**Written evidence submitted by the BDA (DTY0078)**

## 1. Introduction

1.1 The British Dental Association (BDA) is the professional association and trade union for dentists in the UK.

1.2 Postcode lotteries of care were the norm pre-COVID, but the pandemic has taken these problems to new extremes. NHS Dentistry - as currently structured and resourced – is incapable of meeting demand. It is certainly not a universal service, in line with the founding principles of our National Health Service.

1.3 At the core of the access crisis is a workforce crisis. While the number of dentists registered to practice has gradually increased for many years, NHS capacity has declined. The current discredited NHS contract and more than a decade of real-terms cuts to funding and pay, mean dentists increasingly are moving away from the NHS – either entirely or by reducing their proportion of NHS work. The service is at a tipping point, and without ambitious and urgent change recovery may not be possible.

1.4 This is also in part, a result of a long-term and structural underfunding of a service that only commissions enough dentistry for around half the population.

1.5 While government accepted over a decade ago that NHS dentistry needed reform, little progress has been made. Reform initiatives have lacked ambition and urgency, and efforts have been undermined by an unwillingness to provide funding to facilitate change. We have seen years of extensive piloting and prototyping of new clinical pathways and remuneration models. It is vital that the learnings are not lost in designing a reformed contract.

1.6 While marginal changes were implemented to the contract in autumn 2022, these do not represent anything approaching a 'reformed' contract. They are minor tweaks to a failed system and will not solve the difficulties faced by NHS dentistry.

1.7 Even before COVID practices were experiencing growing difficulties in delivering their contracted NHS activity. In 2014-15, there was £54.5 million in under-delivered NHS dental activity, but by 2019-20 this had increased to £169 million. This is not the result of over-commissioning or a lack of unmet patient need. The core reason is that NHS practices simply cannot recruit a sufficient workforce to deliver their contract. An increasing number of dentists are no longer willing to work within a broken NHS system.

## 2. Access

2.1 Access problems are not new. The Government claim that 75% of those attempting to secure an NHS dental appointment in 2022 got one, based on responses to the latest GP Patient Survey. This is a clear fall from 92% in 2019, but selective use of this data further masks the depth and breadth of access challenges both prior to and post pandemic.

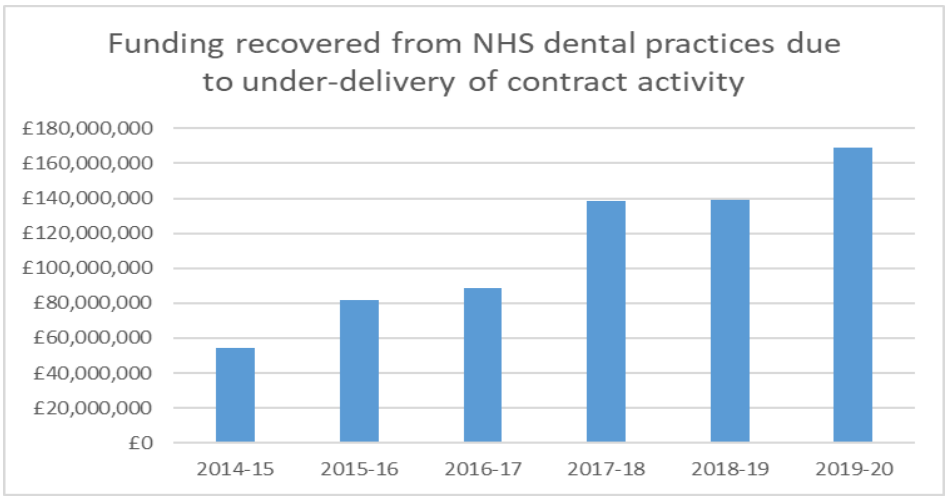
2.2 Analysis of the 2019 GP Survey indicated that over 1.4 million adults tried and failed to access dental care. [1] A further two million were estimated not to have tried in the belief they would be

unable to secure an appointment. 130,000 adults reported that they were on waiting lists and over 700,000 cited costs as a barrier. Overall, pre-pandemic unmet need was over four million people, or nearly one in ten adults.

2.3 Figures from the 2022 survey indicate that unmet need has risen by every measure, equating to over 11 million people, or almost one in four of England's adult population. Nearly six million tried and failed to get an appointment in the past two years, and 3.6 million did not try because they thought they could not secure an appointment. Those put off by cost are equivalent of over one million adults, those on waiting lists estimated at around 0.5 million.

2.4 Unmet demand is a designed feature of the system. Since 2006, England has not had a 'patient need-led' NHS dental service. Even if dentists wanted to work in the system, the amount of NHS dentistry that can be delivered is capped. Practices are commissioned to deliver a specific number of Units of Dental Activity (UDAs) and cannot deliver above this level even if there is demand for it. Commissioning only delivers services for roughly half the adult population, which has remained largely unchanged since the 2006 contract was introduced.

2.5 For commissioning to translate into patient access there must be a workforce to deliver it. This has become a growing challenge for practices. As measured by its cash value, there has been a 310% increase in under-delivered NHS activity between 2014-20. This is not a result of falling patient demand or over-commissioning but reflects that NHS contracts have become increasingly difficult to fulfil because practices cannot attract the necessary workforce. While the access crisis has become more visible since the start of the pandemic, there is a long-term problem of a failing and under-funded NHS dental system, with a contractual framework in which many dentists are no longer prepared to work.



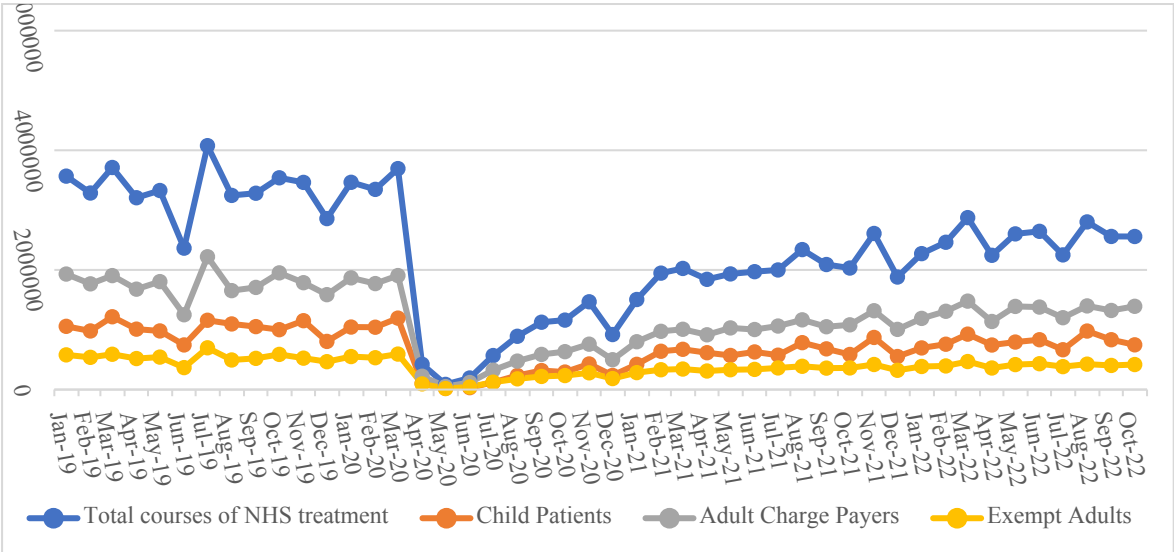

**NHSBSA, NHS Payments to Dentists**

2.6 There has also been increasingly over-bearing contract management and changing interpretations of how clinical activity should be claimed for in UDAs. There has effectively been a shifting of the goalposts as to what is now regarded as an acceptable NHS claim, compared to when UDA targets were initially calculated in 2005. This means that even where clinical output remains constant, the number of UDAs earned in exchange has fallen. In context, where NHS

[1] Millions 'missing out' on NHS dentistry - BBC News

practices have clearly been struggling, the approach has been to tighten the screws, rather than offer support.

2.7 COVID has raised the stakes. The suspension of routine care, and subsequent restrictions mean over 47 million NHS dental appointments have been lost since lockdown, equivalent to well over a year's worth of NHS dentistry in normal times. Dentistry is now the number one issue raised with Healthwatch, with 4 in 5 people (79%) who contact them saying they found it difficult to access timely dental care.




**Courses of treatment delivered in NHS General Dental Services (England), NHS BSA**

2.8 In 2022, the BBC contacted every NHS dental practice in England[2] and found that 91% were unable to accept new adult patients, with 80% unable to accept new child patients. No practices were accepting new adult NHS patients in 37% of all local authorities.

2.9 NHS activity for 2022/23 to date has yet to recover to pre-pandemic levels. Challenges remain with staff and patient absence as a result of ongoing infection. There is also the reality that patients have delayed seeking care and are presenting with more advanced, complex disease, which the contract rewards with very few UDAs relative to the time taken to provide the care. However, the biggest factor is that practices are simply unable to recruit and retain dentists to work under the NHS contract.

2.10 Those from low income or vulnerable groups are being disproportionately impacted. Polling for Healthwatch England in May indicated most affluent patients are six times more likely able to pay for private dental care than their least affluent counterparts.

## 3. What steps should the Government and NHS England take to improve access to NHS dental services?

[2] Full extent of NHS dentistry shortage revealed by far-reaching BBC research - BBC News

3.1 Every vacancy translates into thousands of patients unable to access care. Improving access means confronting the drivers of current workforce problems; the failings of the NHS contract and the current financial settlement.

*Workforce*

3.2 A failed system is driving NHS dentists away. In recent surveys[3] over half of dentists report having reduced their NHS commitment since the start of the pandemic – by 27% on average. This movement is going unseen in official workforce data but the NHS's own UDA delivery data demonstrates that there is a significant reduction in the amount of NHS care in the current financial year.

3.3 The workforce crisis has deepened since last year, with more vacancies going unfilled for longer periods. 95% of practices with high NHS commitments reported difficulties when recruiting associates, with more than half of all practices with vacancies reporting that they had vacant posts for over six months. 90% of practices reported difficulty recruiting dental nurses.

3.4 Reflecting the ongoing challenge of delivering NHS activity, the proportion of dentists reporting their intention to reduce – or further reduce – the amount of NHS work they undertake stands at 74% this year.[4] The BDA 2022 annual survey of general dental practitioners found that almost two-thirds experienced low or very low morale, the worst results ever recorded.

3.5 75% of NHS practice owners told us they were very or extremely stressed. 91% stated that increased practice costs were causing them stress, and 79% cited staffing, recruitment, and retention issues. For associate dentists, the main factors identified were staff shortages/ turnover and hitting NHS targets, at 71% and 67% respectively.

3.6 Government workforce data counts heads, not commitment. It shows that in 2021/22, 24,272 dentists performed 'some' NHS activity, a modest recovery on the previous year, but still lower than levels seen in 2017/18. This data gives the same status to a dentist doing 1 check-up a year as an NHS full-timer.

3.7 There is a clear need to base a workforce strategy on a comprehensive review of existing capacity and to derive a Whole Time Equivalent count of NHS dentists to accurately represent where 'dental deserts' sit. Even with this, it would be unwise to view the workforce challenges solely through the lens of recruiting new dentists, when the NHS is not able to retain those currently working in it.

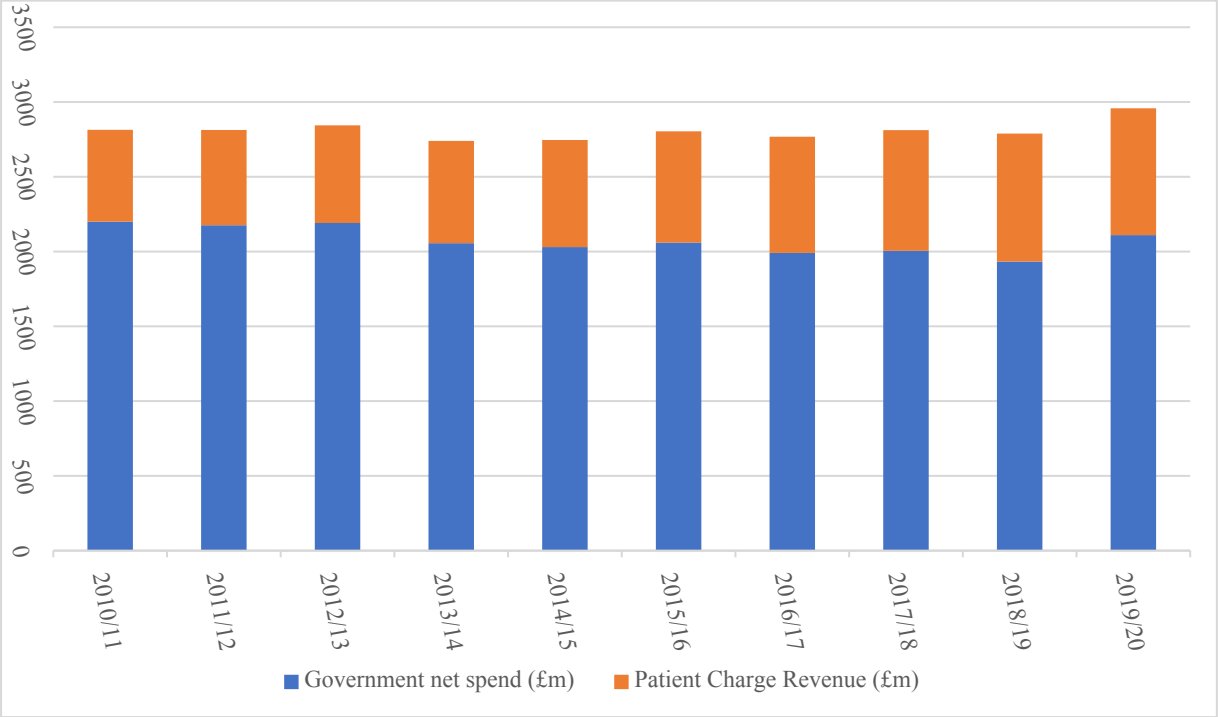
3.8 This is evident when looking at overseas dentists who come to the UK. For EU/ EEA registrants, many do not stay registered long term. BDA analysis found that, of those EU/EEA dentists who first joined the register in 2016, only 56% remained so in 2022. This is consistent with previous research, analysing data from 2006-16, which found over 50% had left the register within two to three years of entry. 'Quick fixes' around recruiting dentists internationally are not a sustainable solution.

[3] BDA 2023 GDS Survey
[4] BDA 2023 GDS Survey

*Funding*

3.9 Sustainable funding is a prerequisite. Negotiations have yet to begin on reform of the NHS contract, however at the outset the government's stated objectives to improve access and workforce retention cannot be achieved on a standstill budget. At present the service is neither universal in scale nor comprehensive in scope. If there is no movement, the only routes forward amount to rationing of care.

3.10 The budget for high street NHS dentistry in England has remained at around £2.9 billion per year for a decade. This has meant cuts unparalleled in the NHS. Government contributions to the service were lower in 2019-20 than in 2010-11. In real terms, net government spend on dentistry in England was cut by over a quarter between 2010-20. The real-terms spend remains well-below 2010/11 levels, representing a 38% cut since 2010.[5] No attempt has been made to keep pace with prices or population growth, and with inflation at a record high it would take around £1.5 billion to restore levels of resource to those seen in 2010. Dentists are required to do more with less and there are inevitable pressures on pay, as practices face sharply rising expenses, a tight labour market and static budgets.




***General and Personal Dental Services spend (England) Source: DHSC Accounts***

3.11 Since 2006 England has not had a 'need/demand led' service, and financial prerogatives are hard wired into the current model. Dental care is effectively capped, with sufficient services commissioned for roughly half the English population. Whilst not without problems of their own, the uncapped NHS systems in Scotland and Northern Ireland have not led to unaffordable, drastic fluctuations in the dental budget.

[5] NHS Digital

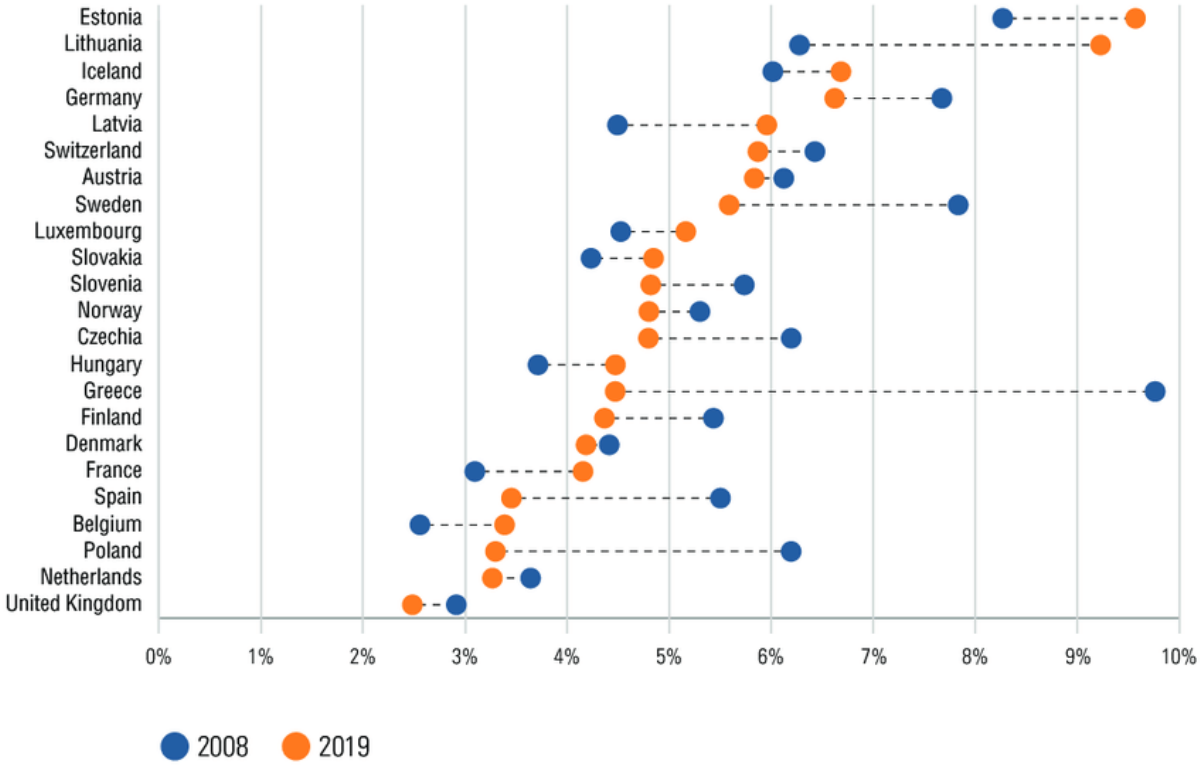
3.12 Annual uplifts should be made to contracts to apply the DDRB recommendation on dentists' pay and a negotiated increase in the funding to deliver NHS services. Following years of public sector pay freezes and caps from 2010, uplifts have been consistently behind inflation, leading to the real-terms reduction in funding for NHS dentistry. The current inflationary environment presents significant challenges to dental practices, as the below inflation uplift for this year means that funding notionally allocated to increase dentists' take-home pay will undoubtedly be used to meet increased practice operating costs. Strikingly, in cash terms, dentists' pay is now lower than it was in 2010[6]. This stagnation in pay is a significant factor of the workforce crisis in NHS dentistry.

3.13 While additional funding is clearly needed to improve access, it must be done through appropriate mechanisms and ultimately, a reformed contract. The £50 million funding announced in January 2022 demonstrated how not to proceed. Ultimately, less than a third of this investment was spent, and the lowest uptakes tracked regions with historic workforce challenges. Funding was announced at a time when dentists were already struggling to deliver challenging NHS targets, with more to lose by failing those targets than delivering under the separate short-term scheme. Practices were given days to apply to participate in the scheme and then weeks to deliver significant increases in activity. For many practices, struggling to recruit dentists to deliver their existing NHS activity, this would have been impossible to take on.

3.14 More recent exercises by regional commissioners have provided greater notice of new funding streams to deliver access or urgent care provision. These have come with options for participation to be funded in addition to existing contracts or have allowed practices to substitute a proportion of their UDAs for different NHS activity. These schemes, while still in their early days, have proved popular with dentists and critical to this is that the remuneration model is not based on UDAs.

3.15 OECD data indicates that the UK spends the lowest proportion of its health budget on dentistry of any European nation and England has the lowest spend per capita of any UK nation.

[6] NHS Digital




***Expenditure on dental outpatient care, as % of total health expenditure, 2008-19 Source: OECD***

3.16 Sustainable funding must not mean overreliance on patient charge levels. Dental charges are designed to lower demand for services and have succeeded on this front since their inception. However, since 2010 dental charges have evolved from a contribution into a substitute for meaningful state investment. Pre-COVID, government contributions into a flat budget fell each year, plugged by inflation-busting charge increases. Given the clear barrier these charges represent to higher needs patients this cannot form a basis for any recovery. These charges should never provide cover for cuts.

*Contract Reform*

3.17 The discredited UDA contract places targets ahead of patient care. It means that dentists are paid the same amount for completing vastly different amounts of clinical work. It disincentivises practices from taking on new, high needs patients and forces practices to approach dentistry with a focus on 'drilling and filling', rather than prevention. It also means that two NHS practices on the same street can be paid different amounts for doing the same clinical work.

3.18 The BDA has long advocated for a prevention-focused capitation-based contract as the basis for reform. This moves away from paying dentists based on treatment and instead pays them on the provision of a long-term, preventative approach to patient care. Any reformed contract also needs to have the flexibility to accommodate patients with higher treatment need.

3.19 The UDA's core failing is that the three broad bands[7] that treatments are grouped into mean that remuneration received often bears little relation to the complexity and volume of

[7] Note: The marginal changes have sub-divided Band Two into 3 sub-bands.

treatment provided. The payment for a course of treatment is dictated by the highest band into which any component treatment falls. Though the recent marginal changes have sub-divided the second band, there is still not a good alignment between payments and the time, costs and skill involved.

| Example patient | A | B | C | D |
|---|---|---|---|---|
| Treatment | Examination, x-ray,one small filling | Examination, x-ray, scale,polish, and two fillings | Examination, x-ray,one molar endodontic treatment | Examination, x-ray, one extraction,two molar endodontic treatments |
| Estimated time involved[8] | 40minutes | 75minutes | 96minutes | 189minutes |
| UDAs | Three | Three | Seven | Seven |

3.20 This has wide ranging implications for how NHS dentistry operates. For dentists, it is demoralising to provide treatments where the reward is not well aligned with their efforts.Some treatments will also be provided at a financial loss.

3.21 This contract creates financial disincentives to treat high-needs patients. This effectively leads, as per the inverse care law, to NHS dentistry being least available to those that most need it.

3.22 It also fails to provide any recognition of the value of prevention, nor is it directly remunerated. Instead, the focus of the remuneration model is to pay dentists when they undertake a clinical intervention. This is often referred to as a 'drilling and filling' approach to dentistry. The Steele Review argued that 'so long as we see value for taxpayers' money as measured only by the production of "widgets" (fillings, dentures, extractions or crowns), it is difficult to escape the cycle of intervention and repair that has persisted from a different age'[9].

3.23 Each practice has its own UDA value, rather than this being based on a national fee, compounding the inequalities caused by the banding of treatments. Recent changes have led to a £23/UDA minimum rate, which is still set at an inadequate level to deliver the care required. Furthermore, inconsistency remains, with an average of £28 and some practices having a value as high as £35. Practices on the same street, providing the same treatments, could be paid significantly different sums.

4. **What role should ICSs play in improving dental services in their local area?**

[8] Bearne, A. and Kravitz, A., 2000, The 1999 BDA Heathrow Timings Inquiry, *British Dental Journal*, 188:4, pp.189-194

[9] Steele, J., 2009, *NHS Dental Services in England - An Independent Review*

4.1 Many ICSs are concerned about taking on responsibility for dental commissioning and the NHS Confederation has called for urgent action at national level before all ICSs take this new responsibility on in April.

4.2 We agree with the NHS Confederation's conclusion that the issues facing NHS dentistry cannot be resolved at local level. These are national problems which require national solutions. There is a need for far more rapid progress with national dental contract reform to provide systems with an NHS dental contract that can allow them to commission effectively. [10]

4.3 Dental providers have however worked in collaboration with commissioners to find ways to deliver on shared priorities and improve access for patients in their localities even in this context of crisis in funding and workforce. In shaping services around the needs of their local populations, systems need to build on this sound foundation and work closely with the dental profession.

4.4 There are successful examples, such as the longstanding Healthy Living Dentistry programme funded in Greater Manchester, which takes a proactive approach to general health and was achieved through commissioners working in collaboration with local dentists.

4.5 Dentistry cannot be an afterthought for ICSs. Clinical engagement from dentists must be embedded at all levels (starting with the strategic advisory level) in each ICS to ensure that learning is not lost and that innovations are built on firm foundations. We know that the most vulnerable have suffered most from access issues caused by underfunding and want to see the programmes already initiated by the profession supported and actioned by the new systems.

**5. How should inequalities in accessing NHS dental services be addressed?**

5.1 We have set out below how principles to tackle oral health inequality can be 'designed in' to a reformed contract model, for example utilising weighted capitation. The nation's oral health gap is set to widen, and there is a necessity to be ambitious, and alert to the impact of policy choices on historically underserved groups and communities, particularly given current cost of living pressures.

**6. Does the NHS dental contract need further reform?**

6.1 The recent tweaks to the NHS dental contract do not constitute reform. We share the view of the Health Committee expressed in 2008 and 2022 that the UDA system is not fit for purpose. A fundamental break from this model is required to improve access for patients, and years of testing new models provides learning that can and must be built on.

*Prototypes and pilots*

6.2 From 2011, DHSC embarked on a Dental Contract Reform Programme that involved a series of pilots and prototypes in which, at its peak, around 100 practices tested a new approach to delivering and paying for NHS dentistry; significantly, embracing capitation as the major

[10] A renewed vision for the NHS, NHS Confederation

component of the remuneration package.

6.3 In March 2021, NHSE, the Office of the Chief Dental Officer and DHSC indicated that the evaluation of the prototypes had led to the conclusion that, in their current form, they were not fit for rollout. The BDA believes that the prototypes offered much of value as a basis for substantive reform but shared the view that changes needed to be made, which is why we engaged extensively with DHSC and others over several years to develop proposals to address these inadequacies.

6.4 The prototypes did not fully address the problems of the current system. They continued to use UDAs to pay for some activity and did not weight payments based on patient need. There was also a patient access bottleneck created by the implementation of new oral health assessment that is likely to have contributed to falls in the numbers of patients seen. It is our view that the prototype model provided a basis on which to develop a contract that was fit for rollout. For example, the lengthy oral health assessments could have been modified to free up time to see new patients. There were challenges to overcome, but they were not insurmountable.

6.5 What the prototypes perhaps best demonstrated was that, if a system is to deliver high quality prevention-based NHS care, it requires better levels of resourcing. While there were limits to what the precise prototype model was able to deliver, it is crucial that the substantial learning from these extended trials is not lost and is applied to developing future contractual reforms, avoiding the need for further piloting ahead of the implementation of a reformed contract.

*Recent marginal changes*

6.6 With the prototypes abandoned, NHSE pledged to pursue ‘rapid, modest and marginal changes’ to the current contract alongside consideration of a reformed system. Negotiations on these marginal changes took place from autumn 2021 to spring 2022. For some practices these changes will improve their ability to deliver NHS activity, but they fall far short of what is necessary to make the NHS an attractive working environment for dentists and to address the access crisis.

6.7 These changes were billed as enhancing both patient access and workforce retention. Under 3% of dentists surveyed by the BDA since these changes came into effect believe they will incentivise their practices to take on new NHS patients, or encourage dentists at their practices to remain in the NHS.

6.8 NHSE stated that 'these reforms represent the first significant change to the contract since its introduction in 2006' which only emphasises the government’s failure to act for over a decade. Many of these solutions were identified years ago. In 2008, the Select Committee recommended 'in the short term, the Department should consider increasing the number of UDA bands so that dentists are rewarded for providing appropriate treatment'. It took 14 years for this to be implemented.

*Next steps*

6.9 NHSE has indicated that it intends to pursue a ‘gradual’ approach to contract reform. To date negotiations have focused on tweaks to the existing contract. Only one meeting in the last 18

months has focused on options for a reformed contract not based on UDAs. This approach underestimates the crisis facing NHS dentistry and the need for urgent, ambitious reform. Without action in the coming months, NHS dentists will leave the service and it will be difficult, if not impossible, to persuade them to return.

6.10 We are also concerned that small changes made now, in the absence of a long-term vision for NHS dentistry, could make it more difficult to implement the necessary contractual reforms in future.

6.11 The BDA would not welcome the untested, 'big bang' approach of 2006. There has been significant testing already and it would be possible to implement a reformed contract in a phased way that delivered change rapidly without doing so all at once. NHSE, with the support of DHSC, must move to enter into serious negotiations with the BDA on a reformed contract. This should draw on the learnings from the prototypes, and where they need to be improved. We see no reason why these negotiations, drawing on more than a decade of work, could not conclude this calendar year, with the view to begin a phased roll-out of a reformed contract from April 2024.

6.12 The contract reform process has been ongoing for more than a decade. In that time, the state of NHS dentistry has only declined. It is essential that we make urgent progress in agreeing and implementing a new long-term settlement for the service.

*The shape of reform*

6.13 The BDA supports a prevention-focused capitation-based system. The key features of this system would be:

1. Dentists are paid per patient on their list

2. Payments should be based on a national tariff to remove the practice-by-practice inequalities of the current system

3. Payments are weighted to reflect patient need, ensuring that there are incentives to take on high-needs patients

4. Payments are weighted for new patients, as they are for GPs, to reflect higher need and to incentivise practices to expand access

6.14 A prevention-focused capitation-based system would shift the financial incentives so that 'drilling and filling' would no longer be the focus of targets and instead, dentists would be rewarded for appropriately working with patients to manage and improve their oral health. If access is the patient priority and the political priority, then it is logical to align the contractual incentives to this objective, so that practices are paid per patient in their care.

6.15 The BDA propose that these payments are weighted (and based on a national fee, rather than varying from practice to practice). Through the work done with the DHSC to develop the prototype model, payment based on age, sex and deprivation was explored, but there are also other approaches that could be taken, such as individual patient weighting based on an oral health assessment. In 2008 the Health Select Committee argued that funding should better

match oral health need, rather than patterns of historical provision. Weighted capitation provides a route to achieve this, and tackle oral health inequalities. Relating payments to the costs of providing care for specific patients may also help to counter concerns of 'under-treatment' that come with capitation systems.

6.16 In line with this approach of funding following patients, the BDA believes that the current caps on NHS dentistry should be removed, so that dentists are able to provide as much access and care as there is need in their communities. This would simultaneously do away with activity targets that are the cause of significant stress for dentists.

6.17 There is also the crucial dynamic of the patient-dentist relationship. While the 2006 contract ended formal patient registration, many still believe it exists and in effect; most regularly attending patients return to the same practice and dentist with who they have an established relationship. If 'dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship'[11], then capitation could restore that link between dentist and patient with continuity of care to manage and improve their oral health.

7. **What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?**

7.1 A fit for purpose contract is the strongest incentive to aid recruitment and retention. However, alongside meaningful reform, there is opportunity to bring forward policies that recognise and reward NHS commitment and make the service a more attractive workplace.

- *Reintroduction of NHS commitment payments.* A sliding scale of commitment payments for higher NHS dental activity to incentivise full-time NHS work. A system like this was in place in England pre-2006 and continues to operate in Scotland.

- *Late career retention support payments.* A system to retain experienced NHS dentists at later stages in their careers. This could be linked to a non-clinical role in mentoring early career dentists.

- *Introduction of protected training and development time.* Contracts should contain protected, funded time for training and development, including clinical audit and peer review that can support quality improvement.

- *Improvements to the parental leave arrangements.* Allow dentists who both work for the NHS to share parental leave entitlement and increase paid paternity leave from two to six weeks. At present, NHS dentists moving between roles in the GDS and a hospital would lose their continuity of service for parental leave purposes. A redefinition of the eligibility requirement would remove the disincentive to return to general dental practice, after undertaking a period of further training in hospital.

- *Comprehensive occupational health services, including flu vaccinations for dentists and dental teams.* This is in line with the rest of the NHS workforce and could provide a return on investment in the shape of a healthier and more supported workforce. While

[11] House of Commons - Health - Fifth Report (parliament.uk)

specific vaccination programmes would be inexpensive, a temporary extension during COVID illustrated the symbolism of being part of the ‘NHS family’.

***Jan 2023***