

Abstracts

Papers presented at the BASCD Spring Presidential meeting in Cambridge, UK, March 2006

Salaried Primary Dental Care Services: A Vision

Janet Clarke, Chair of Central Committee for Community and Public Health Dentistry, British Dental Association.

Objective To consider current legislative and policy changes in England that directly affect the Salaried Primary Dental Care Services (SPDCS) and explore the impact of these on the service after April 1st 2006. ***Issues*** The final outcome of the review of SPDCS - Creating the Future, set out proposals to modernise career structures for salaried dentists. The Acting Chief Dental Officer has also confirmed that NHS Employers will be negotiating a new payscale for non specialists in the service. The Department of Health has just issued a Factsheet on commissioning SPDCS after April 1st 2006 and Directions are awaited. ***Impact*** Salaried services in England will either be new Personal Dental Services or Primary Care Trust Dental Services from 1st April. All services will operate in the same way as the General Dental Service (Performers Lists, dental charges, use of FP17 and collecting Units of Dental Activity). ***Conclusion*** Services might have both specialist lead teams (for example providing Special Care Dentistry) and generalists teams (providing general dentistry). Services need clear and detailed service level agreements or contracts to describe and protect the valuable work they currently do.

Specialisation in Special Care Dentistry

Janice Fiske, Guy's, King's and St Thomas' Hospital, London, UK

This presentation outlined what Special Care Dentistry (SCD) is; why a Specialty is needed; and what the current situation is. SCD describes the oral health care requirements and delivery of treatment for people with impairment, disability and/or complex medical conditions. There are 10 million people in the UK with disability/long-term illness that limits daily activities. For many reasons disability is increasing. Whilst the ethos of SCD has always been directed towards reducing health inequalities, the oral health of people with disability remains poorer than in the general population. People at the complex/severe end of the disability spectrum have most difficulty in accessing care. One of the reasons for this is lack of specialist training in SCD. A Specialty in SCD would provide a career pathway with appropriate education and training, workforce development to meet the needs of disabled people and training/support for other sectors of the dental workforce.

In December 2005, the GDC supported, in principle, the development of a Specialty in SCD and is currently consulting on the composition of the group that will take this forward.

Specialisation and Specialist Lists: Implications for the Primary Secondary Care Interface

John Lowry, Chairman Standing Dental Advisory Committee, Oral & Maxillofacial Surgery, Royal Bolton Hospital, Bolton, UK

Specialisation in dentistry evolved within both acute general and dental teaching hospitals with major advances resulting from experience gained in the management of the casualties of armed conflict. The establishment of the NHS in 1948 saw consultant dental surgeons appointed in parity with medical colleagues; an essential pre-requisite being the Fellowship in Dental Surgery denoting equality of training. Consultant work in general hospitals although predominantly surgical included a diagnostic and advisory service in any branch of dentistry where the treatment required the 'skill, knowledge and facilities ' not available to the general dental practitioner. Consultant appointments in non-surgical dental specialties formerly confined to dental teaching hospitals progressively emerged initially in orthodontics and restorative dentistry. However practitioners in the primary care setting continued to provide specialised services and the vision of senior colleagues including Professor Sir Paul Bramley and later Dame Margaret Seward provided the catalyst for the formal establishment of a range of specialties by the General Dental Council. This together with more recent administrative changes has resulted in a number of innovative models for the delivery of specialist services and the aim should be to build on these with more cohesive working for the benefit of our patients.

Reconfiguration of Salaried Primary Dental Care Services in Cheshire- a case study.

K.M. Milsom, C.Temple, Halton NHS Primary Care Trust

Objective: To describe both the existing structure of salaried primary dental care services in four Primary Care Trusts in Cheshire and a proposal to integrate the services in light of the reorganisation associated with "Commissioning a Patient-led NHS". ***Method:*** A descriptive case study. **Results:** A plan for the integration of salaried primary dental care services within South Cheshire was drawn up. Outline agreement was reached to formally link the integrated service with the local Foundation Trust acute hospital. Due to the merging of Primary Care Trusts as part of the NHS reorganisation, the plan was shelved. ***Conclusion:*** Benefits of an integrated salaried primary dental care service were demonstrated, but ultimately change is unlikely to occur without the active support of the parent Primary Care Trust.