

COVID-19 guidance and standard operating procedure

For the provision of urgent dental care in primary care dental settings (from 8 June 2020) and designated urgent dental care provider sites

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

Updated on 4 June 2020

Content changes since the previous version are highlighted in yellow.

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1. Scope

This guidance is applicable in England. Dental services operating under contract to the NHS in Northern Ireland, Scotland and Wales should refer to guidance and standard operating procedures (SOPs) produced by the governing bodies and regulators in their devolved administration. This document covers a local systems approach to the organisation and operation of urgent dental care (UDC) provision. It includes:

- system-level guidance: of particular relevance to local commissioning teams, local dental networks, local dental committees, managed clinical networks, and local PHE dental public health colleagues
- standard operating procedures for UDC services (in primary dental care settings and designated UDC provider sites): of particular relevance to dental providers and dental teams.

It is appreciated that multiple teams and providers across primary, secondary and social care may be working together as part of local UDC systems. Therefore, this document should be considered alongside other guidance which may be applicable in a particular care context (for example, hospital trust standard operating procedures for COVID-19 should be considered if UDC is delivered as part of secondary care in a hospital setting).

It is recognised that communities and health systems vary in size and complexity. This document sets out principles for system development and service delivery which will need local interpretation according to local structures, geography and capacity.

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

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

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

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

2.1 Introduction

As part of COVID-19 primary care recovery, from 8 June primary care dental services (general dental practices and community dental services) may open to resume face-to-face care (both routine and urgent) for appropriate patient groups. This includes delivery of both AGP and non-AGP procedures. All care must be delivered in accordance with the infection prevention and control and PPE requirements set out at Appendix 3.

While this will re-introduce significant dental activity to local health systems, primary care dental services may still face pandemic related limitations and challenges (eg PPE availability, staffing issues). Therefore, there is still a requirement for delivery of robust and safe urgent dental care services through NHS regional urgent dental care (UDC) systems and primary dental care providers.

COVID-19 UDC systems and primary dental care providers should deliver:

- **a clear local message for the public**, that advises what to do if people have a dental problem, both in and out of hours
- **remote consultation and triage** that includes:
 - risk assessment and triage of the patient
 - this may also include advice, analgesia or antimicrobials where appropriate in line with prescribing guidelines (AAA), or
 - the arrangement of a face-to-face consultation and/or treatment – by the provider if appropriate or at an appropriate UDC site.

This remote stage should specifically identify those patients who are confirmed or suspected COVID-19 patients or their household contacts, those who are shielded (individuals at the [highest risk of severe illness from COVID-19](#)) and [patients at increased risk](#), in order to inform decisions on the most appropriate provider and approach for the delivery of face-to-face care if required.

- **face-to-face consultation and treatment that should only be provided following the remote risk assessment and triage of the patient.**

Urgent dental services will be predominantly delivered by general dental practices and community dental services, which should, wherever possible, deliver face-to-face urgent care (non-AGP and AGP where the appropriate PPE is available and subject to capacity) for the appropriate patient groups.

All other urgent care (including for patients with possible/confirmed COVID-19 and household contacts, when care cannot be delayed) should take place at UDC provider sites designated by local commissioning teams as part of the locally organised system approach.

All services must be delivered using the appropriate personal protective equipment (PPE) for the clinical procedures (AGP and/or non-AGP) to be carried out.

The local systems and individual providers must ensure that face-to-face assessment and/or treatment is delivered in a way that allows appropriate separation (through physical or temporal measures, eg zones, sessions/appointment times) and treatment of all patients. The following patient groups should be considered:

1. Patients who are possible or confirmed COVID-19 patients – including patients who meet the [case definition](#), or those living in their household:

These patients should only be seen at designated UDC provider sites.

2. Patients who are [shielded](#) - those at the highest risk of severe illness from COVID-19:

Significant efforts should be made to ensure that shielded patients in particular are separated from other patient groups. The approach to care should be aligned with local systems and protocols to support shielded patients, eg shielded patients may require domiciliary care or referral to a designated shielded UDC site. See Appendix 1 for further information.

3. Patients who are [at increased risk of severe illness](#) from COVID-19.
4. Patients who do not fit one of the above categories.

Similarly, consideration should be given to the type of urgent dental care to be provided (AGP or non AGP – see Appendix 3) which will determine the PPE requirements.

- Level 2 PPE is required for non-AGPs.

- Level 3 PPE is required for AGPs

When delivering care, aerosol generating procedures should be avoided if possible.

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

- life-threatening emergencies, eg airway [obstruction](#) or breathing/swallowing difficulties due to facial swelling
- trauma including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent tooth
- oro-facial swelling that is significant and worsening post-extraction
- bleeding that the patient cannot control with local measures
- dental conditions that have resulted in acute and severe systemic illness
- severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice
- fractured teeth or tooth with pulpal exposure

- dental and soft tissue infections without a systemic effect
- suspected oral / health and neck cancer (for referral via the 2 week suspected cancer referral pathway)
- oro-dental conditions that are likely to exacerbate systemic medical conditions.

Urgent dental problems have previously been organised into three categories of need based on level of urgency, as defined by the Scottish Dental Clinical Effectiveness Programme (SDCEP, 2007). Given that primary dental care providers may now resume face-to-face activity, this additional capacity should allow for a wider range of dental problems to be provided for, including those which may be considered less urgent.

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

Local dental networks, commissioners, managed clinical networks and local dental committees should work together with local dental public health colleagues to develop their current urgent dental care system in a way that meets the principles set out above, to meet the dental needs of their local populations and to appropriately support staff to provide services safely.

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

2.2 Key principles for local UDC systems

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

- UDC systems should be organised in an integrated way that reflects specific local circumstances, which is joined up across primary, secondary and social care, and which is co-ordinated across the wider regional and local COVID-19 response and recovery arrangements. Particular consideration should be given to:
 - the face-to-face care which all primary care dental settings may now provide for appropriate patient groups (subject to capacity and PPE availability) and how this supports UDC delivery.
 - using and adapting existing UDC arrangements within the existing local integrated urgent care system (eg expanding out-of-hours service arrangements to cover weekdays).
 - managing UDC and referrals effectively between primary and secondary care; secondary care settings will be particularly affected during expected COVID-19 surges and this will have implications for certain areas of UDC provision, eg A&E, oral and maxillofacial surgery, two-week urgent cancer pathways
 - local approaches and the wider primary care operating model to care for shielded patients and patients at increased risk, especially measures being taken to reduce

travel and contact (eg pharmacy delivery services; domiciliary and social care arrangements); see Appendix 1

- prioritisation of urgent dental care needs, in line with the wider local COVID-19 response; it is understood that as the COVID-19 pandemic develops, there will be times when service capacity across the whole of health and social care is reduced: therefore, the capacity of the local UDC system will vary and the most urgent cases will need to be prioritised accordingly
- collaboration between services, to enable appropriate care provision and resilience across the system.
- The patient pathway should take account of two stages, a remote stage and a face-to-face stage if necessary, as set out in the standard operating procedures (SOPs) in Section 3 below. The pathway is illustrated in Appendix 2.
 - Both stages may now be undertaken by any single provider (primary care dental services and designated UDC sites). As detailed in section 3, once remote risk assessment and dental triage are complete, the professional judgement of the clinician will determine whether the patient continues to be managed remotely or face-to-face.
- In meeting patient needs, all primary care dental services are now able to provide face-to-face urgent care for appropriate patient groups (subject to capacity and availability of appropriate PPE) as part of the UDC system, supported by existing UDC provision (including currently designated general dental practices and community dental services; secondary care providers; A&E). In light of this development, local commissioning teams should consider:
 - Developing existing UDC provision to focus on care which may be more challenging or inappropriate for primary care dental services to provide. For example:
 - care involving AGPs (it is likely that the availability of level 3 PPE will be variable and may restrict the type of care primary care dental settings can provide)
 - care for patients with possible/confirmed COVID-19 and household contacts
 - care for shielded patients.
 - Allowing for patient separation requirements (physical or temporal) between or within services, taking into account the patient groups listed in Section 2.1: for example, the local separation approach for shielded patients or patients at increased risk.
 - See Appendix 1 for further information on approaches for shielded patients and patients at increased risk.
 - Reviewing patient access to urgent care, to ensure all patient groups have access to non-AGP and AGP care via the appropriate dental services. Consideration should be given to access within rural and urban areas and associated travel distances.
 - Reviewing system design to enable a smooth pathway for patients, taking into account relationships with other providers (eg NHS 111 and DOS updates) to ensure that patients can access appropriate care in the most timely way possible,

minimising the possibility of patients being signposted/referred back and forth between services.

- Reviewing any local protocols to ensure they align with clinical guidelines, for example appropriate antimicrobial prescribing (see letter [here](#) for further information).
- Reviewing patient and public communications to ensure clear messaging about access to urgent care, given that all primary care dental services are now able to undertake face-to-face care for appropriate patient groups, as well as remote triage.
- Consideration should be given to working locally with the necessary stakeholders to support people who may be considered socially marginalised or vulnerable to access urgent care.
- At a system level, ensuring appropriate opening hours, for both remote management and face-to-face care, that account for in-hours and out-of-hours access.
- Ensuring the involvement of dental laboratory services to support the local UDC system.
- Workforce redeployment **may still** be required to ensure UDC services are appropriately staffed in a way that best fits local circumstances. NHS contract arrangements in the current COVID-19 situation (outlined [here](#)) enable this.
 - Service resilience and contingency planning should be considered with regards to potential staff absence due to sickness.
- With regards to indemnity in the context of COVID-19:
 - Where dental services are being provided by NHS trusts, the Clinical Negligence Scheme for Trusts and Liabilities to Third Parties Scheme will provide indemnity for clinical negligence and other claims, respectively. However, these existing schemes do not extend to non-NHS trust settings, such as general dental practices.
 - Where dental services are being provided out of non-NHS trust settings, existing indemnity arrangements should be relied on as far as possible. Where existing arrangements are not sufficient, the Coronavirus Act 2020 enables the Secretary of State to provide clinical negligence indemnity. The scheme being established by NHS Resolution to implement this is called the Clinical Negligence Scheme for Coronavirus (CNSC).
 - Further information on the CNSC and how it applies is on the [NHS Resolution website](#). Please check this regularly as information and FAQs will be updated.
- During periods of sustained community transmission of COVID-19, dental teams should use PPE to treat patients based on the type of urgent care they are providing. Therefore, depending on the type of face-to-face care being provided by a dental service, the service must have the appropriate PPE, as set out in Appendix 3. Advice on the supply of PPE is [here](#).

- Major regulators have issued guidance to support healthcare professionals in these challenging circumstances, encouraging partnership working, flexibility and operating in line with the best available guidance.
- Further information about regulation during the COVID-19 pandemic from the [General Dental Council](#) and [General Medical Council](#) can be found on their websites.
- COVID-19 information governance advice for health and care professionals can be found [here](#).
- A [life assurance scheme](#) launched for eligible frontline health and care workers during the COVID-19 pandemic covers frontline workers within dental services, including dentists, dental nurses, dental hygienists and dental therapists.
- Dental teams may consider referring vulnerable patients to NHS Volunteer Responders where appropriate (see guidance on the Royal Voluntary Service website [here](#)), who can be asked to help people needing additional support (eg delivering medicines; driving patients to appointments).
 - Dental teams can make referrals via the NHS Volunteer Responders [referrers' portal](#) or by calling 0808 196 3382.
 - Patients can also self-refer by calling 0808 196 3646 between 8am and 8pm.
- Although these principles for UDC systems will be interpreted according to local population needs, there are a number of actions which all dental services should undertake. These are detailed in Appendix 4.

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

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

It is important to retain the initial remote stage, particularly to identify possible/confirmed cases (and household contacts) and patients who are shielded or at increased risk, to ensure safe care. In addition, this stage helps with preventing inappropriate attendance, supporting appointment planning, and maintaining social distancing and patient separation. As detailed in section 3.1, once remote risk assessment and dental triage are complete, the professional judgement of the clinician will determine whether the patient continues to be managed remotely or face-to-face.

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

1. SOP for remote management stage
2. SOP for face-to-face management stage

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

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

3.1 SOP for remote management stage

3.1.1 Key principles

1. Dental teams should be aware of this SOP, the current national and local COVID-19 guidance (including approaches for managing shielded patients and patients at increased risk – see Appendix 1) and the possible [COVID-19](#) case definition.
2. Keep staff safe through regular risk assessments, following [guidance for employers and businesses](#), and through the measures set out in the 'Keeping staff safe' section of Appendix 4.
 - Further information on risk assessment is available:
 - NHS Employers: risk assessments for staff – [here](#)
 - Risk reduction framework for NHS staff at risk of COVID-19 infection - [here](#)
 - Resources for staff support and wellbeing are at Appendix 7.
3. Use information and communications (eg telephone, website, text) to outline the appropriate UDC access arrangements for patients.

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

Ensure early identification of patients with possible/confirmed COVID-19 and their household contacts, shielded patients and patients at increased risk.

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

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

3.1.1.1 Service information and communications

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

Public-facing materials on COVID-19 are available [here](#) and [here](#).

Services should display/provide the appropriate information to:

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

3.1.1.2 Risk assessment

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

- which patient group the patient belongs to
- the associated risk to the patient if they were to contract COVID-19
- whether the patient has COVID-19 related isolation requirements.

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

As part of risk assessment, COVID-19 screening questions should be asked in line with the [case definition](#) for possible COVID-19 and [isolation requirements](#) (please check regularly for updates and amend questions as necessary):

- Do you or anyone in your household have COVID-19?
- Do you have a new, continuous cough?
- Do you have a high temperature (37.8°C or over)?
- Do you have a loss of, or change in, your normal sense of taste or smell?
- Does anyone in your household have a new, continuous cough, or a high temperature, or a loss of, or change in, their normal sense of taste or smell?
- If you or anyone in your household has, or has had, possible or confirmed COVID-19, are you still in the self/household isolation period?

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

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

- patients who are [shielded](#) – those at the highest risk of severe illness from COVID-19
- patients who are [at increased risk](#) of severe illness from COVID-19
- patients who do not fit one of the above categories

Patients who are in the shielded group will usually have been informed of their shielded status by their GP. Please note that the cohort of shielded patients will change over the course of the pandemic, based on new diagnoses and/or disease progression and management. Therefore where necessary, contact the patient's GP or hospital specialist to provide further information on their shielded status.

Patients' records and taking a good medical and social history will identify those at increased risk of severe illness (definitions in the links above).

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

3.1.1.3 Dental triage

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

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

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

3.1.1.4 Remote patient management

- Each patient should be assessed and managed on their own merit, taking into account their best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.
- **Based on risk assessment and triage outcomes, use clinical judgement to determine whether care should continue remotely or face-to-face.**
 - **For remote care:**
 - **Provide advice, analgesia or antimicrobials where appropriate in line with prescribing guidelines (AAA)**
 - **Further information on **remote prescribing protocol** can be found at [Appendix 5](#).**
 - **The Faculty of General Dental Practice (UK) has provided updated information and guidance on **remote prescribing and advice** during the COVID-19 pandemic – see [here](#).**
 - **The GDC has set out **guidance for remote consultations and prescribing** [here](#).**
 - **The **dental antimicrobial stewardship toolkit** is [here](#)**
 - **SDCEP guidance on **drugs for the management of dental problems during the COVID-19 pandemic** is [here](#).**

- A joint letter from PHE, RCS England, FGDP (UK) and the BDA on **prescribing antibiotics for urgent dental care during sustained transmission of COVID-19** is [here](#).
- Following initial concerns around the use of ibuprofen in the context of COVID-19, the government has published advice [here](#). An expert working group has concluded there is currently insufficient evidence to establish a link between use of ibuprofen and susceptibility to contracting COVID-19 or the worsening of its symptoms.
- Where face-to-face clinical assessment and/or treatment is required, arrange care at an appropriate dental service/care setting in line with patient group and care requirements.
 - Dental services should familiarise themselves with any local referral arrangements to support this (eg referrals to UDC provider site in the scenario where dental practice cannot accept a patient for care or referrals to domiciliary care providers who may be able to support shielded patients in line with local arrangements).
 - Dental services should take into consideration social distancing and physical and temporal separation requirements for all patient groups (including measures detailed in section 3.2.1.1) which may impact appointment planning.
- For any remote care provided, or face-to-face care arranged, where applicable manage shielded patients and patients at increased risk in line with local approaches and arrangements for these groups (see Appendix 1).
- Shielded patients should have a named lead care co-ordinator in primary or secondary care, to support care planning (further information [here](#)). Where necessary dental teams should contact the patient's care co-ordinator, GP or medical specialist to plan care for this group.
- Clinical records should be kept for remote patient consultation.
- The Compass e-triage data collection tool should be completed for telephone triage activity. Further advice is available on the NHS BSA website via the following links:
 - Compass login [here](#)
 - Guidance [here](#)
- FP17 forms should **not** be submitted for telephone triage, as per [advice given on 15 April 2020](#)
- Patient charges do not apply for telephone triage or remote consultation alone. Normal charging regimes only apply for face-to-face care.

3.2 SOP for face-to-face management stage

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

3.2.1 Key principles

1. Ensure the SOP as outlined in Section 3.1 has been followed, to promote remote risk assessment and triage, ensure patients can be cared for in a setting appropriate for their specific urgent care requirements, and reduce exposure risk.
2. Dental teams should be aware of this SOP, the current national and local COVID-19 guidance (including approaches for managing shielded patients and patients at increased risk – see Appendix 1) and the possible [COVID-19](#) case definition.
3. Keep staff safe through regular risk assessments, following [guidance for employers and businesses](#), and through the measures set out in the ‘keeping staff safe’ section of Appendix 4.

Further information on risk assessment is available:

- NHS Employers: risk assessments for staff – [here](#)
- Risk reduction framework for NHS staff at risk of COVID-19 infection - [here](#)

Resources for staff support and wellbeing are at Appendix 7.

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

Particular attention should be paid to [patients with possible/confirmed COVID-19 and their household contacts](#), shielded patients and patients at increased risk.

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

[When accepting patients, providers should have regard to the patient group, the likely procedure required and the availability of appropriate PPE.](#)

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

- Each patient should be assessed and managed on their own merit, taking into account the patient’s best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.
- Manage the patient’s condition with as little intervention as possible to minimise exposure risk.

- If treatment is required, all equipment and materials for treatment should be assembled in surgery before beginning.
- Aerosol generating procedures should be avoided if possible. Where necessary they should only be undertaken at a dental service (primary care dental setting or designated UDC provider site) where level 3 PPE is available.
- If an aerosol generating procedure is necessary, the use of high power suction and rubber dam is recommended where possible.
- Treatment should be completed in one visit wherever possible.
- Follow guidance and local approaches and arrangements for the management of patients who are shielded or at increased risk (see Appendix 1).

Dental care for shielded groups should be managed through domiciliary visits as far as possible, unless this is clinically inappropriate. Dental teams should organise domiciliary visits collaboratively through the patient's lead co-ordinator and with other health and social care teams, using a multi-disciplinary approach to promote holistic care, minimise exposure risk and maximise efficiency in care provision.

- Where domiciliary visits are necessary, these should be appropriately risk assessed and managed.

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

7. Use robust infection prevention and control procedures in line with government advice (found [here](#)).
8. Follow PPE protocols in line with government advice summarised in Section 2.2, with further detail at Appendix 3.
9. Prepare for incident management.

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

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

- The Resuscitation Council UK provides an infographic to support CPR protocol in primary care – found [here](#).
- Further detail on preparation for incident management for unwell patients with possible/confirmed COVID-19 is provided at [Appendix 6](#).

3.2.1.1 Patient management: social distancing and separation

- Although it is recognised that dental treatment will require closer contact, [social distancing measures](#) should be applied as far as possible throughout the service.
- For all patients, physical (eg separate waiting areas and treatment rooms) and temporal (eg appropriately spaced appointments, sessions for specific patient groups) separation measures should be employed.
 - Consideration should be given to both patient group and the type of treatment undertaken (ie increased risk associated with aerosol generating procedures means there are additional PPE and decontamination requirements).
 - Appropriate zoning should be undertaken. Sites, areas and facilities should be demarcated clearly for the specific patient groups they have been designated to receive (eg to separate patients who are shielded or at increased risk).
- Additional physical and temporal separation measures should be taken for shielded groups or groups at increased risk where possible, for example:
 - the local care delivery protocols for these groups should be followed, noting these patients (especially those shielded) should not come into contact with others unless absolutely necessary.
 - these patients could be seen in the morning only, allowing maximum time for air clearance/ventilation overnight
 - these patients could be seen in a surgery, which minimises the number of people passing.
- Practical considerations for the dental service are advised as follows:
 - Patient escorts should only be allowed where absolutely necessary (eg child attending with parent). As far as possible, one escort only should be allowed per patient, and this escort should be from the patient's household to minimise exposure risk.

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

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

– Patient flow:

- Limit the entry points to the dental service for patients and visitors, including deliveries
- Minimise the number of patients within the dental service at any one time

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

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

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

- Waiting rooms, reception and communal areas should allow for 2 metre separation, ideally marked on chairs and flooring.
- If staff in reception and communal areas are unable to maintain 2 metre separation with the public, they should wear a fluid-resistant surgical mask for a session.
- As far as possible, keep areas appropriately ventilated, eg opening windows.

- Reception:

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

- Staff working arrangements:

- As few staff as possible should be allocated to see patients, particularly those shielded, to minimise contacts without compromising the safe delivery of care.

- Similarly, where possible, staff should work with a limited group of colleagues to minimise contact between individuals or different teams, and, if required, facilitate contact tracing and tracking.
- If face-to-face risk assessment and triage validation is required before treatment begins, patients should be initially seen in a room large enough to provide social distancing, and the clinician should wear PPE in line with [PHE guidance](#).
- Toilet facilities:
- Control access to toilets. Patients should request access so that environmental cleaning (including handles) can be performed after each use
 - Signage should be placed to notify persons to close the toilet lid when flushing to reduce risk
 - Ideally, provide paper towels for hand drying
 - Waste bins should be provided lined with foot-operated or automated opening
 - When not in use, the toilet door should always be kept closed
 - Signage should be placed to promote good hand hygiene
- Use signage to support social distancing, good hand hygiene and good infection prevention and control practice throughout the service (including clinical and non-clinical areas, toilet facilities and entry and exit points).

3.2.1.2 Patient management: clinical approaches

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

The **dental antimicrobial stewardship toolkit** can be found [here](#).

SDCEP guidance on **drugs for the management of dental problems during the COVID-19 pandemic** is [here](#).

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

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

NHS England has been working with the Faculty of Dental Surgery at the Royal College of Surgeons to develop **pragmatic clinical guidance** for different specialty areas of dentistry which is applicable to dental teams working in UDC systems in the COVID-19 pandemic. This guidance can be found [here](#).

3.2.1.3 Infection prevention and control and PPE

Follow robust COVID-19 infection control procedures, as set out in government guidance for pandemic coronavirus [here](#). This includes information on PPE, decontamination and waste.

Key points from this guidance, as they apply in a UDC context, have been summarised at Appendix 3. This includes detail around PPE requirements based on the type of urgent care being provided (aerosol generating or non-aerosol generating procedure).

Advice on the supply of PPE is [here](#).

To find your NHS regional infection prevention and control team, search 'infection prevention control + your NHS region'.

Appendix 1: Approaches for shielded patients and patients at increased risk

Primary, community and secondary care services will be working in new ways to shield those at most risk of severe illness from COVID-19, protect those at increased risk, and manage the ongoing health and care needs of both groups. For example: dedicated home visiting services may be set up as part of some local healthcare systems; local councils are responsible for coordinating social support for shielded groups and Primary Care Networks may have access to social prescribing services.

Dental services should align with local approaches for both groups as appropriate.

- Efforts should be made to minimise contact risk for these groups.

- **Shielded patients** are at the highest possible risk from COVID-19 and should not come into contact with others or attend dental settings unless absolutely necessary.

- Where face-to-face care is required, dental teams should align with any local arrangements for shielded patients or patients at increased risk.

- Consult the patient's GP and/or other dedicated health and social care professionals as necessary to arrange face-to-face care in a way that aligns with the patient's overall care needs and minimises contact risk.

- Where appropriate, urgent dental care may be provided on a domiciliary visit by a dedicated dental team. If there is limited capacity for domiciliary care provision, consideration should be given to prioritising patients at highest risk (ie shielded patients).

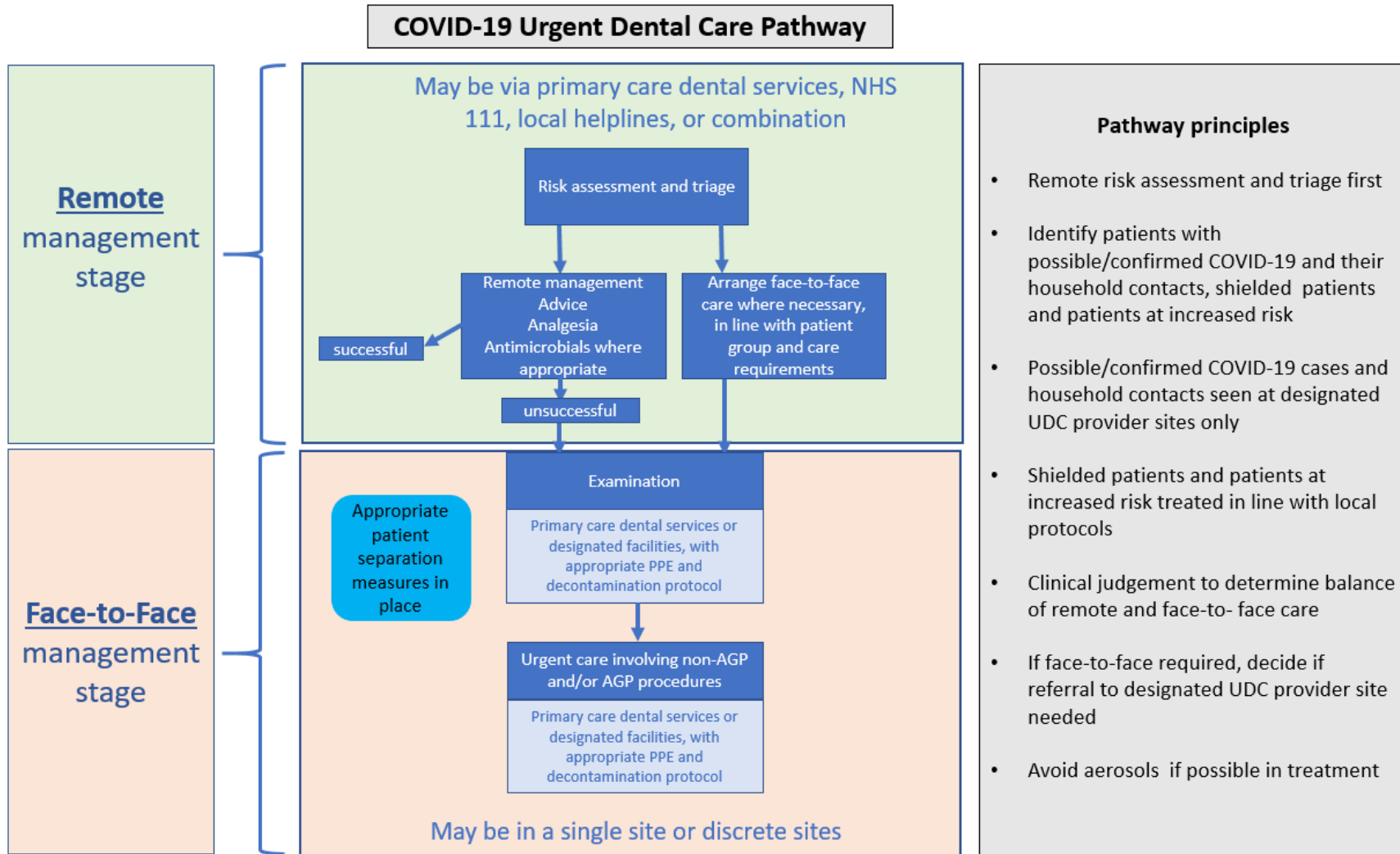
- Dental care for shielded groups should be managed through domiciliary visits as far as possible, unless this is clinically inappropriate. Dental teams should organise domiciliary visits collaboratively through the patient's lead co-ordinator and with other health and social care teams, using a multi-disciplinary approach to promote holistic care, minimise exposure risk and maximise efficiency in care provision.

- Where a domiciliary visit is not possible or clinically inappropriate, access to a dental service provider that can deliver urgent care in line with the patient's specific needs will be required. The provider must have appropriate measures in place to separate patients from possible COVID-19 cases (eg designated UDC provider site for shielded groups, that does not accept possible COVID-19 cases).

- Strict infection prevention and control measures should be followed at all times for the protection of these patients.

In the event that a dental team identifies a shielded patient or patient at increased risk as having possible COVID-19 symptoms, refer to a medical practitioner for further assessment.

Appendix 2: Patient pathways



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

See [Dental Transition to Recovery: standard operating procedure](#) for PHE guidance for infection prevention and control in dental care settings (Appendix 1, page 20 of that document).

Appendix 4: Actions for dental services

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

Appointing a COVID-19 lead

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

Keeping staff safe

1. Government guidance for business and employers is found [here](#).
2. All staff should be risk assessed on an ongoing basis to protect them and keep possible **confirmed** cases, household contacts, staff who should be shielded, or those at increased risk, away from work.

Further information on risk assessment is available:

- NHS Employers: risk assessments for staff – [here](#)
- Risk reduction framework for NHS staff at risk of COVID-19 infection - [here](#)

3. In line with government advice, it is recommended that as part of risk assessment, dental services review resource requirements for service operations and commitments. Where appropriate, this should allow staff to stay at or work from home to avoid non-essential travel and contact; or to participate in local workforce redeployment efforts in line with local arrangements.
4. [COVID-19 guidance](#) around social distancing and good hygiene practice should be promoted as far as possible in the workplace.

5. Staff testing:

- Essential workers with symptoms of COVID-19, or who live with someone with symptoms of COVID-19, can access testing via the [GOV.UK website](#).
- Further information on the NHS test and trace service is found [here](#).
- The Government has published [Information about the COVID-19 antibody testing programme](#).

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

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 and go home. Decontamination should be carried out as for a patient with symptoms of COVID-19 – for further information see [here](#). No additional precautions need be taken for patient and staff contacts **unless** they develop relevant symptoms.

If a staff member tests positive for COVID-19, no additional precautions need be taken for patient and staff contacts **unless** they develop relevant symptoms.

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

Guidance for healthcare workers who have been exposed to someone with symptoms of COVID-19 in healthcare settings is available on the [GOV.UK website](#).

Staff at increased risk from COVID-19 (including staff in shielded groups)

The government has issued guidance on:

- [shielding](#) for people at highest risk of severe illness from COVID-19
- [stringent social distancing](#) for people at increased risk of severe illness 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.

Staff at highest risk (shielded) should not come into work. They should stay at home and, if possible, work from home with all possible support in place.

Remote working should also be prioritised for staff at increased risk. However if they are not able to work from home, dental providers should support these staff to follow stringent social distancing requirements (e.g. staying more than 2 metres away from others).

Employers liability and respirator fit testing

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

Informing the public and commissioners of service status

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

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

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

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

Communicating with the local UDC system

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

Keeping aware of updates, alerts and communications

Regularly check for NHS updates to COVID-19 guidance for dental services, found [here](#).

Prepare to receive communications in the following ways:

1. At urgent times of need: Central Alerting System

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

Please ensure that you have registered for receiving CAS alerts directly from the Medicines and Healthcare products Regulatory Agency (MHRA):

<https://www.cas.mhra.gov.uk/Register.aspx>

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

If you do not yet have a practice nhs.net account, please go to the NHS registration website where you will be guided through the short process.

<https://support.nhs.net/knowledge-base/registering-dentists/>

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

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

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

3. Additional information

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

You can sign up to the [primary care bulletin here](#)

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

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

Appendix 5: Remote prescribing protocol

Remote prescribing

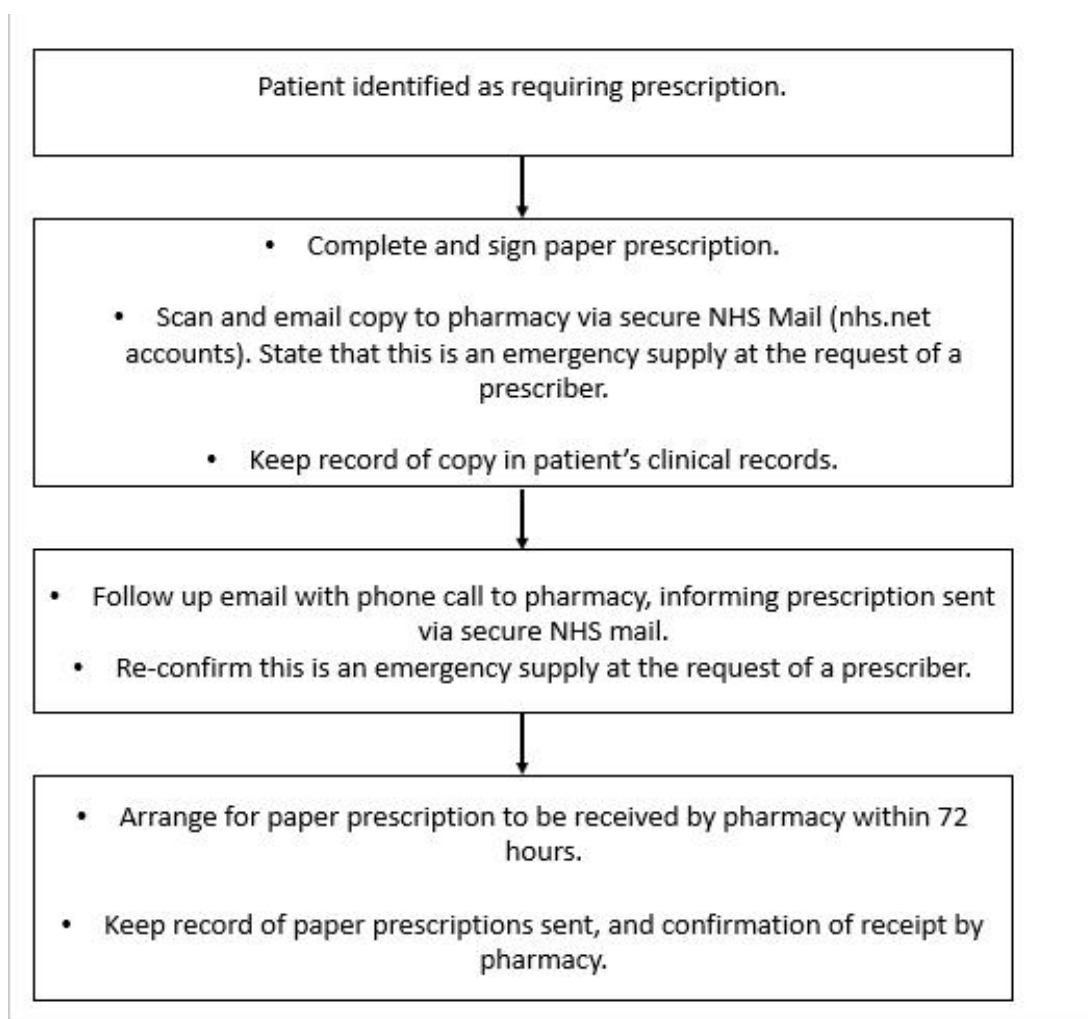
NHS dentists in England can currently only prescribe drugs using paper prescriptions (NHS FP10D forms). Dental services in England are not connected to electronic prescribing services (which allow prescriptions to be sent direct from prescriber to pharmacy). While all pharmacies are still able to accept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

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

Protocol

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

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



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

Delivery of prescription items

Shielded patients

Pharmacies are required to act as a 'backstop' for delivery of medicines for shielded patients and therefore, the following can be advised to them:

- Where patients currently have prescriptions delivered to them, or collected for them by a nominated carer, friend or volunteer, they should continue to do this. There are also online pharmacies that provide delivery.
- If the patient does not currently have their prescriptions collected or delivered, they can arrange this by:

- asking someone who can pick up their prescription from the local pharmacy this includes asking a volunteer (this is the best option, if possible)
- contacting their pharmacy to ask them to deliver for them. An NHS Home Delivery Service has been commissioned from community pharmacies to ensure delivery of medicines to shielded patients.

Non-shielded patients

Pharmacies are not required to act as a 'backstop' for delivery of medicines to non-shielded patients including those self-isolating with possible COVID-19. Normal arrangements apply, where patients make their own arrangements, which includes in some cases the pharmacy delivering to them.

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

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

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

- Develop and rehearse the service provider's COVID-19 triage protocols and isolation procedures:
 - agree practice approach for each stage of the potential scenarios
 - confirm role and responsibilities for each staff member
 - appoint an incident manager
 - confirm lead for discussions with patients/NHS 111
 - prepare an aide-memoire for staff
 - rehearse practice response.
- Review the coronavirus infection prevention and control protocols [here](#).
- Review guidance for first responders [here](#).
- Anticipate impacts on service schedule. Practices are advised to review the likelihood of disruption to services and prioritise the most urgent clinical work on the day.

Appendix 7: Staff support and wellbeing

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

Mental health and wellbeing resources

The government has issued [guidance](#) for the public on the mental health and wellbeing aspects of COVID-19.

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

- a free wellbeing support helpline **0300 131 7000**, available from 7.00 am – 11.00 pm seven days a week, providing confidential listening from trained professionals and specialist advice - including coaching, bereavement care, mental health and financial help
- a 24/7 text alternative to the above helpline - simply text **FRONTLINE** to 85258
- [online](#) peer to peer, team and personal resilience support, including through [Silver Cloud](#), and free mindfulness apps including [Unmind](#), [Headspace](#) [Sleepio](#) and [Daylight](#)

These services can be used in addition to the support available from your own NHS organisations. Please email feedback to nhsi.wellbeingc19@nhs.net.

NHS Employers has resources to support staff wellbeing during the COVID-19 pandemic [here](#).

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

NHS Education for Scotland has developed resources for staff mental health and wellbeing support, found [here](#).

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

BDA members can find further information about access to counselling and emotional support [here](#).

The [Dentists' Health Support Trust](#) provides confidential help and support for dental professionals.

Mental health and wellbeing courses have been commissioned by HEE Midlands & East Dental School, found [here](#).

Access the MindEd COVID-19 Staff Resilience Hub [here](#)

The World Health Organization has published [WHO Mental Health Considerations During COVID-19](#).

[MIND UK](#) and [Every Mind Matters](#) have published specific resources in the context of COVID-19.

MindEd is a free learning resource about the mental health of children, young people and older adults. More information [here](#).

Information on mental health and wellbeing from the Academy of Medical Royal Colleges is found [here](#).

The Intensive Care Society has developed a [wellbeing resource pack](#).

[BMJ Learning Modules](#) cover COVID-19 treatment, fast tracked students, return to practice and wellbeing.

A BMJ learning module on dealing with pressure in your foundation years is accessed [here](#).

Wider support, guidance and learning resources

The [BDA Benevolent Fund](#) for those requesting financial support.

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

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

NHS workforce feedback hub

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

Appendix 8: Feedback

This is a dynamic document that will be reviewed as the situation changes, and we appreciate any feedback which could be used to improve this SOP and adapt to lessons identified. Thank you to everyone who has responded to previous versions of the Standard Operating Procedure.

If you would like to provide feedback on this version of the SOP [please complete this email template](#).

If you have an operational query regarding this SOP (rather than feedback), please contact your commissioner in the first instance.