

# COVID-19 guidance and standard operating procedure

## Urgent dental care systems in the context of coronavirus

### Delay phase

**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.**

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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 – 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.

This guidance is applicable to the delay phase of COVID-19 pandemic management. Guidance, particularly in relation to risk assessment and service provision, is likely to be updated as the pandemic situation develops, depending on management phase and the evidence-based national approach.

We are grateful to 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.

## 2. Context for UDC systems

This section sets out the context in which local UDC systems will operate, including the background on the COVID-19 pandemic, general guidance for the public, and the key patient groups that need to be considered when developing care pathways.

### 2.1 Novel coronavirus pandemic

Novel coronavirus may be referred to as:

- severe acute respiratory syndrome coronavirus 2, SARS-CoV-2: this is the name of the virus
- coronavirus disease, COVID-19: this is the name of the disease.

The coronavirus pandemic has restructured the way that we live and work. We recognise the stress and worry that we are all going through: we are living in changing times. The prime minister's announcement on 23 March directs our entire population to stay at home and only go outside for food, health reasons or essential work.

The delivery of urgent dental care will be part of a co-ordinated response to COVID-19. Due to the escalating numbers of cases in England, and the burden that this is placing across the health system, we have to develop new ways of working between NHS 111, primary care, community services and secondary care. To most effectively meet the needs of our communities in this challenging time, we must deliver care differently now and plan for how we will best deliver care in the future. Local systems will need to determine how they can best work collaboratively, informed by key principles to protect the public, patients and staff.

## 2.2 Guidance for patients and the public

### 2.2.1 General information

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General information on measures the entire population should take is available [here](#). People are advised to stay at home unless they need to leave the house for food, health reasons, or essential work. Further guidance is available including information about COVID-19 and [how to prevent spread](#), and [what to do if people have symptoms](#).

### 2.2.2 NHS 111

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NHS 111 has an [online coronavirus service](#), running alongside its standard online service, which can provide advice to patients with an urgent health concern. Patients with possible COVID-19 are directed to NHS 111 online for health advice in the first instance. The NHS 111 telephone service should be used only when online access is not possible.

## 2.3 Key patient groups: summary

### 2.3.1 Patients with COVID-19 and symptoms of COVID-19

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Public Health England (PHE) has defined the current [case definition for COVID-19](#), and provided guidance on [testing and case reporting](#).

Most patients with COVID-19 will have mild symptoms and will be able to care for themselves at home. There will, however, be a significant number of patients who contract moderate or severe illness from COVID-19 requiring primary or secondary care input.

**Staff** who meet the case definition for possible COVID-19 will need to stay at home but can work remotely if they are well enough to do so. Plans for testing for NHS staff are outlined [here](#).

### 2.3.2 Patients at increased risk of severe illness from COVID-19

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Those who are at increased risk of severe illness from coronavirus (COVID-19) are advised to stringently follow social distancing measures. This includes anyone over 70, anyone under 70 who would qualify for a flu jab on health grounds, and pregnant women. Full guidance can be found [here](#).

### 2.3.3 Shielded patients: highest risk of severe illness from COVID-19

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Those at the [highest risk of severe illness from COVID-19](#) are advised to shield themselves and stay at home for 12 weeks.

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# 3. COVID-19: Guidance for local UDC systems

## 3.1 Introduction

As we are in the delay phase of the coronavirus pandemic, stringent measures have been put in place to prevent sustained transmission of COVID-19. As part of this, **the provision of all routine, non-urgent dental care including orthodontics has been stopped in England until further notice.**

Therefore, across every NHS region there is a requirement for delivery of robust and safe services through the provision of NHS regional urgent dental care (UDC) systems to provide care for urgent and emergency dental problems.

Each COVID-19 UDC system should deliver:

- **a clear local message for the public**, that routine dental care is not available during this delay phase of the COVID-19 pandemic and that advises them what to do if they have a dental emergency
- **a remote consultation and triage service** whose outcomes are:
  - advice, analgesia, antimicrobials where appropriate (AAA), or
  - referral, when absolutely necessary and treatment cannot be delayed, to a designated UDC site for a face-to-face consultation and treatment.

Any referral should specifically identify those patients who are shielded (those individuals at the [highest risk of severe illness from COVID-19](#) who are advised to shield themselves and stay at home for 12 weeks) and patients at increased risk, to inform the route for referral in line with local protocols.

- **a face-to-face consultation and treatment service** that should only be accessed following remote triage using a range of providers and locations



supported with appropriate personal protective equipment (PPE) for the clinical procedures (AGP, non-AGP) to be carried out at the site.

Aerosol generating procedures (AGP) should be avoided unless absolutely necessary.

Each local UDC system will involve provision of necessary face-to-face treatment at a number of specific, designated sites in a way that allows appropriate separation (through physical or temporal measures, eg zones, sessions/appointment times) and treatment of all patients.

When developing these sites and separation protocols, the following patient groups should be considered:

1. Patients who are possible or confirmed COVID-19 patients – including patients with symptoms (new, persistent cough or high temperature), or those living in their household:

As we are now in the sustained transmission phase of COVID-19, we need to consider that all patients may potentially have the virus. Therefore, for **all patients** attending any face-to-face consultation and treatment **at any UDC site**, it is important that there is adequate separation either physically or by spacing appointments to ensure that risk of potential contamination is reduced.

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. These should be aligned with local systems and protocols to support shielded patients.**

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, when developing the UDC sites, consideration should be given to the type of urgent dental care to be provided.

- Sites undertaking only non-AGP procedures will require Level 2 PPE.
- Sites undertaking AGPs will require Level 3 PPE.

- Sites delivering AGP and non-AGP will require Level 2 and Level 3 PPE.

The range of conditions provided for by local UDC systems are likely to include, but are not limited to:

- Life-threatening emergencies, eg airway restriction 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 cancer
- oro-dental conditions that are likely to exacerbate systemic medical conditions.

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 define and implement a system 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 the development of some specific and bespoke arrangements, for those who are being shielded.

## 3.2 Key principles for local UDC systems

- UDC systems will need to flex and adapt as the COVID-19 pandemic develops, approaches across the wider health sector change and the level of service provision varies.
- 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 arrangements. Particular consideration should be given to:
  - 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 UDC service standard

operating procedure (SOP) in Section 4 below. The pathway is illustrated in Appendix 2.

- In meeting patient needs, any service (general dental practice, community dental service, or secondary care provider and A&E) may be appropriate to provide care as part of the UDC system, depending on patient, urgent care needs, and PPE requirements. Consideration should be given to:
  - using established UDC service providers that are already part of the existing local integrated UDC system
  - patient separation requirements (physical or temporal) between or within services, taking into account the patient groups listed in Section 3.1: for example, the local separation approach for shielded patients or patients at increased risk
  - the selection of provider sites with regards to patient access in rural and urban areas: eg a general dental practice in a remote rural area may be designated to deliver a particular level of UDC provision to avoid patients travelling long distances to other UDC sites
  - appropriate opening hours that account for in-hours and out-of-hours access.
- In the preparedness letter of 25 March, all primary care dental services (general dental practices and community dental services) were asked to establish (independently or by collaboration with others) a remote urgent care service providing telephone triage for their patients with urgent needs during usual working hours, and wherever possible treating with advice, analgesia and antimicrobial means where appropriate. If the patient's condition could not be managed by these means, they would need to be referred to the appropriate part of the local UDC system for face-to-face consultation and treatment, as necessary.

**As systems develop, it may be that commissioners modify plans for remote triage provision in line with the wider co-ordinated system approach:** ie telephone triage and remote services may be provided by primary care dental services as per the original request, or as part of a co-ordinated approach in the local system (eg only certain services are asked

to provide this remote service, or a local dental helpline is used to centralise triage for the region or parts of it, or involvement of NHS 111).

- At a system level, access to telephone triage and remote services would be expected during in-hours and out-of-hours, as would normally be the case.
- Workforce redeployment is likely to 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.
  - Where there are no existing indemnity arrangements in place, [legislation](#) is now enacted to ensure indemnity is provided for clinical negligence liabilities arising from NHS activities carried out for the purposes of dealing with, or in consequence of, the coronavirus outbreak.
  - Service resilience and contingency planning should be considered with regards to potential staff absence due to sickness.
- During periods of widespread 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 at a UDC site, the site must have the appropriate PPE, as set out in Table 1 (further details on infection prevention and control and PPE are found in Appendix 3).

<b>Table 1: Personal protective equipment (PPE) for COVID-19 urgent dental care settings</b>			
	<b>Waiting room/reception</b>	<b>Dental surgery</b>	<b>Dental surgery</b>
	No clinical treatment	Non AGP treatment	Treatments involving AGPs
<b>Good hand hygiene</b>	Yes	Yes	Yes
<b>Disposable gloves</b>	No	Yes	Yes
<b>Disposable plastic apron</b>	No	Yes	No
<b>Disposable gown*</b>	No	No	Yes*
<b>Fluid-resistant surgical mask</b>	Yes	Yes	No
<b>Filtering face piece (FFP3) respirator**</b>	No	No	Yes
<b>Eye protection***</b>	No	Yes	Yes

\* Fluid-resistant gowns (or long-sleeved waterproof apron) must be worn during aerosol generating procedures (AGPs). If non-fluid-resistant gowns are used, a disposable plastic apron should be worn underneath.

\*\*If wearing an FFP3 that is not fluid resistant, a full-face shield/visor must be worn.

\*\*\*Eye protection ideally should be disposable. If polycarbonate safety glasses/goggles or equivalent are used, they should be disinfected in line with manufacturers' guidance.

- PPE has been ordered and supplied directly via PHE initially. Local consultants in dental public health have supported NHS regions with the ordering process. This process is subject to change as PPE delivery systems are developed.
- PHE has facilitated interim local fit-testing training for FFP3 masks where it has been requested. Fit testing can also be accessed via any appropriately trained personnel from other local sources, eg NHS trusts.

- Communications and referral information should be made available to all teams and providers in the local UDC system and be reflected in the NHS 111 pathways and dispositions.
- Clear information about UDC access and local arrangements should be made available to patients and the public.
- Clear information about UDC access and local arrangements should be made available to directory of services (DOS) teams and NHS 111 systems.
  - Dental services are asked to support this by informing commissioners of service status, as outlined in Appendix 4.
- 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](#).
- 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.

## 4. COVID-19: standard operating procedures for UDC services

The patient pathway for UDC is considered to have two broad stages – remote management and face-to-face management (see Appendix 2). As far as possible, patients should be managed remotely and exit the pathway at the end of this stage. Those patients who cannot be managed remotely will enter the face-to-face stage of the pathway.

As such, this standard operating procedure has been divided as follows:

1. SOP for remote management stage:
  - this SOP is applicable to all services providing urgent dental care (remote and/or face-to-face care) within the local system.
2. SOP for face-to-face management stage:
  - this SOP is applicable only to services receiving patients to provide urgent care face-to-face.

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

As well as the relevant SOP(s), dental service providers should also ensure they are undertaking the actions expected of all dental services as detailed at Appendix 4.

### 4.1 SOP for remote management stage

#### 4.1.1 Key principles

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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.
3. The service should use information and communications (eg telephone, website, text) to outline the appropriate UDC access arrangements for patients, discourage inappropriate access and attendance, and support efforts to prevent non-essential contact and travel.
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 3.1), urgency of dental problem and associated UDC needs.
  - Ensure early identification of shielded patients and patients at increased risk.
5. Wherever possible manage patients with urgent dental care needs remotely through the provision of advice, analgesia and antimicrobial means where appropriate.

If the patient's condition cannot be managed by these means, refer them to the appropriate part of the local UDC system for face-to-face consultation and treatment – for example:

- direct referral to a designated dental service providing face-to-face urgent care, which is suitable for the patient's needs (this may be the same service as the patient has contacted, or a different service)
- direct referral to wider parts of the integrated urgent care system, eg secondary care where necessary
- signposting to a local dental helpline.

Information about patient group and UDC needs will influence the destination the patient is referred to, and/or the time of their appointment, in line with local and service-level separation measures for face-to-face management.

#### 4.1.1.1 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](#) and may be downloaded for use as appropriate.
- For services that are not providing face-to-face care, where necessary the appropriate information should be displayed at service entry points to signpost patients who may turn up at the premises.
- For services that have been designated to provide face-to-face care, appropriate information should be displayed or provided to make clear which patient groups they are receiving, and to control entry to specific sites and areas, in line with care requirements.

#### 4.1.1.2 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 4.1.1.3), will be important in determining the patient management approach.

As part of risk assessment, the following questions should be included, in line with the case definition for possible COVID-19 and isolation requirements:

- *Do you have a new, continuous cough?*
- *Do you have a high temperature (37.8C or over)?*

- *Does anyone in your household have a new, continuous cough or a high temperature?*
- *If you or anyone in your household has tested positive for coronavirus, 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 have been informed of their shielded status by their GP.

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.

#### 4.1.1.3 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 deferred
  - if urgent dental care needs can be managed remotely (eg patient requires advice only)

- if urgent dental care needs cannot be managed remotely, whether management can be delayed; if it cannot be delayed, referral to the appropriate part of the local UDC system will be necessary
- if face-to-face management is required, the most appropriate place and time for the patient to be seen (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](#).

#### 4.1.1.4 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.
- Clinical records should be kept for remote patient consultation. Additionally, dental services must be able to identify and retrieve patient records developed as part of the COVID-19 UDC system for evaluation purposes.
- Based on risk assessment and triage outcomes, wherever possible manage patients who have contacted the practice with urgent dental care needs remotely through the provision of advice, analgesia and antimicrobial means where appropriate.
- 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. This can be found [here](#).
- The GDC has set out **guidance for remote consultations and prescribing** [here](#).

- 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 found [here](#).
- Further information around **considerations for analgesia** during the COVID-19 pandemic can be found at Appendix 6.
- Where applicable, manage patients in line with local approaches and arrangements for groups that are shielded or at increased risk (eg there may be a prescription delivery service rather than patients travelling outside of home to pharmacies). See Appendix 1.
- If the patient cannot be managed remotely and urgent clinical assessment and/or treatment is required, the patient should be referred to the appropriate part of the local UDC system.
  - Practice/services should familiarise themselves with any local signposting or referral arrangements in place to support this (eg specific referral procedures)

## 4.2 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 4.1, to promote remote management wherever possible, and in doing so reduce non-essential contact and travel and minimise cross-infection risk.

### 4.2.1 Key principles

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1. Ensure the SOP as outlined in Section 4.1 has been followed, to promote remote management and minimise face-to-face contact as far as possible.
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.
4. All UDC service providers should have clear protocols for patient care, noting the requirement for appropriate zoning and separation measures for all patients. Particular attention should be paid to 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 4.1.1.2 and 4.1.1.3) in case there are changes, the patient is unaware of their risk status, or the patient accesses a service inappropriately.
  - The service should only provide treatment for cases which it has been designated to receive (eg patients with possible/confirmed COVID-19 should not be accepted at facilities that have not been designated to treat cases). Where the service cannot accept a patient based on their risk status and/or care needs, that patient should be referred to the appropriate part of the local UDC system.
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 possible manage patients through advice, analgesia and antimicrobial means where appropriate.
    - If treatment is required, all equipment and materials for treatment should be assembled in surgery before beginning.
    - Aerosols should be avoided wherever possible.

- 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 local approaches and arrangements for the management of patients who are shielded or at increased risk (see Appendix 1).
  - Where domiciliary visits are necessary, these should be appropriately risk assessed and managed. Where patients are shielded or at increased risk, these visits should be organised in line with the principles of local protocols for these groups (see Appendix 1).
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 3.2, with further detail at Appendix 3.
  9. Prepare for incident management.
    - Resuscitation Council (UK) guidance on CPR and resuscitation in the context of COVID-19 is found [here](#).
    - Further detail on preparation for incident management for unwell patients with possible/confirmed COVID-19 is provided at Appendix 7.

#### **4.2.1.1 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.
  - During the remote management stage, if patients plan to travel to the UDC service by car, they may be advised to wait in their car until the time of their appointment.



- On entering the building, all visitors to the UDC service should be told to wash their hands or use hand sanitiser
- 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 few staff as possible should be allocated to see patients, particularly those shielded, to minimise contacts without compromising the safe delivery of care.
- If face-to-face 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](#).

#### 4.2.1.2 Patient management: clinical approaches

- 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. This can be found [here](#).
- The GDC has set out **guidance for remote consultations and prescribing** [here](#).
- The **dental antimicrobial stewardship toolkit** can be found [here](#).
- Further information around **considerations for analgesia** during the COVID-19 pandemic can be found at Appendix 6.
- 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](#).

#### 4.2.1.3 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).
- Useful contacts:
  - Find your NHS regional infection prevention and control team: search ‘infection prevention control + your NHS region’
  - Find your local PHE health protection team [here](#)

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

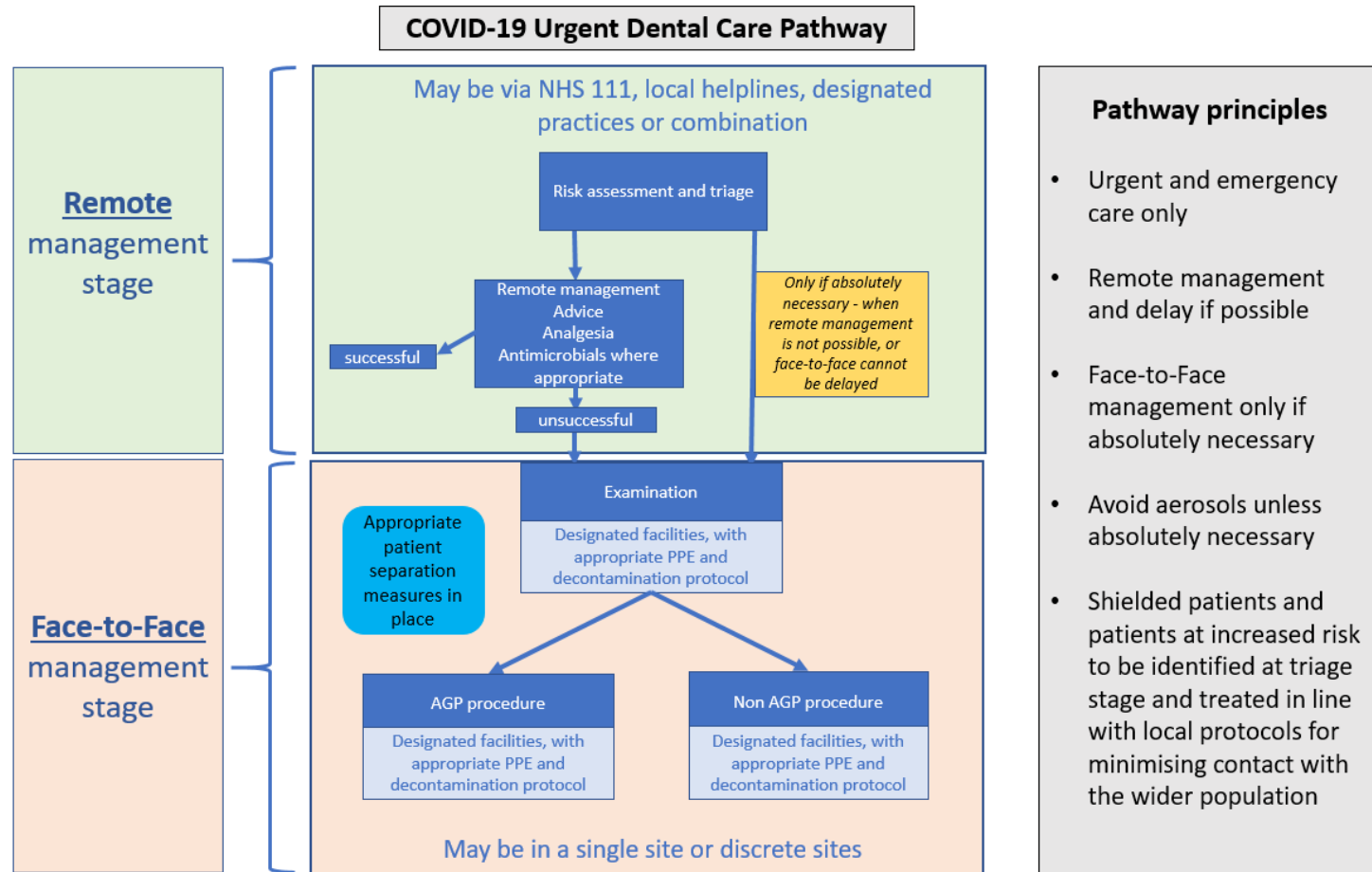
Primary, community and secondary care services will be working in new ways to shield those at most risk of severe illness from COVID-19, protect those at increased risk, and manage the ongoing health and care needs of both groups. For example, dedicated home visiting services may be set up as part of some local healthcare systems. Dental services should align with local approaches as appropriate. These patient groups should not come into contact with others or attend dental settings unless absolutely necessary.

- As far as possible, the management of these patient groups should be carried out remotely and invasive treatment delayed.
- Where remote management is not possible, dental teams should align with any local arrangements for shielded patients or patients at increased risk when providing face-to-face care.
  - 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).
  - Where a domiciliary visit is not possible or inappropriate, access to a designated UDC provider that can deliver care in line with the patient's specific needs will be required. The provider site chosen must have appropriate measures in place to separate patients from possible COVID-19 cases (eg they do not receive possible/confirmed 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: Guidance for infection prevention and control in urgent dental care settings

## 1. Background

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**The evidence base on COVID-19 is rapidly evolving. Further updates may be made to this guidance as new detail or evidence emerges.**

This section outlines the infection prevention and control advice for dentists and the dental team involved in the provision of urgent dental care for patients who are possible or confirmed case of COVID-19 or whose COVID-19 status is unknown. It is based on the best evidence available from previous pandemic and inter-pandemic periods and is considered good practice in response to this COVID-19 pandemic.

This is a summary of the current [infection prevention and control](#) guidance on personal protective equipment which contains full details and should be read by dental teams. This summary puts some of the content into a dental context for urgent dental care.

## 2. Patient placement/assessment for infection risk

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Patients must be triaged/assessed for infection risk to ensure they are directed to the correct urgent dental care site for treatment.

Whenever possible, patients should be treated with advice, analgesia and antimicrobials where appropriate.

### 3. Clinical settings and care requirements

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Waiting rooms and reception areas should allow for 2 metre separation. The care environment should be kept clean and clutter free. All non-essential items including toys, books and magazines should be removed from reception and waiting areas.

Urgent dental care falls into two categories depending on whether the treatment includes aerosol generating procedures (AGPs) or not. AGPs should be avoided where possible.

#### Standard infection control precautions

All urgent dental care centres will follow standard infection control precautions (SICPs) necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources. In dental settings, there is guidance from HTM01-05 and NICE describing infection prevention and control measures that should be used by all staff, in all settings, always, for all patients.

#### Transmission-based precautions

In addition to SICPs, transmission-based precautions (TBPs) are applied when SICPs alone are insufficient to prevent cross-transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent and are classified based on routes of transmission:

- **Contact precautions:** used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment. This is the most common route of infection transmission.
- **Droplet precautions:** used to prevent and control infection transmission over short distances via droplets ( $>5\mu\text{m}$ ) from the patient to a mucosal surface or the conjunctivae of a dental team member. A distance of approximately 1 metre around the infected individual is the area of risk for droplet transmission which is why dental teams routinely wear surgical masks and eye protection for treating patients.
- **Airborne precautions:** used to prevent and control infection transmission via aerosols ( $\leq 5\mu\text{m}$ ) from the respiratory tract of the patient directly onto a

mucosal surface or conjunctivae of one of the dental team without necessarily having close contact.

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

### **Staff considerations, hand and respiratory hygiene**

Hand hygiene, washing thoroughly with soap and water, is essential to reduce the transmission of infection. All dental staff and patients/carers should decontaminate their hands with alcohol-based hand rub when entering and leaving urgent dental care services. See Figures 1a and 1b below.

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

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

Any procedures should be carried out with a single patient and only staff who are needed to undertake the procedure present in the room with the doors shut. Dental care professionals working in urgent care settings should be trained in all aspects of infection prevention and control (IPC) and fully familiar with HTM01 05 for decontamination.

Training should include donning (putting on) and doffing (taking off) PPE. See Figure 2 below.

Cleaning staff should also be trained in IPC measures.

### **Personal protective equipment**

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



- 1. Non-AGP treatment** of all patients involves compliance with standard infection control procedures. This will ensure there is no contact or droplet transmission of COVID-19. Eye protection, disposable fluid-resistant surgical mask, disposable apron and gloves should be worn.
- 2. For all AGPs**, to prevent aerosol transmission, disposable, fluid-repellent surgical gown (or waterproof long-sleeved protective apron), gloves, eye protection and an FFP3 respirator should be worn by those undertaking or assisting in the procedure.

Urgent care, including examination, taking radiographs, using hand instruments, extractions and suction, are not classed as AGPs so universal precautions should be used for these.

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

Risk reduction of droplet contamination can be undertaken by using high-speed suction and use of rubber dam.

**All AGPs should be avoided at this time unless essential and only used for urgent and emergency care.**

High-speed dental drills are accepted as AGPs. 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 enhanced PPE.

Particular care should be taken to avoid surgical extractions at this time. Where it is necessary to remove bone, **slow handpieces** should be used with irrigation to reduce the risk.

The use of **3-in-1 syringes, ultrasonic scalers or other pieces of dental equipment** powered by air compressor should be avoided at this time and should not be the only reason to wear an FFP3 mask. If, however, they are used as an adjunct to treatment with high-speed drills, staff will already have donned PPE for AGPs.

**This guidance is based on the UK approach to PPE set out [here](#)**

Table 1 shows the application of the guidance to the UDC setting.

<b>Table 1: Personal protective equipment (PPE) for COVID-19 urgent dental care settings</b>			
	<b>Waiting room/reception</b>	<b>Dental surgery</b>	<b>Dental surgery</b>
	No clinical treatment	Non AGP treatment	Treatments involving AGPs
<b>Good hand hygiene</b>	Yes	Yes	Yes
<b>Disposable gloves</b>	No	Yes	Yes
<b>Disposable plastic apron</b>	No	Yes	No
<b>Disposable gown*</b>	No	No	Yes*
<b>Fluid-resistant surgical mask</b>	Yes	Yes	No
<b>Filtering face piece (FFP3) respirator**</b>	No	No	Yes
<b>Eye protection***</b>	No	Yes	Yes

\* Fluid-resistant gowns (or long-sleeved waterproof apron) must be worn during aerosol generating procedures (AGPs). If non-fluid-resistant gowns are used, a disposable plastic apron should be worn underneath.

\*\*If wearing an FFP3 that is not fluid-resistant, a full-face shield/visor must be worn.

\*\*\*Eye protection ideally should be disposable. If polycarbonate safety glasses/goggles or equivalent are used, they should be disinfected in line with manufacturers' guidance.

### **Filtering face piece (FFP3) respirators for aerosol generating procedures**

FFP3 respirators must be:

- fit-tested on all healthcare staff who may be required to wear an FFP3 respirator to ensure an adequate seal/fit according to the manufacturers' guidance
- fit-checked (according to the manufacturers' guidance) by staff every time an FFP3 respirator is donned to ensure an adequate seal has been achieved

- compatible with other facial protection used – ie protective eyewear – so that this does not interfere with the seal of the respiratory protection; regular prescription glasses are not considered adequate eye protection
- disposed of and replaced if breathing becomes difficult, the respirator is damaged or distorted, the respirator becomes obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained; in effect this may mean that FFP3s may be worn once for dental AGPs and then discarded as clinical waste (hand hygiene must always be performed after disposal)
- shielded from ‘splatter’ in situations where FFP3s are used for a ‘session’ with a fluid resistant surgical mask or visor to protect the respirator from droplets; a session ends when the healthcare worker leaves the care setting/exposure environment; sessional use should always be risk assessed; PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
- FFP3s should be removed outside the dental surgery where AGPs have been generated in line with doffing protocol.

## Decontamination

Decontamination following treatment should follow HTM01 05

**In addition, when an AGP has been used**, it is recommended that the room is left vacant with the door closed for 20 minutes in a negative pressure isolation room or **one hour for a neutral pressure room** before performing a terminal clean.

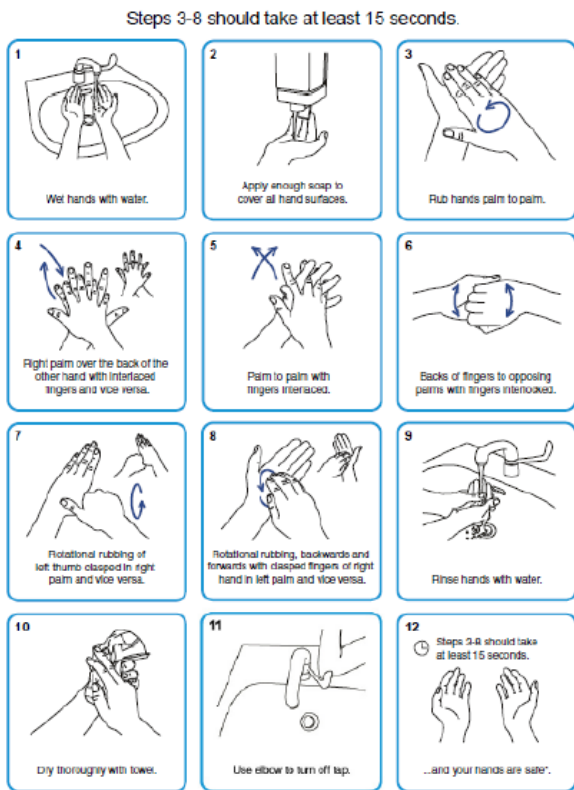
Windows to the outside in neutral pressure rooms can be opened. If the room needs to be put back into use urgently, then it is recommended that the room is cleaned as in the guidance below.

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/reducing-the-risk-of-transmission-of-covid-19-in-the-hospital-setting>

**Figure 1: Hand hygiene**

*1a: Best practice – how to hand wash*

*1b: Best practice – how to hand rub*



\*Any skin complaints should be referred to local occupational health or GP.



Guidance on putting on (donning) PPE for aerosol generating procedures (AGPs), and a video showing how to safely don (put on) PPE specific to COVID-19 for AGPs and which should be used in conjunction with the quick guide to donning PPE and local policies - can be viewed [here](#).

**Figure 2: Best practice – donning and doffing PPE**

**Quick guide** COVID-19

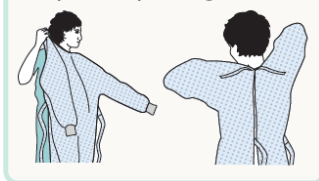
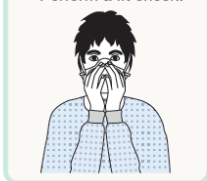
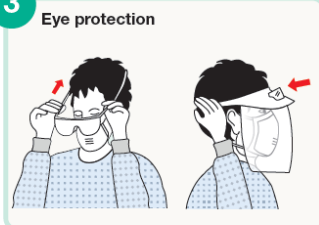

Public Health England **Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)**

This is undertaken outside the patient's room.

**Pre-donning instructions**

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

**Perform hand hygiene before putting on PPE**




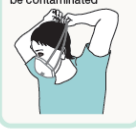

- 1 Put on the long-sleeved fluid repellent disposable gown**  

- 2 Respirator**  
Perform a fit check.  

- 3 Eye protection**  

- 4 Gloves**  


**Quick guide** COVID-19

Public Health England **Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)**

PPE should be removed in an order that minimises the potential for cross contamination.

**The order of removal of PPE is as follows:**

- 1 Gloves –**  
the outsides of the gloves are contaminated  
  
Clean hands with alcohol gel
- 2 Gown –**  
the front of the gown and sleeves will be contaminated  

- 3 Eye protection –**  
the outside will be contaminated  

- 4 Respirator**  
Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated  

- 5 Wash hands with soap and water**  


# Appendix 4: Actions for dental services

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

## **Appointing a COVID-19 lead**

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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**

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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 cases, household contacts, staff who should be shielded, or those at increased risk, away from work.
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.

## **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**

Staff who have been exposed to someone with symptoms of COVID-19 in healthcare settings, even if not using adequate PPE, do not need to stay at home **unless** they develop symptoms.

### **Staff at increased risk from COVID-19**

The government has issued [guidance](#) about stringent social distancing and shielding for vulnerable groups at particular risk of severe complications from COVID-19. Staff who fall into these categories should not see patients face to face, regardless of whether a patient has symptoms of COVID-19 or not. Remote working should be prioritised for these staff.

### **Staff support and wellbeing**

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

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

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

The following **learning resource** is available to staff:

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. [More details here](#).

## **Informing the public and commissioners of service status**

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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.

These measures are necessary for both practices/services providing remote care only, as well as those designated to receive patients. 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**

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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

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- 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. Supportive additional information

We will 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 follow these Twitter accounts to keep up to date:

- NHS England and NHS Improvement: @NHSEngland
- Department for Health and Social Care @DHSC
- Public Health England @PHE\_uk.

# Appendix 5: Remote prescribing protocol

## Remote prescribing

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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.

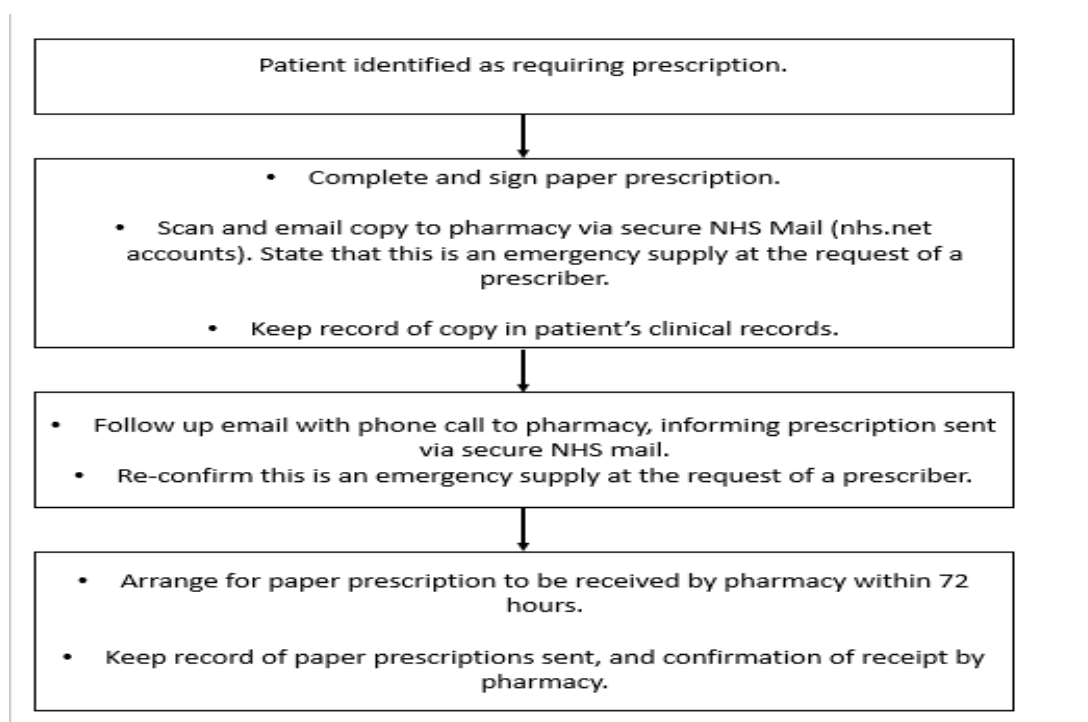
The law allows for pharmacies to supply urgent medicines at the request of the prescriber, under the condition that the prescriber must supply the pharmacy with a paper prescription within 72 hours of the request. The pharmacist must be satisfied that a remote request is from a dentist and that the dentist 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

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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

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### 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.

### **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.

# Appendix 6: Considerations for analgesia

Regarding analgesia, please find the latest information regarding ibuprofen use and COVID-19 [here](#).

- The evidence is currently being reviewed. However, patients who are possible/confirmed cases, and their household contacts, should take paracetamol in preference to ibuprofen.
- Where appropriate, liaise with GP/medical and pharmacy colleagues for queries regarding analgesia for patients.

# Appendix 7: 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](#).
- 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 8: Feedback

This is a dynamic document that will be reviewed as the situation changes and will respond to evidenced feedback and identified lessons.

Feedback should be given in the template below and sent to [england.spocksh@nhs.net](mailto:england.spocksh@nhs.net). Subject line for your e-mail: COVID-19-PRIMARY-CARE-SOP-FEEDBACK; **add** your organisation and your initials.

COVID-19 standard operating procedure V2 – March 2020 Primary care – general practice							
No	Name	Represented organisation	Observation and comments			Suggested amendments	Rationale for proposed amendment
			Page and section number	Original text	Comments		
1							
2							
3							
4							



