Written evidence submitted by Healthwatch Richmond (DTY0068)

Background

Healthwatch Richmond was set up by the Health and Social Care Act 2012. Our relevant duties as set out in the Act with respect to this submission are to:

- Obtain the views of people about their needs and experience of local health and social care services,
- Make these views known to those involved in the commissioning and scrutiny of care services
- Make recommendations about how those services could or should be improved
- Provide information and advice to the public about accessing health and social care services and the options available to them.

In the pursuit of these statutory activities, we have heard from over 600 residents of the London Borough of Richmond upon Thames and have helped around 300 people, who could not otherwise find NHS dental services, to access care.

Around half of these experiences were collected in late 2020 and are detailed within our report *Dentistry Services During Coronavirus*, published in February 2021[1]. This report, which found that half of patients were unable to access dental care unless they could pay, was submitted to NHS England prior to publication. Its conclusions provided an early warning of the impending crisis:

"It is clear that a substantial backlog of care exists, is very likely to be growing, and that this is repeated across the country…. The very limited availability of dentistry continues to have a significant impact on our population. 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."

Whilst we commend our published report to the Committee as evidence in its own right, this submission goes beyond that report and details the unpublished experience and insight that we have gained from our statutory activities, speaking to and supporting a large number of our residents to access care. We also consider available data and concludes that the crisis in NHS Dentistry is fuelled by:

1. insufficient capacity within NHS dentistry
2. the inability of patients to access that NHS dental capacity.

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

1. Improve the functionality of the NHS.uk website to enable people to search for NHS dentists offering appointments to their category of patient.

Finding a dentist that accepts NHS patients has been a major challenge for patients since the start of the pandemic and this situation is at best not improving and at worst deteriorating:

- Prior to March 2020, dental enquiries accounted for 8.4% of our statutory activity to *"Provide information and advice to the public about accessing health and social care"*.
- In the year to date, this has risen to 32.1% of this statutory activity.

[1] *Dentistry Services During Coronavirus, Healthwatch Richmond, February 2021*

The reason for this is that, whilst capacity is limited, available capacity is impossible for many people to identify. Most reasonably accessible information points to this NHS website: https://www.nhs.uk/service-search/find-a-dentist

The search function provided by this nhs.uk page returns the nearest 50 dentists, irrespective of whether or not they are taking on NHS patients. Evidence (see item 3 below) shows that less than 1 in 50 dentists are accepting NHS patients. As a result, in many areas of the country, including most of the area that we serve, when correctly used, the nhs.uk website that patients are directed to use to find an NHS dentist will return a list that includes 0 dentists taking on NHS patients.

Of the 300 local residents who have contacted us for help, many have already tried calling many, sometimes all, of the dentists on this list without success which demonstrates that the public have no realistic prospect of finding an NHS dentist via the existing system.

Were the search function on nhs.uk altered to return dentists taking NHS patients, most people would be able to find an NHS dentist that could see them relatively easily. The insufficient capacity, which we evidence in item 3, would then become a more acute challenge.

2. Enforcing the requirement for dentists with NHS contracts to keep the NHS updated on whether or not they are taking on NHS patients.

Dentists holding NHS contracts are contractually obliged to *"update the NHS website regularly to make it clear which practices are taking on new patients and the services available, improving access"* [2]

We reviewed the records of the 50 nearest dentists to our office. Only 6 could have been considered to have met this contractual obligation, over half had not provided any update for more than 2 years and often considerably longer. Without this information being kept up to date regularly by dentists, it is unlikely that:

- NHS England can be assured of the actual capacity within NHS Dentistry (should that figure differ from the 2% we evidence under item 3)
- Patients can realistically identify practices that are likely to offer them NHS care

The contractual obligation announced on 28th November 2022 should be enforced and compliance monitored regularly.

3. Increase the capacity of NHS Dentistry

NHS Dentistry Capacity has deteriorated since the start of the pandemic and indeed since our February 2021 report.

- In 2020/21 we were able to identify one or two dentists taking new NHS patients with the London Borough of Richmond upon Thames. We have been unable to identify any provision within the borough for the past year.
- At the time of writing this submission, <2% of NHS dentists (less than 1 in 50) have advised the NHS that they are accepting new patients (Sources: 1.93% from national NHS.uk data aggregated by dentalchoices.org.uk, 1.46% source NHS.uk[3])

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[2] *New measures to improve access to dental care,* https://www.gov.uk/government/news/new-measures-to-improve-access-to-dental-care, published 28 November 2022

- The NHS dental statistics for England dashboard provides evidence of the scale of the NHS Dentistry Crisis. NHS dentistry delivered 32.3 million fewer Courses of Treatment, or 70.4 million fewer Units of Dental Activity (UDAs), between April 2020 and March 2022, the latest date for which data is available, compared to the levels delivered 2019-2020:
    - There were 23.3 million fewer courses of treatment (COT), or 48.7 million fewer Units of Dental Activity (UDAs), delivered in the year from April 2020 and March 2021 than in 2019-2020
    - There were 9 million fewer COT, or 21.7 million fewer UDAs, delivered in 2021-2022 than in 2019-2020.

No data for 2022-2023 is currently available. Our experience of this period does not suggest that NHS dentistry is recovering. Without this data, it is difficult to accurately understand the scale of the crisis. The scale of the lower performance during 2020-2022 (-32.3 million COT, -70.4 million UDAs) is compelling evidence that there is considerable unmet need within NHS Dentistry. It is likely that this cumulative unmet need will create demand beyond that which existed before the pandemic and therefore require increased capacity to meet.

Any solution therefore needs to recognise and articulate both the extent of the unmet need that built up from 2020 to date, and set out how this to plan for recovering from this.

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

The role of ICSs in improving dental services is limited given that the main drivers are capacity and accessibility and the evidently significant scale of the crisis.

For ICSs to play a role in integrating or locally targeting dental care, and there is clear value in this, patients would ideally access dental care from within their system. Unfortunately, current capacity of <2% NHS contracted dentists taking on new patients does not allow this. Often the nearest NHS Dental provision is some distance from a person's ICS footprint, indeed in many cases it is in a neighbouring region which limits the role that ICSs could play. Indeed, it is unclear how NHS dentistry funding would work on an ICS footprint basis.

The highest priority should be given to creating additional capacity within ICSs to meet currently unmet needs whilst retaining patients within the ICS footprint. Whilst it is likely that more funds will be required to pay for additional capacity, it is feasible that unspent funding from underperforming contracts could be used to deliver additional capacity within the ICS. This capacity should be used to:

1. Provide primary care dentistry to people who have had temporary emergency dental care, resolving their needs and reducing the revolving door of temporary Emergency NHS Dental care.
2. Provide care to those people unable to register with a dentist within their Place and unable to reasonably access alternatives within their ICS.

Our understanding is that ICSs in London are making arrangements to manage NHS dentistry at a regional level due largely to capacity pressures involved in managing NHS Dentistry at an ICS level. In many respects this limits the role of ICSs and it is unclear what benefits this has over the status quo.

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[3] Spreadsheet available from nhs.uk, checked 22/01/2022: https://www.nhs.uk/service-search/other-services/Dentists/TW2-6QS/Export/12/-0.343725949525833/51.4455070495605/3/0?distance=25&ResultsOnPageValue=100&isNational=0&totalItems=1670¤tPage=1,

The transfer of responsibility to ICSs presents significant risk and unclear benefits in the short term. It is also unclear how success would be judged as no baseline is available from which ICSs can be judged on whether they improve care or not. This baseline should include a full and fair assessment of need, including the backlog of undelivered COTs/UDAs accrued during the pandemic and the pressure that this creates on the system, as well as the current capacity within NHS dentistry.

It is likely that this baseline will identify the need for additional financial investment over several years to resolve the backlog, return NHS Dentistry to an acceptable level of provision within a reasonable period of time and to improve access for the population.

How should inequalities in accessing NHS dental services be addressed?

Currently access is inherently unequal as it is not based on need. Those with access to the internet and private transport are better able to identify and access NHS Dentistry services as they can both search and travel over a wider radius.

We have evidence, though it was more widely reported by the BBC investigation, to suggest that some people are at higher risk of being overcharged for NHS dentistry. Examples of this include parents being required to register with a dentist as a private patient to secure NHS dentistry care for their children (also reported by the BBC), and people prepaying for "NHS dental treatment" but then being offered only private treatment options with additional costs beyond the NHS Bands.

Vulnerable people, parents, pregnant people, those with English as an additional language, digitally excluded people and those with limited mobility or without access to private transport are particularly at risk of this unequal treatment as they are less able to access alternative NHS dentistry provision.

Should ICSs have success in improving NHS Dentistry, it is likely that, because new patients will need to register outside of their ICS, that this will disproportionately benefit those who were registered with dentists before the pandemic. This will create inequalities for those who were not associated with a practice prior to the pandemic. These inequalities are likely to disproportionately impact people who have moved including, but not limited to students, migrants, refugees, older people, young children and their parents.

Does the NHS dental contract need further reform?

We are not placed to comment on this.

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

We are not placed to comment on this

Jan 2023