**PDS Liaison Group Meeting**

**Meeting 2 Note**

**01 December 2022**

**1. Welcome**

ZI welcomed the group and noted apologies from JW. He covered the key discussion points from the last meeting.

**2. CDO Advisory Group Meeting Overview and Discussion**

A brief overview was given regarding the items discussed in CDO advisory meeting 2.

The restorative section of the revised determination 1 draft was shared with the group for discussion.

The main points made were:

*Fillings*

* It was noted that streamlining would be a good change however, PDS members shared same concerns from CDO Advisory Group. There would be a need for clarity on practitioner opinion to separate clinical need vs aesthetic.

*Endodontics*

* A number of PDS patients require re-treatment of failed endodontic treatment. This is still being considering for inclusion.
* Inclusion of pulpotomy was raised. As this was also discussed in the CDO advisory meeting it was noted that it is being considered for inclusion.

*Temporary Crowns*

* Consider using stainless-steel crown to stabilise permanent teeth. Pre-formed crowns are also used on a palliative basis in care-home settings.
* Perhaps use of the word “temporary” may need clarification or terminology change.

*Crowns*

* Conversation needed with labs regarding how lab fees will be set with lab based items.
* Important to future proof as price of scanners is decreasing. That will filter into cost of lab based work e.g. milled crowns.

*Post /Core Retention*

* Language used is open to misinterpretation. Members highlighted it currently reads a possible indication to post OR core. It should read as (post- and-core) together.

*Inlay/Onlay*

* Members welcomed clinical freedom to be able to use what is best.
* Members asked if veneers be included in inlay /onlay section as ‘’extra-coronal’ treatment/restorations (even if it requires proviso about case selection).
* Another comment was made on potential to include internal bleaching, which is being considered.
* It was asked if the intention to have Determination 1 and no discretionary fee list. There was confirmation that the intention is for **no** discretionary fees but want the codes to be broad enough to include a wide range of treatments etc.
* Members highlighted that sometimes there is in an indication for veneer post trauma etc., and there is a need for the least destructive treatment option to be available for the patient.

*Conventional bridges*

* There were no additional comments or queries.

*Extraction*

* Members agreed that a lower third molar extraction is complex and should have extra code.
* It was highlighted that it wasn’t clear where a soft tissue biopsy would sit. Within PDS this treatment is possible but maybe not in GDS as there would still be a need to send to hospital to be reported on.

Wording may need to expanded to cover both GDS and PDS circumstance.

*Sedation*

* Wording requires change to include PDS use.
* It was asked if it could be checked if the sedation modality narrative is in line with current SDCEP and other guidance.
* It was asked if wording for sedation assessment could be widened to include pre assessment for general anaesthesia and enable them to be counted as activity. This is unlikely.
* Possibility to split into routine sedation and advanced sedation techniques.
* Suggestion that rather than ‘sedation assessment’, to use “behaviour management assessment” so patient can be referred on correctly. Possibility of “pre-operative sedation assessment” was suggested. This would be an assessment prior to the sedation under treatment appointment.
* It was asked if oral as well as inhalation and IV sedation could be included

*Dentures*

* Members asked if there could be some alignment between payment and fees.
* Wording of the section would be discussed. As a number of queries were highlighted:

In the circumstance that acrylic would not be suitable for patient, it was queried what if it was for their best interest i.e. allergy, not be able to cope with the full plate etc. There was an ask for special trays to be explicitly included with dentures, this then gives basis of conversation with lab side of dentures. Additionally, the code currently reads like acrylic are treatment of choice.

* In CoCr narrative, it was asked if there could be the inclusion of wording used in crowns and bridges sections – that good OH and stable dentition, is an imperative.

*Splints*

2 codes, 1 is trauma, 2 is lab-made.

* Members noted the codes seem very broad.
* It was asked if wording could be changed to include fluoride trays (especially in post-radiotherapy patients), sports mouth guards and, orthodontic retainers.
* Comment made that the lab fees for soft splint and some hard splints are significantly different and perhaps a distinction needs to be made

*Domiciliary*

* It was noted that in the PDS, some practitioners see many domiciliary cases and should be treated as ‘enhanced skill’ GDPs with an ‘opt out’ of claiming the dom fee when “out on” a domiciliary session rather than individual dom case. It was agreed that there is a need to align with both groups.
* Members asked if there would be a way to highlight the requirement for registered patient to be seen on dom basis if living within a 5 mile radius of the practice and the fee available.

The discussions were then concluded and it was noted to the members that the points made will be fed back to advisory group for any changes or amendments.

**4.** **Review of key themes discussed at previous meeting on 17 November 2022**

Concern regarding unrealistic turnaround time for feedback comments after last meeting was acknowledged.

It was asked if there were any additional comments members would like to make following the previous meeting.

There were no additional comments made.

**5. Complexity Tool**

A brief overview was given on complexity case mix for PDS within R4.

A member of the group with experience of previous discussions was then asked to speak more about the use of case mix going forward to reflect complexity of certain cases (according to an external meeting they had attended and from their area).

* It was noted that there was a considerable discussion on tools available. Within R4, the Bateman tool was being used. There was encouragement to look at the modified case tool but no obvious push (via IT systems). It had then become apparent that practitioners were not using it and more routinely default to BDA tool. Only when it was obvious the modified tool was to be used, did practitioners do that.

PDS were asked which tool should be used going forward with the expectation of this being rigidly applied. It was agreed by the group that the **Bateman tool** would be used and incorporated into any new system.

**6. AOB and Sum Up**

It was noted that implant maintenance had not been discussed and that going back to original care provider just isn’t viable for people especially if they are now resident in a care setting.

A number of queries and points were made by members:

* Members noted that if there was to be placement of implants in primary care, it would need to be part of commissioned enhanced restorative practice.
* Mouthguards and splints – concerns raised re there being no differentiation between soft and hard splints – pointed out that a soft splint is considerably cheaper than a hard ‘Michigan’ splint.
* Can soft single colour (or no colour) sports mouthguards be included since if the Det I is genuinely preventive it should be there with a proviso when permanent teeth are erupted (children only?)
* Can fluoride trays be included (with proviso for post head and neck radiotherapy patients & ? other conditions)
* Can thought be given about trauma retainers as often it takes a couple of  splits to complete the treatment, and can there be clarification that this also includes a visit for retainer removal as that is a separate appt)
* Ortho practices completing treatment but sending patient for retainer construction back onto referring GDP, there may be a need to clarify that in ortho section of original Det I.
* Can the exemption from dom fees for enhanced skills GDPs also be applied to PDS dentists as some dentists spend a lot of time doing doms and the current system doesn’t work for them as it can trigger Prior Approval for every case – which delays care so they spend time trying to find a workaround?
* Members stressed that the caveat that registered dentists must see their patients on a dom basis if the live within a 5 mile radius of the practice -  members stated that GDPs routinely try to bump dom patients to PDS when they are within a 5 m radius and it takes up a lot of time getting some GDPs to accept that reality
* There was a final ask about implant maintenance especially for residents in care homes – may be too complex at the moment but seemingly an increasing problem.

**7. Concluding Remark and Next Steps**

The CDO thanked members for what was a very good discussion and the points raised will be fed back to the CDO Advisory Group Chairs.

If, on reflection, anything has been missed, members should email the team to highlight the concern.

The next CDO Advisory Group meeting would be 15 December. It was requested that PDS group members could return any comments before then and the meeting was then concluded.

**CDO & Dentistry Division**

**Scottish Government**

**December 2022**