BDA
Northern Ireland

To: Éilis Haughey
Committee for Health
Northern Ireland Assembly
Parliament Buildings
Stormont
Belfast
BT4 3XX

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Ref: C260/20 - revised Northern Ireland Operational Dental Guidance

Dear Éilis

Thank you for the committee's invitation to share our views on the revised GDS Operational Guidance as circulated to all GDPs on 22nd October, and the implications at practice level.

The Committee will be aware that the practise of dentistry has been massively impacted by COVID-19. With the first wave, dentists were required to cease all Aerosol Generating Procedures (AGPs).
We moved to Phase 3 of GDS recovery from 20 July, which permitted 'routine dentistry' to be carried out, albeit in far from normal conditions. Those conditions were set by the new Standard Operating Procedures *'Preparation for the re-establishment of the General Dental Services -Operational Guidance,* released in June.

General practice has seen the introduction of extensive new infection prevention control measures. While these are primarily aimed at ensuring practitioner and patient safety, they have also served to seriously curtail the numbers of patients that can be seen on a daily basis. New restrictions have included a standard 1 hour surgery fallow-time after each AGP procedure, with additional time required for environmental cleaning measures; new enhanced Level II PPE requirements which must be worn by dentist and dental nurse for carrying out AGPs; and social distancing measures. Together, these are the most significant restrictions to have been applied to general dental practice, and they have fundamentally altered the way dentists and dental teams can work.

The latest revisions to the Operational Guidance for Northern Ireland made in October essentially transposed key recommendations from other landmark guidance documents, namely the updated Infection prevention and control (IPC) recommendations compiled on behalf of all 4 UK countries[1], and the SDCEP Rapid Review on Mitigation of Aerosol Generating Procedures in Dentistry[2]. In that sense, our guidance is less an original piece of work, but draws on the latest expert learning conducted on a UK-wide basis with direct input from Northern Ireland, and from international sources. This joint approach has given officials here limited scope to deviate from.

[1] COVID-19: Infection prevention and control dental appendix

[2] Scottish Dental Clinical Effectiveness Programme: Mitigation of Aerosol Generating Procedures in Dentistry -a Rapid review, 25 September

BDA has inputted directly into the SDCEP Rapid Review at a UK national level, and locally by our participation on the GDS re-establishment group that has overseen the development of local guidance.

No professional body would wish to see any additional or unnecessary restrictions imposed on their members, particularly where this has such a detrimental impact on patient throughput. This is particularly the case for a GDS contract that has been activity based, and which required practitioners to be highly efficient in seeing maximum numbers of patients due to the low margins, or nil margins on offer.

BDA has sought to take a responsible view that puts the safety of dental practitioners, their staff and the general public first, while also seeking to robustly defend the ongoing financial viability of dental practices throughout this pandemic. Our objections have not necessarily been with the restrictions that have been introduced per sé, but in ensuring practitioners receive adequate levels of corresponding financial support to be able to mitigate their considerable impact, and to ensure the continued provision of patient care under the GDS.

Revised Operational Guidance

Under the revised guidance issued in October[3], the headline change was a default reduction of fallow-time from 1 hour, to 30 minutes, subject to having at least 1 air change per hour in surgery and having natural or mechanical ventilation. Lower fallow-times can be achieved, the lowest permissible fallow-time being 10 minutes if a surgery has a sufficiently high ventilation rate/other mitigations in place such as high-speed suction or use of rubber dam. The actual ventilation capacity will vary from surgery to surgery.

No Group A Aerosol Generating Procedures will be permitted to be carried out in dental surgeries that have no natural or mechanical ventilation under the new guidance, which is clearly hugely impactful for those practices concerned. We have urged the acting CDO to agree to commission an audit of practices ventilation capacity to establish a baseline and to see where capital investment may be required for surgeries that will require additional ventilation measures.

In addition to guidance on ventilation, the revised guidance retains the requirement to use level 2 PPE for AGPs, including disposable gloves, fluid resistant gown, fit-tested FFP3 mask and eye/face protection (visors). The physical and mental toll of wearing this enhanced PPE on dentists and nurses is arguably as big a limiting factor as fallow-time provisions. It is exhausting, it causes heat stress, and it severely impacts on how many AGPs can be carried out in reality.

The net result of the new guidance means that it is far from 'business as usual' in the GDS. Fallow-time restrictions -albeit at a reduced level -look to be a permanent feature; enhanced PPE for AGPs is still a requirement; and when combined with the other factors such as social distancing measures and environmental cleaning means that practices here are severely limited in the numbers of patients they can reasonably see in a day.

While the reduced fallow-times are welcome, they are not the panacea that some had predicted. There is still considerable work to be done to work through the implications at practice level of the new guidance, and how individual surgeries and practices are equipped to meet fallow-times. While some practices are likely to require support with ventilation equipment to be able to continue to provide patient care, we have urged DoH to take a supportive approach that considers the full range of limiting factors in their entirety, and avoids adding yet more pressure to what practitioners already face on a daily basis.

[3] http://www.hscbusiness.hscni.net/pdf/Prep_GDS_Re-establishment_211020.pdf

Interrelated issues

When considering the implications of the guidance, there are a range of interrelated issues to be considered. Fallow-time is one of those, but PPE is also a very significant limiting factor. While DoH has provided some additional funding to practices to help mitigate the costs of PPE (which practices have to source and purchase themselves), this is at a fixed rate. Therefore, practices are constrained financially in the number of AGPs they can carry out. We do welcome a recent commitment made by DoH to re-evaluate how PPE is compensated where activity levels may increase. Removing this financial constraint will be important in enabling practices to provide the maximum care that is possible, albeit in what is a considerably constrained working environment.

We have emphasised that it is the outworking of this guidance at a practice level that will prove crucial. In recent months, we have finally arrived at a situation whereby a previously inadequate Financial Support Scheme (FSS) is now helping to establish a degree of financial stability for the majority of general dental practices. That has only been achieved by the additional £3.7m provided by DoH to end the 20% abatement and cover additional PPE costs previously not incurred. Furthermore, an additional £5m to the GDS to maintain patient contributions, and therefore funding levels at a stable level to the end of the financial year helps maintain that stability. However, changes to one aspect of this arrangement, namely activity would incur a corresponding increase in much higher than pre-COVID variable costs in practice.

Private dentistry

Health Service dental fees in Northern Ireland have not kept pace with inflationary increases over the past decade, and are such that there is no fat in the system left to absorb any increased costs. In addition, private earnings that have historically subsidised Health Service dentistry have been similarly hit, and without receiving any bespoke support.

We are bitterly disappointed that Minister Dodds has failed to agree to a suggestion from Minister Swann for her department to establish a Business Support Grant Scheme, to be administered by BSO to compensate lost income in Private dentistry.

We do have particular concerns for the ongoing viability of mixed/private-oriented practices who do not receive significant FSS support, and who have missed out on qualifying for various other support measures, yet continue to be burdened with having to pay industrial rates and other fixed costs. The risks to mixed/private-oriented dental practices, and the need for additional government support are laid clear in a recent investigation into the resilience of mixed NHS/Private dental practices following the first wave of the COVID-19 Pandemic[4].

If mainly private practices do fold, it will have a considerable knock-on impact for the estimated 100,000 Health Service patients who are registered with these practices.[5]

Looking ahead

Even if all practices had the infrastructure in place to attain the lowest fallow-times possible under the guidance, other significant limiting factors to patient throughput will remain so long as the risk profile of COVID remains high.

BDA has issued calls for government help with capital investment in ventilation where this may be required. At a typical cost of £3000-£5000 to upgrade ventilation per surgery, and substantially more

[4] Investigation into the resilience of mixed NHS/Private dental practices following the first wave of the COVID-19 Pandemic

[5] Derived from unpublished statistics - BSO Internal Management Information obtained upon request

where buildings are less suited to upgrade, practices can ill-afford this significant additional expenditure at a time when their revenue has been severely impacted by COVID. However, as stated previously we are urging for a considered, measured approach to be taken locally that does not impose additional pressure on dentists by way of unattainable activity levels. Experience shows that reduced fallow-time is not the silver bullet that may have been initially thought, and other significant factors are also at play. All need considered together.

Seeing how the new guidance works in practice will take time. That process has started, but the practice ventilation audit must happen, while FSS 2 arrangements will also need time to bed in.

At a practical level, we have highlighted specific issues with certain aspects of the guidance, such as asking if single use gowns that are properly laundered are permissible, as opposed to the substantial cost -both financially and to the environment of single-use disposable gowns. There continue to be supply issues with single use gowns which makes reusable an important option to be able to maintain patient care.

FSS 2 negotiations are due to conclude imminently. We are hopeful that this scheme will be such as to allow the majority of practitioners to continue to provide patients with as much care as is possible in the current constrained circumstances, and with some degree of financial certainty at least until the end of this financial year. There is no doubt that patient activity rates will continue to be significantly impacted during the period between now and April, and beyond.

An important consideration will be how General Dental Services will adapt after April; a return to the pre-COVID position of high patient throughput/maximum efficiencies will be impossible while these new restrictions look set to be permanent features. This then leads on to discussions around a long awaited new GDS contract -what would this look like? -what funding will be available to the GDS? -and what will dentists be expected to deliver in return?

At the heart of these deliberations must be patient care. We have considerable ground to make up in Northern Ireland on addressing considerable oral health inequalities and poor oral health outcomes, exemplified by the paediatric GA extraction rate being over three times higher here than in England. Rather than a GDS system based on treatment and, 'drill and fill', can we move to a system that is more prevention based, and rewards success for caring for the population's oral health needs, while simultaneously remunerating GDPs adequately for the services they provide?

These past few months have shown that early and regular communication between the profession's recognised representatives in the BDA, DoH and HSCB officials is the only way to navigate these hugely difficult challenges pertaining to dentistry. That collaborative approach will be essential as we try to find a way forward beyond the current financial year.

Keeping GDS afloat

The fundamentals are that the cost of delivering Health Service dentistry had already gone up considerably pre-COVID, while dental earnings have failed to keep pace with inflation. Dental earnings in real terms have reduced by over 30%, and the number of Principals and Associates who describe their morale as 'high' or 'very high' had dropped to just 12.9% and 15.9% respectively.[6] This already worrying trend has simply been exacerbated under COVID.

Keeping GDPs in business, and being able to present Health Service dentistry as a viable business proposition in its own right is crucial to the future sustainability of Health Service dentistry and the GDS.

[6] NHS Digital, Dentists' Working Patterns, Motivation and Morale - 2018/19 and 2019/20, August 2020

Having a financial envelope that recognises the additional costs of delivering dentistry, not least those considerable new costs such as Level II PPE -which often exceed individual rates of treatment -and being realistic about the care government wishes to commission, is essential. We must avoid any cliff-edge scenario, and ensure as smooth a transition as possible to safeguard the financial viability of practices. We strongly believe that we have an opportunity to put prevention and better population oral health outcomes at the centre of a new GDS remuneration model, while addressing many of the underlying issues that have blighted the current contractual arrangements over the past decade.

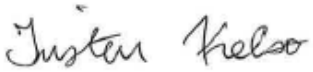
Connected with any new contractual arrangements is having sufficient capacity in place within DoH to be able to carry these significant pieces of work. We do have grave concerns at how under-resourced the GDOS unit in DoH is to be able to take this important work forward. In addition, the lack of DoH resource has similarly proved a major barrier in being able to take forward a meaningful overhaul of the Oral Health Strategy which embarrassingly dates back to 2007, or to advance the two Child and Elderly Oral Health Options groups announced at BDA's Oral Health Matters Summit at Stormont last October.

We once again urge the Permanent Secretary to recognise the need for additional staffing to be able to address these crucial issues, and the public interest that this work would represent. Staff are considerably stretched, while lack of manpower cannot be a plausible reason not to address the massive oral health issues we face in Northern Ireland.
A strategic approach to the future of Health Service dentistry and oral health provision is required now, more than ever. BDA stands ready to play our part in these important workstreams. We have campaigned vociferously to have oral health issues heard.

Finally, I refer you to a paper compiled on behalf of our Northern Ireland Dental Practice Committee - below -that provides further detail and insight into the current constraints severely limiting activity in General Dental Services.

I trust this information will prove helpful to the committee. Thank you for your ongoing interest in dentistry matters.

Yours sincerely



Tristen Kelso

Director, BDA Northern Ireland

Encs. BDA NIPDC paper: Interrelated factors limiting dental activity in Northern Ireland

BDA
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NIDPC
Interrelated factors limiting dental activity in Northern Ireland

1. BDA Practice Survey findings

While the reduced fallow times in the updated Operational Dental Guidance are to be welcomed, the NIDPC cautions that significant restrictions on GDP activity levels remain. Lower fallow time periods will help, but they by no means solve the current access to dentistry issue.

The BDA October Practice Survey revealed that 77% of NI dental practices are currently operating at less than 30% of pre-COVID levels of activity.[7] When asked what were the main obstacles to increasing activity, respondents reported the following:

- 93% - Fallow Time
- 85% - PPE costs
- 78% - Introducing mitigation measures to reduce fallow time (e.g. ventilation changes)
- 78% - Financial/cash flow problems
- 76% - Ongoing social distancing requirements (e.g. changes to waiting areas that restrict patient throughput)
- 61% - Staff availability
- 59% - Childcare availability for staff
- 46% - Reluctance of patients to attend surgery
- 45% - PPE availability
- 28% - PPE Fit testing

Of most concern, 82% of practice owners reported that, based on current levels of activity, costs, and financial support, they would only be able to maintain the financial sustainability of their dental practice for less than a year. 22% reported they could survive less than three months.

2. Physical limitations/Impact of COVID restrictions

Despite provisions for reduced fallow times, GDP activity levels remain significantly constrained by COVID related restrictions, and in particular the physically & mentally exhausting nature of wearing Level 2 PPE. NIDPC members estimate that GDPs can only be expected to treat 4 AGP patients per day, or 10 non-AGP patients per day. For comparison, pre-COVID, GDPs would expect to see 30-40 patients in a given day.

Wearing Level 2 PPE is an exhausting experience which places a physical, and mental limit on the number of AGPs a GDP can realistically complete in a given month. Many practices have taken the decision not to book AGPs back-to-back as its simply too demanding on both GDPs and the accompanying dental nurses. Those that do achieve a relatively high rate of AGPs per day often have AGP days and non-AGP days per week to manage the physical and mental toll.

[7] The BDA UK-wide Practice Survey was carried out between 14-26th October. The survey received 148 valid responses from Northern Ireland - representing 40% of the total number of dental practices in Northern Ireland. Data shown relates only to respondents who have a Health Service commitment of over 50%.

Members are concerned that a major staff crisis is looming due to the new demands associated with wearing Level 2 PPE. Achieving a higher AGP activity rate would place added physical and mental pressure on the accompanying dental nurses as well as the GDPs. Many GDPs are doubtful their nurses would accept the more intensive schedule lower fallow times could make possible if the PPE/ventilation issues were addressed.

Due to COVID working restrictions, GDPs have also been forced to reduce clinical time due to practice bubble arrangements. This means that dental teams often split their days in practice – working between two treatment rooms to avoid any delay due to fallow time restrictions – reducing the chance of COVID spreading between staff. This reduces the likelihood of an entire dental practice having to shut down due to an outbreak of COVID.

Finally, we also caution that under the revised guidance environmental cleaning requirements have not been reduced. Practices report it takes between 10 to 15 minutes after the end of the fallow period to clean and prepare the treatment room for another patient. Therefore even where ventilation is in place to theoretically achieve a 10 minute fallow period, this becomes 25 minutes in reality, while a 30 minute fallow period is 45 minutes without counting the time it takes to actually treat the patient. See Figure 1 below.

Fig 1 – Impact of 30 minute fallow time & environment cleaning on dental activity

Aerosol Generating Procedure (AGP)	Appointment time (mins)	Fallow time + cleaning time (mins)	Total time required (mins)	Total possible appts per day COVID	Total possible appts per day pre-COVID
1001 - Scale & Polish	15	45	60	7.5	30
1401 - Permanent filling	20	45	65	6.9	22.5
1404 - Permanent filling (3 surfaces)	30	45	75	6	15

3. The current PPE compensation model limits dental activity

Despite the reduced fallow time provisions, GDP activity levels remain significantly constrained by the current PPE compensation model which places a hard financial limit on the number of AGPs a GDP can carry out in a given month.

Since August, the Department of Health has compensated GDPs for the increased PPE costs associated with AGPs by removing the 20% abatement from a GDP's Financial Support Scheme (FSS) payments. The Department's position is that as dental activity rates are comparatively very low due to COVID restrictions, the corresponding reduction in variable material/lab bill costs cancels out any increased PPE cost.

However, according to the BDA NI September Activity Survey, 75% of NI GDPs reported that the removal of the abatement from GDS FSS payments did not cover the true cost of providing AGP treatments on the Health Service, and 72% of respondents cited PPE costs as a key inhibitor to increasing activity.[8]

[8] The BDA NI Activity Survey was caried out between Thursday 27th August and Wednesday 02nd September. The survey received 424 valid individual responses – representing 37% of the total number of GDPs in Northern Ireland.

According to the BDA October Practice Survey, 85% of NI practice owners reported that PPE costs were an obstacle to increasing activity levels at their practice.[9]

The key issue is that the cost of sourcing Level 2 PPE has remained very high, and there is only a certain number of AGPs a GDP can undertake within a given month and remain financially sustainable without additional support.

According to HSCB engagement with dental suppliers, the cost of PPE per AGP (for both GDP & Nurse) is circa £21. The average payment per GDP in September 2020 – including item of Service, Financial Support Scheme and Registration Fee payments – was £7783.[10] According to DoH, 20% of that figure - £1557 - should cover PPE costs. At £21 per AGP, this allows the average GDP to carry out a maximum of 74 AGPs per month.

However, it's important to note that the £1557 PPE budget above must also cover the cost of the Level 1 PPE requirements, the environmental cleaning PPE requirements, the materials/lab bills associated with carrying out the treatment, and the increased clinical waste costs associated with the increased use of PPE. As a result, the maximum number of funded AGPs per month will be much lower.

This funding restriction significantly limits the impact of the reduced fallow times within the NI Operational Dental Guidance. Even if GDPs were physically able to provide over 100 AGPs per month, the current funding model would not allow it – See Figure 2 below.

Fig 2. Average AGP funding versus cost of PPE per number of AGPs completed

4. High costs make improvements to practice ventilation levels uneconomic

The revised NI Operational Dental Guidance suggests that the fallow time associated with an Aerosol Generating Procedure (AGP) could be reduced to as little as ten minutes if a treatment room features more than 10 air changes per hour (ACH). However, not every treatment room in every dental practice will have this level of ACH. Some treatment rooms may not even feature natural or mechanical ventilation, which now bar them from being used for Group A AGPs no matter the fallow time period.

The lack of necessary ventilation equipment will be a significant barrier to increasing capacity and addressing the significant patient backlog. According to the October BDA Practice Survey, 78% of

[9] The BDA UK-wide Practice Survey was carried out between 14-26th October. The survey received 148 valid responses from Northern Ireland - representing 40% of the total number of dental practices in Northern Ireland. Data shown relates only to respondents who have a Health Service commitment of over 50%.

[10] Derived from unpublished statistics - BSO Internal Management Information obtained upon request. To obtain an accurate figure the following cohorts were removed – Orthodontists, GDPs who do not receive an FSS payment, any GDP that did not qualify for the removal of the 20% abatement.

practices reported that introducing mitigation measures to reduce fallow time (e.g. ventilation changes) was an obstacle to increasing activity levels.[11]

In addition, for those practices without the necessary ACH levels to achieve the lowest fallow times, the potential cost of upgrading their premises is beyond reach -typically £3000 to £5000 per surgery. This level of investment is out of the question for Health Service focused practices with a fixed income stream and no means to increase income levels to cover the cost of installation. According to the October BDA Practice Survey, 70% of Practice Owners reported they did not have ready access to funds to invest in new equipment (like ventilation) to increase capacity.[12]

We have asked HSCB to carry out an immediate audit of every dental practice to ascertain the ACH status of their treatment rooms. Once a clear picture emerges, should the Department of Health aspire to increase dental activity, then a capital funding package will be needed to allow practices to obtain and install the necessary ventilation equipment.

[11] The BDA UK-wide Practice Survey was carried out between 14-26th October. The survey received 148 valid responses from Northern Ireland - representing 40% of the total number of dental practices in Northern Ireland. Data shown relates only to respondents who have a Health Service commitment of over 50%.

[12] Ibid