COVID-19: Can anything change for the better?

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Key points

- Understandable changes had to happen
- All nations had different approaches
- Is 'build back better' really happening in dentistry?

Introduction

As dentistry continues to grapple with the pandemic, the axis of patient footfall, looming recession and restrictions rotates at pace, with no-one really sure of how the trio will find their balance. A school report card of the last 12 months would probably read something like: *'dentistry has done really well under pressure in the circumstances. English could be improved and there are signs of regression. Scottish and Welsh are coming on nicely, and Northern Ireland is steady'*.

As an overall review, that's probably about where things are right now. Yet school report cards were all about areas to improve on in the following term either having shown some promise or having been left behind; it was an opportunity. This opportunity is perhaps where 'build back better' has come from. The pandemic has offered dentistry an opportunity to assess its report card during a period of no activity and see how it can improve. The question is, with the vaccination programme rollout offering hope for a return to something akin to normality, has it taken the opportunity?

Areas of success

I've often wondered why dentistry didn't make more of the video technology available. A search of the *Nature* portfolio of 'teledentistry' reveals 55 mentions across five journals – 49 of them in *BDJ* – with 24 of those occurring since the announcement of the first lockdown on 23 March. Clearly the pandemic meant such measures were a necessity, but was dentistry too late and reactionary rather than being on par with its GP colleagues?

Yes, obviously you cannot fit an *iPhone* in your mouth to give a dentist an in-detail look. Barriers such as image quality, the

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reliability of internet connection and patient factors such as the ability to connect to the consultation – even for meetings over Zoom, GoToMeeting and/or Microsoft Teams you will *always* have to tell someone they're on mute – will create issues. Previous research has also highlighted that factors such as lighting, manual dexterity, familiarity with mobile/tablet devices and the digital literacy of the patient to utilise technology-based consultations, would be – in the context of oral cavity assessments – difficult to do with any great certainty or effectiveness.[1]

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But, if there was an opportunity to pre-screen a patient, discuss their problem or, if the appointment was a routine follow-up, to discuss how they had been getting on, wouldn't that be of benefit to patients? Why didn't special care dentistry and community dental services utilise video consultations prior to the pandemic to determine the extent of a patient's impairment or disability? In Wales, for example, as part of the Dental Recovery Plan, Assessment of Clinical Oral Risks and Need (ACORN) – designed to shift the focus from treatment to patient engagement, prevention and management of dental diseases as chronic conditions – formed the first part of the appointment.

So, why couldn't it become an integral part of dentistry post-COVID-19? I'm well-aware of how busy NHS practitioners are, so a fair riposte would be 'we struggle as it is, and this is excessive'. But does that apply to community services, to private practitioners and to any patient looking for cosmetic treatments? With uncertainty surrounding COVID-19 protocols, patient hesitancy to visit their dentist and the treatment of those considered vulnerable or shielding, video consultations could – and should – play a key role in any pre-assessment undertaken. Imagine if a team member could take or update patient history, discuss the treatment options and costs of treatment before the patient even attends the clinic – the 'red tape' many see as a burden during

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an appointment would be significantly reduced. This would not only reduce the time spent within the clinic, but could also give the patient sufficient time to consider their options before treatment commenced, another important consideration in the litigious environment dentistry operates within. Whatever the rationale, in the right setting and with the right funding, video consultations and the use of integrated technology has been a success for many and should form a part of dentistry as we move out of the pandemic.

A grand event

Whilst face-to-face events were rather abruptly curtailed when the pandemic struck some 12 months ago, the appetite for learning certainly didn't diminish. With so much new information to share, the demand was greater than ever. Education and learning provide an opportunity to adapt and strengthen skills, to provide a vital defence in times of uncertainly.

Learning is not just about keeping up to date with CPD, it is so much more than that. It is about sharing knowledge, whether that is sharing clinical know-how to help with key clinical issues or to inspire change; or perhaps it is sharing learning that will help you to adapt, or even excel, in the longer-term.

Being able to demonstrate that you are undertaking a continuous journey of learning is also vital as a tool for strengthening your position if you have to ask your indemnity provider to deal with a professional challenge. It shows you are doing everything you can as a professional to maintain skills and learn about current best practice, particularly if you are doing regular self-reflection and choosing your learning accordingly. It indicates that you are continually revising procedures and considering best practice before embarking on vital patient care.

Having chaired and partaken in a webinar, I can say with some certainty that the emergence of webinars front and centre of the events scene was a welcome development. Am I bored of speaking to the same four walls? Yes. Did the BDA adapt its educational role during the pandemic and discovered even greater popularity, meaning you could see and speak to other people? Also yes.

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Besides the necessary human interaction during times of lockdown, it showed a way forward for the integration of digital and in-person events. Is it absolutely necessary to travel across the country to a press conference, an event or seminar? Hands-on courses may boom post-COVID to bring back that face-to-face element we've all missed, but there is space for 'hybrid' events.

I asked Elise Cole, Head of BDA Events, about the opportunities BDA members have been able to enjoy.

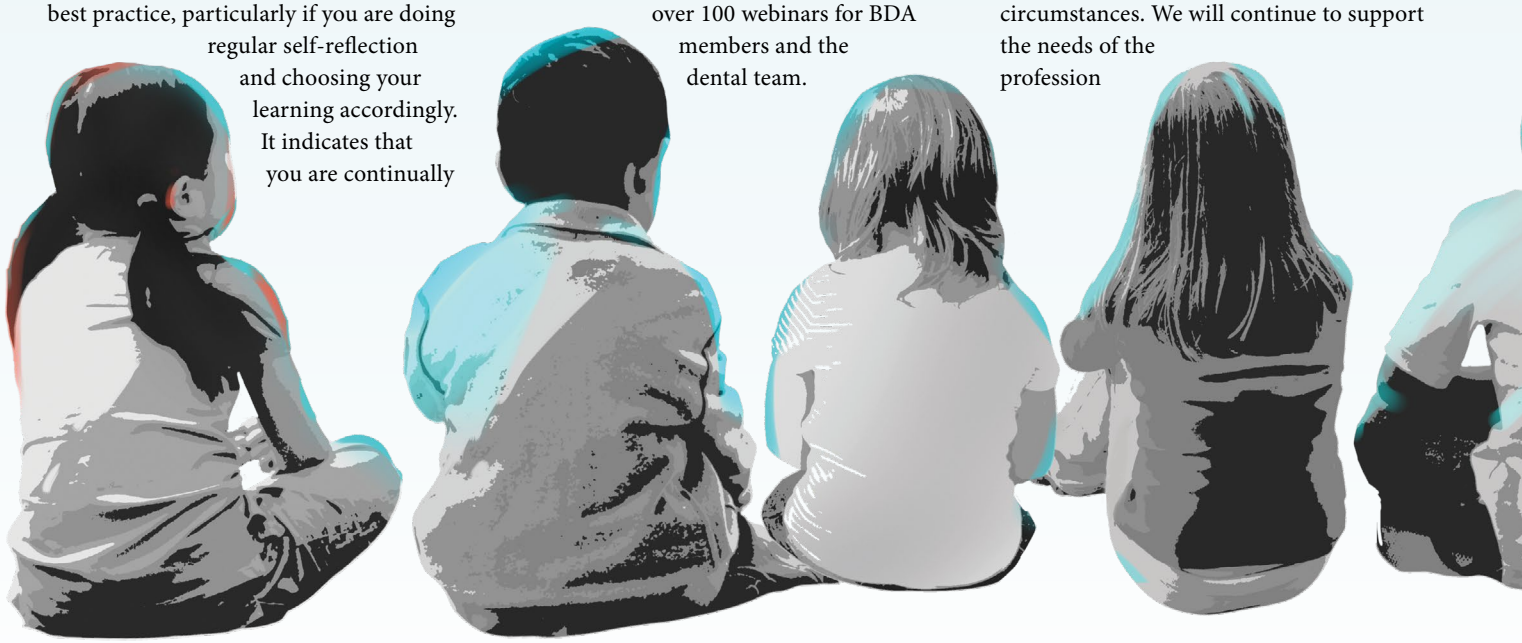
'Since May 2020, we have facilitated over 100 webinars for BDA members and the dental team. The majority of these have been made available to BDA members as an integral part of membership with no extra cost, with over 27,000 bookings taken so far.

'There has been a weekly webinar series of live lectures produced by the team in conjunction with leading experts; the range of subjects already delivered since Spring 2020 include clinical tips and techniques, GDC recommended CPD topics, business and staff management best practice and areas of personal development.

'It has also given us the opportunity to deliver longer, more in-depth sessions of CPD in the form of online seminars and interactive, small group courses. Webinars organised at local level by BDA branches and sections across the UK, usually total two to three each week, can be attended by anyone in the UK, as there is now no physical geographical restriction with digital events.

'We look forward to continuing to provide access to CPD digitally in the post-COVID world as well as resuming our much-loved face-to-face events. In due course face-to-face events will return, to offer the opportunity to experience hands-on workshops, to network in person and to immerse yourself in learning in a different way.'

Emma Charles, Events Manager, added: 'Whilst there is so much uncertainty about the future, we know for sure that professionals in dentistry will always need to continue developing and learning to adapt in an ever-changing world. Over the past year, we've witnessed a profession that has remained passionate about their vocation and have worked tirelessly in very difficult circumstances. We will continue to support the needs of the profession



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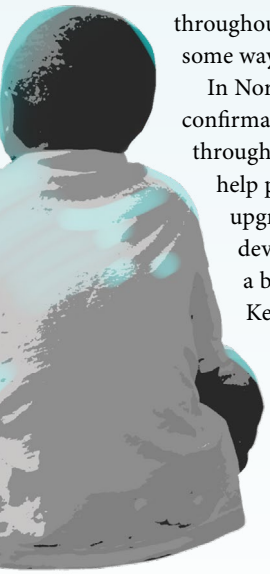
and teams and to ensure they can access learning at a crucial time when it's proven more important than ever to keep ahead of the curve.'

In a way, any organisation that had a strong digital footprint and was accepting of change was better prepared for what has transpired in the last 12 months. That may sound easier than it is – previous research suggests clinicians themselves can often be the biggest barrier to implementing change.[1] In fact, Watt *et al* previously stated: *'Organisational issues were also both a barrier and facilitator of change. In dental practices where a team approach had been adopted and good communication systems had been established, change appeared to be more easily achieved. Autonomy within the team appeared to be an important factor. Associates who were given little control over how they worked complained that change was not an option.'*[2] The pandemic clearly necessitated the need for change, so maybe it isn't as alien as some practice owners, associates and departmental heads believe it is.

Supportive trio

It's also worth reviewing how each nation has approached supporting its workforce. A quick search of the BDA's live coronavirus update pages show how they have performed; welcoming announcements from Scotland, Wales and Northern Ireland on funding for ventilation, contract and payment arrangements a plenty. There will always be more that could be done – dentistry was a 'Cinderella service' prior to the pandemic and operated without the necessary funding – but purely compared to their English counterparts, each health service and Chief Dental Officer throughout the pandemic has gone some way to supporting dentists.



In Northern Ireland, recent confirmation of the £1.5m patient throughput funding scheme to help practices with ventilation upgrades was a positive development, although in a blog last month, Tristen Kelso, National Director of BDA Northern Ireland, wrote: 'Ministers are warning that next year's budget situation is set to be very challenging, with the Finance Minister saying it effectively represents 'a standstill of the 2020-21 budget position'. The chairs of Northern Ireland's Health Trusts have also warned of 'significant shortfalls' in the draft Health budget. The Department of Health has highlighted 'significant gaps in relation to awarding pay uplifts'.[3]

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In Wales, the Welsh Government's commitment to offer capital funding to help dental practices secure new equipment to expand patient numbers was warmly welcomed, as Health Minister Vaughan Gething MS agreed a funding package of £450,000 in 2020-21 to support dental practices in improving surgery ventilation.

In Scotland, the securing of a revised funding package for NHS dentists, followed by an increase of 30% to the General Dental Practice Allowance (GPDA) and a 30% increase to the cap in the summer, was also welcomed. On top of this, extra funding was made available for Vocational Dental Practitioners (VDPs). And while these points might reflect the degree to which dentistry ran on fumes, they are still welcome developments and perhaps reflect how the service is viewed in those countries.

Could do better

Speaking of how the service is viewed in each country, the eagle-eyed amongst you will question support for the self-employed or private practitioners. It's fair to say support for these areas has been nothing short of pitiful. Take private practice. The private sector is worth £3.6bn out of the £7.1bn spent on dentistry in the UK,[4] and yet, with the exception of the furlough scheme and access to credit, all four UK governments have singularly failed to even recognise the 'mixed' approach on which many practices base their financial model. Private practices were left out on a limb during lockdown, while almost all their neighbours on the high-street got support on business rates. NHS contractors were offered support, but now face real questions on what will be maintained in the months ahead, while restrictions remain in place and patient numbers haven't recovered. Social distancing and other infection control measures have and will remain to have an impact on the ability of practices to deliver care and maintain their bottom line, but corresponding support has been absent or uneven.

I may sound like a broken record, having previously written about the unfair support being made available to those in the private sector, but it really is like watching the government with a favourite child while the other sees the world go by, longing for an ounce of the love being shown. Remember the slogan 'whatever it takes' from the Chancellor? Rather than doing whatever it took to support a hugely profitable section of dentistry that has a profound impact on NHS spend, inaction from the government fostered a feeling of 'House Montague *vs* House Capulet'.

The same 'do nothing' approach also applied to the self-employed. The measures announced by the Chancellor last year to support the self-employed during the COVID-19 outbreak simply did not support the majority of self-employed dentists. While practice owners were able to benefit from some relief via support for businesses, self-employed associate dentists working under them are likely to be hit hard. Those operating exclusively on a private basis were ineligible for any packages of support for lost income, beyond mortgage holidays and self-assessment deferrals for income tax, so many self-employed dentists working in largely or exclusively private practice saw their incomes fall to zero.

While self-employed associates earning less than £50,000 are eligible to claim under the SEISS, and are eligible for the business interruption scheme, questions must continue to be asked about why these areas have not been supported like their NHS colleagues, given the key roles both will play in the re-building of the service post-pandemic.

Little wonder that, as the pandemic stretches on, dentists are becoming frayed around the edges. In a Dental Protection survey of nearly 500 dental professionals,[5] 45% of respondents felt their mental wellbeing was worse compared to the start of the pandemic, and nearly half (48%) said they feel pessimistic about the future. A further 60% said that concern

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for the health of their family and friends was the main factor affecting their mental wellbeing, with 58% citing loss of income/financial worries, and half of the respondents (50%) saying that adapting to new policies and guidance – including restrictions on appointments – was having the most impact on their mental wellbeing.

A third (33%) also said they had experienced verbal or physical abuse from patients or patients' relatives – largely due to not being able to offer an appointment soon enough. A further 5% said they had experienced verbal abuse outside of the surgery.

A number of dentists commenting on their experiences anonymously in the survey said:

- 'People are very angry in general, short tempered and impatient. They lack understanding of the protocols we have to follow. It is very draining.'
- 'I often receive verbal abuse in nearby shops from irate patients.'
- 'I am routinely verbally abused when unable to offer out of hours treatment to other practice patients who are still not open, or from patients not registered with any practice.'

In the Dentists' Working Patterns, Motivation and Morale - 2018/19 and 2019/20 published in August and reflecting *pre-COVID-19* feelings, over 60% of principal dentists and over half of all associate dentists across the UK either 'strongly agree' or 'agree' with the statement *'I often think about leaving general dental practice'*, with notably high scores for principals in Wales and associate dentists in Northern Ireland.[6]

Both dental groups in Scotland recorded a reduction in agreement to the leaving question, which is in line with an increase in both motivation and morale recorded for these dentists compared to the previous survey.

Perhaps it's reasons like these there are growing whispers of more and more practices handing back their NHS contracts. Morale was rocky before, and for many must now be even lower – long days spent practising dentistry in head-to-toe PPE may be a necessity, but that is not to say it isn't incredibly draining. With patient access a problem prior to the pandemic, practices not taking on new patients and NHS contracts being handed back is not a good combination. Throw recruitment into the mix – another issue pre-pandemic – and would you blame them for handing in their NHS contracts, even against a backdrop of little/no support for mixed and fully private practice? Just how bad must it be to be operating within the NHS, particularly in England, for that to be a serious consideration?

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Regression

You may have also noticed England were not mentioned when praising the support given to their workforce. And why would I, when in December, England's Department of Health's decision to impose targets in Q4 of 45% pre-pandemic activity that will effectively force dentists to shift focus from the heavy backlog of priority urgent cases to high volumes of routine check-ups when the national guidance is 'stay at home'. It's nothing short of bonkers.

In January the BDA asked where the public stood on visiting the dentist under the guidance, and nearly half (46%) of the public said they were 'less likely' to even attempt to seek routine dental care with 29% of people stating they were 'much less likely'.[7] Throw in the number of patients making appointments and cancelling them – at the end of their first working week in January nearly 80% of practices surveyed reported cancellations and do not attends were higher than before the Christmas break – and the decision looks ludicrous. In a letter on contract arrangements, Chief Dental Officer for England, Sara Hurley, alongside Interim Director of Primary Care Commissioning Transformation Gabi Darby, wrote to NHS dental colleagues stating *'We recognise there may be exceptional circumstances when this activity target may not be deliverable'* and *'From Jan - Mar 2021 an adjustment will be made to the contract value to reflect variable costs not incurred by contractors for activity that is not delivered'* – or in other words, clawback.[8] If a stay-at-home orders from the government during a global pandemic aren't 'exceptional circumstances' then I'm not sure what are, what their definition of exceptional circumstances are, nor their understanding of the phrase.

In a recent 'State of the Nation' press conference, Alan Suggett, specialist dental accountant at UNW and NASDAL Media Officer, commented that if a practice wasn't hitting up to 36% of that target, it would be more financially prudent to close their doors rather than continue treating patients. What sort of state of affairs is that?

Alan stated: 'First and foremost, my concern is for a small but significant number of practices that will be unable to hit the threshold of 45% of UDA contract amounts and how that 'cliff edge' will affect them. The fact that many NHS practices are already hitting this target is good news but irrelevant to those that cannot.

'Another perhaps unconsidered consequence of the Q4 rules is pay cuts of more than 65% for some self-employed dental associates who carry out NHS work. During the COVID 19 crisis a very important measure of financial protection has been given to NHS associates as so far they have been paid in full. Q4 rules brought this to an end for those associates who work in practices which cannot hit the 45% UDA threshold.

'I feel that a fair compromise is quite simple – remove the 'cliff edge' at 36%. I worry that without this change, a small percentage of the total NHS contract holders could be in real trouble. In addition, the associates who work in those practices could suffer a pay cut in excess of 65%.'

As I write this, the announcement that the target has been revised to 60% from 1 April – 1 October, with the 'cliff edge' remaining at 36%, has been met with shock and disgust. Practices are already working unsustainably to try and meet perverse targets, and now hundreds face an existential threat. Perhaps it's the final nail in NHS dentistry's coffin, and a reason why there's a petition, with 10,7878 signatures to date, calling for an independent review of the existing contract and a radical rethink of the way in which dental services are delivered.[9] The House of Commons has previously acknowledged the current system as 'failing by any criteria', which makes the Department of Health and Social Care's response to the petition even more baffling:

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'There are currently no plans for an independent review of dentistry.

NHS England and Improvement (NHSE&I) has a duty to commission NHS dental services to meet local need. We acknowledge there are regional hotspots where access is an issue and NHSE&I have been active in many of these areas, prior to the pandemic, ensuring that services better meet patient needs.

We recognise, however, the limitations of the current NHS dental contract, which is why NHSE&I has also introduced initiatives such as 'flexible commissioning' which allow local NHS teams to commission a wider range of preventative services from NHS dental practices, which also make use of the full skill mix of all disciplines within the dental team, with the aim of providing an increase service for patients and a multidisciplinary approach to delivery of NHS dental care.

Health Education England is also continuing to explore opportunities for flexible dental training pathways through their Advancing Dental Care programme, the aim of which is to improve dental workforce retention.

The Department has also been working closely with NHSE&I to test a new way of providing NHS dentistry which includes a remuneration model which incentivises an increased focus on prevention. It is yet not clear whether the approach has been able to offer sustainability for practices or value for money for the NHS. We have been working closely with prototype practices to understand this further and this information will feed into the evaluation report due to be published later this year.

Current NHS dental provision is particularly affected by the risk of COVID-19 transmission. The requirement for enhanced levels of PPE and increased PHE infection prevention and control procedures has significantly reduced the numbers of patients that NHS dental practices are safely able to see. Our immediate focus for dentistry must be tackling the impact that the COVID-19 pandemic is having on the provision of dental services and working with the profession to restore vital patient access to services, as safely and quickly as possible.

To facilitate these aims, the Department is working closely with NHS England and Improvement and the Office of the Chief Dental Officer on contractual arrangements for 2021/22 onwards. An announcement will be made shortly regarding these arrangements. Whilst the current focus remains on improving access to dental services in light of the pandemic, prevention focussed work is also ongoing to improve oral health.

Public Health England's Child Oral Health Improvement Programme Board and the Adult Oral Health Oversight Group have continued to meet and provide strategic oversight for oral health improvement during the COVID-19 outbreak. This sits alongside the sugar reduction programme aiming to encourage food and drink companies to reduce the amount of sugar in popular products.

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Water fluoridation is clinically proven to improve oral health and reduce oral health inequalities. The upcoming Health and Care Bill will give the Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes. This will remove the burden from local authorities and allow for processes to be streamlined.[9]

Conclusion

Maybe it is because the grass is always greener, but from my seat it looks as though everyone bar NHS dentistry in England is attempting to give their nation's workforce the right support, integrate pandemic successes and build back a better service. They could do a lot worse than take a peek at how the Welsh, Scottish and Northern Irish have supported throughout. Why, when contract reform is so high on the to-do list of everyone involved with NHS dentistry in England, an imposition of a 60% target in these circumstances seems like a good idea is beyond me.

With the right funding, video consultations have the potential to bring around real change to the day-to-day operations of (primarily) those in secondary care, possibly high-street dentistry too. And whatever service is built back, it will be done so by those in private practice and by those who are self-employed.

The mental health, wellbeing and morale of those in the national health services are well-documented, but if those offering private services are not shown the same level of support, governments must understand this risks the total capitulation of dentistry. The current do nothing approach will leave the entire profession in a significantly worse position that it found itself before the pandemic, and that is a scenario we cannot accept. ◆

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