Lanarkshire Local Dental Committee

Friday 30th October 2020

On Thursday 29/10/20 the Lanarkshire LDC met virtually to discuss the impact of the latest PCA and the ongoing issues COVID-19 is presenting for the profession. A summary of the issues raised is detailed below:

COVID Tiering

It was announced yesterday that Lanarkshire would fall under TIER 3 of the new COVID protection levels, which came as a surprise to many who were anticipating a tier 4 restriction. North & South Lanarkshire are currently the worst hit areas of Scotland with regards to COVID-19, with Lanarkshire hospitals already struggling with the increased demand on acute services. Members of the LDC raised concern that the profession was being asked to increase work load as of 1st November, at a time when virus infection rates, hospitalisations and deaths are all increasing in the community. It was noted that this completely contradicts the Scottish Government framework, which states that in Tier 3 public services should be limited to "*essential face-to-face services only (online where possible)*". The question was raised as to whether practices should be closing to all but emergencies only, however guidance received from Shelley Percival, Clinical Director, yesterday stated that the CDO had advised that "*the NHS stands aside from the Scottish Government tiering system therefore practices should not have to close unless advised to do so by the local health protection team*". The newly published SOP for Dental Teams in Scotland (https://www.scottishdental.org/wp-content/uploads/2020/10/SOP-Guide-COVID-19.pdf) gives further details about what services dental practices would be expected to provide should Lanarkshire progress to Tier 4 on page 4.

The question was also posed as to why dentistry is being treated differently to all other health care sectors, whom are currently being asked to reduce patient contacts. Furthermore, why have we progressed to phase 4 of remobilisation at all when our original guidance stated this would not be appropriate until such a time that a vaccination was in widespread circulation or transmission rates were negligible? LDC members proposed this was perhaps because many practitioners had lobbied for private dentistry to be allowed to resume and that it was unlikely the SG would be able to stop the provision of private dentistry again, so they couldn't be seen to be allowing the development of a 2-tier system within dentistry.

VDPs

There is still much uncertainty regarding what is happening with regards to VT and dental graduates. There is ongoing speculation that the current BDS5 will not be allowed to graduate due to lack of clinical experience. There have also been rumours circulating that the dental schools will not be taking on a new BDS1 in 2021 if the final years have to repeat. This raises questions about an absence of VTs for VT practices both in 2021 and in 2026. It also poses the question what will happen in 2022; will there be a double year graduating and requiring VT places, or are all BDS years going to have to repeat a year? There is also uncertainty surrounding the current years' VTs and what will be expected of them. Are they going to

have enough clinical experience to gain satisfactory completion or will their VT be extended e.g. to a 2-year programme? The LDC intends to take these questions to NES and will report back any response.

LDC members also expressed concern for last year's VTs and the lack of financial support available to them. It was noted that these new associates are facing challenges finding employment as principals do not want to employ associates without COVID top-ups to transfer. Even if they are able to attain an associate position, the amount they will be earning will be significantly less than their VT salary once deductions are taken off for e.g. principal, lab fees, superannuation etc. A letter had been sent to the SG by the ex-VTs expressing their financial concerns and asking for additional support, however it has been declined by the SG.

Emergencies

The question was raised whether we are still obliged to see NHS emergencies within 24 hours considering all the restrictions we currently have in place. Page 14 of the new SOP appears to suggest this is not the case and gives the time frames listed below as targets for seeing emergencies. It clearly states, however, that "*timeframes are only indicative and will need to be adapted to suit individual practice and patients' circumstances*", which would also give practices some leeway.

- SDCEP 'emergency' to be seen within 1 hour
- SDCEP 'urgent care' to be seen within 48 hours
- SDCEP 'non-urgent care' to be seen within 7 days

Prior Approvals

PSD has confirmed any prior approvals that were closed during lock down will require re-approval. In the scenario where the patient has already paid the maximum patient fee for their 'first' course of treatment, you must add the following observations to your claim such that the patient is not financially penalised: ***"Previous claim closed due to COVID. The previous claim and this claim will take patient charge over max – please amend"***

However, it is unclear how practice management software will know how to differentiate in these scenarios and not charge the patient's account as treatment is completed. This will likely require discussion with individual PMS suppliers.

SDR 148/PCA(D)(2020)13

The new PCA was discussed, with some of the key issues surmised as follows:

- 1/11/20 should not be seen as a return to business as usual. It is expected patient throughput will remain reduced at around 20-30% of pre-COVID footfall. There was a general consensus amongst members that activity levels are unlikely to change dramatically come the 1st November.
- PPE deliveries will be based on seeing 10 patients (per surgery), of which 5 can be for AGPs.
- Patient charges will be re-introduced but still no expectation for GP17s to be signed by patients.
- There will be a 2.8% pay rise on caps/cons, included in the Nov/paid Dec schedule and backdated from 1/4/20. This will be paid in lines 1 & 2 of schedule.
- Prior approval limit raised to £430.
- Return of the 3-month rule for sending completed claims as of 1/11/20.
- Revised financial support measures:

- As of 1/11/20 – 28/2/21 ALL NHS dental contractors will automatically receive an increased top-up payment of 85%. The next 4 months are being treated as a transitional period to give practitioners time to adjust to the new system. This is not dependent upon activity levels.
- As of 1/3/21 top up payments will become tiered based upon activity levels and levels of patient registration.
- A baseline activity level will be calculated from the assessment period 1/4/19 – 31/3/20 (i.e. pre-COVID) for the PRACTICE as a whole, not based on individual practitioner activity.
- From 1/3/21 PRACTICE activity levels will be compared to the baseline levels to determine the ongoing level of financial support received:
    - RAISE TIER (continue to receive 85% top up)
        - Item of Service activity $\geq$ 20% compared to baseline
        - NHS patient registration must remain >95% compared to 1/3/20
    - MAINTAIN TIER (reduced to 80% top up)
        - IoS activity 10 - 20% compared to baseline
        - Patient registration must remain >90%
    - REDUCE TIER (reduced to 40% top up)
        - IoS activity <10% compared to baseline
        - Patient registration <90%
- VDP activity will be excluded from this assessment

There is still considerable confusion surrounding the latest PCA, which appears to have raised more questions than it has answered. We have collated the following FAQs and would encourage GDPs to comment if they have any additional questions not covered here, as our list is by no means exhaustive. It is the intention of the LDC to then raise all questions with PSD and the SG.

Q) How is Item of Service activity going to being measured?
It has not yet been decided how activity is going to be measured and is apparently still 'under consultation'. It remains unclear whether it will be by volume of claims completed or value of claims completed, however we will argue that whatever system is devised must give consideration to the following:
- Long treatment plans will likely take many months to complete. A practitioner could be busy for months and yet no activity would be recorded until the course of treatment was closed?
- Will codes e.g. children's exams or COVID codes such as triaging etc, that currently have no fee associated with them still count as activity? If not, are children going to be disadvantaged as practitioners preferentially provide treatment that will help keep activity levels up?

Q) What happens to activity levels if a dentist wants annual leave or is off-sick or has to self-isolate?
Activity levels are going to measured for the practice as a whole (minus VDP activity) so all dentists working at the practice will receive the same tiering based on practice activity level. If a dentist wishes to take annual leave, it is our belief that financial support will not suffer so long as other dentists in the practice are able to make up the 'lost hours', however, this only works in larger practices where there are multiple dentists available to cover the time off. This raises the question what arrangements will be in place for small/single-handed practices? How will they be able to take time off without it impacting on activity levels?

Q) How will they assess patient registration levels when these can be affected by many factors out with our control?

- If a practitioner has a large proportion of elderly patients (whom are more vulnerable to COVID) and the 2nd wave is as deadly as we are being warned, what happens if patient registration drops significantly due to deaths? Will deaths be excluded from patient registration calculations as not within our control?
- What happens to patients treated by VTS, who will be transferred over to VT list and thus excluded from practice calculations? Will this register as a drop in patient registrations even though the patients haven't actually left the practice?
- What happens, e.g. if a new practice opens nearby with much shorter waiting lists and so many patients leave a practice so that they can be seen sooner? Again, this would affect patient registration levels through no fault of the practice.

Q) Will patients still need to be 'dentally fit' before forms can be sent?

- If we are to prioritise patients, e.g. treating emergencies, focussing on caries stabilisation first, then can we put just this on a course of treatment and send it so that activity is registered? Or would we be unable to send claim until entire treatment plan is complete, in which case it could be months before any activity is recorded?

Q) How will they account for changes to the workforce since the assessment period?

- What happens if a dentist has left the practice since the assessment period and the practice has been unable to replace them over lock down?
- What happens if a dentist has gone off on maternity leave and the practice has been unable to take on a locum as there is no top ups available to pay them with (as these cease when mat payments commence)?
- Will the activity of the absent practitioner be taken off the baseline practice activity level or will the remaining practitioners be expected to provide double the amount of work?

Q) What happens if there is an individual practitioner who records zero activity, will they still be entitled to top ups if the practice as a whole is able to keep up required activity levels?

- For example, a dentist who is shielding for health reasons and so cannot work?
- What happens if a VT trainer is predominantly nursing for their VT or allowing the VT to treat the patients such that they may meet the requirements for their training year? The VT activity will not count as practice activity, yet the trainer may not have the opportunity to undertake their own activity?