Dear Dental Council Staff, Board members and advisory committee

Thank you for the opportunity to comment on the **Draft Infection Prevention and Control Practice Standard:** Supplementary risk management principles for oral health during the COVID-19 pandemic.

I appreciate the work that the Dental Council and their advisory committee has undertaken to describe the appropriate way for oral health services to continue during the COVID-19 pandemic. I also appreciate your efforts to ensure that new guidelines in place in advance of the Government's new traffic light system going live. Oral health practitioners require as much notice as possible of changes to guidelines in order to plan their appointment book and ensure they have the correct PPE in stock.

My concerns about the proposed new risk management principles relate to the provision of oral health services to children under 12 years.

Currently, children under 12 years are not eligible to be vaccinated. Figure 3 on page 8 of the discussion document outlines the risk-based precautions. As children under 12 are not able to be vaccinated they fall into the moderate risk category within these guidelines. This then requires the use of N95 masks and room stand downs for all procedures (except for multi-chair clinics!). This is simply not manageable for services which treat predominantly or exclusively children. It would effectively have us working under stricter protocols than we were during level 3 lockdown (where a distinction was made between aerosol-generating procedures and those that did not generate an aerosol).

While the stand down time can be reduced by improving the number of air exchanges, there are significant costs involved in achieving this, and there is a delay while air conditioning companies etc work through the hundreds of practices needing to make these changes. Improvements in air exchanges cannot be achieved particularly quickly or easily for some practices.

The cost of using full PPE is significant as we know. We understand that one paediatric dental practice is charging a surcharge of $38.50 to cover the cost of full PPE – this becomes an additional barrier to accessing specialist treatment during a time when publicly-funded dental services are really struggling.

Another thing to consider is the number of support people able to attend with a child patient. In my practice we ask for just one parent to come, and

for other children not to come unless they have an appointment with me also. This is very difficult for some families to achieve when there is no-one available to look after any sibling(s) the child patient may have. This is especially the case for families needing to travel up to 6 hours return for specialist paediatric dental care. Where complicated treatment plans are to be discussed (e.g treatment under general anaesthetic, management of hypomineralised first permanent molars, partial anodontia etc) often the parent themselves likes to have a support person with them (often another parent, grandparent, auntie or uncle).

I have noticed that the parents of some special needs children have mask exemptions, presumably to facilitate better communication with their child. These adults often decline to wear a mask in the dental setting as well as out in the community. If a parent/caregiver refuses to wear one of our masks when offered to them do we have to turn the child away?

The fact that stand down times don't apply for multi-chair clinics but do for single chair surgeries when treating children under 12 seems to be a real anomaly. Is this intended to be an exemption for Community Oral Health Services, Hospital Clinics and teaching institutions (which will also assist open plan practices undertaking predominantly orthodontic treatment)? Such an exemption however would not apply for oral health therapists, dentists and dental specialists treating children in community dental practices? It really doesn't make sense as the risks are clearly higher for multi-chair clinics than single surgeries with a closed door.

Children deserve to access the oral health services they require in a timely fashion. I would like to suggest that for children under 12 years, who due to no fault of their own are unable to be vaccinated, that their parent/caregiver is used as a proxy for determining the patient's COVID risk status. For example if the parent is able to present a valid My Vaccine Pass and/or a negative COVID test, then the child should be treated as low risk. The PCR test is not particularly well tolerated by children, especially those presenting to hospitals or private practices for specialist care (i.e. medically compromised, special needs and/or anxious children).

Using the parent as a proxy would allow paediatric dental services to continue in a more efficient manner, preventing a further backlog of children waiting for oral examinations and treatment, within both public and private settings.

Thank you for taking the time to read and consider my submission.

Yours sincerely

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