OCDO
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NHS

Standard operating procedure

Transition to recovery

A phased transition for dental practices towards the resumption of the full range of dental provision

This guidance is correct at the time of publishing but may be updated subsequently to reflect changes in advice as necessary.

Please use the hyperlinks to confirm the information you are disseminating to the public is accurate. The document is intended to be used as a PDF and not printed: weblinks are hyperlinked and full addresses not given.

The latest version of this guidance is available here.

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Contents

This standard operating procedure (SOP) does not replace the need for clinical judgement based on the individual presentation and modifying factors. Neither does this guidance supersede existing legislation or regulations across the England. Employers should consider the specific conditions of each individual place of work and comply with all applicable legislation and regulations, including the Health and Safety at Work Act 1974 etc. While the SOP is applicable to all dental practices in England providing NHS dental care the key tenets and processes are equally applicable in delivering safe care in the private dental sector.

Introduction and background

The national IPC Guidance has been revised and published by UK Health Security Agency (UK HAS) on behalf of the Department of Health and Social Care (DHSC). It is applicable to all UK settings where healthcare is delivered. The infection prevention and control (IPC) for seasonal respiratory infections in health and care settings for winter 2021 to 2022 takes into consideration the impact of all seasonal respiratory infections.

The IPC principles and expected safe systems of work are outlined in the main body of the revised guidance. The accompanying revised Dental Appendix[1] provides further detail applicable to all those providing dental care in England. Dental practice owners, principals, associates, dental care professionals and dental practice managers should refer to both documents. This SOP has been revised to complement the updated UK IPC guidance for dental settings and support the safe and effective restoration of clinical activity and increase access for patients.

The revised UK IPC guidance adopts the hierarchy of controls framework (Section 10). Many of the processes and measures described in the hierarchy of controls are well established features, described in previous SOPs and successfully adopted by dental practices. A summary of the key areas and measures that should be in place in dental settings is at Appendix A of this SOP.

The revised guidance requires all practices to screen patients for COVID-19 prior to attending for care. An example of screening questions applicable to dental settings is contained in Appendix 1 of the main guidance -Sample screening tool for COVID-19 for use in health and care settings (winter 2021 to 2022).

[1] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-dental-appendix#summary

Section 1: Principles of care

Delivery of NHS care to include the full range of treatment options:

- Urgent care
- Routine care

Urgent Dental Care (UDC)

All practices should be accepting urgent dental care presentations and/or referrals from NHS 111. In addition, some dental providers will have arrangements with their local commissioning team to provide additional UDC services for their locality (eg if they are operating as a designated Urgent Dental Care Centre). Local arrangements will vary, and practices should ensure that they are fully acquainted and complying with the local contractual expectations and/or pathways as well as keeping their details on the Directory of Services fully updated.

Regional UDC systems are to be maintained in a way that is agile enough to respond to population need or any re-imposition of local containment measures. All practices are expected to provide additional support to the local UDC system, if necessary, eg in the event of a local outbreak.

Prioritisation of patients with the greatest clinical need remains:

- Patients with urgent dental care needs.
    - In addition to prioritising the urgent dental care needs of their existing patients, practices are expected to accept referrals/new patients seeking urgent dental care.
    - A key component of urgent care is the provision of follow on care to further stabilise disease, treat and prevent. This should be delivered in line with the principles outlined in the document Avoidance of Doubt: Provision of Phased Treatments and in line with Delivering Better Oral Health updated Nov 21

- Re-call of patients with incomplete care plans, oral health needs that may have increased, developed, or gone unmet during the pandemic eg children,

patients with high oral disease risk, patients whose oral health impacts on systemic health, and those who have been through stabilisation and need review.

- Dental teams should continue to implement NICE guidance on risk-based recall intervals (see here), to support optimisation of their service capacity.

Access

Reduced access to dental care may disproportionately affect certain patient groups and this should be mitigated as far as possible; some examples of the impact on health inequalities and inclusion groups can be found in Section 4.

Dental practices should ensure patients have clear information about how to access dental services; this information should be made available in accessible formats to all patients, including those who do not have digital access and those for whom English is a second language.

Receptions should be open to patients to allow booking of appointments face to face, while following risk assessment and social distancing measures. This is to avoid disadvantaging patients with poor access to phones or other devices.

If practices are aware that a patient/patient group has specific access needs, these should be addressed by the practice as far as possible, and this information should be passed on in any referrals.

Section 2: Approach for service planning and delivery

Patient triage

To reduce the risk of transmission all practices are to screen patients prior to attending for care. Dental practices should use the UK IPC sample screening tool for COVID-19 for use in health and care settings (winter 2021 to 2022) and regularly refer back to the uk.gov site for any updates or amendments to the screening questions.

- Practices should also identify, and risk assess any necessary accompanying persons (eg parents or carers accompanying patients)
- Patients should also be screen/risk assessed on arrival at the dental practice.

On completion of the screening and risk assessment the practice should determine whether the patient is to be placed on the respiratory or non-respiratory pathway and whether face to face dental care is to proceed. To maximise access when care may need to be deferred at short notice, practices should run a short notice cancellation list to minimise any lost clinical activity.

An algorithm of the patient pathway is shown in Figure 1.

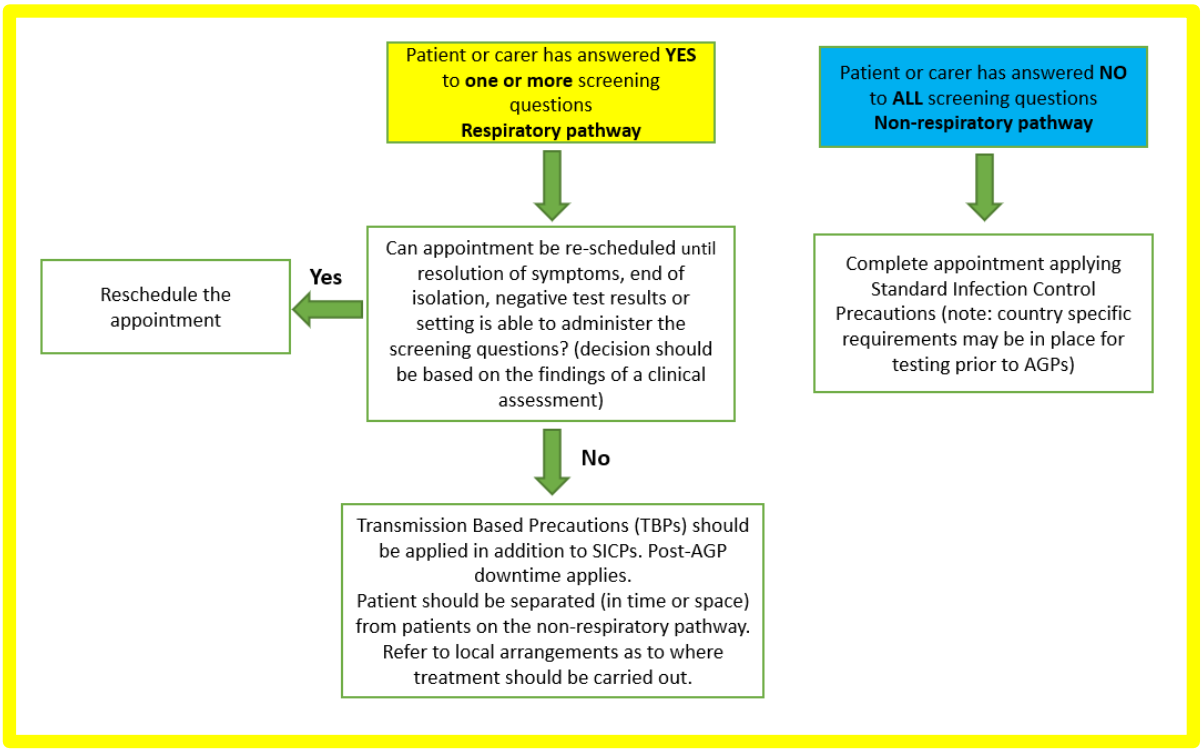

Figure 1: Diagram summarising the two pathways for patients attending dental settings (Source: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-dental-appendix#summary

- **For patients placed on the non-respiratory pathway, dental care may proceed using standard infection control precautions for both non-aerosol generating procedures (AGP) and AGP treatments, without the requirement for post AGP down time (fallow time).**

- For patients on the respiratory pathway, a further clinical assessment (ie triage by a **dental professional**) is required to determine whether routine care may be deferred until any respiratory symptoms resolve and when any COVID-19 isolation/quarantine periods has been completed.

  - 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.

  - Where care is deemed to be necessary and/or urgent patients on the respiratory pathway may attend for face-to-face care at any dental service, but they must be separated in time or space from other patients. This may require practices to maintain some protected urgent care slots to allow delivery of care in such cases.

  - **Transmission based precautions (TBPs) will be required for patients on the respiratory pathway** - further information on patient placement and separation requirements may be found at Section 12 and 13 of the revised dental appendix published here.

  - Post AGP down time is only required for patients treated on the respiratory pathway.
    - Post AGP down time commences at the point of cessation of the AGP. The length of time will vary dependent on the clinic's ventilation parameters, duration of AGP and nature of mitigation measures adopted.

- Risk mitigation and fallow time calculation is contained in the revised dental appendix. Practices may wish to consider the use of an online 'Fallow Time' Calculator, an example may be found here.

- **Patients who are at high risk or extremely high risk (previously known as clinically extremely vulnerable)** should be identified as part of remote risk assessment. They may be seen for dental care in the same way as other patients.

  - For most of these patients the risk of COVID-19 infection (and therefore having a serious outcome) will now be considerably reduced because of the vaccine programme. However, some patients may still wish to continue to take extra precautions to keep themselves safe, even if they are fully vaccinated against COVID-19. The requirement for access to care in an appropriate timescale, additional physical and temporal separation measures should be taken into consideration for these patients.

  - The latest government guidance is here, including information on supporting those that remain at higher risk, ie the immunosuppressed, some renal patients and those with haematological cancers.

  - 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.

Domiciliary dental services (including delivery in residential care settings)

For domiciliary dental care (eg care home, patient's own home), where the COVID-19 risk assessment for the care setting deems it appropriate, resumption of the full range of domiciliary dental services (including routine and urgent care) to all relevant settings is recommended, particularly to support groups at high risk of oral disease (eg care home residents, people shielding, people who are housebound).

The revised IPC guidance applies to domiciliary care.

Patients must be risk assessed in line with the guidance and screened, prior to the visit and by the team on their arrival.

- Patients on the non-respiratory pathway may be visited and cared for using SICPs.
- For suspect or confirmed COVID-19 patients they should be treated using the respiratory pathway:
    - Routine care visits should be deferred.
    - If care cannot be deferred; TBPs must be used.
    - Patients who require urgent care involving an AGP, should be supported to receive that care in an appropriate clinical dental setting.

Further details on staff testing as a precursor to domiciliary and care homes visits is at Appendix B.

COVID-19 service continuity

Dental practices should review their business continuity plans to ensure arrangements are in place to minimise the impact of a local incident on services. This should include scenarios that could temporarily disrupt delivery of services from practice premises or disrupt staff availability (eg local outbreak; case(s) of COVID-19 in practice). Plans should consider high levels of staff sickness and self-isolation, call handling, staff and patient communication and, ultimately, denial of access to premises for staff and patients.

Business continuity arrangements should recognise the opportunities to maintain patient services through remote working, collaboration with other local dental providers, and integration with the local Urgent Dental Care system. Using clinical judgement and experience of recent months, dental teams may need to consider how to prioritise their workload to deliver the best possible care to their patients.

In the event of COVID-19 impacting the delivery of services, practices should:

- Inform their local commissioner in line with local reporting/escalation processes
- Be aware of, and follow, any local containment plans or additional precautions instituted by national direction or local systems (eg local authorities, regional NHS England and NHS Improvement commissioning teams; local health protection/PHE)

- Communicate service changes to patients.

Section 3: Supporting the Dental Team

COVID-19 vaccinations

The advent of the COVID-19 vaccination programme, and the prioritisation of dental staff for the vaccine, has been an important addition to the evidence-based multi-layered approach to personal protection and an essential community-wide measure for reducing the spread of disease to dental staff and patients.

Since January 2021 all members of the dental team who have contact with patients, including both dental professionals and non-clinical staff (eg reception teams, domestic staff), have been eligible for the COVID-19 vaccination. Most dental staff will have been fully vaccinated in line with the expectation that healthcare workers fulfil their duty of care towards their patients in taking all reasonable precautions to protect themselves and their patients from communicable diseases. A booster vaccine is now available for dental staff who have had a second dose of the vaccine at least 6 months ago.

Individuals who have not yet received the vaccination should be supported and encouraged to take up the offer of the 1st and 2nd doses. For those who have not yet been vaccinated or received their booster please book a vaccination appointment online here (Or by calling 119 if online booking is not possible).

The Department of Health and Social Care (DHSC) has formally announced that individuals undertaking Care Quality Commission (CQC) regulated activities in England must be fully vaccinated against COVID-19 to protect patients no later than 1st April 2022, regardless of their employer, including secondary and primary care. This applies to the whole of the dental sector in England (both NHS and private care).

The government regulations are expected to come into effect from 1st April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3rd February 2022, in order to have received their second dose by the 1st April 2022 deadline.

Maintaining staff risk assessments

To safeguard the health of their staff and minimise the risk of infection, it is essential that all dental practices regularly review risk assessments for all their staff (clinical, administrative and domestic staff), recording discussion with team members and the agreed actions. Risk assessments should include consideration of the risk of complications from all respiratory infections, such as COVID-19 and influenza.

Further guidance is also available through:

- NHS Employers: risk assessments for staff – here
- Risk reduction framework for NHS staff at risk of COVID-19 infection – here.
- Health and Safety Executive guidance on working safely - here
- Section 6 of IPC Dental Appendix ***HYPERLINK***

Staff at increased risk from COVID-19 and other respiratory infections

These staff, including Black, Asian and minority ethnic staff and pregnant women, should be risk assessed so that appropriate measures are put in place to minimise exposure to risk and support safe working. Risk assessments should be updated in light of changes to individual staff circumstances or local risk of COVID-19. Support from Occupational Health may be required.

- The government has published COVID-19 guidance for pregnant employees.

Staff with symptoms

Staff with symptoms that may be caused by COVID-19 should stay at home as per advice for the public and arrange to have a test.

Staff testing negative for COVID-19 by PCR who remain symptomatic of another respiratory infection should consider the risk to service users particularly if they are immunosuppressed or otherwise medically vulnerable before returning to work. Once medically fit to return to work, if staff are in doubt about any risk they may pose to service users or colleagues this should be discussed with their line manager in the first instance.

Symptomatic 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 should inform their line manager and return home.

Staff notified as contacts of COVID-19

The updated government guidance for healthcare workers (HCW), includes information on staff exposure to COVID-19, testing, guidance on HCW identified as contacts and Test and Trace.

Return to work criteria are set out in this NHS letter.

Further clarification for dental staff was provided in August 2021 bulletin found here.

Advice is available on how and when staff should pause use of the NHS COVID-19 contact tracing app.

Staff COVID-19 testing

Symptomatic staff can access PCR testing via the GOV.UK website (or call 119) and should identify themselves as essential workers. Further information on how to arrange for a test can be found in the COVID-19: getting tested guidance.

Lateral flow antigen testing has been rolled out in primary care for **asymptomatic** staff delivering NHS services in England. The latest information and guidance on lateral flow antigen testing in primary care can be found here. Patient-facing primary care staff are asked to test themselves twice weekly and report their results to Public Health England (PHE), via the NHS Digital online platform. Please be aware that it is a statutory requirement to report all results, including negative, positive or void. FAQs for primary care are also available, as well as a brief guide for staff on how to self-administer the tests.

Information about the COVID-19 **antibody testing programme** can be found on the GOV.UK website.

Further detail on the requirements for staff testing prior to domiciliary visits is at Appendix B.

Resilience: supporting the workforce

Despite the change in guidance for the general population, the dental practice remains a high-risk healthcare setting for COVID-19. To manage risk and prevent transmission there remains a necessity for social distancing measures in staff areas/facilities, consideration of measures such as staggering breaks and limited use of changing areas/rooms to single occupancy at any one time.

To ensure that staff are working safely, refer to COVID-secure guidelines and the Health and Safety Executive's working safely guide. The pace of the clinical day should be reviewed in order to accommodate regular breaks and rest periods.

The following **mental health and wellbeing resources** are available to staff:

- NHS Employers has resources to support staff wellbeing during the COVID-19 pandemic here and NHS Looking After You Too
- 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.
- NHS Practitioner Health has developed frontline wellbeing support during COVID-19.
- BDA members can find further information about access to counselling and emotional support here.
- Domestic abuse helpline here.

Practice Team Responsibilities

Practices should **maintain** a COVID-19 lead (and deputies if necessary) to ensure:

- Practice has the latest information relating to COVID-19 through official updates, alerts and communications including:
    - CAS alerts from MHRA
    - NHS dentistry and oral health bulletin https://www.england.nhs.uk/email-bulletins/dentistry-oral-health-update/
    - Bulletins from local and national NHS Primary Care Commissioning

    - Updates to infection prevention and control guidance
- A single point of communication with Regional NHS England and NHS Improvement commissioning team (for information cascade), Local Dental Network and Local Dental Committee.
- The development and implementation of practice policies and procedures,
- Compliance and audit of completed staff and practice risk assessments and a review schedule.
- Audit of COVID-19 cases and COVID-19 related significant events within the practice (staff and patients), log of lessons identified with documentation to evidence lessons learnt and implemented
- Queries are directed to local infection control teams and dental practice advisors (DPAs).
- The Regional commissioning team is informed of service status if operations are affected by the pandemic (eg in the event of a local outbreak) so the Directory of Services can be kept up to date.
- Contact and connections with the local UDC system are maintained

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

Section 4: Health inequalities and inclusion health

Oral health inequalities remain a significant public health problem in England as reported by PHE (19 March 2021). PHE identify a range of barriers to NHS care at individual, societal and policy level which include costs, lack of availability of services and services not commissioned to meet local needs.

Evidence suggests that existing health inequalities have been compounded by COVID-19. The pandemic continues to have a disproportionate impact on certain sections of the population: older people, people living in deprived areas, BAME groups and vulnerable groups. The long-term economic impact of the pandemic is likely to further exacerbate oral health inequalities.

At a practice level, an awareness of the need to target time and access at those in greatest need is an enduring tenet. However, during the pandemic some vulnerable/high needs patients may have been displaced out of area and/or relocated into your area due to measures applied by local authorities. These include homeless people, travellers, migrants/refugees and looked after children. Ensuring availability and flexibility in access to meet the needs of these patient groups is a continuing expectation. Advice on dental care for refugees and migrants has been published by PHE.

Dental practices continue to play an important role, working with voluntary and community organisations, to make sure those who are most excluded are signposted to their care.

Appendix A: Hierarchy of Controls

Hierarchy of controls	Some example control measures in a dental context
Elimination (Screening)	▪ Screen all patients, workers, and visitors for clinical and epidemiological risk factors for COVID-19 ▪ Visitors and patient escorts must not enter the facility if they have symptoms of COVID-19 or have been advised to self-isolate ▪ Patients ○ Pre-appointment screening of patients onto either "Respiratory" or "Non-Respiratory" Pathways ▪ Do not treat suspected/confirmed COVID-19 patients when routine care can be appropriately deferred ▪ If care cannot be deferred for suspect or confirmed COVID -19 patients they must be treated using the respiratory pathway; TBPs pathway must be used. Entry to the practice should be coordinated to avoid or minimize use of common areas, isolate from other patients in both space and time. ▪ Staff ○ Staff must not report to work if they have symptoms of COVID-19 or have been advised to self-isolate for any reason ○ Staff who have tested asymptomatically positive using LFD test must isolate and not report to work further to confirmation via PCR test. ○ Consideration should be given to non-clinical staff who typically enter clinical areas as part of their job role and alternative arrangements made wherever possible
Substitution	For any patients with respiratory symptoms in keeping with a suspected or confirmed COVID-19 definition – perform patient consultations over phone as far as possible rather than in person.
Engineering controls (Practice infrastructure accommodation/furnishings)	▪ Use of COVID-19 related signage to enhance screening protocols, implement 'check in', and deliver key messages such as respiratory hygiene/masks/social distancing ▪ Installations of partitions at appropriate places (eg reception desks) to separate staff from presenting patients (consideration needs to be given to impact on air flow before installation and any cleaning requirements) ▪ Improve ventilation by opening windows on the premises ▪ Effective mechanical ventilation ▪ Provision of additional hand hygiene and face mask stations ▪ Adhere to social/physical distancing and space requirements ▪ Identification and frequent cleaning of high touch surfaces ▪ Optimal chair spacing throughout practice, including patient waiting areas and staff communal areas, eg Rest room and office areas. ▪ Remove high touch items such as toys and magazines from communal areas ▪ Consider dedicated use of single room facilities for performing AGPs on high/higher risk patients

Administration controls (Practice policies and procedures)	▪ Make efforts to reduce number of people on premises at any one time ▪ Reduce number of deliveries to areas by coordinating as many supplies as possible in as few deliveries as possible. ▪ Patients and Waiting Areas ○ Implement social distancing requirements in all communal areas ○ Avoid face to face waiting arrangements in waiting areas ○ Reduce waiting time for individuals in waiting areas, ○ Patients should wait in their car or outdoors if possible until telephoned by reception to enter the building for appointment. ○ Maintain one-way flow of patients through the practice with development of pathways/one-way systems/dedicated assessment rooms ○ Reduce movement of patients and avoid concurrent activity (two-way exchange of patients between clinic and waiting areas). ▪ Staff and Clinical Areas ○ Ensure up to date staff training on infection prevention and control and implementation of IPC guidelines ○ Support/encourage vaccination policies for all dental care workers ○ Reduce number of staff in break areas/changing rooms/offices and display maximum occupancy on entry to and within the room. ○ Working from behind or at the side of the individual (no face to face close contact) wherever possible ○ Adopt protocols that reduce viral load and saliva being aerosolised by use of protocols such as dental dam, and high-volume ○ evacuation (suction) ○ Calculate and implement appropriate 'fallow times' if COVID-19 suspect or confirmed patients are being treated in the facility
Personal Protective Equipment (PPE) and additional infection control considerations (protecting the worker)	▪ Adopt PPE protocols consistent with UK IPC Guidance - SICPs as baseline ▪ Ensure that PPE is appropriately used (eg team training on selection, donning, doffing, fit testing, fit checking) ▪ Use of face coverings (although not classed as PPE) by patients and escorts – a Type IIR mask ▪ Enhanced PPE for staff when a risk assessment indicates this is required ▪ Have enough PPE supplies available based on the risk-based infection control precautions required for patients receiving care in the facility ▪ Defer or transfer care if appropriate PPE is not available

Appendix B: Delivering Domiciliary Dental Services

In delivering domiciliary dental services, the following should be taken into account:

- For Care Home visits: All members of the domiciliary dental teams will need to demonstrate that they have been vaccinated in line with Government direction for healthcare staff in care home settings.
- Further guidance on care home visiting to reduce the risk of COVID-19 transmission is found here.
- Local policies and arrangements may vary depending on local transmission rates, outbreaks and wider COVID-19 recovery plans.
- Care should be provided in line with the care home COVID risk assessment (as the extent to which domiciliary care will be appropriate will vary from home to home

Domiciliary teams should:

- Undertake remote risk assessment of domiciliary patients (and any carers in attendance), determine the patient pathway (respiratory / non-respiratory) as per UK IPC guidance, to support care planning, appointment scheduling and PPE.
- Undertake pre-visit COVID-19 risk assessment and testing of dental team.
- As well as undertaking their own risk assessment, dental teams should be part of a risk assessment by the care home/home-care team.

Staff Testing

- Team members will need to demonstrate that they are complying with the NHS asymptomatic staff testing regime (an important component of Infection Prevention and Control, which all NHS organisations and staff have a duty to adhere to) , completing the twice weekly testing (a test every 3 to 4 days) and recording their results.
    - Proof of a negative LFD within the last 72 hours may be accepted by care home managers but care home managers reserve the right to risk assess and request a negative PCR (undertaken in the previous 72 hours).

- All visiting professionals who are not regularly tested through another route such as NHS staff, should be tested on the day of their visit, similar to visitors. For further guidance on testing for visiting professionals, see here.

For visits to an individual's private home: Domiciliary dental teams are expected to be able to demonstrate compliance with the NHS asymptomatic staff testing regime and proof of a negative LFD within 72 hours.

- Where there is no evidence that the domiciliary dental team is adhering to the LFD Asymptomatic testing then proof of a negative PCR within the last 72 hours is recommended prior to entry to a domiciliary care setting (including private homes and care homes).

- The patient and the health and social care professionals involved in the patient's care (eg GP, carer) should be consulted to inform the risk assessment and decision for any additional team testing prior to attending where appropriate.

Emergency Domiciliary Visits

In emergency situations where proof of either a negative PCR test or a negative lateral flow test within 72 hours before entry to any domiciliary care setting (including private homes and care homes) is not possible, following a risk assessment , a lateral flow test should be undertaken at the door of the domiciliary care setting prior to entry to administer urgent care.

Note:

For dental team members who have recently tested positive for COVID-19 using a PCR test, they should not test (with PCR or LFD) within 90 days unless they become symptomatic.

Staff members cannot be tested regularly because they fall into this 90-day window should use evidence of their positive PCR result to show that they are currently exempt from testing until the 90-day period is over.

Once the 90-day period is over, professionals should continue to follow their relevant testing regime. For more information, see guidance here.