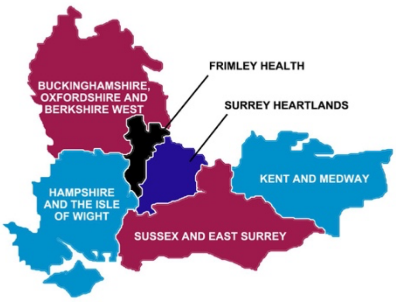
NHS England and NHS Improvement South-East

Since the three previous areas of the NHS England and NHS Improvement South East (NHS EI SE) region have united as one, I have been appointed to take a senior role to coordinate the work of the clinical dental advisers (CDAs) of our expanded region. Many GDPs in Kent, Surrey and Sussex will know me, either through my work as a CDA for Kent and then Kent, Surrey and Sussex (KSS) or for the many years when I was a programme director and associate dean for dental foundation training and performers list validation by experience (PLVE) for Health Education Kent, Surrey and Sussex and latterly for Health Education London and KSS.



The clinical dental adviser team for NHS EI SE consists of one full-time CDA and ten part-time CDAs who are also general dental practitioners. The other CDAs are: Yeti Bello, Matt Botha, Verna Easterby-Smith, Clair Hamill, Adrian Moore, Kully Nijjar, Achal Prashad, Simon Quelch, Shab Shivji and Tina Tanna.

At the present time, GDPs face necessary changes to dental practice as a result of Covid that have made dental practise increasingly challenging. It is recognised that the majority of general dental practices and teams have been doing their best to help patients via the so called 3 A's - Assessment/Advice and Analgesia and Antibiotics and now with face to face appointments where and when necessary. The Community Dental Services across the region have also worked hard to support especially those more vulnerable patients and those with special needs.

From early in the Covid lockdown, your local dental committees have also been endeavouring to support dental teams and have been active in supporting the work to establish arrangements for urgent dental care. Their work has included ensuring that information is cascaded to dentists particularly also via their websites which have proved to be most useful. I have also been struck by the commitment of the NHS EI SE staff in their efforts to support dental practice teams and access to dentistry for patients. Hopefully you will have seen the letter of acknowledgement and thanks sent out to all dental teams by our regional medical director Vaughan Lewis.

A significant number of issues are drawn to the attention of NHS EI SE every month. These can be via emails and telephone calls from patients and dental teams with general queries or formal complaints. Most formal complaints are reviewed by a clinical dental adviser and their comments are included in a response letter from the complaints department to the complainant. We have in the past periodically published various learning from these sources.

The following are a few of the issues raised, which I hope will be of interest and may provoke discussion in your practice and help to avoid some of these frequent problems.
I've also added a section on the issues that frequently cause difficulties when using DERs/Rego and I hope that may help colleagues avoid these common problems.

Huw Winstone
Senior Dental Clinical Adviser
November 2020

The Executive Summary in Case You're in A Hurry -

1. **Good Records**. Over and over this supports your diagnosis and treatment planning. A complaint by a patient answered and the dentist supported by:
   - comprehensive clinical records including
   - a clear indication of a risk assessed dental recall interval,
   - available NHS option/s offered
   - private options clearly stated as such and costs clearly stated
   - explanation to the patient of the advantages and disadvantages – risks and benefits of treatments – detail in the records
   - ensure the patient understands the options
   - issue an FP17DC treatment plan – signed if the patient accepts any private treatment options – signatures by patients currently suspended see - https://www.gov.uk/government/publications/temporary-approval-to-suspend-the-need-for-signatures-on-prescriptions-dental-and-ophthalmic-forms/suspension-of-patient-signatures-on-prescription-dental-and-general-ophthalmic-services-forms

2. **Sedation**
   - Within NHS general dental services, sedation is always a separate course of treatment.
   - If your patient pays a patient charge advise them that there will be a separate charge levied by the sedation practice.
   - If you are queried, a good explanation of this is at https://www.nhs.uk/using-the-nhs/nhs-services/dentists/understanding-nhs-dental-charges/ See – If You Get Referred to Another Dentist.
   - Referring for sedation – detail the treatment you believe is clinically indicated but advise your patient that the sedation practice will examine and discuss the actual treatment to be provided.
   - If you cannot take x-rays or cannot fully examine e.g. a very nervous or phobic patient, advise the patient or their carer/parent of this and advise that the treatment you have detailed may change e.g. after x-rays available or an examination which have to be undertaken when the patient is sedated.
   - Be aware of the treatment delays for sedation (& GA), manage patient's expectations of this and encourage and support patients to have treatment with LA only and not sedation when possible.

3. **Practice-Based Complaints Scheme**
   - One person, experienced in complaints handling and knowledgeable about the NHS complaints process, should be appointed by the NHS provider (contract holder) to investigate and respond to complaints regarding NHS dental services at the practice
   - Dentists, DCPs & other practice staff should cooperate with complaints investigations, including providing information verbally or in writing about their involvement in the service complained about.
   - Dentists should not usually go it alone and issue their own response letter. There should be a coordinated practice response.
   - The provider is ultimately responsible to the NHS for the practice-based complaints system.

NHS

4. Using DERs/Rego

- Ensure the practice monitors responses from DERs/Rego. Consider appointing a staff member to do this as part of their job role.
- When referring, complete any medical conditions, medication or patient associated modifiers by selecting these. **
- Do not enter any of the above as free text as it will not be recognised, and your referral will not be routed correctly.
- Referral reasons – you can select more than one. No need to make separate referrals for the same patient.
- Enter additional information as free text in the Supplementary Information field – this is frequently necessary to prevent your referral being returned to you.
- Ensure you know how to attach not just x-rays but also documents and images/photos.
- Consider the Rego Uploader app for your mobile device – easily take photos which won't be stored on your device, so no data security issue.
- Avoid referring when you are certain it is clinically not indicated or when a second opinion is not necessary – "because the patient insists".
- **FINALLY – THE MOST FREQUENT QUERY TO THE VANTAGE DERS/REGO HELPDESK** – "My referral is not going to the service I want it to!" – read the advice above **, enter information by selecting options, understand the pathways for referrals. The information you enter and the way you enter it determines the routing for your referral.
- The DERs/Rego Helpdesk will not move your referral to a different referral service provider to that selected by the logic running in DERs/Rego. The pathways within DERS/Rego and the algorithms that direct referrals are reviewed as necessary by groups which include Consultants, Specialists, GDPs and NHS Commissioners.
- **Online help** - https://referrals.management/livezilla/knowledgebase.php

5. Now why not read the detailed examples that follow?

All the complaint examples that follow arose from issues that occurred prior to the Covid pandemic.

Patient Charges

<u>Example 1</u>
Firstly, it's <u>*good*</u> to record a patient complaint where I was able to support a GDP and practice.

A patient had urgent, followed by band 2 courses of treatment, including periodontal treatment over several visits as well as a filling. BPE was 3's and 4's. A referral for extraction of UL6 and UL8 (with sedation) was made. Three months later the patient had not heard from the sedation practice. He phoned the dental practice and was told he could have the extractions there. At a subsequent appointment at the dental practice – over four months after his previous visit and after discussion with his dentist, the patient decided to wait for the sedation appointment at the sedation referral practice. An examination was carried out, further necessary scaling was offered, and all of this was recorded. The patient's complaint was that he should not have been charged (a band one charge) for the follow up course as he attended for extractions which he decided not to have.

On reviewing this complaint, for the banded courses of treatment there were FP17DCs for the original band 2 and follow up band 1 course of treatment. Radiographs included bitewings and periapical of teeth needing extraction. A Rego referral with good details had been promptly made. An examination interval of four months after a course of periodontal treatment for a patient with BPE 3's and 4's seemed to me to be entirely appropriate.

In my comments which were included in the patient response letter, I was able to explain NHS patient charges and confirm it was correct for the practice to close the first course of treatment (as sedation is always regarded as a separate course). I confirmed that these charges were correct and also whilst the patient had not had an appointment for sedation at that stage (due to Covid closure) I mentioned that there would be a further band two charge. I did also express my appreciation of this patient's concerns regarding their NHS patient charges as these can be difficult to understand.

In fact, as a gesture of goodwill, the practice offered to refund the band one charge.

<u>Example 2</u>
Another example – although <u>*not so good*</u>. A patient complained about their dentist as the patient experienced a delay in treating his symptoms with respect to a carious bridged tooth requiring extraction. The patient was referred through DERs/Rego for the extraction as it may have required a surgical approach. The patient also raised concerns about some of the charges for treatment. This included private charges for treatments that should have been offered within the NHS. There were no records of NHS as well as private options for some treatments – including the addition of teeth to a denture.

The patient was informed that their referral would be to a hospital, but this referral was actually correctly routed to a practice based intermediate minor oral surgery (IMOS) provider. The patient contacted the practice a few times to query when they would receive an appointment for their extraction as he had symptoms. The practice did not check DERs/Rego for waiting times or attempt to contact the IMOS provider.

When referring patients through DERs/Rego, keep an eye on the system to see where they are sent and waiting times, so communication with the patient can be maintained. There are currently delays in dental services including secondary services, so practices are encouraged to continue with AAA and face to face treatment where necessary to assist patients. When offering treatment privately make sure that you fulfil your contractual obligations and make patients aware what is available on the NHS.

FP17DC and consent forms are essential as part of valid consent. The requirement for patients to sign FP17PR and FP17 DC forms is currently suspended – see: https://www.gov.uk/government/publications/temporary-approval-to-suspend-the-need-for-signatures-on-prescriptions-dental-and-ophthalmic-forms/suspension-of-patient-signatures-on-prescription-dental-and-general-ophthalmic-services-forms

Practices will currently need to manage the issue of treatment plans, forms and hard copy information to patients in line with the infection prevention and control guidance that applies at the time.

Referral of a child for sedation

A patient's parent complained that they were referred for two fillings in deciduous teeth with sedation. The treatment actually carried out on referral was three extractions.
No x-rays were taken by either practice.
The sedation practice response detailed that due to the patient's anxiety it was difficult to undertake an examination, but it was clear that extractions would be needed. The referring GDP had not commented on any difficulty in examining and neither practice commented whether it was also impossible to take x-rays.
The sedation practice had issued an FP17DC treatment plan that detailed three extractions. This was signed by the patient's parent.

My response for the patient's parent highlighted the difficulties of examining a very nervous patient. I was able to comment that the sedation provider's response with regards to this seemed to be clinically very feasible.

In the response for the parent I also included that in one of our bulletins we would be passing on the message to dentists that when they refer children who have decayed teeth, they need to make it clear to parents/guardians that they cannot guarantee that the teeth can be filled. This is especially true when x-rays are either not possible or not felt necessary and when examining a patient is difficult. As a result, I would like to thank them for taking the trouble to draw their experiences to the attention of NHS England.

However, this could also apply for adult patients and to patients referred to consultant led services, where we would all no doubt explain to a patient that the consultant will discuss appropriate treatment and that sometimes we, in practice, cannot be certain which option will be considered to be most appropriate.

It's a Practice Based Complaints Procedure

Frequently when reviewing patient complaints and the documents provided by the practice it becomes apparent that the practice has passed the complaint to a performer/associate dentist to respond to with no input from the designated practice complaints manager.

A complaint I reviewed during the lockdown, concerned a patient who earlier in the year, had an examination, bitewings and a treatment plan for scaling and a replacement filling.

The FP17DC showed the NHS charge as £21.60 – band 1 and the NHS and private fillings boxes were both ticked. A private fee was also entered for the private filling. No entries were included in the clinical records to detail the NHS and private options offered. At the filling appointment the dentist did not replace the filling but smoothed the tooth. The patient complained because she had not agreed to this alternative treatment. The tooth subsequently gave symptoms and the patient went to another practice where the filling was replaced. Also included in the patient's complaint was that she was charged a deposit for a private hygienist visit when this was not offered as NHS. The patient had not been made aware at the time that this was a private hygiene appointment and could have been provided within the NHS for no additional charge.

The FP17DC and clinical records were also unclear regarding the filling. There was no entry for the filling as an NHS option on the FP17DC as a band 2 treatment and as the patient had not mentioned this, it appeared this was not an issue for her. However, as there were no entries in the clinical records as to why only a private option was listed, it was not clear whether the patient was fully aware of the NHS filling option.

As the saying goes - **"When you're in a hole – stop digging"**

Amongst the files sent to me was a response which was clearly from the dentist and was far from ideal.

The primary aims of the NHS England complaints process are detailed here: https://www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf

Central to the aims is to enable a patient to raise concerns and receive an explanation of their diagnosis and healthcare.

Additionally, a response letter should always contain an apology and any remedial action if that is appropriate.

In the example above, the response letter from the practitioner was brief and factual. In my opinion, there should have been, as a minimum, an apology that the patient communication was not ideal. The dentist's response included the facts that he had carried out a "periodontal six-point pocket charting" (evidence not included with the files) and the patient had been charged Band 1. A patient is unlikely to understand such terms and any response should address that fact.

The alteration in treatment plan was not explained other than "I checked the x-rays" and "I decided not to go ahead with the treatment". This is clearly inadequate.

Remedial Action – In this example, the patient had opted to go to another practice and had not given the initial dentist or practice the opportunity to rectify this issue. The patient says "my experience left me with no trust in the standard of care at xyz dental …"
As a result, there is little option for remediation by the initial dentist. An apology to the patient that she had lost this trust, had suffered symptoms from the tooth and had the inconvenience of another dental appointment would have been appropriate and conciliatory. It did seem to me that scaling should have been offered within the band one charge the patient paid. This was not offered within the NHS and she had to pay separately elsewhere for that.

The response from the dentist also included that the patient should contact the practice with regards to the refund of the deposit for the hygienist appointment that did not happen. This was not very constructive or helpful.

The practice response – situation retrieved

When I highlighted the poor response letter to the complaints department, they contacted the practice and a comprehensive response was subsequently received from the practice, including apologies from the practice and dentist, a refund of the deposit paid, explanations from the dentist regarding the NHS and private options and an acknowledgement from the dentist that with hindsight it would have been better to replace the filling. The response also included some actions by the dentist and practice to try to ensure this type of complaint is avoided in future especially with regards to communication with patients, consent and caries management.

So, a far better outcome from the complaints process.

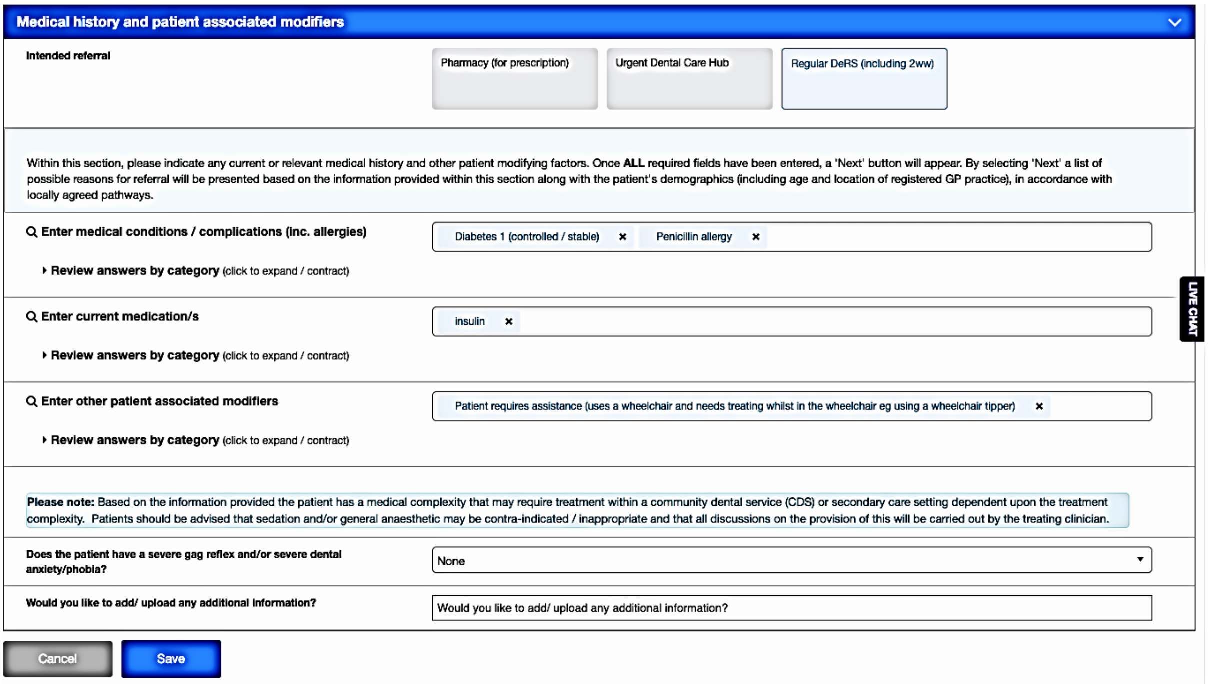
Practices should remember that whilst the individual dentist in a disputed consultation should be involved in the practice investigation of a complaint, **it is the provider who bears ultimate responsibility**. If the complainant subsequently uses their right to contact the **Health Services Ombudsman**, then it is the provider that the Ombudsman's office will communicate with and hold responsible.

Dental Electronic Referrals (DERs) Vantage Rego

Kent, Surrey and Sussex dental practices have “enjoyed” DERs for over five years and this system was recently introduced across Hampshire/Isle of Wight and Thames Valley in February 2020. The system now being South East Region wide has many benefits to patient care if we can ensure all dentists are using the system appropriately.

Some common issues that cause referral problems using DERs –

1. Ensure you select all necessary **Medical History and Patient Associated Modifiers**



Medical history and patient associated modifiers

Intended referral: Pharmacy (for prescription) | Urgent Dental Care Hub | Regular DeRS (including 2ww)

Within this section, please indicate any current or relevant medical history and other patient modifying factors. Once **ALL** required fields have been entered, a 'Next' button will appear. By selecting 'Next' a list of possible reasons for referral will be presented based on the information provided within this section along with the patient's demographics (including age and location of registered GP practice), in accordance with locally agreed pathways.

Enter medical conditions / complications (inc. allergies): Diabetes 1 (controlled / stable) × Penicillin allergy ×

Review answers by category (click to expand / contract)

Enter current medication/s: Insulin ×

Review answers by category (click to expand / contract)

Enter other patient associated modifiers: Patient requires assistance (uses a wheelchair and needs treating whilst in the wheelchair eg using a wheelchair tipper) ×

Review answers by category (click to expand / contract)

Please note: Based on the information provided the patient has a medical complexity that may require treatment within a community dental service (CDS) or secondary care setting dependent upon the treatment complexity. Patients should be advised that sedation and/or general anaesthetic may be contra-indicated / inappropriate and that all discussions on the provision of this will be carried out by the treating clinician.

Does the patient have a severe gag reflex and/or severe dental anxiety/phobia? None

Would you like to add/ upload any additional information? Would you like to add/ upload any additional information?

Cancel | Save

LIVE CHAT

This is the first screen in DERs after selecting the practitioner and patient.

The various medical conditions, medication and other patient associated modifiers trigger logic built into DERs which influences the options for the service the referral is routed to. Simply entering these details into the free text boxes will not do that and the referral may not then be correctly routed. It is therefore extremely important to ensure you:

- provide all details about the patient in the relevant sections by selecting relevant medical conditions/complications, medication and other patient modifiers
- do not as an alternative enter this information in a free text box and
- do not leave sections as ‘none’ (unless they are appropriate to do so)

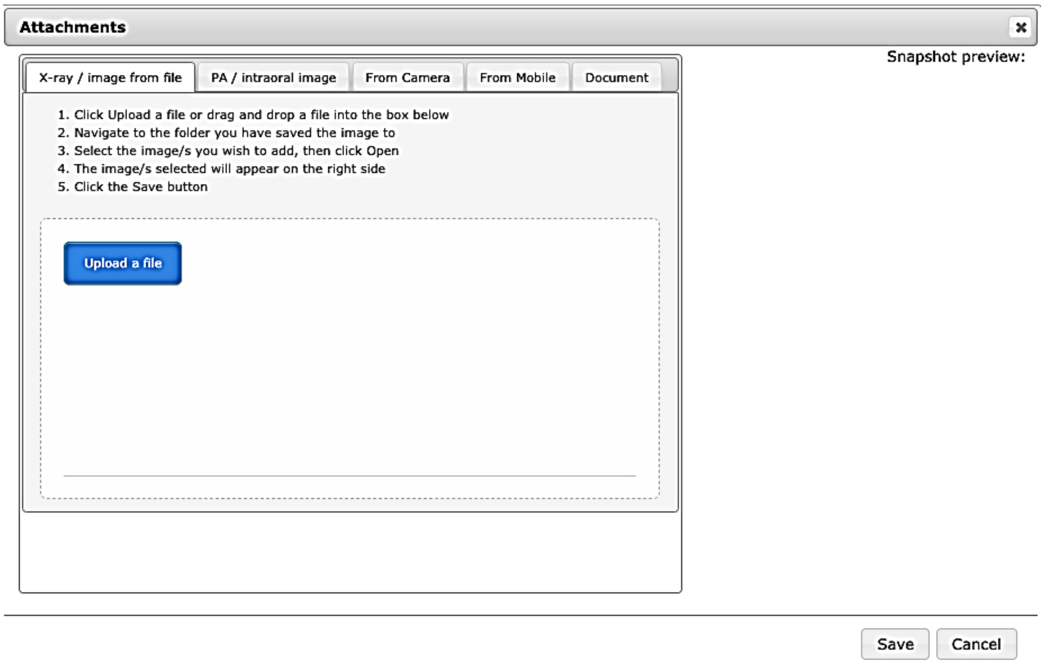
as the referral cannot be ‘triaged’ by the algorithms behind the system if you do not give the correct information by selecting options about your specific patient’s needs.

2. **“I’m stuck and cannot go to the next screen!”** – this will be because not all fields are completed. In the example image above the additional information question needs to be completed – even if it is selecting None. Once selected the NEXT option appears.

3. After the screen above is the option to select all **reasons for the referral** – you can select more than one and the system will give access to the referral information you select i.e. extractions and endo can be referred at the same time so you do not need to complete patient details for separate referrals.

4. **Supplementary Information** – the next screen has a supplementary information free text box. Whilst the options you have previously selected give a lot of information, for most referrals, there is more detail you can offer to the service accepting the referral. Failure to complete this section with required clinical information can result in a referral being returned to you to request further information; if you have it, think about providing it now so you do not delay the referral.

5. Just below this is the facility to **attach x-rays, documents or images** from cameras/mobile devices. The latter is really useful to illustrate what you see e.g. for oral pathology.



Select the mobile option and use the Rego uploader (an app available for iOS or Android). Users can upload images taken on a mobile device or upload images direct from a computer. The images taken using the Rego uploader are not stored on the mobile device.

If there is a previous referral response, consultant advice or any other relevant documents you should upload these at this point also.

6. **Best ways to ensure your referral is returned to you**:
   a. Failure to upload radiographs for extractions – OPG/DPT usually required for third molar removals.
   b. Failure to upload radiograph/s for endodontic referrals.
   <u>Solution</u> – Obviously upload radiograph/s or if there is an accepted reason that you cannot load a radiograph enter this in the supplementary text box
   c. Refer teeth with a hopeless prognosis – e.g. due to caries or periodontal bone loss for endodontic or other restorative treatment – against your clinical judgement

“because the patient wants this” or “because the patient (or parent) insists on this”. I can appreciate that some patients and parents can have unreasonably optimistic expectations or have been given unreasonable hope by another practitioner.
Solution – Difficult. If your patient fails to have confidence in your opinion, please if possible, ask another practitioner in your practice to come and give their opinion which may help your patient appreciate your opinions.

d. Refer for treatment not included in the referral protocol or established guidelines (e.g. NICE 3rd molars).

7. Finally – **the most common query for the DERs/Rego Helpdesk:**

I’m reliably informed that many, many calls to the helpdesk and emails to the dental team relate to dentists and their teams complaining that DERs/Rego will not offer them the specialist, CDS clinic or hospital they want to refer to. Hopefully from point 1 above, you can appreciate that the logic built into the algorithms which underpin DERs/Rego use the information you provide to route referrals to the most appropriate referral provider.

The easiest way to explain this is to use extractions as an example (but it works for all treatment which is too complex to be performed by a GDP under the mandatory GDS/PDS contract). In the case of extractions, many of these can be safely undertaken by a Tier 2 service provided by an accredited oral surgeon in a primary care setting. Once you have determined the complexity of the tooth is not a Tier 1 procedure, you should complete the referral with all relevant information regarding the patient, giving clear details of their medical history and any patient modifying factors. The algorithms will determine, based on your answers, if the referral is likely to be able to be undertaken in Tier 2 (by an IMOS provider/performer in primary care) or whether the referral needs to be directed to Tier 3 (hospital). As a GDP you cannot decide for the referral to go to hospital and bypass Tier 2 first unless the information you have provided in the medication/patient modifying section deems the referral is too complex for treatment within a primary care setting. As the patient has to choose an IMOS provider and a hospital provider when making the referral, if the IMOS provider details appear first in the referral, the system has determined from your answers that the referral is suitable for treatment in Primary Care and the referral will be sent to an IMOS practice. If the hospital appears first, then the system has determined from your answers that the referral may be better suited to hospital care. This does not mean that the patient will be seen/treated in these locations specifically as on review of the OPG/x-ray/supporting information and free text information at the IMOS practice or at the hospital by a specialist/consultant, the referral may be moved up or down a tier to ensure the patient’s treatment is undertaken in the most appropriate location for their specific needs. It is important to remember that an x-ray cannot be read by the system so all relevant sections must be answered. If a referral on review is deemed to not meet Tier 2/3 requirements it will be returned to you.

So, the logic behind the DERs/Rego system routes referrals to the most appropriate service for the treatment the patient requires based on the answers to the questions within the referral. The pathways within DERS/Rego and the algorithms that direct referrals are reviewed as necessary by focus groups (old KSS terminology) or pathway review groups (old HTV terminology) which include Consultants, Specialists, GDPs, Commissioners and the DERS provider Vantage, to ensure these reflect any changes to commissioned services or updates in clinical standards/guidance.

Online help guides to using Rego are available at:
https://referrals.management/livezilla/knowledgebase.php

Huw Winstone
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NHS England and NHS Improvement South-East
V2