2nd February 2022

Dear Teams,

Updated SOPs, new contract targets, new isolation requirements, and vaccination requirements

We are all hoping that 2022 may be the year when we return to some semblance of normality in our professional and personal lives amidst the COVID pandemic. We have all been through some very testing times professionally, as a group and as individuals. For me, the real test has been to make the right decisions at the right time to ensure that every decision I make promotes your safety while at work.

Key to being a compliant healthcare worker is to know the various guidance in force at the current time. This document is intended to summarise the key areas of guidance that all members of ADG should follow.

As you know, NHSE issued new SOPs on November 21st to commence the process of stepping down the prevailing SOPs to enable a higher throughput of dentistry. No later than 72 hours later, on 24th November 2021 the Omicron variant emerged in South Africa and was reported to WHO. I was therefore dutibound to hold off from stepping down our enhanced SOPs pending analysis and following the science of the infectivity and morbidity of Omicron.

I have followed the situation closely using .gov statistics:

- Omicron is far more infective than Delta and causes far more viral shedding which may explain the infectivity
- Immunologically, Omicron attaches to ACE2 receptors in the upper respiratory tract preferentially and much less attachment in the lower respiratory tract, thus causing significant upper respiratory tract symptoms and less lower respiratory tract symptoms
- Whereas there has been an increase in hospitalisations, the tendency towards a cytokine storm and death is much reduced as a result of the different binding behavior to ACE2 receptors in the lower respiratory tract
- There is a much higher risk of hospitalisation if you are not double vaccinated and boosted
- The weekly death rate where COVID-19 is on the death certificate is not showing any exponential rise and appears to be levelling:

https://coronavirus.data.gov.uk/details/deaths?areaType=overview%26areaName=United%20Kingdom#card-deaths_within_28_days_of_positive_test_by_date_of_death

- The mortality rate of Omicron is 0.2% which is comparable to seasonal flu
- Omicron is sweeping the globe swiftly as the predominant variant, which, given the upper notable features, may result in herd immunity without severe disease which is excellent news
- Omicron may assist turn the course of pandemic to endemic status, which is the natural history of any pandemic, and as did occur with the Spanish Flu pandemic in 1918
- We may see additional variants of COVID that could alter the course of our advice. The recent emergence of 'Stealth Omicron' (BA.2) is being monitored and does appear to be spreading rapidly but currently does not seem to be posing an additional threat

I am happy for now, and subject to absence of a new strain that Omicron does not pose a significant threat even with the Omicron subvariants. I could not be sure about that just before

Christmas, but I am pleased that government statistics (which are in fact 1-2 weeks behind). On 13th January, Omicron incidence showed a 40% collapse of Omicron cases from the previous week :

https://www.youtube.com/watch?v=5R2wq-JlpME

The lag in reporting means that we are likely to be well ahead of this now.

I had always believed through science that as the original Wuham strain mutated, it would do so and eventually become weaker to the point where a less virulent form of virus would help us develop herd immunity without severe disease. Unless we have another mutation that results in a different epidemiological trajectory, I am quietly confident the Omicron could be the mutation that brings an end to the pandemic. This is not guaranteed but is our hope.

You can be assured that me and my executive team will not rest on our laurels, and should this situation change, then we will advise you and reconsider our SOPs.

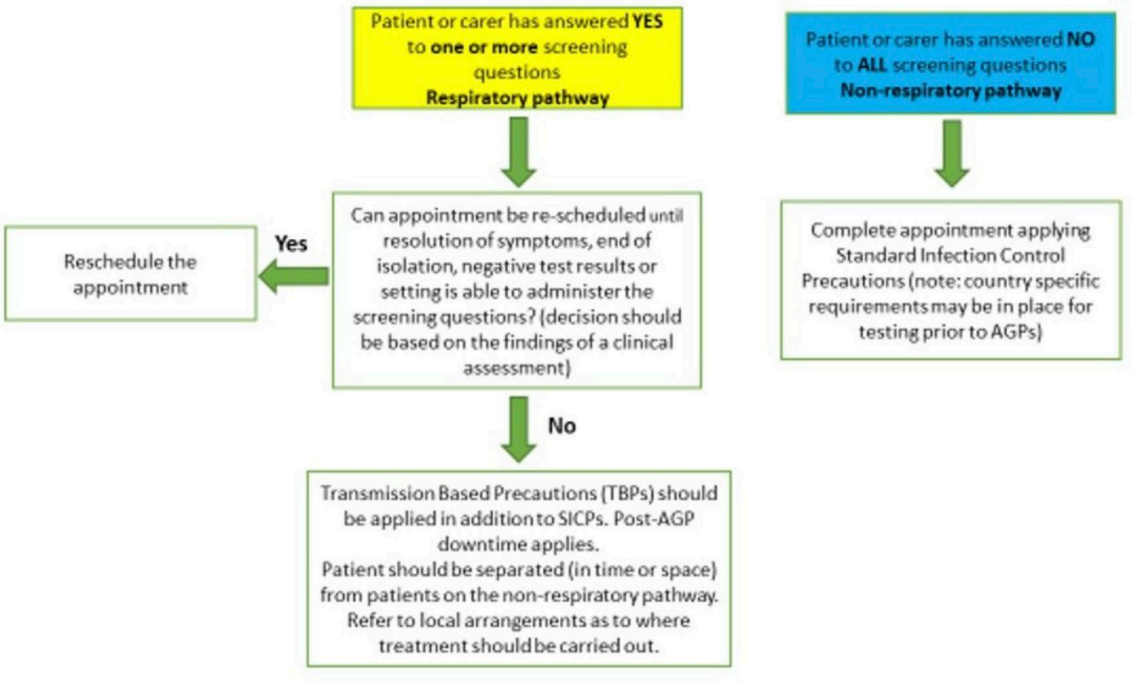
I already advised managers that we will accept most of the SOPs issued to us on Nov 21, 2021, by NHSE. This includes loss of fallow time. These are summarised below.

Updated SOPs

These will follow the following guidance:

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

Patients will be risk assessed to enter one of two pathways **- respiratory and non-respiratory with screening PRIOR to appointment**. Patients will be sent an online form via EXACT to fill out to undertake this risk assessment:



Sample screening form to determine if patient is a respiratory or non-respiratory patient:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1035192/Appendix_1_Sample_Screening_Tool.pdf

A similar form will be sent via the EXACT patient portal and screening will be completed electronically.

Respiratory and Non-respiratory Pathways:

Our practice teams have mixed views about the rapid step down in PPE for Aerosol Generated Procedures (AGPs). To support the mental welfare of our staff, we will propose a phased step down in PPE, with a strategic review every 2 weeks.

- Non-respiratory patients can be seen with standard infection control procedures (SCIP) -routine PPE, Type II/IIR masks when non-AGPs are performed. When AGPs are performed, FFP3 masks should be worn provisionally. This policy will be reviewed practice by practice every 2 weeks until practice teams are happy to move to standard infection control procedures and step-down use of FFP3 to Type IIR surgical masks with AGPs. Surgical drapes will not be necessary. Neither will it be necessary to mop floors between patients. Surface cleaning will follow pre-covid standard infection control procedures. **No Fallow time will be required between appointments and treatment henceforth.**

- Respiratory patients need to be treated with "Transmission-based Precautions" (TBP) in place and can be rearranged to a later date if not urgent - however if in pain we should make provisions to see those patients, but those patients must be spatially and temporally remote from unnecessary contact with staff or other patients. We should do our utmost to minimise contact and see those patients at the end of the day, ideally with a controlled transfer to and from the surgery. For these patents **fallow time is observed as per RCS guidelines**, and enhanced cross-infection procedures are followed, to include use of FFP2/FFP3 mask wearing and surgical drapes.

There are some key points about the changes to SOPS:

1. Patients will have access to our Front of House admin teams. We will therefore continue to support mask wearing in reception areas, screens, air scrubbers, and open windows where practical, one-way systems, and social distancing of 2 meters where possible and decontamination of high touch items. We no-longer support the use of thermometers due to their unreliability and due to the need for social distancing as a priority
2. Hand sanitisation stations will be re-instated for patients on entry to the building
3. When staff are accessing toilets, kitchens, and communal areas, they should consider the possibility and need to wipe surfaces/not share utensils due to the possibility (low risk) of 'fomite transmission'. Common sense must be always exercised to prevent a Covid outbreak occurring within the team.

   Centers for Disease Control and Prevention wrote in April 2021: "However, based on available epidemiological data and studies of environmental transmission factors, surface transmission is not the main route by which SARS-CoV-2 spreads, and the risk is considered to be low."

4. For non-respiratory patients, FFP3 masks will be worn for AGPs provisionally with view to step down to Type IIR masks as soon as possible. Standard Infection Control Procedures will generally apply (SICPs) other than wearing FFP3 masks for AGPs provisionally until further risk assessment allows us to phase our FFP3 masks.

5. For AGPs in non-respiratory patients: we plan to phase out enhanced PPE by April 2022 unless there is any new transmission-based risk identified.

6. For AGPs in respiratory patients: we will continue to use enhanced cross infection control procedures until advised otherwise by Public Health England.

7. Use of air scrubbers: All air scrubbers are high fluence UV-C devices, with HEPA13 and activated carbon filters, and when appropriately positioned phenomenally reduce the particle count in the air and recirculate the air. This has been tested with sensitive particle counters by Dr.Raj Wadhwani and the particle count reduction is profound and demonstrable. Virus particles are not planktonic but live on air particles, hence the concern about aerosols. Pathogens live on particles typically less than 5 microns in diameter, and our air scrubbers remove 99.97% of particles that are larger than 0.3 microns rapidly when kept on. The BDA and OCDO also recommend open windows to facilitate true air exchanges, and I would support this, particularly during the winter season when undertaking AGP work. The air scrubbers and open windows will also substantially reduce the viral load in the air and this must be considered to be a priority over warmth in the winter months. In the Summer months there will be a natural tendency to open windows in any case.

8. "Receptions should be open to patients to allow booking of appointments face to face, while following risk assessment and social distancing measures.". One-way systems will therefore cease.

9. For patient screening, it will be adequate to send out automated forms, and patient telephone screening is not required. Our Front of House (FoH) Professionals should however identify potentially infectious people via the Patient Portal forms. Such patients cannot be permitted to attend appointments without a clinical triage by their dentist. Dr Adrian Jacques has spoken to the compliance team of the BDA on our behalf and has confirmed that automated risk assessment forms are acceptable, and that telephone triage is not needed.

10. Although the guidance above does indicate that we should not refuse to see COVID positive patients, please remember that most COVID positive patients will be self-isolating and would be concerned about breaking the law by travelling when they should be in quarantine. It would only be in a dire situation that they would be seeking assistance – pain, swelling, trismus, bleeding. A loose crown or bridge would not warrant a Covid positive patient to attend premises. We would only be doing the bear minimum and where possible on a non-AGP basis. We should bear in mind that circa 1 in 5 patients, particularly children are asymptomatic carriers of the disease, and we are presented with Covid positive patients in our midst every single day. We need to therefore apply the principles of Universal precautions.

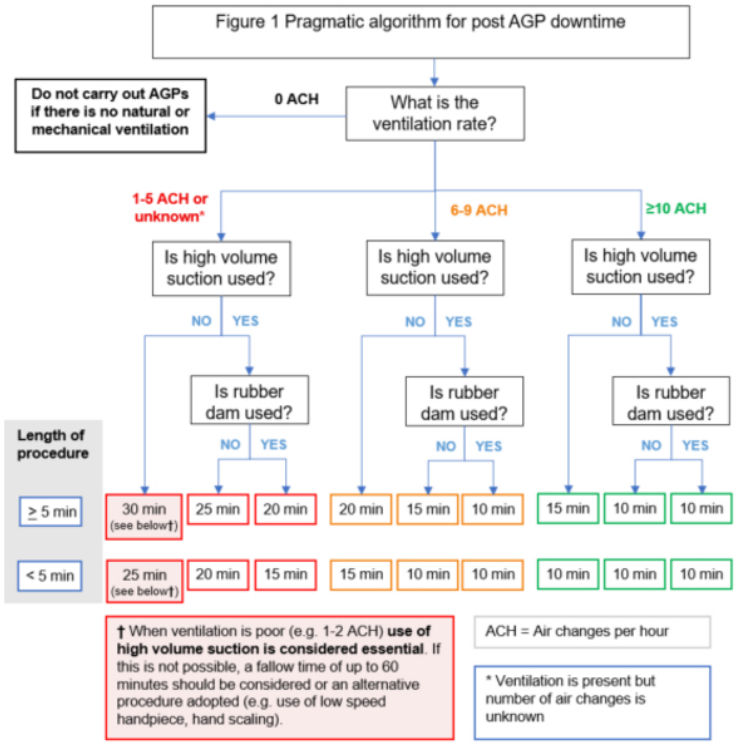
11. The ever-changing SOPs, and the burden of delayed care for patients and their demands will create an element of mental anxiety. All members of the team must recognise this and do all they can to support and protect the welfare and mental well-

being of their colleagues. PMs should identify anxious individuals with view to providing pastoral support by prevailing arrangements.

Fallow Time Considerations for Respiratory Pathway Patients

When undertaking an AGP, please follow the SDCEP post-AGP fallow time requirement as stipulated below which is dependent on-air changes per hour (ACH) in the treatment room. Within Antwerp Dental Group, each treatment room has been risk assessed on ACH according to room size and use of Dentair High UVC air scrubbers operating at 50% efficiency. For most rooms within ADG, the post AGP fallow time for respiratory patients will be 10 minutes.

https://www.sdcep.org.uk/wp-content/uploads/2021/04/SDCEP-Mitigation-of-AGPs-in-Dentistry-Rapid-Review-v1.2-April-2021.pdf



Please note – post AGP down-time will not be required when treating successive members of the same family who routinely live together (Sara Hurley).

Additional considerations for patients who are within 'respiratory pathway':

- Patients who have ANY respiratory symptoms should have non-urgent treatment deferred. This will include appointments such as exams, hygiene appointments, denture appointments, routine restorations etc

- Patients with respiratory symptoms who are in pain should receive a clinical triage by the dentist before being provided with an appointment. Such appointments need to be managed in a controlled manner so that these patients are spatially and temporally

separated from other patients who are in attendance to minimise cross contamination (preferably at the end of a day to minimise contact with others):

BDA interprets the 'SOPs' as: "Patients on the respiratory pathway whose treatment cannot be deferred should be segregated or isolated from other patients with two metres physical distancing to continue."

- Due to the requirements to self-isolate it is unlikely that there will be a high percentage of 'respiratory' patients attending, and therefore it is unlikely that their will be a significant 'end of day' burden

- The practices will operate a controlled transfer of 'respiratory' patients where such patients will wait in a car in a practice or adjacent public car park and be called in to minimise contact with other patients or staff. Clinicians and supporting nurses will operate a controlled transfer while wearing enhanced PPE, i.e.. Drape, FFP3 mask etc

UDAs - 85% NHS contract target

You will be aware that NHSE have now chosen to underwrite 100% of notional contract activity in return for achieving 85 % of pre-covid activity from the beginning of January. Each UDA will now be paid at 1.18 x historical value:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1462-key-steps-in-2022-to-deliver-for-patients-in-NHS-dentistry-december-2021.pdf

The relevant section from this document is appended:

"Between January and March 2022 clawback will not be applied to practices delivering at least 85% of contracted UDAs, reflecting the level many practices have already been delivering before the IPC changes and giving practices some contractual flexibility as they adjust to the new IPC. There will be no lower threshold in Q4, so that for delivery below 85% normal clawback will apply, although mitigating circumstances for underperformance will be taken into account through the exceptions process, which will remain in place, providing a safety net for practices."

As part of contract requirements, each practice contract is now required to see and support new patients who are are need of urgent dental care. We are no longer required to provide 'whole patient care' for these patients. Courses of treatment can be provided under the guidance 'Provision of Phased Treatments':

https://www.england.nhs.uk/publication/avoidance-of-doubt-provision-of-phased-treatments/

As of April 1st, 2022, contract delivery will be returning to 100% of contract targets, and there will be a culmination of easement of contract requirements.

Where practices are faced with 'exceptional circumstances' where contract delivery is inhibited by COVID related absence from December 1st 2021 to March 31st 2022, practices are able to make an 'exceptional circumstances' claim for consideration to enable a credit of UDAs:

https://bda.org/news-centre/latest-news-articles/Pages/England-Additional-exceptional-circumstances-announced.aspx

For retrospective claims to be considered for December 2021 such a claim needs to be logged on NHSBSA before January 31st 2022.

New Isolation Requirements

- Healthcare workers are required to self-isolate if they have a positive LFT test during usual biweekly testing. They are no longer required to take a confirmatory PCR test

- Healthcare workers can now end COVID quarantine after 5 full days if they are COVID-negative with rapid LFT devices when tested consecutively on day 5 and day 6 and do not have a temperature.

- For the avoidance of doubt, the morning of day 6 (after negative LFT) will the first day permitted to return to work as long as the previous LFT was performed 24 hours prior and was negative and the worker is medical fit and well

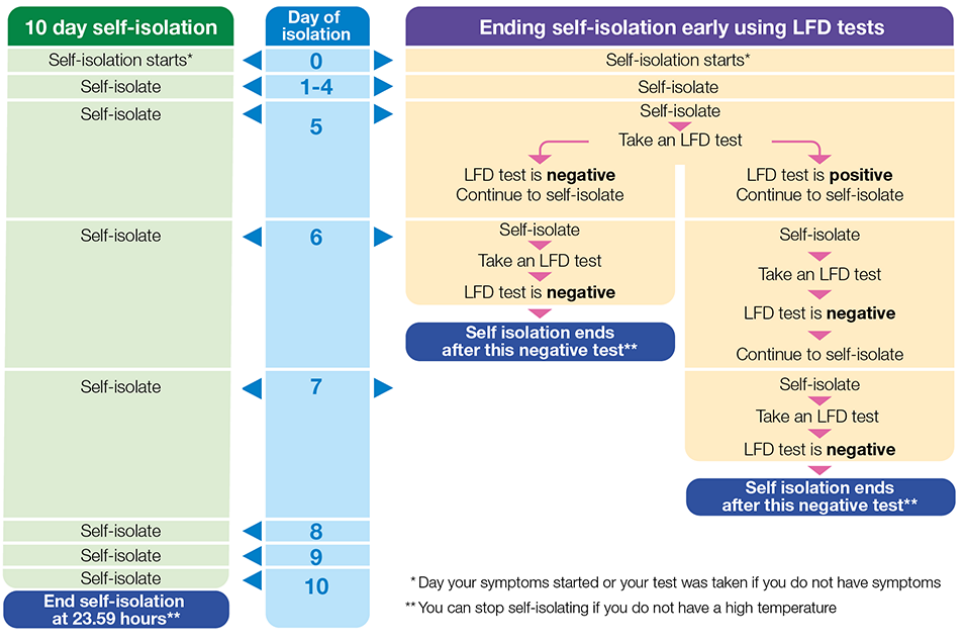
- For staff ending quarantine before Day 10, they are required to perform LFTs every day until Day 10 after they have returned to work

https://www.gov.uk/government/news/self-isolation-for-those-with-covid-19-can-end-after-five-full-days-following-two-negative-lfd-tests

- If the healthcare worker is not Covid negative after a rapid LFT on day 5 then they must continue to test daily, until two consecutive tests taken 24 hours apart confirm a negative covid status up to a maximum of 10 days

- For staff who continue to test LFT positive at Day 10, they must continue to isolate and continue to daily LFD test until a negative result or until day 14, when the requirement to test daily ceases and the staff member is permitted to return to work providing they are medically fit.

- It is worth noting a difference in SOPs when our staff are working as 'healthcare workers' and when at home as civilians. Even though healthcare staff are not permitted to return to the workplace on Day 10 if LFT positive, the 'stay at home' guidance is discharged at the end of a full 10 Days, and staff are allowed to leave their home at Day 10 unless they are symptomatic.



Mandatory Vaccination of all workers in Health and Social Care settings

The Health & Social Care Act 2008 Regulations 2014 was amended on January 6th, 2022, to enforce mandatory vaccination requirements for healthcare workers who engage in CQC regulated activity as a condition of deployment, unless they are medically exempt:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/01/C1545-update-vcod-for-healthcare-workers-phase-2-implementation.pdf

"…. unvaccinated individuals will need to have had their first dose of an approved COVID-19 vaccine by 3 February 2022 (this date is subject to change), in order to have received their second dose by the 31 March 2022 deadline. "

Clinical exemptions from vaccination:

https://www.gov.uk/guidance/covid-19-medical-exemptions-proving-you-are-unable-to-get-vaccinated

Individuals can claim clinical exemption from the requirement to have a COVID vaccination on the following grounds:

- A medical condition (your NHS COVID pass) needs to be endorsed with your medical exemption for you to be clinically exempt such as severe allergy, adverse reaction, autism, learning disabilities, combination of such impairments, end of life care
- You are taking part in a vaccination trial
- Temporary exemption due to pregnancy. A Mat B1 certificate can be used for self- certification for temporary exemption which expires 16 weeks after giving birth

ADG Practice Managers will now be seeking a medical exemption certificate from all healthcare workers who are unvaccinated. From April 1st, 2022, unvaccinated workers without medical exemption will not be permitted to work and will not be receiving any support pay, whether the worker is employed or self-employed.

Should there be any legal change to the position of mandatory vaccination in the Health and Social Care Act 2008, then we will of course relax mandatory vaccination requirement.

These SOPs, based on national guidance and law will supersede contractual provisions.

Resources and Key Standard Operating Procedures Reference Materials

.gov guidance on Coronavirus
https://www.gov.uk/coronavirus

Preparedness Letters
https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-dental-care/

Transition to Recovery: Dentistry's Standard Operating Procedures
https://www.england.nhs.uk/coronavirus/publication/dental-standard-operating-procedure-transition-to-recovery/

COVID-19 Infection Prevention and control dental guidance
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

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

Avoidance of doubt : provision of phased treatments
https://www.england.nhs.uk/publication/avoidance-of-doubt-provision-of-phased-treatments/

Infection Prevention and control for seasonal respiratory infections

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations

Stay At Home Guidance

https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Key Steps in 2022 to deliver for NHS Patients
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1462-key-steps-in-2022-to-deliver-for-patients-in-NHS-dentistry-december-2021.pdf

Mitigation of Aerosol Generating Procedures In Dentistry
https://www.sdcep.org.uk/wp-content/uploads/2021/04/SDCEP-Mitigation-of-AGPs-in-Dentistry-Rapid-Review-v1.2-April-2021.pdf

FGDP – Implications of COVID-19 for the safe management of general dental practice
https://dentistry.co.uk/wp-content/uploads/2020/10/FGDP-CGDent-Implications-of-COVID-19-for-the-safe-management-of-general-dental-practice-2-October-2020-v2.pdf

Deaths of people with their first positive test for COVID19
https://coronavirus.data.gov.uk/details/deaths?areaType=overview%26areaName=United%20Kingdom#card-deaths_within_28_days_of_positive_test_by_date_of_death

Exceptional Circumstances Claim from NHSBSA
https://bda.org/news-centre/latest-news-articles/Pages/England-Additional-exceptional-circumstances-announced.aspx