How does dentistry move from survival to revival?

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Introduction

There's a lovely quote circulating that says 'while we're not in the same boat, we're all going through the same storm'. It's the most accurate description of living through the pandemic I've seen and heard. We all have our differing takes on how best to make our way through to the other side, and we're all in a different place.

And that's a pretty accurate description of where dentistry is at the moment. There are wild differences of opinion on how the profession transitions from lockdown survival to practical and financial revival, and it is those differences that threaten to take dentistry through two very different paths out of the storm.

Being patient

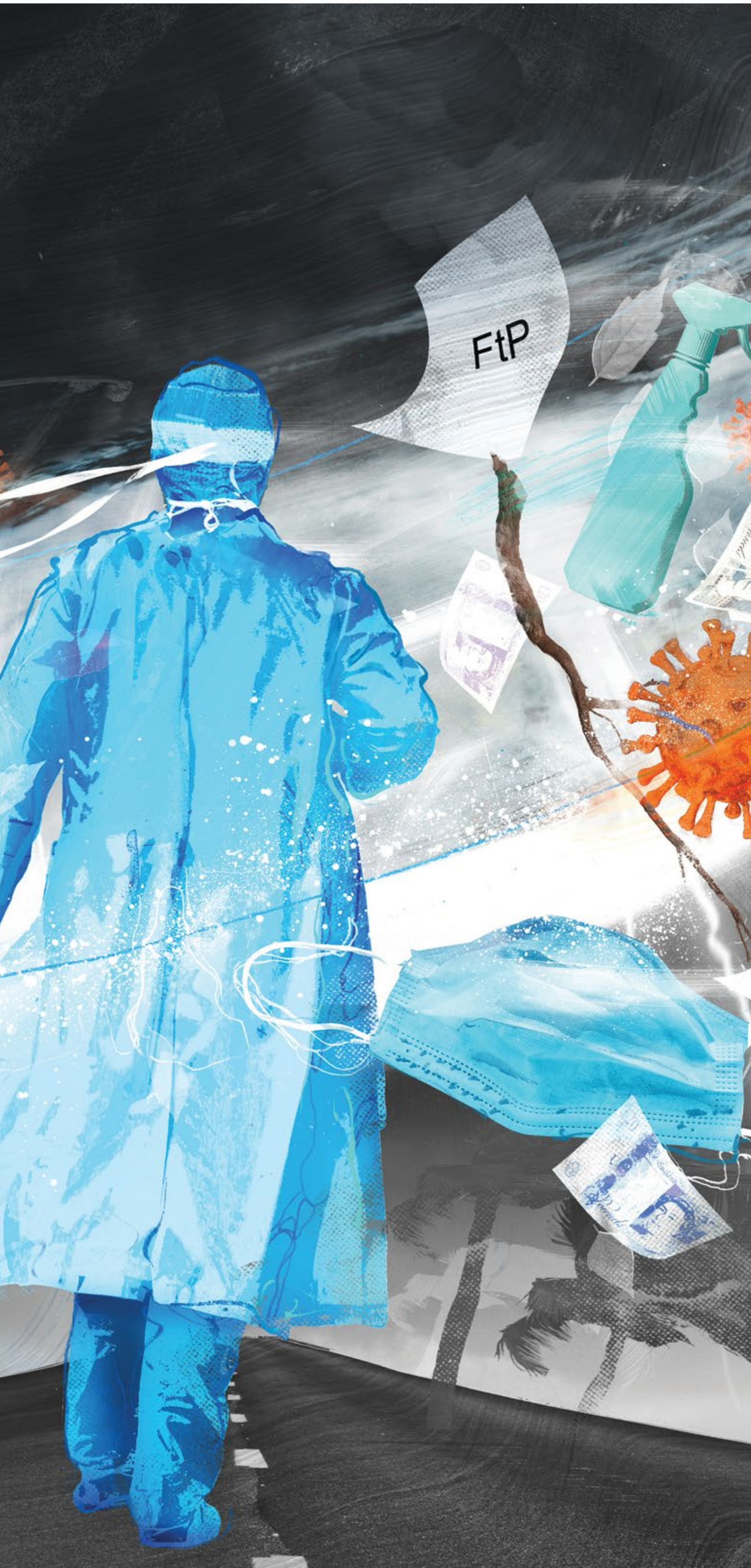
It was fascinating to see how the different sectors of the profession dealt with the cessation of dental services on the say-so of the Chief Dental Officer, particularly in England. NHS practices closed their doors, and those offering private services followed suit. Yet, as time went on, patience appeared to be wearing thin. Some practices and practitioners started campaigns to open again stating they were ready to do so and they were 'the safest place you could be'. Patients also appeared to run out of patience, with those in need of urgent work and unable to find urgent treatment centres willing to treat them taking to social media to voice their disapproval. Both parties clamoured for the opening of the dentist.

And then the Office of the Chief Dental Officer in England announced that from 8 June, dentistry could resume. And both parties continued to be unimpressed. Practices then suggested they weren't given enough time to plan, to get the necessary PPE and to put COVID-19 secure protocols in place, and patients continued to demand the reinstatement of regular dental services. Some eight weeks later and at the time of writing, there appears to be little sign of the storm subsiding.

In a crowded field, two issues intertwined stick out more than most; aerosol generated procedures (AGPs) and fallow time. In May, prior to the re-opening of dental services, The COVID-19 Dental Services Evidence Review (CoDER) Working Group, led by Professors Jan Clarkson and Craig Ramsay, conducted and produced a rapid review of internationally-produced guidance from 16 countries on the re-opening of dental services.[1]

The review produced the following key messages:

- Most sources recommend patient triage by telephone; some recommend also temperature screening at reception
- Most sources recommend avoiding aerosol-generating procedures (AGPs), if possible
- Most sources recommend surgical masks for non-COVID-19 cases not requiring AGPs
- Most sources recommend filtering facepiece class 2 (FFP2, equivalent to N95) masks for non-COVID-19 cases undergoing AGPs and all suspected or confirmed COVID-19 cases undergoing any procedure



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Key points

- Hurdles persist
- Lack of evidence hampering a desire to open up
- Financial concerns linger

- Sources include recommendations on how to reduce the risk of transmission (e.g. use of pre-operative mouthwashes; high volume suction; rubber dam; and Personal Protective Equipment [PPE])
- Most sources recommend cleaning and disinfection procedures
- Across sources, for most statements there is no referenced, underpinning evidence and some of them are unlikely to have strong (or any) research evidence
- All sources emphasise the need to focus on activities that minimise risk (to staff/ patients/public) but still support high-quality clinical care
- There is a need to consider the inter-relationship between the appropriate use of PPE (including donning and doffing), AGPs and interventions to reduce aerosol generation
- There is a highly variable level of detail given across international sources.

It is perhaps the last of the key messages that caused so much consternation. With such variance in data – not a surprise given how quickly COVID-19 developed and is continuing to develop – how could the working group establish definitive recommendations for practitioners to follow? Yet what did the profession cry out for? Clear guidance.

On 24 July, the same working group produced another rapid review on Aerosol Generating Procedures and their Mitigation in International Dental Guidance Documents.[2] Again the review fell short of the profession's hopes and expectations, highlighting the following key messages:

- There is a highly variable level of details provided across international resources
- Just over half of the documents (56%) provide a definition of AGPs
- 98% of countries state that AGPs can be provided for non-COVID-19 patients
- 94% of countries recommend the use of a face mask and goggles or a face shield for non-COVID-19 patients

- Surgical masks are advised by 21 countries (33%) for non-COVID-19 patients while 44 countries (70%) recommend the use of FFP2/N95 masks and 12 countries (19%) recommend the use of FFP3 masks
- 82% of documents recommend the use of a pre-procedural mouthwash for non-COVID-19 patients
- 48% of documents suggest a fallow period after the providing AGP treatment for non-COVID-19 patients, with times ranging from 2 to 180 minutes
- Most countries making recommendations for COVID-19 patients advised the same mitigation as for non-COVID patients
- There is a lack of evidence provided to support the majority of recommendations.

More countries were included – 58 this time – and the report is designed to inform the Scottish Dental Clinical Effectiveness Programme (SDCEP) Aerosol Generating Procedures in Dental Practice Rapid Review, which many hope will provide the guidance necessary to ramp up their phased re-opening.

Filling the void

In the absence of clear guidance, others have attempted to fill the void. While of critical need and urgency, this absence and void creates its own issues. We have seen members of the public campaigning for shorter fallow times, a difficult and complex topic even those with relevant degrees and doctorates are struggling to come to a consensus on. We have seen members of the profession – and not just in dentistry – not involved in high-level discussions surrounding the complexities of dentistry and the pandemic put forward opinion-based definitive solutions with an air of confidence that are not backed up with robust evidence. In an editorial for *Evidence Based Dentistry*, Professor Elizabeth Kay said it best when she wrote wrote:

'Unfortunately, also during this crisis, I have witnessed (albeit viewed remotely via email or online), in the various arenas in which I work and communicate, individuals and organisations competing to be the 'owners' of the scientific truths, and a will to be seen as THE most knowledgeable source of information. Suddenly, everywhere, there seem to be 'experts' in some aspect of communicable disease, microbiology, immunology, and everywhere people seem to be popping up who seem to believe that they know best about the disease, and that they have the keys to unlocking the current dilemmas and challenges facing dentistry. These people, often part of large and prestigious organisations or institutions, claim that they know the 'correct' 'evidence-based' way forward, and they seem to feel able to tell dentistry what actions it should be taking. They are keen, understandably, to provide leadership to a profession which finds itself in a desperately difficult situation, clinically, financially, and ethically. This will to advise, while entirely understandable, is also dangerous.'[3]

That is why, while the Cochrane reviews may not provide the answers many practitioners want, they provide the answers and guidance the profession needs. In May of this year, the newly-formed British Association of Private Dentistry produced a Return to Practice Position Paper[4] which they stated was *'designed to help the industry in its return to normal clinical working practices'*. It also stated *'that whilst this paper provides a strongly evidence-based overview of our current status, the topics discussed are broad and further research is needed in many areas.'*

Under the subheading 'PPE: Current Science', the paper states the following: *'A recent opinion piece on dental aerosols by Dominic O'Hooley, provides his considered viewpoint on this. (O'Hooley, 2020) (See Appendix 1, Table 1). This brings us to specific proposed modalities for risk mitigation as we move towards the reestablishment of full dental service provision in the UK.'*[4]

Set aside for a minute that the table contains a survey from two members of the BAPD's scientific committee, the reference to O'Hooley's considered viewpoint is to a post on the BAPD's Facebook page.

In June, the same organisation produced an International Fit Test/Fallow Time Comparison table designed ultimately to bring about change in the UK's current guidance of a 60-minute fallow period. The table was unreferenced and, after checking, contained inaccurate data from other countries. At a time where peer reviewed, ethically-approved robust research and studies to generate evidence are sorely needed, as a profession we must be mindful of presenting opinions as evidence that have not undergone this thorough, often lengthy process. Surely this approach must be the cornerstone any professional engaging in research would seek to strive for? Patients are relying on us to provide a safe environment should they be in need of the service. I would be mortified were I to discover a loved one attended a dental practice that re-opened and reduced its fallow time based on blogs and social media sources.

For those reading this thinking I have unfairly singled out these examples for criticism, that is simply not the case. Any editor worth their salt will do some basic checking of references and sources before publishing an article. The speed at which COVID-19 continues to develop means research cannot keep pace with the situation, as Professor Kay pointed out. How is it possible to be confident in the evidence when it is not there? There are no data on long-term effects of COVID-19. There is very little – if any – definitive data as a result. We cannot and should not allow evidence designed to guide our response to the crisis be considered if it has not undergone the peer review process, let alone be published and used. The UK has long been seen as the gold standard of health and safety pertaining to dentistry by observers and colleagues across the world, and I would question whether a return to practice guide lacking peer review continues to meet that threshold for quality and excellence. The continued absence of robust evidence may be a hurdle the profession encounters for some time to come, and we have to be ready to accept that.

PPE

Once you've overcome the paucity of data and evidence on how to safely return to practice, put COVID-19 secure structures in place to keep staff and patients safe and once you've made peace with the 60-minute fallow period, the next hurdle to overcome is personal protective equipment (PPE). At the height of lockdown, there were national outcries of frontline staff not having enough

nor having adequate PPE to ensure their safety. The infamously heralded shipment of PPE from Turkey that arrived late and failed British safety standards felt emblematic of the supply problems facing frontline workers. While reports now suggest there is no critical shortage – the Office of the Chief Dental Officer for England has moved to reassure practitioners PPE is available to purchase from wholesalers – researchers at King's College London and Harvard have identified frontline workers are at a greater risk of contracting COVID-19 than the general public, even with adequate PPE.[5]

According to the data, healthcare workers from Black, Asian and minority ethnic (BAME) backgrounds were more likely to test positive. Researchers say their findings highlight the importance of adequate availability and use of PPE, but also the need for additional strategies to protect healthcare workers. These include ensuring correct application and removal of PPE and avoiding reuse, which was associated with increased risk.

Using the COVID Symptom Tracker App, researchers from King's College London and Harvard looked at data from 2,035,395 individuals and 99,795 frontline health-care workers in the UK and US. They found that the prevalence of Sars-CoV-2, the virus which causes COVID-19, was 2,747 cases per 100,000 frontline health-care workers compared with 242 cases per 100,000 people in the general community. Although the research does not specify dentistry, securing PPE ahead of or during any potential second wave should be considered critical to dentistry's survival. One practice owner I spoke to who wished to remain anonymous believes a second wave would cripple what's left of their business and dentistry as a paid-for entity.

'NHS practices have received financial support, but it's nowhere near enough to survive', they told me. 'Friends of mine have said they could only survive a second wave if the financial support from the government was improved on, and I can't see that happening.

'I run a private practice and received zero financial aid. It is not fair. I am operating as safely as I possibly can, but the overheads aren't sustainable. I have no choice but to pass on higher PPE costs to patients. I have members of staff who have failed fit test after fit test. It's not their fault, but how am I supposed to run a practice without my team? Like many others, if there's a second wave I may as well not bother re-opening.'

What about staff after returning from abroad?

The government has said that no travel is 'risk-free' during the pandemic and that people returning from some countries abroad should self-isolate for two weeks. There are exceptions:

- People arriving from exempt countries do not need to self-isolate. There is a list of exempt countries on the gov.uk website
- People who are registered healthcare professionals do not need to self-isolate.

The BDA advises that you take the following steps:

1. Check whether member of staff is returning from one of the countries which are exempt from the quarantine guidelines. If you are in Scotland, please refer to the specific advice from the Scottish Government (Northern Ireland and Wales currently follow the same guidelines as England)
2. Is the employee GDC registrant? If they are, they do not need to self-isolate. They will need to complete a Public Health Passenger Locator Form before they return to the UK
3. Non-GDC registrants, receptionists, managers, will need to self-isolate for 14 days

SSP is not payable for staff self-isolating after returning from holiday.

Subject to being eligible under the job retention scheme, practices may be able to furlough staff who are self-isolating after returning to the UK. If it is possible under the rules of the scheme, both employer and employee would need to agree.

If the furloughed workers scheme cannot be used, then staff who have to isolate should either be on paid holiday (if the member of staff has paid holiday to take) or unpaid leave. Whether it is paid or unpaid leave should be subject to agreement between the parties.

Problems

This cliff edge is one many practices currently face. Some dentists are having difficulty securing a reliable and affordable supply of PPE. There are also concerns that dentists are having difficulties securing an appointment for fit-testing, not to mention one study suggesting getting masks, visors, glasses and gloves to successfully fit were causing more difficulties for women than their male counterparts.[6]

According to the BDA, PPE shortages – and the need for kit not previously required – means the cost of treating each patient has increased by up to 6,000%. Costs for PPE per patient appointment were about 35p to 45p pre-pandemic, but could now stand at £20 to £30 depending on exact PPE requirements and usage.

{my}dentist is just one example of this. In an email to patients, the company wrote: *'To ensure we can continue supporting our patients, we have had to introduce a temporary Covid Safety Supplement payable on each visit where you have a private dental treatment (excluding patients on dental plans), in common with many other dental providers.'*

The £35 charge to cover the extra cost of PPE is only payable when there is a risk of a spray. There is a £7 charge for other procedures. They are not the only ones – many other dental practices have notices on websites detailing 'temporary PPE charges' patients will face depending on what work they need during the appointment.

With most practices operating at less than 25% of pre-pandemic capacity, in large due to the need for a fallow period, pre-screening patients for COVID-19 symptoms and taking their temperature before allowing them in the dental practice, this has doubled the amount of time and resources needed for simple procedures.

Mick Armstrong, BDA Chair, said 'The amount a private dentist charges a patient will always vary from practice to practice and will of course depend on the treatment provided. For NHS treatment, patient charges are fixed across England.

'The costs of providing dental treatment have risen astronomically, as practices adopt additional safety measures, including use of full PPE for many procedures. The result is some private dentists have little choice other

than to pass on some costs to patients.

'Facing fewer patients and higher costs many practices now fear for their futures. A service millions of patients depends on needs this government to throw it a lifeline.'

However, some observers I have spoken to believe Armstrong's suggestion that practices have 'no choice' but to pass on the costs is somewhat wide of the mark. With no VAT on PPE also a factor, is it absolutely necessary for private practitioners to pass on the additional costs to patients at a time of global recession?

One practice owner I spoke to thought the move was crass and would result in having unnecessary, possibly awkward conversations with patients at a time when the general public may have money worries.

The owner said: 'Any 'COVID supplement is a bit of a blunt tool and when broken down is tantamount to profiteering. The costs for PPE supplies vary on a week to week basis, so how can you add a fixed levy on? Some weeks you may cover it, some weeks you might not. It doesn't make a great deal of sense until we know how long PPE prices will continue to be higher than usual.

'In the early stages of the pandemic, no-one knew how long it would last. Once we got the green light to resume services, the same applied to the significant levels of PPE we needed to carry out treatments. We took the decision not to add a levy – we feel that's the right thing to do.'

Financial recovery

Putting aside the ethical dilemma of passing on PPE costs to patients, the facts make for grim reading. Fewer patients and higher costs is not a recipe for financial revival post-COVID-19. The double-headed monster of patient concerns about the safety of visiting allied with a recession means many practitioners forecast they will not survive the winter.

In March the BDA urged government to extend the Business Rates Retail Discount of 100% offered to leisure and hospitality sectors to dental practices, to ease potentially crippling losses from the pandemic.

At the time, properties benefiting from the relief included shops, restaurants, cafes and cinemas, live music venues and hotels. Premises used by dentists, doctors and others were excluded. This prompted the BDA to write an open letter to Secretary of State for Housing, Communities and Local Government Robert Jenrick, calling for a full extension of relief to all practices.

Five months later, and not one private practice was listened to by the government. This created what could be perceived as a divide between NHS practices – those who received support and private ones who have not. BDA Chair Mick Armstrong told the Commons Health and Social Care Committee that the combination of higher costs and lower patient numbers presented an 'existential' threat to the service. Only 8% of practices report they were confident in maintaining their financial sustainability under these conditions.

To keep the pressure on the government, the BDA launched a petition to extend the COVID-19 business rates relief to healthcare providers in England. At the time of writing, the petition has received 7,200 signatories.

Armstrong added: 'Support that's been missing during lockdown is needed now more than ever. With so many practitioners fearing for their futures, healthcare cannot remain excluded from rates relief.'

> 'According to the BDA, PPE shortages – and the need for kit not previously required – means the cost of treating each patient has increased by up to 6,000%'

'Whatever it takes'

I, like many others, watched with interest when Chancellor Sunak said he'd do whatever it took to save businesses throughout the height of the pandemic. Was that possible? Would support be in the form of a grant or a loan? How sustainable was that? Perhaps unsurprisingly, 'whatever it takes' was soon followed by an admission he could not support every sector and every job. As LaingBuisson[7] values the NHS dentistry market at £3.5bn mark and the private sector at around £3.6bn, and any market growth dependant on the expansion of private care, it becomes unfathomable that the private sector has received no support.

'Rishi Sunak said he'd do 'whatever it takes' to protect the economy, Armstrong said. 'Well, that has to include dentistry. We are not looking for special treatment. We just need the same support that's been given to our neighbours on the high street. The government extended relief to include betting shops. It's ludicrous that dedicated health professionals are still not getting the help they need.'

With the Coronavirus Job Retention Scheme closing on 31 October 2020 and no longer open to new applications, this presents a very real danger to the livelihoods of dental practitioners. Practices who had previously claimed under it can continue to do so until October. Employers now have the option to bring furloughed employees back to work for any amount of time and any shift pattern, while still being able to claim this grant for the hours not worked.

However, from 1 August 2020, the level of grant is being reduced each month. To be eligible for the grant employers must pay furloughed employees 80% of their wages, up to a cap of £2,500 per month for the time they are being furloughed.

Whatever the support, the situation remains precarious. The profession cannot be left to pray there is no significant second wave, for not even divine intervention will aid the current move from survival to revival if that were to happen. While we are all indeed in the same storm but different boats, we can only hope financial aid makes that boat fast enough to sail out of choppy waters.

The petition to extend Business Relief Rates is available to sign at: https://petition.parliament.uk/petitions/318568 ◆

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