



## **BDA response to the General Dental Council's consultation on principles of specialist listing**

**April 2019**

### **Introduction and overview**

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and our membership also includes dental students.
2. We welcome the opportunity to feed back to this consultation.

### **General points**

3. We note the comment about future consideration of changes to the system of mediated entry to the specialist lists. This is an area of importance to the BDA and we look forward to engaging further with the discussion and consultation on this subject in the course of this year.
4. We would like to comment about the composition of the Specialty Working Group that is currently involved in considering matters of specialist listing at the GDC, and which has informed this consultation document. The membership of the WG appears to consist of the Chief Dental Officers of the UK's four countries; Health Education England and the deaneries of the devolved countries; the Faculty of General Dental Practice; the Dental Schools Council; the Royal Colleges of England, Edinburgh and Glasgow; the Association of Dental Hospitals; and the Advisory Board for Speciality Training in Dentistry.
5. Despite several requests, the GDC has declined to invite the BDA to contribute to the work of this group. The reasons have variably been cited as 'not wishing to have representative/membership organisations' on the group, or that the BDA's membership is 'only a percentage of registered dentists, not all'. Both reasons demonstrate a fundamental misunderstanding of the BDA's role as a trade union and professional organisation; we will raise this with the GDC at other opportunities.
6. However, it needs to be noted that the membership of the working group has been composed entirely of individuals and organisations who have representative or political roles in relation to dentistry and have subjective interests in this area, many of a workforce planning/funding nature. We have no issue with the organisations and individuals on the group; there is no doubt that they should all be involved. It needs to be pointed out, however, that the BDA would have been able to put an objective perspective on the discussions on behalf of a very wide group of professionals in all spheres of practice.

7. Given that this objective voice has not been included, we believe that this consultation and its proposals are in part more political than the GDC might realise. The GDC has no role in workforce planning, but we are concerned that there are some workforce policy points raised within the document, particularly in the context of the comment in the introduction about the GDC being 'the sole author of the consultation proposals'.
8. Going forward, we would appreciate a realisation that the current working group does include membership and special interest groups, and a subsequent invitation of a BDA representative with relevant expertise and experience, potentially the Chair or Vice Chair of the BDA's hospitals committee, to contribute to its further work.

## Consultation questions

### Section 1

1. **Do the proposed purposes of specialist listing accurately and sufficiently represent the benefits of listing branches of dentistry as specialities?**

Yes, we support the purposes outlined.

We would make the comment that specialists in dental public health do not deliver specialist care directly to patients and so are not directly "part" of patient pathways. They do, however, support specialist care as they work with commissioners on pathway design and procurement. We wish to ensure, and receive confirmation, that the GDC intends for this meaning to be included in the wording of the list of purposes.

2. **Are there additional purposes and/or criteria that should be considered?**

We have no further purposes to add.

3. **Do you have any other comments about the proposed purposes and/or criteria?**

We agree with the points, including that the listing should have a dental public health need that is not solely or primarily the commercial benefit of those practising the specialty. We would comment, however, that the public health need should not be solely influenced by decisions in the NHS to fund or not fund the treatment or the training pathway.

### Section 2

1. **What types of evidence should be considered, or required, before adding or removing a dental speciality?**

The GDC must be clear and transparent in the level of proof it requires to de-list a specialty. We believe that both dental public health and independent academic evidence should be provided as a basic minimum.

Without the need for such evidence there is the possibility that the NHS may seek to de-fund certain treatments deliberately and subsequently use this as evidence that said treatment was no longer current and hence appropriate for de-listing of a specialty, without agreement from those actually providing the care, and to the detriment of patients in need. Nothing would subsequently stop the NHS from providing said treatments again albeit no longer by 'specialists'.

If the GDC believes that specialist listing exists to 'support the provision of specialist care for patients as part of effective patient pathways', then workforce planning – that is, the

NHS-funded provision of specialist care, and related training pathways – must not be a factor in considerations for de-listing or amalgamating lists.

Such a development would also have a great deal of jeopardy for those with job descriptions that require a specialist status as an essential criterion. Without an existing speciality to underpin such posts, it is difficult to envisage what would happen, for instance, to a hospital dental consultant in that speciality – would they be expected to renounce the title ‘specialist’ or expected to train for additional years in a different area to return to the use of the title in a similar discipline? Professionals would be unlikely to support such changes, and the systems that underpin care provision would also be destabilised, as many referral pathways rely on the existence of specialist care.

A better approach to any de-listing in such cases would be a closing of the speciality to new entrants, so that change is not sudden, but takes place over longer time periods.

**2. What should the role of the GDC be in responding to requests for the addition or removal of specialist lists?**

The GDC of course has the role of holding the lists and would have to ask for relevant evidence. It would have to ensure that any evidence to delist a speciality does not include monetary arguments in terms of the funding of training, or the funding of a treatment. Workforce planning is an issue for government, not the GDC. The NHS, its trusts and arms-length bodies have the power to reduce funding for training and treatment provision, and thus the power to steer how many professionals train and provide services in a given speciality. However, specialist training is also sometimes self-funded by dedicated professionals, and such training often subsidises NHS training and workforce provision. The GDC’s role should therefore be one of listening to arguments solely based on the need for patient care at the appropriate level; not arguments of system change.

**3. What other stakeholders should have a role in the process of adding or removing specialist lists, and what should that role be?**

The GDC quite clearly relies on stakeholders for relevant information. Such information should come, as mentioned above, from dental public health and independent academic research. In other words, the evidence for the need for a speciality should come from independent evidence, not from funding decisions at NHS level. The specialist societies and the British Dental Association should also be involved in testing any evidence at an early stage, as well as via formal consultation. If relevant stakeholders are only invited to comment on a finalised consultation proposal rather than contribute to the initial thought process, where influence is provided by those funding services, this reduces trust in the objectivity of the consultation.

### **Section 3**

**1. What do you believe the appropriate regulatory levers for maintaining accreditation on specialist lists should be?**

Evidence of actively working and updating professional knowledge in the speciality. Currently, this should be underpinned by CPD, and CPD needs to reflect all areas of practice. The current CPD system might be too restrictive to demonstrate the maintenance of accreditation on a specialist list if the individual has a wide area of work and expertise.

**2. Should consideration be given to developing the specialties from 'listing' to specialist registers?**

We do not support such a move. Within medicine, doctors undertaking some form of 'specialist' training are then linked to a list in that specialty. In dentistry, the fundamental training is that of a generalist, with the option of undertaking additional specialist training or not. The professional identity is obtained on the basis of the dental degree and the inclusion in the register before moving into other career paths. We support a retention of the current system.

**3. If so, how would such a development be ideally funded?**

n/a

**Section 4**

**1. Are you responding to this consultation as an individual, or on behalf of an organisation?**

Organisation.

**2. If you are responding to the consultation on behalf of an organisation, please tell us the name of your organisation and how many members you represent.**

British Dental Association.

In our trade union role, we represent all dentists in the UK in all spheres of practice on the wider aspects of dentistry. This representation is irrespective of membership numbers as a professional trade union has a specific legal representative responsibility for all members of the profession. Membership numbers are therefore not relevant in this instance as this has relevance only to individual representation where such representation becomes necessary. Our representative committees include members and non-members.

**3. If you are responding as an individual, and are a GDC registrant, please tell us your category of registration and any specialist lists of which you are a member.**

Not applicable.

**4. The GDC may wish to contact you in the future for more information about your answers. Please provide your name and your preferred contact details (email address, phone number or address).**

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