BDA
British Dental Association

Widening the focus

Why lessons from dentistry during the pandemic must be learned

“

Dental healthcare systems... are part of the healthcare systems of the United Kingdom, but are not an important aspect of the matters within the scope of Module 3.”

Rt Hon Baroness Hallett DBE
Chair, UK Covid-19 Inquiry
16 February 2023

Foreword

The Nuffield Trust has warned that dentistry faces the greatest crisis in its history. [1]
No part of the health service witnessed such a fall in capacity during the pandemic. None has seen such a limited recovery.

Yet dentistry does not even appear to be on the menu for this inquiry. Failure to take a whole-system approach to future pandemic planning - and to this inquiry – will carry real consequences for millions of patients.

Dentistry faced major problems before lockdown, but the pandemic proved a catalyst, and turbocharged them into a genuinely existential threat to the service.

None of this was inevitable. The crisis our patients now face is the result of political choices, that plainly must be avoided in both the planning and response to any future pandemic.

At lockdown dentistry was viewed like an optional extra rather than a core part of our health service. Private dentistry, which provides care to millions and on which the mixed economy of most NHS practices depends, was treated like it didn't exist.

At the time of writing only two references to dentistry have been made by this inquiry. The first is correspondence that underlines that dentistry is not an "important" part of this process[2]. The second to simply confirm the CV of Scotland's former National Clinical Director of Healthcare Quality and Strategy, Professor Jason Leitch.[3]

This inquiry has a responsibility to ensure the mistakes of the past are not repeated, and that, future pandemic responses avoid causing lasting collateral damage to core parts of our health service.

Eddie Crouch
Chair, British Dental Association

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[1] Bold action or slow decay? The state of NHS dentistry and future policy actions, Nuffield Trust, 2023
[2] Correspondence from Rt Hon Baroness Hallett DBE, https://covid19.public-inquiry.uk/wp-content/uploads/2023/02/2023-02-16-Dental-Alliance-Determination-of-CP-application-Module-3-Decline.pdf
[3] Transcript of Module 2A Public Hearing on 22 January 2024

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Executive summary

This inquiry risks repeating a key error from the pandemic, and the planning that proceeded it.

Quite simply the preparation for and handling of the pandemic adopted a narrow focus meaning that critical issues were missed.

Dentistry matters, and the lessons learned here must not be over-looked.

The pandemic led to unprecedented restrictions being placed on dental treatment, which impacted on both dental professionals and the patients they supported.

Yet, as we will set out in this evidence, there was a fundamental failure to take dentistry seriously in both the planning for a pandemic and the response to it. These failures included failures to heed warnings about PPE supplies, failures to communicate clearly and in a timely manner to dentists and patients, failures to financially support all dental practices, failures to appropriately coordinate policy across governments, and failures to consider the importance of oral health.

It is of critical importance that the Inquiry helps the UK to learn these lessons.

Introduction

In this document we start by setting out a clear set of recommendations on the lessons learnt for the Inquiry, for Government, for clinical leaders and for pandemic planners. These draw on the direct experience of our members during the pandemic and provide the basis for ensuring dentistry in the UK is prepared for future pandemics.

The Inquiry must properly consider evidence on dentistry and make recommendations on it. Dentists provide an essential healthcare service, which was wrongly neglected during the pandemic, and the Inquiry must ensure that it does not continue this neglect.

In our evidence, we catalogue the breadth of failures before and during the pandemic that impact on dentists and their patients. There was a lack of planning considering dentistry, with the consequence that there was little preparation for how to deliver dental services amidst an airborne respiratory viral pandemic. This was then compounded by the slow speed of the responses and repeated failures in communication, inadequate financial support, a failure to appreciate and understand the role of private dentistry, many issues with the supply of PPE, insufficient support with ventilation for surgeries, and the slow speed from NHS England in establishing urgent care provision, relative to dentists' willingness to step up to provide it.

Providing the backdrop to these pandemic-specific problems is an NHS dental service that was already struggling with broken contracts and under-funding. The failure to grapple with these problems in more favourable circumstances left NHS dentistry particularly vulnerable to the impacts of the pandemic.

The combination of these pandemic failings, and fundamental weaknesses within the service, led to dentistry seeing a collapse in capacity seen nowhere else in the health service, and dentistry is yet to recovery to pre-pandemic levels of activity.

Alongside these challenges, it is also important for us to acknowledge the positive elements of the pandemic response. The vaccine roll-out undoubtedly saved many lives, and we strongly welcomed the appropriate prioritisation of dentists and dental teams in accessing vaccines and subsequent boosters. The financial support packages for NHS dental practices that we were able to negotiate saved many from bankruptcy and, while not perfect, ensured that they remained

financially viable to deliver patient care. The dental profession also stepped up to the challenge. Dentists volunteered for redeployment in hospitals, stepped forward to establish Urgent Dental Care Centres, many supported the roll out of the vaccination programme and provided urgent treatments. They responded to ever-changing guidance, Standard Operating Procedures and contractual requirements to ensure that their staff and patients were kept as safe as possible.

Given the devolution of health policy and much of the covid response, combined with nation specific inquiries and investigations, this submission largely focuses on England and the UK Government, while drawing broader lessons where applicable.

Recommendations

Our recommendations are as follows:

1. Pandemic planning and preparation must be comprehensive, considering contingencies for how all aspects of the health system, including dentistry, will respond and be facilitated to provide essential care.

2. Some of the choices made at the outset of the pandemic effectively categorised dentistry as a 'non-essential' service. This was a significant error and must be avoided in the future. As such, the Inquiry should consider how this lesson can most effectively be learnt and then applied in future pandemics.

3. In any future pandemic, government and its arms-length bodies must have appropriate processes and capacity in place to facilitate timely and clear communication with the dental profession. This must be supported by Government, and NHS bodies having the capacity to make rapid decisions when responding to crises circumstances.

4. The co-ordination between health departments across the UK should be significantly improved to prevent mixed messages for dentists, their dental teams, and the public they seek to provide dental services to each day.

5. The response to future pandemics must recognise that dentistry is delivered through mixed NHS and private provision, and that financial measures must provide adequate support to both sectors.

6. There must be appropriate planning and procedures put in place to ensure robust, consistent and reliable supplies of PPE for dentistry in the event of any future pandemic, to ensure that there will be no repeat of the significant disruption to patient care.

7. In future pandemics, governments must ensure that there is appropriate funding in place to support dental practices with meeting the costs of new requirements, particularly where investment has a direct impact on patient access.

8. There should be consideration of 'future proofing' dental practices and testing the sector's resilience and preparedness - for example, in terms of ventilation - for a future pandemic now, so that this is not left to the 11th hour.

9. Contingency planning for the mobilisation and operation of Urgent Dental Care Centres for pandemics and other civil emergencies must be significantly improved, with lessons learnt from the pandemic experience.

10. Policy makers must have the foresight, and capacity to act on such foresight, to ensure that public policy problems are addressed in good time, so that health systems are sufficiently resilient to withstand plausible crises.

Why the focus of the Inquiry must be widened

Dentistry matters.

Many dentists have told us that the COVID-19 pandemic has been the most challenging experience in their professional lives, many of them working to deliver quality care for their patients within underfunded, understaffed and underprepared systems, and with concerns about the availability of the necessary protective equipment to ensure their own safety. It is vital that these experiences are not forgotten and that critical lessons are learnt, and solutions implemented.

Dentistry is not an 'optional extra'. Dental teams are made up of key workers, providing an essential healthcare service to millions of patients every year. In doing so, they help get patients out of pain, support them with managing oral health, treat decay and gum disease, and prevent future disease occurring. Maintaining good oral health is important for a person's overall health. There are known links between oral health and diabetes management and cardiovascular health. Poor oral health is a risk factor in hospital-acquired pneumonia. Dental care is a core component of healthcare.

This can be a life-or-death issue. Oral cancers, often detected at a routine checkup, claim more lives than care accidents and ongoing access problems are jeopardising early detection. It is also translating into a reported spike in dental sepsis cases in our hospitals.

Up and down the country dental practices are on every local high street and they are an integral part of the local community and economy. In England alone there are approximately 12,000 high street practices[4]. The dental industry accounts for billions in private and public expenditure each year. Private dentistry accounts for well over half of spend on high street dentistry - an estimated £6.4 billion of the £10.1 billion spent in 2021-22 was spent on private care.

Yet at many points during the pandemic, it felt like dentistry was overlooked. The planning and response all replicated what the Nuffield Trust has described as 'decades of policy neglect' of dentistry[5]. The Inquiry must not perpetuate that neglect.

The narrative from the then-Government was that many of the challenges now facing NHS dentistry are an inevitable consequence of the pandemic.

The reality is that the pandemic proved a catalyst, aggravating systemic and structural problems in an NHS service already facing significant crisis. This was caused by a failure to consider and tackle issues such as NHS dental contracts that are unfit for purpose, chronic underfunding, a recruitment and retention crisis, and oral health inequalities.

Choices made during the pandemic, rather than merely the existence of a pandemic, compounded these problems and left NHS dentistry, in particular, in the weakest state in its history.

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[4] CQC Annual Report 2018/19 https://www.cqc.org.uk/sites/default/files/20190812_annualreport201819.pdf
[5] Thea Stein, Chief Executive, Nuffield Trust, Health and Social Care Committee, March 2024 https://committees.parliament.uk/oralevidence/14526/html/

We feel that the focus of the Inquiry must be widened, so that the attention is not placed solely on those who have been appointed as core participants. Instead, the Inquiry must ensure that it looks comprehensively at the health system and how it was impacted by the pandemic. This will ensure that lessons are learned, not merely for dentistry, but the wider health service.

We are proud to give a voice to our members who continued to see their patients through the height of the pandemic and shut their doors only when told to do so by Government. However, pandemic planning and preparation cannot be based on professional goodwill. It is clear that better whole system planning and a better response could have improved the outcomes during the pandemic, reduced the disruption to dental services, and the consequent impact on patients' oral health that continues today.

We provided an initial high-level response to a series of questions set by the Inquiry under Module 3. However, we have not been invited to provide any further evidence and the focus has now moved to organisations who were recognised by the UK COVID-19 Inquiry to be core participants. The BDA hopes this evidence will prompt further enquiry into dentistry during the pandemic. We believe that there is a tangible risk of 'medicalising' pandemic planning, and our core messages for the Inquiry and for pandemic planners is that it is critical that they engage with all health professionals and the wider support teams. If not, then there is the potential for some of the mistakes made in approaching the COVID-19 pandemic to be made again during future pandemics.

About the BDA

The BDA is the voice of dentists and dental students in the UK. As a trade union and professional body, we represent all fields of dentistry. During the pandemic we provided an extensive range of written and over-the-phone advice to members, and the wider profession. We also played a significant role as a trade union in safeguarding the functioning of dental practices. We explained to NHS leaders the direct impacts of the pandemic on dentistry, ensured they understood the challenges and that these decisions were clinically led, and ensured that dental services were delivered safely for staff and patients.

Preparedness and planning

A key learning point is that the, now well-documented, limited UK preparedness ahead of the pandemic never really fully considered dentistry.

The BDA was invited to attend a small number of meetings concerning flu pandemic preparedness planning between 2015-20, including one Exercise Pica meeting in 2018 that focused on primary care. The planning as it pertained to dentists was largely focused on their anticipated role in administering flu vaccines and of potential redeployment to support other frontline healthcare roles. The failure to consider non-flu pandemics clearly influenced this approach, and contributed to the failure to consider how dentistry could continue to be delivered in the context of a pandemic respiratory virus.

There was a failure to consider the particular risks and requirements of working with the oral cavity amidst a pandemic respiratory virus. Dentistry is a profession where the dentist works in close proximity to the patient's mouth and many procedures produce aerosol, which is a mixture of water and patients' saliva or blood. These aerosols can potentially result in the spread of infection and diseases, including COVID-19. Yet this potential for exposure to airborne viruses for dentists and their teams did not appear to have been factored into pandemic planning. The reality was there was very little advance consideration of how these risks could be managed and mitigated. This appears to reflect the perceived lack of importance placed on dentistry and the

public's oral health. Rather than prepare for how to provide an essential health service during the pandemic, the instinct was to instead consider it – wrongly – non-essential. This had lasting impacts on how dentistry was treated throughout the pandemic, with unnecessary adverse effects for dentists and their patients.

Communication from political and clinical leaders

Government communications and political and clinical direction relating to dentistry, whether addressing the profession or the public, were unacceptably poor at many points during the pandemic. It was clear that a lack of capacity within government meant that there was a failure to comprehensively consider all areas of healthcare and this fed through into a failure to communicate decisions in a timely manner.

Ahead of the first lockdown we accepted the case for it, however many dentists have told us that their main recollections of the earliest stages of the pandemic were uncertainty, fear and immense frustration at the lack of specific information for them and their practices.

As the pandemic progressed, there were many instances where there was a vacuum of information. It appeared that unnecessary bottlenecks in approval for official communications led to days or even weeks of delays in information and guidance being shared with the profession. When the communications did arrive, messages were often open to interpretation and required detailed follow up queries.

This was particularly stark within England. Announcements from the Office of the Chief Dental Officer (England) were consistently behind those from the devolved nations creating the impression of a leadership vacuum in England. These announcements often came with short notice ahead of their required implementation or were even issued after-the-fact, with requirements and arrangements applying retrospectively.

The 're-opening' of practices in England provides an illustration of this point.

Dentists in England were justifiably angered when they first heard about this during a government news conference, rather than in direct communications from professional leaders. This announcement gave practices just over a week to remobilise for re-opening, which was compounded by the delay in issuing the Standard Operating Procedures under which practices could reopen. Practices were required to reopen before that guidance had been published.

Subsequent official messages to the public implied a return to "business as usual" that remained far removed from reality. This poor communication from the government resulted in widespread frustration amongst the dental profession and left patients unclear about what levels of service they could access. Failure to manage patient expectations has been the single greatest criticism of the Government's COVID record among dentists.

Similarly, clarity on whether practices could remain open during the subsequent local, regional and national lockdowns were not immediately forthcoming.

In any future pandemic, government and its arms-length bodies must have appropriate processes in place to facilitate timely and clear communication with the dental profession.

Alongside this, there was a consistent failure to properly consider the existence of private dentistry, with a lack of clarity whether guidance issued by NHS bodies and/or the Chief Dental Officer for England applied to solely private practices. Requests to issue clarifications were rarely taken up.

The variation between the nations also caused uncertainty and confusion, for example, in Wales dental practices could remain open for patients on an urgent basis for face-to-face assessment if deemed appropriate throughout the pandemic, but that was not the case in other parts of the UK. More joined-up thinking across devolved government could have delivered more consistent policy approaches across the UK.

Many practices ended up urgently seeking information from anywhere they could get it. The BDA quickly provided its own resources, for members to support compliance challenges such as PPE, and a return-to-work toolkit, which was heavily used by our members.

Financial support for dentistry

NHS dentistry

The BDA worked closely with the NHS across the UK to ensure that practices and dentists were as financially well supported as possible, while their capacity to delivery NHS treatment was constrained. In all four NHS systems, the payments dentists receive for NHS work are based on treatment activity and therefore there was a significant risk that the restrictions on this activity would have a devastating impact on the financial viability of dental practices that deliver NHS dental services. Planning for pandemic flu had envisaged that existing contractual force majeure provisions would be used to respond to such events, but these immediately proved to be insufficient and were abandoned.

We worked hard to ensure that the NHS provided the necessary financial support and the packages we were able to secure undoubtedly prevented the widespread financial collapse of NHS dental practices. However, the packages, their implementation and communication were far from perfect.

Most of the financial arrangements included some form of abatement, which it was claimed was in respect of variable costs not incurred by practices. These abatements were arbitrary and imposed (rather than agreed), with no clear rationale provided as to how the NHS had reached the figures involved, which specific costs they were in respect of, and how these costs had been quantified. This meant that incomes for NHS practices were only partially protected, and these abatements undermined practices' ability to meet, often volatile and increased, variable costs.

In England, as the pandemic continued, income protection measures were coupled with increasing activity requirements. These often changed on a quarterly basis. In some instances, practices were informed the day before the quarter began what the new activity requirements were and in others they were informed after the quarter had started, imposing the requirements retrospectively. This chaotic approach underscores the earlier points made about confused communications, and the underlying disarray in decision-making.

Private and mixed dentistry

Most dental practices provided both NHS and private care, and pandemic provisions provided almost no support with the private income practices lost. Solely private dental practices were particularly badly affected by this, receiving no NHS support, but also not qualifying for schemes targeted at other high street businesses, despite being required to close to routine care and then to operate at significantly reduced capacity. Practices in Wales were not instructed to close, but experienced similar capacity issues.

Unlike other areas of healthcare, the private dental sector is, by spend, larger than NHS provision and a significant proportion of the public routinely and regularly access private dental care.

Income from private treatment will often act as a subsidy for the much lower NHS fees and therefore the loss of this income destabilises the provision of NHS services. The pandemic response failed to acknowledge this mixed economy in dental provision, and therefore caused much greater disruption to the delivery of dental services than was necessary.

General dental practitioners are mostly self-employed and were therefore ineligible for the Coronavirus Job Retention Scheme (CJRS). The income thresholds for the Self-Employment Income Support Scheme were such that most dentists were ineligible for support. A capped monthly payment, as per the CJRS, rather than an income threshold for eligibility would have been a more equitable way for the Government to have supported self-employed people, including dentists.

In addition to this, dental practices were not afforded the business rate holiday that other high street business were able to access and many practices did not qualify for small business grants. There were widespread difficulties in accessing the Coronavirus Business Interruption Loans.

In response to concerns about the financial viability of the sector during the pandemic, the Chief Dental Officer (England) commissioned an 'Investigation into the resilience of mixed NHS/Private dental practices following the first wave of the COVID-19 Pandemic'. This recommended the various measures to enhance and extend the financial support available to dental practices, including extending eligibility for business rates relief and the Retail, Hospitality and Leisure Grant and for Government to guarantee loans to ensure practices had access to finance. Of the nine recommendations, the BDA considers only one to have been pursued.

The response to future pandemics must recognise that dentistry is delivered through mixed NHS and private provision, and that financial measures must provide adequate support to both sectors.

Personal protective equipment supply

In the early stages of the world becoming aware of a novel coronavirus, there was disruption to the availability of the personal protective equipment (PPE) needed to deliver dental services. The BDA alerted authorities to the shortage of PPE in early February 2020, as supply chains from China were disrupted.

While commercial UK suppliers were given access to strategic stockpiles, our initial concern that dentists would soon have to 'down drills' was viewed by many senior health leaders within Government as an overreaction. Little over a month later that is precisely what transpired. It appears that the decision to order dental practices to close for routine in-person care was taken at least, in part, due to a lack of PPE to continue the provision of dental services[6]. There was clearly a failure to adequately plan for the PPE necessary to deal with a coronavirus pandemic and for the stockpiling of these PPE supplies.

The ease with which the concerns of dentists – acting a canary in the coalmine – were dismissed is another example of the failure of senior decision-makers to take dentists and dentistry seriously.

As routine delivery of dentistry resumed in England, there were significant PPE supply issues, despite free provision to NHS practices. In some cases, supply was only provided for a week, and so some practices resorted to obtaining masks from welding companies. Some dental practices had donated their PPE supplies to other parts of the NHS at the start of the pandemic, only to find that they were unable to replenish stocks when required to reopen at short notice. Practices needed to source enhanced PPE that were not previously routinely used, and there were then issues in ensuring appropriate fit testing of masks took place. NHS provision proved inconsistent,

[6] Note: practices in Wales were not instructed to close.

with different brands of FFP3 masks issued to practices, requiring repeated re-fit testing of staff or, where the alternative brands proved unsuitable for the clinician, for further downing of tools.

In Northern Ireland, when routine dentistry resumed, no provision had been made for either directly supplying practices with the enhanced Level II PPE required, or additional funding to enable practices to attempt to purchase their own. This followed a period of considerable uncertainty where many practitioners were holding off on being fit-tested for masks because of the expectation that this would have been part of the PPE offer. Under the current Operational Guidance for Northern Ireland, three sets of PPE were required for each Aerosol Generating Procedure, taking into account a set each of Level II PPE for the dentist and dental nurse, and a set for cleaning the room down after the procedure, at a total cost averaging in the region of £21-30 . In contrast, the NHS remuneration received for an amalgam filling equates to just £9.64. The situation that would have been imposed on practitioners where every NHS procedure carried out by a dentist would generate a hefty loss was simply unworkable, and the BDA campaigned strongly for financial support for practices. Funding was later made available to support practices with these increased PPE costs.

Fallow time and use of air exchangers for ventilation

Fallow time was a very significant challenge for dentistry, with the added uncertainty on the use of air exchangers. Fallow time refers to the period of necessary 'down time' following dental procedures carrying a higher risk of exposure to potentially infectious aerosols to allow for the settling of aerosol particles and appropriate decontamination. Most courses of dental treatment, for example, any involving drilling or scale and polish, involve Aerosol Generating Procedures (AGPs), which create airborne particles that can contain viruses and bacteria.

Given concerns about airborne virus transmission, after each such procedure dentists were required to leave treatment rooms empty for up to an hour before cleaning, which dramatically lowered the number of patients they were able to treat. The length of the fallow time could be reduced based on the number of air exchanges in the surgery per hour. Therefore, improving in-surgery ventilation could have a significant impact on clinical capacity.

In England, there was no funding at all to support practices with ventilation costs, and in the rest of the UK support was insufficient. The interruption to services under the fallow time arrangements could have been significantly reduced – and patient throughput increased – by installing high-capacity ventilation equipment.

It was necessary for the BDA to lobby key system regulators for clarity regarding the requirements. The issue of air-changes-per-hour, in particular how they should be calculated, was never really resolved and in reality, interim arrangements were put in place to support dental practices where air changes were unknown.

Protocols imposed turned a typical 30-minute pre-COVID appointment into one that took two hours. Rather than working from one surgery, some practices had one dentist rotating between surgeries to maximise activity, but this was still obviously at a significantly reduced rate to normal. Only improved ventilation provided meaningful gains in clinical capacity.

When the Scottish Government made a decision to extend funding for ventilation and electric speed adjusting handpieces to help cover the maintenance costs of equipment damaged due to additional cleaning because of increased COVID-19 protocols, this was initially welcomed. However, a BDA survey in Scotland showed that over 30% of dentists chose not to apply for the funding; one of the conditions for receiving the grant was that dentists had to commit to deliver NHS dentistry for 3 years, with some respondents being unwilling to do this given concerns around NHS funding arrangements.

Funding for increased ventilation was also made available in Wales and Northern Ireland.

In future pandemics, governments must ensure that there is appropriate funding in place to support dental practices with meeting the costs of new requirements, particularly where investment has a direct impact on patient access.

Patient access

As the UK confronted a novel virus, we recognised Government's responsibility to act, sometimes without waiting on a clear evidence base to emerge. It was inevitable that this would disrupt patient access to care to some degree. However, the extent of the disruption and the long-term damage done to patient access to dental services were not inevitable, and were the fault of failures in planning and response, combined with missed opportunities to learn lessons as the pandemic progressed.

Urgent Dental Care Centres

Where all routine dental care was paused, Urgent Dental Care Centres (UDCs) were established to provide emergency care for a limited number of dental patients. Many dentists stepped up to rapidly establish UDCs and to provide urgent care, even when there was considerable uncertainty about the risks. However, in contrast to the rapid response of the profession, the organisation and implementation of the urgent care system from NHS bodies was frustratingly slow. The formation of UDCs felt, at times, hampered by the central authorities and key decision makers rather than supported. Locally organised dentists had arranged emergency care hubs in rapid time, and many felt they were then sat waiting for the go ahead while their patients suffered. These UDCs, often operated by primary care contractors, were in a number of cases operating before they had knew how much or even whether they would be paid.

Government, and NHS bodies, need the capacity to make rapid decisions when responding to crises circumstances, and there is clearly the need for improved contingency planning about the operation of UDCs for pandemics and other civil emergencies.

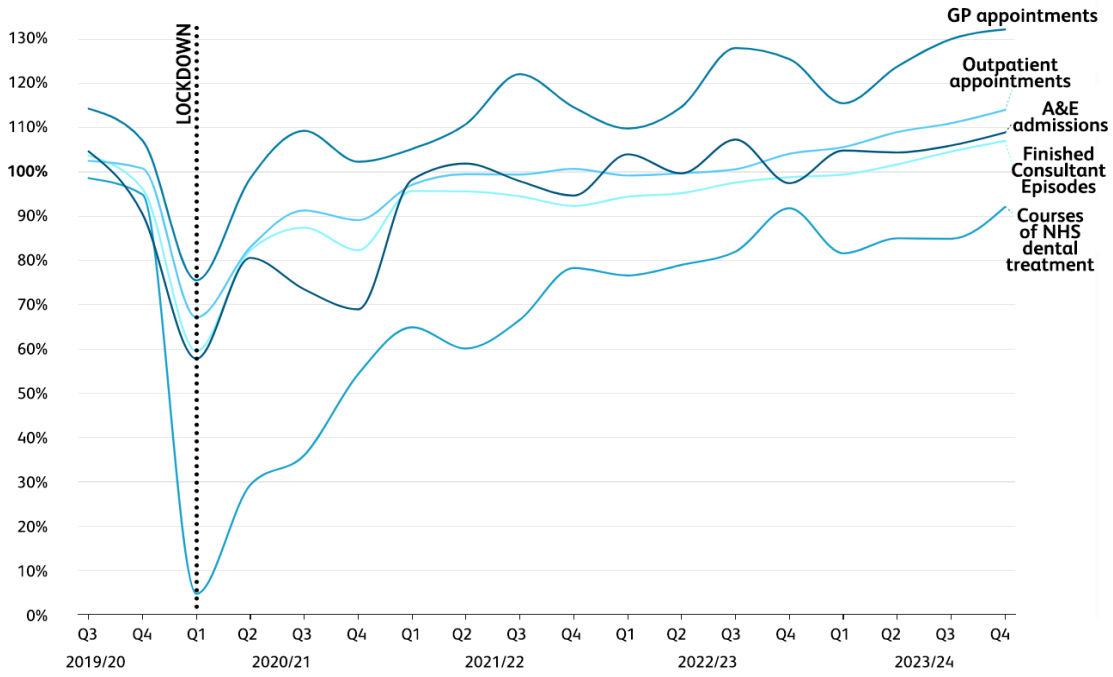
A unique impact

The decisions made around urgent dental care, the failure to plan for how to deliver routine dental care amidst a pandemic, the lack of a coherent and supported approach to improving ventilation and multiple other failings have had long-term impacts on both service sustainability and the nation's oral health. The backlog of care will take years to clear, and Organisation for Economic Co-operation and Development (OECD) data suggests the UK had seen one of the most significant decreases in attendance[7].

Cumulatively, the plans and approaches taken towards dentistry have resulted in the largest fall in capacity anywhere in the NHS and have resulted in the most limited recovery.

[7] Figure 7.15, 'Availability of dentists and consultations with dentists', *Health at a Glance: Europe 2022: State of Health in the EU Cycle*, OECD, 2022, https://www.oecd-ilibrary.org/sites/e4ba581d-en/index.html?itemId=/content/component/e4ba581d-en

Activity in NHS primary and secondary care as % of pre-COVID norms (England)



Activity delivered by quarter as a proportion of pre-COVID averages from 2018/19.

Data from NHS Dental statistics, Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data, Hospital Admitted Patient Care Activity, and Appointments in General Practice

The choices made by Government – on suspension of services, and on restoration of services and recovery – left dentistry lagging behind other parts of the health service. This gulf has been sustained and eclipses even those parts of secondary care that have been subject to widespread industrial action.

When practices resumed face-to-face care, "business as usual" remained a distant prospect: 64 per cent of practices surveyed by the BDA in October 2020 estimated they could only treat less than half of the patients they saw before the pandemic. Official data shows NHS treatments delivered in October that year were still a third of the levels achieved the year before. Well over 50 million NHS dental appointments have been lost since lockdown, the equivalent of well over a year's worth of dentistry in normal times.

Again, dentistry was left the outlier in the wider heath service. General practice has more than made up on patient contacts since lockdown, and areas like outpatients have almost covered lost ground.

	Lost capacity 2020/21-2023/24
NHS dental courses of treatment	33.3%
Finished Consultant Episodes	7.0%
A&E admissions	5.9%
Outpatient Appointments	1.9%
General Practice (Total Count of appointments)	-13.6%

Activity lost in sectors in England. Estimates based on comparing activity delivered since Q1 2020/21 against average delivery for 2018/19.

As the country emerged from the pandemic, there are now widespread 'dental deserts' where NHS appointments in England cannot be obtained with the inevitable impact on the health of the nation.

Unmet need for NHS dentistry in England now stands at 13 million patients, well over 1 in 4 of the adult population, and more than 3 times the levels seen in in 2019.[8]

This historic backlog means dentists are now seeing patients presenting late, and with higher levels of need. Unsurprisingly the very first oral health survey of 5-year-olds published since lockdown shows a widening gap between rich and poor. And with regular reports of 'DIY' dentistry we are continuing to see scenes that have no place in a wealthy 21st century nation.

One of the areas where waiting lists have been impacted particularly hard is for those who have been referred to the community dental service within each nation, which provides care to vulnerable adults and children. Their severe waiting times (for example up to two years within England) are leaving this cohort in immense pain and distress. The children and adults on these waiting lists, frequently have a complex mix of medical conditions, often including autism and learning disabilities, with some people unable to communicate the fact that they are in pain. Problems with eating, speaking and sleeping are unacceptable to anyone, let alone our most vulnerable patients.

A catalyst for the current crisis

The crisis facing dentistry pre-dates COVID.

NHS dentistry entered into the pandemic in a highly weakened state. In all four NHS systems, the contractual frameworks for NHS dentistry were not fit for purpose, and these broken contracts were further hamstrung by a decade of austerity.

Pandemic policy accelerated trends long in motion, both the exodus from the NHS workforce and the depth and breadth of access problems.

This situation underscores the need for state capacity to address public policy problems with foresight, and of ensuring that health systems are not run down, but instead properly invested in. The aim of policy makers, in part, should be to ensure that systems are sufficiently resilient to withstand plausible crises. Instead, NHS dentistry has faced an approach of doing the bare minimum for the service to survive under favourable circumstances, and it is inevitable then that, when tested, NHS dentistry has been pushed to breaking point.

It will be impossible to restore pre-pandemic activity within NHS dentistry without fundamental change to the current contracts in place. Years of systemic underfunding has been exacerbated by soaring inflation and increased costs for dentistry that means many NHS dental services providers now face the prospect of delivering NHS care at a loss.

In Scotland, reforms have already been made to payments post-pandemic. Efforts at reform are at various stages elsewhere in the UK and must be taken forward at pace.

Impacts on workforce wellbeing

During the first few months of the COVID-19 pandemic and at a time when the full effect and consequences of the virus was still unclear, many dentists and other dental care professionals,

[8] BDA analysis of GP Survey 2024 data by Ipsos

including dental nurses, courageously volunteered to take on other duties, for example dental staff were redeployed to frontline roles such as working in intensive care units or geriatric departments or working in the staff swabbing test centres. The physical stress of having to wear enhanced Level II PPE for extended periods took its toll on dentists, and also on the wider dental team. This often involved working weekends and bank holidays and many struggled to get appropriate remuneration for their time and efforts. We have heard upsetting accounts of dental staff being redeployed to work in areas without adequate protection. We know that many will carry a lasting mental health burden from the experiences and some still require long term support.

Morale was further impacted by NHS bodies assuming a punitive and conditions-based approach to NHS contracts for general dental practitioners, as 'opening up' progressed. The introduction of targets at short notice and often for quarters of the year, rather than the full financial year, left dentists feeling unable to take leave, so as to avoid missing their target and facing financial penalty.

Some dentists have also been impacted by Long COVID and whilst COVID sickness policies were in place, the BDA is dismayed that better support has not been in place.

Conclusion

We hope this evidence will prompt further enquiry into dentistry during the pandemic by the UK COVID-19 Inquiry itself, among Government officials, and all other stakeholders who are assessing what lessons can be learnt.

The BDA believes that the dental experiences, as described in this submission, form a critical aspect of evaluating what went wrong and informing a better approach to any future pandemic.

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