British Dental Association

Health and Social Care Bill

Proposed amendments - Commons Committee stage

The BDA welcomes the provision for dental services to be commissioned by the NHS Commissioning Board, although it must be clarified whether this means all types of services. Commissioning by primary care trusts has been of variable quality and we believe that national commissioning will lead to greater consistency of approach and will ensure that dentistry is not overlooked.

Whilst there are significant advantages in central commissioning of dental services by the NHS Commissioning Board, we are nonetheless anxious to ensure that mechanisms are in place to strengthen the ability of commissioners and providers to develop services that are responsive to local needs, and to ensure that they are fully integrated with other NHS services. There will be a delicate balance to be struck between central determination and local flexibility. Local input is a key element which needs to be secured within the Bill.

There are other areas in the Government’s proposals on which we seek clarification. These include the services to be provided for children, the role of Monitor, and education and training for the healthcare workforce.

1. Clarification of the scope of the Board’s responsibilities for dentistry

The intention for responsibility for commissioning general dental services (family dentistry) to move from primary care trusts to the National Commissioning Board has been well documented and has the support of the BDA. The intention for hospital services also to be commissioned by the Board was made clear by Earl Howe, Parliamentary Under-Secretary of State for Health, in a House of Lords debate on 13 January.

The BDA believes that all dental services should be commissioned centrally because of the dynamic and complementary nature of the relationships between general dental services, salaried primary dental care services (SPDCS - also known as community dentistry, for vulnerable groups), hospital dental services and out-of-hours services. This approach would ensure consistency in commissioning and safeguard care for vulnerable groups. Despite this stated intention, the current wording in clauses 9 and 11 leaves open to question where commissioning for all dental services will sit.
Proposed amendment 1

- Clause 9 – Duties of consortia as to commissioning certain health services (page 5)
  - In clause 9(2) insert a new clause 9(2)(b) as follows:
    
    ‘(b) in paragraph (c) [of section 3(1) the NHS Act 2006], delete the word ‘dental’’
  
  and renumber the clauses accordingly.

Rationale

This clause relates to the duties of consortia. We seek confirmation that all dental services will be commissioned by the Board and so it is necessary to remove this responsibility from the duties of consortia.

Proposed amendment 2

- Clause 11 – Power to require the Board to commission certain health services (page 7)
  - In clause 11, in new section 3B(1)(a) delete ‘of a prescribed description’

Rationale

The rationale is the same. This deletion will ensure that all dental services are commissioned by the Board and not just those ‘of a prescribed description’.

- We also seek clarification of the term Primary dental services. They have generally been considered to be services provided by either general dental practitioners or SPDCS, but the explanatory notes to clause 11 (paragraph 128) refer to both SPDCS and hospital services as ‘secondary dental services’. It is this confusion that is causing the BDA concern.

- Clause 19 – further provision about the Board (page 14) – adding new section 13AT – Exercise of functions of the Board – also suggests that the Board may delegate any of its functions to a Special Health Authority, a commissioning consortium or such other body as may be prescribed.

2. School dental inspections

The Bill envisages extending to local authorities new duties to provide for the dental inspection and treatment of schoolchildren [Schedule 1 of the 2006 Act].

It appears that the Bill provides for inspection and treatment of identified need in schoolchildren, but it is not clear if re-introducing routine, systematic school dental screening is envisaged. We support inspection and treatment for targeted priority groups, but this will not be appropriate in all areas. Routine screening has been proven to be ineffective in improving the oral health of schoolchildren as it does not lead to treatment of those in need and is ineffective in tackling oral health inequalities. A multi-faceted approach to oral health inequalities that targets pre-
school children and their parents would be a more effective strategy for dealing with this issue.

The Public Health Outcomes Framework includes one oral health indicator – the reduction in the caries (decay) rate in five-year-old children. We support this outcome and there are a number of effective measures that can achieve it, but they must start well before the child begins school and so we do not see how they will be captured by this provision.

Proposed amendment 3

- Clause 13 – Other services etc provided as part of the health service (page 8)
  - Add a new clause 13(4) as follows:
    
    13(4) In paragraph 1 after ‘must’ insert ‘consider the benefits for appropriate priority groups and where appropriate’

    And renumber the clauses accordingly

    Rationale

    This clause as presently worded puts a duty, as opposed to the ability in appropriate circumstances, to provide for dental inspection and treatment of schoolchildren.

3. Dental public health

The Bill passes to local authorities duties in relation to public health and dental public health, which we welcome, and a duty to appoint a Director of Public Health. There is no duty to ensure that they have the benefit of specialist dental public health advice which is essential if local public health measures are to lead to oral health improvement and reduce oral health inequalities.

There is no reference in the Bill to where Consultants in Dental Public Health will sit in the new structure and how their expertise will be utilised. Consultants in Dental Public Health play a pivotal role in identifying need and balancing the provision of services to provide the maximum health benefits to diverse populations. We would welcome the inclusion in clause 25 of a duty on a local authority to appoint a dentist to have responsibility for dental public health (a Consultant in Dental Public Health).

Proposed amendment 4

- Clause 25 Other health service functions of local authorities under the 2006 Act (page 44)
  - Add a new subclause 25(4) (amending Section 111 of the 2006 Act) as follows:

    ‘(4) A local authority or local authorities acting jointly must appoint an appropriately qualified dentist to have responsibility for dental public health to be known as the Consultant in Dental Public Health.’

    Rationale: As above.
4. Licensing of dental service providers by Monitor

The Bill proposes that any person who provides NHS health care services must be licensed by Monitor, although there is a provision for exemption regulations.

Dental service providers (dentists, for the most part) are already heavily regulated by their professional regulator, by performers lists provisions, by the terms of their NHS contract and now by the Care Quality Commission. We believe that it is disproportionate to include dentists in economic regulation as there is no evidence of risk to patients or the health service from lack of competition, patient choice or lack of continuity of service. We believe that it would impose an unnecessary burden which, according to clause 56, is contrary to its duty to review regulatory burdens. The explanatory notes (paragraph 607) suggest that general medical practitioners may not be covered by the licensing requirements and we seek confirmation that dentists will not be required to be licensed.

Proposed amendment 5

- Clause 76 – Exemption regulations to the requirement to be licensed (page 77)
  
  o Add a new section 76(2) as follows:
    
    ‘(2) Regulations shall provide for the grant of exemption from the requirement in section 74(1) for providers of general dental services’.

  And renumber the subclauses accordingly.

- We also seek clarification of whether Monitor will have a role in determining the pricing of contract values/capitation fees for general dental services (family dentistry) (chapter 5). Section 103 of the 2006 Act provides that the Secretary of State may give directions as to payments under general dental services contracts and must consult those it affects. If Monitor is involved, there must be the obligation on it to consult as contained in clause 57(7).

- Although there is the requirement in clause 56 to review regulatory burdens, there is no specific provision to ensure that its duty is fulfilled.

5. Taking advantage of local professional expertise - 1

We have argued above for the appointment of Consultants in Dental Public Health in local authorities. There are other important sources of local professional expertise; Dental Practice Advisers, Local Dental Committees and, in some areas, Oral Health Advisory Groups.

The BDA is concerned that there is no statutory duty on local authorities, through the Health and Wellbeing Boards, to consult local representative committees when devising a health and wellbeing strategy and joint strategic needs assessment. (clauses 176 and 177).

We suggest that their ability (Clause 178) to respond to dental needs, to inform the joint health and wellbeing strategy, the joint strategic needs assessment and the
National Commissioning Board, and to encourage integrated working across local healthcare providers will be significantly enhanced by the statutory responsibility to include representatives of relevant health professions in their constitutions and to consult them.

These amendments are supported by the Optical Confederation.

Proposed amendment 6

- Clause 176(6) – Joint strategic needs assessments and strategies
  - In new Section 116(8)(A) of the Local Government and Public Involvement in Health Act 2007 before ‘may’ insert ‘must consult committees representative of local health professionals and’

Proposed amendment 7

- Clause 179 – Duties of Health and Wellbeing Boards
  - Insert new subsection

  ‘(179)(6) A Health and Wellbeing Board may encourage providers of health or social care services in its area to work closely with the Health and Wellbeing Board and in an integrated manner by consulting local representative committees.’

  And renumber accordingly.

6. Taking advantage of expertise centrally

We welcome a central Board responsible for commissioning dental services on a national basis, and its duty to promote autonomy of providers, but in order for it to be effective it must have access to expertise through an appropriately constituted consultative committee.

For the successful commissioning of dentistry, it is essential that expert dental advice is available to the Board. The Bill states (in Schedule 1, paragraph 10) that ‘the Board can appoint such committees and sub-committees as it considers appropriate’. These appointments will be important because they will help to ensure that the right expertise informs commissioning decisions. In order for dental care to be commissioned so that it effectively meets patients’ needs, the BDA believes that a national dental advisory group should sit alongside the Board to support the commissioning of dentistry across the country. This could be added to the Bill in Schedule 1. The advisory group should include representation from all the different dental services (general dental services, salaried dental services and hospital dental services) and provide clinical input into the management of the national commissioning process.
Proposed amendment 8

- Schedule 1 – The National Health Service Commissioning Board (page 224)
  - In paragraph 10 insert new paragraph 10(2)
    ‘The Board shall appoint a consultative committee on the commissioning of dental services’.
    And renumber accordingly.

Proposed amendment 9

This amendment has the support of the Optical Confederation.

- Clause 16 – Regulations as to the exercise of functions by the Board or consortia (page 13)
  - In Clause 16(5)(6), for ‘may’ substitute ‘must’ so that it reads: ‘The regulations must require the Board to consult prescribed persons before exercising any of its functions by virtue of subsection (4)(b) or (5).

Rationale

It is essential that the Board consults representatives of providers of services on the proposed terms and conditions and model commissioning contracts if they are to be workable.

7. Commissioning arrangements by the Board or consortia

We do not understand the meaning or implications of this paragraph. The explanatory notes (paragraph 422) says ‘Paragraph 9 inserts new section 12ZA into the NHS Act, which makes special provision about commissioning arrangements made by the NHS Commissioning Board and commissioning consortia. For example, it allows those bodies to make their facilities and employees available to service providers.’ So it can be conferred that it applies only to facilities owned by and employees employed by the Board and consortia. As it stands, however, it might suggest that the assets of independent dental providers can be appropriated by the Board and transferred and so we are seeking clarification.

Proposed amendment 10

- Schedule 4, paragraph 9 (page 236) – delete paragraph 9(3)
  
This provides that: ‘If the Board or a commissioning consortium arranges for the provision of facilities by a service provider, it may also make arrangements for those facilities to be made available to another service provider or to an eligible voluntary organisation’.

Rationale

This appears to enable the Board to transfer the assets of an independently-owned general dental practice to any other provider. This would be inequitable as the assets are owned by the provider and have been acquired
as a result of personal investment. It must be clear in the Bill that this cannot be applied to primary dental care providers.

8. **Taking advantage of local expertise - 2**

The BDA believes that Local Dental Committees (LDCs) have much to offer Health and Wellbeing Boards, joint strategic needs assessments and health and wellbeing strategies, but they can only do so if they are formally recognised and have the resources to function effectively. With the 2006 NHS dental contract changes, the ability of LDCs to recruit members and to collect subscriptions has been severely affected by the changes that were made to the Act at that time. We therefore propose that these arrangements for LDCs are strengthened as follows:

**Proposed amendment 11**

- Schedule 4, paragraph 51 (page 245) – For Clause 51 substitute

‘For section 113 (Local Dental Committees) substitute

**113 Local Dental Committees**

(1) The Board, the local authority and the Health and Wellbeing Board shall each recognise a committee formed for an area which it is satisfied is representative of dental practitioners providing or performing general dental services or services to which section 107 refers.

(2) A committee recognised under this section is called the Local Dental Committee for the area for which it is formed.

(3) Any such committee may delegate any of its functions, with or without restrictions or conditions, to sub-committees composed of members of that committee.

(4) Regulations shall require the Board, in the exercise of its functions relating to primary dental services, to consult any committee recognised by it under this section.

(5) A committee recognised under this section has such other functions as may be prescribed.

(6) A committee recognised under this section must in respect of each year determine the amount of its administrative expenses for that year attributable to persons of whom it is representative under subsection (1). 

(7) The Board shall

(a) on the request of a committee recognised by it allot to that committee such sums for defraying the expenses referred to in subsection (6) as the Board may determine, and

(b) arrange for the deduction of the amount of such sums from the remuneration of persons of whom it is representative under subsection (1).
(8) The administrative expenses of a committee include the travelling and subsistence allowances payable to its members.’

9. **Education and training for the healthcare workforce**

Concurrently with the Bill, the Department of Health is consulting until the end of March on proposals for transferring responsibility for the education and training of the healthcare workforce to providers (*Liberating the NHS: developing the healthcare workforce*). The dental workforce is educated and trained principally in university dental schools, and national responsibility, oversight and provision must be managed centrally. The BDA is concerned at the implications for dental service providers, most of whom are small family practices, if they are expected to take responsibility for assessing workforce need, arranging for training and paying for it by means of a levy. The consultation stresses that the changes are significant and that time must be taken ‘to develop the proposals to ensure that the appropriate legislation is in place, that the administrative arrangements are appropriate and proportionate…’. We seek assurance that nothing in the Bill pre-empts proper consultation and consideration of the implications of the proposals for the entire healthcare service provider sector.

10 February 2011.