GDPC 2012 002

General Dental Practice Committee

Triennial Report for England for the Session 2009-2012

26 January 2012

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Introduction

The General Dental Practice Committee (GDPC) represents all general dental practitioners in the UK, whether they are private, NHS or mixed. The Chair, Vice-Chairs and Executive sub-committee meet regularly with Government policy makers to ensure that the voice of the profession is heard and to maintain the profile of primary care dentistry as a vital part of wellbeing and of the Health Service. As the full GDPC meets only three times a year, it is vital that the Committee gives a clear steer to the Chair and members of the Executive sub-committee about what issues they want addressed and what outcomes should be sought. This report summarises the current issues that have been addressed by the GDPC and BDA that affect general dental practice.

Health services have been devolved to the Scottish, Welsh and Northern Ireland Governments with the Department of Health in Westminster covering England. The different health services in the UK have different approaches to health care, reflecting the differences in the health of the population. While health services have been devolved, some aspects, such as professional regulation remain UK-wide issues.

1. NHS Reforms (England)

1.1 Where did they come from?

- Following the General Election in May 2010 the new government announced intentions to reform the health service by 2015.

- The reforms were proposed in the Department of Health White Paper *Equity and Excellence: Liberating the NHS* and its subsequent supporting papers released between July 2010 and March 2011. The reforms have been controversial and a pause was declared in the progress of the Health and Social Care Bill in April and the Future Forum was established to gather feedback from professions and interested parties on the Bill. The Bill was re-introduced into Parliament in September 2010 with some amendments.

- The purpose of the reforms is to refine and streamline the NHS. The stated intention is to provide management savings by making greater use of clinicians in decision making. One of the most controversial proposals was the focus on increasing competition as a way of driving quality improvement. Private providers would have a greater scope to bid to provide secondary care services from GP-led fund-holders.

- The most important new bodies mentioned in the Bill are described below. The new structure as far as is possible is set out in the diagram below. There can be no certainty at this stage, however, about the structural changes as the Bill may be changed and the structures may be adapted by the NHS Commissioning Board once it is established in full in April 2013.

    - **NHS Commissioning Board (NHSCB)** – responsible for commissioning all primary care services (including dentistry) as well as hospital services in the

case of dentistry, and delegating responsibility for commissioning most secondary care services to GP-led Clinical Commissioning Groups. It will be established in shadow form in April 2012.

- **GP-led Clinical Commissioning Groups (CCG)** – responsible for commissioning all secondary services, including Foundation Trusts. They will have some powers to "top-up" other primary care services where evidence shows that they are under-resourced. Individual GP contracts will be held by the NHS Commissioning Board. CCGs will be made up of GPs and other health professionals as well as supporting staff and managers. Not every GP who falls within the boundaries of a CCG will formally sit on it. Boundaries are expected to match those of Local Authorities.

- **Health and Wellbeing Boards (HWB)** – sitting in top-tier local authorities, there will be 152 of these. Their role is to ensure that services are commissioned to meet local need and that there is "local democratic legitimacy in health". These objectives will be assessed primarily through the Joint Strategic Needs Assessment (JSNA). These should include an oral health section. The HWB will make representations to the NHSCB to commission services and work with CCGs to ensure provision of services

- **NHSCB Field Force Teams** – these are the Board's local offices. The exact role of the Field Force Teams is vague at the moment. Early indicators are that they will provide an interface, of administration and management in line with the national model, between the NHSCB and primary care contractors/CCGs. They could fulfil contract management responsibilities, though clinical expertise is expected to reside in the LPNs. The Field Force may have the power to alter local contracts in response to local need. The shadow NHSCB will develop plans for the Field Force.

- **Local Professional Networks (LPNs)** – current proposals are that there will be between 20 and 50 of these for dentistry and also networks for pharmacy and optometry. They will bring together clinical leaders to inform best practice and streamline referrals. It is intended that they will work closely with the HWB to inform the JSNA, and with LDCs to ensure that there are clear lines of accountability and contact. They would provide clinical expertise where required. Their focus would be on quality improvement, strategic planning, and service design and implementation. Pilots are running in England to assess what the exact scope of their role should be.

- **Clinical Senates** – there has been little official development of these bodies. It appears that there may be 15 of these spread over England which will provide advice to CCGs when required and contain a range of health care professionals including dentists. It is not clear what their governance arrangements will be or how they will interact with LPNs, CCGs or the NHSCB.

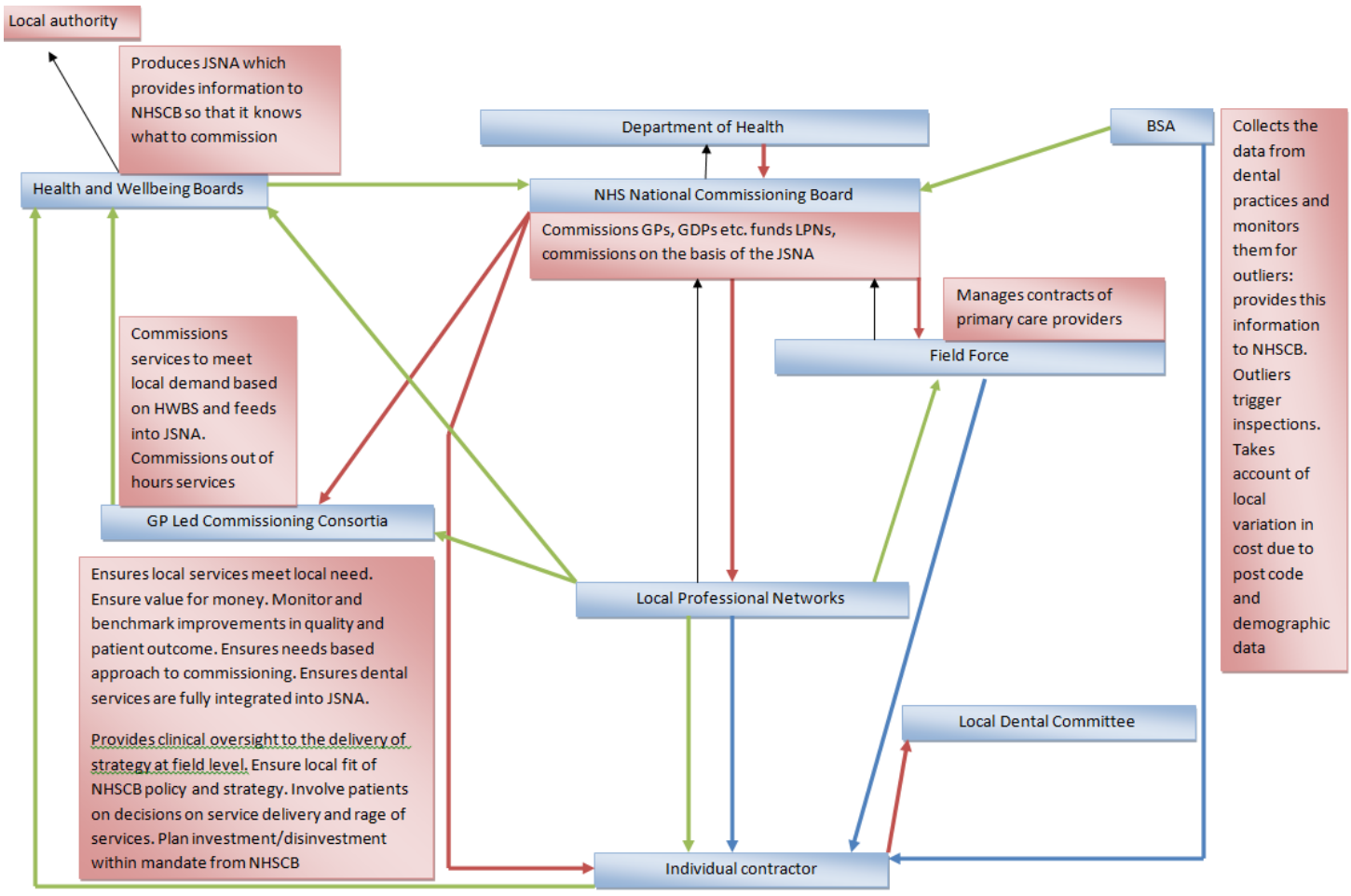
- **Clinical networks** – clinical networks, such as the cancer network, will continue to exist with the same function that they have now.

- **HealthWatch England** – this will be a national body with local branches that will take over from the existing Local Involvement Networks. It will be located in the Care Quality Commission and ensure that there is a strong patient input into the local NHS. It will have direct access to the Secretary of State for Health.

- **Care Quality Commission (CQC)** – CQC will continue with its same role and remit as it currently has.

- **Monitor** – Monitor will retain its function as the economic regulator of Foundation Trusts and continue to assess their financial situation. The Bill extends its remit to cover the licensing of all providers of NHS care but the Secretary of State can make exclusions through regulation.

Figure 1: Potential structure of NHS dentistry



1.2 What are the changes proposed that affect general dental practice?

- The main change that affects dentistry is the removal of Primary Care Trusts/Strategic Health Authorities. With PCTs gone, all of their responsibilities will fall to their successor body, the NHSCB. Rather than 152 different ways of commissioning services, managing performers lists and handling pension contributions, all of these roles will be undertaken by the NHSCB centrally and locally.

- Regulation by Monitor would impose yet another burden of bureaucracy on practices and the BDA is actively seeking exemption for dental service providers.

1.3 GDPC policy

- GDPC policy on the reforms has been led by the move to centralised commissioning. This was welcomed as the variable quality in commissioning of PCTs was a source of major problems for the profession. The intention to make as many administrative activities centralised and under a single system was also welcomed.

- GDPC stressed that the budget for dentistry should be sufficient to deliver the care that is expected, must continue to increase in real terms and not be reliant on savings from management costs to secure its growth.

- The BDA responded to all the White Papers published. The responses were largely positive as the move to central commissioning with the ability to vary contracts in light of local needs was supported by the Committee. Concerns were raised about the role of increased competition and whether, as a result of this, Monitor would be invited to regulate dentistry. The Chair met with the Future Forum and stressed that the reforms had to protect those with an NHS commitment and not allow unfettered market access into a clinically sensitive area where continuity of care and personal relationships are valued.

- After April 2013 the NHSCB will take over GDS and PDS contracts. There is presently a stocktaking exercise taking place and PCT clusters are ensuring that contracts are regularised prior to transfer. This must not be an opportunity to attempt to reduce contract values or remove contracts entirely.

- GDPC has recommended that LDCs have a significant, and independent, role in the LPNs to ensure that the voice of the profession is heard and that there is democratic accountability to the profession; and suggested that GDPC members locally should be involved in any professional appointments to LPNs.

1.4 Progress to date

- The Chair has met with the Department of Health team that is overseeing the transition, particularly the establishment of LPNs and the transference of powers from PCTs to CCGs. The Executive Sub-Committee has met with Sam Illingworth, who is developing the dental side of LPNs.

- Most bodies are being piloted, are in pathfinder stages or in shadow form already and will begin to assume powers in April 2013. Establishment of the new system in its entirety is expected in 2015.

1.5 What are the continuing policy issues?

- The NHS remains under pressure to deliver substantial savings that will continue in the long term while improving quality of outcomes.

- GDPC is represented on the DH working group developing standard processes for contract management. Just how the Field Force will be constituted and is not yet known.

- The governance arrangements of the LPNs, how they will relate to the central board, and what fund-holding they will have are still not determined.

- The BDA has been encouraging Local Authorities to understand the importance of dentists in communities and encouraging dentists and LDCs to increase contact with Local Authorities, local Health and Wellbeing Boards and GP-led CCGs.

2. Dental Contract Pilots (England)

2.1 How did they develop?

- Following our continued lobbying since 2006, the current contract pilots arose from the Steele Review of NHS dentistry published in June 2009. The Committee welcomed the report which criticised the current UDA contract and proposed a reform to the system which should be more responsive to patient need, rather than targets. With the change of government, GDPC renewed its pressure on DH and was able to convince Ministers that the fundamental principles in the Steele Review should be carried forward into the Conservative policies for dentistry for a new dental contract based on capitation, registration and quality.

- The Department of Health established a series of working groups to examine different proposals from the Steele Review. GDPC sent 21 members to these groups. Work was also done on developing an oral health assessment and clinical care pathways for dentistry. There was a short hiatus following the General Election in May 2010 but work resumed.

2.2 What is being piloted?

- The pilots are testing aspects of a new contract, not a new contract in its entirety. The core principles being assessed are:

  - **Capitation** – The payments in a new contract will be based on capitation. The theory is that this will better reflect patient need and free dentists from the activity treadmill. The payments will be based on age, gender, and the index of deprivation of the patient's postcode. These are three proxy indicators of health that are outside of the clinician's control. The intention is to base payments on predicted need. DH has calculated capitation values for the pilots based on the existing dental budget and past activity under the UDA system.

  - **Quality** – A dental quality and outcomes framework (DQOF) has been developed, designed to measure improved outcomes for patients. The majority of indicators are clinical outcomes that will be assessed through electronic returns by the practice. There is a single indicator on patient safety. The remainder measure patient experience via BSA patient surveys.

- **Registration** – Registration will be re-introduced as it was a Conservative Party manifesto pledge. Whether there will be a limit on the number of patients that a single dentist can register or on the period of registration has yet to be discussed.

- **Oral Health Assessment** – The pilots are testing a uniform and semi-automated oral health assessment (OHA). This will standardise information and allow DH to monitor changes in health over a period of time. It also supplies personal information to the patient on their oral health status to encourage self-care. Patients will be classified as red, amber or green and advanced restorative care will be restricted for red patients. Pilot practices have been required to have an up-to-date IT system. Full computerisation will be required for the new contract and DH has indicated that it envisages no central funding for this.

2.3 What is the timescale?

- Pilots began on 01 September with 70 sites.
- Evaluation is scheduled to begin in April 2012. DH has said that a public consultation on a new contract may begin in June 2012. GDPC is represented on the contract steering group by the Chair and Vice-Chair Henrik Overgaard-Nielsen.
- Any new contract may not be introduced until 2015 or even 2016 depending on Parliamentary time because the Department maintains that primary legislation is required.
- The Department has said that a new system of patient charges will be introduced as part of the new contract.

2.4 GDPC policy

- GDPC supports the move away from a payment system based on UDAs and sees possibilities in the use of capitation, provided that the payments are sufficient to meet need. It has developed some basic principles underpinning the negotiating process and these will continue to be refined.
- The Committee was concerned about the potential difficulties when patients were not able to be given the NHS care they wanted because of their oral health status. The Committee has called on DH to take responsibility for communicating patients' responsibility to improve their oral health and for managing public expectations.
- GDPC has continued to call for the "NHS offer" to be clarified.
- GDPC representatives on the Steele working groups reported the position of the profession to DH at the meetings. They were involved in the development of the DQOF and the assessment of weighting applied to them, and were careful to stress that involvement with the process did not entail agreement or support of the outcome, as they were a voice around the table and not the controlling group.

- Representatives from GDPC Executive attended pilot meetings held by DH for PCTs and pilot sites. They urged the pilot sites to work with the systems to provide reliable evidence on how the proposed system may work.

2.5 Actions going forward

- GDPC has asked the Department for early discussions and negotiations on the development of any new contract. Apart from the structure and detailed terms, of particular concern will be transitional arrangements and protection of practice viability, and the cost of computer systems. We will look to address issues such as sale of practices.

- The Remuneration Sub-Committee has started work on financial modelling of a capitation-based contract. The overall dental budget is anticipated to remain the same as it is now; the change is the distribution of that budget according to the patient, rather than activity. The BDA commissioned consultants, the Office of Health Economics, to analyse the effect that capitation could have on a practice's income. This analysis will now be applied to some particular practices to see how capitation payments might actually affect income in practice or the number of patients needing to be registered. This work will be central to determining the impact of the new contract on practice viability.

3. Pay discussions, 2009, 2010, 2011 (England)

3.1 Pay

- Historically the Remuneration Sub-Committee produced evidence on expenses, morale, motivation, recruitment, and retention which formed part of the BDA's evidence to the Doctors' and Dentists' Review Body (DDRB). DDRB assessed the information and made recommendations to DH on the basis of the evidence presented to it. This would involve meeting the rise in costs of providing dentistry as well as providing a pay rise in line with comparable professions. For 2011-12 and 2012-13 the Secretary of State for Health suspended DDRB's recommendation making role on the basis that the government had already determined that there would be a pay freeze for anyone earning over £21,000. DH would discuss expenses directly with the BDA.

- In recent years our evidence has increasingly distinguished between the situations in England, Wales, Northern Ireland and Scotland and we are now in a position where we need to present different evidence to different government departments. This year, the Scottish government has decided to ask DDRB to consider the matter of expenses for dentists in Scotland.

3.2 2010-11 **(evidence submitted September 2009)**

- The BDA recommended a 3.8 per cent contract uplift in England to meet the rising expenses. DDRB recommended 1.44 per cent and DH awarded 0.9 per cent on contract values after applying a one per cent efficiency saving.

3.3 2011-12 (Evidence submitted October 2010)

- BDA evidence showed that a 3.32 per cent increase in contract values would be required if expenses were to be met and the government were to achieve a pay freeze for the profession and not a pay cut. After applying a four per cent efficiency saving DH provided a 0.5 per cent uplift and a requirement for contractors to adopt *Delivering Better Oral Health* best practice guidelines.

3.4 2012-13 (Evidence submitted October 2011)

- BDA submitted evidence DDRB on morale, recruitment and retention and developed arguments relating to expenses in the usual way. Discussions with DH on the contract value uplifts are continuing, with DH again requiring an efficiency saving of four per cent. We have repeated our view that seeking further efficiencies is unacceptable in the light of data from the NHS Information Centre showing how dental earnings are reducing.

4. Pensions (UK)

- Following a review by the Business Services Agency in 2010 it became apparent that some associates in England were making little or no superannuation contributions despite significant NHS activity. A second issue was that the NHS pensions regulations were changed to exclude superannuation payments to 'third parties'. Associates who incorporate become third parties commissioned through their company. It also emerged that some associates working for corporate bodies would no longer be eligible to make contributions if their corporate did not hold the NHS contract.

- GDPC made it clear that those working for the NHS should receive the appropriate level of superannuation relative to their earnings. Associates can opt out of superannuation but must be fully aware that they are doing so and worked with DH on the best way of dealing with the problem DH identified almost 700 practices where there were anomalous payments. These practices and associates were written to requesting that the supplied figures for net pensionable earnings were reviewed. If no response was received, further action may be pursued. GDPC supported this approach as both proportionate and fair as exclusion could occur by mistake. The new arrangements will require both provider and performer signatures on superannuation declarations.

- Initially it was the intention of DH to terminate all superannuation for incorporated associates and clawback payments that had been made. GDPC disagreed with the DH interpretation of the original regulations and following strong representation from the GDPC Chair a period of grace of two months was agreed so those associates would have time to determine whether they wished to remain incorporated and lose the NHS pension or to de-incorporate. DH also agreed that there would be no clawback.

5. Seniority pay (England)

- The Statement of Financial Entitlements had a cut-off period for seniority pay so that dentists reaching 55 after 31 March 2011 were no longer entitled to the payments. In spite of repeated reminders from GDPC and an eventual agreement that the payments should continue, the regulations were not changed in time. The result was that DH lawyers advised that the payments as they stand breach provisions of the Equality Act 2009 which came into force early last year.

- The Chair of GDPC has written to Ministers and DH and a meeting was held with the Minister. Discussions with DH are continuing about what can be done to develop a replacement scheme and in the meantime re-introduce comparable arrangements. It is unacceptable for this income to be lost in dentistry and we believe that if it is not reinstated, those practitioners deprived of the payments deserve some form of compensation.

- An alternative payment system will most likely need to be established. GDPC will need to be clear on what it expects from such a system and how it could be administered. DH has stated that it would like a replacement scheme in place by April 2013.

6. Care Quality Commission (England)

- The Care Quality Commission (CQC) is the regulatory body for all providers of health and social care in England. It assesses the provider, rather than the practitioner. It has a responsibility to ensure that all locations where dentistry is provided meet minimum requirements and have adequate procedures in place for safe patient care.

- CQC was formed in April 2009 by the merger of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. CQC is funded by the government and through registration fees.

- Regulation of dental providers was first mooted in the late 1990s when the legislation was first developed for CQC's various predecessors (CHI, CHAI and the Healthcare Commission). It was also called for by the OFT when it reported in 2003 following its first inquiry into the private dentistry market. There have been numerous consultations over the years and the BDA's views have been consistent.

- GDPC supports regulation where it shown to be proportionate, relevant, targeted, value for money, non-duplicative and beneficial to patients. GDPC does not consider that the manner in which CQC regulation has been implemented meets these criteria.

- The Chair met with Labour Ministers and, following the general election, Conservative Ministers to argue that the registration process was being mishandled and that the proposed registration was unreasonable and unrepresentative of any danger posed by dentists. Ministers accepted that the process was not as smooth as it could be but refused to remove dentistry from the remit of CQC or even delay the process given the ill-preparedness of CQC.

- The CQC initially proposed fees of:

> (c) Where the service provider provides dental services the fee is to be determined with reference to the number of locations at or from which those services are provided, as follows –

Number of locations	*Fee Payable*
1	£1,500
2 to 3	£3,000
4 to 10	£6,000
11 to 50	£12,000
51 to 100	£24,000
More than 100	£48,000

- But following public consultation the fees dropped to:

> (c) Where the service provider provides dental services or independent ambulance services the fee is to be determined with reference to the number of locations at or from which those services are provided, as follows –

Number of locations	**Fee payable**
1	£800
2 to 3	£1,600
4 to 10	£6,000
11 to 50	£12,000
51 to 100	£24,000
More than 100	£48,000

- The BDA took every opportunity to raise the profession's concerns and anger about CQC to relevant bodies. This included the House of Commons Health Select Committee (HSC) and the National Audit Office, both of which held inquiries on CQC. The HSC report found the CQC to have severely neglected its duties and blamed this on the untimely and poorly run registration of dental practices, for which, it pointed out, the danger to the public was far smaller than the organisations that CQC failed properly to monitor while it spent time and resources registering dental practices.

- Although CQC registration could not be prevented there has been wide recognition that CQC mishandled the registration of dental practices and must improve its approach.

- The Health Select Committee inquiry into the CQC was particularly critical of the lack of information that had been made available to registrants and the poor planning that had gone into the registration of dental practices. The Health Select Committee echoed the BDA's position that registration of dental practices had resulted in a loss of focus for the CQC.

- The Department of Health is also running an inquiry into the CQC and has consulted with the BDA.

7. HTM 01-05 (England)

- HTM 01-05, the Health Technical Memorandum issued by the Department of Health to standardise and rationalise decontamination in dental practices in England, was introduced in 2009. All practices in England must have been compliant with the essential standards by the end of 2010. There is no timescale for compliance with the "best practice" provisions.

- GDPC has been vocal in challenging the evidence base of the changes proposed in HTM 01-05. The variable situations of dental practices and different levels of previous decontamination compliance have made an assessment of the costs of compliance with HTM 01-05 impossible. Despite this the BDA has tried to establish some costs for the purpose of contract uplift negotiations.

- The BDA asked the Department for the evidence underpinning the four requirements that are causing the profession the most concern: provision of a separate decontamination room; two sinks incorporated into a single unit; rinse water quality; and instrument storage times. DH conceded that there was little published evidence and agreed to provide information from ongoing research in these areas. It also agreed to provide further explanation for the requirements which were not supported by evidence and where further research was not being undertaken. The CDO has subsequently stated that, where they are not supported by evidence, the requirements are supported by the general principles of risk reduction - a significant shift from DH's original assertion that all requirements were underpinned by evidence. It has subsequently acknowledged that the need for a separate decontamination room is based on professional advice as there is very little published evidence to demonstrate a reduction in risk. Similarly, in its explanation for the use of two sinks, it refers to the Health and Safety Executive's general principles of risk reduction by the separation of hazards. DH had already acknowledged that current recommendations for storage times are based on contamination rates in other clinical areas which are not comparable to dentistry.

8 Education and Workforce UK

- **CPD**: The General Dental Council is reviewing its continuing professional development (CPD) scheme which has been in place for ten years. The GDC also envisages making changes in preparation for a future revalidation scheme. Formal changes to the CPD scheme will be proposed in a consultation expected for the first half of 2012. The BDA has responded to earlier consultations through its Education & Standards and Ethics committees, noting that the current scheme has been proportionate and that we would not wish to see any major changes to it per se

- **Revalidation**: Following initial plans some years ago, the GDC consulted on revised proposals for revalidation at the end of 2010. The BDA strongly criticised the proposals as being disproportionate, not evidence-based, and not cost-effective, having departed

significantly from the original proposals. The Government published its command paper *Enabling Excellence* in February 2011, in which it asks all non-medical regulators to compile an evidence-base for their individual revalidation proposals. Both the consultation responses and the command paper have resulted in the GDC reviewing its proposals and researching the evidence base further.

The BDA meets regularly with the GDC and receives updates on the GDC's planning. It is generally accepted that dentistry will have a revalidation system, but the detail is in the process of being reviewed. New proposals are expected for later in 2012. The earliest start of revalidation is expected to be 2015.

- **Dental nurse training:** The BDA has recently raised concerns with the GDC about new quality assurance mechanisms for dental nurse training, which we are concerned will have an adverse effect on the provision of courses, and therefore the availability of places, from 2012 onwards. We await an outcome.

- **Foundation (vocational) training (England):** A national recruitment system to vocational training/dental foundation training was introduced in autumn 2011. The national recruitment approach was supported by BDA Students Committee as an improvement on the unruly scramble for places that characterised the previous scheme. We have, however, raised our concerns on some of the detail, particularly on the lack of choice both for trainers and young dentists in the system.

  Most recently, it has become clear that there are insufficient places to go round and the BDA wrote to the CDO stressing the importance of providing places for all UK graduates wishing to work in the NHS. Although DH maintains that it funds sufficient places, some of these are taken by overseas applicants which leaves UK graduates without a place. The matter will next be discussed at the next meeting of the Dental Programme Board of Medical Education England on which the BDA/GDPC has places. The notification process just before Christmas did not run smoothly, causing considerable anxiety to those students without a place on the first round. The BDA has written to and met the Chair of COPDEND to express concern and stress the need for a full evaluation of the arrangements.

- **Workforce (England)**: The BDA Executive Board Chair is on the Board of NHS Medical Education England (MEE), an independent advisory non-departmental public body with a remit for medicine, dentistry, pharmacy and healthcare science. Under the new arrangements for the NHS, MEE will change to Health Education England (HEE) in the near future. The Dental Programme Board (DPB) is an MEE sub-committee looking at training and workforce in general. In 2011, it published reports on skills mix and workforce supply. A review of the dental workforce has been commissioned by the DH, to be undertaken by the Centre for Workforce Intelligence (CfWI).

  The BDA provided extensive comments on the skills mix report, focusing on the need to ensure any changes in the balance of the number of professionals must not destabilise the current workforce. Reviews of workforce need to take into account the numbers currently in training, the extensive care that older people with multiple restorations will need in the next 20-30 years, and the current level of training for DCPs. We will comment further as this work continues into 2012.

9 Professional regulators (UK)

9.1 What is the issue?

- The Government command paper *Enabling Excellence* is extending the role of the **Council for Health Regulatory Excellence** (CHRE) in regulating the regulators. The CHRE is in the process of reviewing the GDC's work with a view to cost-effectiveness and efficiency. It published a number of highly critical reports in 2011, highlighting shortcomings particularly with regard to the fitness-to-practise arrangements, which have been identified to be costly, slow and sometimes inconsistent.

- The Command Paper also asked CHRE to consider the **size of regulators**. Following CHRE's report, the DH has made a recommendation that the GDC's Council should be reduced from 24 to 8 by the time the current Council term ends in 2013. The Chair will in future be appointed, not elected.

- The **Law Commission** is currently conducting a review of all Acts of Parliament relating to healthcare regulators. It is expected that the Acts, including the Dentists Act 1984 as amended, will be repealed and a new, single Act introduced around 2014.

- The GDC is in the process of reviewing much of its current **guidance**, including *Standards for Dental Professionals* and its supplementary booklets, ethical advertising guidance, and *Scope of Practice.* Apart from the detail of the guidance, these reviews will include considerations about the use of the title 'Dr' by dentists, and a policy on direct access to DCPs.

- The GDC has changed its committee structure, disbanding its previous standing committees and creating a single **Policy Advisory Committee** (PAC) which will now consider and make recommendations on all policy areas except finances. The PAC is formed by ten Council members who will in return create 'Task and Finish' groups for specific subject matters.

- With the disbanding of the Education Committee, the responsibility for **quality assurance** of new and existing education programmes has been delegated to the Chief Executive, to be supported by a group of experts.

9.2 BDA policy

- The BDA has released a number of statements about the GDC's efficiency, use of the annual retention fee, and concerns about over-regulation.

- We have responded to a consultation on the modernisation of the FTP procedures, supporting the introduction of case adjudicators in general as they will speed up the process for less serious cases, but with some concerns about their range of powers.

- We continue to monitor the situation and respond to proposals as they are consulted upon.

- The BDA has had an initial meeting with the Law Commission and is part of a stakeholder group which will be consulted throughout the process.

- We have provided feedback on the GDC's open consultations on the *Standards* and *Scope of Practice* reviews, and on a 2010 consultation about ethical advertising which included our strongly-voiced support for the use of the title 'Dr' by dentists. We included comments about direct access in our response to the *Scope of Practice* review.

- We have voiced our concerns about the delegation of quality assurance of dental programmes to the Chief Executive, raising the need for appropriate input from educators.

9.3 What next?

- There will be a further consultation as well as a draft Section 60 Order later in 2012, to which the Association will respond.

- The BDA will interact with the Law Commission throughout the review of the health professionals' legislation.

- The GDC is continuing with its *Standards* review in 2012, and formal consultations are expected throughout the year. A draft BDA position statement on direct access has been drafted by the DCP Strategy WG, with support from the Education & Standards and Ethics committees, which is being submitted for approval by the Representative Body. We also covered the topic in our evidence-based submission to the OFT inquiry.

10 Office of Fair Trading Inquiry into the Dental Market (UK)

10.1 What is it?

- In September 2011 the Office of Fair Trading (OFT) announced that they would be starting a report into the state of the dental market in the UK. It expects to report 'by March'.

- The OFT described the purpose of the report as "to examine whether the UK dentistry market is working well for consumers. It will examine how dentistry services are sold and the extent to which there is access to accurate and impartial information to help make informed decisions. It will consider consumers' ability to assess and act on the information that is provided, as well as the nature of competition between providers of dental services. These issues will be considered within the context of both NHS and private dentistry."

- The announcement of the inquiry was followed by the release of a *Which*? report into dentistry, which was very critical of standards. In 2003 the OFT published a report of its first inquiry, into private dentistry, following a super complaint from *Which*? This report will look at both NHS and private dentistry.

- The OFT will assess the current state of the dental market: regulation, competition and patient care.

- Regulation: The OFT will assess if there are on-going professional barriers to entry which restrict consumers' ability to access specialists or complementary dental care professionals. They will also examine the existing regulatory structure.

- Competition: This will involve analyses of the nature of competition between dental practices and whether a high concentration of practices has an effect on quality and price. The OFT will also look at barriers into the NHS market.

- Patient care: The OFT will assess if there is sufficient transparency of information for consumers to make informed choices between dental practices, treatments, private and NHS provision, and different payment methods. They will also check whether there is adequate support to enable consumer switching and whether there are effective complaints mechanisms in place.

10.2 What has been done?

- The BDA submitted detailed evidence to the OFT in January 2012 which is reflective of GDPC policy found in this and other documents.

- BDA evidence: An NOP patient survey, a practice owner survey and a local market case study were conducted.

10.3 Next steps

- Following the submission of our evidence the BDA will continue to engage with the OFT while they assess all the information they receive. The OFT will determine what it considers to be the state of the dental market in the UK and make recommendations. The BDA will be working to ensure that the recommendations of the OFT are feasible, reasonable and actually in the best interests of patients and the profession in the long term.

- If the OFT considers that there is a particular issue that is causing problems or there is a particular entity which is affecting the market it can refer the party or the whole sector to the Competition Commission for evaluation.

11. Tooth Whitening (UK)

11.1 What was the issue?

- The EU Cosmetics Directive regulates tooth whitening products. The directive made it illegal to supply products containing over 0.1 per cent hydrogen peroxide or compounds that release it, although use of products with higher concentrations continued. DH had indicated that it would not take action against dentists using products they deemed appropriate for their patients. The legal situation remained unclear throughout the 2000s.

11.2 BDA policy

- In 2008, the Scientific Committee on Consumer Products (SCCP) published its opinion that products between 0.1 per cent and six per cent hydrogen peroxide should be controlled exclusively by dentists, and that their use should include a clinical examination. Through a working group of the Council of European Dentists (CED), chaired by BDA Chair of Representative Body, Stuart Johnston, the BDA lobbied the European Commission successfully to accept these findings. There was resistance in some European countries to the proposed changes to the directive due to the legal situation having evolved differently.

11.3 Outcomes

- In September 2011, a vote in the European Council confirmed that the SCCP opinion should be accepted. The directive was changed accordingly, and the new legal situation will be ratified by October 2012 in all European countries. The important points to note are that:

    a) products between 0.1 and six per cent hydrogen peroxide can only be supplied to dentists and a clinical examination must be undertaken before use. This has been conveyed to the GDC, and work will continue to address illegal provision of tooth whitening by beauty salon staff and other non-dental individuals.

    b) products over six per cent remain illegal for the time being. The Council of European Dentists (CED) will continue to work on an evidence base that can be submitted to the SCCP for future consideration.

12. Dental Amalgam (UK)

12.1 What is the issue?

- Both the European Union and the United Nations are considering new regulations to restrict the worldwide use of mercury. The BDA has been working hard to ensure that the reasons dental amalgam is such an important tool in the dentist's arsenal are well understood, and is taking a lead role in the international discussions representing both the CED, by the Chair of Executive Board, Susie Sanderson, and the World Dental Federation (FDI), again by Stuart Johnston.

12.2 The situation so far

- In 2008 the EU's independent Scientific Committees on Emerging and Newly Identified Health Risks (SCENIHR) and on Health and Environmental Risks (SCHER) investigated the safety of dental amalgam and alternative materials and environmental issues. Their report concluded that dental health can be adequately ensured by both types of material; that the materials are considered safe to use.

- At the global level, the Governing Council of the United Nations Environment Programme (UNEP) decided in 2009 to begin negotiations to agree a legally-binding agreement limiting the use of mercury. The Intergovernmental Negotiating Committee

has met several times since then, and is working towards finalising an agreement by early 2013. The FDI sits at the negotiating table through its Dental Amalgam Task Team.

- CED and FDI have aligned their positions in view of the different work streams on this issue. They have taken the position that the phasing out of amalgam will only be appropriate when viable replacement restorative materials are available. Due to its ease of use, durability and cost-effectiveness, dental amalgam continues to be the most appropriate filling material for many restorations, and that restrictions on the use of amalgam would damage the financial stability of health systems as well as impact on individual patients' ability to afford dental care. Both organisations have called on governments to encourage the effective prevention of caries through health promotion programmes - which would result in the reduction in the use of all current restorative materials, including amalgam.

- The EU is currently undertaking a full lifecycle assessment of the use of dental amalgam, and has invited the participation of dental stakeholders. The outcome of the review should be published in March of next year.

- The BDA will continue to ensure that national and international organisations understand the benefits of the use of amalgam and the implications for oral health of restricting the use of mercury, and we will keep members up to date with any further developments as they occur.

13. Public Affairs (England)

- The Chair of GDPC, along with other BDA committee chairs, plays a key role in determining the content of political documents such as manifestos for General Elections. The most recent manifesto for England, produced for the 2010 General Election, focused on six priorities. They were:

    1. Reform NHS dentistry to create a system that works for patients and dentists
    2. Help primary care trusts deliver NHS dental care that meets patients' needs
    3. Fulfil the promise of access to NHS dental care for all who require it
    4. Eradicate oral health inequalities
    5. Stop the rot: harness the potential of fluoride to prevent tooth decay
    6. Safeguard the future of dental services in hospitals, salaried services and academia.

    Full details of the manifesto are available at: http://www.bda.org/news-centre/parliamentary-bulletins/26045-general-election-2010.aspx.

- Senior members of GDPC play a prominent part in the BDA's public affairs activities. They are often asked to represent the profession, the BDA or GDPC at one-to-one meetings with MPs, Peers and MEPs, the political party conferences and other events.

- The 2009-12 session has seen both Chair John Milne and Vice Chair Henrik Overgaard-Nielsen represent the BDA at fringe events at the main political party

conferences, acting as spokespeople on issues including the benefits of local government of working with the health professions, care for disadvantaged patient groups and localism in healthcare. One-to-one meetings have been held with influential politicians including the current and previous chairs of the House of Commons Health Select Committee, Ministers and shadow ministers and others. GDPC is also represented at other political events, including the annual reception of the All-Party Parliamentary Group for Dentistry at the Houses of Parliament. Dr Overgaard-Nielsen also hosted a visit for MPs and Peers at his Fulham surgery, allowing the visitors to see for themselves the realities of dental practice.

- They also play a prominent role in the BDA's media relations and other communications activities, regularly featuring in national and regional newspapers and on radio and television. Issues of quality and competition raised by the launch of the Office of Fair Trading's investigation into dentistry and *Which*?'s mystery shopper survey of dental practices have prompted a spate of recent coverage. A summary of the BDA's media appearances is published monthly on the BDA website.

- Members of GDPC who are interested in representing the BDA in the media are encouraged to register with the BDA press office as volunteer spokespeople. Email charlotte.booth@bda.org to express interest.

Annex 1

The long and carefully-trodden path to dental pilots

The BDA welcomed as positive news the announcement that pilots intended to find a system to replace the much-criticised 2006 general dental services contract in England have begun. It follows six years of campaigning which has seen the BDA maintain pressure on successive governments for reforms that will, it is hoped, improve the working lives of practitioners and care for patients.

Problems from the outset

Concerns about the new contract emerged before it was even implemented in 2006 as it became clear that key elements of the reforms, including the banded patient charge system and the use of Units of Dental Activity (UDAs) to measure practitioners' activity, were not only to be imposed without agreement with the profession, but also without first being piloted. A BDA survey of Local Dental Committees (LDCs) published in the months before implementation also reported widespread problems arising with the details of dentists' contracts and inflexibility from primary care trusts (PCTs) in calculating contract values.

Omens for the success of the new contract worsened as the deadline for dentists to sign it approached and, even in the weeks and in some instances hours prior to the deadline, practitioners still hadn't received the paperwork they needed to make decisions about whether to sign. Their concerns about the chaos surrounding the implementation seemed to be borne out when it emerged that approximately one in 10 practitioners had decided not to sign the contracts they had been offered. An earlier BDA warning that a failure properly to manage the transition and provide dentists with the information they needed ahead of the new contract's implementation had proved correct. With a realisation of the magnitude of the problems created by the new arrangements growing rapidly, the BDA quickly called for them to be reviewed, with Executive Board Chair Dr Susie Sanderson in her speech to the 2006 British Dental Conference calling for a full and transparent examination and a commitment to address their flaws.

Unpopular with the profession

The BDA continued its campaigning, highlighting problems throughout 2006. Further evidence of the chaotic administration associated with the reforms, which had contributed to many practitioners opting not to sign the new contracts they had been offered, came in August, with new figures underlining the slow rate at which contracts signed 'in dispute' were being resolved. October saw further bad news for Government with NHS Information Centre (NHSIC) statistics confirming the significant number of dentists driven out of the NHS by the botched reforms and the profession delivering a damning verdict on the changes in a BDA survey that identified pessimism about what the changes would mean for their ability to treat more patients.

Problems persist

A further BDA survey, published in March 2007 to mark the anniversary of the introduction of the new system, confirmed that the problems were not easing, with the BDA pointing out that the changes were not achieving the aims the Government had set out for them and arguing that they were failing for dentists and patients alike. A special conference staged by the BDA to mark the anniversary saw Susie Sanderson call again for a review and for Government to scrap the UDA as the currency of dentists' performance. Demands for a review were stepped up in April, with the BDA writing to the Department of Health asking for a particular emphasis on removing the UDA as the sole indicator of dentists' performance, allowing the transfer of contracts between providers, and for PCTs to be paid the whole of their commissioning budgets directly. Further evidence of the practical problems created by the reforms emerged in August 2007, with practices being destabilised by the threat of clawback of monies by PCTs, sparking a call for an amnesty by the BDA. And it wasn't just dentists who were struggling with the reforms. A survey of both dentists and patients by the Commission for Public and Patient Involvement in Health (CPPIH) in October 2007 highlighted the breadth of stakeholders negatively affected, a point reinforced by BDA commentary on the results.

Politicians acknowledge problems

Problems with UDA targets were exposed again in November 2007, when data obtained by the BDA exposed the fact that almost half of dentists with an NHS contract in England had not managed to complete 96 per cent of their UDA targets, the amount required to be free of the threat of clawback from PCTs. Publishing the figures the BDA called for all PCTs to be understanding and constructive in their approach to resolving such scenarios. BDA's arguments for a reappraisal of the contract resonated sufficiently with Members of the London Assembly that a report produced by the body agreed that a reconsideration of how preventive care could be encouraged was needed.

Impact of BDA arguments grows

With BDA campaigning gaining traction with politicians, 2008 was going to be a vital time in the fight for reform. The year began with a strengthening of the consensus between dentists' and patients' groups about the failure of the contract. Research published by Citizens Advice highlighted the significant number of patients unable to access NHS care, sparking the BDA to reiterate its argument that the Government's own goal of increased access was not yet being achieved and to stress the importance of PCTs engaging constructively with practitioners. Concerns about the impact of the changes on patients' ability to access care were prominent again in February, when NHSIC statistics confirmed that half a million patients had lost access since the reforms, a development branded by Susie Sanderson a "milestone in the failure of the reforms".

The clearest indication yet that BDA campaigning was beginning to turn the tide followed soon afterwards when Dr Sanderson was asked to appear before the House of Commons Health Select Committee's inquiry into dental services. Having already submitted written evidence to the inquiry, the BDA was one of a number of witnesses called to appear before the influential panel of MPs. Highlighting issues with the contract including problems with the

UDA, Dr Sanderson called for the Department of Health and PCTs to work constructively with the profession to seek solutions. With the BDA's arguments having forged a consensus about the problems dentists and their patients were facing, it was time for a new phase of campaigning in which all parties had to look forward and engage constructively to start building a better future. Setting out a vision for a UDA-free future, the BDA called for prevention and quality of outcomes to be at the centre of any new arrangements that were to be developed.

The breakthrough

2 July 2008 was a pivotal day on the path to reform. It saw the publication of the report of the Health Select Committee's inquiry, a document so strong in its criticisms that the BDA branded it a "…damning indictment…" of the reforms and urged the Department of Health to look seriously at its recommendations for the good of the profession and patients alike. Maintaining pressure for change and once again pointing the way forward, the BDA intensified its lobbying of then Dental Minister Ann Keen MP in September, stressing the need to consider the time and resources necessary to provide quality care to patients as a foundation for the development of reform. Acknowledgement of the need for engagement to divine a way forward appeared to emerge in October, with Mrs Keen pledging to work more closely with the profession as the Department published its response to the Health Select Committee's report.

Despite this pledge, the way forward had not yet been smoothed, and the BDA was compelled to step forward publicly to defend the profession against suggestions by the Department of Health that dentists were 'gaming' the much-criticised contract and challenge it to produce evidence for its claims.

Steeled for change

Progress continued though, and just two weeks before Christmas dentists and their patients received the news that the Government was to commission an independent review of dentistry which would be led by Professor Jimmy Steele of Newcastle University. The announcement, the significance of which was signalled by the fact it was made by the then-Secretary of State Alan Johnson MP, was described as a "…step forward…" by the BDA, which urged the review group to look carefully at the problems it was tasked with addressing.

With the Labour Government waiting for Professor Steele's review and speculation about the date of the next General Election beginning, in May 2009 the Conservative Party published *Transforming NHS Dentistry*, a blueprint for the reforms it would pursue if elected. The document appeared to respond directly to BDA lobbying, featuring pledges to pilot change properly, scrap the UDA and reward preventive care. The publication precipitated a flurry of activity over a six-week period. Susie Sanderson used her platform at the British Dental Conference in Glasgow to applaud Professor Steele's insistence on independence and determination to deliver a worthwhile report, and to challenge Government to demonstrate its serious commitment to the process with the extent to which it accepted the recommendations. As Dr Sanderson addressed dentists in Glasgow, at Westminster it was confirmed that Mr Johnson was to pass the health portfolio to Andy Burnham MP. Just weeks later, Professor Steele's report was published. Applauding the publication, General

Dental Practice Committee Chair Dr John Milne said that the review team had clearly listened to patients and dentists and stressed the importance of constructive engagement as the detail of reforms was worked out.

Taking politics out of dentistry

With the long-anticipated General Election called, the early months of 2010 saw the BDA set out in a manifesto what it believed should be the priorities for the elected new government. Seeing through the reform process was high on the list of the BDA's priorities. With concerns rife that a change of government may see the principles of a Labour-commissioned review abandoned, Dr Milne moved to issue an open plea in a blog for the BDA's website that the principles set out in the Steele report were not allowed to become a political football. At the same time, the long-talked about notion of pilots to guide reform became more than just an idea, with an announcement that 30 practices were to be involved in finding ways to improve services. The BDA's response once again underlined the importance of engagement with the profession to maximise the chances of success.

A close result in the General Election saw the formation of a Coalition Government by the Conservative and Liberal Democrat parties. By the middle of July the new administration was ready to publish its blueprint for health, featuring pledges mirroring BDA campaigning including a commitment to piloting change and an emphasis on outcomes. Responding, John Milne said the commitment to piloting was reassuring and explained that the BDA would continue to urge the new Minister for dentistry, Conservative Peer Earl Howe, to take forward Professor Steele's recommendations. Dr Milne's call appeared to have been heeded when, in September 2010, the Department of Health announced that Professor Steele would have a continued role in developing a new dental contract. The BDA expressed support for the move.

Pilots become a reality

Three months later, it was announced that 2011 would see the start of pilots that would focus on continuing care and moving away from targets, an announcement that received another positive response from the BDA, which again stressed the need for continued engagement with the profession as change progressed. That message appeared to have hit home when, in April, it was confirmed that Secretary of State for Health Andrew Lansley MP would be appearing at the 2011 British Dental Conference in Manchester to outline his thoughts on the reform of dentistry and be questioned by practitioners. At another Conference, the annual gathering of Local Dental Committees which took place in London in June, John Milne stressed to practitioners that the reforms must work for Government, patients and dentists alike, and made a plea that the reforms were properly funded so that practitioners could provide all patients with the treatment they needed.