L ocal councils are to have a say in how NHS dental services are commissioned and run. Whilst primary and secondary dental services are to be commissioned by the NHS Commissioning Board through the establishment of health and wellbeing boards at every upper tier authority from 2015 (although they could be operating in shadow form as early as from 2012).

Until now, local councils have only been involved in the provision of social care. A separate new body, called Public Health England, will be created to improve public health and reduce health inequalities between the richest and poorest. At the same time, the number of health Arm’s Length Bodies (ALBs) is to be reduced from 18 to between eight and 10. Organisations which are no longer needed will be removed from the sector, with essential work moved to other bodies. ALBs facing the chop include the Health Protection Agency, and the National Patient Safety Agency.

The proposed reform of the NHS and the abolishment of Primary Care Trusts has been met with skepticism and mixed reactions in a wide range of stakeholder groups. There is widespread concern that there will not be enough dental expertise amongst board members involved in the commissioning of dental services, and a lack of thorough knowledge of how dental practices are run. In the proposed structure, the channels of responsibility are opaque and confusing, and there are question marks of where accountability will lie.

Dr Susie Sanderson, the British Dental Association’s Executive Board Chair, has said that: “There will clearly need to be an involvement of experts such as consultants in dental public health, dental practice advisers and local dental committees to ensure that patients’ needs are addressed as services are commissioned.”

According to Paul Burstow, Minister of State for Care Services, local authorities will have the power to require information and attendance at scrutiny meetings of any provider that

The NHS reforms come at the same time that a new general dental practitioner contract is being drafted. Last December the Department of Health announced that pilots will begin and will test any contract models that focus on providing continuing care for registered patients and improving access. They will also explore ways of moving away from the target-driven basis of the current dental contract and instead focus on prevention and quality of care. The new contract is due to be published in 2014; however, dental groups have expressed concern over the timing of the NHS reform and are worried that energies will be diverted into implementing the new contract rather than on securing a good deal for dentists and patients.

Lord Coelyn, Vice-Chair of the All-Party Group for Dentistry, has highlighted that in 2005 a new dental contract was introduced at the same time as PCTs were reorganised and that during the restructuring many dental leads and commissioners were not in post to oversee the implementation of the new contract.

The NHS reforms pose questions such as what criteria will the local authority council be measuring, and to what level will they be able to scrutinise? What happens if a council deems a practice not performing adequately? Who will monitor practices, and will they be qualified? Such issues will remain unanswered for some time while the next structure of Health and wellbeing boards are formed.