Written evidence submitted by the British Dental Association (CBP0034)

Introduction

1. The BDA is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, community dental services, hospitals, academia, and dental public health.

2. We welcome the Committee's decision to hold this inquiry. The initial suspension of services and ongoing low capacity as a result of ongoing pandemic restrictions has had an unparalleled impact on dental services, and the resulting backlogs will take years to clear if no action is taken.

3. Access problems were widespread pre-COVID, and over 30 million dental appointments in NHS high street services have been lost since the first lockdown. Each missed routine appointment is a missed opportunity to catch problems early, translating into higher costs to the NHS, and worse outcomes for our patients. For those in pain, this means unacceptable delays, and a reliance on avoidable antibiotics.

4. Community Dental Service (CDS)[1] patients – those with learning disabilities, who are housebound or have other disabling conditions which prevent them from visiting a dentist on the high street – faced yearlong waiting times pre-COVID in many places, and these have worsened since the start of the pandemic owing to limits on elective procedures. There has been limited disclosure of data relating to both paediatric and vulnerable adult patients since the outset of the pandemic, however we understand that some patients can now expect delays of over four years through referral to treatment. Full disclosure is the only way we can meaningfully plan and prioritise.

5. As we told the Committee last summer, primary dental care services faced existential challenges as a result of COVID. These have magnified, and strategies adopted by government, such as controversial imposed activity targets, have forced a focus away from the urgent cases – which need to be our priority – and towards routine cases that enable practices to hit perverse activity measures. Meanwhile, capital funding that has been offered to dentists by every other UK nation to enhance capacity, has not been offered in England. The overall response is undermining dedicated practices, and risks accelerating the long-term drift away from the NHS.

6. Evidenced easing of COVID restrictions, wedded to appropriate investment, could yield immediate gains for capacity in dentistry. However, if we are to get on top of historic backlogs NHS dental services require transformational change. Even before the pandemic, access problems and high levels of unmet need were the norm. An activity-based primary care NHS contract has proved wholly incompatible with delivering dental care during a pandemic, which has a cascade effect across all dental services in England. The rollout of better systems and appropriate resourcing are now necessities.

7. The BDA would be pleased to give oral evidence if it would be helpful to the inquiry.

The scale of the backlog and pent-up demand

[1] Dental treatment for people with special needs nhs.uk (accessed 30Aug21) https://www.nhs.uk/using-the-nhs/nhs-services/dentists/dental-treatment-for-people-with-special-needs/

8. NHS dental services cover a workforce based in high street, community and hospital settings, working in a wide range of specialities. The impact of COVID on specific services and patient cohorts has varied, as have the knock-on effects on backlogs and ongoing demand.

9. Demand for services is greater than ever across the general population, with many vulnerable groups (veterans and service families[2], refugees, those experiencing homelessness, etc) left without access to NHS services. Oral health inequalities are widening for those unable to access care or who have long waits for treatment.

Routine and urgent care

10. High street NHS General Dental Services have long faced significant pent-up demand reflecting ongoing capacity issues, with only enough services commissioned to cover around half of the English population. Consequently, the pre-COVID 'business as usual' saw many patients unable to secure timely access to appropriate dental services, close to home and appropriate to their needs.

11. In the spring of 2020, all routine dental care in England was paused for over two months. With social distancing and additional decontamination between patients essential since then, dentists have been able to see only a fraction of their usual patients.

12. Nearly 30 million appointments in high street General Dental Services were lost in the 12 months since the first lockdown: representing over two thirds the total volume of treatment delivered in a typical year. With dentists still limited in how many patients they can see, this unprecedented backlog continues to grow.

13. The proportion of children seen by an NHS dentist in the last 12 months fell from 59% as of 31 March 2020 to just 23% on 31 March 2021. Potentially over 9 million children missed out on the recommended maximum recall during the first year of the pandemic.

14. Official data is not maintained on waiting lists for primary care in England. However, research from Healthwatch England has indicated patients being asked to wait up to three years for routine appointments - or six weeks for emergency care.[3]

15. Demand today is unlikely to take the same shape as it did pre-pandemic, or indeed in the early stages of lockdown. The disruption to access and ongoing care, the parallel suspension of public health programmes, and changes in lifestyle and dietary habits during lockdown are, taken together, likely to increase demand for treatment, albeit not uniformly. Delays to diagnosis inevitably mean poorer outcomes for patients, and more extensive and expensive interventions.

16. Urgent care represented over 60% of all courses of treatment delivered when practices reopened in June 2020. While urgent care levels delivered are now similar to the pre COVID period (around 300,000 per month) this still represents a much higher proportion of total treatment delivered in what is a very limited service. Given wider factors in play, it is not clear that current demand for urgent care is being met.

17. It is now widely expected that oral health inequality will widen, and greater treatment need is likely to emerge in more deprived communities. Scotland's participation figures during the pandemic have shown reduced capacity impacting most on those in the least affluent communities, who were already the least likely to attend. Data is not currently published in the same format in England.

Elective surgery

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[2] Veterans and service families are covered by the Armed Forces Covenant: https://www.armedforcescovenant.gov.uk/wp-content/uploads/2021/06/NHS-health-care-for-the-Armed-Forces-community-JUNE-2021_ISSUE.pdf

[3] https://www.healthwatch.co.uk/report/2021-05-24/dentistry-during-covid-19-insight-briefing

18. Prior to COVID, tooth decay was consistently the number one reason for hospital admissions among young children. While tooth extractions under General Anaesthetic may lose this status as a result of the suspension and ongoing disruption to elective surgery, levels of demand have not dissipated. Dentists in hospital and community services are responsible for performing these procedures, serving both vulnerable adult and paediatric patients.

19. Along with partners including Mencap we have sought data on the size of backlogs for GA extractions since the outset of the pandemic. This has featured in contact with officials, and formal requests direct to the Secretary of State. However, we are still awaiting full disclosure.

20. The lack of robust data means activity has not been accurately reflected in recovery planning for elective surgery. Yearlong waiting times were standard before COVID, and we understand that the total wait from referral through to treatment for some patients requiring sedation may now be as long as four years. Clearly without disclosure on the scale of the problem there is no basis to develop an effective plan.

21. Access to theatre space remains a major issue for dentistry. The CDS deliver surgery under GA in hospital theatres but are contracted separately to other trust services, meaning many have struggled to gain access.

22. In 2020 waiting times for consultant led secondary care dental services rose to an average waiting time of 21 weeks with only 35% of the patients being seen within 18 weeks and this has improved slightly in 2021 with average waits of 14 weeks and 60 percent within 18 weeks[4]. Those national figures, however, mask the dramatic regional differences faced by patients. There are patients waiting in excess of 104 weeks. RTT data shows patients in the Southwest in 2021 were waiting on average 74 weeks compared with 8 weeks in London. Such regional disparities are not limited to hospital dental services.

Domiciliary care

23. Domiciliary care is a small part of NHS dentistry, serving a highly vulnerable population, both the housebound and those in care homes. These groups were largely unable to access mainstream dental care during lockdown, and face ongoing barriers and high levels of need.

24. Historic analysis suggest levels of commissioning were wholly inadequate, equivalent to providing coverage to under 1.3% of the population whose activity is significantly limited by disability or ill health. BSA data indicates 62,634 visits took place in 2019, and that figures fell to less than 25,000 in 2020, with 75% of that activity taking place in the first 3 months before lockdown.

25. In 2019, the Care Quality Commission concluded that care home residents required better, more consistent dental provision. Clearly the pandemic has moved us further from that objective.

What capacity is available within the NHS to deal with the current backlog?

26. There are historic limitations on capacity across all NHS dental services. Both long term systemic factors, and policies and approaches adopted during the pandemic risk impeding progress on tackling the backlogs.

27. Successive budget cuts to the system at all levels have left the dental profession facing rock bottom morale and while COVID camaraderie has driven the NHS to go above and beyond, the existing workforce is stretched to capacity.

Infection Prevention and Control

28. Restrictions designed early in the pandemic are without question the single biggest limiting factor on capacity across the service, and will set clear limits on progress as long as they remain in force.

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[4] NHS England (2021) Consultant-led referral to treatment waiting times data (accessed 30Aug21 https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/

29. Most courses of dental treatment – for example any involving drilling – are Aerosol Generating Procedures (AGPs), which create airborne particles that can contain pathogens. Since services reopened, following each AGP dentists have been required to leave the treatment room empty for up to an hour before it can be cleaned. This so-called 'fallow time' dramatically reduces the number of patients they can treat.

30. Evidence is accumulating that infective aerosols arise principally from coughing by COVID-positive patients, with medical interventions posing a relatively very low risk. In light of this, and with the progress made by the vaccine programme the BDA has sought commitment to a roadmap to ease restrictions. In response, all four UK Chief Dental Officers issued a rare joint statement stating that: *"All four UK Chief Dental Officers share their profession's ambition for increasing access which needs to be done safely and effectively, which is why there is now going to be a further review of the UK-wide infection control guidance in the light of the current science and prevalence."*

31. At the time of writing, we are yet to see a definitive break with IPC protocols designed in the first wave.

Ventilation

32. 'Fallow time' between appointments can be significantly reduced – and patient throughput increased – by installing high-capacity ventilation. While all devolved nations have agreed to fund such equipment, there has been no corresponding commitment in England. The Scottish Government has recently committed £5m to ventilation, and a further £7.5m for drills that generate less aerosol. England remains the only UK country to offer dentists no help with the significant cost of improving their ventilation systems.

33. Beyond having a transformative effect on throughput of patients, spend on ventilation would also likely be cost neutral given increased patient charge revenues from paying NHS patients.

Funding and contractual arrangements

34. High street NHS providers are contracted to deliver a set number of activity measures called Units of Dental Activity (UDAs). Since the outset of the pandemic NHSE have maintained funding at full contract value for practices (subject to significant abatements), while they have been able to carry out less treatment due to the limitations outlined above.

35. Funding has been subject to imposed activity targets from 1 January 2021, which obliged contract holders to hit a threshold of 45% of pre-COVID activity, or face financial penalties. This target rose to 60% from 1 April. The government stated that this approach was designed to boost patient access. However, this approach has been widely criticised as setting perverse incentives to prioritise routine over urgent care – or 'volume over need' – in order to hit these targets.

36. 55% of practices were unable to meet their 60% target in July, and so will face 'clawback' and need to return a proportion of their contract value. Around 1 in 10 practices are below the 'cliff edge' of 36% activity and face the return of the majority of their NHS funding. The continued operation, and likely increase in these targets from 1 October, will have a real impact on the sustainability of thousands of practices, serving millions of patients. They simply cannot hit these targets under current constraints and this threatens their financial viability and in turn provision of NHS dentistry.

37. The majority of funds clawed back before the pandemic for contract 'under delivery' were not reinvested in NHS dentistry. In 2019-20, this was approximately £139m, which represented a substantial loss of access, and over the five years from 2015-16 to 2019-20 over £500m has been lost. Given the likely volume of practices now facing clawback and the 'cliff edge' this budget must be retained and re-invested locally in NHS dentistry.

38. Less NHS dentistry was commissioned and delivered in 2019/20 when compared to a decade ago, and overall spend had fallen in both cash and real terms. In real terms, net Government spend on General Dental Practice in England had been cut by over a third the decade before the start of the pandemic. There are questions as to whether the commissioning model in operation can meaningfully adapt to reflect the shape of demand as we emerge from the pandemic, and indeed longer-term demographic changes.

39. General Dental Services contracts are usually held in perpetuity, based on delivery of a set number of UDAs. Most of the primary care dentistry budget is, therefore, predetermined each year unless new services are commissioned or current contract holders terminate their contract. 'Flexible commissioning' can allow a practice to direct a proportion of the contract value towards activity that the current contract does not largely cover (like prevention, supervised brushing or activity in care homes) but there is limited leeway to address emerging challenges.

40. In some local areas, commissioners have used additional new funding to commission urgent care services to meet the current level of demand. These have operated outside of the UDA model, which is particularly ill-suited to delivering urgent treatment. The BDA understands that where these schemes have been established, they have been well-received by practices and have made a significant contribution to alleviating the backlog of urgent care need. Similar schemes could easily be established elsewhere, but it is vital that NHSE provides central direction and support, as well as making funds available.

41. While we have welcomed commitments from government to see through reform of the dental contract, under the leadership from NHSE, there is a risk that inertia and a failure to make a decisive break from targets will endanger the pandemic recovery. We have waited for more than a decade for necessary reform to take place and the pandemic has only served to emphasise the need for change.

42. The Welsh Government, which operated the same activity based contractual model, has recognised its incompatibility with delivering care both in the pandemic and beyond, and confirmed there will be no return to UDAs. This Committee has previously described the current GDS contract as 'unfit for purpose' and failure to make a decisive break from this model would further jeopardize the recovery of dental services in England.

43. Patient charge revenue, on which the service has grown increasingly over reliant, fell by over £0.6b from 2019/20 to 2020/21 as a result of lower patient throughput. Having been in long term decline, direct government contributions have had to reach historically high levels in order maintain operations during the pandemic. We are concerned that patient charge increases will be sought to 'balance the books', and at much higher levels than the recent pattern of annual 5% increases. Given the documented impact charges have on patients willingness to seek treatment, particularly those on modest incomes, this approach must be avoided.

Workforce

44. The pandemic and the government's policy response will likely deepen existing recruitment and retention problems, and accelerate a long term drift away from NHS dentistry.

45. According to a May 2021 survey of dentists in England nearly half (47%) indicated they were now likely to change career or seek early retirement in the next 12 months should current COVID restrictions remain in place. The same proportion stated they were likely to reduce their NHS commitment. Working in high-level PPE mandated under current infection control procedures has had a devastating impact on dentists' morale, with nearly 9 in 10 (88%) indicating it is having a high impact on their morale. 78% cited financial uncertainty as having a high impact, and their inability to provide pre-COVID levels of care. Two thirds cited hitting NHS targets imposed by the Government on 1 January 2021. Since the New Year the workforce reported the highest levels of stress compared to any point since the onset of the pandemic.

46. In 2020/21 the number of dentists performing NHS activity fell by 951 on the previous year. Given the self-employed nature of the high street dental service it is difficult to create a proxy for Whole Time Equivalent in NHS dentistry. Government commentary has typically highlighted the growing number of dentists performing 'some' NHS dentistry, 22,003 dentists in 2009-10, 23,733 dentists in 2020-21. However, official figures present those undertaking 5% or 100% NHS work as carrying the same weight. The total volume of NHS dentistry delivered fell in the decade prior to the pandemic, with volumes delivered per head by nearly a fifth.

47. In this context we wholeheartedly support calls to legislate for annual workforce planning within the Health and Care Bill. Meaningful data is essential to underpin effective commissioning and delivery of services during the COVID recovery.

48. Dentistry is a mixed economy with substantial private provision. Dentists and their teams therefore have a choice whether to work in NHS, mixed or private care. Unless the NHS can offer a better working environment, with an improved contractual framework, then dentists will continue to exit NHS dentistry. This is a pivotal moment for NHS care.

Domiciliary care

49. Whereas General Medical Practice has seen a national approach to delivering 'Enhanced Healthcare in Care Homes' through the Directed Enhanced Service, a similar joined up approach is lacking in dentistry. Instead, local commissioners are left to design and fund schemes for their area, leading to a postcode lottery.

50. NHSE/I should draw on areas with successful local schemes to develop a national approach to meeting the oral health needs of those requiring care outside of the dental practice, informed by a needs assessment to ensure that the level of commissioning is commensurate with the oral health need and delivered through new funding rather than by 'flexible commissioning' that simply shifts resources away from other patients who attend practices, for whom there is also a backlog and unmet need.

Dental Public Health

51. Pledges to expand supervised tooth brushing and water fluoridation are crucial long term commitments, but are not meaningful ways of tackling the current backlog, and must not be viewed as a substitute for ensuring patients have timely access to dental care. Investment in these preventive programmes must be pursed in parallel with the wider restoration of dental services.

52. What must also be factored in, is the so called 'public health backlog'. Many Dental Public Health initiatives to improve oral health will have been postponed as teams tackled the pandemic from the outset. In addition, the current movement and fragmentation of clinicians from Public Health England to other receiver organisations, such as NHSE/I or the Office for Health Promotion within the DHSC has meant that there will be a period of instability while the new organisations and systems bed in from 1 October.

53. DPH advice and support underpins the whole of NHS dental services. For those teams moving to NHSE, the future uncertainty of the NHS reforms and new legislation is an additional barrier. The current system is hampering the effective delivery of services across the dental profession.