OCDO

OFFICE OF CHIEF DENTAL OFFICER ENGLAND

NHS

Standard operating procedure

Transition to recovery

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

This guidance is correct at the time of publishing, but may be updated subsequently to reflect changes in advice as necessary. Any changes since version 3 (published 28 August 2020) are highlighted in yellow.

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

The latest version of this guidance is available here.

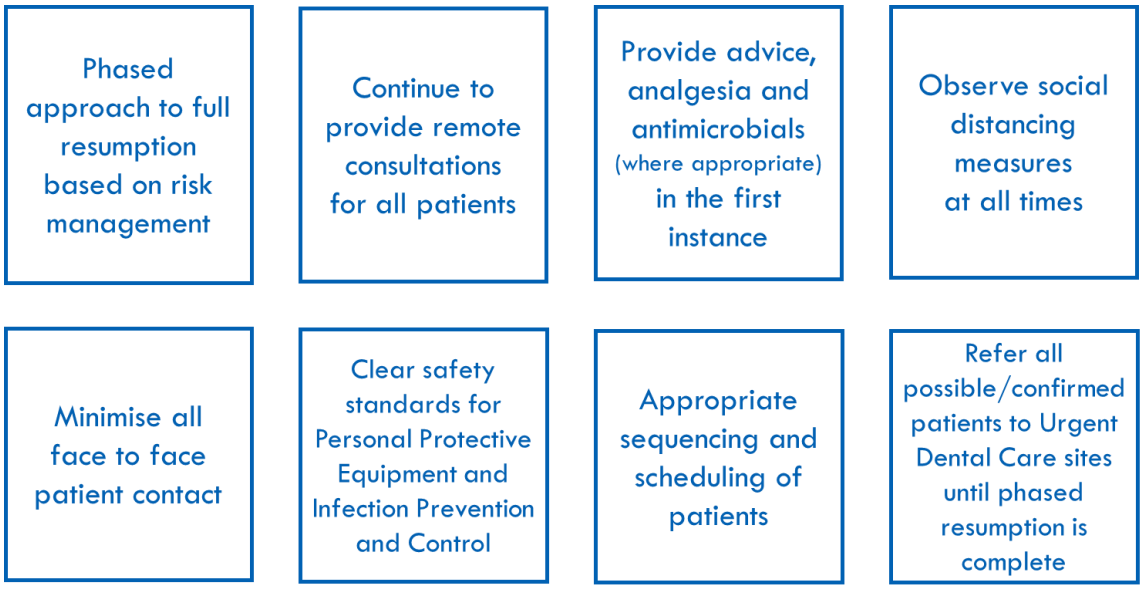
Published 27 October 2020: Version 4

Contents

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

Section 1: Key Principles

Our shared goal is to deliver the safe and effective provision of the full range of care in all practices. Our enduring priorities are the protection of patients, the dental team and the wider community. It remains a significant responsibility of the whole dental team to ensure that the risk of transmission of COVID-19 between patients, staff, staff and patients, is minimised. The decisions on pace and patient priorities, as ever, sit with the individual practitioner, who is best placed to judge their patient population needs.



All dental practices should continue to provide remote consultations with triage and advice as necessary options. This will enable practices to identify patients who are confirmed or suspected COVID-19 cases or household/support bubble contacts, those who are clinically extremely vulnerable, in order to ensure safe care in an appropriate setting.

- Patients and their household contacts/support bubble contacts that are not suspected or confirmed COVID-19 may be offered face-to-face appointments with the primary care dental practice.

- Patients who are clinically extremely vulnerable (previously advised to shield) may be seen for dental care in the same way as other patients. Where possible, without compromising the requirement for access to care in an appropriate timescale, additional efforts should be made to minimise their exposure to risk.

    - Given their risk status, it is particularly important that shared decision-making features in the approach to care for this group, so that care plans can be developed in the patient's best interests.

- For clinically extremely vulnerable patients - dental services should take note of care approaches as outlined in Appendix 8.

- Primary dental care providers may carry out both non-AGP and AGP care, subject to availability of the appropriate PPE and in line with infection prevention and control guidance.

- Patients including COVID-19 and their household/support bubble contacts, need to be identified through an initial remote stage of the dental care pathway followed by a face-to-face stage at Fig 1.

- Suspected and confirmed COVID-19 patients and their household/support bubble contacts requiring urgent face-to-face care are to be referred to Urgent Dental Care hubs.

When scheduling an appointment for face-to-face care:

- Care should be delivered in a dental service/care setting which is appropriate and suitably equipped for the patient's care requirements (eg appropriate PPE available for AGPs).

- Dental services should take into consideration social distancing and physical and temporal separation requirements which may impact appointment planning and/or referrals.

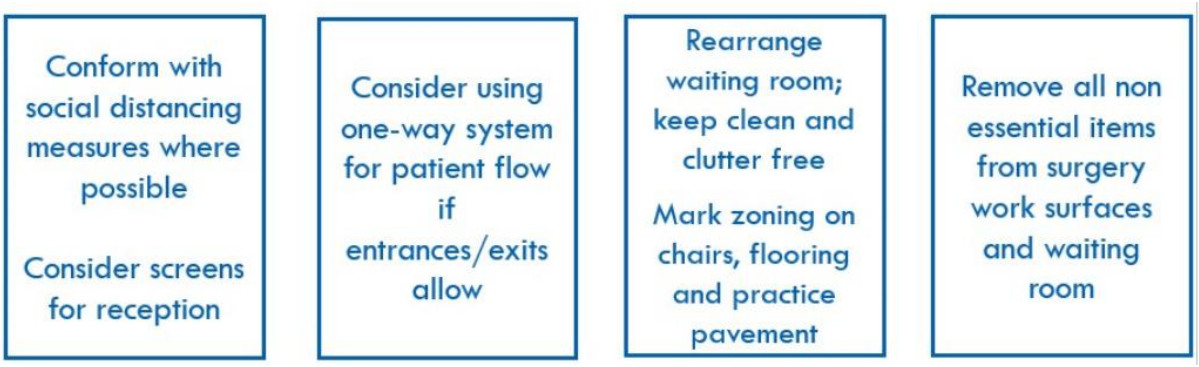
- Robust infection prevention and control procedures in line with government advice must be adhered to. See the Dental Appendix to COVID-19: Guidance for the remobilisation of services within health and care settings- Infection prevention and control recommendations. Both documents are also accessible at: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Social Distancing

Patient flow and practice layout should be considered, including a risk assessment of staff rooms and communal areas in order to comply with social distancing measures throughout the practice. To aid practices in assessing the practice environment and designing risk management procedures a sample check list of practical considerations is included at Appendix 2. For example:

- Measures to separate and minimise the number of patients in practice at any one time.
- Follow guidance on face coverings in primary and community care settings – here, and hospital settings – here.

- Establishing single entry and exit points for patients, with alcohol hand gel available for patient use.
- Reception interactions:
    - measures to minimise reception use eg digital appointment booking (online, email), receipts
    - consider fitting physical barrier at reception eg Perspex shield
    - set up contactless / card payment where possible
- Allow for 2m distancing where possible, ideally marked on floors.
- Where 2 metre separation is not possible, maintain 1 metre with additional precautions.
- Remove unnecessary items (eg magazines, toys, tv remote) from the waiting area.



Section 2: Supporting the Dental Team

Risk Assessment

All Staff

Employers will need to consider detailed risk management approaches to safeguarding the health of their staff and minimise the risk of infection. It is therefore essential that all dental practices undertake and review risk assessments for all their staff (clinical, administrative and domestic staff), recording discussion with team members and the agreed actions. Further information is available in the Health and Safety Executive's working-safely-guide. Further guidance is also available through the Faculty of Occupational Medicine Risk Reduction Framework.

- NHS Employers: risk assessments for staff – here
- Risk reduction framework for NHS staff at risk of COVID-19 infection – here.

Staff who have possible/confirmed COVID-19, or who are living in households or part of support bubbles with possible/confirmed COVID-19, should stay at home and not come into work. They must self-isolate and order a test immediately at GOV.UK website or call 119 if they have no internet access. If the test is negative, they no longer need to self-isolate. If, however, the test is positive, they must complete the remainder of their allotted self-isolation and the NHS test and trace service will send them instructions of how to share details of people with whom they have had close or recent contact. Further information on the NHS test and trace service is found here.

See guidance:

- For households with possible/confirmed COVID-19 – here
- For members of support bubbles developing symptoms, and on support bubbles and isolation – here

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

These staff, including Black, Asian and minority ethnic staff and pregnant women, should be risk assessed so that appropriate measures are put in place to minimise exposure to risk and support safe working. Support from Occupational Health may be required.

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

For clinically extremely vulnerable staff in particular, they should be consulted with on how they can work safely – this may be from home or on-site at the workplace. Workplaces must be made safe by following COVID-secure guidelines if they are

returning to work on-site. See further information on work, employment rights and statutory sick pay here.

Resilience: supporting the workforce

Our workforce and their resilience remain at the heart of best practice and high-quality patient care. As our primary care and community care dental practices commence the journey back to full operating capability our teams must feel confident that their safety and well-being remains a high priority. To ensure that staff are working safely the pace of the clinical day should be reviewed in order to accommodate regular breaks and rest periods. To maintain social distancing measures in staff areas/facilities consider measures such as staggering breaks and limited use of changing areas/rooms to single occupancy at any one time.

There may also be concerns around an increased chance of infection in the workplace, managing challenging domestic situations as well as other concerns. It is important to understand concerns and provide information about the measures taken and the support available to staff.

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

- NHS Employers has resources to support staff wellbeing during the COVID-19 pandemic here.
- The World Health Organization has published WHO Mental Health Considerations During COVID-19.
- MIND UK and Every Mind Matters have published specific resources in the context of COVID-19.
- NHS Practitioner Health has developed frontline wellbeing support during COVID-19.
- BDA members can find further information about access to counselling and emotional support here.
- Domestic abuse helpline here.

Consider the impact that the current unprecedented circumstances could have on the wellbeing of everyone who works in the practice and ensure appropriate support is in place

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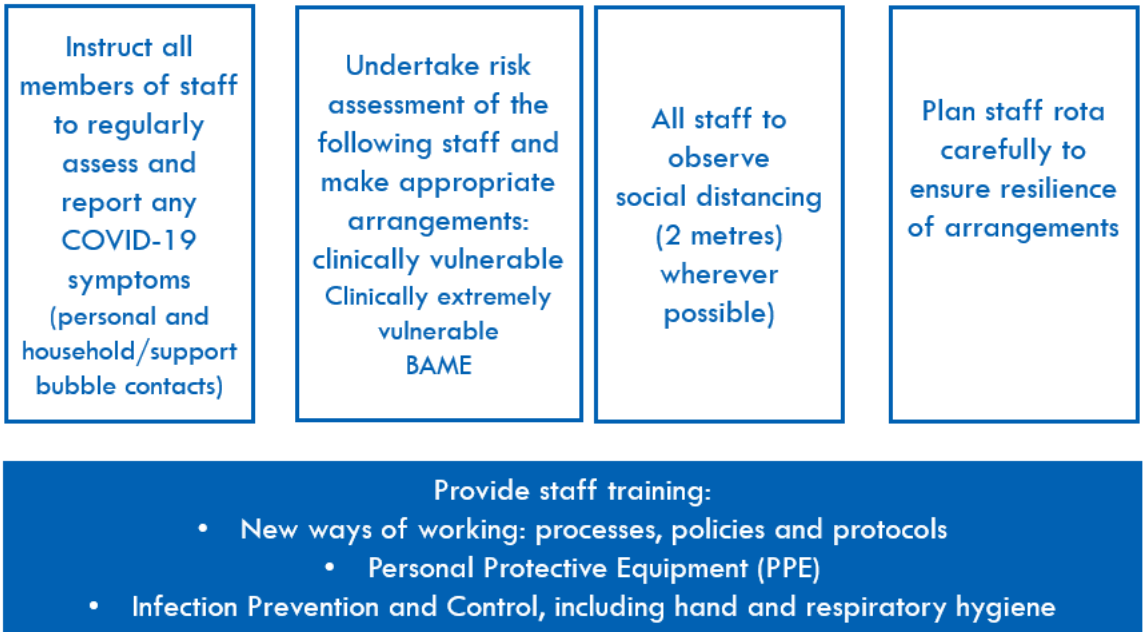
- Provides individual coaching support for primary care staff and can be accessed by video link or telephone with highly trained, experienced coaches
- This support is available to all dental staff and provides opportunities to process experiences, develop coping skills, deal with difficult conversations and develop strategies for self-management in difficult circumstances

Practice Team Responsibilities

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

- Practice is updated with the latest information relating to COVID-19 in dentistry in England.
- Practice has a single point of communication with the Regional NHS England and NHS Improvement (keeping updated and disseminating updates), Local Dental Network and Local Dental Committee.
- Practice activities are co-ordinated to include training, preparation for 'new ways of working' and implementation of this guidance and any subsequent revisions to guidance.
- The development and implementation of practice policies and procedures.
- Queries are directed to local infection control teams and dental practice advisors (DPAs).
- Monitoring of stock levels and ensure PPE is available for the practice, arrange for PPE fit testing as necessary, with local/regional points of contact.
- Training and awareness of this SOP amongst staff.



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

Additional training for staff may be necessary and should be provided prior to recommencing any dental provision. Please consider the below:

- Rubber dam placement.
- Four handed technique;
- Decontamination and Infection Prevention & Control courses on e-Learning for Health website.
- Updated resuscitation guidelines.
- Scenario-based team training in the practice.

- Remote consultation/triaging.
- Patient prioritisation and determinants.
- Training in new IT software tools eg online medical history software.
- Scenario-based team training of new policies & procedure.

Section 3: Transition Beyond Initial Operating Capacity Care Planning

Having resumed the provision of face to face care, practices will need to re-build capability and capacity, working with their staff to optimise time and resources as well as manage patient expectation. While supporting their current patient base, where capacity allows, new patients should also be seen, particularly those with dental emergencies.

Practices will need to plan their response to local outbreaks of COVID-19, and any outbreak control measures (eg locally declared lockdown) instituted by national direction or local systems.

Primary care dental practices are not expected to provide face-to-face care for patients who have COVID-19 symptoms, who have swab-tested positive for COVID-19, or who have close contact with a COVID-19 case ie living in the same household/support bubble and should therefore be self-isolating or has been notified as a close contact by NHS Test and trace.

Where the practice is unable to or cannot accept a patient based on their patient group and/or care needs, that patient should be referred to the appropriate part of their local UDC system. Consideration should be given to liaising (with patient's consent) with the patient's general medical practitioner.

Routine and Urgent Dental care

As a means of reducing footfall and non-essential face-to-face contact within the dental environment, remote contact should be made with all patients prior to appointments at the dental practice. These remote consultations should include the dental triage and COVID-19 risk assessment. Guidance is given in Appendix 3.

There are a number of remote video conferencing applications that are currently being used within the NHS. While these may not yet have been disseminated within the primary dental care sector, there are many alternatives that would suffice during this transition period. NHS Digital has guidance on approved video consultation systems that could be utilised, and alternatives for those settings who are in need of a video consulting system as a short-term measure where approved NHS systems may not be easily accessible.

Where video may not be possible as a first line measure, use of the telephone may be adequate.

For all remote points of contact, General Data Protection Regulations (GDPR) must be followed as per current guidelines during the pandemic.

The General Dental Council (GDC) has set out principles and guidance for remote consultations and prescribing. The Faculty of General Dental Practice (UK) has also

provided updated information and guidance on remote prescribing and advice during the COVID-19 pandemic.

In identifying and prioritising patients, consider methods for logging practitioner/practice time and resources expended on patient record triage together with the outcome of any "remote" patient consultation and pre-appointment screening.

Within the available capacity, recommencing deferred courses of treatment, recall and re-assessments will need to prioritise groups with the greatest need. Practices should consider prioritising patients:

- Who have contacted the COVID-19 UDC system and already been triaged for urgent dental care and/or require follow-up care.
- With incomplete care plans.
- With frequent recall according to NICE recall guidelines eg children, high oral disease risk, those patients whose oral health impacts on systemic health and those who have been through stabilisation and need review.
- With routine dental care needs, not applicable to any of the above cohorts.
- In sequencing and scheduling of patients the aim will continue to be the need to minimise the risk of transmission of COVID-19 between staff, patients, patients and staff.

Face-to-face care

Prioritisation of patients to be seen face-to-face will depend upon the clinical judgement and expertise of the practitioner, once information has been gathered from the remote consultation.

With the dental triage and the patient's COVID-19 risk assessment complete, practitioners should refer to the COVID-19 risk assessed care pathways described in Section 2.2 of the Dental Appendix to the COVID-19: Guidance for the remobilisation of services within health and care settings- Infection prevention and control recommendations.

When care planning, shared decision-making is important, to weigh up the benefits of dental treatment against exposure risk and plan care in the patient's best interests. This is of importance to clinically extremely vulnerable patients at the highest risk from COVID-19. When face-to-face care is required for patients that are clinically extremely vulnerable, then – without compromising the requirement for access to care in an appropriate timescale, where possible – additional physical and temporal separation measures should be taken.

In appreciating that the clinical treatment options and approaches to care may be unfamiliar to some patients, fully informed consent will be important, as will any decision by the professional not to offer a particular treatment because of a wider

risk assessment. Recording valid consent and detailing any risk assessment supporting a treatment plan remains a high priority.

Treatment planning will need to be guided by care pathways outlined in the IPC Guidance for dental settings, with reference to the categorisation of dental procedures according to aerosol production which is available at Table 3.1 of https://www.sdcep.org.uk/wp-content/uploads/2020/09/SDCEP-Mitigation-of-AGPS-in-Dentistry-Rapid-Review.pdf, section 3 page 10.

Treatment planning with a focus on stabilisation should be delivered in line with the principles outlined in the Avoidance of Doubt: Provision of Phased Treatments and complemented with a strong focus on prevention of disease progression, including periodontal management, oral health prevention including fluoride applications (ie Delivering Better Oral Health).

Aerosol generating procedures (AGPs) should be undertaken with the appropriate risk assessment, IPC and PPE protocols. Guidance is contained in the UK IPC Guidance for Dental Settings, in the Dental Appendix to the COVID-19: Guidance for the remobilisation of services within health and care settings- Infection prevention and control recommendations.

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

Where risk assessments limit use of AGP within a treatment plan, clinical guidance for non-AGP approaches is in Appendices 4-7 of this SOP.

Dental AGPs include the following:

- High-speed air / electric rotor (ie > 60,000 rpm)
- Ultrasonic scaler (including piezo)
- Piezo surgical handpiece
- Air polishers

Using high-speed drills to open an access cavity or surgical high-speed drills to undertake surgical extraction of a tooth/root will necessitate use of additional PPE as for AGPs.

Regarding 3-in-1 syringes:

- Research showed that use of the 3-in-1 syringe with either air-only or water-only resulted in lower levels of contamination, with water-only causing the least contamination.

- Where a combined 3-in-1 syringe is used very briefly, standard infection control precautions should be adequate. Copious use of a combined 3-in-1 syringe when not using airborne precautions should be avoided.

Urgent dental care, including examination, taking radiographs, using hand instruments, extractions and suction, are not classed as AGPs so universal precautions that prevent droplet contamination should be used.

Non-AGPs include:

- Remote consultations
- Oral health assessment
- Preventative and self-care measures delivered in line with Delivering Better Oral Health, non-AGP aspects
- Hand instrumentation/scaling (Appendix 4 – non-AGP periodontal treatment)
- Simple dental extractions
- Caries excavation with hand instruments (Appendix 5 –AMIRD)
- Caries removal with slow speed and high-volume suction (Appendix 5 - AMIRD)
- Placement of restorative material (Appendix 5 - AMIRD)
- Orthodontic treatment
- Removable denture stages (if patient has normal gag reflex)
- Paediatric oral health including stainless steel crowns (Hall crown) and silver diamine fluoride applications (Appendix 6)

Appendix 1 Guidance for infection prevention and control in dental care settings

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

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

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

Appendix 2: Practice Checklist

Practice layout	TICK
Assess and design patient flow allowing for social distancing and minimising patient-to-patient contact	
Design appointment scheduling to minimise number of patients within the practice at any one time	
Utilise floor markings – indicating flow and social distancing requirements	
Considered process for remote payment and appointment scheduling	
Facility to accept card/contactless payment	
Placement of COVID-19 and hand/cough etiquette signage	
Place physical barrier at reception	
Remove unnecessary items from waiting and reception areas	
Plan ventilation of all areas	
Hand sanitising stations at point of entry and exit	
Staff considerations	
Ensure social distancing within staff areas/facilities	
Process for laundering staff uniforms	
Risk assess staff for return to work	
Consider staff scheduling (rota)	
Process for reviewing staff health and well-being	
Devise a protocol for all staff to follow if they, or someone they live with, develops COVID-19 symptoms, including whether they should apply for a COVID-19 test	

Putting tools in place to facilitate effective staff communications while working in “clinical, where individual staff members always work with the same colleagues to limit contact between the teams and, if required, contact track and trace	
Making staff aware of available resources eg mental health, resilience, self-care	
Check if there is information relevant to this phase or return available from your indemnity provider	
Review and update continuity plan with required amendments	
Supplies	
Paper towels for hand drying (preferred)	
Personal Protective Equipment supplies sourced	
Medical emergency drugs checked and in date	
Hand hygiene products: sanitisers, soap, paper towels	
Stabilisation materials eg restorative materials	
Rubber dam kit and supplies	
Restore contracted services eg laboratory staff and clinical waste services	
Single use stationary or means to disinfect	
Check dental materials for expiry date and order as required	
Reprocess instruments prior to returning them to use	
Equipment	
Organise engineer visits for maintenance and testing as required	
Check all equipment is functioning and fit for purpose, including washer disinfector, steriliser, ultrasonic bath, reverse osmosis machine	
Reconnect compressor as per manufacturer’s instructions. Turn on mains electricity, close drains, turn compressor on. Perform any housekeeping and maintenance testing	
Carry out safety and quality assurance checks in radiographic equipment	

	Test the Automated External Defibrillator (AED)	
	Ensure rechargeable items are fully charged and operational	
	If the practice has a drinking water dispenser for staff use, recommission as per manufacturer's instructions	
	Check for and install computer software updates	
	Check operation of chair and light functions. Open air and water lines to unit	
	Flush dental unit water lines with biocidal as per manufacturer's instructions	
	Clean and lubricate couplings and air motors then reconnect, as per manufacturer's instructions	
	Test hand pieces for functionality	
	Test suction system. Run cleaning solution through hoses. Check that the cup fill, bowl flush and spittoon have water flowing	
	Appropriate Portable Appliance Testing is carried out	
	Personal Protective Equipment & Infection Prevention & Control	
	Staff are aware and familiar with PPE recommendations	
	Designate area identified for donning and doffing of PPE	
	Staff are aware and familiar with IPC guidance	
	Process in place for cleaning and disinfecting regularly touched items eg reception desks, card machines, door handles, chair arms	
	Rota for cleaning and disinfection of toilet after each use	
	Training	
	Staff know how to don and doff PPE	
	Infection prevention and control	
	Decontamination processes	
	IT training, eg tele-dentistry software and use of any triage custom screens or templates	

	Administrative asks including any changes to payment methods and appointment protocols	
	Performed scenario-based training on patient flow and new COVID-19 alterations	
	Basic Life Support and CPR update	
	Rubber dam/Four handed technique training (if required)	
	Considered any further individual/team training requirements	
	Screening	
	Develop a process for screening of both staff and patients	
	Means for recording and logging screening results (staff and patients)	
	Patient communication	
	Develop a process for communicating COVID-19 related changes to patients	
	Update website and answer machine messaging if required	
	Devise a method for tracking patient progression with treatment, so that you can monitor those awaiting AGPs	
	Place a sign(s) on door/window stating that patients suspected or confirmed COVID-19 should not enter the practice and indicating that the practice is only open for patients with a pre-arranged appointment. Include details of how to contact the practice	
	Care plan organisations	
	Prioritise patients into recommended cohorts OR Review the list of patients that contacted the practice during closure and begin to book appointments, prioritising these on the basis of clinical need and available treatments	
	Check NHS e-mail accounts daily for updates from UK government, health board or other organisations. Ensure any updates are communicated to patients and staff as appropriate	
	Practice procedures	
	Patient movement/journey through practice	
	Patient appointment booking	

Remote patient triage prior to attendance	
Medical history completion	
COVID-19 assessment	
PPE	
Treatment protocols	
Cleaning procedures: • Environmental cleaning • Standard infection control precautions • Transmission based precautions	
Treatment payment options	
Use of toilet facilities	
Staff working patterns	
Team communication	
Team reporting of COVID-19 status	
Dealing with known or suspected COVID-19 symptoms in practice	
Laundry	
CPR	
External	
Inform external providers, eg insurance company, indemnity provider, waste contractors, IT provider, pharmacy, suppliers, maintenance contractors, dental laboratories, utilities and telecoms of practice reopening date	

Appendix 3: Arranging a remote point of contact

Explain to the patient that due to:

- Government guidelines on social distancing
- By way of trying to reduce the spread of infection

Patients will be remotely contacted by the practice to enable future dental care to be planned appropriately.

Inform the patient that a remote point of contact will be made by a member of staff at the practice (either via telephone or video) and that notes will be made on the patients clinical record (call will not be recorded).

Note that consent has been gained for this remote contact to take place.

- Arrange a convenient date and time for the remote point of contact.
- Explain there will be a time-frame within which the practice will attempt to make contact.
- Follow practice protocol for patients that require an interpreter. If unable to communicate remotely due to language barrier, consider face to face appointment.

- Advise best to complete this point of contact when the patient is free to talk, and confidentiality can be maintained.

- Remote point of contact should be prioritised for patients that are vulnerable or clinically extremely vulnerable from COVID-19.

- Ensure all correct contact numbers are noted and agree on the best number to contact the patient on.

- Practices should establish and develop a protocol for any planned remote points of contact that are missed (eg a failure to accept the call may be treated as a missed appointment and that there is no guarantee of a second call).

Appendix 4: Clinical guideline 3 - Management of periodontal treatment (non-AGP)

This Appendix has been developed by the British Society of Periodontology and Implant Dentistry (BSP) in collaboration with the OCDO team. It focusses on the management of plaque induced periodontal conditions, principally gingivitis and all grades of periodontitis Stages I, II, III, IV (mild, moderate, severe, very severe).

> *It specifically provides guidance on the provision of periodontal care for patients who are: 1) not known to be COVID-19 +VE or 2) not known to be exhibiting any symptoms of COVID-19.*
>
> *For COVID-19 +VE patients, those exhibiting symptoms, or residing with people who are self-isolating due to suspected COVID-19, treatment should be delayed where possible for 14 days, or to a point where they are clinically fully recovered and have had no fever for the last five days. Otherwise, this group should be referred to an Urgent Dental Care Centre (UDC) for management.*

This SOP embraces the European S3-level treatment *guidelines* published in May 2020. BSP currently endorse these guidelines and are in the process of adapting them to the UK and Irish context, through a formal process, and anticipate publishing an updated version in July 2020.

Table 1: demonstrates the stepwise sequence for treatment of periodontitis and gingivitis.

Steps 1, 2 and 4 are sufficient to stabilise periodontal health in the majority of sites and in the majority of patients, and the evidence-based guidelines demonstrate that there is no difference in outcome from employing non-AGP instruments (hand scaling and root surface therapy using hand curettes) as opposed to AGP instruments such as sonic/ultrasonic scaling devices.

Until more robust research evidence emerges on the safety and most appropriate protocols, periodontal care can continue without AGP, and should be regarded as an essential health procedure. For surgical aspects of Step 3, care requires specialist level 2/3 enhanced skills.

Step 3 procedures involving non-AGPs (re-instrumentation of non-responding sites by hand) may also be performed with the appropriate level of PPE *recommended*.

The S3-treatment guidelines do not support superiority for ultrasonic / sonic instruments over hand instruments, and strongly recommend either may be used for sub-gingival treatment, either alone or in combination.

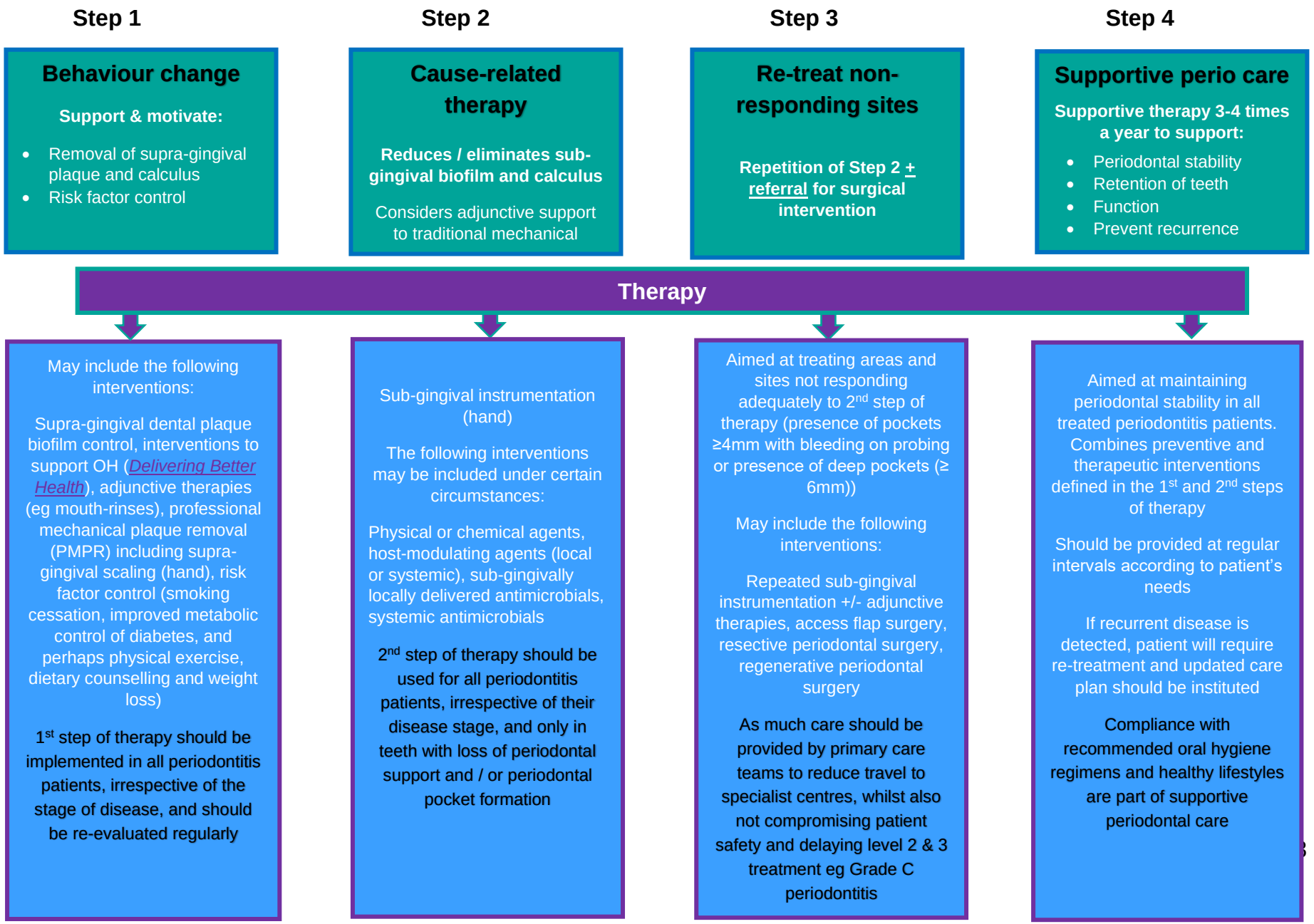
New World Workshop Classification (WWC)

We are aware that a number of dental teams within NHS commissioned services are concerned about the perceived complexity of the WWC, due to the manner in which it has been taught in some areas. We would reassure those teams that the BSP implementation plan is extremely simple and being adopted by other countries for this reason. However, we recognise the need for time to adapt to such changes and the desire of some teams to continue to use the extant classification system.

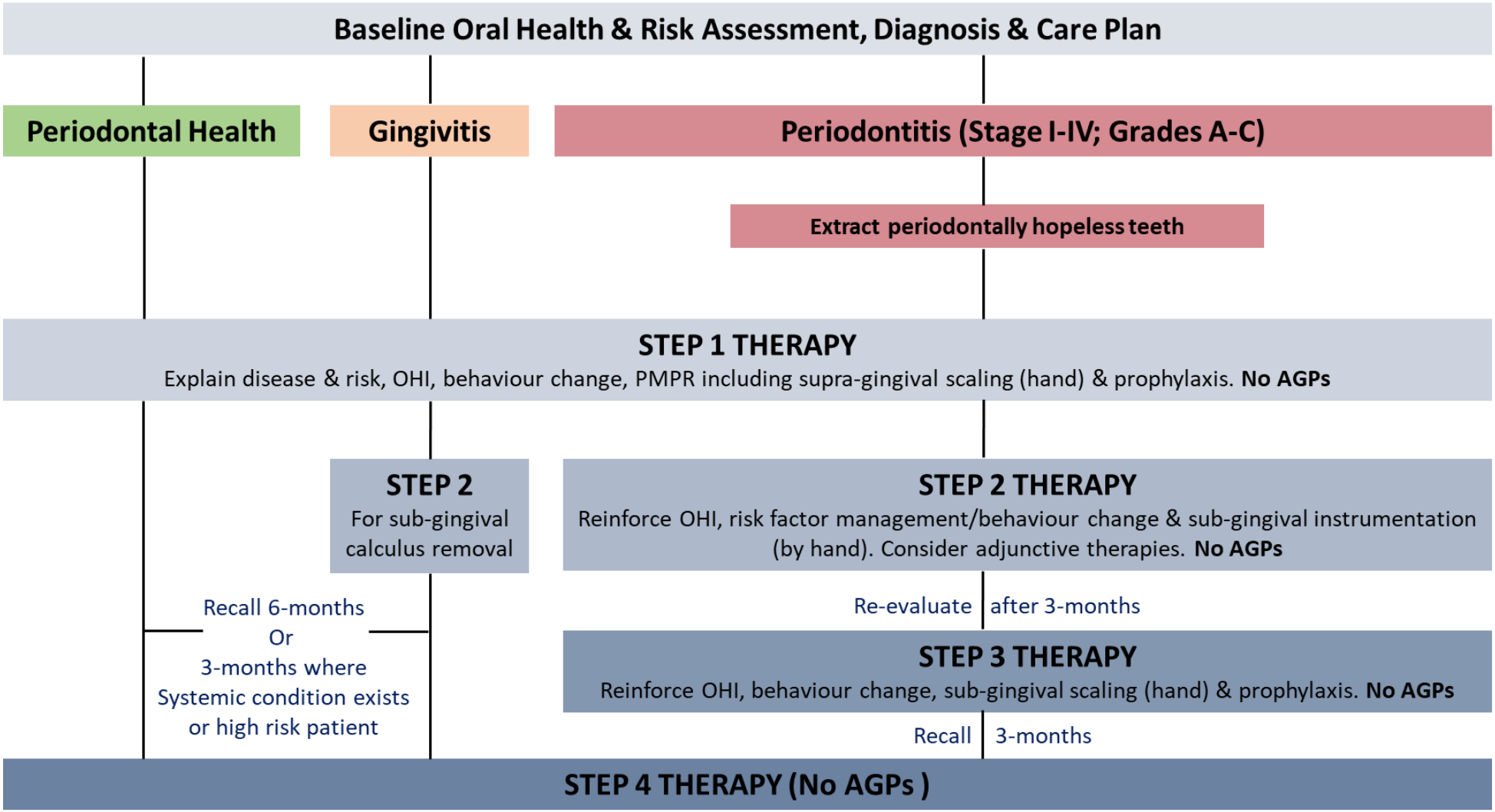
Therefore, we would like to reassure front line clinical teams that in the interim, NHS England's commissioned services can continue to use the existing (extant) classification system, while acquainting themselves with the principles of the BSP WWC implementation, if they find this easier to deliver.

Effective care can be delivered using either system in the presence of appropriate examination, risk assessment and treatment planning (and hence a failure to immediately transition should not be considered poor practice). The existing BPE system and associated BSP WWC will form the basis for future care pathway and commissioning development.

Table 1: Flow Chart



Flow Chart of Steps of Minimally-Invasive Periodontal Treatment (without AGP)



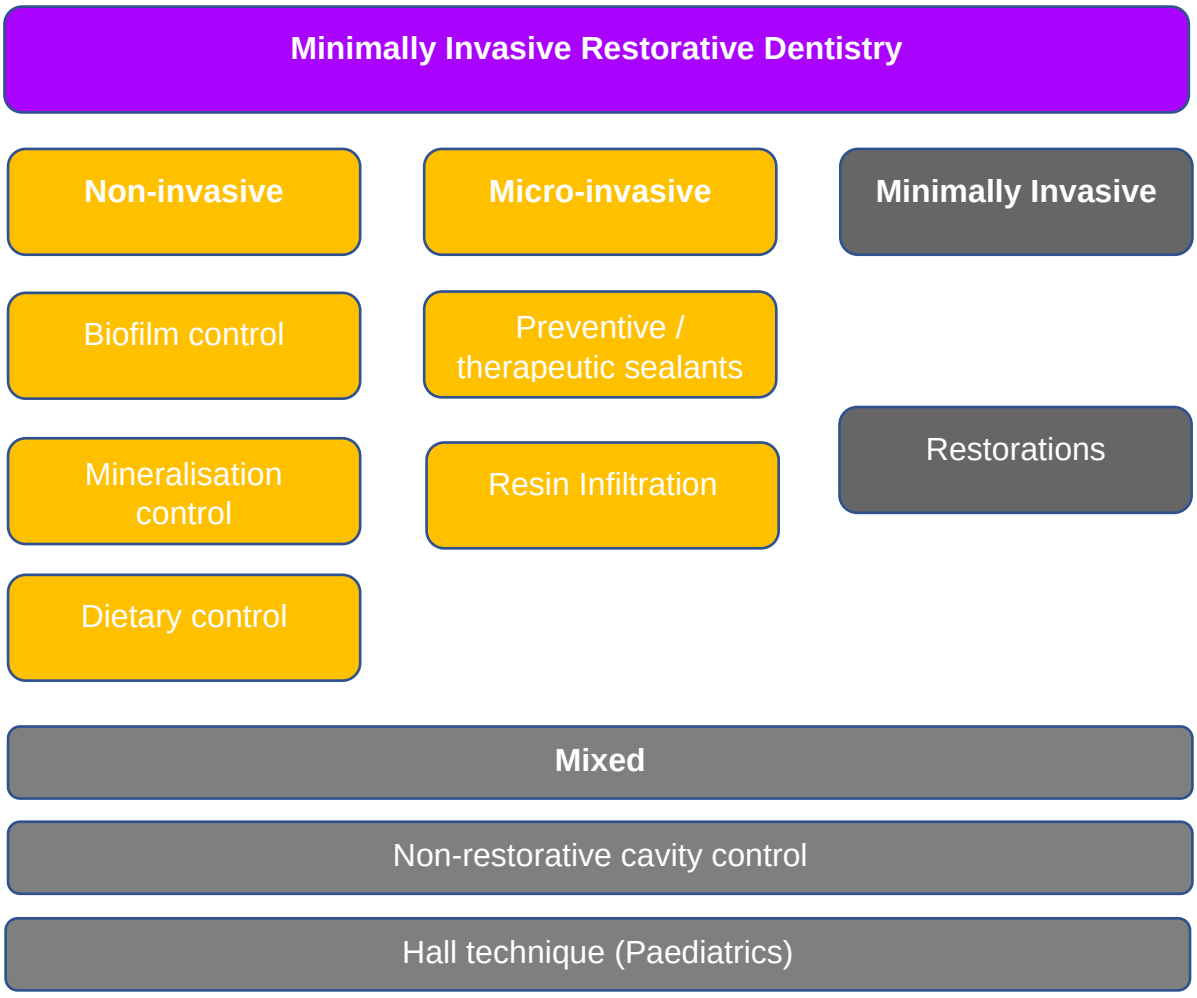
Appendix 5: Clinical guideline - Advanced Minimally Invasive Restorative Dentistry (AMIRD): caries management

We recognise dental teams may use a variety of acceptable techniques, and a shift towards a preventative and minimally invasive clinical philosophy is a journey to best practice that should be supported by appropriate support and training.

This Appendix outlines three distinct areas of advanced minimally invasive restorative dentistry (AMIRD) in managing dental caries, prevention and self-care:

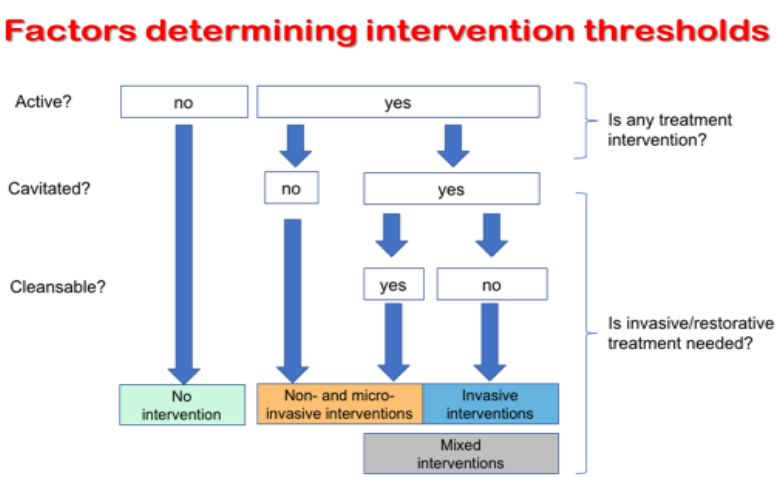
- non-invasive prevention: inactive carious lesions, focusing on susceptibility assessment, non-AGP preventative measures;
- micro-invasive management: for early, non-cavitated, active carious lesions, non-AGP, preventive / therapeutic sealants and resin infiltration;
- minimally invasive restorations: Risk-managed AGP, MI restorative management of patients with active cavitated, deep carious lesions;

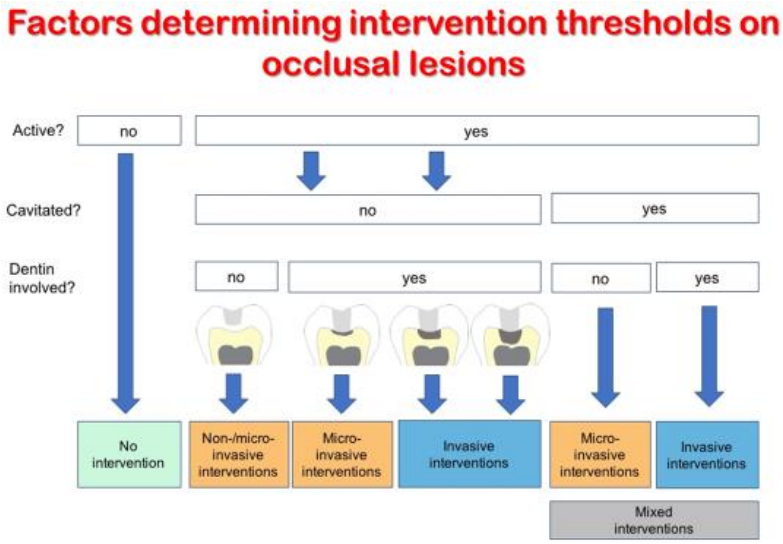
Flowchart 1. When to intervene in the caries process? An expert Delphi consensus statement.[1]



[1] Clinical Oral Investigations 2019; https://doi.org/10.1007/s00784-019-03058-w

5.1 Factors determining caries intervention





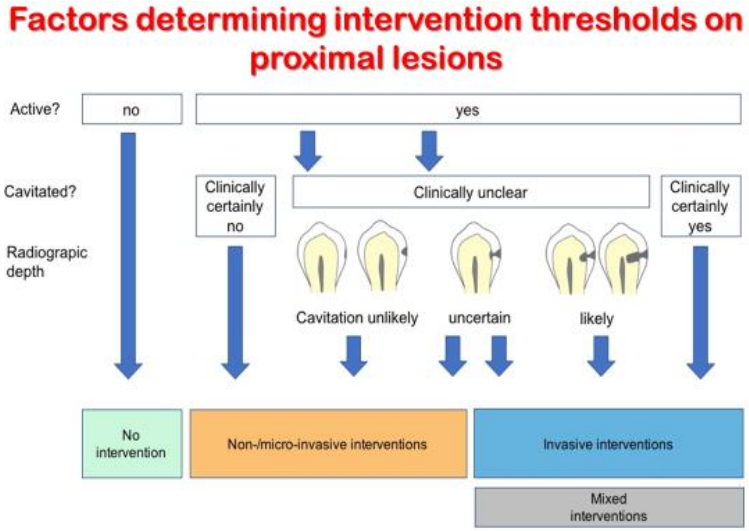


Figure 1. Factors determining when to intervene in the caries process. Is the lesion active, cavitated, cleansable?

Figure 2. The factors specific for occlusal lesions.

Figure 3. The factors specific for proximal lesions.

AMIRD - Non-invasive caries management

Table 2. Non-invasive prevention principles and techniques.

Non-invasive, non-AGP procedures	
Biofilm control	• Oral hygiene - Delivering better oral health • Relevant oral hygiene procedures • Toothpastes with fluoride • Mouthwashes • Rotating/oscillating brushes and flossing
	• Instructed by all clinical oral healthcare team members
Mineralisation control (based on caries susceptibility assessment and at-risk tooth surfaces)	• Application of fluoride varnishes • CPP-ACP (casein phosphopeptide-amorphous calcium phosphate, products containing Recaldent) containing pastes • β-TCP (beta-tricalcium phosphate) containing agents and other remineralisation agents • CHX (chlorhexidine) / Silver Diamine Fluoride in adults (no / limited evidence) • Silver Diamine Fluoride in paediatric patients (UK licence for treating dentine sensitivity)
	Delivery by dentists and dental hygienists & therapists
Dietary control	• Advice on dietary control
	• Delivery/instruction by all clinical oral healthcare team members

AMIRD - Micro-invasive caries management

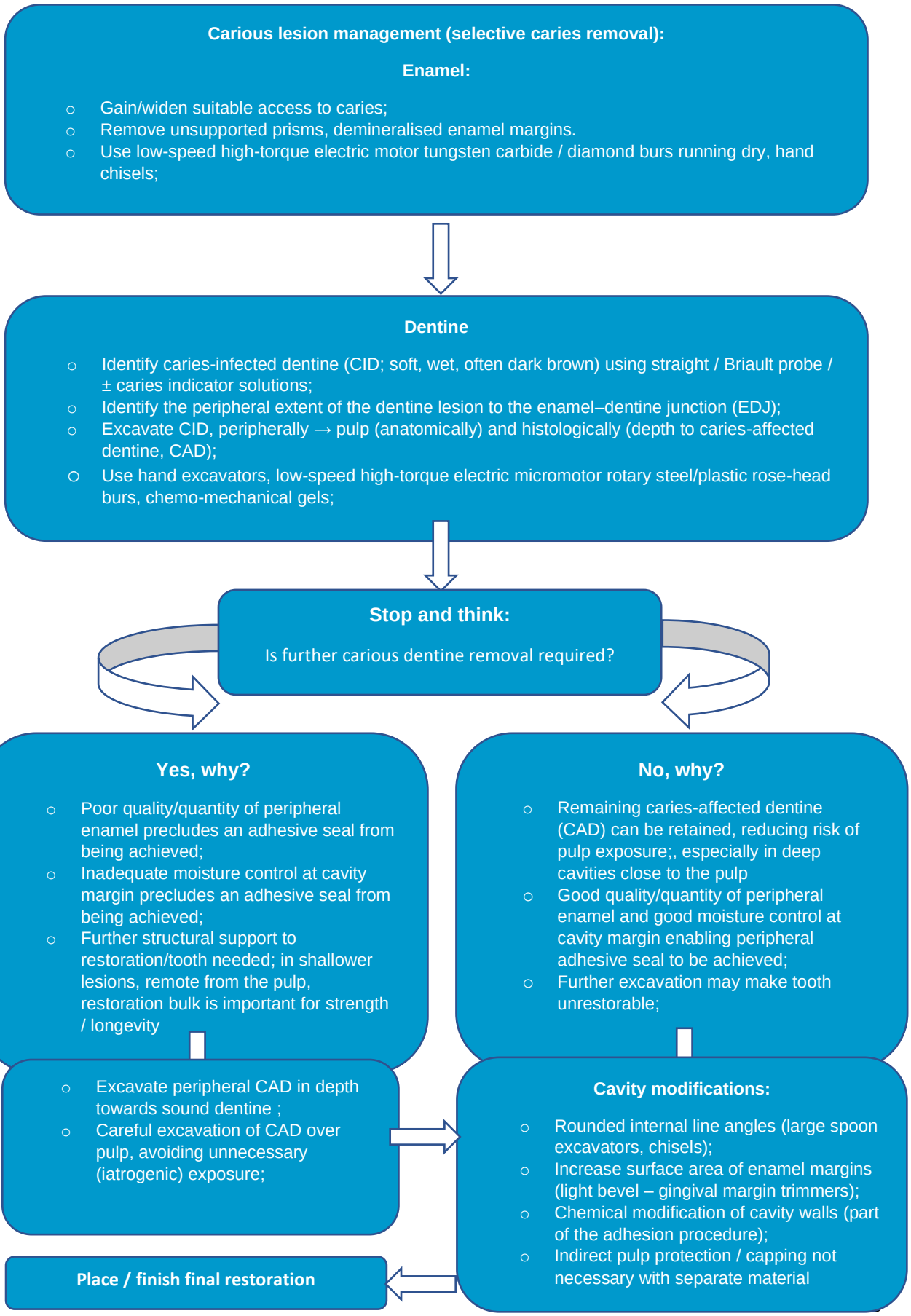
Table 3. Micro-invasive dentistry; principles and techniques for early carious lesions.

Micro-invasive, non-AGPs	

Sealants:
 	
Caries sealing is a procedure that may be used where active early carious lesions are detected in:
 	
1) Accessible non-cavitated surfaces (including occlusal surfaces), confirmed through clinical ± radiographic examination
	• Preventative & therapeutic* fissure sealant using proprietary sealants:
	  ○ Flowable resin composite
	  ○ Glass-hybrid, GIC (glass-ionomer cement) / RM-GIC (resin modified glass-ionomer cement) (where moisture control is not optimal)
	
	<u>Resin composite:</u>
	
	Adhesion: Composite: 37% orthophosphoric acid-etch enamel fissures (20 secs), wash and dry (10 secs) using separate low pressure water / air streams or wet / dry cotton wool pledgets
	
	Restoration: flowed into fissure pattern, light cure (470nm for 20 secs); check occlusion pre-isolation and after its removal
	
	<u>GIC / RM-GIC:</u>
	
	Adhesion: 10% polyacrylic acid conditioning of enamel fissures (15 secs), use separate low pressure water / air streams to wash and dry tooth surfaces or wet / dry cotton wool pledgets / paper points (10 secs)
	
	Restoration: application into fissure pattern, auto-cure / light cured (470nm for 20 secs); check occlusion pre-isolation and after its removal.
	
	*in therapeutic fissure sealing, micro-cavitated fissures may require widening

	Delivery by dentists and dental hygienists & therapists
Resin infiltration For accessible smooth surface, early non-cavitated enamel lesions	Same as for sealants Follow standard published protocols but limit/no use of 3-1 air-water syringes
	Delivery by dentists and dental hygienists & therapists

AMIRD - Minimally invasive restorations, risk-mitigated AGP principles



Appendix 6: Management of caries for the paediatric patient

Management of dental caries, prevention and self-care 0-16 year olds.

Prevention and self-care

Every child and young person should continue to receive tailored oral health advice in line with Delivering Better Oral Health. Clinicians should document the exact advice given in order to fulfil contractual obligations. For example, “Advised to stop bottle use and introduce an open top or free-flow cup, to move from brushing once daily to twice daily, emphasised the importance of brushing last thing at night.” It will not suffice to write “prevention given”. Oral health advice can be given as part of a remote consultation.

Patients should be encouraged to perform optimal self-care in order to minimise the development of new disease. Use of digital health tech can be used to deliver and reinforce key prevention messages. The following videos deliver key information in line with Delivering Better Oral Health and can be freely distributed and placed on practice websites or social media pages if used in their entirety:

0-3 video https://youtu.be/owbp5F0K45c
3-6 video https://www.youtube.com/watch?v=lQE4xxk1r5g
7+ video https://www.youtube.com/watch?v=GHS27DHyIi0

Clinicians may also wish to signpost to oral health apps listed in the NHS Apps Library such as Brush DJ [www.brushdj.com]. Health technology has been shown to motivate positive behaviour change.

Primary Dentition

Management of caries in the primary dentition should favour minimally invasive oral healthcare including consideration of the use of less invasive measures such as silver diamine fluoride (SDF) and Hall crowns, and where appropriate considering extractions over traditional conservative approaches.

The success of placing a preformed metal crown via the Hall Technique requires careful and appropriate case selection, excellent patient management and long-term monitoring. For guidance on the indications, effectiveness, and step-by-step guide on how to place a Hall Crown, refer to the Hall Technique - A minimal intervention, child centred approach to managing the carious primary molar.

Permanent Dentition

Management of caries in the permanent dentition may favour temporisation and stabilisation for a six-month period to minimise an AGP. Clinicians should refer to the

recently published Scottish Dental Clinical Effectiveness Programme (SDCEP) guidelines on management of caries in children.

Appendix 7: Management of (non-AGP) Endodontics

This Appendix has been developed by the British Endodontics Society (BES) in collaboration with the OCDO team. This document details proposed workflows for the management of endodontic problems in the graduated return to dental treatment provision. Triaging of patients to assess individual risk of COVID-19 transmission is essential prior to appropriate scheduling of any endodontic care.

The aim of these proposals is to relieve symptoms, minimise (where possible) the number of visits to complete treatment, while at the same providing the favourable outcomes that are associated with contemporary endodontic therapy and reduce unnecessary loss of teeth.

The document uses diagnostic terminology currently adopted in most dental schools in the UK and described in the AAE Consensus Conference Recommended Diagnostic Terminology in 2009[1]. As an aid for those unfamiliar with this terminology, Table 1 offers a description of symptoms associated with the common diagnostic terms.

Table 1

Symptoms	Pulpal/Apical Diagnoses	Treatment
Short duration sharp pain Not spontaneous in onset Cold stimulus worse than hot	Reversible Pulpitis	Caries management, restoration with vital pulp therapy if required
Pain on thermal stimulus Spontaneous pain Lingering pain Referral of pain Postural affects Analgesics ineffective	Irreversible Pulpitis	Root canal treatment
Unresponsive to sensibility testing Tenderness to palpation/ percussion Possible periapical changes on radiograph	Symptomatic Apical Periodontitis	Root canal treatment
Spontaneous pain Extreme tenderness Swelling Possible fever, malaise and lymphadenopathy	Acute Apical Abscess	Incision and drainage, consider antibiotic therapy if indicated Two stage root canal treatment advised
Unresponsive to sensibility testing	Chronic Apical Abscess	Root canal treatment

No symptoms Periapical radiolucency on radiograph		
Unresponsive to sensibility testing Sinus tract +/- pus discharge Minimal or no pain Periapical radiolucency on radiograph	Asymptomatic Apical Periodontitis	Root canal treatment

*If tooth has been **Previously Treated** or has had **Previously Initiated Treatment** decision should be based upon apical diagnosis.

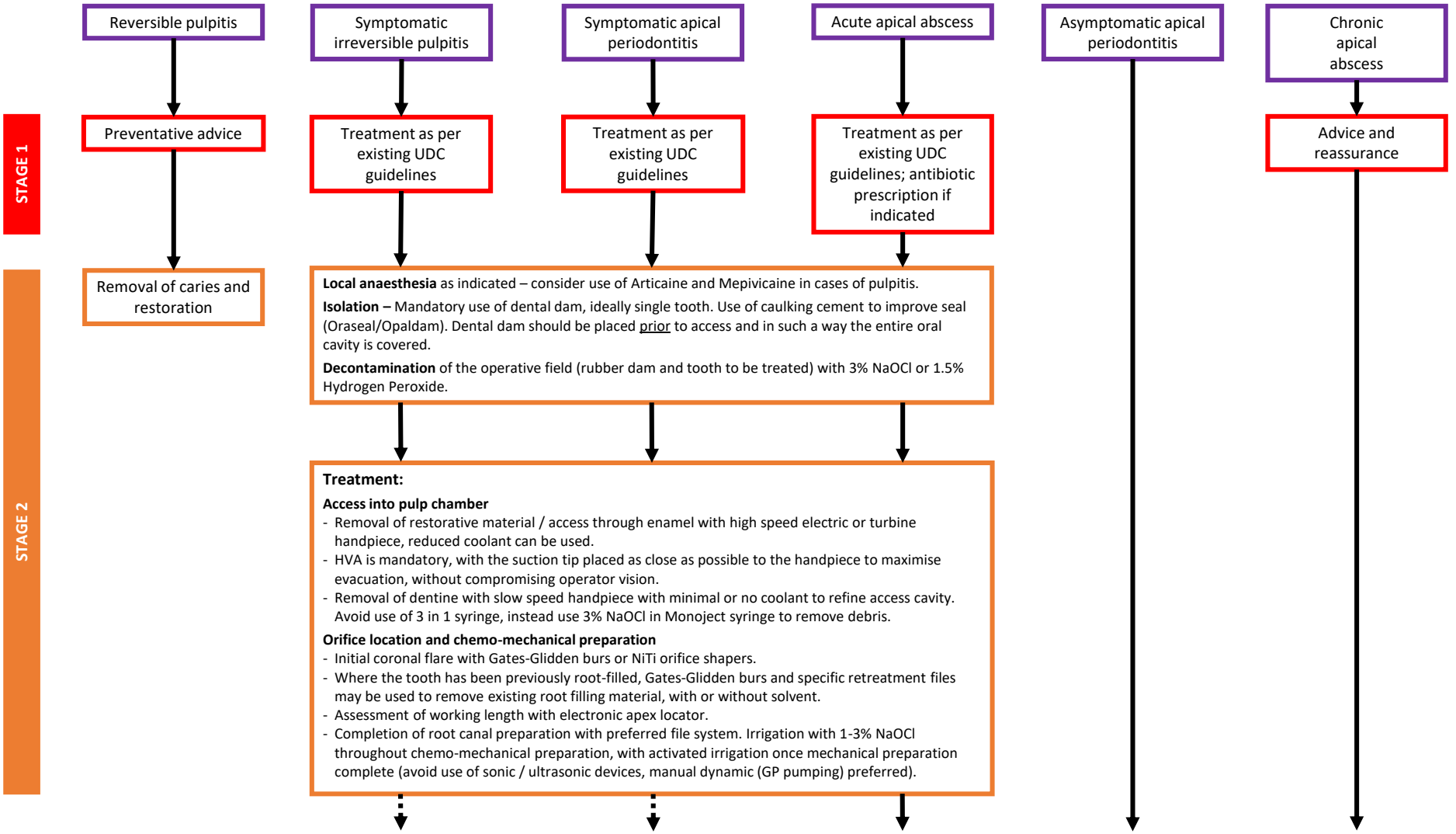
Table 2 shows a flowchart of proposed actions for all common endodontic diagnoses (dento-alveolar trauma is not included in this table), along with the suggested treatment protocols for management, based on the existing ESE quality guidelines for endodontic treatment[2]

Stage 1 (red) - refers to urgent dental care treatment.

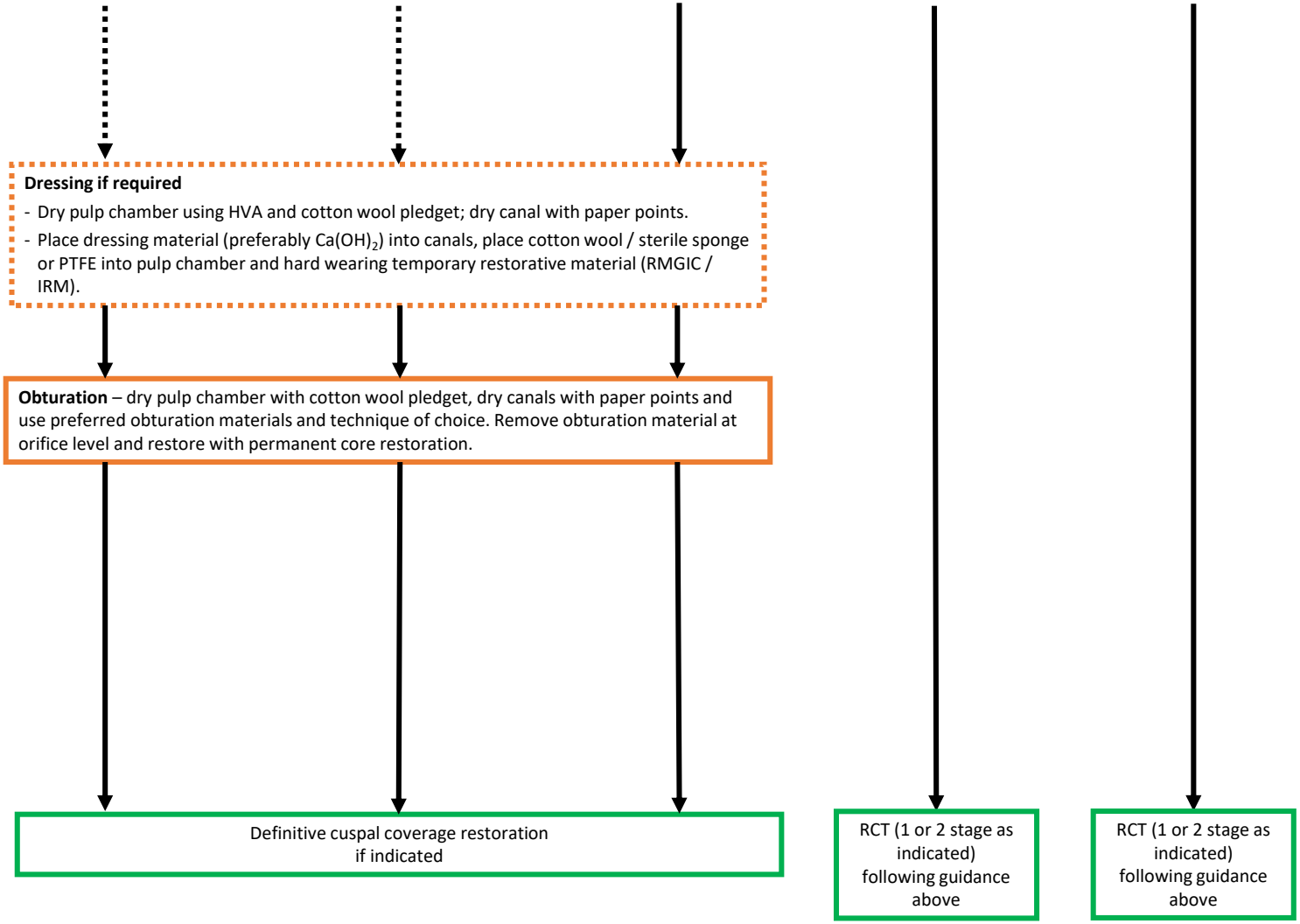
Stage 2 (amber) - refers to treatment in primary care for managing endodontic problems.

Stage 3 (green) - refers to treatment that should be deferred to a later stage.

Table 2:


Reversible pulpitis
Symptomatic irreversible pulpitis
Symptomatic apical periodontitis
Acute apical abscess
Asymptomatic apical periodontitis
Chronic apical abscess
STAGE 1
Preventative advice
Treatment as per existing UDC guidelines
Treatment as per existing UDC guidelines
Treatment as per existing UDC guidelines; antibiotic prescription if indicated
Advice and reassurance
STAGE 2
Removal of caries and restoration
Local anaesthesia as indicated – consider use of Articaine and Mepivicaine in cases of pulpitis.
Isolation – Mandatory use of dental dam, ideally single tooth. Use of caulking cement to improve seal (Oraseal/Opaldam). Dental dam should be placed prior to access and in such a way the entire oral cavity is covered.
Decontamination of the operative field (rubber dam and tooth to be treated) with 3% NaOCl or 1.5% Hydrogen Peroxide.
Treatment:
Access into pulp chamber
- Removal of restorative material / access through enamel with high speed electric or turbine handpiece, reduced coolant can be used.
- HVA is mandatory, with the suction tip placed as close as possible to the handpiece to maximise evacuation, without compromising operator vision.
- Removal of dentine with slow speed handpiece with minimal or no coolant to refine access cavity. Avoid use of 3 in 1 syringe, instead use 3% NaOCl in Monoject syringe to remove debris.
Orifice location and chemo-mechanical preparation
- Initial coronal flare with Gates-Glidden burs or NiTi orifice shapers.
- Where the tooth has been previously root-filled, Gates-Glidden burs and specific retreatment files may be used to remove existing root filling material, with or without solvent.
- Assessment of working length with electronic apex locator.
- Completion of root canal preparation with preferred file system. Irrigation with 1-3% NaOCl throughout chemo-mechanical preparation, with activated irrigation once mechanical preparation complete (avoid use of sonic / ultrasonic devices, manual dynamic (GP pumping) preferred).

STAGE 2



STAGE 3

References

1. AAE Consensus Conference Recommended Diagnostic Terminology. Journal of Endodontics, 35, 1634, 2009.
2. Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology. International Endodontic Journal, 39, 921–930, 2006.
3. British Endodontic Society. 2020 https://britishendodonticsociety.org.uk/wp-content/uploads/2020/03/BES-AAA-Document-31st-March-v1.1.pdf

Appendix 8: Approaches for clinically extremely vulnerable patients

- Clinically extremely vulnerable (CEV) patients should be identified in the remote management stage of the patient pathway.

- CEV patients may be seen for dental care in the same way as other patients, as government shielding advice has been paused.

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

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

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

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

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

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