Page 2: Your information

Q1

Your details

First name	**Philip**
Surname	**Sussex**
City/town	[redacted]
Email	[redacted]

Q2 **dentist or dental specialist**

Your submission is in the capacity as

Page 3: Name of company/organisation

Q3 **Respondent skipped this question**

Name of company/organisation

Page 4: Your Person ID number

Q4

Please add your Dental Council Person ID registration number

[redacted]

Page 5: Please provide your feedback by responding to the following question

Q5

Do you support the proposed Supplementary risk management principles for oral health during the COVID-19 pandemic? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.

No

Q6

Please share any comments you have below:

The statement that "Stand down time is required for only high and moderate risk patients, irrespective of the care provided" is at variance with both the NHS guideline cited in Acknowledgements and the SDCEP rapid review also cited. The UK approach is very clear that a room stand down period is only required after a very limited range of Aerosol Generating Procedures (AGPs) - there is simply no justification for room stand down when no AGP has been performed.

The guidelines as they stand will have significant negative dental public health outcomes which will disproportionately affect Maori and vulnerable children who are more at risk of dental caries across Nelson Marlborough. This is because all of our high risk children are seen for 6 monthly, 15 minute fluoride varnish appointments. According to the guidelines, because children cannot be vaccinated they will all now be considered Moderate Risk necessitating a 15 minute appointment followed by a 25 minute room stand-down period. As Clinical Director, I will have to suspend our entire Fluoride Varnish program because our DHB simply doesn't have the clinic capacity for this approach and I will have to re-prioritise the clinic time I have away from prevention and into treatment. Similarly, all our other non-AGP appointments will also need room stand down periods and this makes no sense. For example a 15 minute appointment to place a rubber separator ring (a very low risk, non AGP procedure) will now need a 45 minute booking as will the appointment for the subsequent Hall Crown.

Ironically, if we were in a DHB with multi-chair clinics there is an exemption within the new guidance regarding the need for room stand-down. DHBs like ours with single clinics will be severely disadvantaged and experience rapidly growing arrears - perversely there is now an incentive to create more of the less safe multi-chair clinics.

I would also suggest that the requirement to change a fabric gown, wear and plastic apron or full length single use gown is also not required for non-AGP procedures. There is a huge environmental impact from this decision which has no clinical justification.

The new guideline fails to link to the MoH traffic light system which has varying responses, based on local rates of Covid-19 community transmission – instead it represents a one size fits all national approach and appears to be out of step with the Ministry of Health. This will result in an unjustifiably cautious approach being taken in areas of New Zealand when there is no community transmission (both now and in the future when the pandemic begins to wane).

As a dental public health specialist I am extremely concerned about the unintended consequences this practice standard will have both for children and adults, as private practitioners are forced to pass on the costs relating to unjustified room stand down periods in particular.

Thank you for considering my submission.

On further reflection I note that there are considerable downstream adverse impacts for Maori and vulnerable populations arising from the draft guidelines because of the barriers to care that are created.

The increased cost of dental care for groups who already struggle to afford it will be a significant additional barrier to care – in private practice this is likely to be in the form of a surcharge applied to appointments for unvaccinated patients when a room stand down is required. With Maori vaccination rates much lower than non-Maori they will be disproportionately impacted. Over time these significant infection control costs are likely to be incorporated into prices generally (as happened in New Zealand in the late 1980's after infection control standards changed).

In reality however, the guidelines are structured in such a way that the only rational approach will be for providers to only offer care to fully vaccinated patients or those with a negative Covid-19 test in the past 72 hours. This has significant resource implications for laboratory testing in NZ and is likely to cause huge anxiety for parents and children given nasal PCR testing is at this time the only widely available test. Given every unvaccinated child and adult will likely be required to have repeat Covid tests for each and every dental appointment, has DCNZ had this approach endorsed by the Ministry of Health? **I believe that in the absence risk factors established during screening, all children 12 years of age and under should be managed as per the Low Risk pathway (at least for non-Aerosol Generating Procedures).**

Furthermore, if implemented, these guidelines will lead to the routine Covid-19 testing of all asymptomatic unvaccinated patients and this is out of step with what is required for out-patients in New Zealand hospitals at present. All of the DCNZ 'Moderate Risk' patients would be 'green streamed' in our DHB. They would be seen in ED or Outpatients with staff employing standard PPE of surgical masks and eye protection only - no single use gowns, no prior Covid-19 testing and no room stand down requirements. Key to this approach is appropriate front door screening.

Given such policy will disproportionately disadvantage Maori and potentially breach Treaty of Waitangi Crown obligations, these guidelines must be grounded in science and subject to appropriate scrutiny. Room stand-down requirements for non-AGP procedures are not evidence based and are at variance with the very NHS UK guidelines which DCNZ reference. Having to stand down every community oral health dental clinic in our DHB for 25 minutes between every patient will result in us treating considerably less than half the normal number of patients. It is absolutely not equitable with other areas of the country who are using multi-chair clinics and have been granted an exemption to this requirement. The alternative of requiring Covid-19 testing of small children before each and every dental appointment is in my opinion unrealistic, and if implemented, will be another very real barrier to care particularly for vulnerable groups.

I believe that an independent infectious diseases expert and medical microbiologist such as Dr Richard Everts at Nelson Hospital should be asked to rapidly review these guidelines to help get the balancing of risk right.

Thank you for considering my second submission