
Committee for Health
Room 419, Parliament Buildings
Stormont
BT4 3XX

**COVID-19 Disease Response**

**Written submission to Committee for Health**

The British Dental Association (BDA) is the voice of dentists and dental students in the UK. As the recognised trade union and professional body, we represent all fields of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia, public health and research.

We welcome this important opportunity to provide members with an update ahead of the committee's session on dentistry on 8th October.

This briefing has been compiled with input from BDA Northern Ireland's committees, including Northern Ireland Dental Practice Committee (NIDPC), Northern Ireland Salaried Dentists Committee (NISDC), Northern Ireland Hospitals Group, and Northern Ireland Council.

We trust what follows will update members on the continued significant issues facing the dental profession, and the continued provision of dentistry in Northern Ireland at this time, including particular concerns within General Dental Services (GDS), Community Dental Services (CDS) and hospital dental services.

We would like to thank the Health Committee for the responsive, diligent and compassionate way it has taken forward issues facing the dental profession and the continued provision of dental care over the past six tumultuous months, including at times when the profession felt like they had nowhere else to turn.

The committee's ongoing scrutiny role will be key in navigating the future sustainability of NHS dental services, and the wellbeing of those dental professionals who underpin these.

## Introduction

## 1. General Dental Services (GDS)

Six months on from the start of the pandemic, and two months since 'routine dentistry' was permitted to resume, the provision of health service dentistry remains incredibly constrained by new restrictions introduced following Covid.
Practitioners lack any degree of certainty over their financial futures, and indeed they remain fearful that supports could be reduced at any time by DoH while faced with additional costs, including PPE should activity rates be increased; morale has reached rock-bottom; and pre-COVID BDA warnings made about the sustainability of Health Service dentistry are ringing true.

While a degree of stability in GDS was secured following DoH agreeing to end the 20% abatement of FSS payments and provide an additional £3.8m towards enhanced PPE costs over a x4 month period at end of August while continuing to cover patient contributions, these were only temporary measures.

General Dental Practitioners still lack any real degree of certainty around what future financial support arrangements will be in place from one month to the next, as FSS rolls forward on a one month basis, while morale across the profession is at a new all-time low. Warnings included in DoH correspondence that funding levels may be reduced due to DoH budgetary constraints have only heightened concerns that these vital supports could be pulled, at a time when practices and practitioners are fighting for their survival, and remain dependent on the current level of Financial Support Scheme (FSS) payments continuing.

The asynchronous nature of *restrictions first, financial mitigations later*, have seriously heightened practitioner anxiety levels. The most serious issues have arisen when cognisance of the full financial impact of new restrictions on practitioners have not been fully acknowledged -or adequately mitigated for -in a timely fashion at a departmental level. We saw this most evidently in relation to PPE costs at end of July.

### Reduced capacity

Not only are dentists working through a significant backlog of appointments that were cancelled during lockdown, but their capacity to see and treat patients is extremely limited following new restrictions introduced in Operational Guidance[1] that require a default one hour fallow-time, and wearing enhanced Level II PPE when carrying out Aerosol Generating Procedures, as well as applying new social distancing measures in practice.

Whereby pre-COVID, a dentist may have seen typically in excess of 30 patients per day, capacity is now at around 20%-25%, with the capacity to see just 6 or 7 patients per day because of these new restrictions. Contrary to the impression that dentistry has returned to 'business as usual' following the permitted return of routine dentistry and being able to carry out AGPs, the reality in practice is very different.

[1] Preparation for the Re-establishment of the General Dental Services - Operational Guidance, HSCB, 09 September 2020

**PPE**

On 20th July, 'routine dentistry', including AGPs was permitted to re-start in practice. Crucially, this happened without any provision having been made for either directly supplying practices with the enhanced Level II PPE required, or additional funding to enable practices to attempt to purchase their own.

This followed a period of considerable uncertainty where many practitioners were holding off on being fit-tested for masks because of the expectation that this would have been part of the PPE offer. In neighbouring jurisdictions, enhanced PPE has been supplied to dental practices, or access given to purchase from central supply chains at a significantly reduced price.

Under the current Operational Guidance for Northern Ireland, three sets of PPE are required for each Aerosol Generating Procedure, taking into account a set each of Level II PPE for the dentist and dental nurse, and a set for cleaning the room down after the procedure, at a total cost averaging in the region of £21-30[2]. In contrast, the remuneration received for an amalgam filling equates to just £9.64.

The situation that would have been imposed on practitioners where every NHS procedure carried out by a dentist would generate a hefty loss was simply unworkable, and came at a time when the Urgent Dental Care Centres were to be stood down completely. This lack of consideration for the impact on practice finances, and expecting GDPs to move from generating already low fees under the GDS to an actual loss-making situation for every item of treatment undertaken is what created mass panic and anger within the general dental population.

Dentists were put into a desperate situation; they had no choice but to seek out the support of elected representatives, the Health committee, and the media to share their concerns and to highlight the urgency of the situation. At the same time, DoH continued to unjustifiably apply a 20% abatement for 'variable costs not incurred' by practitioners, when new, significant additional costs and significant supply issues associated with PPE were being incurred. And all at a time when Private dentistry missed out on being eligible for various support packages.

A one-off supply of approx. £800k Level I PPE was small consolation, and had little impact on the bigger picture concerns at the time. The BSO response that it could not supply sufficient quantities of enhanced PPE to GDPs, and for them to secure their own, was wholly inconsiderate and irresponsible.

Looking ahead to the next wave, GDPs have no clarity on whether PPE will be provided to them, or if the initial additional allowance to help mitigate PPE costs will continue. This is deeply unsettling in a scenario where PPE costs often exceed the fee dentists receive for a procedure.

**A Profession pushed to the brink**

At the end of July, GDPs involved in providing NHS dentistry were pushed to the brink. A petition calling on DoH to *'Save NHS Dentistry in Northern Ireland'* was set up by Campaigning organisation '38 degrees', attracting over 7,000 signatures in a matter of weeks. This petition shows the support among the public for the need to protect access to NHS dental services here, and will be formally handed over to DoH in the coming days.

[2] 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.

Additional support in the form of an extra £3.8m to remove the 20% abatement to FSS payments, and help cover PPE costs for a x4 month period came at the end of August. Had this additional funding not been made available, the only option left to us and the profession at large would have been to take legal or industrial action, with many practitioners feeling they were being forced to withdraw from providing Health Service dentistry.

In England, the Government's new PPE Strategy[3] makes provision for free PPE to be made available to dental practices with NHS contracts via a PPE Portal, while clarification is being sought whether private practices will be able to access this supply at cost price. In Northern Ireland, practitioners simply do not have clarity around whether PPE costs will continue to be mitigated for under future FSS funding arrangements, or if direct supply is an option. We need urgent clarity on this issue.

**Financial Support Scheme -lack of financial certainty**

While the Financial Support Scheme (FSS) has continued to date, unlike their colleagues in neighbouring jurisdictions, practitioners do not have any degree of certainty about how long, or at what level of funding they will continue to receive from DoH. As business operators, they have nothing tangible to assure their banks about what income they will generate beyond the current month.

The FSS has rolled over on a month to month basis. With such continued disruption to activity rates at a practice level, practitioners remain dependent on the continuation of the FSS to maintain their Health Service income. Moreover, we have impressed upon DoH the importance to the financial viability of dental practices to continue to top up the shortfall from reduced patient contributions as a result of lower activity levels. We understand a bid for additional funding has been made by DoH to Department of Finance to continue to cover patient contributions, but have no knowledge of when the outcome of the bid will be known. In the meantime, practitioners remain on tenterhooks.

We call for a systematic approach from DoH that commits to offsetting all of the significant additional costs being incurred by practices as a result of Covid. For instance, we do not know if DoH intends to continue to provide additional funding towards PPE costs after the initial 4 month period of funding expires. This is very much at odds with the situation that our colleagues in England and Scotland enjoy.

- Dentists are being expected to carry on providing NHS dentistry, but without knowing if this will make business sense going forward;
- Additional costs of PPE going forward (initial support provided for a x4 month period); as activity rates potentially increase, so too will variable costs incurred, which dilutes the current funding arrangements;
- To guarantee financial viability, funding should be available to ensure practices are, 'no worse off than had COVID not happened'. Practices have already lost access to significant private revenue without recompense, they cannot absorb the prospect of significantly reduced levels of NHS income as well

[3] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

**Struggling with the patient backlog**

Since the end of July, GDPs have been working as hard as they can, in extremely constrained and physically difficult working conditions to treat the backlog of patients that built up over the lockdown. Routine dentistry being permitted does not translate to 'business as usual' in dentistry, far from it. For example, Item of Service claims – a proxy for activity – fell by 77% in the period April-June 2020 compared to the same period last year.

New *Operational Guidance for the re-establishment of the GDS* was published by HSCB on 19th June. This introduced a one hour fallow time after an AGP is carried out, before cleaning and decontamination. What would have been a 30 minute appointment now translates into a 2 hour turnaround time, and has meant going from seeing typically 25-30 patients per day per surgery, to around 5 or 6.

Capacity in practices to see patients has significantly reduced at the same time as a backlog has built up. Moreover, as well as prioritising patients according to need, practitioners are also having to balance their capacity in proportion to their pre-COVID NHS/Private split, according to the terms of the FSS. While its right that NHS patients do not lose out, the disparity in remuneration levels between private and NHS is undoubtedly serving to create a situation whereby practices are torn between continuing to provide NHS care and trying to do what is best to keep their businesses financially viable.

This is a legacy of DoH's policy of running down GDS remuneration and HS dentistry over many years. We warned about an impending sustainability crisis, and COVID has brought this to the fore in particularly stark terms.

**Fallow-time restrictions -a permanent feature in dentistry?**

There is very real concern about the implications for practices if fallow-time restrictions, albeit at a reduced level, become a permanent fixture in UK dental practices.

A Rapid Review by the Scottish Dental Clinical Effectiveness Programme (SDCEP) on *Mitigation of Aerosol Generating Procedures in Dentistry*[4] has recently recommended moving to a pragmatic benchmark fallow time, dictated by ventilation rate, of 15-30 minutes, or when ventilation is poor and high volume suction is not used, up to 60 minutes. A 10 minute fallow time is theoretically possible where surgeries can achieve optimal air changes, and where high-volume suction and rubber dam is applied.

The SDCEP recommendations do not represent guidance. However, it is expected that Northern Ireland's Operational Guidance will be amended to reflect many of the recommendations contained within this report.

BDA has participated in good faith in both the SDCEP Working Group, and in the GDS Re-establishment Group which will produce amended Operational Guidance for Northern Ireland. While our primary concern remains the safety of dentists, dental staff and patients, we do have very grave concerns about potential implications of ongoing fallow-time restrictions on the financial viability of dental practices.

Assuming our new Operational Guidance makes provision for attaining a reduced fallow-time, this will require significant additional levels of capital investment in surgeries, in terms of new ventilation, heat exchangers, professional fees and structural works to buildings to achieve the necessary

[4] https://www.sdcep.org.uk/published-guidance/covid-19-practice-recovery/rapid-review-of-agps/

ventilation/air changes stipulated. Practices will not be able to assume this significant burden, and it will require additional financial support from Government to cover any additional costs being faced by the profession in order to continue to provide NHS care.

There is also the concern about ongoing additional costs which could be placed on general dental practices as a result of a fallow-time being embedded. Perversely, because Item of Service fees are at such an inadequate level, the lower the fallow time applied and the higher the activity, the more practice losses will be compounded for every treatment provided. This adds additional pressures on practice finances at a time when NHS dental remuneration has not been sustainable over many years. The required investment comes at the worst possible time for practices, and on top of the upfront costs is likely to incur ongoing maintenance costs. We would urge the committee to explore with DoH how it proposes to support dental practices with these unforeseen costs, in removing financial barriers to enable activity rates to grow as practices feel able. We are deeply concerned that DoH would seek to impose an artificial target of pre-COVID activity, without addressing the root causes -namely, the more you work, the more money you lose.

Finally, while reduced fallow times may be theoretically achievable, the requirement to wear enhanced PPE to conduct most dental procedures, and the significant physical toll/heat stress for practitioners will continue to be a limiting factor. We urge DoH to take practitioner wellbeing into account with regard to any expectations or conditions it may consider imposing around activity levels in a future FSS funding scheme.

- Enhanced PPE costs now exceed fees which dentists receive for providing many treatments as pre-COVID SDR fees continue to be applied
- Moving to force increased patient activity rates in a reduced fallow-time environment, while continuing to apply pre-COVID SDR fees will simply exacerbate individual loss-making situation of treatments
- While an additional £3.8m has been provided towards Level II PPE costs for an initial 4 month period, dentists are understandably extremely nervous about the financial impact if these new variable costs are not continued to be addressed, and at an enhanced rate if activity rates are to increase as DoH is proposing

**Impact of 60 minute fallow time**

| SDR Code & Description | Appointment time | Fallow time + cleaning time | Total time required | Total possible appts per day | SDR 2019/20 Fee | PPE cost | Daily SDR earnings minus PPE cost |
|---|---|---|---|---|---|---|---|
| 1001 - Scale & Polish | 15 | 75 | 90 | 5.0 | £14.33 | £20.00 | -£28.35 |
| 1401 - Permanent filling (1 surface) | 20 | 75 | 95 | 4.7 | £9.64 | £20.00 | -£49.07 |
| 1404 - Permanent filling (3 surfaces) | 30 | 75 | 105 | 4.3 | £24.80 | £20.00 | £20.57 |

**Impact of 30 minute fallow time**

| SDR Code & Description | Appointment time | Fallow time + cleaning time | Total time required | Total possible appts per day | SDR 2019/20 Fee | PPE cost | Daily SDR earnings minus PPE cost |
|---|---|---|---|---|---|---|---|
| 1001 - Scale & Polish | 15 | 45 | 60 | 7.5 | £14.33 | £20.00 | -£42.53 |
| 1401 - Permanent filling | 20 | 45 | 65 | 6.9 | £9.64 | £20.00 | -£71.72 |
| 1404 - Permanent filling (3 surfaces) | 30 | 45 | 75 | 6.0 | £24.80 | £20.00 | £28.80 |

**Impact of 10 minute fallow time**

| SDR Code & Description | Appointment time | Fallow time + cleaning time | Total time required | Total possible appts per day | SDR 2019/20 Fee | PPE cost (per AGP) | Daily SDR earnings minus PPE cost |
|---|---|---|---|---|---|---|---|
| 1001 - Scale & Polish | 15 | 25 | 40 | 11.3 | £14.33 | £20.00 | -£63.79 |
| 1401 - Permanent filling | 20 | 25 | 45 | 10.0 | £9.64 | £20.00 | -£103.60 |
| 1404 - Permanent filling (3 surfaces) | 30 | 25 | 55 | 8.2 | £24.80 | £20.00 | £39.27 |

## Morale and wellbeing within the dental profession

Prior to COVID, the morale of the dental profession in Northern Ireland was already at extremely low levels, with just 14% of GDPs reporting their morale as '*high*' or '*very high*'[5] According to a recent BDA NI practice survey[6], the figure now worryingly sits below 3%. This represents a total collapse of morale in dentistry, and into the realms of wellbeing.

[5]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/902451/CCS0320352414-001_DDRB_2020_Web_Accessible.pdf

[6] 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. 88.3% of NI GDPs rated their morale as a dentist as low, including 62.6% as very low. Less than 3% rated their morale as High/Very High

COVID has had an absolutely devastating impact on the dental profession. The practise of dentistry has been severely disrupted; business models reliant on high activity rates/low Item of Service fees are no longer fit for purpose; DoH financial support has failed to provide any degree of future certainty, while the Executive has failed to provide any bespoke support for the private part of dental practices.

The physical stress of having to wear enhanced Level II PPE for extended periods has also taken its toll on dentists, and on the wider dental team.

Since COVID, dentists have been required to take on additional duties, such as redeployment, providing care to unregistered patients, and being required to provide cover 7 days a week with the removal of the out of hours service. Dentists are burned-out, have been left reeling from the manner in which DoH has inadequately supported them with additional financial pressures around PPE, and have received treatment at odds with their General Medical colleagues.

Morale in the dental profession has reached such a low level, that we fear this has become a widespread wellbeing issue, a situation that has worsened as a result of systemic failings and mismanagement. We urge government to recognise the seriousness of the situation facing our dental workforce, and to act with compassion and provide the support required urgently, rather than assuming a 'stick' and conditions-based approach.

Regrettably, there have been occasions during this pandemic where DoH has added to the stress of the profession significantly, applying unreasonable conditions to FSS support, and treating the profession in a way that has been perceived to be lacking in respect and trust. According to our recent survey, 79.5% of NI GDPs believe the Department of Health has not valued the service provided by Dental Practitioners since the start of the COVID pandemic[7].

Individual practitioners, such as those off on maternity during the reference period have been overlooked under FSS, and the lack of an appeals mechanism has added to the perception of unfairness. We still have examples of Educational Supervisors who don't know what they have been paid under FSS for their work as a trainer; where maternity cases have received additional payments without any breakdown or calculation of how payments have been made; dentists eligible to receive seniority payments who were being denied their full entitlements under FSS, and a system that is seemingly inflexible to accommodate new entrants. Unfortunately, all too often the process that ensues resembles 'ping-pong' between DoH, HSCB and BSO, rather than providing clear explanations and fair solutions taking into account 'individual circumstances', as had been promised.

An appeals panel is essential to bring transparency and a fair resolution to such cases where individual circumstances should be taken into account. We repeat our calls for this to be put in place, with input from BDA as well as DoH, HSCB and BSO.

We have recently raised high level concerns directly with the Minister as 'lessons learned' in our submission to the Surge Framework document, and raising our ongoing concerns with the FSS to the GDOS section in DoH.

[7] Ibid

BDA has received countless numbers of emails, phone calls and text messages from very worried practitioners. We take this opportunity to share a recent communication to give some insight into the mood of the profession, and the challenges of being a dentist at this time:

**A dentist's perspective** -an email received by BDA on 1st October

*Today was an AGP day for myself. Working between multiple surgeries and multiple nurses I saw 14 agp and 2 non agp patients. 2 of which were unregistered and in pain. I completed 6 first stages for which I am paid next to nothing. In total I made less than £200 working an 11 hour day without lunch. In pre covid times I could've made that seeing check ups in 90 minutes.*

*I am doing exactly what the government have asked. Trying to treat emergencies, then treatment that has arisen since covid or I cancelled. I'm trying to do as much denture work as I can because these patients tend to have worse health and will need to shield as winter progresses. I have postponed all prophylactic check ups and have faced a lot of flak and grief for having done so.*

*It's bad enough that I've had 11 days off since 4th April, that the board can't communicate with itself, never mind the profession. I've had one staff member tell me she's taking early retirement and another is going for a hospital appointment ? Cancer tomorrow. The prospect of DoH penalising us if we don't meet their artificial activity rates? Couldn't make it up.*

*I appreciate the guidance and inspiring leadership BDA have provided throughout this period. I have never felt like the profession would crumble under this. But tonight, knowing that the covid numbers are going to increase and the prospect that the department want us to follow a target-driven path so contrary to the public guidance, where we are rewarded for breaking guidelines… I just can't see how those two positions can be reconciled.*

We emphasise, the vast majority of dentists are working in extremely difficult circumstances to provide the best care possible to their patients. More must be done to help manage the expectations placed on dentists, so that the public and department is fully cognisant of the pressures they are under and act accordingly.

We call on DoH to adopt a more compassionate and proactive approach to helping the profession get through this crisis. If NHS dentistry in the GDS is valued, then it is in DoH's interests as much as GDPs to do what is necessary to help practices survive, and to support independent contractors as much as possible to be in a position to carry on seeing Health Service patients. Major financial barriers, not least PPE costs must be taken away.

### Support for Private dentistry

While the majority of practices in Northern Ireland are mainly Health Service committed, they nearly all have some element of private income. It is recognised that private dentistry has subsidised the wholly inadequate NHS fees/remuneration model for years.

Despite having written three times to the Minister for the Economy calling for support for mixed/private-oriented practices for their private component, no bespoke support has been forthcoming. Following our letter to the First and deputy First Ministers and other Executive Ministers in July, the Health Minister did write to the Minister for the Economy putting the case for a 'Business Support Programme' for private dentistry. We still have not received any update of where this issue is at.

We recently wrote again to Minister Swann to highlight the worsening plight of private practice, and enclosed a report by Jason Wong, OCDO England that revealed mixed/private practices are at most financial risk and in need of additional government support. We repeated calls for additional government support for private practices, including full rates relief for all dental practices. If these practices fail, it will have major repercussions for NHS dentistry, not least the hundreds of thousands of NHS patients registered that will be left without access to a dentist.

Dentists remain concerned about their continued ability to offer NHS dentistry in a way that is financially viable and makes business sense going forward. A divergence of NHS vs Private rates has developed over recent years; we do question how a GDS model that is based on a 'high throughput, low margin' GDS, can continue to work in a post-COVID world of social distancing, increased costs such as PPE, and fallow-time being embedded as a permanent fixture etc?

The reality is that Private dentistry has been subsidising NHS /GDS dentistry for some time. We need to see meaningful Executive support for those practices at risk. Furthermore, additional and adequate levels of investment in the GDS is vital if we want to avoid a collapse of NHS dentistry. COVID has brought all of these longstanding issues to the fore like never before.

**DDRB: pre-COVID, long-term issues**

*'The delays to the pay award process in Northern Ireland continue to be unacceptable'* - DDRB 48th Report, July 2020.

COVID has brought into focus what BDA has been saying for years about a sustainability crisis in NHS dentistry/the GDS, positions which have now been echoed by the Review Body itself: lengthy delays in pay uplifts being awarded; low morale; decreasing trends in dental earnings that DDRB has said *'are also cause for concern'*.

The pay review body highlights that *'overall earnings are not keeping pace with DDRB recommendations for NHS earnings, and this has the potential to impact on the attractiveness of continuing to work in the dental profession'.*

Other than the setting up a GDS Turnover Group which has not yet reported, these significant issues that have been left to fester within the GDS need to be urgently addressed. Years of neglect of dentistry and undervaluing dental professionals has exacerbated the scale of the challenges which are now so apparent.

**Resumption of RQIA inspections**

The decision taken by the Chief Medical Officer to mandate the RQIA to resume their statutory inspection regime, to include dental practices from week commencing 24 August came at the worst possible time for struggling practitioners. The CMO's failure to consult with BDA on this issue in advance was badly received by the profession. While RQIA have been willing to engage with us on ways of minimising the impact on practices, the imposition of physical inspections while practices are seeking to apply social distancing controls is at odds with the virtual inspection model taken elsewhere. The manner in which the resumption of inspections was handled by the CMO showed little regard for the dental profession, and the pressures they were facing.

**A proper strategy to enable recovery**

General Dental Practitioners don't want to turn their backs on the NHS. However, the choice may be taken out of their hands unless this crisis is properly managed over the months ahead. Concerted action is needed now to *Save NHS Dentistry in Northern Ireland*.

To BDA, it seems we have been single-handedly pressing for the strategic work to shape the future of dentistry and oral health provision, and essential contractual reform over recent years. We have made the case for a new Oral Health Strategy to replace a document that was published in 2007; an updated GDS contract that delivers better oral health outcomes as opposed to outputs; immediate action to improve the oral health outcomes of the young and the elderly with the setting up of Oral Health 'Options Groups' -which still haven't met. Dentistry has been allowed to wither on the vine in Northern Ireland. Unfortunately, such a laissez-faire approach is simply no longer an option if we value the recovery of dentistry post-COVID.

## 2. Community Dental Services

The pandemic has had a major impact on community dental services, resulting in huge backlogs in care of vulnerable patients. Reductions in available theatre space, and reduced capacity of lists has seen special needs lists almost halted between April and June, with only a small amount of recovery during July and August.

**General Anaesthetic (GA) provision**
There is reduced access to day care provision and reduced numbers on the lists. This is leading to increases in the waiting times and with a second wave and future winter pressures, it can only get worse.

Special Care patients are particularly affected as we can only do one/two per list as they require comprehensive care. At present mainly emergency patients are being facilitated meaning those already on the list are waiting longer. Increased funding for staffing/facilities will be required in the future to manage these issues.
Some Trusts are reporting children's General Anaesthetic (GA) extraction waiting times for treatment increasing from 55 weeks pre-covid, to 152 weeks assuming continuation of current post-covid capacity.

The picture is even more bleak for special needs patients requiring GA's -in some Trusts, waiting times have risen from 44 weeks pre-covid to 196 weeks.

**Vulnerable patients**
The reduction in dental clinics and restrictions re AGPs are impacting on all CDS patients but particularly on vulnerable medically at-risk patients. Some are reluctant to attend HSC facilities as they have been shielding and are worried about the risks of contracting the virus. Those in nursing/residential care are reluctant to admit HSC staff especially when there is increasing community spread of the virus. CDS dentists continue to work with the homes to ensure emergency care is accessed in a timely fashion.

Although all dental patients are impacted, the effect on vulnerable patients is more significant and will lead to a further widening of oral health inequalities.

**Workforce Stress**
CDS staff have worked all through the pandemic, either redeployed to work in the UDCs, clinics or redeployed to swab or work in nursing homes. Sickness rates are increasing. There are issues with access to childcare, and schools returning have affected attendance. This is likely to be an increasing concern.

We remain concerned that 6 months later, CDS dentists who have worked on the frontline, at weekends and outside of their normal working hours still have not been provided with an agreed temporary regional rate of pay. Once again, securing any agreement on as confined an issue as this seems to take an inordinate amount of time, and involve approval not only by Department of Health, but also Department of Finance. In contrast, staff are expected to work without knowing what rate of pay they will receive. This is deeply unfair, and points to a dysfunctional approach taken in Northern Ireland to resolve these issues, as is the case every year with applying the DDRB pay uplift recommendations. It only serves to erode goodwill, and damage morale of staff.

**Urgent Dental Care Centres (UDCs)**
Health Centres continue to be used for the UDCs, and this is impacting on the resetting of CDS services in some Trusts. There are particular issues with dental nurse and Dentist cover in some Trusts, while the outstanding issues of lack of remuneration for weekend working for CDS Dentists has still not been resolved despite it being escalated to the Minister of Health.

Poor communication between the various parties involved in the centres has resulted in a request being submitted from the Clinical Directors of the Trusts for a roundtable meeting with all of the key stakeholders to find a resolution to these issues.

## 3. Hospital dental services

Hospital dental services are in a major state of flux following COVID, with many services not having fully resumed. There is limited provision to take on new referrals in many areas, with capacity only for urgent cases. The largely open plan layout of the School of Dentistry, and the new restrictions around carrying out Aerosol Generating Procedures has significantly reduced capacity to approximately 10-20% of the patients that could be seen pre-COVID.

As general practice gradually re-opens, the need for referrals will increase, but the type of service provided may have to change significantly, perhaps to something akin to a treatment planning service in light of limited capacity.

Head and neck oncology referrals are seeing very advanced cancers presenting, many of which are inoperable. Oral cancer screening has and will continue to suffer with reduced patient flow in general practice as a result of the new restrictions.

Practitioners are also supporting the return of student dentists, but their work on phantom heads and simulated training will be very different than gaining real life experience in clinic. This could have further repercussions on the readiness of next year's Foundation Dentist intake, and additional work that may be needed by Educational Supervisors.

As CDS clinics continue to be disrupted, some of the School of Dentistry capacity is being taken for the community service, which is also impacting on hospital services.

Morale among hospital dentists is incredibly low, and there is a degree of concern over how staff may be redeployed in a second wave. Perhaps most frustrating to hospital dentists is that there appear to be no easy solutions to these problems given the physical layout of the building. Practitioners are doing as much as they can in extremely constrained circumstances.

**Recommendations**

1. GDPs urgently require financial certainty. Adequate levels of support must cover all of the significant additional costs imposed by COVID, including ongoing PPE costs and patient contributions, in order to maximise the financial viability of practices, to at least a pre-COVID level. GDPs must not be pushed to the brink again.

2. We reiterate our calls for additional support to be provided to mixed/private-oriented practices, including extension of full rates relief to all dental practices, and for clarity around a Business Support Programme proposed by the Health Minister to the Economy Minister, using BSO to distribute grants

3. A fit-for-purpose appeals mechanism, with BDA input established to resolve all outstanding and ongoing individual concerns/queries relating to FSS payments, and provide much needed transparency around how payments are calculated

4. PPE: General dental practices were disgracefully excluded from access to a central supply of PPE during the first wave. We need to know now if GDPs will have access to free enhanced PPE from central supplies, or if ongoing help with enhanced PPE costs will continue with financial support beyond the initial x4 month period, and with increases in proportion to increased activity levels, plus other increased variable costs faced by practices in order to ensure dentist practices are no less financially viable under COVID

5. A Government financial support scheme to be provided for any capital /structural works that may be required to comply with new fallow-time restrictions, or to attain reduced fallow-times where practitioners want to pursue this option, and not under duress through the imposition of artificial activity levels. Also a recognition that the inadequate SDR Item of Service fee structure perpetuates a loss-making scenario where activity does increase, which is providing a major barrier to activity rates increasing organically

6. DoH to prioritise addressing longstanding issues within GDS, including those highlighted in the DDRB 48th Report by the pay review body: address unacceptable delays in awarding pay uplifts; address the decline in dental earnings over the past decade. Also, to provide additional investment needed to make the GDS /practitioner remuneration sustainable in its own right, without the need to be subsidised by private activity; a GDS contract model that is fit-for-purpose following the new restrictions imposed by COVID that has disrupted business models

7. NI Executive as a whole to address the delays in seeking sign-off for additional funding -to implement timely annual pay uplifts, make timely awards of additional funding needed to respond to new pressures; sign-off on an overtime rate for CDS. The current process between DoH and DoF is remote, convoluted, and slow

8. DoH must address the collapse in morale within the dental profession, and take action to avoid any further systemic stressors reducing morale even further. We urge a more compassionate and proactive approach from DoH, working with us to address the myriad of issues that have built up within dentistry over recent years. Workforce capacity in DoH can no longer be the limiting factor for progress, and responsibility needs to be taken as such by DoH at a senior level

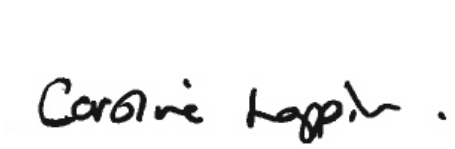
9. An urgent decision to be taken on what overtime rate of pay will apply to CDS dentists who have worked beyond their normal hours, after 6 months of delay. Additional support to facilitate the rebuilding of CDS services, and to clear the backlog of care for vulnerable patients

10. An overarching plan for the resetting of dental services -general, community and hospital -is required. There is an opportunity to rebuild a model that addresses the oral health needs of the population better, while also empowering the dental workforce through a fit-for-purpose remuneration model. In essence, a new deliberate Oral Health Strategy.

11. We repeat our calls for dentistry to have direct representation at a senior level within DoH, including on the Management Board. Decisions continue to be taken with significant direct implications for dentistry, but with dentistry feeling remote and detached from the process. We also ask DoH to apply those 'lessons learned' in our response to the *Draft Surge Planning Strategic Framework* of 11th September

12. Fundamentally, DoH must provide whatever support is necessary to help the dental profession -and dental services -get through this crisis. An approach that is all stick and no carrot will perpetuate an all-out crisis in the profession and will lead to a situation where GDPs can see no future or business sense in continuing to provide Health Service dentistry. The profession has been pushed to the brink on a number of occasions -we urge compassionate leadership to avoid such a scenario from materialising

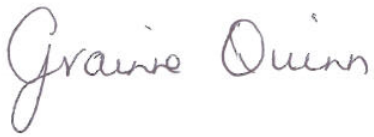
Tristen Kelso, Director BDA NI



Caroline Lappin, Chair NI Council

Richard Graham, Chair NIDPC

Gerry McKenna, Chair NI Hospitals Group



Grainne Quinn, Chair NISDC

**2nd October 2020**