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Dear colleague

This is the fifth in a series of regular updates to general dental practices and community dental services regarding the emerging COVID-19 situation. An electronic copy of this letter and all our other relevant guidance can be found here: www.england.nhs.uk/coronavirus/primary-care/**.**

We also send out a regular primary care bulletin, which you can sign up for here: www.england.nhs.uk/email-bulletins/primary-care-bulletin/**.**

With the gradual resumption of face-to-face dental care in practices across England, we want to reiterate our gratitude for the ongoing commitment to quality care.

In light of the emerging evidence and recommendations for Infection prevention and Control, we continue to review the risk management measures for dental practices and will keep you informed of any developments. However, the potential for localised and regional resurgence of COVID-19 will endure. To this end, regions will retain their urgent dental care capability, and practices should be prepared to comply with any localised public health measures and restrictions.

Regional directors and public health leads will provide the necessary direction and practices are reminded to remain connected with their regional teams.

1. Resumption of dental services

As detailed in our letter of 28 May, restrictions around the provision of face-to-face care were lifted for primary care dental services on 8 June.

Practices need to risk assess staff, patients and care delivery and establish the appropriate PPE, IPC and social distancing and separation measures to ensure the safety of patients and dental teams, but we ask that this is done as quickly as possible.

In recognition of the above, we remind all dental practices to keep their local commissioners informed of service status and opening hours (see existing guidance, Appendix 4: Informing the public and commissioners of service status, p25-26).

1.1 Patient management

The patient pathway for dental care should consist of two broad stages – remote management and face-to-face management – for both urgent and routine care. It is important to retain the initial remote stage, particularly to identify possible/confirmed COVID-19 cases (and household contacts), patients who are shielding, and patients at increased risk, to ensure safe care in an appropriate setting. This stage also helps to prevent inappropriate attendance, support appointment planning, and maintain social distancing and patient separation.

Once remote risk assessment and dental triage are complete, the professional judgement of the clinician will determine whether the patient continues to be managed remotely or face to face. Any face-to-face care required should be arranged at a dental service/care setting which is appropriate and suitably equipped for the patient's care requirements (eg service with Level 3 PPE available for aerosol generating procedures (AGPs); domiciliary setting/site with appropriate separation measures for patients who are shielded; designated UDC provider site for patients with COVID-19).

1.2 Guidance and standard operating procedures

The following guidance and SOPs are available to support dental teams:

- **Transition to recovery SOP** supports dental teams through the transition from restarting face-to-face care to the full resumption of dental care services.

- **Urgent dental care SOP** provides guidance for urgent dental care delivery in all primary care dental settings (general dental practices and community dental services), as well as designated UDC provider sites, as part of local UDC systems.

2. Financial and contractual arrangements for dental services in England

On 25 March 2020 NHS England and NHS Improvement wrote to dental practices detailing immediate steps to revise the operation of the 2020/21 contract that reflected service disruption due to COVID-19 for practices participating as required in the COVID-19 response. We also committed to work with the British Dental Association to agree a fair reduction for any variable costs associated with service delivery (e.g. in recognition of reduced consumable costs) will be applied to all contract values.

This letter sets out the detail of the abatement and contractual handling for non-urgent dental care centres (UDC) and UDC practices.

2.1 Contractual arrangements: 1 April to 7 June

A. Non UDC practices
As all service provision has been delivered remotely it is recognised that consumable (laboratory and materials) and other variable costs in practices will be lower over this period. In light of this, we have agreed with the BDA that it would be appropriate to apply a **16.75% abatement** to the total contract value across the period 1 April 2020 – 7 June 2020. This will be enacted through reconciliation over the period to 31 March 2021.

B. UDC practices
We remain grateful to those practices that have opened their premises and mobilised UDC centres. This has been an essential part of the national effort to manage the impact of the pandemic and to provide urgent and emergency care. We recognise that practices will have incurred additional cost burdens for items such as consumables, resource and administration. Given this impact, we have agreed with the BDA that is would be appropriate to apply **no abatement** to UDC practices for the period that they are operational. For any period of time where the practice was not operating as a UDC they will be subject to the 16.75% contract abatement as outlined above. We will gain assurance of UDC activity via workforce returns, transmitted activity to NHSBSA and eTriage.

2.2 Contractual arrangements 8 June onwards

From 8 June all practices have been able to resume provision of face-to-face services in a way that is safe, operationally deliverable and allows flexibility to do what is best for patients and their teams.

We are maintaining the UDC centres as they provide a critical service, in particular for provision of AGPs, where appropriate, and for resilience within the system in the event of regional or localised outbreaks.

From 20 July 2020 we expect that all practices should have been able to mobilise for face to face interventions. We recognise that capacity is constrained and that it may not be possible to deliver historical unit of dental activity (UDA) activity levels during this period, but we expect practices to be making all possible, proactive efforts to be delivering as comprehensive a service as possible, with particular regard to need which has not been met during phase one of the incident and any health inequalities issues which have emerged locally.

We are working with the BDA and profession to establish an appropriate mechanism for the measurement of activity, patient outcomes and quality of care provision while services are affected by the pandemic. The contractual arrangements need to appropriately take account of the increasing activity levels, the constrained capacity due to infection prevention and control guidance and the increased costs of PPE.

In advance of this agreement we propose to operate the following arrangements:

- From 8 June we have moved to a 0% abatement for all contracts.
- For UDC practices this will apply automatically from 8 June.

- For non UDC practices this is conditional on specific assurance that individual practices are open for face-to-face interventions, are adhering to contractual hours with reasonable staffing levels for NHS services in place and are performing the highest possible levels of activity, with no undue priority being given to private activity over NHS activity.
- Accordingly, any practice not delivering the equivalent of at least 20% of usual volumes of patient care activity will be deemed to be non-compliant with the above criteria.
- In addition any practice that has significantly increased private practice provision at a rate that exceeds that for NHS provision while we provide this funding stability may be deemed to be non-compliant with the above criteria. We will seek specific assurance from contract holders on this matter and in the event of any subsequent concerns may then carry out a spot check to provide assurance.
- Where this assurance is not received, we will revert to operating pre-existing contract arrangements from 20 July.

This is a temporary holding arrangement that recognises reduced variable costs that are offset by additional PPE costs. We are working to rapidly complete work with the BDA and the profession to have established the new mechanism for the measurement of activity, patient outcomes and quality of care provision.

Contractual requirements will be:

- maintenance of the eTriage system for recording of telephone/remote consultations
- FP17 data to be transmitted from all practices to evaluate treatment interventions at a practice level and patient outcomes.
- Submission of declaration around equivalence of NHS service offer and private service offer. This will include a statement of relative volumes of private activity and NHS activity for specified treatments.
- Submission of declaration over continued staff engagement (see section 2.3 below)

In the event of a second phase or regional lockdown, we would seek to shift affected contracts back to the operating model utilised within the period 1 April 2020 to 7 June 2020.

The above conditions apply to all General Dental Service contracts and Personal Dental Service contracts that provide mandatory, advanced mandatory and prototype activity.

2.3 Further assurance

The principles behind the arrangements introduced in the letter of 25 March were to provide a fixed period of income stability, that allowed practices to provide continuity of employment for staff and to cover fixed costs relating to the NHS proportion of their business.

This rapidly established a mechanism whereby practices were able to address their costs for the NHS proportions of business as follows:

Expenditure area	Principles and purpose
Staffing	Preserve income; maintain payments to staff (employed and associates) that provided income stability for individuals and that enabled redeployment to other parts of the COVID response.
Other fixed costs (e.g. facilities, fixed business overheads)	Preserve income; maintain ability to meet essential and unavoidable business costs
Variable costs (e.g. consumables, lab fees)	Reduced income through abatement; reflecting commensurate reduced expenditure

The agreement to provide this stability of income was linked to a requirement on practices to ensure that all staff, including associates, non-clinical and others, continue to be paid at previous levels. This continues to be an essential requirement as we move forward and ensure that all practices are playing their part in delivering services as part of the resumption of routine dentistry across the country.

We are therefore requiring all practices to provide assurance over their continued contracting with and employment of staff, and to confirm that through the temporary funding arrangements they have not gained any windfall profits arising from the continued NHS funding being made available to support staff and essential business overheads.

We will implement a simple assurance mechanism via the newly implemented workforce data collection with a signed declaration of adherence from each practice. This will be an explicit condition of the funding stability provided above.

3. PPE and fit testing

3.1 Respirator fit testing

Plans are in place to train fit testers from the dental sector across NHS regions, who will each fit test colleagues in local practices. This is a collaborative arrangement between:

- our regions and their Local Dental Networks which, working with the local profession, will identify those to be trained
- Health Education England (HEE) regions which will identify venues and organise bookings for courses working with Respiratory Protective Assessment Ltd (RPA) which will provide the trainer

- Public Health England which has funded RPA to support the COVID-19 response and specifically support these courses.

Once trained, fit testers will be provided with a fit testing kit to enable them to begin testing in their region. We are arranging for fit testers to be engaged under an honorary agreement for these activities, which will cover any liabilities arising through that agreement.

For further details on local arrangements, please contact your local regional dental team. Details of regional contacts are in this letter.

RPA also has helpful information on its website.

3.2 Dental care provision PPE and IPC requirement

PPE and IPC requirements for dental settings remain as described in Appendix 1 of the Transition to recovery SOP, and referring to Table 4 in the IPC guidance.

4. Workforce issues

4.1 Risk assessments

All primary care organisations remain legally responsible for securing appropriate occupational health assessments (including staff risk assessments) for their employees, including those at-risk and vulnerable groups within their workforce. Further information on risk assessment is available:

- NHS Employers: risk assessments for staff
- Faculty of Occupational Medicine: risk reduction framework for NHS staff at risk of COVID-19 infection

4.2 Impact of COVID-19 on dental training

HEE aims to minimise the impact on progression of dentists currently in training while ensuring patient safety, and to continue with dental foundation training (DFT), dental core training (DCT) and specialty training (ST) recruitments with as little disruption to usual start dates as possible.

More information on this can be found on the HEE website, under ‘Information for dental trainees’.

- **Dental foundation training**: Recruitment to 2020/21 DFT was undertaken in November 2019 and is complete; new trainees will begin training on 1 September 2020 as planned.

Clinical training for 2019/20 dental foundation trainees has been disrupted. Work is underway to minimise the impact and enable foundation dentists to progress to the next stage of their careers.

- **Dental core and specialty training**: DCT and ST recruitment is underway through evidence-based self-assessment. The HEE website outlines how it is dealing with progression.

  Due to postponement of the college examinations required for trainees to evidence completion of the curriculum, extensions to training are required.

Thank you for your continued contribution to the national response which has not gone unrecognised.

With very best wishes

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