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COVID-19 guidance and standard operating procedure

For the provision of urgent dental care in primary care dental settings and designated urgent dental care provider sites

Version 4 (updated 27 October 2020)

This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate. Check if this is the latest version here.

Content changes since version 3 (published 28 August 2020) are highlighted in yellow.

We appreciate any feedback which could be used to improve this SOP. If you would like to provide feedback please complete this email template.

Operational queries regarding this SOP should be directed to your regional commissioning team.

Contents

1. Scope

This guidance is applicable in England. This document covers a local systems approach to the organisation and operation of urgent dental care (UDC) provision. This document should be considered alongside other guidance which may be applicable in a particular care context (for example, hospital trust standard operating procedures for COVID-19 should be considered if UDC is delivered as part of secondary care in a hospital setting).

We trust healthcare professionals to use their clinical judgement when applying guidance around patient management in what we appreciate is a highly challenging, rapidly changing environment.

We are grateful to the following for their support in producing this SOP:

- Public Health England (PHE), for their advice and support in developing this document
- The Faculty of Dental Surgery at the Royal College of Surgeons, and the Faculty of General Dental Practice (UK), for working with NHS England to develop clinical guidance for dental teams applicable in the COVID-19 context
- Health Education England Yorkshire & Humber, Imran Suida and Alex Coleman, for producing and sharing a video demonstrating an example of a patient care pathway and practice set up for urgent dental care.

2. COVID-19: Guidance for local UDC systems and primary dental care providers

2.1 Introduction

Primary care dental services (general dental practices and community dental services) should now be open for face-to-face care. This includes delivery of both aerosol generating procedures (AGPs) and non-aerosol generating procedures.

This will re-introduce significant dental activity to local health systems, reducing the need for supplementary UDC capacity. NHS England and NHS Improvement regional teams will put in place UDC arrangements as necessary to supplement general dental practice and community dental services who should see urgent patients wherever possible in the first instance, including those who may not be regular patients.

Regional teams should ensure sufficient UDC capacity to be available to see the following patient groups where it is judged that this cannot take place in general practice settings

1. Patients who are possible or confirmed COVID-19 patients – including patients who meet the case definition, or household/support bubble contacts of people with possible or confirmed COVID-19 and where treatment cannot wait

2. Urgent dental care which may be more challenging or inappropriate for primary care dental services to provide.

Similarly, consideration should be given to both the type of urgent dental care to be provided (AGP or non AGP) – and the patient risk pathway (see Appendix 3) which will determine the personal protective equipment (PPE) requirements.

AGPs should be undertaken with the appropriate risk assessment, infection prevention and control (IPC) and PPE protocols. They should only be undertaken at a dental service (primary care dental setting or designated UDC provider site) where the appropriate PPE is available.

- **For patients who are COVID-19 possible/confirmed cases and contacts** – avoid AGPs where possible, unless there is no alternative treatment option and/or the AGP intervention cannot be deferred.

The range of conditions provided for by local integrated UDC systems (primary care, secondary care and A&E) is likely to include, but is not limited to:

- life-threatening emergencies, eg airway obstruction or breathing/swallowing difficulties due to facial swelling

- trauma including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent tooth

- oro-facial swelling that is significant and worsening post-extraction

- bleeding that the patient cannot control with local measures

- dental conditions that have resulted in acute and severe systemic illness

- severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice
- fractured teeth or tooth with pulpal exposure
- dental and soft tissue infections without a systemic effect
- suspected oral / health and neck cancer (for referral via the two-week suspected cancer referral pathway)
- oro-dental conditions that are likely to exacerbate systemic medical conditions.

Urgent dental problems have previously been organised into three categories of need based on level of urgency, as defined by the Scottish Dental Clinical Effectiveness Programme (SDCEP, 2007).

Each patient should be assessed and managed on their own merit, taking into account the patient's best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.

Local dental networks, commissioners, managed clinical networks and local dental committees should continue to work together with local dental public health colleagues to maintain their current urgent dental care system in a way that meets the principles set out above and to meet the prevailing dental needs of their local populations.

The exact mechanisms, facilities and approaches will need to reflect existing local arrangements in way that that can be flexed. It will also require review of specific and bespoke arrangements, for those who are being shielded and those at increased risk.

In addition, UDC systems need to allow for local outbreaks of COVID-19, and any outbreak control measures (eg locally declared lockdown) instituted by national direction or local systems.

2.2 Key principles for local UDC systems

This guidance and SOP recognises the resumption of face-to-face care by primary dental care providers for appropriate patient groups. Therefore, the principles set out in this section should be considered against this change and the implications for existing local systems:

- UDC systems should be organised in an integrated way that reflects specific local circumstances. Consideration should be given to:
    - ensuring the system is agile enough to allow for local/regional outbreaks of COVID-19 and associated outbreak control (including lockdown) measures.
    - using and adapting existing UDC arrangements within the existing local integrated urgent care system (eg expanding out-of-hours service arrangements to cover weekdays).
    - managing UDC and referrals effectively between primary and secondary care; secondary care settings will be particularly affected during expected COVID-19 surges and this will have implications for certain areas of UDC

provision, eg A&E, oral and maxillofacial surgery, two-week urgent cancer pathways.

  - prioritisation of urgent dental care needs, in line with the wider local COVID-19 response; it is understood that as the COVID-19 pandemic develops, there will be times when service capacity across the whole of health and social care is reduced: therefore, the capacity of the local UDC system will vary and the most urgent cases will need to be prioritised accordingly.

  - collaboration between services, to enable appropriate care provision and resilience across the system.

- The patient pathway should take account of two stages, a remote stage and a face-to-face stage if necessary, as set out in the SOPs in Section 3 below. The pathway is illustrated in Appendix 2.

- Both stages may now be undertaken by any single provider (primary care dental services and designated UDC sites). As detailed in section 3, 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.

- In meeting patient needs, all primary care dental services are now able to provide face-to-face urgent care for appropriate patient groups (subject to capacity and availability of appropriate PPE) supported by existing UDC provision (including currently designated general dental practices and community dental services; secondary care providers; A&E). In light of this development, local commissioning teams should consider:

- Focusing UDCs on:

  - Care for patients with possible/confirmed COVID-19 and household/support bubble contacts

  - Care which may be more challenging or inappropriate for primary care dental services to provide.

- Allowing for patient separation requirements (physical or temporal) between or within services, taking into account the patient groups listed in Section 2.1 and patient risk pathways, as defined in UK IPC Guidance and the accompanying dental appendix (see Appendix 3).

- Reviewing patient access to urgent care, to ensure all patient groups have access to non-AGP and AGP care via the appropriate dental services. Consideration should be given to access within rural and urban areas and associated travel distances.

- Reviewing system design to enable a smooth pathway for patients, taking into account relationships with other providers (eg NHS 111 and DOS updates) to ensure that patients can access appropriate care in the most timely way possible, minimising the possibility of patients being signposted/referred back and forth between services.

- Reviewing any local protocols to ensure they align with clinical guidelines, for example appropriate antimicrobial prescribing (see letter here for further information).

- Reviewing patient and public communications to ensure clear messaging about access to urgent care, given that all primary care dental services are now able to undertake face-to-face care for appropriate patient groups, as well as remote triage.

- Consideration should be given to working locally with the necessary stakeholders to support people who may be considered socially marginalised or vulnerable to access urgent care.

- At a system level, ensuring appropriate opening hours, for both remote management and face-to-face care, that account for in-hours and out-of-hours access.

- Ensuring the involvement of dental laboratory services to support the local UDC system.

- Workforce redeployment may still be required to ensure UDC services are appropriately staffed in a way that best fits local circumstances. NHS contract arrangements in the current COVID-19 situation (outlined here) enable this.

- Service resilience and contingency planning should be considered with regards to potential staff absence due to sickness.

- With regards to indemnity in the context of COVID-19:

    - Where dental services are being provided by NHS trusts, the Clinical Negligence Scheme for Trusts and Liabilities to Third Parties Scheme will provide indemnity for clinical negligence and other claims, respectively. However, these existing schemes do not extend to non-NHS trust settings, such as general dental practices.

    - Where dental services are being provided out of non-NHS trust settings, existing indemnity arrangements should be relied on as far as possible. Where existing arrangements are not sufficient, the Coronavirus Act 2020 enables the Secretary of State to provide clinical negligence indemnity. The scheme being established by NHS Resolution to implement this is called the Clinical Negligence Scheme for Coronavirus (CNSC).

    - Further information on the CNSC and how it applies is on the NHS Resolution website. Please check this regularly as information and FAQs will be updated.

- Dental teams should use PPE to treat patients based on the type of urgent care they are providing and the patient risk pathway. Therefore, depending on the type of face-to-face care being provided by a dental service, and the patients it is accepting, the service must have the appropriate PPE, as set out in Appendix 3. Advice on the supply of PPE is here.

- Major regulators have issued guidance to support healthcare professionals in these challenging circumstances, encouraging partnership working, flexibility and operating in line with the best available guidance.

- Further information about regulation during the COVID-19 pandemic from the General Dental Council and General Medical Council can be found on their websites.

- COVID-19 information governance advice for health and care professionals can be found here.

- A life assurance scheme launched for eligible frontline health and care workers during the COVID-19 pandemic covers frontline workers within dental services, including dentists, dental nurses, dental hygienists and dental therapists.

- Dental teams may consider referring vulnerable patients to NHS Volunteer Responders where appropriate (see guidance on the Royal Voluntary Service website here), who can be asked to help people needing additional support (eg delivering medicines; driving patients to appointments).

- Dental teams can make referrals via the NHS Volunteer Responders referrers' portal or by calling 0808 196 3382.

- Patients can also self-refer by calling 0808 196 3646 between 8am and 8pm.

Although these principles for UDC systems will be interpreted according to local population needs, there are a number of actions which all dental services should undertake. These are detailed in Appendix 4.

3. COVID-19: standard operating procedures for UDC services

Whilst face-to-face care has resumed in primary care dental services, the patient pathway for UDC in any setting still consists of two broad stages – remote management and face-to-face management (see Appendix 2) – recognising that both elements may now be undertaken by any single provider (primary care dental services and designated UDC sites).

It is important to retain the initial remote stage, particularly to identify possible/confirmed cases (and household/support bubble contacts), and patients who are clinically extremely vulnerable, to ensure safe care. In addition, this stage helps with preventing inappropriate attendance, supporting appointment planning, and maintaining social distancing and patient separation. As detailed in section 3.1, 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.

Therefore, this standard operating procedure has been divided as follows:

1. SOP for remote management stage

2. SOP for face-to-face management stage

For each SOP, key principles are listed, with further details set out beneath.

As well as following these SOPs, dental service providers should also ensure they are undertaking the actions expected of all dental services as detailed at Appendix 4.

In the situation of a local outbreak, in some instances, providers may receive regional direction to divert from part or parts of these SOPs, as part of outbreak control measures.

3.1 SOP for remote management stage

3.1.1 Key principles

Dental teams should be aware of this SOP, the current national and local COVID-19 guidance (including approaches for managing clinically extremely vulnerable patients – see Appendix 1; and local outbreak scenarios) and the possible COVID-19 case definition.

Keep staff safe through regular risk assessments, following guidance for employers and businesses, and through the measures set out in the 'Keeping staff safe' section of Appendix 4.

- Further information on risk assessment is available:
  - NHS Employers: risk assessments for staff – here
  - Risk reduction framework for NHS staff at risk of COVID-19 infection - here
  - Health and Safety Executive - here
- Resources for staff support and wellbeing are at Appendix 7.

Use information and communications (eg telephone, website, text) to outline the appropriate UDC access arrangements for patients.

Remotely (eg by telephone or video link) risk assess and triage those patients contacting the service for urgent dental care, to determine patient group (as per Section 2.1), patient risk pathway (see Appendix 3), urgency of dental problem and associated UDC needs.

Ensure early identification of patients with possible/confirmed COVID-19 and household/support bubble contacts, and patients who are clinically extremely vulnerable.

Use clinical judgement and shared decision making to determine whether patient management should continue remotely or face-to-face, based on risk assessment and triage outcomes.

Details on remote patient management and the arrangement of appropriate face-to-face care are in section 3.1.1.4.

3.1.1.1 Service information and communications

Effective communications to patients at an early stage should reduce the number of patients contacting the service inappropriately. Different communications routes should be considered (eg telephone, text, website).

Public-facing materials on COVID-19 are available here and here.

Services should display/provide the appropriate information to:

- Prevent patients with possible/confirmed COVID-19 or household/support bubble contacts entering sites inappropriately
- Signpost and support patients who may turn up to a service without having undergone remote risk assessment and triage, and/or without having an appointment booked.
- Make clear which patient groups they are receiving
- Control entry to specific sites and areas, in line with care requirements
- Signpost and support patients who may turn up to closed premises

3.1.1.2 Risk assessment

Patient risk assessment should be conducted remotely (eg telephone, video link) to determine:

- which patient group the patient belongs to
- whether the patient is on the high, medium, or low risk pathway, as per IPC guidance (see Appendix 3)
- the associated risk to the patients if they were to contract COVID-19
- whether the patient has COVID-19 related isolation requirements.

This is information, together with the degree of urgency of the patient's dental condition (see dental triage, Section 3.1.1.3), will be important in determining the patient management approach.

As part of risk assessment, COVID-19 screening questions should be asked in line with the case definition for possible COVID-19 and isolation requirements including quarantine advice for those entering or returning to the UK. Questions should include but may not be restricted to the following. Please check guidance regularly for updates and amend question set as necessary:

- Do you, anyone in your household, or anyone in your support bubble, have any symptoms of COVID-19 – including:
    - a new, continuous cough; or
    - a high temperature (37.8^{o}C or over); or
    - a loss of, or change in, normal sense of taste or smell?
- If you, anyone in your household, or anyone in your support bubble have, or have had, possible COVID-19, are you still in the self/household isolation period?
  If you, anyone in your household, or anyone in your support bubble have tested positive for COVID-19, are you still in the self/household isolation period?
- If you have been notified by NHS Test and Trace that you've been in contact with a person with COVID-19, are you still in the isolation period? (See isolation requirements here)
- If you have entered or returned to the UK in the last 14 days, are you required to self-isolate?

If the patient **answers yes to any of the above**, then they belong to the group of patients who are possible or confirmed COVID-19 patients or household/support bubble contacts.

If the patient **answers no to all of the above**, continue risk assessment to determine which patient group they belong to:

- patients who are clinically extremely vulnerable – those at the highest risk of severe illness from COVID-19
- patients who do not fit one of the above categories

Patients' records and taking a good medical and social history should help to identify those who are clinically extremely vulnerable (definitions in the links above).

Patients who are clinically extremely vulnerable may previously have been advised to shield themselves (until 1 August 2020 when the government paused shielding advice). Please note that the cohort of clinically extremely vulnerable patients may change, based on new diagnoses and/or disease progression and management. Appendix 1 provides further details.

Risk assessment should also determine the patient risk pathway (high, medium or low), as defined in UK IPC guidance (see Appendix 3), to inform care planning.

In cases where remote management is not possible, consideration should also be given to risk assessing persons who may be accompanying the patient to a face-to-face appointment (eg the parent or carer of a child patient). Patient escorts should be from the same household or support bubble as the patient as far as possible.

The approach to risk assessment may change during the management of local outbreaks, in which case dental providers should follow local guidance.

3.1.1.3 Dental triage

Dental triage should be conducted remotely (eg telephone, video link) to determine:

- if the patient has a need for routine non-urgent care (including orthodontics), which should be dealt with outside of urgent care provision
- if urgent dental care needs can be managed remotely (eg patient requires advice only)
- if face-to-face management is required, the most appropriate place and time for the patient to be seen for face-to-face care (in line with patient group, patient risk pathway, and care requirements)
- prioritisation of patients with the most urgent care needs, in line with the local UDC system approach to variable workforce capacity issues across health services.

The Scottish Dental Clinical Effectiveness Programme (SDCEP) has developed guidance around triage for acute dental problems during the COVID-19 pandemic, which is found here.

3.1.1.4 Remote patient management

- Each patient should be assessed and managed on their own merit, taking into account their best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.
- When care planning, shared decision making is important to weigh up the benefits of dental treatment against exposure risk, and plan care in the patient's best interests. This is of particular importance to clinically extremely vulnerable patients at the highest risk from COVID-19.
- Based on risk assessment and triage outcomes, use clinical judgement and shared decision making to determine whether care should continue remotely or face-to-face.
- For remote care:
    - Provide advice, analgesia or antimicrobials where appropriate in line with prescribing guidelines (AAA)
    - Further information on **remote prescribing protocol** can be found at Appendix 5.
    - The Faculty of General Dental Practice (UK) has provided updated information and guidance on **remote prescribing and advice** during the COVID-19 pandemic – see here.

- The GDC has set out **guidance for remote consultations and prescribing** here.
- The **dental antimicrobial stewardship toolkit** is here
- SDCEP guidance on **drugs for the management of dental problems during the COVID-19 pandemic** is here.
- A joint letter from PHE, RCS England, FGDP (UK) and the BDA on **prescribing antibiotics for urgent dental care during sustained transmission of COVID-19** is here.
- Following initial concerns around the use of ibuprofen in the context of COVID-19, the government has published advice here. An expert working group has concluded there is currently insufficient evidence to establish a link between use of ibuprofen and susceptibility to contracting COVID-19 or the worsening of its symptoms.

- Where face-to-face clinical assessment and/or treatment is required, arrange care at an appropriate dental service/care setting in line with patient group, patient risk pathway and care requirements.
  - Dental services should familiarise themselves with any local referral arrangements to support this (eg referrals to UDC provider site for patients with possible/confirmed COVID-19).
  - Dental services should take into consideration social distancing and physical and temporal separation requirements for all patient groups and patient risk pathways (including measures detailed in section 3.2.1.1) which may impact appointment planning.
- For clinically extremely vulnerable patients – for any remote care provided, or face-to-face care arranged – manage in line with approaches set out in Appendix 1.
- Clinical records should be kept for remote patient consultation.
- The Compass e-triage data collection tool should be completed for telephone triage activity. Further advice is available on the NHS BSA website via the following links:
  - Compass login here
  - Guidance here
- FP17 forms should **not** be submitted for telephone triage, as per advice given on 15 April 2020
- Patient charges do not apply for telephone triage or remote consultation alone. Normal charging regimes only apply for face-to-face care.

3.2 SOP for face-to-face management stage

Services receiving patients to provide face-to-face care are expected to have also followed the SOP outlined in Section 3.1, to minimise cross-infection risk and ensure safe face-to-face care is undertaken at an appropriate care setting.

3.2.1 Key principles

Ensure the SOP as outlined in Section 3.1 has been followed, to promote remote risk assessment and triage, ensure patients can be cared for in a setting appropriate for their specific urgent care requirements, and reduce exposure risk.

Dental teams should be aware of this SOP, the current national and local COVID-19 guidance (including approaches for managing clinically extremely vulnerable patients – see Appendix 1) and the possible COVID-19 case definition.

Keep staff safe through regular risk assessments, following guidance for employers and businesses, and through the measures set out in the 'keeping staff safe' section of Appendix 4.

- Further information on risk assessment is available:
    - NHS Employers: risk assessments for staff – here
    - Risk reduction framework for NHS staff at risk of COVID-19 infection - here
    - Health and Safety Executive - here

- Resources for staff support and wellbeing are at Appendix 7.

All UDC service providers should have clear protocols for patient care, noting the requirements for social distancing and the appropriate zoning and separation measures for all patients.

- Particular attention should be paid to patients with possible/confirmed COVID-19 and their household/support bubble contacts, and patients who are clinically extremely vulnerable.

Where appropriate, repeat risk assessment and dental triage when the patient arrives at the service (in line with sections 3.1.1.2 and 3.1.1.3) in case there are changes, the patient is unaware of their risk status, or the patient has accessed a service inappropriately.

- When accepting patients, providers should have regard to the patient group (see section 2.1), patient risk pathway (see Appendix 3), the likely procedure required and the availability of appropriate PPE.

When face-to-face assessment and/or treatment is undertaken:

- Each patient should be assessed and managed on their own merit, taking into account the patient's best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.

- When care planning, shared decision making is important to weigh up the benefits of dental treatment against exposure risk, and plan care in the patient's best interests. This is of particular importance to clinically extremely vulnerable patients at the highest risk from COVID-19.

- If treatment is required, all equipment and materials for treatment should be assembled in surgery before beginning.

- Aerosol generating procedures should be undertaken with the appropriate risk assessment, IPC and PPE protocols. They should only be undertaken at a dental

service (primary care dental setting or designated UDC provider site) where the appropriate PPE is available.

    - **For patients who are COVID-19 possible/confirmed cases and contacts** – avoid AGPs where possible, unless there is no alternative treatment option and/or the AGP intervention cannot be deferred.

- For AGPs, the use of high power suction and rubber dam is recommended where possible.

- Treatment should be completed in one visit wherever possible.

- For clinically extremely vulnerable patients, manage in line with approaches set out in Appendix 1.

- Where domiciliary visits are necessary for any patient, these should be appropriately risk assessed and managed. Follow local referral arrangements and protocols for domiciliary care provision where applicable.

- A FP17 form should be submitted for each patient seen in the usual way and normal patient charging regimes apply.

Use robust infection prevention and control procedures in line with government guidance (see Appendix 3).

Follow PPE protocols in line with government guidance (see Appendix 3).

Prepare for incident management.

- PHE has provided COVID-19 guidance for first responders, including information on PPE, cardiopulmonary resuscitation (CPR), providing assistance to unwell individuals and cleaning. First responders include professionals who, as part of their normal roles, provide immediate assistance requiring first contact until further medical assistance arrives.

- In line with this guidance, with regards to CPR, chest compressions and defibrillation (as part of resuscitation) are not considered AGPs (see further information here). Therefore, dental staff can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres.

- The Resuscitation Council UK provides an infographic to support CPR protocol in primary care – found here.

- Further detail on preparation for incident management for unwell patients with possible/confirmed COVID-19 is provided at Appendix 6.

3.2.1.1 Patient management: social distancing and separation

- Although it is recognised that dental treatment will require closer contact, social distancing measures should be applied as far as possible throughout the service. This is important for both patient and 'staff-only' areas, and both patient-facing and non-patient-facing activities.

- For all patients, physical (eg separate waiting areas and treatment rooms) and temporal (eg appropriately spaced appointments, sessions for specific patient groups) separation measures should be employed.

- Consideration should be given to patient group (see section 2.1), patient risk pathway (see Appendix 3) and the type of treatment undertaken (ie increased risk associated with aerosol generating procedures means there are additional PPE and decontamination requirements).

- Appropriate zoning should be undertaken. Sites, areas and facilities should be designated and demarcated clearly for specific patient groups and patient risk pathways.

- For patients who are clinically extremely vulnerable – where possible, without compromising the requirement for access to urgent care in an appropriate timescale, additional physical and temporal separation measures should be taken, for example:

    - these patients could be seen first thing in the morning, allowing maximum time for air clearance/ventilation overnight, and reducing chance of contact with other people in the clinic.

    - these patients could be seen in a surgery, which minimises the number of people passing.

- Practical considerations for the dental service are advised as follows:

    - Patient escorts should only be allowed where absolutely necessary (eg child attending with parent). As far as possible, one escort only should be allowed per patient, and this escort should be from the patient's household (or support bubble) to minimise exposure risk.

    - Consideration should be given to capacity and consent, and how these can be managed appropriately in a way that minimises contact risk. For example, for child patients, if a person with parental responsibility cannot accompany the child due to social isolation, the child could be brought by a responsible adult from their household and the person with parental responsibility contacted by telephone by the dental team.

    - As far as possible, patients (with necessary escorts only) should not enter the dental service until the time of their appointment or until a member of staff advises them to do so. For example, they could wait in their vehicle or in a suitable area outside the dental service.

      Follow guidance on face masks/coverings in primary and community care settings – here, and hospital settings – here. This is for all staff, patients and the public.

    - Patient flow:

        - Limit the entry points to the dental service for patients and visitors, including deliveries.
        - Minimise the number of patients within the dental service at any one time.
        - Minimise potential for patient-patient contact within the dental service, eg in reception areas and waiting rooms.

- Plan and design patient flow throughout the practice – floor markings will facilitate this.
- Consider escorting patients directly into the surgery to avoid waiting in the practice.
- Health Education England, Yorkshire and Humber have created a video which describes the patient care pathway and practice setup for Urgent Dental Care in Yorkshire and Humber during COVID-19. It shares examples of good practice following current guidance and may be of use to support dental services elsewhere in England.

- At the appropriate entry and exit points, all visitors to the dental service should be told to wash their hands or use hand sanitiser, and the appropriate hand hygiene agents made available.

- The number of patients and staff in waiting rooms, reception and communal areas should be minimised as far as possible.

  - Waiting rooms, reception and communal areas should allow for 2 metre separation where possible, ideally marked on chairs and flooring.

  - Where 2 metre separation is not possible, maintain 1 metre with additional precautions.

  - If staff in reception and communal areas are unable to maintain 2 metre separation with the public, they should wear a fluid-resistant surgical mask for a session.

  - As far as possible, keep areas appropriately ventilated, eg opening windows.

- Reception:
  - where possible, reception areas should be fitted with a physical barrier (eg Perspex shield)
  - face-to-face payment and appointment bookings should be minimised, with consideration given to telephone and online methods
  - card payment machines and any tablets for patient use should be cleaned and disinfected after each use.

- Staff working arrangements:
  - As few staff as possible should be allocated to see patients, particularly patients who are clinically extremely vulnerable and those with possible/confirmed COVID-19 and household/support bubble contacts, to minimise contacts without compromising the safe delivery of care.
  - Similarly, where possible, staff should work with a limited group of colleagues to minimise contact between individuals or different teams, and, if required, facilitate contact tracing and tracking.
  - Ensure social distancing is also implemented in staff-only' areas (eg staff room, decontamination room) and for staff activities which do not involve patients (eg sorting stock). For example: promoting 2 metre social distancing where possible (otherwise 1 metre with additional precautions); setting occupancy limits at the entrance to 'staff-only' areas; making hand hygiene agents available; ventilating staff areas as far as possible.

- If face-to-face risk assessment and triage validation is required before treatment begins, patients should be initially seen in a room large enough to provide social

distancing, and the clinician should wear PPE in line with government guidance (see Appendix 3).

- Toilet facilities:
  - Control patient and staff access to toilets (eg patients should request access) so that environmental cleaning (including handles) can be performed after each use
  - Signage should be placed to notify persons to close the toilet lid when flushing to reduce risk
  - Ideally, provide paper towels for hand drying
  - Waste bins should be provided lined with foot-operated or automated opening
  - When not in use, the toilet door should always be kept closed
  - Signage should be placed to promote good hand hygiene

- Use signage to support social distancing, good hand hygiene and good infection prevention and control practice throughout the service (including clinical and non-clinical areas, toilet facilities, entry and exit points, and 'staff-only' areas).

3.2.1.2 Patient management: clinical approaches

- Further information on **remote prescribing protocol** can be found at Appendix 5.

- The **dental antimicrobial stewardship toolkit** can be found here.

- SDCEP guidance on **drugs for the management of dental problems during the COVID-19 pandemic** is here.

- A letter from PHE, RCS England, FGDP (UK) and the BDA on **prescribing antibiotics for urgent dental care during sustained transmission of COVID-19** is here.

- Following initial concerns around the use of ibuprofen in the context of COVID-19, the government has published advice here. An expert working group has concluded there is currently insufficient evidence to establish a link between use of ibuprofen and susceptibility to contracting COVID-19 or the worsening of its symptoms.

- **Clinical guidance** to support urgent dental treatment planning options, under COVID-19 pandemic limitations, has been developed by the Faculty of Dental Surgery at the Royal College of Surgeons. This guidance can be found here.

3.2.1.3 Infection prevention and control and PPE

- Follow **UK Infection Prevention Control (IPC) Guidance for Dental Settings**, detailed in the Dental Appendix to the COVID-19: Guidance for the remobilisation of services within health and care settings- Infection prevention and control recommendations.

- This annex also includes guidance on:
  - PPE requirements based on the type of urgent care being provided (AGP or non AGP) and patient risk pathway
  - Ventilation
  - AGPs and the requirement for downtime (fallow time) following an AGP procedure, including a pragmatic algorithm for calculating the duration of post-AGP downtime as proposed by SDCEP

- Decontamination

- Advice on the supply of PPE is here.

- To find your NHS regional infection prevention and control team, search ‘infection prevention control + your NHS region’.

Appendix 1: Approaches for clinically extremely vulnerable patients

- Clinically extremely vulnerable and patients who may be at increased risk present should be identified in the remote management stage of the patient pathway.

- Clinically extremely vulnerable patients may be seen for urgent dental care in the same way as other patients.,

- When care planning, shared decision making is important to weigh up the benefits of dental treatment against exposure risk, and plan care in the patient's best interests. This is of particular importance to clinically extremely vulnerable patients at the highest risk from COVID-19.

- The patient's GP or wider health and social care professional(s) may be consulted to plan care as necessary, taking into account overall care needs, medical history and exposure risk as is usual practice

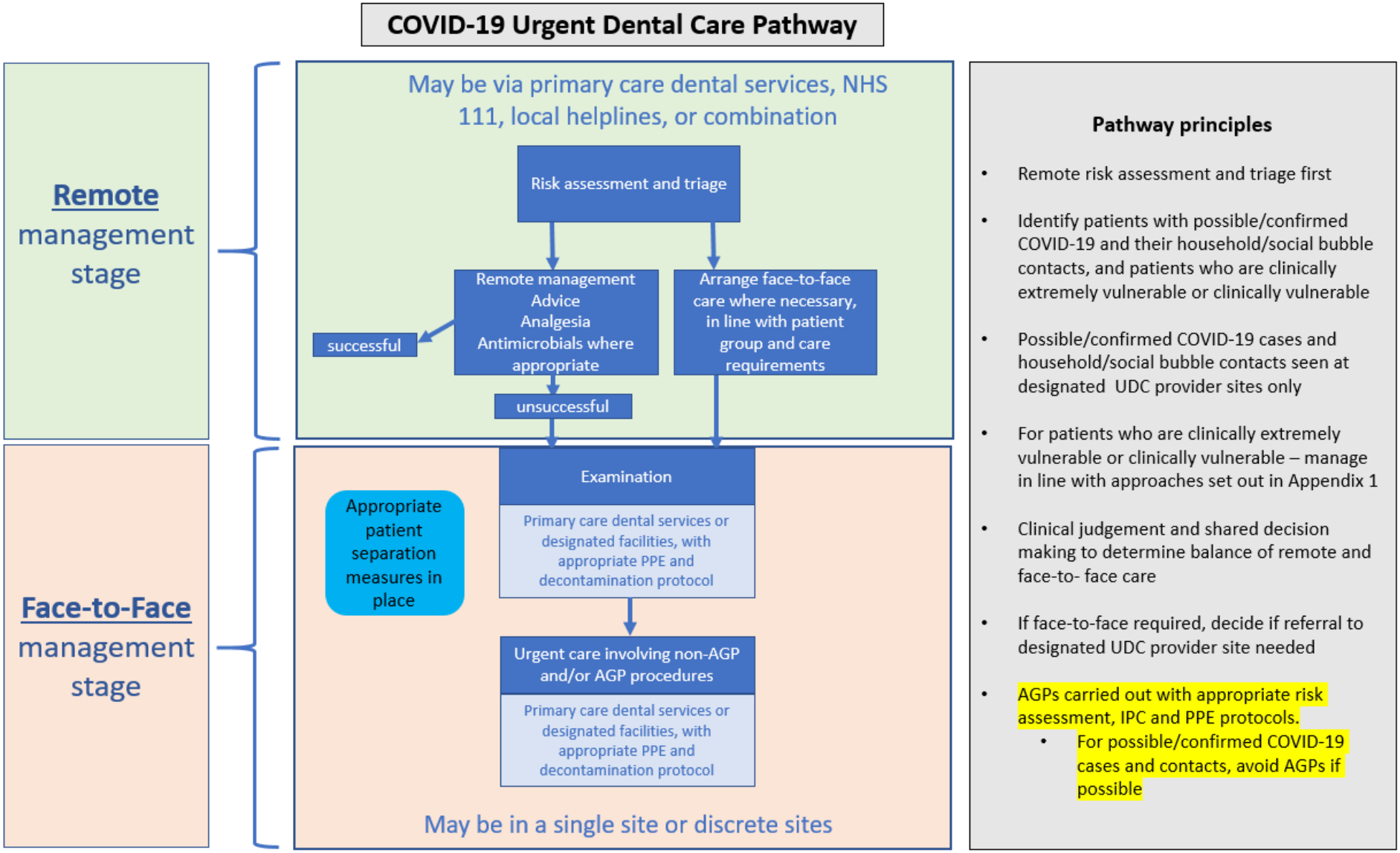
- When face-to-face care is required - where possible, without compromising the requirement for access to urgent care in an appropriate timescale, additional physical and temporal separation measures should be taken for these groups (see section 3.2.1.1).

- Dental services may wish to link to local arrangements put in place to support these groups (eg local volunteer networks may be able to organise collection of prescription items)

- Follow any additional precautions introduced to protect these groups during a local outbreak, as issued locally.

In the event that a dental team identifies a patient who is clinically extremely vulnerable as having possible COVID-19 symptoms, refer to a medical practitioner for further assessment.

Appendix 2: Patient pathways



Appendix 3: Guidance for infection prevention and control in dental care settings

Please refer to the **UK Infection Prevention Control (IPC) Guidance for Dental Settings**, to be found as a Dental Appendix to the COVID-19: Guidance for the remobilisation of services within health and care settings- Infection prevention and control recommendations. Both publications are also accessible here.

This UK Infection Prevention Control (IPC) Guidance for Dental Settings is the national benchmark for infection prevention and control and minimum expectation for safe practice applicable to patient care in all dental practices in England.

As detailed in the UK IPC Guidance for dental settings FFP3 masks are recommended for AGP procedures. As recommended in the main IPC guidance on page 41, “FFP3 and loose fitting powered hoods provide the highest level of protection and are recommended when caring for patients in areas where high risk aerosol generating procedures (AGPs) are being performed. Where the risk assessment shows an FFP2 respirator is suitable, they are recommended as a safe alternative”. This means that as there are existing stocks of FFP2 masks, it is understood that it may be necessary for practices to continue to use these until staff are successfully fit tested and supplied with the appropriate FFP3.

Appendix 4: Actions for dental services

All dental service providers are expected to undertake the following actions.

Appointing a COVID-19 lead

Appoint a COVID-19 lead for the co-ordination of activities within a dental service, training, preparation and implementation of SOPs and any subsequent revisions to guidance, and implementation of any national or regional guidance with respect to outbreak control measures (including lockdown) where necessary. Ensure communication with the dental team and regular communication with any other parts of the local UDC system as necessary (eg the commissioning team or collaborating services).

Keeping staff safe

1. Government COVID-secure guidelines for businesses and employers are found here

2. Guidance and resources from Health and Safety Executive are found here.

3. All staff should be risk assessed on an ongoing basis to protect them, ensure they are supported to work safely, and keep them away from work where necessary. As part of this, identify staff who are possible/confirmed COVID-19 cases, household/support bubble contacts, or clinically extremely vulnerable.

   Further information on risk assessment is available:

   - NHS Employers: risk assessments for staff – here
   - Risk reduction framework for NHS staff at risk of COVID-19 infection – here
   - Health and Safety Executive – here

4. In line with government advice, it is recommended that as part of risk assessment, dental services review resource requirements for service operations and commitments. Where appropriate, this should allow staff to stay at or work from home to avoid non-essential travel and contact; or to participate in local workforce redeployment efforts in line with local arrangements.

5. COVID-19 guidance around social distancing and good hygiene practice should be promoted as far as possible in the workplace. This includes both patient and 'staff-only' areas, and both patient-facing and non-patient-facing activities (see section 3.2.1.1 for further detail).

6. Staff testing:

   - Essential workers with symptoms of COVID-19, or who live with someone with symptoms of COVID-19, can access testing via the GOV.UK website.
   - Further information on the NHS test and trace service is found here.

- The Government has published information about the COVID-19 antibody testing programme. This letter from the NHS provides further information on implementation and roll-out.

7. Resources to support staff and promote mental health and wellbeing are at Appendix 7. These should be shared with dental teams.

Staff who are possible/confirmed COVID-19 cases or household/support bubble contacts

Dental staff with symptoms of COVID-19 should stay at home as per advice for the public. Staff who are well enough to continue working from home should be supported to do so. If staff become unwell with symptoms of COVID-19 while at work, they should stop work immediately and go home. This guidance also applies to staff with a household member with symptoms of COVID-19.

PHE have published guidance for healthcare workers, with detail on testing and self-isolation requirements. Where testing is required, dental staff may access testing via the GOV.UK website and should identify themselves as essential workers. Guidance on how to arrange for a test can be found in the COVID-19: getting tested guidance.

If staff become unwell with symptoms of COVID-19 while at work, they should stop work immediately and go home.

Staff who are self-isolating are eligible for testing and can book a test via the GOV.UK website or call 119 if they have no internet access.

Further information on the NHS test and trace service, including what happens and what to do if you test positive or have had close contact with someone who has tested positive, is found here.

Staff who are well enough to continue working from home should be supported to do so.

Staff exposed to someone with symptoms of COVID-19 in healthcare settings

PHE has published guidance for healthcare workers who have been exposed to someone with symptoms of COVID-19 in healthcare settings.

Staff at increased risk from COVID-19 (including clinically extremely vulnerable groups)

These staff, including Black, Asian and Minority Ethnic staff and pregnant women, should be risk assessed (see point 3, page 24) so that appropriate measures are put in place to minimise exposure to risk and support safe working (eg taking up an alternative role; adjusting working patterns). Support from Occupational Health may be required.

Staff members who are pregnant can find further advice from NHS Employers here and the Royal College of Obstetrics and Gynaecologists here.

For clinically extremely vulnerable staff in particular:

- They should be consulted with on how they can work safely – this may be from home or on-site at the workplace. Workplaces must be made safe by following COVID-secure guidelines if they are returning to work on-site. See further information on work, employment rights and statutory sick pay here.

Employers liability and respirator fit testing

Fit testing of PPE may be performed by dental staff with appropriate training, or third party contractors that specialise in such services. Dental contractors should inform their employers liability (EL) insurer that all staff undertaking aerosol generating procedures are required to be fit tested for appropriate PPE, to ensure their EL insurance cover is sufficient. In addition, contractors should also notify their insurers if they are performing the fit testing for their own staff or that of other local dental contractors, again to ensure EL cover is adequate.

Informing the public and commissioners of service status

To provide accurate information to the public, all dental services should:

- update their messaging and websites
- contact their regional commissioner, should practice availability hours alter as a result of staffing
- inform the commissioner of these changes and the arrangements for cover.

The regional commissioner will then inform the directory of services (DOS) lead or the NHS BSA as necessary, so that NHS 111 is up to date with the correct information.

Keeping commissioners and the DOS up to date will help to signpost patients, support NHS 111 service provision, and enable resilience or contingency mechanisms within the local UDC system in times of limited capacity.

Communicating with the local UDC system

Dental services should consider how best to communicate rapidly with their staff, with other dental services, with local pharmacies and with other health and social care teams to ensure that the local UDC system is as robust as possible.

Keeping aware of updates, alerts and communications

Regularly check for NHS updates to COVID-19 guidance for dental services, found here.

Prepare to receive communications in the following ways:

1. At urgent times of need: Central Alerting System

For urgent patient safety communications, we will contact you through the **Central Alerting System** (CAS).

Please ensure that you have registered for receiving CAS alerts directly from the Medicines and Healthcare products Regulatory Agency (MHRA): https://www.cas.mhra.gov.uk/Register.aspx

Practice action: when registering on CAS, please use a general practice email account, not a personal one – for continuity of access. Ideally use an nhs.net email account – it is more secure. Please register a mobile phone number for emergency communications using the link above.

If you do not yet have a practice nhs.net account, please go to the NHS registration website where you will be guided through the short process. https://support.nhs.net/knowledge-base/registering-dentists/

2. At less urgent times: commissioner's cascade/NHS BSA

For less urgent COVID-19 communications, we will email you via your local commissioner or the NHS BSA.

Practice action: Please share a dedicated nhs.net COVID-19 generic practice email with your commissioner and the NHS BSA to receive communications. In the event of user absence, practices should ensure e-mails are automatically forwarded to an alternative nhs.net account and designated deputy.

3. Additional information

We use a variety of additional methods to keep you informed of the emerging situation, alongside Royal Colleges, regulators and professional bodies, through formal and informal networks, including social and wider media.

You can sign up to the primary care bulletin here

You can follow these Twitter accounts to keep up to date:

- NHS England and NHS Improvement: @NHSEngland
- Department of Health and Social Care: @DHSCgovuk
- Public Health England: @PHE_uk

Appendix 5: Remote prescribing protocol

Remote prescribing

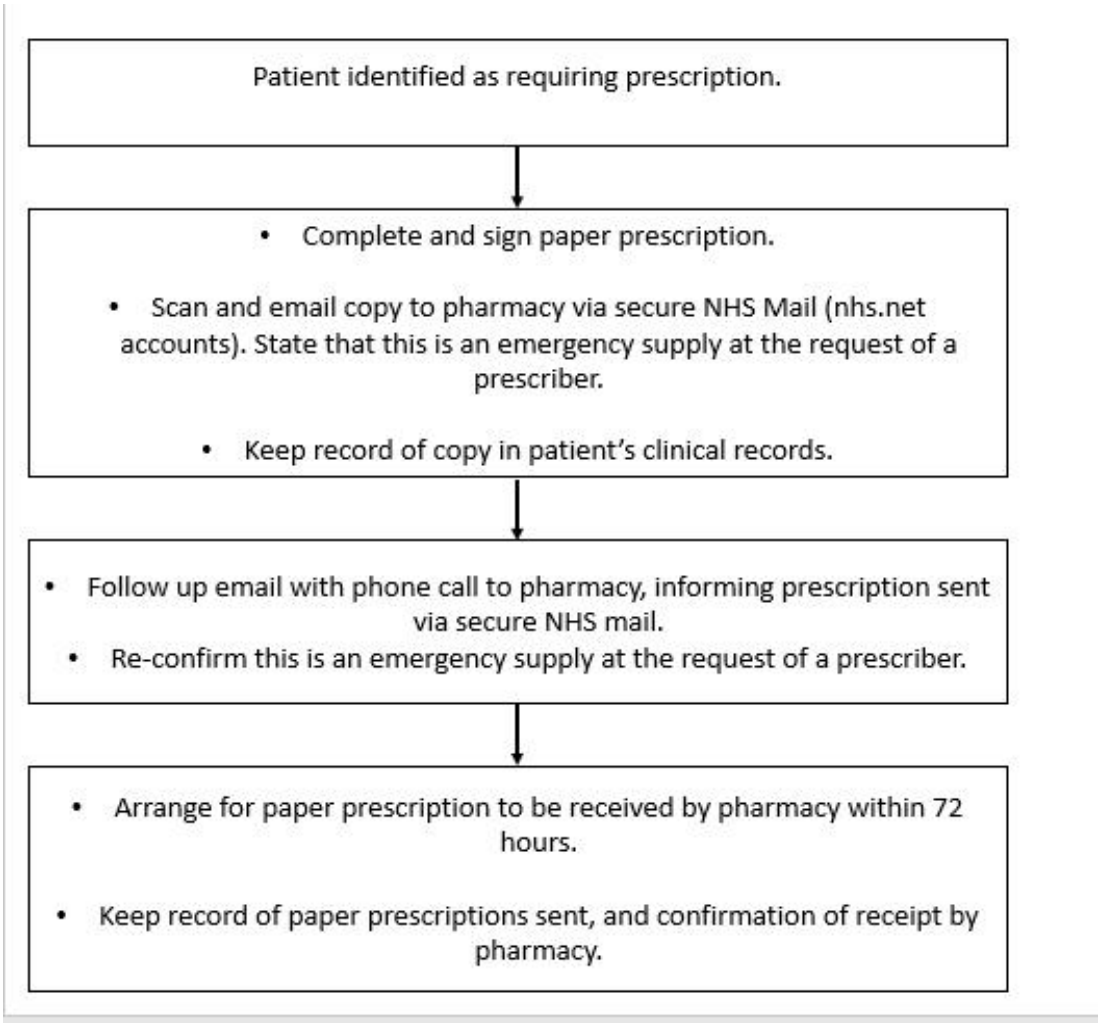
NHS dentists in England can currently only prescribe drugs using paper prescriptions (NHS FP10D forms). Dental services in England are not connected to electronic prescribing services (which allow prescriptions to be sent direct from prescriber to pharmacy). While all pharmacies are still able to accept paper prescriptions, as the COVID-19 pandemic progresses this may be problematic in the face of remote working procedures, social distancing and isolation requirements.

The law allows for pharmacies to supply urgent medicines at the request of the prescriber, under the condition that the prescriber must supply the pharmacy with a paper prescription within 72 hours of the request. The pharmacist must be satisfied that a remote request is from a dentist and that the dentist is unable to provide a prescription immediately due to an emergency (eg patient cannot collect the prescription from the prescriber, the prescriber is unable to drop off prescription at the pharmacy and patient urgently needs the medicine(s), etc).

Protocol

Dental services should work with pharmacy colleagues and align with the local approach and local arrangements for remote prescribing.

A recommended remote prescribing protocol is set out below. Given current service pressures across the health system, dental services are advised to establish this protocol arrangement with a number of local pharmacies where possible, to reduce delays and provide patients with a choice as to which pharmacy they go.



Dentists should note that given the current COVID-19 situation, community pharmacies are busier than usual. Therefore, it is advised that all emails are followed up by a phone call to avoid a delay to patients getting their prescription items.

Delivery of prescription items

Normal arrangements apply, where patients make their own arrangements to collect prescription items (which includes in some cases the pharmacy delivering to them). In some areas local arrangements may be in place to support the collection or delivery of prescription items during the pandemic (eg local volunteer networks, home delivery services).

Patients with possible or confirmed COVID-19 and their household/support bubble contacts should be advised not to go to community pharmacies. Dental teams should advise patients who require a prescribed medication that this should collected by someone who is not required to isolate themselves due to contact with the patient (eg neighbour or relative not in the same household/support bubble, or a volunteer) and delivered to the patient's home.

Appendix 6: Preparation for incident management for unwell patients with possible/confirmed COVID-19

Service providers may wish to draw on their existing protocols for dealing with medical emergencies in practice, as the incident management principles are the same:

- Develop and rehearse the service provider's COVID-19 triage protocols and isolation procedures:

  – agree practice approach for each stage of the potential scenarios

  – confirm role and responsibilities for each staff member

  – appoint an incident manager

  – confirm lead for discussions with patients/NHS 111

  – prepare an aide-memoire for staff

  – rehearse practice response.

- Review the coronavirus infection prevention and control protocols here.
- Review guidance for first responders here.
- Anticipate impacts on service schedule. Practices are advised to review the likelihood of disruption to services and prioritise the most urgent clinical work on the day.

Appendix 7: Staff support and wellbeing

We recognise the impact the COVID-19 response is having and will continue to have on dental teams, and it is important to support them as much as possible during their continued commitment to patient care.

Mental health and wellbeing resources

- The government has issued guidance for the public on the mental health and wellbeing aspects of COVID-19.

- All NHS staff have access to a range of support (#OurNHSPeople Wellbeing Support) through one point of contact:

- a free wellbeing support helpline **0300 131 7000**, available from 7.00 am – 11.00 pm seven days a week, providing confidential listening from trained professionals and specialist advice - including coaching, bereavement care, mental health and financial help
- a 24/7 text alternative to the above helpline - simply text **FRONTLINE** to 85258
- online peer to peer, team and personal resilience support, including through Silver Cloud, and free mindfulness apps including Unmind, Headspace Sleepio and Daylight
- These services can be used in addition to the support available from your own NHS organisations. Please email feedback to nhsi.wellbeingc19@nhs.net.

- NHS Employers has resources to support staff wellbeing during the COVID-19 pandemic here.

- NHS Practitioner Health has developed frontline wellbeing support during COVID-19, where confidential advice and support is available to dental practitioners.

- NHS Education for Scotland has developed resources for staff mental health and wellbeing support, found here.

- NHS staff have been given free access to a number of wellbeing apps until the end of December 2020 to support their mental health and wellbeing, including Unmind, Headspace, Sleepio and Daylight. More information here.

- BDA members can find further information about access to counselling and emotional support here.

- The Dentists' Health Support Trust provides confidential help and support for dental professionals.
- Mental health and wellbeing courses have been commissioned by HEE Midlands & East Dental School, found here.
- Access the MindEd COVID-19 Staff Resilience Hub here
- The World Health Organization has published WHO Mental Health Considerations During COVID-19.
- MIND UK and Every Mind Matters have published specific resources in the context of COVID-19.
- MindEd is a free learning resource about the mental health of children, young people and older adults. More information here.
- Information on mental health and wellbeing from the Academy of Medical Royal Colleges is found here.
- The Intensive Care Society has developed a wellbeing resource pack.
- BMJ Learning Modules cover COVID-19 treatment, fast tracked students, return to practice and wellbeing.
- A BMJ learning module on dealing with pressure in your foundation years is accessed here.

Wider support, guidance and learning resources

The BDA Benevolent Fund for those requesting financial support.

For key workers: the government has published guidance for schools, childcare providers, colleges and local authorities in England on maintaining educational provision for key workers, to support Health and Social care workers to continue to support the NHS.

Health Education England e-Learning for Healthcare has created an e-learning programme in response to the COVID-19 pandemic that is free to access for the entire UK health and care workforce – found here.

NHS workforce feedback hub

NHS England and NHS Improvement has an online feedback hub so that its leaders can listen and respond to the needs and experiences of the NHS workforce at this unprecedented time. The hub is private and anonymous, and asks participants to share how they are feeling, what more can be done to support them, and how the NHS can adjust its communications as part of the COVID-19 response. It is being run by Ipsos MORI, the independent research organisation, and is open to anyone working in the NHS. See here to learn more and to register.