NHS0032

Written evidence submitted by the British Dental Association

Summary

1. The BDA's evidence to Committee sets out in detail the available data on the extent of NHS backlogs and waiting times in NHS dentistry and the evidence on the various causes of these. These are both long-standing issues, as well as particular ways in which the pandemic has impacted on the provision of dental care.

2. Our evidence sets out that:
    - Over 37 million dental appointments in NHS high street services have been lost since the first lockdown.
    - None of the multi-billion pound NHS 'catch-up' programme has been allocated to high street dentistry. Funding for NHS dentistry in England has fallen to such an extent that we estimate that it would take an additional £879 million to restore funding to 2010 levels.
    - 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. This suggests over 9 million children exceeded the recommended maximum recall period during the first year of the pandemic.
    - There are patients who have waited in excess of 104 weeks for consultant led secondary care dental services.
    - Nearly two-thirds of high-street dental practices (62%) estimate they are continuing to operate under 70% of their pre-COVID capacity.
    - Infection Prevention and Control Guidance continues to reduce the capacity of dental practices, with 62% of dentists saying that newl- published guidance will make little to no difference to the volume of patients they can see.
    - Capital funding that has been offered to dentists by every other UK nation to enhance treatment capacity through improved ventilation has not been offered in England.
    - The number of dentists performing NHS activity fell by 951 in 2020/21. This reduces the NHS dentist workforce in England to levels last seen in 2013/14.
    - There is an urgent need to reform the NHS dental contract so that the NHS is seen as an attractive working environment for dentists and so that it can deliver the care patients need.

Introduction

3. 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.

4. 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.

5. Access problems were widespread pre-COVID, and over 37 million dental appointments in NHS high street services have been lost since the first lockdown. This is as a result of the suspension of routine services in spring 2020 and then enhanced Infection Prevention and Control guidance that have restricted capacity to ensure the safety of patients and dental teams. 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. As a result of these access issues, dentistry has been the number one problem raised with Healthwatch, with four in five (79%) patients saying they found it difficult to access timely care.

6. 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.

7. 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 more time-consuming 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 through improved ventilation has not been offered in England. The overall response is undermining dedicated practices, and risks accelerating the long-term drift away from the NHS.

8. These pandemic pressures come after a decade in which the resources available to fund NHS dentistry in England have fallen to such an extent that we estimate that it would take an additional £879 million to restore funding to 2010 levels. However, while investment to support NHS dental services is necessary, it is not sufficient to resolve the COVID backlog and the historic problems. If we are to resolve these issues, then transformational change is required. 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 contracts and appropriate resourcing are now necessities.

9. At the time of writing none of the multi-billion pound NHS 'catch-up' programme has been allocated to high street dentistry. Despite messages from both the BDA and Healthwatch England to the Treasury, echoed by growing numbers of cross-party MPs, no additional funds were allocated in the budget or spending review to underpin the recovery, reform and rebuild of high street dental services. As Sir Robert Francis noted ahead of the budget *"every part of the country is facing a dental care crisis, with NHS dentistry at risk of vanishing into the void. The Government needs to use the forthcoming spending review to provide vital investment in services like dentistry that help keep us all healthy and ensure we build back better for current and future generations."* Failure to act here will have ongoing impact on service sustainability, and with it scope to tackle the unprecedented backlogs.

10. Dentistry must also not be an afterthought in the health service reforms brought forward by the Health and Care Bill currently going through Parliament. The Bill shifts the responsibility for commissioning primary care dentistry to the new Integrated Care Systems. However, as it stands

[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/

dentistry is not in any way included in the governance structures and programmes of work of either Integrated Care Boards or Integrated Care Partnerships. We cannot effectively tackle the huge backlogs in NHS dentistry without dentists having a voice in the making of commissioning decisions which affect their services and the millions of patients they treat.

11. 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

12. 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.

13. Demand for services is greater than ever across the general population, with many vulnerable groups (veterans and service families[2], refugees and asylum seekers, 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

14. 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.

15. 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.

16. Nearly 30 million appointments in high street General Dental Services were lost in the 12 months following the first lockdown: representing over two thirds the total volume of treatment delivered in a typical year. As of the end of October 2021 the figure is now at over 37 million, and with dentists still facing clear limits on how many patients they can see, this unprecedented backlog continues to grow.

17. 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. This suggests over 9 million children exceeded the recommended maximum recall period during the first year of the pandemic.

18. Official data is not collected on waiting lists in England for primary dental care. 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.

19. 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. Delays to diagnosis inevitably mean poorer outcomes for patients, and more extensive and expensive interventions.

20. 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

[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

what is a very limited service. Given wider factors in play, it is not clear that current demand for urgent care is being met.

21. 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

22. 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.

23. 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.

24. The lack of robust data means activity here does not even fall within the recovery plan 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.

25. Access to theatre space remains a major issue for dentistry. The CDS who are contracted separately from the trust to deliver surgery under GA in hospital theatres, struggle to gain access to theatre space.

26. While patients are unable to access routine care, or are stuck on long waiting lists, their oral health will be deteriorating. Early detection and treatment of all oral disease including oral cancer is of vital importance to the success and cost of care.

27. 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 seen within 18 weeks[3]. 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

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

29. Historic analysis suggest levels of commissioning were wholly inadequate pre-pandemic, 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.

30. 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.

[3] 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/

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

31. 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.

32. 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 (IPC)

33. Until 26 November 2021, dentistry continued to operate under IPC guidance that had been designed early in the pandemic and this was without question the single biggest limiting factor on capacity across the service. Our most recent research found that nearly two-thirds of practices (62%) estimate they are continuing to operate under 70% of their pre-COVID capacity.

34. There is now an updated IPC guidance and associated Standard Operating Procedure in use, but its scope to increase capacity is relatively limited. Nearly a third of dentists have said they have no intention of relaxing their COVID precautions as a result of the new guidance. Half say that the Omicron variant has had a significant impact on their willingness to alter their infection prevention control practices.

35. The new model places patients on two pathways, given the likelihood of them suffering from respiratory illness. Those on the non-respiratory pathway can be managed in line with pre-COVID standard infection control precautions. Any placed on the respiratory pathway, based on symptoms of respiratory illness, will remain subject to enhanced precautions, including maintaining 'fallow time' gaps of up to an hour between Aerosol Generating Procedures (AGPs). Screening to determine the pathway takes place both before attendance and on arrival at the practice. Given the prevalence of common winter flus, colds and other respiratory infections, we are concerned that in effect many patients will continue to be subject to the same enhanced infection control practices that severely restrict capacity. As a result, 62% of dentists say they think the new guidance will make little to no difference to the volume of patients they can treat.

36. Most courses of dental treatment – for example any involving drilling – are 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. These arrangements remain in place for those patients assigned to the respiratory pathway.

Ventilation

37. ‘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 £5 million to ventilation, and a further £7.5 million 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.

38. 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

39. 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 has maintained funding for practices at full contract value, whilst practices have been able to carry out less treatment due to the limitations outlined above.

40. 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 and then 65% from 1 October. 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.

41. Nearly a third (29%) of practices were unable to meet their 60% target in August, and so will face 'clawback' and need to return a proportion of their contract value. Nearly 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 of these targets is having 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 for patients.

42. 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 £139 million, which represented a substantial loss of access, and over the five years from 2015-16 to 2019-20 over £500 million 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.

43. 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.

44. General Dental Services contracts are based on a set, and capped, number of Units of Dental Activity (UDAs), meaning that the number of treatments that can be done in any year is fixed. This means that, if once IPC guidance is fully relaxed practices had capacity to increase the NHS treatment they provide, the contract would prevent them from doing so. This is a clear impediment to clearing the backlog at a time when all efforts should be directed at providing the care patients need. To increase NHS capacity either requires significant additional commissioning or the relaxation of the upper limit on UDAs. Dentists in Northern Ireland and Scotland work to an NHS contract with no such cap on treatments without seeing unaffordable fluctuations or increases in the government spend on NHS dentistry.

45. 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.

46. 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 UDA 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. 70 per cent of dentists say that the uncertainty over long-term reforms is having a high impact on their morale.

47. The Welsh Government, which until recently 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. Both Conservative and Labour parties have committed to reforming the dental contract in England ahead of the 2010 election, and the Health and Social Care Select Committee has previously described the current GDS contract as 'unfit for purpose'. Failure to make a decisive break from this model would further jeopardize the recovery of dental services in England.

48. 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

49. 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.

50. In 2020/21 the number of dentists performing NHS activity fell by 951 on the previous year. This reduces the NHS dentist workforce to levels last seen in 2013/14. 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. Official data captures the growing number of dentists performing 'some' NHS dentistry, 22,003 dentists in 2009-10, 23,733 dentists in 2020-21. However, figures present those undertaking 5% or 100% NHS work as carrying the same weight, while the total volume of NHS dentistry delivered, and delivered per head, has fallen by as much as 15% in the same period.

51. Our most recent research, conducted in early December 2021, found that over 40% of dentists indicate they are now likely to change career or seek early retirement in the next 12 months given the current pressures on the service. Over half state they are likely to reduce their NHS commitment. 1 in 10 estimate their practices will close in the next 12 months.

52. 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.

53. 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 dental care in which dentists have never been more needed to provide NHS services, but increasing numbers of dentists simply cannot keep their practices viable within the NHS framework and so are forced to increase their private provision or leave the profession altogether.

Domiciliary care

54. 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. There are successful schemes in operation, such Residential Oral Care Sheffield, but these cannot be left as local initiatives when their widespread adoption would be of such benefit to an often vulnerable and high-needs patient group.

55. 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. This should be supported 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

56. 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.

57. What must also be factored in, is the so called 'public health backlog'. Many Dental Public Health initiatives to improve oral health 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.

58. 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.

December 2021