The Impact of COVID-19 on Access to Dental Services

COVID-19 has had a greater impact on dentistry than some services due to the close proximity dental teams are in when treating patients with an open mouth in a confined space. Social distancing in waiting rooms and additional infection, prevention, control measures (IPC) within surgeries must be adhered to in order to reduce the risk to dental teams, patients and the wider population. IPC guidelines include specific requirements when undertaking Aerosol Generated Procedures (AGPs) which are used for treatment including fillings, scale and polish, root treatment and crown preparation. This requires a fallow time after treatment to allow aerosols to settle before an enhanced clean can be carried out. Fallow time was initially 1 hour but reduced to 30 minutes in many cases by the end of 2020 and in December 2021 the need for fallow time was removed in certain clinical circumstances. As most dental procedures involve the use of AGPs this has had a significant impact on capacity and the number of patients that can safely be seen.

While access to dental care is limited across the country due to COVID-19, practices are concentrating on the provision of urgent care and treatment for patients with the greatest clinical need.

Background

During the first wave of the pandemic all dental practices were required to close for face-to-face care from 25 March 2020 until at least 8 June 2020. This was in the interests of patient and dental team safety. Although closed, practices provided remote advice, analgesia (to help to relieve pain) and anti-microbials (to treat infection) where appropriate, this is known as AAA. Following clinical assessment where this did not address a patient's needs, dental practices were then able to refer patients to Urgent Dental Care (UDC) Hubs that were set up to treat patients with the most urgent need.

In the second phase of the pandemic as infection rates dropped, there was a phased reopening of practices for face-to-face care, with all open by 20 July 2020 at the latest. All practices with an NHS contract are required to deliver a set amount of treatment in any one year. For dentists and their teams to see as many patients as possible, but in a safe manner, NHS England and NHS Improvement (NHSE/I) worked closely with Ministers and determined for the period 20 July to 31 December 2020 this would be a minimum of 20% of historic levels of NHS activity in recognition of the 1 hour fallow time and enhanced clean required. For the period 1 January to 31 March 2021 practices were required to deliver 45% of their contracted activity (70% for orthodontics) which reflected fallow time reducing to 30 minutes in many practices followed by the enhanced clean. From 1 April 2021 practices were required to deliver 60% of their contracted activity (80% for orthodontics) and this increased to 65% (85% for orthodontics) on 1 October 2021. From 1 January 2022 practices are required to deliver 85% of their contracted activity (90% for orthodontics) to reflect that fallow time is only required in some clinical circumstances.

Practices may have to temporarily close if members of the dental team or their household are required to self-isolate in line with Government guidelines. Practices may also have to temporarily stop provision of treatment involving AGPs where they have been unable to obtain their usual make of respirator mask and need to be fit tested to a new model. In both of these instances, where patients require face-to-face urgent care before they are able to reopen, if the practice does not have a "buddy" arrangement with another practice they are able to refer patients to UDC Hubs which remained open when practices resumed face-to-face care for this reason.

Current situation

Although this gradual increase in activity has improved access to urgent dental care and is starting to deliver routine care for those with the greatest clinical need, it is still not 100% of usual activity. It has also not addressed the backlog of care that built up during 2020/21 when practices were closed during the first quarter, when 20% of historic activity was delivered during quarters 2 and 3 and 45% of contracted activity during quarter 4, nor when practices have been required to deliver 60% during the first half of 2021/22 and 65% in quarter 3. The resulting backlog is going to take some considerable time to address and will continue to be carried out on a risk based approach focussing on patients with the greatest clinical need.

The ongoing reduction in activity and backlog means that many patients, including those with a regular dentist, are unable to access routine care at the current time. Although many patients have historically had a dental check-up on a 6 monthly basis, NICE guidance states this is not clinically necessary in many instances and clinically appropriate recall intervals may be between 3 to 24 months dependent upon a patient's oral health, dietary and lifestyle choices. Therefore, many patients who have attempted to have a dental check-up may not have clinically needed this at that time. While practices continue to prioritise patients with an urgent need, where they have the capacity to provide more than urgent care they will prioritise according to clinical need such as patients that require dental treatment before they undergo medical or surgical procedures, those that were part way through a course of treatment when practices closed, those that have received temporary urgent treatment and require completion of this, looked after children and those identified as being in a high risk category and so have been advised they should have more frequent recall intervals.

Although practices have been asked to prioritise patients with an urgent need, it may be necessary for patients with an urgent need to contact more than one practice as each practice's capacity will change on a daily basis dependent upon the number of patients seeking care and staffing levels. Where a practice has the capacity to do so, they will assess patients over the telephone to establish whether the patient requires AAA. If it is established a patient requires a face-to-face appointment, the practice can arrange for them to attend an urgent appointment at the practice or in some instances refer the patient to a UDC Hub.

NHS and private dental care

Whilst most practices provide both NHS and private care, we have made it very clear to all practices that they must spend an equal amount of time on NHS care now as they have historically, albeit some of their surgery time will not be spent on face-to-face care due to fallow time. A common misconception is that practices are attempting to convince patients to be seen privately rather than on the NHS, this is because practices are contracted to provide a set amount of NHS dentistry per year and so are unable to increase the number of NHS appointments they can offer. However, some are able to increase their private hours and number of private appointments available. In some instances, practices may have filled their NHS appointments but still have private appointments available and this is why sometimes patients may only be offered a private appointment when they contact practices. As capacity may change due to the number of patients who contact the practice with an urgent need, patients may need to contact several practices over a varied timescale to obtain an appointment.

Finding a dentist

Patients are not registered with a dentist in the same way as they are with a GP. A practice is only responsible for a patient's care while in treatment, but many will maintain a list of regular patients and will only take on new patients where they have capacity to do so, such as when patients do not return for scheduled check-ups or advise they are moving from the area. The ongoing reduction in activity and backlog means that many patients, including those with a regular dentist, are unable to access routine care at the current time. Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist or by ringing the Kent Dental Helpline on 0300 123 4416 who will provide details of local dental practices providing NHS care. However, for the reasons outlined above, at the current time it is unlikely that they will be able to accept patients for non-urgent care or those people not considered as having greater clinical need.

Improving access

Funding has been offered to all practices across the South East region to increase access by providing additional sessions outside of their normal contracted hours, for example in the evening or at weekends. These sessions are for patients who do not have a regular dentist and have an urgent need but have experienced difficulty accessing this or have only been able to receive temporary care (such as AAA, a temporary filling or first stage root treatment) and require further treatment. There are nine practices in Kent that currently have the staffing levels to safely undertake additional sessions, specifically for patients that would be new to those practices. The offer of additional sessions remains open so that should other practices subsequently determine they have the staffing levels to safely deliver additional sessions, these will be established.

Following a round of procurement in 2019 four brand new dental practices were established in Dartford, Dover, Faversham and Sevenoaks, with a further five in Canterbury, Margate, Sandwich, Sheerness and Sittingbourne being awarded increases to their existing NHS contracts. As part of the same procurement programme, a new practice in Minster on the Isle of Sheppey has recently received planning permission so will be opening in the coming months, plus another new practice is due to open soon in Tonbridge. Overall, this is an increase equivalent to 24 whole time NHS dentists across Kent.

Since April 2020 there have been three practices in Kent which have decided to cease providing NHS dentistry for a variety of reasons. High Street dental practices are independent contractors and therefore free to make such business decisions, NHSE/I has no authority or influence over this.

Where an NHS contract terminates, the funding associated with it returns to NHSE/I to be reinvested in local dentistry by procuring permanent replacement services and/or increasing the provision of specialist dental services. Our Consultant in Dental Public Health is currently compiling oral health profiles which will determine the priority for future commissioning of services across the whole of Kent which we anticipate may identify a need for further increased dental services in the area.

Kent statistics

UDAs commissioned:	2,418,779
Approx. WTE dentists:	346
No. dental practices:	196
UDAs per head of population:	1.30 (South East region average of 1.38)
UDAs from contracts handed back:	7,470
Increased UDAs from 2019 procurement:	168,000
Approx. WTE dentists:	24
UOAs commissioned:	158,005
No. patients per year:	7,524
No. orthodontic practices:	16

UDAs and UOAs (units of dental activity and units of orthodontic activity) are the activity measure for most High Street dental contracts. Each contract must provide a set number of UDAs/UOAs per year in return for a set annual payment. Checks are carried out each year to ensure that all practices are delivering the contracted activity; money is recovered where activity falls short of that agreed.