Morgannwg
Local Dental Committee

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# Morgannwg LDC

## Concerns of Dentists Operating the Reform Contract

### *1. Patient Pathways*

A colleague observed '*Some patients are struggling to understand and accept the changes in patient pathways. I.e. those at high risk of caries and perio may not be entitled to complex treatment such as crowns and endo until their caries and perio is stable. We are having a few patients complain when they are in this position, and it would be useful to have a flowchart or some literature to explain the pathway and why they may not now be entitled to some treatments on the NHS based on their oral health*.'

Another commented '*There has been little information provided to the population in Wales about the contract reform and the care pathways under discussion. It takes a lot of time and effort from us to ''train'' our historic patients to the new way of practising that includes less regular recalls, FV even in adults, it doesn't predict routine S&P on all patients etc.* ***Perhaps a campaign could be carried out informing people about the situation.***'

Some advice from WG would be useful.

### *2. New Patient Problems*

Another colleagues wrote '*I have just had a patient referred from HB as part of our new patient quota (which I am concerned about as the HB has not managed to supply as many as I have requested on any week so far, nor has it confirmed the numbers as I requested they supply half our new patients).The patient attended stating that they had registered as a new patient in another practice but didn't have an appointment there until August so went back to the LHB and only wanted a temporary filling today. We don't have an access contract so doing a band 1.2 would mean no new patient credit and she didn't want an examination. I know that practices who do in hours access can claim them as new patients but what if the practice doesn't have an access contract? My other point was about the DF side of the contract, I saw the email to the HBs to say that the DF metrics in terms of new patients were to be measured separately but they didn't address the fluoride and Acorn issues with that being taken as part of our overall contract with financial penalties attached to them*.'

I realise that this is a HB problem but have included it since it is a recurring concern and might be a good question to include in an FAQ document.

Another colleague commented as follows:

- *Overwhelmingly high needs needing multiple appointments. We only have 45 mins each patient per year. That includes check-ups. We've done the maths.*

- *23.58% of our adults green - huge need for treatment in new patient AND existing patients after the pandemic. 20% of our kids are green (80% therefore are red/amber) - how can we treat all these patients and hit the new patient/existing targets. 45 mins per patient per year!!! There simply isn't enough time in the appointment books.*

- *What sort of message does this send to the practice team? Associate mentality is rock bottom. I fear we will struggle to retain performers. We've struggled through the pandemic, taken a hit on our ACC, invested tens of*

*thousands in active ventilation and now we face financial penalties in a system that is forcing practitioners to treat patients in ways that they would not want their family members treated.*

- *This is corporate negligence from NHS dentistry. What sort of quality are we expecting NHS dentistry to deliver? Third world dentistry? More patients may have access but to what exactly. We are already seeing patients who have been "accepted" for NHS care by other practices who can't get appointments with that practice and are coming to us as new patients for urgent care. It's a total con!*

### *3. Eden, Historical Patients, Asylum Seekers*

Eden is a recurring problem. A colleague wrote *'Poor reporting of metrics on Eden. Making it very difficult to track progress and pay associates.*
*No flexibility in allowing historical patient metric to be supplemented by new patients. We cannot force historical patients to attend. Some move on. Some DNA (twice in a row or frequently) and are 'de-registered'. We do not believe we have enough historical patient to hit the metric.*
*New patients high need. Most referred by LHB are asylum seekers requiring language line. Happy to help but this takes much more time than normal. Practices previously had additional funding for this, but we don't.'*

Another wrote in much more detail about Eden, outlining problems and suggesting solutions as follows:

'*Although **EDEN has improved and it helps practices monitoring their activity, there are still lots of areas to improve**:*

- *1st of all it's only updated once every month and the cut-off date is before the completion of the calendar month. That means that practices do not have constant feedback for their activity, so they implement any changes in their way of practicing on a day-to-day basis. That was also the case with the UDA schedules, that were only updated once every month in a similar pattern. However, the difference is that practices were able to monitor their UDA activity on a day-to-day basis through their software UDA counters, while now, there are no such FV counters, New vs Historic pts counters, early attendance counters etc.* ***It will make things easier if EDEN gets updated more often (eg once weekly, with cut off dates given so figures have more value).***

- *To be honest* ***some of the figures in EDEN do not match in between them****: For example: on our EDEN, the number of Historic and new pts treated (as shown on the 1st page's graphs) doesn't coincide (it is less by 18 pts) with the ''number of pts treated'' a few lines further down on the paragraph ''contract performance overview''.*

- *it is a great help that we have a FV rate breakdown per performer, over the new EDEN version.* ***We would also need a similar NP versus Historic pts breakdown per performer, so we can monitor each individual performer's patient activity. All we are currently provided is the total patient number per performer.***

- *I wonder* ***how EDEN can recognise and credit each contract provider, the number of patients that were referred to practices via 111 and had a UT claim*** *(against those that are historic practice patients or non RMC new patients that had a UT) or even more the lost sessions that were retained for an RMC patient but were not filled either because the patient didn't turn up or because there was no patient referred... We, as a practice, update the spreadsheet provided by the LHB.* ***Perhaps, an extra box could be added on FP17 forms for such claims, where the reference number provided by the RMC could be added.'***

Another colleague referred to Eden in the following terms:

- *The data on Eden is cumulative. Difficult to tease out month on month data. Can't see if improvements are being made month by month as it clumps the year-to-date data together. Performers are missing from the fluoride tables. Others are present who have long since left and haven't performed this financial year?*

- *As things stand only 1/3 of our target is met for month one (according to Eden) even though we know we have hit our numbers. This is because 2/3 of the forms are still open as people need treatment. There should be a box to*

*tick so you can submit a form with the intention to treat (as the orthodontist do when they accept a new case). Otherwise, the Eden data is even more meaningless. We warned the LHB of a huge lag before this contract started.*

### *4. Shortage of Duraphat*

A colleague asks:

'*With all practices now surging to get supplies of Duraphat varnish there may well be difficulties sourcing this shortly (it is already on back order with some suppliers). As I understand it, only Duraphat is licensed for application for decay prevention (as opposed to the others such as Profluorid which are only for desensitising) so a shortage would result in fluoride targets not being met through no fault of the dentists or practice. It may also be worth seeking some clarification as to whether Eden will provide data in line with the schedules produced by compass - as if one is on a calendar month and one is a partial month (17th-17th for example) it will be almost impossible to keep a track on and double check activity levels'*.

### *5. FV as a Public Health measure and its inclusion as an 'all or nothing' metric*

You have been made aware of some colleagues' opposition to using FV in the way that it has been forced on colleagues by making it a metric. I have had correspondence from several colleagues related to concerns around FV. The Australian product leaflet on Duraphat (*https://www.colgateprofessional.com.au/products/products-list/colgate-duraphat-varnish*) states under Information in point 6, Precautions '*Colgate Duraphat is indicated as a spot application fluoride treatment for at risk tooth surfaces and* ***should not be applied to the whole dentition in one session'***. Does this apply in the UK?

Colleagues would feel much more comfortable applying FV as instructed by the WG if these questions could be answered, and the supporting research could be provided to colleagues by PHW.

Some further comments on Fluoride Varnish:

- *We've been involved in contract reform since 2011 and applying fluoride varnish since 2012 so we have more experience with this than almost all general practices in Wales.*

- *In the first instance having a financially penalised metric based on a clinical activity that is totally out of practitioners' control is immoral. Patients can choose whether to have the fluoride varnish or not. What are we meant to do? Assault them? It is not acceptable to say that that's taken into account by the 75% target. The previous CDO said the target is a starting point and may need to be altered.*

- *Children seem to consent to fluoride at the first application only to refuse at a higher rate the second time as they object to the taste. Anecdotally, parents have reported increased anxiety from some young children prior to their dental appointment due to the impending fluoride application. Are we needlessly generating a generation of young children who are more anxious about dental appointments?*

- *Also, how on earth is it possible to differentiate between the benefit of 'spit don't rinse' advice we've been giving since 2011 and the benefit of topical fluoride application?*

- *Increased cost of Duraphat for red and amber adults. Difficult to get hold of. Australia guidance? UK instructions says don't apply in active perio!!!!????!!!!*

### *6. Domiciliary Contracts*

A colleague wrote '*Our LHB has refused to implement a reasonable variation of the metrics for our domiciliary contract. We are forced to keep UDAs as they applied the general contract variation metrics to our domiciliary*

*contract. It would mean an increase in patient numbers of 400% for the year. Ridiculous. UDAs are even more inappropriate for domiciliary contracts than general contracts*.'

### *7. More time being spent on Administrative Tasks*

General complaints about the increasing time it takes to complete administrative tasks these days e.g. ACORNS, writing up treatment notes, explaining pathways to patients etc., all which reduce operating time to meet the metrics.