# Dudley Local Dental Committee

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**Minutes of a meeting of Dudley Local Dental Committee held on Monday 24th November 2014, at the Queens, Belbroughton.**

## Present

Sue Stevens (Chair),David Cooper (Secretary), Annette Southall (Treasurer), Balbir Bhandal, Jennifer Cooke, Naven Pillay, Stephen Rees, Anjum Shaikh, Ranjna Sharma, Hazel Smith, Joanne Thompson, Lucy Thompson and Sheridan McDonald.

The Chair welcomed the newly elected Committee.
At the election there had been five vacancies to be filled and a total of six nominations, namely; Balbir Bhandal, Jennifer Cooke, Naven Pillay, Anjum Shaikh, Sue Stevens and Lucy Thompson. A sitting member of the Committee had resigned thus creating a sixth vacancy. Therefore, all of the nominees were accepted as members.

Before the commencement of the AGM, Sheridan McDonald gave a presentation on the Acceptance and Discharge criteria for referrals to the Paediatric Dental Service. A copy of the criteria is attached to these minutes.

Direct referrals for Undergraduate provision were being accepted at Brierley Hill and Stourbridge.

As Chair of the Paediatric MCN, SM underlined the need for GDPs to become involved with MCNs and assuring that their participation would be welcomed.

It was suggested that a more formal study day with CPD would be welcome, with the presentation of case studies and/or safeguarding issues.

## Apologies

Andy Hargreaves, Dave Philpott.

## Chair's Annual Report

Sue Stevens gave the Chair's annual report.
There were now regular meetings between LDC Chairs and AT representatives. Janet Clarke had been installed as Chair of the LPN and six MCNs had been set up with variable GDP involvement. The level of welcome that GDPs received at these meetings was also variable.

There were now two Consultants in DPH and there were a number of DPAs who worked when called upon by the AT and whose role was now more regulatory than supportive.

Nationally, there was uncertainty over the process of Contract Reform which appeared to have stalled. There was also the spectre of the introduction of tiered care which could be a complication for GDPs.

The BDA led judicial review concerning the role of GDC was due to be heard on 15th December. It was a decision for each individual practitioner as to how to manage payment of the ARF. A motion of no confidence in GDC was to be debated at a special LDC Conference during Officials' Day next week.

There had been major problems with the collection of the Statutory Levy but at long last these had now been resolved.

The role of the LDC continued to be one of support for local practitioners.

**Election of Officers**

Chairman - Sue Stevens and Balbir Bhandal were nominated from the floor. After a vote, Sue Stevens was re-elected as Chair.

Secretary - David Cooper elected unopposed.

Treasurer - Annette Southall elected unopposed.

**Minutes**

These had been circulated. They were accepted by the meeting.

**Matters Arising**

The Area Team will be merging with that of Arden, Hereford and Worcester but will remain based at St Chads in Birmingham.

David Cooper had approached PDS practitioners inviting them to voluntarily contribute to the LDC levy. Only one had offered to contribute.

**Levies and Honoraria**

Payment for April to September had now reached the LDC account and a regular monthly amount of £2100 would now follow.

DC pointed out that it was customary for LDCs to award honoraria to their executive officers in recognition for the time that they spent on LDC business. After some discussion, it was proposed that the Chair should receive two monthly sessional payments at Guild rate, and the Secretary and Treasurer one each. After a vote this proposal was passed.

Payments to the British Dental Guild were up to date and it was agreed that a further donation of £2000 should be made during the next financial year.

**GDPC Meeting Report**

DC had circulated a report of the meeting held in October to all practices.

GDPC elections were due to take place in the New Year and boundary changes meant that there would be two representatives to cover the AT region. This could result in both being elected from Birmingham and none from the Black Country. DC hoped that Dudley practitioners would help to re-elect him at the election.

**LDC Chairs/AT Meeting Report**

SS reported on the recent meeting.

Incorporation was still possible but applicants must show that there would be a benefit for patients.

The AT was attempting to clarify the position of Providers as to whether they had declared themselves as Health Service bodies when originally signing their contracts.

A rather aggressive letter had been sent to Providers regarding surgery opening hours over the Christmas period. Sub-contracting would be permissible but the AT should be informed of any arrangements made.

**LDC Officials' Day**

A special conference of LDCs had been called to debate the following motion;

'This Conference believes that the GDC has failed in its role as the regulator for Dentistry and therefore moves that a new model of regulation is sought that will both protect patients and have the support of the dental profession'.

The special Conference is to be included in the agenda for Officials' Day on 5th December and SS and DC will be in attendance. After some discussion, the Committee unanimously endorsed the motion empowering the Dudley delegate to vote in favour at the Conference.

**Date of Next Meeting**

Monday March 9th at 6.30 at the same venue.

**Acceptance and discharge criteria for CCDS Paediatric Dental Services**

**April 2014**

The Paediatric Dental Team provides care for children up to the age of 16 years old. A range of services are available, this includes treatment by

- Undergraduate dental care professionals (dentists and therapist/hygienist students
- Community Dental Service clinicians
- Consultant

**Important information for referrers:**

**Not all services are available at all clinics and it may not be possible to offer the dental care required at the nearest clinic to a child's home address.**

Consequently, it is important that referrers discuss this with parents/carers prior to referral. All referrals will be assessed in a central location and be allocated based on the content of the referral letter. For this reason, it is imperative that as much information is included as possible to enable the child to be seen by the most appropriate member of staff/student in the best location for that service.

Referrals are accepted from dentists and other health care professionals for children as follows:

**Enhanced services:**

1. Caries and poor co-operation.

   It is inappropriate to refer a child for caries without having provided dietary advice, oral hygiene instruction and some attempt has been made to acclimatise the patient, ie introduction to equipment, placement of temporary dressing.

2. Children with a significant medical condition, learning disability and/or behavioural problems with dental disease requiring treatment that is unable to be provided in a primary care setting. Referrals will also be accepted where co-operation is too poor to be able to undertake a basic dental examination. (Please note: this does not include the pre-cooperative child who is disease free.)

3. Extractions where local anaesthesia alone has been unsuccessful and requires inhalation sedation.

4. In Sandwell, Dudley and Walsall, extractions requiring general anaesthetic. In Birmingham, referrals should be sent directly to Birmingham dental Hospital. Please note: simple orthodontic extractions will not be undertaken using general anaesthetic.

5. Children requiring dental treatment where there are complex social issues to be resolved – please provide as much information as possible to make the reason for referral clear.

**Specialist Services:**

1. Dental anomalies, eg enamel/dentine defects, delayed eruption, supernumerary tooth, molar incisor hypomineralisation etc

2. Poor prognosis permanent teeth in the mixed dentition.

3. Dental trauma – referrals for simple restoration or closed apex endodontic treatment will not be accepted.

4. Non carious tooth tissue loss.

5. Children with a significant medical condition, learning disability and/or behavioural problems who cannot be managed by enhanced practitioners.

6. Adolescents (14 years plus) requiring intravenous sedation for dental treatment – restorations or extractions.

7. Complex or failed extraction where GA is not required.

8. Comprehensive dental care under general anaesthetic for children with learning disabilities (Sandwell, Dudley, Walsall). (Birmingham children should be referred to Birmingham Dental Hospital.) Children with serious medical problems should be referred directly to Birmingham Children's Hospital.

**Student care:**

**PLEASE NOTE:** treatment is only available during term time.

At all other times the referring dentist will be required to see the child eg holiday periods, emergency care or if the care is beyond the scope of an undergraduate. Children not suitable for undergraduate care will not be transferred to Community Dental Services unless they fulfil the acceptance criteria for those services.

1. Any age up to 16, but ages 4 to 13 are ideal.
2. Willing to be treated by students.
3. Be prepared to travel for several appointments.
4. Co-operative
5. Post G.A. preventive care/acclimatisation.
6. Simple preventive care - e.g. fissure sealants, dietary advice, disclosing and brushing etc
7. Scaling, polishing, periodontal care
8. Microabrasion
9. Extractions under L.A.
10. Pulp treatments, preformed metal crowns, anterior composites.

**Discharge**

If a child is referred by a dentist, he/she will be discharged to the referring dentist upon completion of the course of treatment.

Children referred by other health care professionals will be signposted to NHS General Dental Services or undergraduate teaching clinics upon completion of treatment

The exceptions to this will include:

- Children with significant medical needs which require them to receive ongoing care from a Specialist or clinician with additional skills in managing the medical issues – this includes challenging behaviour attributed to medical diagnosis (eg ADHD, autistic spectrum).
- Where there is a clinical indication to monitor eg dental trauma, poor prognosis first permanent molars (this list is not exhaustive). In these types of circumstance, shared care will be undertaken with the referring dentist.

Where shared care is being undertaken, it is the responsibility of the general dentist to provide preventive advice, hygiene support and fluoride applications (as clinically indicated).

All children will be discharged from paediatric dentistry upon reaching their 16$^{th}$ birthday, upon completion of treatment. Depending on clinical need, adolescents will be signposted to:

General Dental Services
Special Care dental services
Other Specialist dental services