Introduction

1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, community/salaried services, dental public health, the armed forces, hospitals, academia and research, and includes students.

2 We are pleased to see that the commissioning and funding streams of public health are a priority of this Government as a means of improving the wellbeing of the nation. As part of this ambition, good oral health is an aim that the dental profession strives towards.

3 We urge that clarity be provided swiftly on the role and function of Public Health England (PHE).

4 We have some reservations about the separation of health and public health and the consequent division of accountability of the Secretary of State, and how this then relates to commissioning and funding.

5 We cautiously approve the basic principle of a ring-fenced public health budget, although we would like more information on how the dental public health budget will be calculated and allocated. We have concerns, however, about whether the ring-fenced money will be spent only on public health activity or will also cover salaries for local authority staff employed in public health teams. The financial situation of local authorities is not addressed in this consultation, although they are facing cuts in Government funding of 26 per cent in real terms between 2010-11 and 2014-15 (excluding schools, fire and
police).¹ This translates, on average, to a reduction of 7.25 per cent per year. We are concerned that this will have severe implications for the delivery of public health. The impact assessment for the proposals indicates that any funding will be transferred (page 36) from PCTs to local authorities for the transference of function from the NHS, and we need assurance that the service will not suffer from reduced resources.

**Specific questions**

*Question 1: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?*

**Funding and commissioning routes**

6 Until we have clarity around the full shape of the new NHS and public health infrastructure, we find it difficult to respond to this. As stated in the impact assessment document that accompanies this consultation, “the proposed ring-fenced budget has the potential to have a positive impact but until policy options are clarified, it is too early to accurately determine the impact”².

7 We also have concerns about how the ring fenced budget will be calculated and how the Department has formed early estimates that the spend on public health could be over £4bn.³ We ask the Government to publish the evidence base that supports this figure. Our concerns arise because not all public health money is easily identifiable – for example, funding for training of epidemiologists is found locally, but we believe it is important in the new system that it should be funded centrally. We are looking for a clear indication of the budget for dental public health, and to ensure that it is adequate and safeguarded.

8 Before ring-fenced monies are allocated, it is important to identify the various strands of public health and dental public health funding. We know that there are many small pockets of public health funding in different places. During the transition, PHE must ensure that all monies from every source are identified (including those currently spent on public health in the salaried services). We are anxious to ensure central co-ordination of funding allocation during the transition.

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BDA response to *Funding and commissioning routes for public health*
Dental public health

9 The 2008 *Workforce summary for dental public health* estimated a target of one whole-time Consultant in Dental Public Health per 600,000 population. Dental public health teams should be developed to meet this target. All vacant posts in (dental) public health should be secured and factored into the current baseline calculation for funding. We call for a baseline of funding specifically for dental public health within the public health budget and ask to be included in discussions to ascertain this budget.

10 Within this ring-fenced budget there should be protected money for epidemiology, oral health promotion and oral health services.

11 There are many opportunities for oral health to be integrated into other health promotion services. There should be an oral health component in the Family Nurse Partnership, and we suggest that dentists and dental teams have a role in the multi-professional teams addressing care from minus nine months through to the end of life.

*Question 2: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?*

12 Quality of NHS services must be assured. A robust accountability mechanism is essential to ensure that the voluntary and independent sectors are providing value for money for the taxpayer.

13 We remain very concerned about how PCTs will ensure that all debt is eradicated before the changeover to the NHS Commissioning Board and PHE, and how this will be handled. Dental money is, in theory, currently ring-fenced, although we are aware that savings made in NHS dentistry are being used to reduce deficits in other areas. Greater control will be required to prevent diversion of dental funds once the dental budget is no longer ring-fenced, from April 2011.

14 The Coalition Government has a clear commitment to reduce the incidence of dental decay in five-year-olds. This commitment will be impossible to meet without investment, yet given the diversion of dental funds, we are concerned that PCTs will look to reduce their deficits and will not invest adequately in this commitment prior to the transition.

*Question 3: How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?*

15 There must be clear lines of communication between the NHS Commissioning Board, Public Health England and the local authorities. This tripartite arrangement must ensure that all parties engage with the professions and use the networks of expertise available to inform commissioning decisions. Within

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dentistry, we urge that there should be statutory engagement with local dental committees and meaningful engagement with the full range of dental professionals, making the best use of dental public health teams.

16 Page 36 of the impact assessment assumes that there is one Director of Public Health per PCT (152 in England), and there will be one per upper tier local authority (151 in England), although it is accepted that this may not reflect the true position. Coverage of Consultants in Dental Public Health is even sparser, but it is essential that their expertise be available both centrally and locally.

**Question 4:** Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

17 N/A.

**Question 5:** Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

18 N/A.

**Question 6:** Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

19 N/A.

**Question 7:** Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:

a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and

b) reduce avoidable inequalities in health between population groups and communities?

c) If not, what would work better?

20 N/A.

**Question 8:** Which services should be mandatory for local authorities to provide or commission?

21 Chapter three looks at defining commissioning responsibilities, and paragraph 3.22 refers specifically to dental public health. We cannot comment on other areas of local authority service provision except to say that all services should be provided or commissioned, with flexibility built in, based on population need.

22 The Consultant in Dental Public Health and the dental public health team should be fully integrated into, and recognised as essential to, the wider public health team for the following reasons:
23 Firstly, the value of integrating dental teams into the wider public health ambit is demonstrated in the example of child protection and the markers of disadvantage. Sir Ian Kennedy in his 2010 report quotes the former Children’s Commissioner for England, who recognised that various indicators for maltreatment covered the wide range of public health interventions:

“Many of the children at high risk of maltreatment grow up with multiple disadvantages: lack of preschool learning opportunities, behavioural problems, harsh inconsistent parenting, poor schools, food insecurity, unhealthy diet causing under-nutrition or obesity and dental disease, and an increased risk of illness and death from sudden infant death syndrome, infections, substance abuse, suicide and violent crime.”

24 Secondly, there is emerging evidence for many links between oral and systemic disease. The availability of dental public health advice will be essential for local authorities when commissioning community oral health programmes.

25 The contracts for the provision of oral health care and promotion services should complement the public health work provided and commissioned by local authorities.

**Question 9: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?**

26 We believe that the conditions of the grant should be linked to the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, which must include oral health as a mandatory component. This will ensure that the priorities identified can be tackled using the money designated for that purpose.

27 We seek clarity on who will monitor accountability during the transition and ensure that the best interests of the population are met.

28 We support the idea of place-based budgets enabling multi-agency working and would urge that the dental public health team be involved where appropriate.

**Question 10: Which approaches to developing an allocation formula should we ask ACRA to consider?**

29 The 2006 dental contract showed the flawed nature of using historical baseline data to predict future spend, as this formula cannot account for individual anomalies that are then perpetuated in a new system. To that end, we would recommend the third option that focuses most directly on the population. The caveat to this approach is that it is dependent on the measures selected, and subsequently the geographical area and disease prevalence. The consultation does not discuss a longer term model for the future and we suggest as a fourth option, the design of a new model when the system is fully functional.

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5 Kennedy, Sir Ian, (2010) Getting it right for children and young people. Overcoming cultural barriers in the NHS so as to meet their needs.
Question 11: Which approach should we take to pace-of-change?

30 Ensure that change is managed and all parties are working to the same ideals. Changes must be evidence based and driven not by quick wins but by aiming for longer term improvements in health and wellbeing.

Question 12: Who should be represented in the group developing the formula?

31 N/A.

Question 13: Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

32 N/A.

Question 14: How should we design the health premium to ensure that it incentivises reductions in inequalities?

33 We have to question the rationale for the health premium. At first sight a health premium appears attractive, but we ask why it is needed if money is correctly allocated in the first place, weighted on deprivation. Getting the allocation right in the first place is the best incentive for reducing health inequalities.

34 We reiterate the point about a fourth future long-term formula taking account of an evaluation of the success of the funding allocation.

Question 15: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

35 N/A.

Question 16: What are the key issues the group developing the formula will need to consider?

36 As a matter of course, analysis and evaluation of the formula and system would be appropriate so that any suitable adjustments could be made that would benefit the improvements in health and wellbeing.

37 Patient and public involvement is a key area of the Government reforms and we would urge that local voices be heard, although there is no mention of this in the consultation document.

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