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Mr B. Sneddon
Parliamentary Clerk
Department of Health
Richmond House
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Via email

3 July 2017

Dear Mr Sneddon,

Re: Government response to the House of Lords Select Committee on The Long-Term Sustainability of the NHS and Adult Social Care

The Federation of London Local Dental Committees is a membership body for Local Dental Committees. We represent eleven Local Dental Committees in the Greater London area, covering almost 3000 dentists in 22 London boroughs[1].

We welcome the House of Lords' establishment of a Select Committee to look at the long-term sustainability of the NHS and the publication of their report in line with their timescales as this is a major concern for dentists in London. We recognise that the Government's response to this report has been delayed by the General Election, but wanted to take this opportunity to raise with the Government some points which have arisen from this report. We hope that our opinions are helpful and would be more than happy to expand on any point we raise either in writing or in person.

While we appreciate that the focus of such a Select Committee must be on the system as a whole, it is disappointing that in this report NHS dental services are ignored. Primary care dental services operate in a different environment from most other NHS services and we are concerned that this is not reflected in official documents. The result is that there are statements made about "the NHS" which do not apply to NHS dental services, and recommendations made which may have a negative impact on how NHS primary dental care can be delivered.

Our main concern is the repeated reference to the "free-at-the-point-of-use NHS". Recommendation 15 makes it clear that the prevailing view in Parliament is that the NHS is

[1] The full list of member Local Dental Committees is available on our website: http://www.ldc.org.uk/

free at the point of use. This is incorrect, the NHS is not free at the point of use for most NHS dental patients. Patient charges were first introduced for dental services in 1952, and yet inaccurate messages about a "free-at-the-point-of-use NHS" (when NHS charges for dental services remain) continue to be presented in parliamentary and government documentation. Following the widespread use of fluoride toothpastes, improved public health messaging and of course the work of dentists and the dental team, oral health has dramatically since 1952. As it is clear that patient charges are a barrier to accessing dental care and cause considerable confusion for patients, we do not believe there continues to be any rationale or justification for singling out dental services as a paid for service[2]. Patient charges are a disincentive for patients to seek oral health care which, over time, creates problems for those patients and for the NHS, when conditions have to be dealt with in secondary care, increasing the overall cost of treatment[3]. Addressing patient charges will help alleviate this burden in line with Recommendation 3. Alternatively, patients who *should* visit a dentist are more likely to visit their GP instead, as a consultation with their GP is free. The British Dental Association report cites evidence that approximately 600,000 GP appointments per year are used for dental problems[4]. This means patients do not have access to the specialist care they require and are using the precious time of an already overburdened GP service[5]. Continuous messaging from government, the NHS and other bodies that NHS services are free is confusing to patients and causes many problems for dental practices, which are responsible for collecting NHS patient charges[6]. The recommendation further makes it clear that the prevailing view is that a free at the point of use service is the "most appropriate model". If this is the case we recommend the Government extend this model to primary care dental services.

We therefore urge the Government in its response to the report, and in taking up the recommendations, to either remove patient charges from dental services and replace the shortfall in revenue elsewhere or else to stop the continued use of inaccurate and confusing message.

The integration of services as recommended in Recommendation 4 is a laudable aim but will require investment in NHS primary care dental services. Historically, providers of primary care dental services have not received the same financial support for infrastructure as GP colleagues. If this recommendation is to be achieved fair funding will be needed for dental practices.

The awareness shown in the report of the issues facing clinical professionals because of low morale and over-burdensome and unnecessary regulation is welcomed. We are working with the General Dental Council to improve the system of regulation for dentistry and we look forward to the Government's proposals to address concerns over regulation. Recommendation 14 is for the Government to bring forward legislation to unify the legal framework for healthcare regulation. While regulatory changes are certainly required in order to help the General Dental Council improve its function and to modernise, if the proposal is

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[2] Patient charges causing confusion and acting as a barrier to care was highlighted in Healthwatch Camden's recent report *Accessing dental services in Camden: experiences of local people* available on request from Healthwatch Camden.

[3] British Dental Association 2017 *A Tax on Teeth* https://www.bda.org/news-centre/press-releases/Pages/Dentists-call-for-charges-shake-up.aspx retrieved 04 May 2017

[4] BDA 2017 *Op. Cit.* p.5.

[5] BDA 2017 *Op. Cit*

[6] Ibid.

to merge the regulators we would sound a note of caution and stress the importance of full involvement with the professions directly affected before a decision is made.

Our overall concern with the report is one that is shared by many general dental practitioners: that is there is a culture of short-term planning in the NHS. The particular relevance of this for primary care dental services is in the nature of the dental contracts. Recent contracts put out for tender by the NHS tend to limit the length of the contract to a fixed period of five or seven years. We understand that the principle behind using this time-limited, fixed-term contracts, is to increase competition in the provision of NHS dental services. Competition and market entry is not best achieved through short term contracts, however. Establishing a dental practice, or indeed purchasing an existing one, is extremely costly and it is increasingly difficult to sustain an independent practice on a time-limited contract. Large corporate bodies or hospitals are better placed to absorb the costs of short term contracts, thereby undermining entry to the market, closing a career path for many younger colleagues, and undermining the principle of moving care away from hospitals and into the community. We consider that this attempt at "increasing competition" in the dental market actually serves to stifle entry for independent practice and prejudices the entire system to large providers - a trend that will be extremely difficult to reverse in the future. We are concerned that the intention may be to move all contracts to have a time limit. This would be catastrophic for the public and providers alike. The NHS does not have the resources for large scale procurements that would be required and the administrative cost would far outway any perceived benefit. The added impact of this is to limit patient choice as variation in service models will be greatly reduced. We urge the Government to review the impact of time-limited contracts on competition in relation to primary care dental services and seek a commitment that there will be no extension of the use of time limited contracts to existing primary dental services.

We are extremely concerned that the second recommendation in the report may have a negative and unforeseen impact on dental services. We urge the Government to consider general medical practice completely separately from general dental services, and make explicit recommendations for either service, to avoid unintended consequences.

We welcome the report's conclusion that government should make it clearer to patients that they have responsibilities to ensure that NHS resources are not wasted. In dentistry, many issues are preventable if the patient takes responsibility for their oral health by following the advice from their dentist in their diet and oral hygiene.

It is very sad to confirm to you that areas within London have some of the poorest oral health records in the whole of the country. The level of decayed, missing or filled teeth is far greater than it needs be and it is a disgraceful statistic that dental extractions for children remain the greatest cause of hospital admissions for that age group. More needs to be done to address this appalling and preventable state of affairs in line with Recommendation 31.

Recommendation 17 states that long term funding models are needed to meet future need. Yet, in dentistry we have seen the budget barely increase to meet the needs of a dramatically growing population. The Greater London Authority expects the population of London to increase in the coming years from just over 8.2 million in 2011 to close to 11 million by 2041[7]. Many people coming to London have not had sustained access to dental

[7] https://data.london.gov.uk/dataset/2015-round-population-projections/resource/807c7cba-7227-4d2b-bcd9-75c0ce9b9561# retrieved 11 May 2017

services in the past and so will have greater need, a problem not so significant in many other parts of the country with a more static population[8].

This is not a sustainable oral health care system, especially given the crises that we see in children's oral health[9]. We recommend that the Government makes an explicit commitment to review the dental budget when responding to this recommendation. The support of the Federation of London Local Dental Committees to Recommendation 1 is shown through our commitment to working with NHS England (London Region), the London Local Dental Network and other local stakeholders. At present oral health is absent from many Health and Wellbeing Strategies in London. We would like to see this change and local authorities to take a greater interest in the scope of NHS dental services to impact on overall health improvement. Fulfilling Recommendation 30 will be a key part of ensuring that local issues can be addressed effectively.

As well as children's oral health we have concerns over the oral health of the older adult population within our community. The report is concerned with the integration of health and social care and this is something that we would support. Many older adults, especially those with, for example, Alzheimer's or other dementias, have trouble communicating their oral health concerns with dental professionals. As a result they may, for example, endure avoidable discomfort from ill-fitting dentures, which can cause abscesses and other issues. In such an example, the result is often an apparent loss of appetite, which can lead to malnutrition and dehydration[10]. We would urge the Government, in responding to the report, to recommend to the Care Quality Commission (CQC) that they work with providers of adult social care to ensure they have relationships with local dental practices and that this is supported by NHS England or the local Clinical Commissioning Group. Furthermore, we would suggest that "residents' access to a dentist" should be an indicator included in the CQC's regulation of the social care sector.

We would support greater independence and financial support for Health Education England (HEE) to ensure that adequate training and Continuing Professional Development is available for all health professionals. In addition, we would seek parity for dental practitioners with medical practitioners in terms of the financial aid that is provided to them by the NHS for their CPD. When reviewing this and other recommendations relating to training we would urge the Government to engage with the British Dental Association and other stakeholders to consider how HEE could support dental practices. Caution is required for dental practice over Recommendation 12 which urges a review of "traditional roles". The General Dental Council is clear on what different professions engaged in dentistry can and cannot do and so any review of this recommendation will have to involve a clear discussion with the regulator to ensure that any proposals are feasible[11].

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[8] http://www.migrationobservatory.ox.ac.uk/resources/primers/migrants-in-london-policy-challenges/ half the migrant population of the UK live in London. Retrieved 04 May 2017. Reform to the system of translation services for dental services is also required in London as the current system is *ad hoc*.

[9] For example: http://www.dentistry.co.uk/2016/04/15/nhs-crisis-childrens-oral-health/ retrieved 04 May 2017, the Faculty of Dental Surgery's 2015 report *The state of childrens' oral health in England* available from https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/report-childrens-oral-health/ last accessed 11 May 2017

[10] https://www.alzheimers.org.uk/download/downloads/id/2632/dental_care_and_oral_health.pdf retrieved 12 May 2017

[11] https://archive.gdc-uk.org/professionals/standards/st-scope-of-practice retrieved 04 May 2017

Thank you for taking the time to consider our comments. We would be happy to provide more information on any item should this be required.

Yours sincerely

Mike Clarke,
Chair, Federation of London Local Dental Committees