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 include dental students.

The BDA welcomes the opportunity to respond to relevant questions in this consultation. We support the principles of the Minamata Convention, which aims to reduce the environmental burden of mercury whilst recognising the practical implications for healthcare and other industries around the world and the measures that must be put in place to mitigate these. Together with colleagues from the Council of European Dentists, and working closely with DEFRA, we have played an instrumental role in securing a workable Regulation on Mercury for the EU in relation to dental amalgam. The UK dental profession recognises its responsibility to minimise mercury pollution from dental amalgam restorations, which must be achieved while protecting the best interests of individual patients and within the context of the NHS.

Dental amalgam is a safe, durable and cost-effective material that has been used to treat patients for over 150 years. In some clinical situations it remains the most appropriate, or only, option for the restoration of a decayed tooth. For instance, patients might be unable to sit still for long enough to enable the placement of a composite restoration, or it might not be possible to provide a sufficiently dry intra-oral environment. A BDA member has given the example of a 14-year-old patient with ADHD, showing limited compliance and attention span and not amenable to rubber dam placement, who presented with moderate caries in the permanent teeth; the feasible duration of the operative treatment was compromised due to the patient’s reduced co-operation. The dentist, parent and patient discussed the treatment options and agreed on dental amalgam restorations to provide certainty and longevity, and to avoid the need to repeat the procedure following sub-optimal attempts with alternative materials or successive temporary restorations; the decision was recorded as such in the patient notes. It is therefore essential for dentists to retain the full range of materials at their disposal and make the best choice for the needs of each individual patient.

Q17- Do you have any comments on the proposed approach to the dental provisions in the EU Regulation?
Yes.

- Article 10(3) in England
The BDA is extremely concerned about the lack of a national plan, and about the piecemeal and unambitious scale and scope of existing prevention interventions. Substantial progress in prevention of dental disease is a central requirement of the Minamata Convention in relation to dental amalgam. No coherent national strategy has been developed for England, with the devolution of public health acting as a barrier to the consideration of a nationwide scheme such as those operating successfully in Wales and Scotland. An effective approach to improve oral health and reduce inequalities would be based on the “proportionate universalism” principle, as exemplified by the Childsmile programme, whereby a basic intervention provided population-wide is supplemented by further targeted measures for those at greatest risk of disease. The narrow and inadequately funded schemes currently operating in England, such as Starting Well, do not provide a realistic basis for the scale of oral health improvement required to enable a substantial phase down in amalgam use. Indeed, local authorities have been responding to financial pressures by decommissioning oral health promotion programmes and staff, and prevention activities are being systematically reduced rather than developed.

The BDA is supportive of the intention for contractual reform in general dental practice to deliver a greater emphasis on prevention. However, we are concerned that the current prototypes will not deliver the required change, given that activity measures remain a significant element of the remuneration system being tested.

- Article 10(4) in England
Failure to comply with Article 10(2) does not present a potential risk to patients. This requirement of the EU Regulation is not founded on any evidence of health risks to children or pregnant/breastfeeding women (SCENIHR, 2015). Rather, it represents a concession to the unsubstantiated demands of the anti-amalgam lobby and its vocal calls for an immediate phase out. The BDA recognises the need to implement monitoring of the placement of amalgam restorations in these restricted groups, under the terms of the EU Regulation; this could be carried out by the Care Quality Commission. However, it is imperative that no reference to health risks should appear in official documents in relation to these patients, in the absence of any reliable new evidence to support such a claim, and we urge DEFRA to revise this inaccurate and irresponsible wording. A large-scale public health scare about the safety of dental amalgam restorations would be catastrophic to the NHS.

- Article 10(3) in Wales
In relation to the placement of dental amalgam restorations in the restricted patient groups: “Any medical/clinical justification for its use after July 2018 will be outlined, agreed and widely communicated”. The BDA objects in the strongest possible terms to this proposal – for Wales or for any other part of the UK – and wrote to the UK Chief Dental Officers collectively in September to explain this position. We received no formal response. No list of clinical scenarios can be exhaustive, and it is inevitable that circumstances not covered by such a list will arise in practice, presenting very real problems in relation to regulation. The BDA supports the carefully-constructed wording of the EU Regulation, which allows sufficient freedom for dentists to exercise their clinical judgement and act in the best interests of each patient: “when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient”.
There are considerable additional costs associated with the provision of stainless steel crowns, which must be recognised. Aesthetic acceptability to patients and their parents/carers is also poor.

- Article 10(2) in Scotland
“UK-wide guidance is being developed which will include how decisions to, exceptionally, provide an amalgam filling to a patient in the specified groups should be recorded.” The BDA welcomes this commitment to provide guidance on the documentation of clinical decisions. As stated
above, the freedom to make these decisions in the best interests of each individual patient is paramount.

- Article 10(3) in Scotland
  The BDA would welcome guidance on alternatives to amalgam restorations for use in the restricted patient groups, again providing that dentists are able to exercise clinical judgement on the most appropriate treatment for a particular patient.

- Article 10(4) in Scotland
  It is unclear whether the funding would be sourced from SEPA’s budget; dental practitioners should not be burdened with additional costs relating to enforcement.

- Article 10(2) in Northern Ireland
  “Once Article 10(2) of the EU regulation fully applies, failure to use amalgam in accordance with the guidance would be regarded as unsafe practice.” The BDA appreciates the need for compliance, but objects to this being described as “unsafe practice”. As explained above, there is no evidence base for safety concerns about the placement of dental amalgam restorations in the restricted groups, and the use of this language in official documents is unjustified and unhelpful.

- Article 10(3) in Northern Ireland
  As for England, there is a lack of national strategy and funding for oral health improvement in Northern Ireland to underpin the required scale of phase down of dental amalgam use. The current Statement of Dental Remuneration (SDR) does not favour preventive treatment; any future fee structure must reflect the time taken for prevention. The SDR also fails to support the placement of posterior composite restorations as an alternative to amalgam.

- General
  - It is unclear by what means the phase down of amalgam will be measured. Will this be the total volume of amalgam used, the number of fillings placed or the number of patients treated?
  - There is no discussion of alternative restorative materials, although research and development in this area is a key consideration of the Minamata Convention and is also included in the EU Regulation. Composite restorations are less well characterised in terms of their environmental and health effects. Their placement also requires greater clinical skill and time, which will have implications for dental provision and funding throughout the UK.
  - Since the placement of amalgam restorations is to be restricted in children under 15 years (although there is no evidence base for this age limit), we propose that funding for the provision of fissure sealants should be extended up to this age across the UK. Half of permanent molars do not erupt until after age 12.
  - As outlined in sections 3.2.3-3.2.5 of the proposals, it would seem reasonable to introduce a set of escalating and proportionate criminal and civil penalties for non-compliance. However, these must be imposed correctly and the maximum penalty should not be the default.

Q18- Do you have any views on the best approach to gathering intelligence on non-compliance with the amalgam separator requirement in England?
Yes.

As this is an environmental issue, we support the proposal that the Environment Agency should have responsibility for ensuring that dental practices comply with the requirement to have an amalgam separator in place.
Q19. Do you have any views on the body or bodies that are best placed to enforce and inspect the amalgam separator requirement in Northern Ireland and the best approach to gathering intelligence on non-compliance?
Yes.

BDA Northern Ireland is currently exploring options with the Department of Health and the Health and Social Care Board.

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1 The SCENIHR recognises that dental amalgam is an effective restorative material and is a material of choice for specific restorations... The SCENIHR concludes that current evidence does not preclude the use of either amalgam or alternative materials in dental restorative treatment.