Chair's Report July 2013

23 05 13 Special Care Dentistry MCN

There is a hope for GDP's to have the opportunity to undertake post grad study to provide 'enhanced' services with clinical attachments to Secondary care in the future. There are frequent DCP meetings and a request was made to advertise these meetings on the LDC website so that DCP's in primary care could also attend if they wanted to. As there is no Consultant post locally in Paediatric and Special Care Dentistry there was a suggestion that a CDS attachment where a consultant has sessions in Morriston may be worthwhile and would demonstrate a clinical need. Bariatric services are sparse if non existent in this locality.

12 06 13 Oral Surgery Working Group

Oral Surgery and Sedation services have been tendered for and awarded to Parkway and Cambria. Regarding central referral management the LHB have conceded that this is going to be a very time consuming and expensive exercise. For the moment they are going to 'major' on OS and Ortho referrals but due to manpower the other disciplines will have to wait. There was a discussion re DWSI's and training for enhanced services in Primary care. Protocols have been put in place for the new anticoagulants that do not require INRs and reviewed the bisphosphonate protocol. This information will then be sent by the LHB to GDP's as guidance in due course.

25 06 13 Welsh Dental Committee

As the Primary Care Support services have now disbanded there was a concern raised that there is no safety net for GDP's in trouble. The funds provided for Occupational Health are meant to cover this need. The point was raised that the LHB would be the last place that a GDP would call for help and there was a need for independent support outside the LHB. This was going to be looked into. A paper on recommendations for future Restorative Consultant Services in South Wales should provide guidance on investment in the future. There was a hope that this would be adhered to as restorative services do not seem to be as prioritised as Oral surgery in South Wales particularly.
There is now an FDS DES development for enhanced training and are a level up from DWSI's In England they are going to be a part of Primary care delivery. The diploma will be self funded and there is a danger that funds will be diverted from DF2 level to this DF3.
The Oral health Plan is a 5 year plan and it should have some element of workforce planning in it. It seems that the health boards do not communicate well enough on this and they also now need to include therapists in this plan. If therapists are to work on their own as they are now allowed to do by the GDC they would need a Performer number and presumably a contract if planning to work outside an existing dental surgery.
A hitch with the planned proforma referral letters has arisen as 'best practice' in relation to accurate, timely referrals means that the use of proformas involve explaining to the patient the nature of the referral and could compromise confidentiality as these letters have to be copied not only to the consultant but also to the patient.
HTM-0105 has been altered by England and there will have to be revision of the Welsh one. There will be a new Audit for HTM-0105 which will not be mandatory but there is CPD money to support it.

26 06 13 LHB/LDC Liaison Group

Performance of contract is 95% for all localities. Confusion over charging for OS referrals to be clarified so that the patient does not pay twice.
15 training practice places in ABMU.10 in Swansea.5 in NPT. None in Bridgend.
24 hour retirement Policy now signed off for LHB use.
They will pilot the OOH service initially as they are nearly ready to commence.
Still ambiguity re the vaccinations for TB and LHB to see if an outside surgery will provide this service.
The new guidance from HSE re Sharps is to be sent to all GDP's.
LHB now have guidance as to what is to be included in the Local Oral Health Plan and we will see it when ready and will be available for discussion in September.

02 07 13 Westminster Health Forum. Dentistry 2013: Commissioning, Access and Towards the New Dental Contract.

This was a large gathering of GDP's and specialists wanting some information re the future. This is a précis of the meeting.

John Milne GDPC.

Wanted to see speed of reforms being stepped up now for a workable contract. Concern re lack of clarity on funding and vulnerability of GDP's and patients as a result. Short term contracts not acceptable and bad for patients. So a call for a better designed system to replace a flawed one.
Eric Rooney DPH England.
Now at stage 2 of piloting and further testing needed for a pathway approach. GDP's think it's a better way of working and also for patients. But as the patient assessments for every patient takes so long there is a consequent 25% reduction in access!

Len D'Cuz. GDP

3 points.1.Prevention works, not just tooth decay but also gum disease.
2.Software development needs to be improved to keep up with clinical need.
3.The new way of working increases quality and a disincentive to poor practice.
He thinks that a mixed practice is the only way to survive and clause 59 allows for this flexibility.

Shalin Mehra.Post grad tutor.

Thinks that performers will need educating on this new way of working. The challenges are increased waiting times for first visits and for treatment –more akin to hospital waiting times in some cases.

Mark Pennington. Health Economist.

Total realignment of financial incentives. Capitation can result in cream skimming and only keep healthy patients on list. Risks of increase in referrals to secondary care.

Paul Batchelor. Faculty of Dental Surgery.
Ideal payment system is one with powerful and understandable performance incentives. He questioned a capitation system. Why pay for it if the patient doesn't need it. Clarification needed on KPI's. Are they needed for health improvement info or for performance. He thought that there should be rewards from the right outcome, liberation of the dental profession to be intellectually challenged and develop skills. Allow flexibility to address the fact of economic uncertainty and get ready for an economic downturn.

Evelyn Gilvarry GDC

There will be new standards launched in September 2013. A revised CPD scheme in 2014. No revalidation plans.

Martin Fallowfield Chair BDA.

He discussed the OFT report at length. Continuity of care produces the best outcomes. Shopping around inappropriate. Dentist led teams endorsed by the BDA and the only way to provide full range of treatment. Money to follow patient.

Tony Donaldson. OFT Director.

Dentists held in high regard compared to lawyers. Criticised the lack of info given to patients in the NHS re treatment. He says too many interested groups in complaints handling. Contracts should be the right length

to provide a good return for the profession. Wondered if a clinical dental technician could be considered a DCP and so have Direct access. OFT will look at 'Quackery' next time round, i.e. tooth whitening, Botox etc.

Chris Morris. Hempsons, Solicitors.

Should be one single portal for complaints. But may be only possible for simple cases. So many areas now have their own system. He did wonder if there would be a complaint for a late ambulance if there was a dental emergency and who would you then go to to complain. Too many!.Complaints systems required for patient redress, fitness to practice and patient safety.

Justin Ash. Oasis Dental Care

They carried out a survey of 550 patients and found that treatment plans given to a third of patients, younger patients will move more than the older ones, word of mouth recommendation is the best, under 30 years of age more likely to attend hygienist than over 30. He says there should be more practice information.

Barry Cockroft CDO England.

Usual political blurb and interestingly no one asked him a question. It said it all.!
That's all folks!!!

Rhiain Paul