On behalf of the Auckland Regional Dental Service as part of Waitematā District Health Board:

Thank you for the opportunity to provide feedback on the proposed addition to the Dental Council's Infection and Prevention Control Practice Standard, the Supplementary risk management principles for oral health during the COVID-19 pandemic.

Whilst recognising the importance of the Infection Prevention and Control measures that have been required to be put in place during the COVID-19 pandemic, existing inequities in oral health and access to care continue to be exacerbated through the pandemic because of imposed restrictions to care, especially in Auckland. With the rolling out of the traffic light system of the New Zealand COVID-19 Protection Framework, it is pertinent to focus on reducing inequities and removing barriers to accessing dental care. As the Ministry of Health states "*access to health care is a fundamental right. The legislation will be very clear that access to essential services, including healthcare services, cannot be restricted based on vaccination status*". "*The management of unvaccinated individuals through an alternative pathway is highly likely to negatively impact access to care which must be balanced by a demonstrable benefit. Children form a large group of individuals who are unable to (be) vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care*."

Children are currently unable to be vaccinated, while some adolescents, especially those from the most vulnerable communities, would still be dependent on parent/caregiver consent and support to be vaccinated and have access to a vaccine pass.

Keeping this in mind, the Auckland Regional Dental Services proposes the following measures to consider:

1. Ready access to the vaccination status of adolescents and eligible children via a central portal.

AND

In order to facilitate access to dental services for the entire 0-17 year old population:

2. Removal of the room stand down time requirement for all 0-11 year olds seen in a single room with a door for all procedures. If a stand down time is not required in a multiple chair clinic for 0-11 year olds for any procedure, the removal of the stand down time for this same age cohort could be extended to include all appointments in a single room with a door for any procedure. This could be taken a step further by removal of the room stand down time requirement for all 12-17 year olds also, seen in a single room with a door for all procedures.
3. Extension of the permitted use of multiple chair clinics for 0-11 year olds to include 12-17 year olds also, and associated removal of the room stand down time requirement in multiple chair clinics.

Unimpeded access to our New Zealand public funded dental services for children and adolescents under the age of 18 is paramount for young people to obtain optimal oral health before reaching their adulthood.
The majority of facilities for public funded dental services that are strategically located for easiest access to the most vulnerable populations (fixed COHS clinics in schools and mobile facilities for children / adolescents), have an open plan model, and do not currently meet the ventilation criteria that would enable application of the minimum stand down time.

Categorizing all under 12s, and all unvaccinated (or unable to be proved vaccinated) under 18 year olds to the restrictions of the moderate risk pathway will certainly affect ready access to dental care: namely by the requirement of over 12s to be seen in a room with a door for all procedures, and by the associated requirement of a stand down time for any moderate risk patient who receives any category of dental care in a room with a door.

Vaccination status access:

In the Community Oral Health Service (COHS) we have a model of enduring consent in order to ensure that all enrolled children can receive a basic level of care with examinations, radiographs and preventative care not requiring repeated consent. One of the additional challenges of equitable access for our vulnerable child population during the Covid-19 era has been the requirement to pre-screen for Covid-19 risk before we can examine the child, negating the benefit of enduring consent since families do not always readily respond to our attempts to contact them. As a result certain children may not even be able to be examined or receive preventative treatments since we are unable to make contact with the parents.

If we are also required to ascertain vaccination status for the 12-17 year olds (and in the future children, once eligible to be vaccinated), this will add another layer of challenge for young people to access dental services. Not all vaccinated children in the more vulnerable populations will themselves have ready access to either a digital or paper vaccine pass, and as above, caregivers do not always readily respond to our attempts to contact them.

*Ready access by health care providers to a central NHI database with vaccination status will assist in this, and should be considered.

Inclusion of examinations and non AGPs requiring a post treatment stand down time for the Moderate COVID-19 risk group:

It is understood that the post-treatment stand down requirement is now based on patient Covid-19 risk status rather than being based on procedures received, due to consideration of the more pertinent risk of Aerosol Generating Behaviours. However, for the Moderate risk group this now means that any examination, or NON AGP such as an extraction, will now require a longer stand down time than for an AGP. This is because since unlike during an AGP such as a restorative procedure or ultrasonic scaling, no rubber dam or HVE is actually required / appropriate during these procedures and therefore the stand down time can't be reduced by these measures. This would considerably impact service provision and associated equity of access in the New Zealand Community Oral Health Service until all premises have ventilation upgraded, with a stand down time of 60 minutes likely to be required after each exam / non AGP.

This will especially impact our 12-17 year old cohort in the community oral health service, if unvaccinated or unable to prove vaccination status, since the multiple surgery stand down time exemption does not apply over the age of 12.

The stand down time requirement for all moderate risk patients regardless of procedure will also impact any child under 12 treated in a single surgery with a door, whether treated within the Community Oral Health service or on referral under the SDS scheme to a contracting dentist, with the same potential stand down time of 60 minutes after an examination or non AGP. Therefore, as an example, a young three year old pre-schooler examined in a single room with a door at any facility, would necessitate a potential stand down time of 60 minutes in an inadequately ventilated room.

*Consideration may be required for a risk mitigation stand down time reduction for the Moderate risk birth to 17 age group cohort after an examination or non-AGP in a single room with a door in order to balance the IPC requirements with the effect on service provision.
*Or more radically, consideration may be required to remove all stand down time requirements for all procedures for the birth to 17 age group when dental care is received in a single room with a door, in order to facilitate access to dental services.

Requirement for single room with door for over 12 moderate risk patients for all procedures:
All patients over the age of 12 who are unvaccinated or for whom we are unable to ascertain vaccination status (i.e. a significant proportion of the 12 -17 age cohort in the more vulnerable populations) are now categorized as Moderate risk. All Moderate risk patients over the age of 12 now require treatment in a single room with door closed for all procedures including examinations and even non AGPs. This Moderate risk group over the age of 12 are not included in the multiple surgery room requirement exemption.

In the COHS the majority of facilities are open plan, whether fixed facilities or transportable dental units; NB this would also impact the adolescent mobile providers. Whilst building work can be carried out to remedy this, this will be a long term financial and operational project nationally.

In the mean time there will be a significant impact on access to dental services for the over 12 years old child population because of this "single room with door requirement" even for examinations and simple dental procedures.

*Consideration may be required for removal of the requirement for all patients over the age of 12 who are unvaccinated or for whom we are unable to ascertain vaccination status to receive all dental care in a single room with a door, and to allow them to receive dental care in a multiple chair clinic.

Additional Questions for clarification by DCNZ:

1. What is the definition of a 'low risk' support person for a multiple chair clinic, and what would the IPC recommendation be for a support person who has to be in the room with the child but whose vaccination status cannot be confirmed?
2. Please clarify if people with a vaccine exemption who can get a "My vaccine pass" can be treated as 'low risk' if asymptomatic. If *yes*, please clarify why asymptomatic children who are not eligible to be vaccinated are required to be treated as 'moderate risk'. https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/my-covid-record-proof-vaccination-status/covid-19-vaccine-exemptions-and-certificates
3. Is there the capacity for removing the stand down time *in between* sequential appointments for members of the same family, as per the *UK COVID-19: infection prevention and control dental appendix,* updated 24/11/21.

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Please note that this is a submission from the Auckland Regional Dental Service as part of Waitematā District Health Board and not a personal submission.

Regards
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Auckland Regional Dental Service, Waitematā DHB

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