Questions and Comments for the CDO from Morgannwg LDC

Questions

1. Bearing in mind the constraints still existing and the fact that they are likely to be in place for some time, perhaps with some easing, it would be good to get your views on how you see:

   - Demand for treatment going forward.
   - The capability within the system to meet the demand.
   - The activity within the system.
   - The queue – previous demand that has not been met.

   Furthermore

   - How will these things be affected by number of surgeries being available?
   - How will these things be affected by productivity limitations of the current SOP?
   - How will these thinks be affected by number of dentists and operating DCPs being available?
   - What is your vision for recruitment and retention going forward?

2. Would it be possible to raise a question regarding the courses of treatment being used as a practice performance indicator i.e., the % that is being compared to courses of treatment from pre-pandemic - the 35% figure was mentioned in the first CDO letter with an expectation for it to rise - it seems to be the figure the BSA were issuing to practices a month or so ago - the more recent CDO letter did not seem to expand on this.
   It would be useful to know for this quarter and going into the first 2 quarters if this COT will be used as a target by the LHB against practices - if you have a large list of dentally fit pts it produces a very high COT figure - to try to reproduce it with still reduced patient numbers - which I thought goes against the UDA treadmill model they are trying to move away from. As you know in the COT measure 1 check-up counts the same as a molar endo/crown.

3. Pre COVID contract reform practices were asked not to charge those under 25's and 60+ for fluoride to encourage uptake, and I can confirm that uptake was much improved under these circumstances. In July we were informed that this was no longer the case. We are now calling high risk patients for review and are finding the charge a barrier to acceptance of fluoride varnish with less than 50 % uptake in these groups. Will the charge be continuing for these groups? If so I feel the 80 % target is unachievable.

   The CDO letter says that if we fall below 75% fluoride rate in a month then we will be subject to a 5% reduction in ACV. We cannot have perfect months every month and as an example many children in the practice are in schools that have D2S fluoride applications. During the months around when D2S are applying varnish we see a marked drop in the acceptance of fluoride in children because they are having it done in school. Wouldn't it be fairer to base these decisions on a rolling average rather than on one bad month? I appreciate that D2S is not in schools at the moment, but it illustrates my point that we will see variations in fluoride rates for justifiable reasons and may still be financially penalised.

4.
   - How are the amounts of AGPs carried out being measured? Is this via our reporting to HB weekly?
   - We were told by HB in January that we had not submitted enough claims compared to the rest of the HB in Quarter 3. We were not aware number of claims we being used to measure activity. Number of claims does not give an accurate measure of activity as some claims will take months to complete as patients have multiple extractions and fillings to complete.
   - Are we going to be given guidance figures for numbers of patients seen/treated, due to the covid-19 SOPs there is a maximum ceiling for patient throughput and this will differ for practices dependant on premises, layout , etc.

- New patients?- what mechanism is being used to record this? If it is from FP17 data , then there will be a lag of up to 3 months before the new patients attending will be seen by BSA / LHB as their COTs will take time to complete.
- If we are not raised to 100% ACV, are we still expected to see 2 new patients per week per £165k contract for 90% ACV?

5. How long a face to face appointment does the CDO feel is appropriate for practices to set aside to manage a new adult patient in pain under the NHS? Remember we need to:-
    - Donn PPE (AGP or non-AGP)
    - assess and diagnose with appropriate radiographs,
    - complete the acorn well (this can be done beforehand by a free DCP)
    - diagnose,
    - Give LA (no more out to the waiting room to numb up while we see someone else)
    - treat,
    - Write our notes contemporaneously to FGDP standards,
    - Doff PPe,
    - Apply appropriate fallow time and decontaminate the surgery.

6. **Orthodontics** plays an important part in addressing the 'collective well-being' of young people who have suffered enormously during this pandemic.

    Due to the prolonged waiting time for initial orthodontic assessment, we are finding that a significant proportion of our new patients are:

    a. No longer interested in treatment as they feel too old (17-18yrs) to cope with active fixed appliances.

    b. No longer eligible for NHS treatment as IOTN score too low i.e. have improved with growth.

    c. Their dental health status has reduced to a level where orthodontic treatment is not appropriate without preventative intervention and active perio/restorative treatment.

    Would the CDO consider modifying the orthodontic referral system so that when a new patient is drawn from the waiting list, there is an electronic cross-check that the patient has had an ACORN assessment with their GDP in the previous year and that their status is “GREEN”? Also, that the GDP checks the referral at this ACORN assessment to confirm that the patients need and demand for treatment has remained unchanged during the wait for assessment. This would reduce the number of assessments in the groups above and actively validate the waiting list.

    Linking the preventative benefits of the ACORN assessment with the orthodontic referral must be of value to the patient and clinicians involved.

7. There are concerns about eDen recordings. These are that a “new patient” only gets recorded when the course of treatment is closed, and the form sent off. Clearly if you take on a new patient you may take some time to work through their treatment and will have a lag on form sending off.

    Therefore, the measurement of new patients currently is still predicated toward the lower need, as high needs will take a while to count. How then this works with contract value is a concern.

    Can the CDO address this please?

Comments

1. Like most practices our main concern is when we could reasonably expect significant changes to the AGP SOP which would allow us to see a greater number of patients.
    As a mixed practice with a small NHS contract the 90% NHS payment until September will only go so far.
    At present we are able to see approximately 1/3 normal numbers of patients.

Due to the SOP we have to use 2 surgeries for each dentist and also 2 nurses. Combined with massively increased costs for PPE and clinical waste disposal it is a real struggle.
On top of this we are making no inroads into the ever-growing backlog of treatments and examinations. Patients who have not had a routine appointment for in some cases approaching 18 months are attending with significantly deteriorated oral health and time-consuming treatment needs.

Throughout the pandemic it has been very disappointing that the CDO has repeatedly distanced herself from the situation of private dentistry, which I think is unreasonable given that all practices ostensibly must abide by the guidelines the CDO sets out whether NHS, mixed or wholly private.

Whilst I fully appreciate that any changes are dependent on infection levels, for the good of workforce morale, I think some indication of a "dental roadmap to normality" would be much appreciated at this time. I think continuing with "no end in sight" is now having a tangible detrimental effect on viability of businesses and on personal wellbeing (we have already had a senior nurse leave the profession due to the fact there seemed to be no end point to current onerous working conditions).

2. Fluoride varnish: numerous problems with the 80% measurement being unachievable. How can we be expected to apply fluoride on Urgent bands following an extraction? Over 60/under 25s who do not have x rays, no caries but fall into Amber because they do not brush twice a day who do not want to pay £14.70 for Fluoride. These factors will affect our Fluoride application rate. Will these be taken into consideration? We suggest Fluoride should be a non-chargeable item.

3. Concerning the young child in pain who attends for face-to-face appointment and requires operative dentistry (restoration or extraction) - At what point in the appointment does the CDO suggest that I apply fluoride to the child's teeth?

    a. before I administer the infiltration/block anaesthesia? Or
    b. after I've done the restoration/pulpotomy/extraction?

    Remember, if I don't put the fluoride on at some stage of the appointment my figures will look bad compared to my peers? I cannot justify another appointment at present to administer fluoride alone. Is this really clinically appropriate?

4. I wish to comment about the use of ACV when deciding on the target of number of new patients being taken on. Using this measure duplicates the unfairness recognised around the disparity in UDA values, with those practices on higher UDA values being at a distinct advantage. I suggest targets should be based on number of UDAs attached to a contract which will negate the current disparity.

5. When the percentage of ACV to be paid to practices was originally determined I understand that reduction of laboratory fees was a consideration in determining the formula. Since then there has been considerable increases in expenses relating to PPE (only partially covered by the free provision, particularly in mixed practices), infected waste disposal costs have more that doubled, etc., etc. Perhaps this should be taken into consideration.

6. I see the current state of affairs as a wonderful opportunity to move our practices away from the inequities of the current UDA contract and base dental practice on a preventive based system with measurable outcomes, at the same time encouraging patients to play a greater part in their dental health care. It will require a change in culture and attitude of the profession, but I think is achievable.