

Rt Hon Jeremy Hunt MP  
Department of Health and Social Care  
39 Victoria Street  
London  
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Friday, 29 June 2018

Dear Jeremy,

I am writing to you following the Prime Minister's recent pledge of additional funding for the NHS to mark the service's 70th birthday.

The British Dental Association represents dentists operating across all UK health services, in primary and secondary care, general practice, community and public health settings, academia and training. This means we aim to take a holistic view on proposed spending pledges.

Any additional investment for the NHS is welcome. As part of that, increased and planned investment for NHS dental services is vital to create a sustainable basis for the provision of oral health services for the nation.

Underfunding has placed all service areas where BDA members operate in some degree of jeopardy. We are now seeking clarity that this much-needed funding boost will be shared across primary and secondary care, and other parts of the service where it can achieve the most benefit for patients, and offer the clearest return on investment for taxpayers.

Whilst acute care is undoubtedly under real strain, if any new funding settlement focuses exclusively on reducing political pressure around targets for secondary and emergency care it will not address the upstream drivers of high demand across all service areas, specifically inadequate investment in preventive measures in both primary care and public health services. We wholeheartedly support the philosophy set out in the *Five Year Forward View*, and are clear that targeted investment in these services offers the best opportunity to deliver on that vision.

**Fundamentally we seek assurances that new funding will better enable prevention, and not just cure.**

### ***Honouring pledges on reform of the NHS Dental Contract***

Additional funding must now remove the risk of impasse on reform of the NHS contract.

The recent evaluation report published by the DHSC has demonstrated one in four of the hand-picked practices prototyping a reformed model contract were unable to meet activity and access targets based on current budgets. Practices reported the need to work up to an average of 10 extra hours a month to deliver on their contract.

We support reform and want to see a new prevention-focused contract succeed. Huge efficiencies have already been secured by this sector, but we cannot expect charity or goodwill to be a foundation of any NHS service. Overly ambitious goals have been set on a standstill budget, and it may not be possible to maintain, let alone improve both access and health outcomes on this basis. The missing pieces remain a greater weighting and budget for capitation, and support to ensure that practices remain financial stable during contract roll-out.

Government spending per head in England has fallen by £41 to £36 per person in just 5 years. Correcting that fall could finance 12-15% more time for dentists to spend on prevention with their patients. That would make reform a viable proposition, and ensure practitioners have the time to deliver on both prevention and quality.

Delivering a successful transition from the current widely discredited system has been a government manifesto commitment since 2010. The current contract continues to undermine the sustainability of NHS high street practice. We face emerging recruitment and retention problems, and patients face widening access issues across England. This government now has an opportunity to facilitate a sustainable and genuinely preventive model of care.

### ***Changing tack on charges and funding***

We have noted with concern declining state commitment in NHS dentistry. Whilst spending from government has declined, patient charges have been growing as a proportion of the NHS budget, and will shortly approach a third of total spend.

These charges were designed to discourage patients from seeking treatment, with 1 in 5 patients delaying treatment for reason of cost according to official data. These charges continue to have a demonstrable impact on behaviour among the low income working families who sit above the thresholds for exemptions, and increasingly feel like a substitute for direct investment from government.

As part of any new settlement we would expect sustainable funding that can keep pace with growing demand, and an end to this increasing overreliance on charge revenue within the overall budget.

### ***Protecting the NHS Budget***

We ask that money set aside for NHS dentistry is spent on NHS dentistry.

We remain deeply concerned that underspends in dental budget have been reinvested in other parts of the health budget as a matter of routine.

Since 2006 many dentists across England have been unable to fulfil the targets set within their contracts, and parts of the contract value have been returned to government. But when practitioners have been unable to hit targets, this should not be confused with lack of patient demand.

It is no longer defensible that £85m of clawback a year is being returned to the treasury while some communities are unable to access basic services.

This money needs to be kept in dentistry, particularly given the ad hoc funding available for preventive programmes.

### ***Investing in public health.***

We have long advocated a sustained and properly resourced national effort to address oral health inequalities in England, particularly among children.

We do not accept the message from national agencies that “prevention is someone else’s responsibility” ie: that cash-strapped local authorities must lead. Central government can and should take a role - and does in other disease areas such as obesity - in terms of setting priorities, coordination and public education.

The battle for good oral health is won – or lost – in early years. Scotland’s *Childsmile* initiative has set a model that governments from Chile to Israel are following. The *Starting Well* programme in England risks appearing a poor relation, without a penny of new investment and activity limited to a few wards in 13 local authorities. While the structure of the NHS in England may not enable delivery of a ‘national programme’ on the same basis as Scotland, the situation clearly requires ambition, investment and statements of priority that are not, currently, in evidence.

So to take a joined-up view, we are also seeking clarity on what national spend is to be earmarked for dental public health, and the status of the funding settlement for local government.

Public Health England is sitting on a considerable body of evidence on the cost effectiveness and demonstrable returns on investment oral health interventions can make. In our view it would be completely wrong-headed if public health programmes do not receive the financial support – and strategic coherence – that have been so conspicuous by their absence.

### ***Securing the pipeline of NHS dentists***

Support for the frontline workforce is needed, but parallel action on education and training is needed to maintain the pipeline of talent feeding NHS dentistry.

Currently funding for Dental Foundation Training (DFT) – the bedrock and requirement for careers in NHS practice – remains under threat.

In 2014 we had to entertain the possibility of judicial review to protect trainee pay. We are pleased the previous government changed tack. We are now extremely concerned that Health Education England is likely to recommend redistributing budgets from dental foundation training to postgraduate training for Dental Care Professionals. The funding for DFT for dentists was top-sliced from the dental budget some years ago. If DFT for dental therapists and hygienists is wanted, it must be funded from a separate budget, and DFT places for all dental graduates who wish to do it must be guaranteed.

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Dentistry remains the 'Cinderella Service', and historic unwillingness to engage on the areas set out above is placing considerable pressure across wider NHS services.

Evidence has shown that NHS charges and access problems have pushed large volumes of dental patients to A&E and GPs, or caused them to bottle up problems that ultimately require more expensive treatment. Likewise, failure on early-years prevention has left tooth decay fixed as the number one reason for child hospital admissions, as waiting lists for extractions surge. These failures come at a cost to the NHS, in both money and time.

Dentistry faces growing and changing demands. We continue to confront deep and sustained oral health inequalities. We are only beginning to see new pressures catering for an expanding elderly population who keep their teeth for longer.

Tooth decay is a wholly preventable disease. The Prime Minister has stated her desire to achieve value for money, and see real return on this new financial commitment. With a modest investment we can enable this service to deliver on the ambition of the *Five Year Forward View*.

We look forward to your reply on the points where we are seeking clarification, and will be taking any opportunity given to feed into the ten-year plan later this year. We would of course be keen to meet with you to discuss the detail.

Yours sincerely,



Mick Armstrong  
Chair, British Dental Association

cc. Steve Brine MP, Parliamentary Under Secretary of State for Public Health and Primary Care  
Sara Hurley, Chief Dental Officer