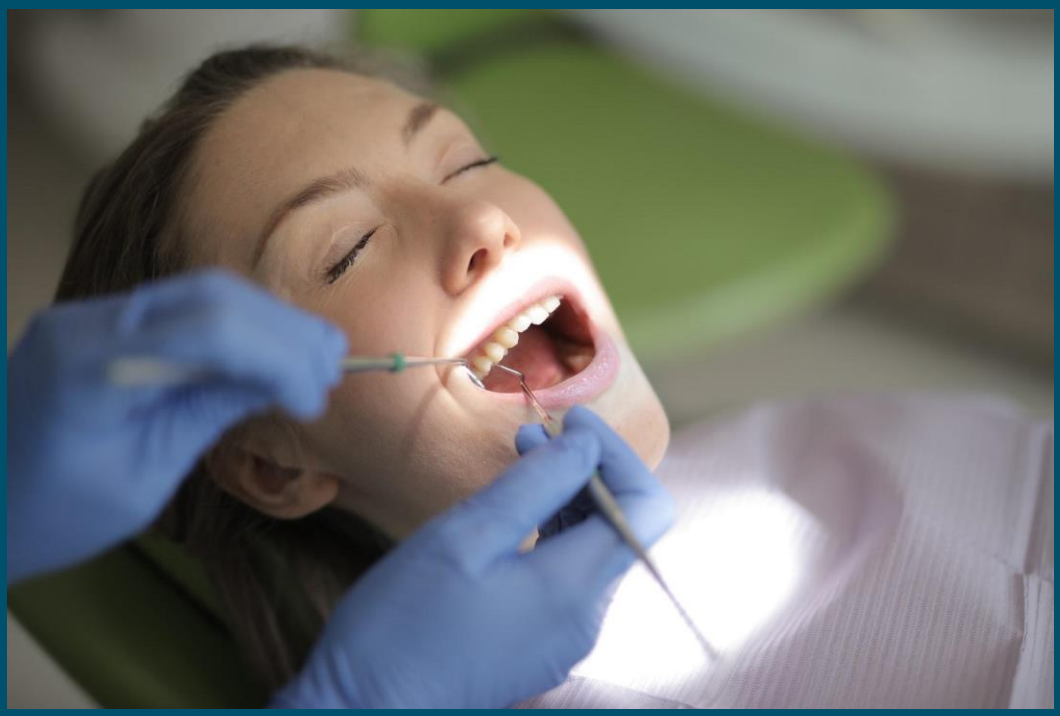
healthwatch Richmond upon Thames

Dentistry Services During Coronavirus



Healthwatch Richmond
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Introduction

Since the beginning of the nationwide lockdown in March 2020, Healthwatch Richmond has received many calls and emails from members of the public regarding dental services in Richmond borough, around 60 at the time of drafting this report and many more since. The feedback from early in the pandemic was shared with Healthwatch England and they were in turn instrumental in pressing for Urgent Dental Care Centres to be set up.

> *"Practices were requested by the office of the Chief Dental Officer to cease face to face treatment on 25th March 2020, following this the London Regional Team (LRT) commissioned a number of Urgent Care hubs and 3 prescribing hubs to facilitate the urgent care, with 40 Urgent Care hubs and 12 Prescribing hubs operating currently."*
>
> ***NHS England's response to this report***

For most of the pandemic, with the exception of a short gap between dental practices closing due to the pandemic and Urgent Dental Centres opening, we were able to signpost people to appropriate support and care.

Dental practices began to reopen later in the year and we were, for the most part, able to help everyone who contacted us to find dental care. However, from 7th September we were unable to identify any dentists who could offer appointments to new patients in a reasonable time frame. After calling several local dental practices, it was clear that most local practices could not see new NHS patients at all or had waiting times ranging from 3-12 months.

To ensure that Richmond residents had access to NHS dentistry we began a project aimed at better understanding the capacity of local dental services during the coronavirus pandemic and people's experiences of accessing care and to make appropriate recommendations on how this service could improve. We did this by:

1. Calling all dental practices in Richmond to identify practices taking or not taking in new NHS patients, and average waiting times for accessing a practice, routine and emergency appointments.
2. Undertaking a survey of people who have accessed or attempted to access dental services in Richmond since the "lockdown", to gather evidence of their experiences and of the capacity of dental services.

The responses from that survey have been collected into this report, and were shared with NHS England and the Local Dental Committee (LDC) for comments, which are addressed in this report and included in full as appendices.

It is important to note for background that people do not need to register with a dentist in the same way as they do with a GP. Similarly, having seen a dentist previously does not mean that you are "registered" with them which is most confusing for the public.

Instead people need to find a dental surgery and phone them to see if there are any dental appointments available. People are also not limited to only visiting a practice within the area they reside in and are therefore able to seek available appointments at any dental practice offering NHS Dental services within London/England

Methodology

We created an online survey to gather feedback from Richmond residents who had either accessed or attempted to access dental care since March 2020.

The online survey was accessible from 6th October 2020 to 5th November 2020. It was promoted by a social media campaign, as well as being shared by local councillors, MPs and local organisations to their service users, supporters and constituents. We received 257 responses. Any responses received after 5th November or comments received by our signposting service were used as qualitative feedback only and are not counted in the quantitative figures.

The survey was promoted online via social media, e-bulletins, and on our website. Local charities were asked to share our survey and many included it in their newsletter and social media channels, as did local councillors and MPs, who shared it with their constituents via newsletters.

Before we launched our survey, we called all dental practices in the borough and inquired whether they were accepting new patients and what the waiting time was to be seen by a dentist for emergency and routine dental appointments. We also considered the 58 calls that we'd received from residents at that point asking for guidance and signposting advice regarding dental care during the pandemic.

Limitations

Due to the social distancing measures prompted by the COVID-19 pandemic, we were unable to survey residents in person, therefore our data collection was carried out entirely online.

This provides limitations for two reasons: the first being that the questions are pre-prepared and filled in individually, which means we are unable to ask follow up questions and inquire further depending on the responses given. The second reason is that not all residents have access to technology such as smartphone, computer or tablet with access to the internet and the ability to complete the survey and are therefore digitally excluded.

This limitation was mitigated to some extent by the fact that we sent out postal surveys inquiring about access to NHS services during the Coronavirus pandemic. These surveys included dentistry as a prompt. We also sent out a Guide to NHS, Care & Support in Richmond in April 2020 to homes across the borough which included details on how to access dentistry and asked people to contact us with any queries or experiences.

These gave people who were digitally excluded the opportunity to raise any concerns that they had and led to 58 contacts being recorded about dentistry outside of the survey. Whilst we are unfortunately unable to identify whether this data is specifically from people who are digitally excluded, we have some confidence that the findings of this report will resonate with people who are digitally excluded.

Findings

256 people responded to our survey and 58 people shared their experience or sought support from Healthwatch Richmond giving a total of 314 people represented by the findings of this report. The findings deal predominantly with the responses to the survey. Findings from those who contacted us directly are used to provide further depth to these.

Whilst the findings of this report are predominantly concerned with primary care dentistry, we have heard anecdotal evidence that suggests that people who need community dentistry (e.g. those with additional needs) involve many similar challenges.

Respondents

Demographics of respondents

There was an even split between respondents to the survey of working age (54.5%) and post working age (54.6%). The population in Richmond is 84% aged under 65 and 16% aged 65 and over so this sample skews significantly towards an older population.

The majority of respondents identified as white or white other (89.1%) which is close to the Richmond population (86%). Relatively few respondents identified as being from a Black and Minority Ethnic background (4.3%) compared to the Richmond population which is 12.4% and 6.6% did not provide their ethnicity. It is therefore difficult to say to what extent the results are representative of the community. However the small actual numbers also mean that we are unable to say anything specifically about the experiences of minority communities.

The majority of respondents reported they had no health conditions (73%) with some reporting a long term condition (15%) or mental health condition (3%). This is slightly higher than would be expected compared to the census data, however the questions asked by our survey and the census were slightly different.

Access to dental services

Of the 256 survey respondents, most had a practice which they accessed regularly before March 2020 (94.1%), 1.6% found a practice after March 2020 and 5.9% were not able to access services with any practice at the time of completing the survey.

Did you access services as a private or NHS patient?	After March 2020	Before March 2020	I do not have a dentist	Grand Total
Private	1.2%	47.7%	-	125
NHS	0.4%	44.9%	-	116
I do not have a dentist		-	5.9%	15
Totals	4	237	15	256

Whilst most respondents already had a dentist which they accessed, younger people were three times more likely not to have a dentist in March 2020 than those over 65 (8.6% vs 2.7%). They are also more likely to have accessed services as an NHS dentist (51.4%) whilst those over 65 were more likely to access services as a private dentist (60.7%).

Booking appointments

Average waiting times

202 people said they had attempted to book a routine appointment with their dental practice, since April 2020.

Days wait for routine appointment	Private	NHS	Grand Total
<1 week	5.9%	4.0%	5.5%
1 week	9.8%	9.0%	24.0%
2-3 weeks	39.2%	8.0%	21.9%
1 month	27.5%	12.0%	10.4%
1-2 months	1.0%	1.0%	1.1%
2-3 months	4.9%	9.0%	7.7%
3-6 months	2.9%	1.0%	2.2%
6 months or more	1.0%	8.0%	4.9%
Not given an appointment	2.9%	46.0%	18.6%
N/A appointment booked before March	4.9%	2.0%	3.8%
Grand Total	102	100	202

Routine appointments

A total of 202 people said they attempted to book a routine dental appointment. Whilst there are differences in how quickly people are able to access care as private patients (82.4% within 1 month) or as NHS patients, (33.0% within 1 month), it is difficult to say whether or not this is a reasonable or significant difference.

What is clearly significant however is that almost half the people seeking NHS care (46.0%) were unable to book a routine appointment at all compared to only 3 patients (2.9%) seeking private care. **People who are able to pay were therefore almost 16 times more likely to have access to dental care than those who are not able to pay**.

In support of this, 30 out of the 58 contacts received by Healthwatch Richmond were from people seeking help with accessing routine NHS dental care.

Satisfaction with routine appointments

Not all respondents provided a rating of their routine care with those who were unable to access care not able to provide a rating.

How would you rate the quality of care you received?	Private	NHS	Not able to access dentistry	Grand Total
1 - Very Poor	3.3%	21.3%	100.0%	11.2%
2 - Poor		4.9%		2.0%
3 - Neither poor nor very poor	4.4%	3.3%		3.9%
4 - Good	13.3%	19.7%		15.8%
5 - Very Good	78.9%	50.8%		67.1%
Total	90	61	1	152

Those who received care were largely positive in their ratings with 82.9% of NHS and private patients rating their care positively.

It appears from the table above that NHS patients are 8 times more likely than private patients to rate their care negatively (26.2% vs 3.3%). The narrative responses however suggest that inability to access care rather than the quality of care received is behind the lower satisfaction with NHS care. Indeed, the same is true of neutral ratings of care.

Of the 24 people who provided neutral or negative ratings of care and narrative responses:

- 2 in 3 spoke about being unable to access care (16 responses).

They still haven't called me back to make the appointment

I haven't been able to see a dentist at all

- 1 in 3 said that they were, or felt that they were, treated differently because of ability to pay for treatment (8 responses).

Because I think they are giving preference to private patients

I feel like they don't care as I'm an NHS patient and can't afford to go private

I have been diagnosed with a gum disease that needs treatment but refused treatment because I am an NHS patient

I could not get any care - they wanted to charge £250/filling because of COVID

Increased charge from about £50 to £95 due to COVID so I declined

being registered as an NHS patient but having to go private I thought was taking liberties of the covid situation.

…there is long waiting list for crowns on the NHS. The alternative to go privately at £550 I declined as I didn't feel it was an emergency, however, I am now on the NHS waiting list.

Conversely across both NHS and Private groups, those rating their care positively, (126 people), most comments related to the quality of care (52) and to how Covid secure the care that they received was (31).

Excellent reception; fabulous first class dentistry; friendly, professional, caring

This practice gives a high standard of care - patient focussed; good communication; attentive; pro-active.

The dentist was professional, thorough, polite and explained everything she performed during the dental examination.

Appointment started on time, surgery ensued no waiting, clear distancing procedures in place, dentist was thorough and clear about treatment

Scrupulously clean and Covid procedures in place.

The process and Covid 19 precautions were explained to me via email and again on the phone when I booked the appointment. The dentist was wearing full PPE and made me feel very confident in her and my safety. She explained every aspect of my appointment as she carried it out.

For a small number of people rating their care positively (6), their care was impacted by Covid however it is clear that they were understanding of the reasons behind this:

The hygienist was not able to use advanced equipment and so the process was slower and less comfortable

I was seen fairly quickly but had to wait for the crown (high speed drill wasn't allowed)

Emergency Appointments

77 people said they attempted to book an emergency appointment.

How did you manage to book an emergency appointment?	NHS	Private
By calling the practice directly	60.0%	78.4%
I was unable to get an appointment	32.5%	16.2%
Via NHS 111	7.5%	5.4%
Grand Total	40	37

Private patients were more likely to be able to access emergency care (82.1%) than NHS patients (68.4%). It is notable that 1 in 3 NHS patients were unable to access urgent or emergency care. This is twice as many as for private patients (1 in 6), however the limited access for both groups of patients is clearly concerning.

How would you rate the quality of care you received?	NHS	Private
1 - Very Poor	35.0%	8.1%
2 - Poor	0.0%	0.0%
3 - Neither poor nor very poor	10.0%	8.1%
4 - Good	10.0%	13.5%
5 - Very Good	45.0%	70.3%
Total	40	37

Those patients who accessed services privately were much more likely to rate their emergency care positively (88.8%) than those who accessed services as NHS patients (55.0%).

As with routine care however the difference in rating appears to be less related to actual quality and more closely correlated to access and ability to pay for dental care. This is confirmed by the narrative and indeed by members of the public contacting Healthwatch Richmond for support outside of this survey.

Positive experiences

Of those who gave positive ratings, the most common reasons for this were because of the quality of care or staff (30 comments), the care being provided in a Covid secure manner (14 comments) and the speed at which care was organised (7 comments). Those who provided positive comments frequently referenced more than one of these factors.

Everything was first class: covid secure, courteous and respectful

Feeling of safety, speed of getting appointment, friendliness of staff, quality of care

The problem was diagnosed swiftly and dealt with appropriately.

Amazingly careful Covid procedures, and the treatment itself was excellently done.

Negative experiences

For those who rated their experience of accessing or trying to access emergency care less favourably (17) this was because they had not been able to access care (11), had experienced long waits for care (4) or had to pay privately for the care that they needed (6).

People rating their experience negatively often referenced having no option other than to use private dental care or to go without care because NHS dental care was unavailable (6). Several people made comments suggesting that they felt their dentists were profiteering unreasonably from the circumstances caused by coronavirus.

I was very relieved to get the appointment but being registered as an NHS patient and having to go private I thought was taking liberties with the covid situation.

I was unhappy with the way he approached my treatment and I felt I was just someone from whom he could make money…. being 75 and on a fixed income, I tried to find a practice that took NHS patients. Every dentist I approached in Teddington, or Twickenham, refused to take me on as a NHS patient

I feel like they don't care as I'm an NHS patient and can't afford to go private. Very bad as I've been in constant pain and I don't know when I can get it sorted

The wanted to charge me £6,500 to replace a cap

No hygienist appointments available under NHS, dental surgery advised to go private which is nearly double the NHS price. Patients having financial issues already in the difficult time of Corona expect some discount rather pay extra

People spoke strongly about the impacts of this care on their wellbeing and on their mental health:

The care was fine; the wait was disgraceful. It greatly impacted me. Being in pain for prolonged periods is very draining. I found it utterly barbaric that I was unable to get much needed dental treatment for months on end. It was very stressful

It's affected my health & wellbeing worrying about my teeth

They left me in pain with an abscess and still haven't returned my call. I suffer from anxiety and depression which I am on medication for and being left in pain with nowhere to turn was awful.

depressed beyond measure

Agonising pain

Fractured tooth- in severe pain

Tooth is infected and the gum area is swollen and puss is there, in a lot of pain since March

Conclusions

Lack of capacity

By triangulating the experiences of 314 Richmond residents who responded to the survey or contacted us for help with accessing care, we are confident that there is a significant lack of access to NHS dentistry for our residents.

The impact of not being able to access care is clearly significant for patients with implications for their physical and emotional health and, in some cases at least substantial financial implications. It is also widespread with almost half (46.0%) of those unable to pay privately being unable to access routine care and almost 1 in 3 (32.5%) of those needing emergency care being unable to access it unless they can pay.

Whilst the impact of the pandemic on dentistry is stark, we know from speaking to dentists as part of our work that they have worked tirelessly to provide care for their patients since the pandemic began.

The level of provision clearly does not meet the needs of the community it serves and, combined with several months without regular dental services operating, there is a significant backlog of unmet need. We asked NHS England to explain why such significant numbers of local residents are unable to access NHS dentistry and to provide a sense of the scale of the backlog of dental care that has been created by coronavirus. They told us that:

> *"Practices were requested by the office of the Chief Dental Officer to cease face to face treatment on 25th March 2020. Following resumption advice in July, practices were asked to ensure a minimum contract delivery of 20% to end December of their full contract levels. Furthermore, The Office of the Chief Dental Officer wrote to all contract holders in December to advise they had worked closely with the government to determine a safe and reasonable contractual arrangement from 1 January to 31 March 2021 and practices are required to deliver 45% of contracted units of dental activity. However, we must note that services are not up to 100% which means the backlog will keep growing."*

It is clear from this response that the backlog of unmet dental need is significant and growing. We also asked NHS England to provide an explanation of what can and will be done to improve access to dentistry. They told us that:

> *"Following guidance to resume services from 8th June… Practices are prioritising children due to reduced capacity through dental surgeries as a result of social distancing, the use of enhanced PPE and the fallow time required following aerosol generating procedures (AGPs). Therefore, Practices are catching up with incomplete treatments that commenced before dental treatment stood down in March, following this practices plans would be to invite existing patients for routine check-ups and reviews and to start providing services to new patients.*
>
> *It is encouraging that your survey of patients confirms that practices have resumed dentistry and treatment is available on the NHS, and in line with guidance it does appears that they may be prioritising urgent cases."*

We also asked the Local Dental Committee (LDC) for comment on this report and they confirmed that dental services will continue to be affected by the backlog of treatment and the unmet needs of patients for some time. They also said that patients and the

public need a clear and honest message about what they can expect from NHS dentistry currently.

The Local Dental Committee provided us with important context on why it is so difficult to increase the supply of dental care:

> *"The guidance provided to the profession in England is at variance with the rest of Europe and is far more restrictive. The current ventilation guidance requires a surgery to have up to 10 air changes an hour. This can only be best achieved with mechanical ventilation which replaces all the air in a room quickly to dissipate any viral loads in the air following dental treatment. Many practices did not have this ventilation in place already, and many may be unable to install it if they are in listed buildings or are renting the property. This reduces the capacity of practices to see patients.*
>
> *Dental practices do not receive capital funding from the NHS [i.e. to install mechanical ventilators]. Instead they have to fund all improvements to the practice themselves. In the current circumstances this will mean taking loans to cover improvements, without the ability to expand their business to cover the cost of development. Most practices have a mixed income model, with both NHS and private work. While the NHS funding remained the private income has reduced, but costs have remained fixed. This has placed practice finances on a precarious footing making investment more difficult."*

It would be easy to be critical of the lack of planning for resumption of normal dental care, however this would ignore the support that NHS England have provided to practices which have enabled them to return to 45% of normal care. Whilst the resumption of 45% of normal care will have some on reducing the challenges that our community experience with accessing dental care it will not reduce the backlog and despite this, people are still contacting us after experiencing significant challenges with accessing care.

Without either additional funding to enable dental practices to increase their capacity further, or a change in the restrictions it is likely that the number of people impacted by this will continue to grow whilst the pandemic continues.

NHS Patients having to pay for care

Some respondents expressed concerns about dentists *"profiteering"* from the pandemic. It is difficult to reconcile these sentiments with the consistently highly ratings of care from those who were able to access the care that they needed.

We asked the Local Dental Committee to provide an explanation of this. They told us that the amount of NHS care commissioned is insufficient which means that dentists may be unable to provide NHS care to everyone who needs it. They also noted that because dentists are only able to provide NHS care within their NHS registered clinics, even if they have capacity within a separate private clinic, they are not allowed to use it for NHS care:

> *"Private dental services exist because the NHS dental budget is insufficient. At December 2019 less than 50 per cent of the adult population of England had visited an NHS dentist in the last two years [32.9 per cent of adults and 49.9 per cent of children in Richmond had visited an NHS dentist].*
>
> *The current NHS dental contract prohibits dentists from providing NHS care outside of the named location of their dental practice. If they do not have a specific domiciliary contract they cannot provide care under the NHS in another location"*

A national issue
Work by Healthwatch England (of which it should be noted the early findings of this report form a significant part) details the experiences of 1,300 people across the country. It echoes our findings and confirms that these findings are widespread and of national importance.

Like us, Healthwatch England found that people are struggling to access NHS dentistry because practices do not have NHS appointments available for many months, or even indefinitely.

Their findings also align with ours in that many people are unable to access urgent or emergency care, resulting in people left with debilitating pain, anxiety and worsening problems requiring additional treatment.

The key cause of both the Healthwatch England findings and ours in Richmond appears to be the acute reduction in capacity caused by coronavirus.

Whilst coronavirus is the obvious primary cause, the context of reducing NHS capacity in the years before the pandemic are likely to have exacerbated this to some extent. This reduction in capacity for Richmond alone is equivalent to almost 40,000 fewer Band 1 treatments (e.g. check-ups) in the 5 years to the start of the pandemic.

"In 2014/15 there were 1,374,424 UDAs by 2019/20 this had fallen to 1,335,160 UDAs commissioned in Richmond" ***- Local Dental Committee***

Recommendations

Whilst our report relates to local provision, and we must call for local improvements, it is impossible to ignore that dentistry is a national issue. It is clear that a substantial backlog of care exists, is very likely to be growing, and that this is repeated across the country.

Given the findings of this report and our understanding of the challenges that dentists face, we are not assured that access to NHS care will improve sufficiently until some considerable time after restrictions on dental care can safely be removed.

The very limited availability of dentistry continues to have a significant impact on our population over the pandemic. It is clear that more needs to be done to increase capacity and nationally led action is indicated to address this both here and across the country as a whole.

There is a concerning view amongst this data that the public believe that dentists are profiteering from the pandemic. This sentiment will continue to grow until capacity is restored and may undermine trust in NHS dentistry.

Some people felt that dentists were unreasonably withholding NHS care to drive more private work. Whilst we can't draw conclusions about this, NHS England should assure themselves that this is not the case.

This view is likely to increase as capacity issues mean that many people cannot access NHS care. Clear and honest communication from NHS England to the public is necessary to set realistic expectations and ensure that the challenges in NHS dentistry capacity do not undermine confidence in NHS dental care.

Appendix 1. NHS England Response

NHS England Regional Team has been working closely with all providers of primary and secondary care, supporting practices to follow National guidance as determined by the Chief Dental Officer throughout the Coronavirus outbreak.

Practices were requested by the office of the Chief Dental Officer to cease face to face treatment on 25th March 2020, following this the London Regional Team (LRT) commissioned a number of Urgent Care hubs and 3 prescribing hubs to facilitate the urgent care. Currently we have 40 urgent care hubs and 12 prescribing hubs. The team supported the Urgent Care Hubs to ensure distribution of Protective Personal Equipment (PPE) and re-deployed staffing from dental practices to these services through volunteering. We agreed a revised patient pathway from NHS 111 to Dental Nurse triage. This service was initially provided telephone triage from 5pm to 8am and received around 12,000 calls a month growing to providing 24hour services and receiving up to 40,000 calls per month

Following the Office of Chief Dental Office's (OCDO) guidance to resume services from 8th June, we asked practices to complete a declaration once they were ready to resume services having put in place their BAME staff risk assessments, PPE equipment, Fit test training as well as infection control measures. Some practices were not ready to resume face to face services until late in September, further impacting resumption of services.

Furthermore, the LRT have supported practice with a programme of Fit testing for all providers and their staff which was sourced by us this included fit testing and fit test training for all Urgent Dental Care Hubs, enabling all practices to deliver aerosol generating procedures. Our infection control team arranged several seminars and literature to support providers in their arrangements to keep patients safe. The LRT received in excess of 500 emails on some days from practice requesting support and advice following the directive to resume services.

LRT supported practices to ensure they were following the Standard operating procedure issued by the OCDO for England on 13th July 2020. The directive contained clear guidance for practices as to how they should provide care to patients and resume dental services. All forms of dentistry are currently embarking on the resumption of services and are prioritising urgent care and priority is being given to urgent cases and the existing backlog of patients already under the care of practices.

Practices are also prioritising children due to reduced capacity through dental surgeries as a result of social distancing, the use of enhanced personal protective equipment (PPE) and the fallow time required following aerosol generating procedures (AGPs). Services included treating emergencies for pain relief, providing fillings, root canal treatments, and extractions which has been evidenced through their contractual activity.

Practices are catching up with incomplete treatments that commenced before dental treatment was stood down in March. Following this practice plans would be to invite existing patients for routine check-ups and reviews and to start providing services to new patients. There has been joint working of the LRT and LDC working alongside each other with regular weekly meetings to discuss the issues facing the profession and how the commissioning team could support.

In addition, we have received several enquiries via MP letters, our customer contact teams and our internal complaints team. We have supported these enquiries by understanding

access concerns and liaising with NHS 111, dental nurse triage services and providers themselves to ensure patients can receive the necessary urgent treatments.

More recently the Department of Health and Social Care (DHSC) are leading on the supply and distribution of PPE i.e. for practices. Practices are responsible for ensuring PPE stock levels and it is not something NHSEI can directly control but we are aware that practices have registered on a central portal to obtain supplies.

For practices the period from March to date has had minimal financial impact as practices continue to be paid at pre-covid levels. Following resumption advice in July, practices were asked to ensure a minimum contract delivery of 20% to end December of their full contract levels. Further advice post September regarding contract activity levels has now been issued by the Chief Dental officer and is being worked through with the LDC.

Furthermore, The OCDO wrote to all contract holders in December to advise they had worked closely with government to determine a safe and reasonable contractual arrangement from 1 January to 31 March 2021 and practices are required to deliver 45% of contracted units of dental activity. In addition, practices can also access free COVID19 related PPE.

It is encouraging that your survey of patients confirms that practices have resumed dentistry and treatment is available on the NHS, and in line with guidance it does appears that they may be prioritising urgent cases.

In 2006 when the new contract was introduced, there is some disparity across London with regards to “Units of Dental Activity” (UDA) allocations. NHS England (London Region) has sought to address this since becoming the responsible organisation for the commissioning of dental services in April 2013.

Where there are opportunities to reinvest in dental services or re-commission services, an oral health needs assessment is undertaken to identify areas of need and priorities for investment to help ensure there is greater equitable access for patients by ensuring that each borough has a provision which is more appropriately matched to the level of need within the existing budget.

With regards to current contractual arrangements with practices, the total UDAs contracted to be delivered by a practice are for each financial year, and there is an expectation that a practice will monitor performed UDAs and manage the flow of patients/treatments such that it can treat existing patients over the full 12 months. When a practice is unable to accept new patients they should direct them to the NHS Choices website (www.nhs.uk) or to dial 111 so that the patient can find details of other practices in the area that are able to accept new patients.

Finally, it may be helpful to advise that due to patient choice, patients are not limited to only visiting a practice within the area they reside in and are therefore able to seek available appointments at any dental practice offering NHS Dental services within London/England.

Appendix 2. Local Dental Committee Response

Kingston and Richmond LDC is pleased to see the interest that Healthwatch Richmond has taken in the provision of primary care dental services. The findings are very concerning for both the public and dental professionals, and reflect many of the longstanding concerns of the profession. Healthwatch Richmond made several requests of the LDC and we provide our responses below. We hope that the responses are helpful, and if any clarification is required we would be very happy to expand on them. We look forward to a long and constructive relationship with Healthwatch Richmond so that together we can work for improved primary care dental services in the borough.

Healthwatch Richmond has asked the LDC to provide a timeline of events of covid-19 for dental practices. We will provide a topline chronology but can provide a more detailed one on request.

25th February - LDC Confederation circulates newsletter with coronavirus guidance and public health messaging.
16th March - dentists told they do not need FFP3 masks in GDS, CQC stops inspections
18th March - in the absence of directives to dentists in England from the Chief Dental Officer or NHS the LDC Confederation recommends that dentists in England follow guidance issued in Scotland and Wales.
25th March - Chief Dental Officer in England writes to practices ceasing all face to face care. Ambiguous wording and lack of clarity causes confusion for private dentistry as it is not clear if they are included in this directive. Practices with NHS contracts start offering telephone triage.
18th April - Flowchart for referrals to Urgent Dental Care Centres in London is issued and circulated by LDC Confederation.
28th May - Government announces that dental practices will be open from 08 June, dentists hear this on the news the same as patients. No communication nor preparation time to ensure adequate stocks of PPE (most dentists did not try to order PPE as they did not want to divert limited stocks away from hospitals).
08 June - In theory practices able to open for face to face care if they have adequate PPE and ventilation.
21 December - London moved into tier 4.
22 December - Quarter four targets for UDA attainment from 01 January 2021 are announced to dental practices. Practices have to achieve a minimum of 45 per cent of their normal UDA activity.

Healthwatch Richmond requested that the above timeline was placed in context. This is very important as we did not want to put down every date that new guidance was issued or other minutia above.

Communication with the profession: Communication with the profession in England was generally poor. The London region team has been meeting regularly with the LDC Confederation and we welcome the clear and honest dialogue this facilitated. Working together with the London Commissioning team we were able to discuss solutions such as the increased service provision of the dental nurse triage in NHS 111, the establishment of urgent dental care hubs and prescription hubs, and to discuss issues as they arose. Some webinars were hosted by the Chief Dental Officer, but these were not discursive and did not provide the answers many were looking for. The LDC Confederation hosted two webinars for all dentists in London and the LDC has hosted webinars for local practitioners to receive and discuss updates. We have been fortunate to be joined by the Chair of the London Dental Network at these meetings.

Guidance: The guidance provided to the profession in England is at variance with the rest of Europe and is far more restrictive. The current ventilation guidance requires a surgery

to have up to 10 air changes an hour. This can only be best achieved with mechanical ventilation which replaces all the air in a room quickly to dissipate any viral loads in the air following dental treatment. Many practices did not have this ventilation in place already, and many may be unable to install it if they are in listed buildings or are renting the property. This reduces the capacity of practices to see patients. Dental practices do not receive capital funding from the NHS. Instead they have to fund all improvements to the practice themselves. In the current circumstances this will mean taking loans to cover improvements, without the ability to expand their business to cover the cost of development. Most practices have a mixed income model, with both NHS and private work. While the NHS funding remained the private income has reduced, but costs have remained fixed. This has placed practice finances on a precarious footing making investment more difficult.

PPE supplies: Many practices were not ordering PPE as they recognised that there was a shortage and if they were not engaged in face to face treatment they did not want to divert limited stocks away from frontline care. When practices heard on the news that they were to reopen for face to face treatment many struggled to find any supplies of even basic PPE such as gloves and aprons. This meant that many could not open on 08 June as announced. Furthermore, in order to provide dental treatments dentists and their teams need to wear advanced PPE called FFP3 masks, which have air filters and cover the face. These were not only in short supply but also require fit testing to ensure that they are air tight. Not every mask will fit every face so practices would need to test multiple masks for each staff member. They would also need to be fit tested by someone who was appropriately trained. Most fit testers usually test the fire brigade and other services. There was a shortage of appropriate testers in London for dentists to access. The issues with getting these masks also delayed the opening of many practices for face to face treatment. With the supply of FFP3 masks being low the cost was high and dental practices did not receive any additional funding to cope with the cost. The dental commissioning team did provide fit training and testing which was helpful, but still practices are dependent on the supply of masks that fit. Each time a model changes a new fit test is required. Despite the expectation that dentists would start seeing patients from 08 June it was not until September that dentists were able to register on the central government PPE portal to order supplies. Until November FFP3 masks were not available on the portal, and even though they are now the aforementioned issue of fit testing remains.
Working in PPE is extremely tiring and emotionally draining. As mentioned the FFP3 masks are sealed which makes them extremely uncomfortable for long use, yet once removed they must be disposed of. In addition, the other PPE such as aprons, are also water tight which makes them extremely hot and uncomfortable to wear. This creates a situation where someone wearing full PPE will get extremely hot, but be unable to drink because they cannot remove their mask. Many FFP3 masks also make it difficult to use certain dental equipment (such as loupes for magnification) inhibiting the type and level of care that can be provided in some circumstances. Dentists and their teams want to provide as much care as possible to their patients, but given the additional physical and emotional burdens that they work under means that the volume of care will be reduced.

Communication with patients and the public: There has been little effort to communicate to the public about dental services beyond vague generalisations that have complicated matters. The LDC produced some public facing text for local healthwatch and local authorities to use to let the public know more about what to expect in the absence of any centralised messaging and hope that this has provided some benefit. We were extremely disappointed to see that patient charges for NHS dental services increased from 14 December by 5 per cent. Additionally we were disappointed that this is not communicated by the NHS or Department of Health who instead leave it up to practices to

explain to patients. On 28 May it was announced that dentistry would be restarting from 08 June. No context was given and there was no management of expectations. The NHS emailed a poster for practices to stick up. With limited resources dentists have to prioritise those in the most need, those with urgent problems and delayed treatments. Yet patients had been given to understand that routine care would now be available as though nothing had ever happened. This has caused confusion and a great deal of anger, understandably.

Access to Dentistry. Healthwatch Richmond has asked for our account of access in Richmond and whether access is determined by the ability to pay. NHS dental charges are set by the Department of Health. The practice only collects the charge which is then passed on to the NHS. Private dental services exist because the NHS dental budget is insufficient. At December 2019 less than 50 per cent of the adult population of England had visited an NHS dentist in the last two years. The current NHS dental contract prohibits dentists from providing NHS care outside of the named location of their dental practice. If they do not have a specific domiciliary contract they cannot provide care under the NHS in another location. Some key figures for Richmond are:

- Excluding the City of London Richmond has the lowest spend for NHS dental services in London.
- There are 20 practices in Richmond with an NHS primary care contract.
- There are 54 dentists working under those contracts (these are not whole time equivalents).
- Up to December 2019 32.9 per cent of adults in Richmond had visited an NHS dentist and 49.9 per cent of children in Richmond had visited an NHS dentist.
- In the financial year ending in March 2019 practices in Richmond had achieved an average of 94.9 per cent of their allocated contract amounts.
- In 2014/15 there were 1,374,424 UDAs by 2019/20 this had fallen to 1,335,160 UDAs commissioned in Richmond.
- South Richmond is the ward with lowest NHS dental access at 29 per cent while Heathfield is the highest is at 56.2 per cent.

To place the above in context; dentists are contracted to deliver a set number of Units of Dental Activity (UDAs) in a contracted year. These UDAs are grouped together into 3 Bands. Patients will receive a Band 1, 2 or 3 course of treatment when they attend a practice, with the attendant NHS patient charge. Each Band credits the dentist with a number of UDAs against their contract. Band 1 treatments deduct 1 UDA from the target, Band 2 treatments deduct 3 UDAs and Band 3 treatments deduct 12 UDAs. If a patient requires more than one sort of treatment then all the costs are wrapped up in to the highest Band. Similarly, if a patient requires more than one type of the same treatment in the same Band they will pay only once, and the dentist will receive only the single allocation of UDAs against their target too. For example:
This means that if a patient needed a single crown they would pay £282.80 and the practice would be credited with 12 UDA. The cost of the necessary dental laboratory work involved comes out of the practice income (i.e. the 12 UDAs). In a case where a patient requires three crowns the patient still only pays £282.80 and the practice still receives only 12 UDAs, but now has to pay the dental laboratory for three crowns rather than the one crown. Against their target the practice will have spent much more time with this patient but it will appear from the UDA perspective as though they have seen a patient who only needed one crown. This system means that a practice that sees patients with high needs will be penalised as they will not only incur higher costs but will also fail to meet their UDA target as they will have less time to provide care to other patients.

The figures above also show that if 95 per cent of contracted activity is delivered and 33 per cent of adults are seen and 50 per cent of children that there is simply not enough activity available commissioned by the NHS. During a pandemic this chronic underfunding and perverse contract has simply exacerbated inequalities.

Healthwatch Richmond has asked what can be done about NHS dental services. In our opinion the entire contract needs to be re-evaluated, NHS dentistry needs to be properly funded to reflect both patient expectation and need, primary care dental services need to be put on a par with primary care medical services and a system of funding to support IT integration needs to be put in place. NHS England is currently consulting on the future of Integrated Care Systems, and part of this is asking if dental services should be managed at the more local level. If this resulted in dental services being funded in a way that helped them serve the same population as GPs and supported integration this would be a positive step. In the meantime we consider that greater use needs to be made of flexible commissioning. UDAs are a poor system but they can be used more effectively than they are currently. Boosted UDA allocation for targeted interventions on specific patient cohorts could help reduce the health burden and health inequalities.