

53. Another potential division suggested by Mr Vinall was between preparatory work, on the one hand, and the actual treatment, on the other. He was, in my view, right to reject Ms Johnson's argument that such a division was somehow barred because preparation was not an item separately listed in the *Charges Regulations*, so it would not be clear how much should be charged under the contract. Regulation 4(8) allows the Secretary of State to identify a fee for any particular service which was not expressly identified in the Regulations, so any uncertainty could easily be addressed.

54. Ms Johnson suggested during the appeal hearing that the course taken by the respondent would be difficult to reconcile with the *NHS Charges Regulations* because of the flat fee for Band 3 work. She suggested that, if an additional fee was levied for a ceramic crown, the dentist might be paid twice over, or that there was at least a risk of such double recovery.

55. I am not comfortable with the way in which this specific argument arose: it was not a point made in the Joint Supplementary Note provided to the judge (see paragraph 28 above), and it was not in the appellant's skeleton argument for the appeal. Beyond the asserted incompatibility, it was not further developed at the hearing. But on the limited basis on which it was made before this court, I do not accept it.

56. The dentist would be paid for the course of treatment under Band 3. In accordance with Schedule 2, Part 1, Table A of the *Contracts Regulations*, the fixing of a crown comprises 12 units of dental activity, which is the basis for the calculation of the sum to be paid to the dentist under the contract. That figure of 12 units is not otherwise broken down. It remains the same even if multiple crowns have to be fitted as part of the same course of treatment. If the additional cost of one particular crown that the dentist fitted was, by agreement, paid for privately, it seems to me to be difficult to say that that upsets the broad scheme or structure of the *NHS Charges Regulations*. The way in which the Bands work is another example of the 'swings and roundabouts' approach identified above, where a dentist may make a profit on some parts of the course of treatment, but not on others.

57. But even if, contrary to that view, the appellant considers that there is a risk of double recovery then, because such a mix of funding is expressly permitted by paragraph 10(1) of Schedule 3, the *NHS Charges Regulations* (and perhaps also the *Contracts Regulations*) would have to be revisited to identify how many units of dental activity, if any, fell away because, for example, the additional costs of the ceramic crown were being met privately. None of that, however, can affect the proper interpretation of the *Contracts Regulations*.

58. Having worked out the way in which the relevant Regulations mesh together, and what they do and do not prohibit, this case becomes relatively straightforward. Here, each of the patients, T, U, V, wanted ceramic crowns. Those were not clinically

necessary for their oral health (Regulation 14), but doubtless for aesthetic reasons, they preferred ceramic crowns over porcelain or other types of crown. Ceramic crowns are more expensive than any other type of crown. There is an additional charge by the laboratory which the dentist has to pay. In those circumstances, there is a positive disincentive to the dentist to offer a ceramic crown. To avoid these difficulties, in the present case, the patients and the dentist reached a pragmatic agreement that the additional costs of a ceramic crown would be paid for privately. That was a part of the course of treatment in each case. In my view, for the reasons I have given, the division was therefore permitted by paragraph 10(1) of Schedule 3.

8.4 Policy Considerations

59. I understand that there is an overriding principle behind all these Regulations to try and ensure that dental care is free of charge. Although Ms Johnson submitted that allowing the mixing of fees in the way that happened in this case would be contrary to that principle, again I disagree.

60. Ceramic crowns are the most expensive type of crown, but are likely to be preferred by the patient for aesthetic reasons. It may be difficult in many cases for a dentist to justify the use of a ceramic crown (as opposed to another type of crown) for oral health reasons. In those circumstances, of course, the dentist could refuse to fit a ceramic crown under the contract altogether, and the patient would be forced to pay the full cost privately. Some of the evidence in this case suggested that the cost might be as much as £900 (although that figure related to two crowns). So what happened here, with the majority of the work being carried out under the contract, but the additional cost of the ceramic crown itself being paid for privately, seems to me to be much closer to the spirit of free dental services than the alternative postulated by the appellant.

61. As I have said, Mr Vinall's written submissions contained a number of policy reasons which supported that approach. I do not set each of them out here. But one which had a particular resonance, for me at least, was the situation where, for aesthetic reasons, patient X wanted a full ceramic crown, whilst patient Y was content with a porcelain crown. Y's crown would be provided under the contract which would, at most, attract a band 3 NHS charge of £306.80. I consider that, whilst the man or woman in the street would regard it as reasonable that X should pay privately for the additional cost involved in the provision of a ceramic crown, he or she would also think it reasonable that X should have the rest of the work done under the contract, so that that work would also not cost more than £306.80. Otherwise X would be in a much worse position than Y, even though they both require crowns.

62. In my view, that is the fundamental policy difficulty with the appellant's position. Ms Johnson fairly conceded that her position was binary: on her case, a patient who wants a ceramic crown which cannot be justified on medical grounds has to pay privately for the full cost of it, whilst a patient who is happy with a porcelain crown pays nothing. That is a stark difference in outcome which cannot be justified on the words of the *Contracts Regulations*, and cannot, in my view, be supported as a matter of policy.

8.5 Consequences

63. At the outset of her oral submissions, Ms Johnson accepted that the *Contracts Regulations* could have been rather better drafted and that the PCC's confidence that the position they set out was clear "may have been misplaced". But she said that the point that arose from the judge's judgment was an important question for the profession and hinted that there may be unintended consequences if this court concluded that the judge had been right in his interpretation.

64. Other than that hint, there was no evidence before this court as to the potential consequences of the judge's decision on the profession as a whole. I do, however, recognise that this is an important issue for the appellant, because it may very well be that there are other disciplinary cases arising out of top-up fees. But if that is right, then it is even more important that the misapprehension about what the *Contracts Regulations* say, under which the appellant appears to have been operating for many years, is resolved now. It must not be forgotten that these are not simply unclear Regulations concerned with what a dentist can and cannot be paid, but unclear Regulations which have been used as a basis for professional misconduct hearings and, as in this case, findings of dishonesty which led to erasure.

8.6 Conclusions

65. For all these reasons, therefore, I have concluded that the judge was right. The 'work on a single tooth' argument, relied on by the PCC and then the appellant before the judge and before this court, is simply not what the *Contracts Regulations* provide. I would therefore dismiss Ground 1 of the Appeal.

9. The Findings of Dishonesty (Ground 3)

9.1 Two Preliminary Matters

66. Two points need to be made at the outset. First, the appellant agreed, at the hearing before Dingemans LJ, that there would be no appeal in respect of the sanction substituted by the judge. It will be remembered that the judge replaced the erasure sanction of the PCC and replaced it with a suspension for 9 months. That suspension period has now been served. Accordingly, the debate about the dishonesty findings is, in one sense at least academic, although I am quite sure that it is not regarded as such by the respondent.

67. Secondly, there can be no doubt that the interpretation of the *Contracts Regulations* was an important element in the judge's reasoning. Indeed, Ground 3 suggests that his interpretation of the Regulations "was pivotal to his decision to quash the findings of dishonesty". So, if my Ladies agree with my conclusion that the judge's interpretation was correct, then it seems to me that the allegations of dishonesty had to be quashed.

68. I would, however, wish to make it clear that, in my view, the findings of dishonesty could not have been sustained in any event. That is the case whatever the correct interpretation of the *Contracts Regulations*. There are a number of reasons for that.

9.2 The PCC Hearing

69. I have no wish to be overly critical of the PCC hearing. On the other hand, it is important, in order to undertake a proper analysis of Ground 3, to identify precisely

how it was that the findings of dishonesty came about. After all, before both the judge and this court, the appellant has sought to uphold the findings of dishonesty made by the PCC. In the light of the conduct of the PCC hearing, I consider that that attempt, valiantly made by Ms Johnson, cannot succeed.

70. First, the PCC had before it neither the *Contracts Regulations*, nor the *NHS Charges Regulations*, nor even the contract between the respondent's practice and the NHS. It seems extraordinary that a PCC charged with investigating what was said to be a dishonest breach of the relevant Regulations did not have copies of those critical documents. I am unable to accept the argument that no such copies were necessary because no point arose on the wording of the relevant Regulations. I agree with the judge's finding at [97] and [137] that there was an unfair process because the appellant should have, but did not, cross-examine the respondent on these documents, because that "was fundamental to the allegation of dishonesty".

71. Secondly, it appears that there was a good deal of expert evidence at the hearing. Obviously, some expert evidence was necessary. But it appears that some of this expert evidence went to what the relevant Regulations meant. In my view, for the reasons already stated, that evidence was inadmissible. To rely on expert evidence as to what the relevant Regulations meant, without even a sight of the Regulations themselves, was a manifest error.

72. Thirdly, it was repeatedly asserted, throughout the PCC hearing and throughout the Determination, that it was a "fundamental tenet" of the *Contracts Regulations* that no mixing of fees was permitted by the Regulations for work on a single tooth. For the reasons that I have already explained, that was not what the *Contracts Regulations* said. Accordingly, the PCC operated throughout on an important misapprehension of the Regulations themselves.

9.3 The Determination

73. This misapprehension fatally infected the Determination in all sorts of ways. For example, the PCC concluded that, because this was a fundamental tenet of NHS charging, it would have been taught to dentists, so that the respondent should not only have known about it, but did in fact know about it. In consequence, the PCC found that she knowingly breached the *Contracts Regulations* and was thereby dishonest (see the judge's summary of this reasoning in the Determination at [95]).

74. This line of reasoning was not only wrong as a matter of interpretation, but it was contrary to the unchallenged evidence given by the respondent to the PCC. She said that she did no private work in her foundation year. She did not believe that the mixing of NHS and private work was part of any training that she received at her practice. She did not give any conscious thought to whether she was in breach of the relevant Regulations and, once she had discussed it with her former supervisor, who told her that she must not do it, she stopped.

75. Crucially, as Mr Kellar demonstrated by reference to the transcript, the respondent was not cross-examined on any of that evidence. None of it was challenged. It was not suggested to her that she was lying or was in some other way mistaken about what training she had or had not received or what her experience had been. Moreover, the expert evidence at the hearing, particularly that of Professor Barker, was not entirely

clear-cut on the question of the training the respondent would have received and the knowledge that she could have been expected to have acquired. In those circumstances, it is impossible to see how there was a proper basis for a finding of dishonesty.

76. In my judgment, the applicable principle was set out by Lord Hughes in *Ivey v Genting Casinos (UK) Limited* [2017] UKSC 67; [2018] AC 391 at [74]. He said:

> "…When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

77. The respondent's actual state of mind was therefore critical to the issue before the PCC as to whether her conduct was honest or dishonest. In the absence of any challenge to her evidence that she did not know of the so-called 'fundamental tenet', the PCC erred in law in finding dishonesty.

78. The judge also analysed these aspects of the evidence and the PCC Determination. Amongst other things, he pointed out that:

a) There was no specific evidence about the contents of training courses on NHS charges provided during the foundation year: [99];

b) There was undisputed evidence that the respondent had spent her foundation year doing entirely NHS work, not private: [100];

c) The respondent had no induction or training at the Practice when she started in September 2017: [102];

d) Although the respondent had had a one-day training course about NHS charging it was unclear what was taught in any detail: [104];

e) There was no evidence that her time spent as a dental nurse/assistant would have provided her with any relevant information: [104].

79. Those were some of the reasons why the judge concluded that the findings of dishonesty in the Determination could not stand. As he put it at [110], the findings were "wrong, were procedurally unfair and were not inferences that could properly be made". I agree.

9.4 Other Evidence Inconsistent with Dishonesty

80. If all that were not enough, there was other evidence that was contrary to any suggestion of dishonesty. There was the fact that, as the judge noted, the arrangements

in relation to the fees in question were all made entirely openly: see [68] and [85]-[86].

81. There were also the circumstances surrounding the allegations which also pointed away from dishonesty. They were committed over an 8 or 9 month period, when the respondent was overworked and was in what the judge described as "an unpleasant, pressurised and poorly-supported situation at the Practice" ([145]). Once the alleged errors had been pointed out to the respondent by her original supervisor, she not only stopped the practice but she educated herself as to what was required and, as the judge expressly found, had shown considerable insight. That is consistent with her evidence: as the judge noted at [157], the respondent is "duly horrified, embarrassed and humbled for what she has done".

82. These were all further strands of the evidence that were plainly inconsistent with any finding of dishonesty.

9.5 Summary

83. For all those reasons, therefore, I would dismiss Ground 3 of the Appeal. In my view, on the unchallenged evidence before the PCC, the findings of dishonesty should never have been made. As I hope I have made plain, that is the position, whatever view is formed of the meaning of the *Contracts Regulations*.

10. Disposal

84. For all these reasons, I would dismiss this appeal.

LADY JUSTICE NICOLA DAVIES

85. I agree.

LADY JUSTICE KING

86. I also agree.