Why re-invent the wheel if you've run out of road?

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Key points

The COVID-19 disruption to 'business as usual' viewed as an opportunity for a profound change in oral healthcare experience for patients and the dental profession.

In delivering change, there are choices with respect to pace, proximity, preparedness, protection and equity, alongside the necessity for the physical safety and emotional support of our workforce.

A COVID-19 legacy hallmarked by a determined revision of the current activity-driven clinical approach, optimising time with patients and delivered as an integrated oral health team.

Abstract

The COVID-19 disruption to 'business as usual' presents an opportunity for a profound change in oral healthcare experience for our patients and our profession. While the prospect of change has dominated professional dialogue for years, the post-COVID-19 era offers choices with respect to pace, proximity, preparedness, protection and equity. There is potential for a determined revision of the current activity-driven clinical approach, with the adoption of the minimally invasive oral care philosophy into routine practice and use of technology to remotely support our patients. Throughout COVID-19, the whole of the dental profession has demonstrated adaptability in redeployment and compassion in delivering care in a variety of settings. These vital traits and bold clinical leadership, prepared to make timely choices and act fast, will underpin our successful transition towards the safe resumption of routine dental services. In making the right choices, we have at hand a future integrated dental team care model with time to concentrate on personalised prevention advice, as well as the provision of effective, highly skilled treatment.

As dentistry emerges from COVID-19 lockdown, with the profession facing an altered healthcare landscape and different societal expectations, I was asked the question: 'Why re-invent the wheel for dentistry if it has run out of road?' I strongly argue that dental care has not run out of road and that COVID-19 presents the opportunity to shift gear and change lanes.

The prospect of change has dominated our professional dialogue for years. In harnessing both past and present discussions, we have the opportunity to realise our profession's acknowledged ambition for reform; however, we need to decide and act fast to ensure that the COVID-19 disruption to 'business as usual' delivers the necessary and profound change in oral healthcare experience for our patients and our profession.

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While no one can predict what the consequences of COVID-19 will be in seven months, or seven years, many assumptions, long taken for granted, will be displaced. Our future, 'a better normal', could and should reflect the innovations in health driven by the COVID-19 response. Our future is not one of predictions but a series of pragmatic, evidence-based choices. The choices we face with respect to pace, proximity, preparedness, protection and equity have impacts that will be felt by patients and practices, with repercussions for clinical, business and service models.

The ongoing need for social distancing, strictures of infection prevention and control (IPC), barriers of personal protective equipment (PPE), as well as the limits on aerosol generating procedures (AGPs), underpin the potential to realise our transition from the predominant model of surgical intervention to oral physician delivering care, emphasising the link between oral and systemic health benefits. A determined revision of the current activity-driven clinical approach provides time to concentrate on personalised prevention advice, as well as the provision of effective, highly skilled treatment. The necessary bold clinical leadership prepared to grasp this opportunity to optimise time with patients offers a less rushed, more considered, team-based approach to oral healthcare delivery.

As we shift from lockdown and an emphasis on urgent care services to focus on transition into recovery, the COVID-19 legacy presents us with uncertainty around the safety of providing AGPs in dental practice. In line with a diminishing risk of sustained COVID-19 transmission in the population, a stepwise resumption of oral healthcare and an iterative approach to how such care is delivered is to be anticipated. As we progress through the conditions-based transition, with the risk-assessed limitations on AGPs, we will need to support our patients in understanding the rationale behind the alternative management options and in appreciating the benefits of minimally invasive oral care (MIOC). Armed with the MIOC philosophy, with patients fully engaged in the shared decision-making, the opportunity to actively apply MIOC in the post-pandemic era brings us all a step closer to breaking the 'repeat restoration cycle'.[1] The

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presciently titled article '"MI"opia or 20/20 vision?'[2] published in the *British Dental Journal* is recommended reading, as is '"Minimum intervention" – MI inspiring future oral healthcare?'[3]

With the surge in remote communication and consultations, social proximity seems possible without the need for physical proximity. With technology being used to minimise footfall into our hospitals, could it be exploited effectively in the oral healthcare sector? Our post-pandemic care model could be complemented with virtual oral healthcare at scale. Limitations in face-to-face care may well be surmounted with innovative augmentation of recall/review periodicity and online video communication services as an intrinsic element of engaging with patients to deliver prevention, reinforcing good oral health habits as patients stabilise ahead of any surgical intervention.

Whatever the mode or innovation, this is the time for equity. We need to ensure no patient in need is left behind. In scoping and drawing up appointment schedules, through and beyond transition, consideration will need to be given to the oral health needs of shielded groups. Within the available capacity, access to care will need to prioritise vulnerable and marginalised groups. For those that are not regular attenders, we must sustain the urgent dental care (UDC) system and augment this with domiciliary care. In meeting this requirement, it would not be unreasonable to expect practices to contribute to sustaining a UDC network.

Overlaying the post-COVID-19 clinical model is the continued ambition to shift away from the current remuneration model based on treatment activity. This remains a necessary step in the post-COVID-19 era if we are to improve outcomes and increase access. The anticipated phased recovery of services may be just the vehicle for greater flexibility in commissioning and scaling up reforms to contract. The COVID-19 oral health legacy should be the realisation of Professor Jimmy Steele's 2009 vision[4] of oral healthcare services melded with the clinical philosophy of MIOC into our working lives and daily routine practice.

Throughout COVID-19, the profession has demonstrated adaptability in redeployment and compassion in delivering care in a variety of settings. COVID-19 has also amplified the personal risks that all healthcare workers face in carrying out their professional duties – risks that must be mitigated with PPE and a safe working environment. While we have a well-established reputation for rigorous IPC, COVID-19 reminds us that we must address both the physical safety and emotional support of our highly valued oral healthcare workforce. Without a physically and psychologically safe environment, high-quality oral healthcare is not possible. In assuring this broader sense of a safe environment, we will rebuild the confidence of the public and our patients in seeking our care, safe in the knowledge that they are protected, at all times, while in our clinics.

There are choices, they are not unique to England nor limited to NHS funded services. The intent, the potential for change and the choices described reflect the on-going UK Chief Dental Officers' discourse. There is a shared ambition and in continuing the dialogue with the profession our planning and conduct of the conditions-based resumption of dental care across the UK remains informed and evidence-based. Whilst science and fact help us in guiding resources and behaviours, we will require solidarity if we are to deliver on the intent; a "better normal" for both the NHS funded as well as the private sector. We all recognize the imperative to consider, decide and act; fate will not create the new normal for the oral healthcare profession; we all must.

References

1. Elderton R. Principles in the management and treatment of dental caries. *In* Elderton R (ed) *The Dentition and Dental Care.* pp 237–262. Oxford: Heinemann Medical Books, 1990.
2. Banerjee A. 'MI'opia or 20/20 vision? *Brit Dent J* 2013; **214:** 101–105.
3. Banerjee A. 'Minimum intervention' – MI inspiring future oral healthcare? *Brit Dent J* 2017; **223:** 133–135.
4. Steele J, Rooney E, Clark J, Wilson T. NHS dental services in England: An independent review led by Professor Jimmy Steele. 2009. Available at http://www.sigwales.org/wp-content/uploads/dh_101180.pdf (accessed May 2020).

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