BDA
British Dental Association

COVID-19 special guidance
Version 1 | Tuesday 2 June 2020

RETURNING TO FACE-TO-FACE CARE

ENGLAND

This toolkit is designed to help practices return to safe clinical practise.

It uses a number of different sources from both this country and abroad. It will be updated as new guidance and evidence becomes available.

Please make sure you are using the most up-to-date version. Members will be notified when updates are made.

Our priority has been and will be the safety of you, your team and your patients, and the financial sustainability of your practice.

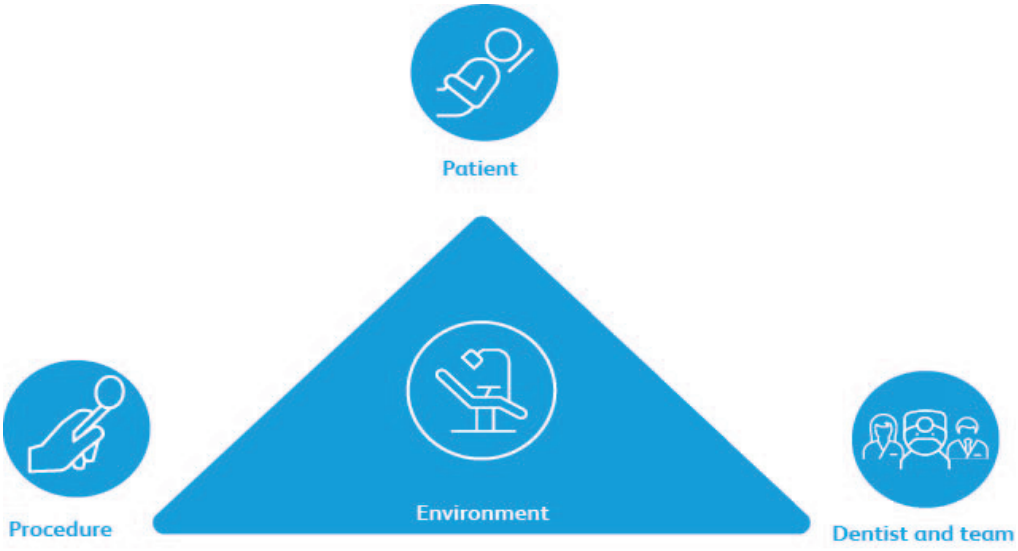
Little evidence but much expertise

Dear member

Owing to the novel nature of COVID-19 there is a lack of conclusive evidence in many areas where clinicians would normally look for it. We have reviewed documentation from governments and official bodies around the world and worked with institutes and organisations in our profession. This toolkit for England is our suggestion of what's achievable in line with the Government's social distancing rules and infection control measures. We know that returning to routine care does not mean business as usual as we knew it before COVID-19. Particularly in the early stages, there will be limits on what can be done clinically and how many patients can be seen in a day, with variation in the extent and speed of progress possible for different practices according to their circumstances.

Much of the decision-making on how to apply this guidance will fall to the practice as well as individual clinicians who work there given the environmental context of the practice, government advice, regulatory guidance, GDC standards, the patient population you treat, as well as the particular patient in your chair and your own clinical judgement.

Your assessment of the risk is based upon four factors:



As dentists, we have to balance our desire to return to caring for our patients with making all the necessary arrangements to reassure our team, our patients and the general public, that their safety is our highest priority. The seriousness of COVID-19 has been confounded by mixed messages given to the dental profession which have left the public and our teams anxious, uncertain and confused.

I hope that we're on the road to fixing some of those problems.

Mick Armstrong
Chair, BDA

"As a long standing member and the owner of several practices, I'd like to congratulate you on the excellent representation thus far on the COVID-19."

Our patients trust us

COVID-19 presents risks to patients and the team directly providing treatment.

Personal protective equipment, other risk reduction factors and infection control reduce that risk since social distancing is not really possible in the dental surgery, though it is in the reception and non-treatment areas. Infected members of the team can also be a vector for transmission.

The patient is a risk to themselves if they fall into one of the vulnerable groups so protecting them when they come into the practice is a key element of the patient journey. The dental procedure planned and carried out influences the level of risk to the team and the environment; the practice and clinical areas feature highly in how risks are mitigated.

Each dental practice operates in a local community and in many cases have been part of that local fabric for many years. Patients build up huge amounts of trust in those practices and create strong bonds with them.

This toolkit is about strengthening those bonds.

Your practice is also located within the wider community of a town, city, county and nation and that geography will have an important influence on how the practice operates. Those subtle differences may require more interpretation and our advisors are here to help you with that when we can. Sometimes though there are no binary answers.

It is important to remember also that when there are dento-legal implications, you should contact your indemnity provider for further advice. If you are a BDA Indemnity member, our advisors are on hand to provide advice over the phone or by email.

Len D'Cruz
Head of BDA Indemnity

Transmission

The World Health Organisation (WHO) declared the Coronavirus disease (COVID-19) outbreak a public health emergency of international concern on 30 January 2020 and a global pandemic on 11 March 2020.

A novel human pneumonia pathogen, severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) was identified in China in December 2019. This was classified as 2019 Novel Corona Virus (2019-nCoV) and the disease was named Coronavirus Disease (COVID-19). It spreads primarily through droplets and fomites. The close-working environment and the potential for aerosol spread of the virus through dental procedures, such as use of high speed handpieces, ultrasonic scalers, air/water syringes, or an infected patient coughing, places dental health workers at an elevated risk of infection.

The typical routes of transmission for the COVID-19 virus are either via direct transmission (cough, sneeze, and droplet inhalation) or via contact transmission (contact with oral, nasal and eye mucous membranes). There is currently a lack of evidence regarding transmission of the virus via dental aerosols, so recommendations are necessarily based on expert opinion and a precautionary assumption that aerosols are infective. Updates may be required as more evidence emerges.

Also, studies have shown that the disease could be transmitted directly or indirectly through saliva. It was reported that live viruses were present in the saliva of infected individuals. Symptomatic patients are the primary transmission sources but asymptomatic patients and patients in the incubation period are also carriers of COVID-19. This incubation period (the time between contracting the virus and when outward symptoms start) averages 5 days but can be up to 14 days. Patients can be infectious during this incubation period but are most contagious when showing symptoms. Until there is widespread testing in the UK it is difficult to know how many people are either carrying or incubating the virus.

As more members of the public have antibody testing and evidence on re-infection emerges, it will become clearer who has immunity to the virus and is therefore less likely to be contagious or to contract it again.

This means that dental practices should consider all patients as if they were infected and adopt universal precautions to ensure staff, patients, clinicians and other members of the public who attend the practice are kept safe.

Dental patients and professionals can be exposed to viruses and bacteria that infect the oral cavity and respiratory tract. Dental care settings always bear the risk of COVID-19 infection due to the procedures which involve face-to-face communication with patients and frequent exposure to saliva, blood, and handling sharp instruments.

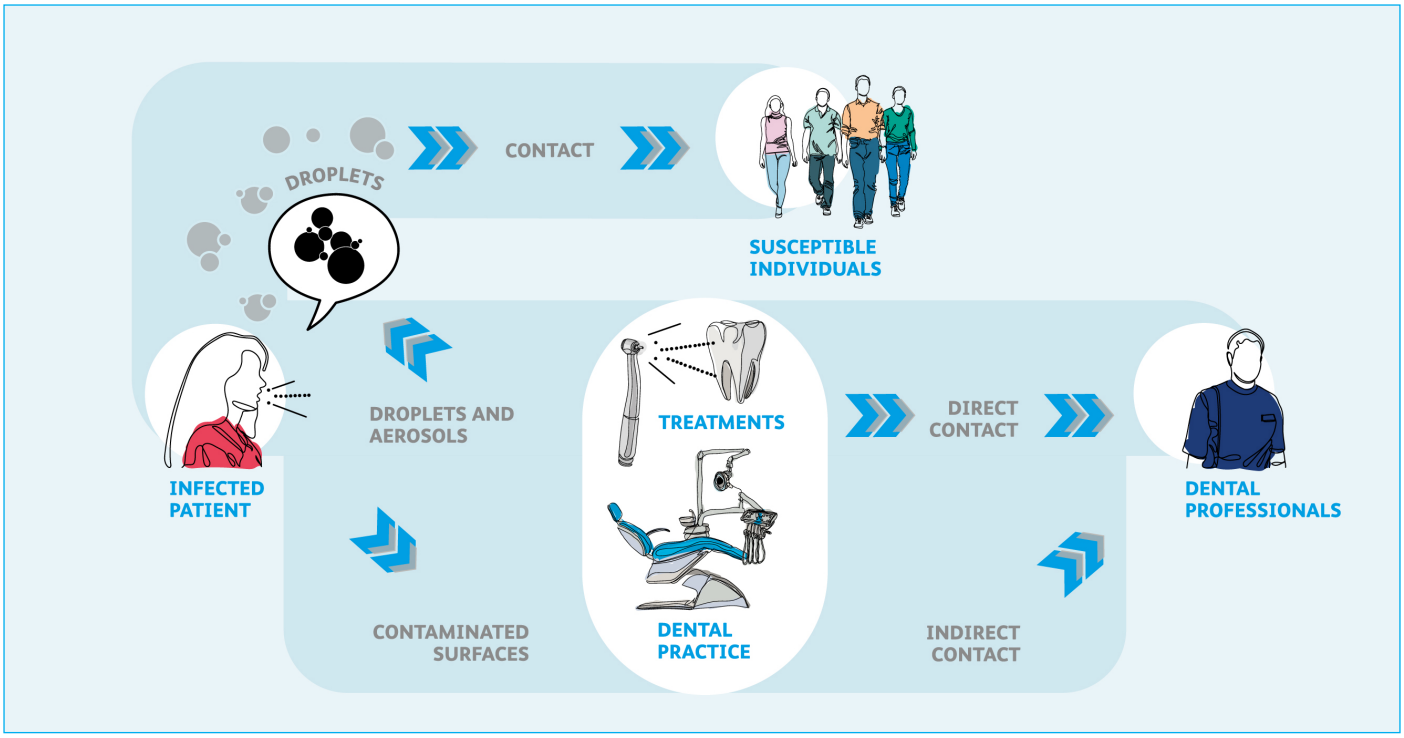
The symptoms of coronavirus (COVID-19) are usually mild, but some people can become very unwell.

MAIN SYMPTOMS

The main symptoms of coronavirus are:

- **High temperature –** this means you feel hot to touch on your chest or back (you do not need to measure your temperature)
- **New, continuous cough –** this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)
- **Loss or change to your sense of smell or taste –** this means you've noticed you cannot smell or taste anything, or things smell or taste different from normal.

Most people with coronavirus have at least one of these symptoms.



Adapted from a figure in International Journal of Science Vol 12 9(2020) *Transmission routes of 2019n Cov and controls in dental practice* Peng X, Xu X, Li Y, Cheng L. Zhou X Ren B

HOW TO USE THIS TOOLKIT

Key:

Priority or restricted access for members
Log in required

The toolkit is ordered so that you can pull out sections to delegate to your team.

For example:

Preparing the site > *Receptionist or practice manager*
Reducing risks for staff and patients > *Practice manager*
Employees > *Practice principal or manager*
Associates > *Practice principal or manager*
Training > *Practice principal*
Communication with patients > *Reception*
Infection control > *Lead nurse*
Pre-appointment triaging > *Dentists*
Patient registration procedures > *Reception*
Clinical issues > *Dentists*

There's more to this toolkit online at bda.org/coronavirus

Watch webinars, complete online learning and download templates

> "I just want to say thank you so so much for all of your hard work on behalf of dentists...it means the world that you speak with clarity and rightly with anger during these uncertain times."

Contents

SAFE PRACTICE

SAFE PRACTISE

1 Preparing the site

There will be some changes you'll need to make to the practice to manage patients' expectations of their experience and which will protect them and the team.

Signage outside

Signs outside should advise patients that they should enter the building only if they have appointments. They should be asked to book appointments and make all other enquiries over the phone. Patients should be directed to the practice website for further information.

The entrance

You could decide to keep the front door locked.

Provide a hand sanitation station upon entry into facility, with a notice to people to use it before entry into the rest of the practice.

Reception

All staff should wear masks or face shields, and practices can install a clear barrier such as a Perspex screen.

Consider individual phone headsets for each front desk staff member.

Promote the circulation of air in the waiting room, preferably with windows opened.

Electronic equipment such as mobile phones, desk phones and other communication devices, tablets, desktops and keyboards (particularly where these are used by many people) should be decontaminated at least twice daily with 70% ethyl alcohol or products as specified by the manufacturer.

PDQ machines and terminals should be wiped after use or covered over with protective covering that can be replaced.

Decontaminate communal areas regularly throughout the day and display a laminated wipe-clean cleaning checklist for patients to see.

Waiting room

Place chairs 2 metres apart where possible.

Place visible 2-metre distance markers on the floor or in obvious locations.

Use barriers (like screens) if possible.

Remove all non-essential toys, reading materials, remote controls or other communal objects.

Communal areas

Communal facilities such as coffee machines should be removed. Water dispensers should offer disposable single-use cups

Wipe all touchable surface areas with an approved surface cleaner on a regular schedule. Remember to include tables, chair arms, doorknobs, light switches, hangers, and anything else with which people come in contact. If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.

Toilets

Ideally patients should not be able to use the toilet facilities. Patients should request access to the facilities to ensure staff know they have been used.

Provide supplies:

Tissues
Alcohol-based hand rub
Liquid soap at sinks
Contactless bins (or foot-pedal operated)

Provide instructions on proper hand washing.

Remove bathroom towels and replace with paper towels.

PATIENT INFORMATION POSTERS

PHE | Best practice: how to hand rub
PHE | Best practice: hand wash

Things to change:

- Social distancing
- Seating configuration
- Remove any unnecessary objects
- Barriers
- Rearrangement of furniture
- Patient information posters
- Wearing of masks
- Hand sanitising station

New equipment to purchase:

- Perspex barriers

2 Reducing risks for staff and patients

Dental practices should undertake regular risk assessments to ensure staff safety.

Appointing a COVID-19 lead

Appoint a COVID-19 lead for the co-ordination of activities within the practice who is responsible for training, preparation and implementation of SOPs and any subsequent revisions to guidance.

Ensure communication with the dental team and regular communication with any other parts of the local UDC system as necessary (for example, the commissioning team or collaborating services).

Keeping staff safe

1. All staff should be risk-assessed on an ongoing basis to protect them and keep possible COVID-19 cases, household contacts, staff who should be shielded, or those at increased risk, away from work.

2. Staff could be asked to complete a questionnaire identifying any COVID-19 symptoms before arriving at the practice each day. Anyone with symptoms should not be permitted to work and should return home to self-isolate.

3. In line with Government advice, it is recommended that as part of risk assessment, dental services review the 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.

4. COVID-19 guidance around social distancing and good hygiene practice should be promoted as far as possible in the workplaces. Staff should be advised to avoid unnecessary close contact with each other, for example, shaking hands and hugging.

Staff with symptoms of COVID-19 and household contacts

Staff with symptoms of COVID-19, or who live with someone with symptoms, should stay at home as per advice for the public. Staff who are well enough to continue working from home should be supported to work from home.

If staff become unwell with symptoms of COVID-19 while at work, they should stop work immediately, cover their face with a mask and leave the workplace.

Staff with suspected COVID-19 should be prioritised for diagnostic testing. Apply via gov.uk.

Staff should self-isolate for seven days or longer if they have symptoms after this time. After this time, as long as they are symptom free, they can return to work. All members of staff who are self-isolating are eligible for Coronavirus testing and should be offered the opportunity if they wish to be tested. Use the self-referral portal to book a test. Staff may require evidence that they are no longer infectious prior to working with extremely vulnerable people, subject to local policy.

If staff live with someone who has COVID-19 symptoms, staff must self-isolate for 14 days from the day of onset in their household member.

Staff at increased risk from COVID-19

The Government has issued guidance about stringent social distancing and shielding for clinically extremely

vulnerable groups at particular risk of severe complications from COVID-19. Staff who fall into these categories should not see patients face-to-face regardless of whether a patient has symptoms of COVID-19 or not. Remote working should be prioritised for these staff.

Staff support and wellbeing

We recognise the impact that 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.

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

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

Pregnancy/breastfeeding

Pregnant/breastfeeding staff members should seek and follow medical guidance from their GP regarding work.

Information on COVID-19 in pregnancy/breastfeeding is very limited; practices may want to consider limiting the exposure of these staff to patients, especially during higher risk procedures (or example, aerosol-generating procedures) if feasible, and based on staffing availability.

COVID-19 employee screening

Consider implementing a daily health screening check point and log for all employees entering the workplace.

Use our screening log to document the tasks each day.

Ask all persons (employees/owners/associates) reporting to work the same questions, remembering to respect their confidentiality.

Clinical staff health status needs to be checked and staff should receive appropriate training on protocols, procedures, and materials.

Dental staff should pay special attention to their own symptoms and stay home or be sent home immediately with symptoms of COVID-19 (fever, cough, sore throat, headache and muscle soreness, which may be accompanied by nasal symptoms).

Black and minority ethic staff

Emerging evidence shows that black and minority ethnic (BME) communities may be disproportionately affected by COVID-19. The reasons for this are not yet fully understood, but the health inequalities present for BME communities have long been recognised.

Within the NHS, 40% of doctors and 20% of nurses are from BME backgrounds, as are substantial numbers of health care support workers and ancillary staff.

Organisations should ensure that line managers are supported to have sensitive and comprehensive conversations with their BME staff, recognising the long-standing context of the poorer experience of BME in all parts of the NHS. They should identify any underlying health conditions that may increase the risks for them in undertaking their frontline roles, in any capacity.

Most importantly, the conversations should also, on an ongoing basis, consider the feelings of BME colleagues, particularly regarding both their physical safety, their psychological safety, and their mental health.

Hand hygiene

COVID-19 is an enveloped virus. This means that the RNA (nucleic acid – the viral genetic material) is coated in a lipid (fatty) layer. Soap is able to dissolve this lipid layer, causing the virus to fall apart and

stopping it from binding to human cells.

Hand hygiene is essential to reduce the transmission of infection. All dental staff and patients/carers should decontaminate their hands with alcohol-based hand rub when entering and leaving the practice.

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of PPE, equipment decontamination and waste handling.

Hands should be washed thoroughly with soap and hot water for 20 seconds and dried using paper towels that are disposed of into a bin with a no-touch lid.

Use liquid soap.

Do this:

- When arriving at the practice
- Before and after any contact with patients
- After contact with contaminated surfaces or equipment.

The bin lid should be foot or sensor-operated to avoid having to touch it.

Hand sanitisers should not be considered a substitute if soap and water are available. If there is no soap or water available, then hand sanitisers should be used. Hand sanitiser must contain a minimum of 60% alcohol to be effective.

Medical grade sanitisers bought by practices usually have around 70% alcohol.

Cough hygiene

Cough hygiene should be observed by staff and patients/carers. Disposable tissues should be available and used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – 'Catch it, bin it, kill it'.

Any procedures should be carried out with a single patient and only staff who are needed to undertake the procedure present in the room with the doors shut.

Clothing

Staff should change into and out of uniforms at work only. Uniforms must not be worn when travelling.

Clinical staff should wear scrub type uniforms and footwear that can be wiped down.

If scrubs are to be worn, change between street clothes and scrubs upon entry and exit, or do the same with other clothing.

If available, gowns should be considered. Change the gown if it becomes soiled.

Disposable gowns should be discarded after use.

Cloth gowns should be laundered after each use.

Washing of garments

Garment parts of PPE that are washable must be removed carefully, without shaking them, from inwards to outwards, and put into a waterproof bag.

Uniforms should be laundered:

- Separately from other household linen;
- In a load not more than half the machine capacity;
- At the maximum temperature the fabric can tolerate (at least 60 degrees for 30 minutes or between 80 and 90 degrees with 10 minutes heat contact with clothes), then ironed or tumbled-dried.

Things to change:

- Wearing of work uniforms to be laundered on site or by laundry service

Consider providing laundry facilities in the practice, or contract with a laundry service.

In the absence of onsite washing machine facilities, pack the garment into a pillowcase, safely enclosing it until it reaches the washing place. Put the garment directly into the washing machine. The pillowcase can be washed with the uniform.

Professional judgment should be exercised with regard to the use of disposable foot covers or head covers.

Patients at risk from Coronavirus

There are two groups of people who are at risk:

A. Clinically extremely vulnerable

1. Solid organ transplant recipients.

2. People with specific cancers:

- People with cancer who are undergoing active chemotherapy

- People with lung cancer who are undergoing radical radiotherapy

- People with cancers of the blood or bone marrow who are at any stage of treatment

- People having immunotherapy or other continuing antibody treatments for cancer

- People having other targeted cancer treatments which can affect the immune system

- People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.

3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).

4. People with rare diseases that significantly increase the risk of infections.

5. People on immunosuppression therapies sufficient to increase risk of infection significantly.

6. Women who are pregnant with significant heart disease, congenital or acquired.

The advice around 'shielding' has been:

1. Do not leave your house.

2. Do not attend any gatherings, including gatherings of friends and families in private spaces, for example, family homes, weddings and religious services.

3. Strictly avoid contact with someone who is displaying symptoms of coronavirus (COVID-19).

As of 1 June the Government is advising people who have been shielding to continue following social distancing measures.

B) Clinically vulnerable

If a patient has any of the following health conditions, they are considered clinically vulnerable, meaning they are at higher risk of severe illness from coronavirus. They are advised to stay at home as much as possible and if they go out to take particular care to minimise contact with others outside their household.

Clinically vulnerable people are those who are:

- Aged 70 or older (regardless of medical conditions)

- Under 70 with an underlying health condition listed below (that is, anyone instructed to get a flu jab each year on medical grounds):

- Chronic (long-term) mild to moderate respiratory

diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis

- Chronic heart disease, such as heart failure
- Chronic kidney disease
- Chronic liver disease, such as hepatitis
- Chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), or cerebral palsy
- Diabetes
- A weakened immune system as the result of certain conditions, treatments like chemotherapy, or medicines such as steroid tablets
- Being seriously overweight (a body mass index (BMI) of 40 or above)
- Pregnant women.

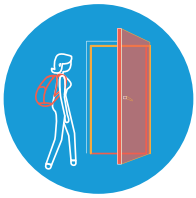
"Huge congratulations on the BDA's activity and advice at the moment. Thank you. Very, very impressive."

3 Employees

Getting to and from work safely

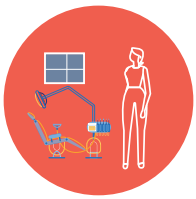
Help protect staff as you reopen the practice by utilising the following strategies. Practise new routines with staff before welcoming patients.

If using public transport is unavoidable, wear a mask or face covering during the journey and make every effort to comply with social distancing of 2 metres. Wash your hands before travelling and immediately on arrival at the practice.



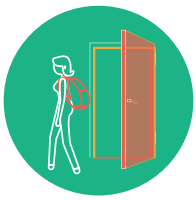
Getting to work

1. Wear clean clothes
2. Put your phone in a plastic bag
3. Pack two pillowcases and use a washable bag like a rucksack



At work

1. Change into clinical work wear
2. Put your home clothes into one pillowcase
3. Prior to clinical activity put on appropriate PPE, including doffing and donning procedures as appropriate



Leaving work

1. Shower if possible
2. Put your work clothes in the other pillowcase
3. Change into the clothes you were wearing on arrival

Arriving home

1. Clean down your car where your hands came into contact with it
2. Enter your home with minimal contact with the premises
3. Wipe down the door
4. Dipose of the bag your phone is in
5. Place pillowcases and all work clothes in washing machine separately from other household items
6. Wash on a < ½ load at max temp on labels. Either line-dry, tumble dry or iron
7. Wipe down the machine
8. Wash your hands
9. Shower and dress in clean clothes

Decompress

1. Relax and recharge
2. Go for a walk
3. Phone a friend
4. Don't forget our counselling and emotional support hotline for members bda.org/healthassured

Download and print this poster for your practice

How to manage staff returning to work

Staff who are on furloughed leave will need to be given notice that the period of furloughed leave is coming to an end and they will need to return to work. There is no legal requirement for employers to give any particular notice period to end furloughed leave. It will be a term of the agreement with staff to go on furloughed leave and is likely to be in the order one or two weeks. Staff can agree to end their furloughed leave earlier if they wish.

Employers may not need all their staff to return to work at the same time. This will involve a selection process of some sort. The employer can choose who to ask to return to work and who to remain on furlough depending on the needs of the business. However, employers need to ensure that their decision does not lead to claims that an employee has been treated less or more favourably due to any protected characteristic such as age, race, disability etc. Where possible, find a way to agree with staff as to who should return to work and who should remain furloughed. It may be advisable to keep a record of why you made any such decisions.

If the practice is reopening, staff will also need some time to:

- Get used to the idea they will be returning to work
- Understand the risks relating to COVID-19 and what the practice is doing to control those risks
- Undertake any online training the practice may want staff to complete to get ready for new policies and procedures in place at the practice
- Attend the practice for fit-testing of masks (where required non-clinical staff do not need fit-tested masks)
- Ensure they have arrangements in place to look after any dependants at home
- Seek further medical advice as to whether they can return to work (if, for example, they have a particular medical condition).

The practice should have an online meeting with staff before it is due to open to discuss returning to work, necessary training, and changes that have been made to working practices. Practices should ensure that such meetings are at convenient times for staff. Meetings may only be held with staff who are on a period of furloughed leave, if they are to explain the processes and procedures for returning to work.

Practice owners/managers should talk to staff individually to discuss any concerns that staff may have about returning to work and to discuss changes to working arrangements. Keep a full written record of any conversations to avoid any misunderstandings at a later date.

If changes are needed to staff contracts of employment, see the section below on changing contracts of employment.

Dealing with staff concerns

Staff may have some concerns about returning to work. The Government has been keen to stress the importance of staying at home and the dangers to particular groups, such as older people or those who have particular medical conditions.

It is therefore important to reassure staff that they going to be coming into a safe environment that has the right policies and procedures in place, and that has the necessary PPE and other equipment.

Ensure you give time for staff to raise concerns about returning to work. Deal with them sensitively. Try to find solutions where possible. Remember that staff do have the right to raise concerns. They also have legal protection from any punishment or detriment the practice may impose because they raised a concern.

Staff may still refuse to come back to work. If the practice:

- Is following established guidance for the return to work after the COVID-19 pandemic including providing the recommended PPE
- It has dealt sensitively with any concerns and questions a member of staff has raised and
- The member of staff refuses to attend work

then the practice may be able to consider disciplinary action for failure to comply with a reasonable management instruction and failure to attend work.

Members are advised to seek advice from our practice support team before starting any such disciplinary action.

Remember that the disciplinary process is designed to give the employee a fair opportunity to answer any allegation before a decision is made to impose a disciplinary sanction.

Staff who are unable to find childcare

Staff may have problems in relation to childcare, especially if schools have not fully reopened by the time the practice is ready to open.

Practices should be sensitive to issues that staff may have with childcare. If a member of staff says that they will be unable to return to work, the practice should have a meeting with that member of staff (which can be a video or phone call) and explore:

- How long the member of staff will experience childcare issues
- Who else may be able to look after the employee's child/children
- What steps the employee has taken to seek alternative childcare, including at the child's normal school which should be providing schooling for key-workers
- Whether the employee may be able to work reduced hours or work extended hours (eg.. evenings/weekends)
- Whether the employee may be able to work from home. Practice managers, for example, may be able to do some of their duties at home for a period of time
- Whether the practice may be able to manage without this employee
- Whether the employee could take annual or unpaid leave until normal child-care functions are resumed.

These meetings or discussions can be held with staff who are on furloughed leave, provided that they are at a convenient time for the staff. HMRC guidance precludes furloughed staff only from undertaking work that generates money or which provides services for the practice. Meetings of this nature are neither.

Staff who want time to look after someone

Employees are entitled to time off work to help someone who depends on them (a "dependant") in an unexpected event or emergency. This could apply to situations to do with Coronavirus. A dependant is usually a family member, but could also be an elderly neighbour or relative who relies on the person for help.

There's no statutory right to pay for this time off.

The amount of time off an employee takes to look after someone must be reasonable for the situation. For example, they might take two days off to start with, and if more time is needed, they can book holiday or take unpaid leave if the practice agrees.

Practices may consider allowing such employees to work reduced hours where practicable.

Staff who are extremely vulnerable

The Government has produced a list of clinically extremely vulnerable people (see page 12) who have been advised to stay at home and shield. These individuals should have received a letter that they are in this group. If they do not wish to return to work and home working is impossible, they should not be forced

to return to the dental practice.

In most cases, employees who fall into this category can continue to be furloughed. Alternatively, they may qualify for Statutory Sick Pay. These employees may fall under the Equality Act 2010 as "disabled" and will have the right to bring a claim for discrimination if they are subjected to any detriment or the employer refuses to make reasonable adjustments.

Practices may wish to alter the terms of employment for its employees. Changes the practice may wish to make could include changing the hours that staff work, including breaks, changes to terms about clothing and uniform, and changes to pay or other benefits.

Staff who are vulnerable

Staff in this category may continue to work in a dental practice if working from home is not possible and all necessary risk assessments have been undertaken with all relevant PPE provided.

If employees in this category refuse to work, alternative arrangements need to be considered such as furlough, taking holiday or unpaid leave. Vulnerable employees may also have additional protection under the Equality Act 2010 so extra care needs to be taken when making decisions about their employment.

Our advisors are here to support members.

Staff who are pregnant

Employers have a legal duty under the Management of Health and Safety at Work Regulations 1999 to assess the risks to employees who are pregnant.

There may be some aspects of work at a dental practice where, even with additional PPE, the risk of catching COVID-19 is higher at work than it would be outside the workplace. The practice has an obligation under those regulations to ensure pregnant members of staff do not have to do such work.

There is a small, theoretical risk that participating in aerosol generating prcedures (AGPs) could lead to an increased chance of contracting COVID-19 from a patient. We therefore suggest that pregnant employees in the first two trimesters are not required to participate in work that includes AGPs.

According to guidance form the Royal College of Obstetricians and Gynaecologists, a more precautionary approach is advised for pregnant women in their final trimester. The guidance suggests such women should avoid patient facing roles. As the guidance currently stands, we advise practices with pregnant members of staff in the final trimester to find work for them which is not patient-facing. Where that is not possible, the employer is obliged to suspend them on full pay until the start of the employee's maternity leave.

Staff absence due to COVID-19

If an employee or someone in the same household gets Coronavirus symptoms, the employee should self-isolate and should receive statutory sick pay (SSP) as a minimum for this time.

Staff should not be punished for self-isolating if they are doing so in compliance with government guidelines.

Managing staff contracts

Changing terms of employment contracts

Practices may wish to alter the terms of employment for their employees. Changes the practice may wish to make could include: changing the hours that staff work, including breaks, changes to terms about clothing and uniform, and changes to pay or other benefits.

There are two ways in which practices can change the terms in an employment contract (advice should be sought on both):

1. Agree those changes with members of staff

Where changes are agreed, those changes can take effect quickly and easily. Of course, the employees must want to agree to make the changes. They may be unwilling to agree to those changes unless there is a benefit to them.

Practice owners should, in any event, start by trying to reach agreement with staff about changes.

Practice owners should arrange to meet relevant staff (which can be via video) to explain what changes the practice would like to make and why. They should also explain why they think employees should agree. Give staff a few days to consider the request and to ask questions. Have a letter ready setting out the changes you would like to agree, with a space for the employee to sign the agreement to the changes.

2. Enforce contractual changes through dismissal and rehire

It is possible to give notice of termination of employment to staff and to offer them a new contract of employment to start at the end of the notice period. Where staff have long notice periods (which staff with long service will have), it will take time for changes to take effect.

Employees with more than two years' service will have rights in relation to unfair dismissal (in Northern Ireland, staff have that right after one year). It can be a fair dismissal to dismiss someone in circumstances where the business needs to implement changes to contracts of employment for business reasons; the employer needs to follow a fair procedure.

A good consultation with staff about proposals to change is key to making a fair procedure to give notice to staff with a view to changing their terms of employment.

Our advice is to agree changes with staff wherever possible. If an employer were to dismiss staff with more than two years' service, and if the employee brought a claim for unfair dismissal, the employer would need to show not only that the changes to the employment contract were necessary and reasonable, but that they had tried to reach agreement with staff beforehand.

Changing contractual terms of self-employed hygienists and therapists

In a sense, it is easier to change contractual terms of self-employed people because they do not have the same employment rights in relation to unfair dismissal. That said, many hygienists and therapists who are engaged by dental practices under a self-employed contract may actually be considered to be employees. For that reasons, and also in the interests of good relations with such staff, we recommend that practices start by trying to agree contractual changes with self-employed hygienists and therapists. If agreement cannot be reached, give notice to terminate only after a consultation with them about proposed changes.

Our advice teams can advise members on these procedures.

Furloughed workers scheme

From July, employers currently using the scheme will have more flexibility to bring their furloughed employees back to work part time whilst still receiving support from the scheme.

This will run through to the end of October 2020. Employers will be asked to pay a percentage towards the salaries of their furloughed staff. The employer payments will substitute the contribution the government is currently making, ensuring that staff continue to receive 80% of their salary, up to £2,500 a month.

From August 2020, the level of government grant provided through the job retention scheme will be slowly tapered to reflect that people will be returning to work. The government will continue to pay 80% of people's salaries in June and July.

In the following months, businesses will be asked to contribute.

The scheme updates mean that the following will apply for the period people are furloughed:

- June and July: The government will pay 80% of wages up to a cap of £2,500 as well as employer National Insurance (ER NICS) and pension contributions. Practices are not required to pay anything.

- August: The government will pay 80% of wages up to a cap of £2,500. Practices will pay ER NICs and pension contributions – for the average claim, this represents 5% of the gross employment costs the practice would have incurred had the employee not been furloughed.

- September: The government will pay 70% of wages up to a cap of £2,187.50. Practices will pay ER NICs

and pension contributions and 10% of wages to make up 80% total up to a cap of £2,500. For the average claim, this represents 14% of the gross employment costs the practice would have incurred had the employee not been furloughed.

- October: The government will pay 60% of wages up to a cap of £1,875. Practices will pay ER NICs and pension contributions and 20% of wages to make up 80% total up to a cap of £2,500. For the average claim, this represents 23% of the gross employment costs the practice would have incurred had the employee not been furloughed.

Annual leave and carry over

In the normal course of events, employees must take annual leave before the end of the leave year. Until COVID-19, annual leave could only be carried over if an employee was unable to take it due to sickness or family leave.

In March 2020, the regulations were amended so that employees can now carry over leave if, as a result of the effects of coronavirus, it was not reasonably practicable for staff to take some of their annual leave.

Staff who are furloughed could take annual leave. So could staff who were not furloughed, but paid by the practice as NHS workers.

The right to carry over leave is likely to apply to employees who

- Have been self-isolating (told specifically by the government to self-isolate) or too sick to take holiday before the end of the leave year

- Have had to continue working could not take paid annual leave.

Where employees have been unable to take annual leave, they may carry up to four weeks' paid leave into their next two holiday leave years.

Managing staff relations

From time to time, relations between the practice and an employee may not be as good as they should be. There may have been issues before the shutdown. Maybe there was a difficult member of staff the practice was already thinking of dismissing. Maybe issues arose because of the shutdown when a member of staff did not want to come to the practice to help with triaging patients.

Practice owners should understand that the COVID-19 pandemic has affected people in different ways. Some people were very scared and wanted to remain at home; others were happy to do what they could to help.

Employment law prefers matters to be dealt with promptly. If there were issues before or during the shutdown, this could be an opportunity to tell staff that this is a new opportunity to work together to reopen the practice and treat patients who are in great need.

If some staff came to the practice to help triage, but other members of staff were unwilling to come in, those who did come in may well resent those who did not. Practices may need to find a way to deal with these issues. It may just be a case of listening carefully to the staff who did come in. Encourage them to move forward and work together in this new chapter.

That is not to say that the practice should ignore problems with staff that arise after the practice reopens. They can be dealt with in the normal way.

Redundancy and termination

The Government's aim has been to avoid the need for redundancies. It has used the furloughed workers scheme to help achieve that aim. That scheme will continue to run until October.

That said, some practices may have concluded that redundancies have to be considered.
Advice is available.

4 Associate relationships

Dealing with associates' concerns

Associates may have some concerns about returning to work. The government has been keen to stress the importance of staying at home and the dangers to particular groups, such as older people or those have particular medical conditions.

It is therefore important to reassure associates that they are going to be coming into a safe environment that has the right policies and procedures in place, and that has the necessary PPE and other equipment.

Ensure you give time for associates to raise concerns about returning to work. Deal with them sensitively. Try to find solutions where possible. Remember that, even though associates are not employees, the law still provides them with a right to raise concerns and offers them legal protection from any punishment or detriment the practice may impose because they raised a concern.

The practice could refuse to pay the associate if:

- The practice is following established guidance for the return to work after the COVID-19 pandemic
- It has dealt sensitively with any concerns and questions an associate has raised
- The associate refuses to attend work.

Depending on the terms of the associate agreement, the practice may be able to give notice of termination.

Members are advised to seek advice from our practice support team before taking such action.

Changes to associate contracts

As yet, we do not know the basis on which practices will be paid for NHS dental work, nor do we know how much private work there will be, or how practice costs will change.

Practices may well want to change terms of associate agreements, including terms relating to:

- Hours of work
- Payment for NHS treatment
- Changes to the licence fee percentage for NHS and / or private work.

Practices may want to make deductions for costs of PPE. Whilst the law does allow business to charge self-employed people for PPE, it may be more sensible simply to negotiate a change in the licence fee. Charging for PPE could encourage self-employed practitioners to bring in their own PPE which may not come from a reliable source.

There are two ways in which practices can change terms of an associate agreement contract (advice should be sought on both):

1. Agree those changes with associates

Where changes are agreed, those changes can take effect quickly and easily. However, associates may be unwilling to agree to those changes unless there is a benefit to them.

In most self-employed associate agreements, including our model associate agreement,

there is no direct obligation on the practice to introduce patients to the associate. We believe it is in both parties' interests to negotiate sensible changes.

We ask practice owners not to try and force changes that are too onerous or disadvantageous to associates.

We ask associates to take a pragmatic and reasonable line with practice owners. Insisting on adherence to existing terms that will harm the practice is unlikely to lead to a good, mutually beneficial, ongoing relationship with the practice.

Practice owners should start by trying to reach agreement with associates about changes. Practice owners should arrange to meet associates (which can be via video) to explain what changes the practice would like to make and why. If there are changes to financial terms, the practice should set out the reasons and justification for the change. Give associates a few days to consider the request and to ask questions.

Have a letter ready setting out the changes you would like to agree, with a space for the associate to sign the agreement to the changes.

2. Enforce contractual changes through termination and offering a new associate agreement

Practices owners can give notice of termination to the associate and then offer a new contract. The disadvantage of this way of changing contracts is that the notice period is often three months. That makes it difficult to effect a fast change.

It would be sensible to ensure practices have constructive discussions with associates about changes the practice wishes to make.

We can help members with these discussions.

5 Training and testing

Training

To ensure the team is confident working under the new arrangements we recommend practice meetings where this document is reviewed.

Each team member could be responsible for implementing the changes to a specific area of the site or clinical protocols, information about which can then be shared.

Our toolkit features training and assessments, and you can earn CPD:

Description	Method	CPD available
Return to face-to-face care assessment	Online learning and assessment	*Coming soon*
Using PPE safely	Online learning	1 hour
PPE and RPE: preparing for a practical and safe return to dental practice	Webinar	1 hour
Understanding your well-being in a COVID-19 world	Webinar	1 hour
Slide deck for group learning	PowerPoint slides	*Coming soon*

bda.org/coronavirus

Other learning resources

Make sure the team is up-to-date on CPR. The Resuscitation Council has updated its statement on COVID-19 in relation to CPR and resuscitation in first aid and community settings.
resus.org.uk

NHS Employers
Health safety and wellbeing support available for NHS staff
nhsemployers.org

WHO
Mental health and psychosocial considerations during the COVID-19 outbreak
who.int

Every Mind Matters
Coronavirus and wellbeing
nhs.uk/oneyou/every-mind-matters

6 Communication with patients

What to expect

Your practice is opening to deliver treatments that haven't been available for the last few months. Your services may be in demand, but some patients may be reluctant to attend owing to perceived risks of possible infection.

Dental practices are highly skilled in infection control and have well-established protocols that are regularly checked and audited against government standards. Organisations concerned with national standards (CQC/HIW/HIS and RQIA) that have a statutory role to check these issues have confirmed the high standards to which dental practices operate. You should be able confidently to reassure patients and demonstrate your team's commitment to maintaining up-to-date infection control procedures.

Communicate your commitment to safety by sending patients an email as the practice opens, reassuring patients of infection control measures and updated process in place. You should update your website and any text messages or social media platforms on which your practice operates.

Patient advice

- With the exception of children and patients in need of support or supervision, patients should come alone
- A distance of at least 2 metres must be observed if another patient is present in the dental practice
- Payment should be arranged preferably by cards
- Patients should be invited to wash hands on arrival
- Explain to the patient that elective procedures may be deferred or reassessed
- Staff will avoid shaking hands
- Treatment is provided only with appointment
- Follow up the patient within 14 days of the appointment to ask whether they have since developed COVID symptoms
- Patient should not present early to the practice
- If necessary they should wait outside the practice
- Patients should come wearing a mask if possible or be prepared to wear one.

Where there is a requirement for practices to provide AAA (advice, analgesia, and antimicrobials where appropriate), telephone triage should be done in a methodical and consistent way.

As we return to work reception staff may become involved in this triage and should have training to do so. Dentists should provide any clinical advice.

Telephone and video consultations should be used where possible. Video consultations can be useful especially for shielding/high risk patients.

After explaining the purpose for the call, proceed with the patient triage form.

"Yes" responses to any of these questions would likely indicate a deeper discussion with the dentist before proceeding with treatment.

Inform patients that these questions will be repeated on arrival to ensure nothing has changed since the phone conversation.

Remind patients/guardians to limit extra companions on their appointment to only essential people in order to reduce the number of people in the reception area.

If patients/parents/guardians seem reluctant in any way, reassure them that although this may seem strange, it is all to prioritise their wellbeing, as well as that of the other patients being seen, you and your team, and any person with whom they might come in contact.

If you need to leave a voicemail or are sending a text message, ask the patient to call the practice prior to their appointment for preliminary screening. (Standard data protection/confidentiality requirements apply.) If your website is capable, you may install the questionnaire and instructions on there for them to access pre- appointment.

Practice tips

Depending on the space available in your waiting room and your patients' best interests, you might consider having your patients wait outside in the car and you can call or text when they should enter the practice. You may decide to lock the front door.

For patients who use other forms of transportation, devise a plan and provide instructions for entering the practice prior to their appointment.

You might consider asking patients to bring their own pens to use (or supply them with a pen to take with them).

If they need to cancel due to illness, you might consider waiving any last-minute cancellation fee policies that might exist.

Schedule appointments to avoid contact with other patients/higher risk patients.

Patients' appointments should be spread out to allow for enough time to disinfect all areas and avoid cross-infection between patients in waiting rooms. Multi-chair surgeries could alternate treatment rooms.

Things to change:

- Update your website
- Message in window
- Print off patient triage forms

New equipment to purchase:

- Pens

7 Infection control

Standard infection control procedures

Standard infection control procedures familiar to dental practices provide the basis of reducing the risk of transmission of infectious agents.

This guidance is in HTM01-05 and the similar other UK docuemtns. Since COVID-19 is transmitted through the air, transmission-based precautions (TBP) need to be applied when caring for patients.

Evidence shows that the virus can survive on some surfaces such as plastic and stainless steel for at least 72 hours and hence any action to limit surface contamination is beneficial.

Contact precautions

Used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment. This is the most common route of infection transmission.

Droplet precautions

Used to prevent and control infection transmission over short distances via droplets (>5µm) from the patient to a mucosal surface or the conjunctivae of a dental team member. A distance of approximately 1 metre around the infected individual is the area of risk for droplet transmission which is why dental teams routinely wear surgical masks and eye protection for treating patients.

Airborne precautions

Used to prevent and control infection transmission via aerosols (≤5µm) from the respiratory tract of the patient directly onto a mucosal surface or conjunctivae of one of the dental team without necessarily having close contact.

Interrupting transmission of COVID-19 requires contact, droplet and aerosol precautions, depending on the procedures undertaken.

Step-by-step cleaning guide

Clean all reusable equipment and surfaces systematically as described below:

- Ensure the whole chair is cleaned from top to base unit
- Clean the light on the dental chair, foot pedals
- Clean the dental stools
- Clean the outside of any material containers used during the procedure. Where possible dispense materials prior to the episode of care and minimise containers on surfaces
- When cleaning the surfaces, work systematically from the top or furthest away point
- Clean wall cabinets, then work surfaces, then base cabinets
- Clean the handles on units/ cupboards
- Clean the computers
- Clean the taps, hand wash basins
- Wipe down the paper towel dispenser
- Wipe down the alcohol gel and soap dispensers
- Clean the door handle, light switches etc.

Following an AGP, the surgery should not be re-entered for at least 60 minutes to allow virus to settle. You might choose to adjust this time if, after carrying out a thorough risk assessment, it is considered that the risk from an AGP can be modified, with any adjustment in the fallow period from 60 minutes clearly documented. Examples of justifiable mitigation are:

- Type of procedure carried out – whether a high or low risk AGE
- Use of rubber dam
- Use of HVA
- Duration of the aerosol generation
- Dimensions of the room
- Methods of ventilation.

Windows to the outside in neutral pressure rooms can be opened

Record the time of entry and exit on a laminated sheet on surgery door

If no AGPs have been generated in the surgery, then cleaning can commence in the normal timeframe

Cleaning and disinfection of the clinic at the end of the day

Infection control procedures for cleaning and closing of the surgery should be followed with particular vigilance to cleaning door handles, switches, chairs work surfaces or anything else that the patient may come into contact with.

Common zones and reception area

Cleaning and disinfection of all common areas including window knobs, handrails, tables, armrests for chairs and armchairs, switches, telephones, etc.

Toilet facilities

Cleaning and disinfection of the sink, switches, toilet.

Floor scrubbed with bleach.

Disinfection and sterilisation area

Autoclave and thermostable cleaning and disinfection.

Clinical areas must be cleaned at least 3 times a day

(at the beginning, at the end of the morning session and at the end of the day).

Cleaning down of surfaces and floors

Disinfectants based on hypochlorous acid or chlorine dioxide solutions are active against enveloped viruses, such as 2019-nCoV and other coronaviruses.

After each patient, cleaning down of vertical surfaces, contact surfaces and flooring with the use of hypochlorous acid or chlorine dioxide based disinfectant solutions should be carried out as per HTM01-05 best practice standard.

Cleaning and disinfection of the clinic at the end of an AGP treatment

Record time of entry and exit on a laminated sheet on the surgery door.

At the appropriate time (60 minutes after the end of the AGP), put on Level 2 PPE and re-enter the surgery.

Follow standard infection control guidelines to clean surgery paying particular attention to door handles and patient contact points.

- Patient care equipment should be cleaned according to manufacturer's instructions, and where possible with chlorine-based disinfectant, 70% alcohol or an alternative disinfectant used within the organisation that is effective against enveloped viruses
- Clean all surfaces, with a neutral detergent, followed by a chlorine based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine
- Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination and disposed as clinical waste
- Disinfect reusable equipment (such as mop handles, buckets)
- The detergent disinfectant should be emptied, and the mop bucket thoroughly cleaned paying particular attention to the outside and the underside of the bucket. Ensure enough solution is available for the full session.

You should follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants as these will differ across each product.

Ventilation/air-conditioning

There is no consensus on the use of air conditioning but there is a recognition of the importance of ventilation/air renovation between patients.

Dilution of surgery air should reduce any risk of potential airborne viral transmission by reducing exposure time to any airborne viral aerosols, and also reduce the chance for these aerosols to settle on surfaces.

It is recommended that any pre-existing ventilation or air conditioning systems that normally run with a recirculation mode should now be set up to run on full outside air extraction where this is possible. The air conditioning unit should never be set up in recirculation mode.

Ventilation should be kept on for longer, with lower ventilation rates when people are absent.

The door of the surgery must remain closed to prevent viral spread.

There is no current evidence to support the use of wall and ceiling-mounted air purification systems with HEPA filtration and other adjuncts including UV light sources and plasma filters within dental surgeries to reduce risk of infection from COVID-19.

Ventilate the treatment room according to the amount of AGP.

Recommissioning of dental unit water lines (DUWL)

As always, the manufacturers guidance for commissioning the chairs should be followed.

However, effective disinfection of the DUWLs is likely to be required during recommissioning and HTM01-05 recommends sodium hypochlorite and isopropanol.

Some manufacturers suggest that their disinfectants can be stored within DUWL systems for a fixed time period to manage biofilm and it is important to follow manufacturer's instructions, as the COVID may have been considerably longer than these products are designed to be effective for and that the internal equipment components can tolerate.

If your DUWLs have been shut down for more than one month there may be considerable biofilm formation and you may need to consider replacing the DUWL tubing.

However, if this is not possible or practical then disinfect the DUWL with hypochlorite with 50 mg/L free chlorine for one hour or equivalent (e.g. 25mg/L for two hours).

As per HTM01-05, all water samples from the DUWL should be tested at accredited laboratories at least 48 hours following disinfection.

Where in-line filters are present, these will also require replacement or treatment using a cleaning solution as recommended by the manufacturer and this step should be performed after the first DUWL flush.

Ensure that any other disposable filters are changed as per manufacturer's instructions.

Spitoon

There is very little risk created by patients using the spittoon before, during or after a treatment. There is a risk the patient will miss the spittoon when rinsing out.

You should ensure thorough flushing of each dental unit and consider (if dental chair and spittoon are connected to domestic water services with appropriate air gap) disinfection as recommended by the manufacturer's instructions.

Stock control

Check stock, including medications to avoid the use of out of date materials.

Consider whether refresher training is required for team members who have not been working.

Think about howl patients will be prioritised according to their treatment needs (e.g. periodontally compromised, high caries risk) when restrictions are lifted further.

Rubber dam

Rubber dams are very effective in reducing bioaerosols and so where it is possible, it should be used when carrying out AGPs. It will not be possible when ultrasonic scalers are used, during oral and periodontal surgery and when preparing teeth with subgingival margins for indirect restorations. In these cases four-handed dentistry with high volume aspiration is advised.

Training in the placement, use and removal of rubber dams safely to avoid splatter across the surgery should be considered.

Personal protective equipment (PPE)

In view of one of the main transmission modes of COVID-19 being airborne and respiratory, much attention across the world has been focussed on deciding what combination of PPE provides the best protection for clinical staff treating dental patients.

Dental workers are potentially at the highest risk of contracting the virus because of operating in such close proximity to the potential source of the virus - the

Advice

The British Dental Industry Association recommends you source PPE through reputable suppliers and avoid purchasing from online sellers, particularly those with seemingly extremely competitively priced products. Some of these sites are not only selling counterfeit/illegal product, but are just 'scammers' with no actual product for sale.

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES Bwrdd Iechyd Cyfunol Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[5]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,6]	✗	✓ single or sessional use[4,6]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[6]	✗	✗

patient's nose and mouth - so setting out appropriate guidelines has been key. The decision to choose a particular type of PPE especially for AGPs, is based on evidence, expert opinion and practicality since clinicians are working for prolonged periods of time doing intricate and sometimes complex procedures.

There will always be some risk in whatever we do but a combination of different protective things, including appropriate PPE will mitigate that risk significantly.

Masks

Facemasks make up one component of barrier protective equipment. They are used most effectively in conjunction with eyewear, gloves, face shield and protective outerwear.

For non-aerosol generating procedures (non-AGPs) fluid-resistant surgical masks (FRSM) Type II are advised and used with the wider PPE measures detailed below.

From the comparative research, what little there currently is in relation to COVID-19, for AGPs the greater comfort of the FFP2 respirator makes it the mask of choice that provides sufficient protection for aerosols created in the dental environment.

FFP3 (filtering face piece level 3) masks provide greater filtration and potentially provide some marginal protection compared to an FFP2 mask.

Where, for cultural, religious or health reasons facial hair is present which will affect the seal of FFP2/3 masks, practices should consider as an alternative, the use of an FFP2 mask with a Type II fluid resistant surgical mask over the borders, in conjunction with a face shield/visor. A through risk assessment needs to be implemented at a local level if this suggestion is adopted.

A risk assessment form is available.

Another alternative is the use of a powered air purifying respirator (PAPR) hood. This does not require any fit testing but wearers may have difficulty using loupes and other aids.

As more research is conducted in dental settings and we learn more about the extent of virus load created in dental aerosols, it might be that practices can revert back to universal precautions that have always been taken which include surgical masks, face shields.

Fit-testing is required for FFP2/3 masks to determine if a particular size or model provides an acceptable fit for each team member who will be wearing them.

Fit testing needs to be conducted by a trained fit tester to verify that the respirator device performs as intended.

Self-seal test for FFP2/3 masks

The user needs to check that the seal is tight whenever they put on the mask to confirm positive and negative seal pressure.

Fluid-repellent gowns

The virus is spread through mucous membranes and conjunctiva. Skin is impervious and the virus is killed by washing with soap and water.

Gowns may provide more protection but the benefit has not been quantified since there is also the added

inconvenient and cost in time of donning and doffing as well as environment and financial cost.

Scrubs should be changed daily and washed at 60º.

Shoe covers

The risk of contamination of shoes in a dental practice setting is low. Indoor shoes that enclose the foot can be worn. Shoes can be wiped down with alcohol or disinfectant at the end of each session.

Eye protection

Though there are currently no published studies on the effectiveness of prevention of COVID-19 transmission through the eye it is recommend that a visor or face shield is used to protect the eye from droplets or splashes. For AGPs, a full-face shield or visor is recommended.

Single use eye protection is the recommendation for AGPs with single or sessional use for non-AGPs.

Reusable visors should be cleaned and decontaminated as per manufactures instructions.

Gloves

Disposable single gloves must be worn for all procedures.

Surgical head cover

During AGPs these have been suggested but are not a basic requirement.

Donning and doffing of PPE

Dental care professionals should be trained in all aspects of infection prevention and control (IPC) and fully familiar with HTM01-05 for decontamination.

Training should include donning (putting on) and doffing (taking off) PPE (See training section).

Don and doff PPE in a separate room to the surgery.

Prior to donning PPE:

- Remove all jewellery and watches
- Tie your hair back if it is long enough
- Perform hand hygiene.

PPE should be donned in the following sequence:

- Perform hand hygiene
- Put on head covering and covering for your shoes
- Put on your disposable (or re-usable) gown and close the Velcro neck fastening and the waist tie.
- If you wear glasses, remove and clean them with an alcohol wipe
- Put on your fluid resistant mask or FFP2/3 respirator mask that has been fit-tested for you.
- Ensure that the mask is flat against your cheeks and mould the nose-piece to fit. Perform a fit check and adjust if any air escapes around the edges.
- Replace your glasses (if worn)
- Put on your full face visor (should cover your whole face and your chin). Check in the mirror to see that it is correctly positioned
- Put on the correct size of disposable gloves and cover the cuffs on your gown
- Remain vigilant about the integrity of your own and others' PPE.

PPE should be doffed in the reverse order, taking extreme care to ensure that contaminated surfaces of PPE are not allowed to come into contact with unprotected parts of the body

After completion of dental care:

- Remove gloves
- Remove gown or protective clothing and discard the gown in a dedicated container for waste or linen
- Discard disposable gowns after each use
- Launder cloth gowns or protective clothing after each session
- Exit the patient room or care area
- Perform hand hygiene
- Remove eye protection
- Carefully remove eye protection by grabbing the

strap and pulling upwards and away from head. Do not touch the front of the eye protection
- Clean and disinfect reusable eye protection according to manufacturer's reprocessing instructions prior to reuse.
- Discard disposable eye protection after use
- Remove and discard surgical mask or respirator
- Do not touch the front of the respirator or mask
- Surgical mask: Carefully untie the mask (or unhook from the ears) and pull it away from the face without touching the front
- Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
- Perform hand hygiene.

All disposable PPE must be placed directly into an bag that is sealed and stored after each patient.

At the end of the working day place all the bags from that day into one orange bag that is then sealed, labelled correctly, and stored safely prior to disposal.

Sessional use of PPE

Aprons and gloves are subject to single use as per standard infection control precautions (SICPs) with disposal and hand hygiene after each patient contact. Respirators, fluid-resistant (Type IIR) surgical masks (FRSM), eye protection and disposable fluid repellent coveralls or long-sleeved disposable fluid repellent gowns can be subject to single sessional use.

A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. A session ends when the healthcare worker leaves the clinical setting or exposure environment. Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity undertaken. there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient.

High volume suction

The use of high-volume evacuation suction with a minimum 8mm orifice aspirator has been shown to reduce aerosol contamination coming from the operative site by 90-98%.

Clean the consulting room and equipment

All dental practices are already required to thoroughly clean the consulting room and sterilise equipment between patients and sufficient time should be allowed between patients to ensure this is conducted effectively.

Contact with people

Remind staff that there should be no handshaking or contact with patients.

Cleaning and disinfection procedures of PPE during decontamination

Wear eye protection, gloves and mask when performing decontamination/disinfection procedures.

Clinical waste disposal be disposed of as per regulations of local system.

Disinfection products

Hypochlorite/chlorine-based solution for disinfection.

Hand washing

Sources recommend hand hygiene following doffing of PPE/decontamination of environment.

9 Urgent dental centres (UDCs)

Whilst urgent dental centres operate, practices will need to know when patients should be referred to them. This will depend what recovery phase the country is in at any given time.

UDCs are intended to provide definitive but basic treatment to get patients through their problems. Urgent dental centres will not be able to provide comprehensive treatment plans.

There will be country and local area-specific standard operating procedure (SOPs) that will be in operation that practices need to be familiar with. These SOPs will set out how the patient pathway for different patient groups such as 'vulnerable' and 'extremely vulnerable' groups who are shielding as well as those in care homes for example.

Definition of need

Class	Description	Treatment
P1	Emergency dental care which requires immediate treatment on the day	Directed to hospital unit depending on severity
P2	Urgent dental care which requires treatment within 24 - 48 hours	Directed to urgent dental care hub for management
P3	Non-urgent dental care that can be managed with triage and AAA (advice, analgesia, antimicrobials) which does require treatment on the day	Can be managed by a planned appointment at a later date

P1 - Requires immediate treatment on the day

Directed to urgent dental care hub and or may require hospital unit depending on severity, for example as those detailed in the Scottish Dental Clinical Effectiveness Programme (SDCEP).

Emergency

- Life threatening emergencies, e.g. airway restriction or breathing/ swallowing difficulties due to facial swelling
- Uncontrollable dental haemorrhage following extractions that cannot possibly be dealt with within the urgent dental centres
- Rapidly increasing swelling around the throat or eye which causes immediate threat to life
- Trauma to head and neck to include dental arches that requires maxillofacial services.

Urgent

- Trauma to teeth requiring urgent management that has defined timeline (tooth avulsion)
- Trauma such as dento-alveolar injuries or avulsion of a permanent tooth
- Oro-facial swelling that is significant and worsening but does not present realistic threat to life
- Lost extraction haemorrhage that is not controllable by local measures but does not present realistic threat to life

- Dental conditions that have resulted in acute and severe systemic illness.

P2 - Urgent dental care

Directed to any of the UDCs for management.

For example:

- Severe dental and facial pain: that is pain that cannot be controlled by the patient following self-help advice or the use of appropriate antimicrobials
- Dental trauma of the teeth and supporting structures that can be managed in outpatient facilities and does not have a defined timeline for care
- Dental and soft tissue infections without a systemic effect
- Oro-dental conditions that are likely to exacerbate systemic medical conditions
- Dental infection that if not treated would escalate to level P1
- Pericoronitis – severe - unresponsive to Triage, AAA.
- Localised swelling without pyrexia that can be managed by local dental measures
- Dental infection that can be treated by removal of a tooth +/- 1st stage RCT.

P3 - Non-urgent dental care

Dental emergency that can be treated in an urgent dental care hub and does not require treatment on the day and can be managed by a planned appointment.

- Mild or moderate pain: that is, pain not associated with an urgent care condition and that
- responds to over the counter medications.
- Minor dental trauma
- Post-extraction bleeding that the patient is able to control using self-help measures.
- Loose or displaced crowns, bridges or veneers.
- Fractured or loose-fitting dentures and other appliances including orthodontics
- Orthodontic emergencies causing trauma.
- Fractured posts Fractured, loose or displaced fillings
- Treatments normally associated with routine dental care
- Bleeding gums.

The different UDC sites for shielded and non-shielded patients reduce the risk burden on those members of the public who were at the highest risk and already likely to be self-isolating.

Group patients mainly by telephone to include risk assessment of potential COVID-19 status (e.g. COVID-19 positive, suspected COVID-19, asymptomatic, special need/shielding).

If practices are still expected to send patients who need AGPs to UDCs they may still need to be referred on after the dentist has reviewed the patients clinical needs. [this might be country specific]

SOPs are in place in the UDC's. There are different SOP's in the devolved nations.

Antimicrobial stewardship is a significant clinical responsibility of all dental practitioners.

Antibiotic prescriptions can be collected from the practice as they will be open. Social distancing etc will apply.

Clinicians need to take specific indemnity advice in relation to their circumstances or in particular clinical situations. The quality of a clinician's defence by their indemnity organisations may be compromised by any decision they make which does not comply with government and or regulatory/processional guidance.

10 Patient registration procedures

Plan the patient's visits with a view to reducing the time they are physically in the practice apart from their clinical care.

Patients who have been identified as vulnerable due to health, disability or shielding should be booked into appropriate sessions to minimise risks to them. There should be appropriate time between appointments to allow for decontamination of the surgery.

Appointment times between treatment rooms can be staggered to reduce patient cross over in the reception area.

Use the following list and resources to help prepare staff for welcoming patients to the practice, during their consultations, and after.

A telephone-first approach

Telephone triage *all* patients in need of dental care. This will reduce non-essential patient contact.

Prioritise patients who have contacted the UDC system and are awaiting care or follow-up care, patients with incomplete care plans, patients with frequent recall (according to NICE) and those who have been through stabilisation and need review.

Assess the patient's dental condition and determine whether the patient needs to be seen in the dental setting. You can use tele-dentistry methods, such as telephone, video call, Skype etc, as alternatives to in-practice care or advice.

A series of questions can help the team screen patients in advance of their appointment, depending on the method of communication you'll be using.

- Our pre-appointment triage form can be used to by receptionist either making appointments or taking incoming calls before booking appointments.

Any patient with signs or symptoms of COVID-19 should be advised to return home immediately and contact NHS 111, and that if urgent or emergency treatment is indicated in a patient with suspected COVID-19, referral should be made into the urgent care system.

The patient should be requested to limit the number of visitors accompanying them to the dental appointment to only those people who are necessary.

Advise patients that they, and anyone accompanying them to the appointment, will be requested to wear a face covering when entering the facility and will undergo screening for fever and symptoms consistent with COVID-19.

Pre-appointment

Patients should only attend with booked appointments.

They should not come before their appointed time.

They should be asked to respect social distancing of 2 metres when in the reception area.

Whenever possible, patients should attend on their own. Children under 16 can be accompanied to the

practice but escorts/patients/guardians/translators must remain in the reception area during the patient's treatment.

If patients arrive early and have their own transport, they should sit in their car or wait outside the practice and only enter when a team member indicates they are ready to see them.

Patients should be seen on time and where this not possible and the clinician is running late, the patient should be phoned and invited to come back later.

Patients should be asked not to bring any unnecessary bags, briefcases, rucksacks, shopping etc with them

Practices could follow a booked appointment with a link to these specific instructions on the website or via an email to the patient

Pre-appointment paperwork such as medical histories and forms should ideally be completed on a mobile device and payment made in advance of the appointment or by contactless card. If cash is being handled payment could be made in a sealed bag.

Suggested patients triage in groups:

Group A: "Healthy patients"

Group B: Shielded patients

Group C: High risk COVID-19, patients who had close contact with confirmed COVID-19

Group D: Confirmed COVID-19 patients

Healthy patients are those patients who are not in any of the other group but may be asymptomatic carriers. Potentially all patients are therefore considered possible carriers.

This might change with a vaccine or antibody testing where patients will have their status officially confirmed and may carry evidence supporting this status.

Welcome

Patients should be directed to use the hand sanitiser available for use on arrival and departure.

The patient should be asked about the presence of fever or other symptoms consistent with COVID-19.

Any patient with signs or symptoms of COVID-19 should be advised to return home immediately and contact NHS 111, and that if urgent or emergency treatment is indicated in a patient with suspected COVID-19, referral should be made into the urgent care system.

Dental team members should enter the room only after wearing full PPE.

Complete a patient triage form (whether or not there is a presence of fever). Remember to maintain the confidentiality of the patient.

Consider providing pens for each patient and then giving it to them to take away, rather than re-using. If re-using, remember to wipe down the pens between transfers back and forth.

To the treatment room

Practice staff should chaperone the patient to the surgery. The patient should not touch anything as they enter the surgery.

If AGP treatment is planned patients should be asked to leave outer garments such as coats, scarves etc outside the treatment room. A lidded plastic storage box can be made available for this.

The patient can be offered hand washing facilities in the surgery or hand sanitiser before sitting in the dental chair.

Saying goodbye

Post-treatment instructions should include a reminder to call the practice to report any signs or symptoms of COVID-19 within next 14 days.

New equipment to purchase:

- Pens
- Sterile wipes
- Masks for patients

11
Clinical issues

The dramatic changes that have been thrust upon us have offered a unique opportunity to reflect on how we deliver dental care to our patients. This crisis may well energise a treatment philosophy that has been passionately advocated by a few but is very much in sync with the pattern of oral health and disease in the UK.

This should be the time we move away from activity-based treatment modalities and methods of payment that reward that structure. 'Minimally invasive dentistry' fits in with reducing AGPs at the immediate time but reframes how we can and should manage the oral health needs of our patients in the 21st Century. The clinical protocols necessary to enable practices and their teams to embark on this patient and tooth friendly journey are beyond the scope of this toolkit but are nevertheless underpinned by it.

The BDJ has published many articles on the subject of minimal invasive dentistry.

Dentists and staff can use this checklist as they prepare the procedures for working in the surgery during the patient's visit and after.

Before treatment

Make sure the surgery is completely set up with all equipment and materials you will use to treat that patient before the patient enters the surgery.

Use disposable barrier coverings for e.g. light handles and switches.

Do not open drawers or cupboards once an AGP is

Have a sign on the surgery door stating: Do not enter.

Informed consent

Discuss with your indemnity provider the need for any consideration of a revised informed consent form.

Limit paperwork in the operatory as much as possible.

If using paper charting, cover with a clear barrier so you may read what is needed for appointment.

Place new chart notes into the document away from patient contact area when possible.

Cover the keyboard of computer with disposable, flexible, clear barrier (e.g. plastic wrap) and change between patients.

Disinfect the keyboard and computer screen after each patient.

Consider using iPads or tablets for note-taking which can be wiped clean after each use.

Limit access to the surgery to the people other than patient when possible.

Limit access to the surgery to the patient only when possible.

Supply a mask and shield to anyone who accompanies the patient.

Work surfaces in the clinical room should be kept clear. Examples include limiting paperwork, covering notes with a barrier and removal of artwork. This also extends to ensuring all equipment in sight should be

minimised to only that which is strictly necessary to avoid viral cross-contamination.

All treatment materials and equipment necessary for the procedure should be available to avoid the nurse needing to leave the room mid procedure especially if it is an AGP.

Keep staffing levels to the minimum required

Mask pre-entry (for chairside staff also) as virus-containing aerosol particles may exist.

No hand shaking, or physical contact. Wash hands and glove in the room.

Review the patient's overall health history, confirming that the screening questions were asked during the check-in procedure, and review if necessary.

Decide on treatment using clinical judgment and known facts, combining:

- Patient health/risk factors/geographic incidence of COVID-19
- Procedural requirements/clinical risks (production of aerosol, inducement of patient cough during procedure, ability to employ use of rubber dam)
- Availability of PPE in relation to risk.

Settling down time

There is some considerable debate about fallow time - the length of time when the surgery room is closed to allow the aerosol to settle after an AGP. It is influenced by factors such as :

- The amount of aerosol in the air created by the AGP
- Size of the room
- Amount of mechanical or natural ventilation.

Not all AGPs are the same – they are influenced by the use of mitigation factors such as rubber dam and high volume suction and the duration of the AGP. The clearance time of the aerosol will depend on the size of the window, (if there is one and how much it opens) and presence of air filtration or extraction systems as air conditioning units. It remains unclear how much viral load is in the actual aerosol created during particular dental procedure, conditional also on the COVID-19 status of the patient and whether that viral load is in fact capable of causing a transmission to a health care worker. More research may quantify this risk.

Current advice is that after an AGP is carried out the clinic room door should remain shut with windows open (where there is one) for 60 minutes and should not be used again until it has been decontaminated.

The length of fallow time commences from the time the AGP ceases which may not necessarily be at the same time the appointment actually ends.

Once the decontamination has been completed the room can be put back into use immediately.

If no AGP has been used there will be a negligible level of aerosol and therefore no fallow period is needed. The treatment room can be decontaminated immediately .

Closed clinic rooms

The door of the clinic must be closed to prevent viral spread.

Only the dental nurse and dentist should be in the clinical area during treatment whenever possible.

All the necessary equipment, instruments and materials should be available for the particular treatment procedure to avoid the nurse having to leave the room during the patient's treatment especially if AGPs are being performed.

Things to change:	New equipment to purchase:
• Mask before entering the surgery • Minimise physical contact • Wash hands and glove in room	• Plastic wrap

Staff must also ensure they are wearing the appropriate PPE to undertake the cleaning (gloves, fluid resistant surgical mask (Type IIR FRSM), eye protection and plastic apron).

Following treatment, and only where possible:

If the patient was given a mask they should replace it, wash their hands with soap and water for 20 seconds in the dedicated hand-washing sink in the surgery or alternatively use hand sanitiser.

The patient should be escorted by another member of staff out of the clinic.

Pre-procedural mouth rinses

There is no published evidence regarding the clinical effectiveness of mouth rinses to reduce COVID-19.

Practices may choose to offer a pre-procedural mouth rinse when the patient takes a seat in the dental chair for reassurance to the patient and staff as it may reduce the level of oral microorganisms in aerosols and spatter generated during dental procedures.

1.5% hydrogen peroxide is an option for pre-operative mouth rinsing if desired. 0.1% povidone iodine and 0.05% hypochlorous acid are possible alternatives, though there is a lack of evidence to support their use.

Patients could also be asked to brush their teeth before attending the practice.

Aerosol generating procedures (AGPs)

There is some discussion whether AGP is the correct term and whether AGE (aerosol generating exposure) should be used to reflect the risk that all sources of aerosols need to be considered that will include breathing, speaking , sneezing and coughing. A binary approach considering dental procedures as either AGP or non-AGP is also considered potentially restrictive in what can be provided to patients. This model of stratified risk continuum is logical but the evidence is undeveloped and it remains unfamiliar to most practitioners. Therefore at present, since most guidance refers to “AGP” and ”non-AGP”, to avoid confusion, this toolkit will continue to use these familiar terms.

Reduce or avoid AGPs.

When working on teeth, as well as in essential hygiene therapy, there are many aerosol generating procedures where the air can become laden with spray. As this can be contaminated with blood and saliva, switching between different treatment rooms if possible, especially following AGPs.

High-volume suction aspirator options are available to deal with this problem to the extent that 99.9% of the potentially hazardous materials are safely removed.

Use professional judgment to employ the lowest aerosol-generating armamentarium when delivering any type of restorative or hygiene care.

As an example, use hand scaling rather than ultrsonic scaling when appropriate. High velocity evacuation should be employed whenever possible.

Determination of risk is based on the nature of the procedure being undertaken

Aerosol generating procedures (AGPs) are defined as any medical and patient care procedure that results in the production of airborne particles (aerosols). AGPs are produced when an air current moves across the surface of a film of liquid; the greater the force of the air the smaller the particles that are produced.

Aerosols contain two types of particle defined by their size:

- Droplets are larger and heavier particles (greater than 5µm). Droplets can travel up to 1 metre from the source and contaminate surfaces within that range

- Droplet nuclei are smaller (1-5 µm) and can stay airborne for long periods of time before landing and contaminating surfaces.

Both types of particle are relevant to COVID-19 transmission, since this may occur via both direct air-borne infection and indirect spread via contact with contaminated surfaces.

AGPs should therefore be restricted wherever possible.

During periods of widespread community transmission of COVID-19 dentists should use PPE to treat patients based on the type of urgent care they are providing. In effect, there is now an assumption that all patients present a risk of transmission of the virus.

Non-AGP treatment of all patients involves compliance with standard infection control procedures. This will ensure there is no contact or droplet transmission of COVID-19. Eye protection, disposable fluid-resistant surgical mask, disposable apron and gloves should be worn.

1. For all AGPs, to prevent aerosol transmission, disposable, fluid-repellent surgical gown (or waterproof long-sleeved protective apron), gloves, eye protection and an FFP3 respirator should be worn by those undertaking or assisting in the procedure.

Which dental procedures are considered to be AGPs?

Non-aerosol generating procedures are listed here:

- Remote consultations
- Oral health assessment
- Preventative and self-care measures delivered in line with Delivering Better Oral Health, non-AGP aspects
- Hand instrumentation/scaling
- Simple dental extractions
- Caries excavation with hand instruments
- Caries removal with slow speed and high-volume suction
- Placement of restorative material
- Orthodontic treatment
- Removable denture stages (if patient has normal gag reflex)
- Paediatric oral health including stainless steel crowns (Hall crown) and diamine fluoride applications.

All AGP procedures should be minimised where possible.

Operators may be concerned at the 'splatter' that is created by dental procedures, but this is droplet contamination which universal precautions will guard against.

AGPs are procedures that include (but are not limited to) the use of:

- The air turbine
- High pressure 3:1 air syringe (the risk of aerosols could be reduced when using a 3:1 if only the irrigation function is used, followed by low pressure air flow from the 3:1 and all performed with directed high-volume suction)
- Surgical motors with irrigant/irrigation
- Ultrasonic scalers and Piezo handpieces
- Rotary endodontic handpieces
- Endosonic handpieces
- Sandblasting, air abrasion, air polishing.

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NHS contractual arrangements

NHS England and Chief Dental Officer for England, Sara Hurley, clarified in their letter of 25 March that the NHS would continue to make monthly payments to all practices equal to 1/12th of their current annual contract value during the period that face-to-face care was stopped. Some requirements were placed on practices in exchange for payments. One of those was to ensure that all staff including associates, nonclinical and others, continued to be paid at previous levels. There would also be a reduction in the contract value for any variable costs associated with service delivery (e.g. consumable costs and laboratory fees) that were not being expended during the period of reduced activity.

Negotiations are ongoing at a national level between NHS England and the BDA as to the level of this abatement in contract values.

The further letter of 28 May confirmed that these temporary contract arrangements making monthly payments to all practices equal to 1/12th of annual contract value would continue, subject to the variable costs abatement. There are ongoing discussions between the BDA and NHS England over the contractual mechanism that will be introduced for the rest of the 2020-21 financial year. In the meantime, practices should be reassured that their contract values will continue to be paid from 8 June and that these payments will not depend upon any specific level of care at that time or delivery of Units of Dental Activity.

Contract holders should assume that the current temporary arrangements and conditions (for example in terms of paying associates) continue until they hear otherwise. We will seek to ensure that NHS England offers as much notice as possible of any change.

The NHS England letter of 28 May was also clear that progression to resumption of the full range of routine dental care would be risk-managed by the individual practice. It is the decision for the practice as to whether care includes aerosol generating procedures. That decision will reflect specific circumstances including practices being able to adopt the appropriate infection control and PPE requirements.

In the event that practices are unable to perform AGPs, NHS England regional teams have been asked to work with local providers to agree the ongoing provision of urgent care centres. This will include support for the provision of AGP during the early stages of resumption of services and assist with any local dental access issues.

Regulatory and standards body statements

GDC

"The central role which GDC has as a regulator is to protect patient safety and to maintain public confidence in dental services. The onset of COVID-19 doesn't change that, but it is changing - and will continue to change - how we do it in practice.

We know the impact this is having on the profession and the level of challenge and uncertainty involved. Many questions and concerns still remain unanswered, not least on the level of support which may be provided by government. We don't want to add to that uncertainty and concern and hope that the information provided here helps you understand what actions we are taking to provide help and clarity where we are able to.

Our approach is based on two core principles:

Minimising the burden of time and attention we impose on registrants.

Maximising the flexibility of registrants to manage their professional activities in response to the challenges of COVID-19.

That doesn't mean that we can withdraw completely. There is still a vital role for regulation, and we are in any case limited in our ability to be flexible in some areas because of the constraints of the legislation under which we operate.

As we all know, circumstances are continuing to change rapidly. Our approaches will need to adapt as the situation changes, but we want to be as clear as we can be about how we are approaching the different areas of our work. So, the information below is as complete as we can currently make it, but it will inevitably need to be updated as the epidemic and its consequences unfold."

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. It exists to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and it encourages care services to improve.

"The CQC encourage dental providers to give proper consideration to the guidance given by Public Heath England (PHE) and the General Dental Council (GDC) alongside communications from the Chief Dental Officer (CDO) regardless of whether their practice is NHS, private, or mixed.

CQC cannot require providers of dental care services to close, unless we find clear evidence of a breach of our regulations that requires consideration of the use of our powers under the Health and Social Care Act 2008 and associated regulations. As part of our regulatory function we will assess the extent to which providers are providing an appropriate level of safety within the context of our regulations. In doing so we will refer to prevailing guidance, not limited to but including guidance from PHE, GDC and communications from the CDO to help us reach a judgement on the extent to which the service currently being provided complies with our Regulations.

In conclusion, if a provider is able to open their practice during the COVID-19 pandemic in a safe manner that will meet the CQC fundamental requirements to be safe and well-led in accordance with our Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014), then they would not be in breach of those CQC regulations and therefore not subject to enforcement action."

This toolkit was produced with reference to:

American Dental Association *Return to Work Interim Guidance Toolkit*

Chartered Institution of Building Services Engineers (CIBSE)'s Coronavirus COVID-19 and hvac systems

Chief Dental Officer's Letter of preparedness Issue 3

Chief Dental Officer's Letter May 1st 2020

Cochrane Review : COVID-19 Dental Services Evidence Review (CoDER) Working Group's Recommendations for the re-opening of dental services: a rapid review of international sources

College of General Dentistry and FGDP UK's Implications of COVID-19 for the safe management of general dental practice - a practical guide

FGDP (UK)'s Antibiotic Prescribing 29th April 2020

JADA's Aerosols and splatter in dentistry

GOV.UK Recommended PPE for primary outpatient community and social care by setting

International Journal of Oral Science's Transmission routes of 2019-nCoV and controls in dental practice

Mobile Transaction's How to clean your credit card machine: tips and steps to follow

NHS Employers' *Risk assessments for staff*

NHS England's Covid 19 Guidance and Standard operating Procedure

Public Health England's *COVID-19: infection prevention and control guidance*

RCOG's COVID-19 and pregnancy

SCDEP's Covid Prescribing April 2020

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