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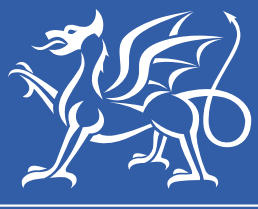

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Consultation Document

Together For Health

A National Oral Health Plan for Wales

Date of issue: **18 July 2012**
Action required: Responses by **12 October 2012**

Overview

This consultation exercise seeks views on the Welsh Government's draft National Oral Health Plan.

How to respond

Please respond by 12 October 2012 using the accompanying response form.

Response forms can be sent to:
Dental Policy Division
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Or completed electronically and sent by email to: dentalconsultation@wales.gsi.gov.uk.

Further information and related documents

Large print, Braille and alternate language versions of this document are available on request.

Contact details

For further information:

Simon Parker
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CF10 3NQ

email: dentalconsultation@wales.gsi.gov.uk

telephone: 029 2082 1609

Data protection

How the views and information you give us will be used

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

Contents

Ministerial Foreword

It gives me great pleasure to present this National Oral Health Plan for consultation. It outlines an agenda for improving oral health and reducing oral health inequalities in Wales over the next five years and beyond. The Plan fits in well with our vision for the NHS in Wales outlined in Together for Health.

To achieve our aims, change is required. The skills, experience and dedication of the dental workforce are, and will remain, a vital resource upon which we will need to draw in order to achieve change. Oral health is an intrinsic part of general health and it is the responsibility of everyone involved in delivering health services, to play a role in helping to deliver the oral health improvement we need to see.

There remain sharp differences between individuals with the best and worst oral health in Wales and our performance lags behind similar countries in some important aspects. Sustainability lies at the heart of our agenda and good health is vital to the creation of a prosperous, successful and sustainable Wales. We must improve the health of everyone in Wales and pay particular attention to the young and reduce health inequalities. We must ensure we have modern NHS dental services delivering high quality care.

Prevention is at the core of this Plan. Reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.

One of our major goals must be to help people take responsibility for ensuring their own good oral health.

Comments about the proposals contained within this document are important to us in determining the final shape of our planning for improvement of oral health and delivery of evidenced based, quality dental services. We seek the views of users of dental services, those working in dental services and those of professionals from the wider fields of health, social care and education. By working together, we believe we can make a real and sustainable difference to the oral health of our country.

Signed

Lesley Griffiths AM
Minister for Health and Social Services

What we need to do to improve oral health

Key Issues

- Inequalities in dental health in children.
- Differing needs of adult age cohorts.
- Oral cancer outcomes.
- Awareness of people's responsibility in taking care of health.

Where we are

- Email pilot ongoing.
- HTM01-05 published (decontamination guidance).
- National minimum standards agreed.
- Designed to Smile in place nationally.

Where we need to be
Key actions to consider to meet Programme for Government Commitments

- Local Health Boards to develop local oral health action plans.
- Roll out integrated NHS IT Systems to all NHS dental practices.
- Develop awareness campaigns for care of high caries risk groups.
- Provide each dental practice with Delivering Better Oral Health Together linked to Designed to Smile.
- Expand Designed to Smile to include vulnerable adults residing in care homes.
- Develop targeted public education programmes on oral health issues.
- 1000 lives campaign to improve antibiotic prescribing; audit HTM01-05; and publish mouthcare bundle for hospital patients.

How do we ensure we have effective and efficient dental services

Key Issues

- Effectiveness of Orthodontic services.
- Need to review the way dentists are paid.
- Patchy access to services in some areas.
- Need to keep NHS dental services affordable.
- 6 month recalls and NICE guidance.
- Patchy access to specialist services delivered in primary care.

Where we are

- Piloting new ways of working.
- Guidance published on effective planning of services.
- HTM01-05 published.

Where we need to be
Key actions to consider to meet Programme for Government Commitments

- Design new primary care service model making use of all the dental team.
- Improve clinical engagement with primary care clinicians.
- Develop new recruitment and retention process for primary and secondary care.
- Ensure appropriate specialist services are available in primary and secondary care.
- New guidance including new clinical pathways.
- Improve access to NHS where patients are finding it difficult.
- Review activity profile of Community Dental Service.
- Ensure policy in place to develop alternative solutions to general anaesthesia.

What we need to do to maintain and improve quality and safety

Key Issues

- Geographical and demographic challenges of workforce.
- Access to high quality post graduate training is available.
- Access to specialist and academic staff.
- Ability to recruit to some posts (geographically).
- Inequitable access of dental nurse training.

Where we are

- Orthodontic MCNs developed (service).
- Some pilot primary care specialist contracts in place.
- New outreach teaching facilities for Dental Foundation Training (DFT) and undergraduates in place.
- Workforce review ongoing.

Where we need to be
Key actions to consider to meet Programme for Government Commitments

- Publish standards for NHS private dental services.
- Develop Dentist with Special Interest (DwSI) process.
- Develop national dental nurse training framework.
- Develop policy and guidance on referral pathways between secondary and primary care.
- Review private dentistry regulations.

Setting the Scene

Having an unhealthy mouth can have a real impact on health and wellbeing. This is particularly important in Wales as oral problems are strongly linked to deprivation. However, there is much we can do to tackle this important public health problem, as oral diseases are almost entirely preventable.

The purpose of this document is to set a way forward for improving oral health in Wales. We want oral health in Wales to be amongst the best in the world. We also want our dental services to deliver high quality care and be best suited to the needs of residents in Wales.

Following an introduction, we have a number of sections that examine the issues relating to oral health in detail. Section 1 focuses on the inequalities in oral disease and who is particularly at risk. Section 2 discusses how we can improve the effectiveness and efficiency of our dental services and describes what needs to happen to the dental workforce in Wales in order to enable the continued delivery of high quality services. Section 3 examines how we can improve the quality of dental services so they promote access and health outcomes, as well as provide excellent treatment. Each of the sections makes recommendations for action that are summarised at the end of the document.

Our vision is to improve the oral health of the people of Wales so everyone can benefit from better oral health throughout their whole life span.

We have set out our key aims and actions for improvement in our ***Programme for Government*** which translates our manifesto into a clear plan to deliver for the people of Wales. ***Together for Health*** aims to have health and health care services in Wales matching the best anywhere. It also aims to encourage people to take responsibility for their own general health and well-being and in doing so improve their oral health.

On oral health and dentistry we specifically aim to:

- continue to increase access to dentists where there are localised problems;
- prevent poor oral health and reduce inequalities through the continued implementation of Designed to Smile to improve the oral health of children;
- invest in raising awareness of people's responsibility in taking care of their own oral health as they should for their general health and well-being;
- ensure dental charges remain affordable and in doing so help tackle oral health inequalities; and
- require Local Health Boards to produce a strategy for specialist dental services.

Section 1: Oral Health Needs and Inequalities

What is happening to the Welsh population?

The population of Wales increased from 2.90 million in 1999 to 3 million in 2010. Between 2001 and 2010 the number of people aged under 45 decreased by 3 % while the number aged 65 and over increased by 9.2 %. The number of live births in Wales increased from 32,325 in 2004 to 33,952 in 2010.

The population of Wales is projected to increase by 8% from 2008 to 3.2 million in 2023. The number of children (0-15) is projected to increase by under 5 % (26,000), the number aged 65 and over is projected to increase by around 35 % (189,000) and the number of people aged 16-64 is projected to increase by 1 % (13,000). The population of Wales will become gradually older with the median age of the population rising from 41.1 years in 2008 to 42.5 years in 2023.

http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx?ReportId=10879

An increase in the population, with particular increases in young children and the elderly will, over time, have major service delivery effects. Action will be required to meet these changing needs of the population.

Child Dental Health

Detailed information on the oral health status in Wales, including comparative data, can be accessed from the Welsh Oral Health Information Unit:

http://www.cardiff.ac.uk/dentl/research/themes/appliedclinicalresearch/epidemiology/oralhealth/index.html

The most common oral disease of childhood is dental caries (tooth decay). Children living in deprived communities in Wales have the poorest dental health in the UK. Tooth decay is found in all population groups but is more common in deprived communities. Whilst half of 5 year old children across Wales have no decayed teeth, the other half experience a high disease burden and have, on average, four teeth decayed or filled or extracted.

The trend in prevalence of child dental decay in Wales is generally static. This suggests many children will continue to suffer with poor dental health unless more action is taken. Children who start brushing with fluoride toothpaste in infancy are less likely to experience tooth decay than those who start brushing later.

The dental health of Welsh 12 year olds has improved. There have been dramatic improvements in decay levels in permanent teeth since fluoridated toothpaste became widely available in the 1970s. However, despite this improved situation Wales still lags behind the rest of the United Kingdom.

In order to maximise oral health improvement a partnership approach needs to be complemented with maximising fluoride delivery in community settings. The

evidence supporting fluoride in reducing dental decay is well established, and local priorities for action at a community level are the use of fluoride toothpaste and fluoride varnish.

Welsh Government child dental health targets

Dental health targets were set in *Eradicating Child Poverty in Wales – Measuring Success:*

http://wales.gov.uk/topics/childrenyoungpeople/publications/eradicating/?lang=en

We intend to vigorously address this inequality in experience of child tooth decay over the next 5 years.

The role of fluoride in prevention

While decay results from bacteria on teeth (through converting sugar in the diet into acid on a frequent basis), simply advising children not to have sugary snacks between meals is rarely effective. ***The scientific evidence suggests almost every proven method to prevent decay involves some delivery of fluoride to teeth surfaces***. Although most toothpaste contains fluoride some children do not brush their teeth at all.

Currently there is no fluoridated water supplied in Wales. The key message the Welsh Government has continued to convey in relation to fluoridation is:

"The Welsh Government has no current plans to fluoridate water supplies in Wales. The Welsh Government acknowledges that in view of the poor dental health in Wales, the introduction of water fluoridation has the potential to deliver significant health gains and address health inequalities. However, it is sensitive to the fact there are small groups of people opposed to it."

Research into the effectiveness of preventive programmes

Currently Designed to Smile is targeted at younger children and seeks to establish patterns of behaviour with long term impact which should carry forward throughout life. It is intended to examine whether Designed to Smile can influence decay levels in 12 year olds by 2020. In 2012 those children are aged 4 years.

Within Wales, there is a study currently underway to examine the cost and effectiveness of fissure sealants and of fluoride varnish in preventing decay commencing from age 6-7 in a community and school settings.

A widening gap between oral health of children from the least well off and the most well off families continues. Action is required to halt these inequalities.

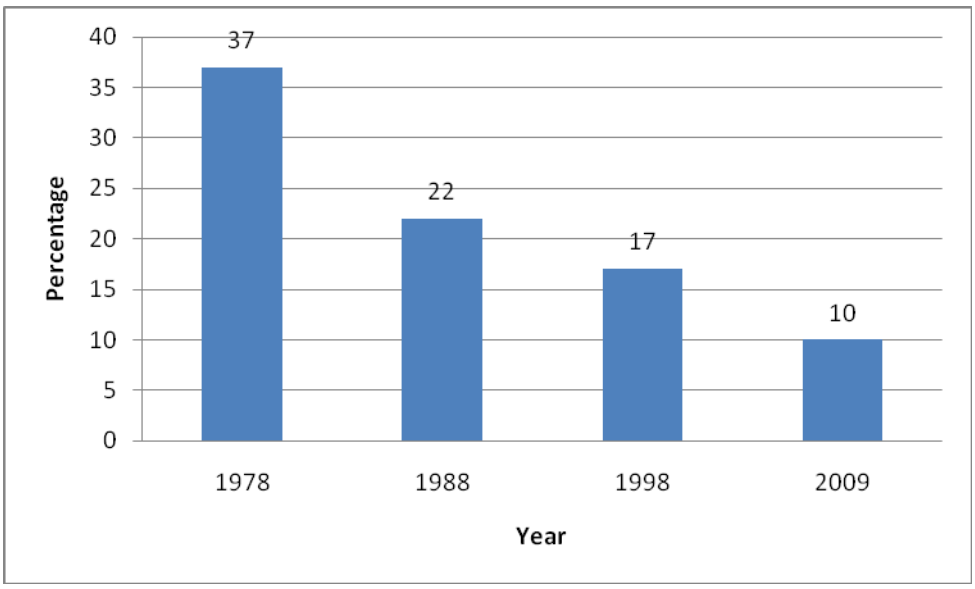
Building capacity in deprived communities through Designed to Smile is critical. Although the evidenced based core of the current programme will remain as the central pillar of the initiative, it is justifiable to extend the scope of the programme to other target groups in order to address oral health inequalities in other age cohorts.

Adult Dental Health

Improvements in oral health in adults

Deprivation levels are linked to numerous health problems (chronic illness, lower life expectancy, dental caries) and unhealthy lifestyles (smoking, drug misuse, poor diet), increasing the need for health resources in those areas. Additionally, those in more deprived areas are less likely to engage with health services, including dental services. In the early years of the 20th Century, it was common for adults in Wales to lose all of their teeth early in life. Tales of young women having their teeth extracted and dentures constructed for a twenty-first birthday or a wedding present were unexceptional. Thankfully those times are past. Successive surveys have shown the percentage of adults in Wales who are without their own teeth has fallen almost fourfold from 37% in 1978 to 10% in 2009 – Figure 1 (The Health and Social Care Information Centre, 2011). Complete tooth loss is now more or less confined to those aged 55 years and older. In 2009 one in five of those aged 65-74 years had no natural teeth with two in five of the population aged 75 years and older.

Figure 1 The proportion of adults in Wales with no natural teeth, 1978-2009



(Source HSCIC 2011)

These changes have come about for a number of reasons. Probably the greatest influence on improving oral health has been the widespread availability and use of toothpastes containing fluoride since the early 1970s. Other factors include improved diet, changed attitudes to oral health, increased access to dental care and advances in dental technology. As a result, patients with a badly decayed back tooth are now more likely to opt to have a filling to save it rather than to have an extraction.

Inequalities in oral health in adults

The changing prevalence of dental disease and improved oral health has a number of implications for future service provision.

- **Young adults** – this group with improved oral health will need to maintain current oral hygiene and dietary practices. For the minority in this cohort who have high levels of dental decay and periodontal disease, targeted prevention and individualised care plans will be required. However, improving oral health does not necessarily mean a lessening of demand for dental care. A bright white smile and perfectly aligned teeth are increasingly seen as an essential component of a healthy body and is becoming a social norm in the young. There are increasing demands on the dental profession to provide orthodontic care for adults, to undertake tooth whitening and other more advanced treatments for aesthetic purposes. NHS dentistry will need to be explicit about what care can be provided. An emphasis on care that is evidence based and a distinction between treatment that is necessary to secure oral health and that which is desirable for cosmetic reasons will be required.

- **Adults in middle-early older age** – this cohort poses the greatest challenge in the coming years as they grow older. The demographics of an ageing population in Wales means over the coming decades, not only will this cohort become larger but older people will have more teeth and retain them for longer. These teeth, which will in many cases be heavily restored, require more care both on the part of their owners and the dental profession than did dentures. This picture will be complicated by co-morbidity which impacts on (i) oral health (e.g. the side effects of drugs on the production of saliva necessary for healthy mouth tissue) and (ii) the ability to receive dental care (e.g. dementia).

  Advances in dental technology (e.g. dental implants) will, as in other areas of health care, see increasing financial demands for dental care resources. It will again be necessary to make explicit use of the evidence base and develop guidelines on what can be expected and delivered under the auspices of NHS dentistry.

- **Older adults** – the cohort of adults who have lost all their own teeth will diminish. However, access to the provision of complete dentures, once the staple of every dental practice, will still need to be secured for a smaller number of patients who require that form of care. Similarly, the needs of those who become partially dentate or who lose their remaining teeth late in life will need to be catered for.

Oral Cancer

We have recently published Together Against Cancer: A Cancer Delivery Plan for Wales. The consultation can be accessed at:

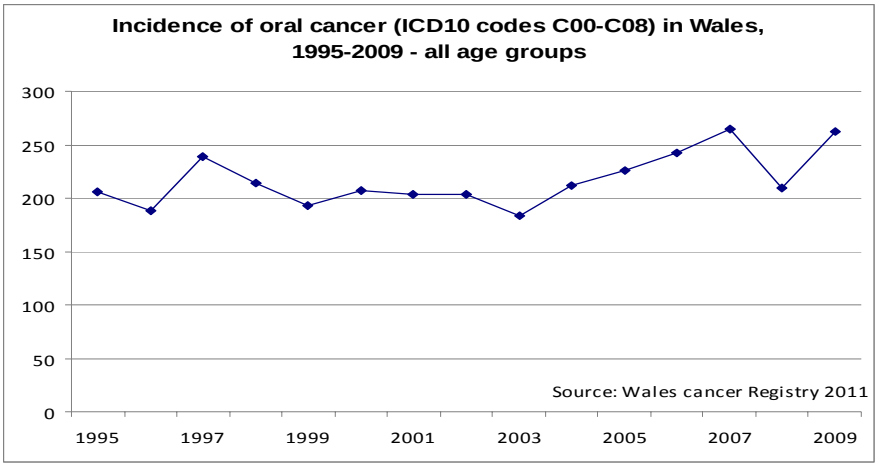
http://wales.gov.uk/consultations/healthsocialcare/delivery/?lang=en

We look forward to responses from the dental profession in Wales.

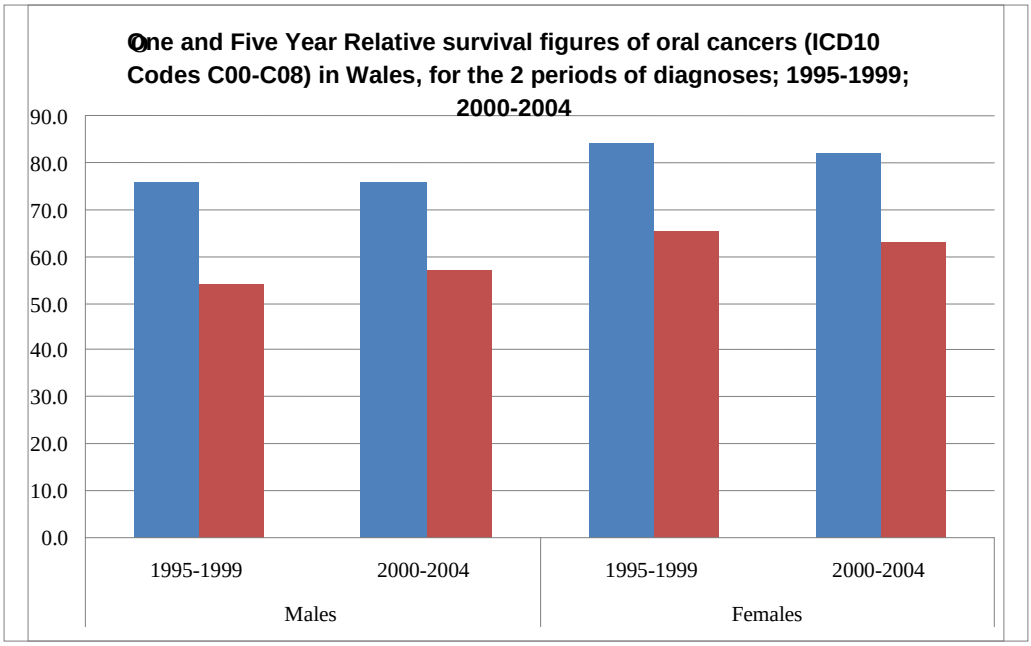
The main causes of oral cancer have long been known and many cases of the disease could be prevented. The most important aetiological factors are tobacco usage and excess consumption of alcohol and these factors together are thought to account for about three-quarters of oral cancer cases in Europe.

Most oral cancer patients are diagnosed at a late stage in their illness. The overall prognosis would be considerably improved if patients could be diagnosed at an earlier stage. Small and early oral cancers are highly curable but many patients, particularly when their cancer is diagnosed at an advanced stage, have to cope with the sometimes debilitating consequences of their treatment. These may include difficulties with speaking, chewing and swallowing and facial disfigurement. Prognosis is best for patients with cancer of the lip, the most accessible site for treatment.

In the UK in 2007, 5,410 persons were diagnosed with an oral cancer (263 in Wales). Across countries the highest incidence, for both males and females, is in Scotland. In the UK and most other countries, oral cancer is more common in men than women. However, the sex ratio in the UK has decreased rapidly from around 5:1 fifty years ago to less than 2:1 today. The risk of developing oral cancer increases with age and in the UK the majority of cases (87%) occur in people aged 50 or over. Data for Welsh residents is shown below:



Five year survival rates for cancers of the lip, oral cavity, tongue, oro-pharynx and hypo-pharynx vary. The best outcome was for cancer of the lip with over 90% of patients surviving five years and most of these will be cured. The five year rates for lip cancer improved slightly for both men and women during the 1990s. The lowest survival was for hypo-pharyngeal tumours. As with most cancers, survival is better for younger rather than older patients. Improvement in survival over time was analysed by deprivation group, and it became clear that most of the improvement had occurred in the affluent group (Coleman et al 1999). The overall survival rates for Wales are shown below:



Source Wales Cancer Registry 2011

Prevention

At least three-quarters of oral cancers could be prevented by the elimination of tobacco smoking and a reduction in alcohol consumption. The removal of these two risk factors also reduces the risk of secondary tumours in people with oral cancer. Smoking cessation is associated with a rapid reduction in the risk of oral cancers, with a 50% reduction in risk within 3 to 5 years. Ten years after smoking cessation, the risk for ex-smokers approaches that for life-long non-smokers. Protection against the sun would further reduce the incidence of lip cancers. The educational needs of primary carers including dentists must be addressed.

Patient delay has been cited as the main reason for late presentation and it seems probable that in both high-risk groups and the general population, neither the symptoms of oral cancer nor the main risk factors are well understood. With rising incidence rates in younger age groups whose expectation of cancer is low, public education is urgently needed.

All dentists have a key role in providing smoking cessation advice to all patients that smoke (including those attending on an irregular basis for emergency treatment).

Action: Dental teams should have access to high quality postgraduate training to address educational needs in this area.

Government and health board sponsored innovative awareness campaigns are required, especially targeted at the high risk groups.

Treatment

Guidelines for improving services for head and neck cancer patients have been published (NICE 2004, University of York 2004). One of the key recommendations of

the NICE guidance is for services for head and neck patients to be centralised, so patients with these relatively rare cancers receive the best specialist and multi-disciplinary care. We consider it a priority patients should have access to services capable of delivering outcomes comparable to the best in the world.

In partnership with the Department of Health in England, other UK government health departments and the Healthcare Quality Improvement Partnership (HQIP), the Welsh Government supports and funds the cost of NHS Wales' participation in the National Clinical Audit and Clinical Outcome Review Programme (NCAPOP). The Welsh Government also seeks to encourage greater participation and learning from clinical audit leading to improved services and safer patient care through improved communication, leadership, feedback and by building on the advice that it receives from its National Clinical Audit Advisory Committee (NCAAC).

Action: We will ask the Welsh Dental Committee (WDC) to set up an expert working group to review oral cancer audit findings in the context of service structures in Wales and report by Summer 2013.

Vulnerable Groups

The description of an individual as "vulnerable" will vary from time to time. There are some groups of people for whom there is evidence of health inequality and thus vulnerability e.g. the frail elderly; people with impairment and disability; people with mental health and medical problems; and those with anxiety and phobia. Vulnerable groups may have conditions which make it difficult to maintain good oral hygiene and to access/receive dental care.

A strategic approach is required to develop effective services for vulnerable adults in Wales and to ensure the current inequalities in access to, and uptake of, services can be addressed and monitored. It has been reported that access to specialised general anaesthetic lists for these groups is difficult. Action must be taken to ensure these vulnerable people have access to specialised care.

The WDC carried out a review on special care dentistry (SCD) in Wales. Complementing this, Public Health Wales carried out a SCD needs assessment. In response to the subsequent WDC report recommendations the Welsh Government set up a task and finish group to formulate an implementation plan for the development of SCD in Wales. The Implementation Plan submitted by the task and finish group has been accepted and published.

http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/information/dentistry/?lang=en

Action: Health Boards should respond to the SCD Implementation Plan within their future planning of dental services as part of the development of a local oral health plan.

Good Practice: Through Programmes for Children with Learning Disability, all children at all special schools in Flintshire and Denbighshire are offered the opportunity to take part in a schools-based oral health improvement programme. A dedicated oral health educator and dental health care support worker with training and experience in Special Care Dentistry work in a multidisciplinary manner to enable the fulfilment of the requirements of the Children's National Services Framework in Flintshire and Denbighshire.

There is also a Programme for Adults with Learning Disability through which residents with learning disability can benefit from a comprehensive programme of oral health promotion. A full–time dedicated oral health educator leads this programme with part-time inputs via two community learning disability link nurses seconded to the Community Dental Service (CDS). The programme has been locally funded since 2004 and further supported and expanded in 2008.

We acknowledge the work of the All Wales Special Interest Group: Special Clinical Needs - an advisory group of special care dentists and dental care professionals working in the Community Dental and Hospital Dental Service in Wales. The group's website is an excellent resource for those interested in developing special care dental services. http://www.sigwales.org/

Action: Health Boards, in partnership with the Local Authority and the Third Sector, should ensure oral care is integrated into general health and social care plans/pathways of patients with complex medical and social problems.

Good Practice: Aneurin Bevan Health Board has prioritised oral health improvement for children within its Public Health Framework and has developed an oral health promotion strategy prioritising children, older people and vulnerable groups. An Oral Health Promotion Steering Group (with a range of stakeholders, including those delivering Designed to Smile) has been set up. Involvement of a range of stakeholders has raised awareness of the importance of oral health among non-dental professionals, helping to integrate oral health into the work of wider health and social care services. The group is chaired by the Director of Public Health which has provided a direct link to the Executive Board that should improve the decision making processes.

Nursing and Residential Homes

We commissioned two surveys of nursing and residential homes to investigate how their residents access dental care, and to help us get a better understanding of their oral health status and the needs of those residents.

http://www.cardiff.ac.uk/dentl/research/themes/appliedclinicalresearch/epidemiology/oralhealth/index.html

The surveys showed many homes do not have written procedures in place to identify whether individuals have natural teeth or dentures, dental problems or want to see a dentist. Access to NHS dental care can prove difficult in some parts of Wales, and some homes reported difficulties in obtaining routine and emergency dental care for residents. There is variation in the extent to which written care plans are used across Wales and in the range of oral health issues these care plans cover. In 1 in 3 homes staff were assisting residents in cleaning teeth or dentures, but they had not received any training in this.

As a direct result of the survey, we recommended that written procedures are adopted and in May 2011 we published an advice leaflet for residential and nursing homes in Wales *Accessing Dental Care for older people in care homes in Wales* **.** This leaflet provides information on the importance of oral health care for older people and how they can access dentistry in Wales.

http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/information/dentalcare/?lang=en

Patients in Hospital

Fundamentals of Care audits show variable practice in supporting patients in hospital to maintain good oral hygiene and oral comfort. Through the Free to Lead, Free to Care and 1000 Lives Plus programmes we are seeking to improve oral hygiene for dependent patients in hospital. We will encourage building on 1000 Lives Plus work to address oral hygiene for patients in hospital launched by the Minister on 17 May 2012, and for residents in care homes and nursing homes.

Action: Health Boards should take account of and implement the guidance published by the 1000 Lives Plus programme “Mouthcare Bundle for Adults in Hospital”.

Good Practice: Abertawe Bro Morgannwg University and Aneurin Bevan Health Boards, working with the Public Health Wales Dental Public Health team, have set up a Task & Finish Group with the Local Dental Committee, Community Dental Service and other stakeholders to develop an integrated domiciliary care system with central referral management.

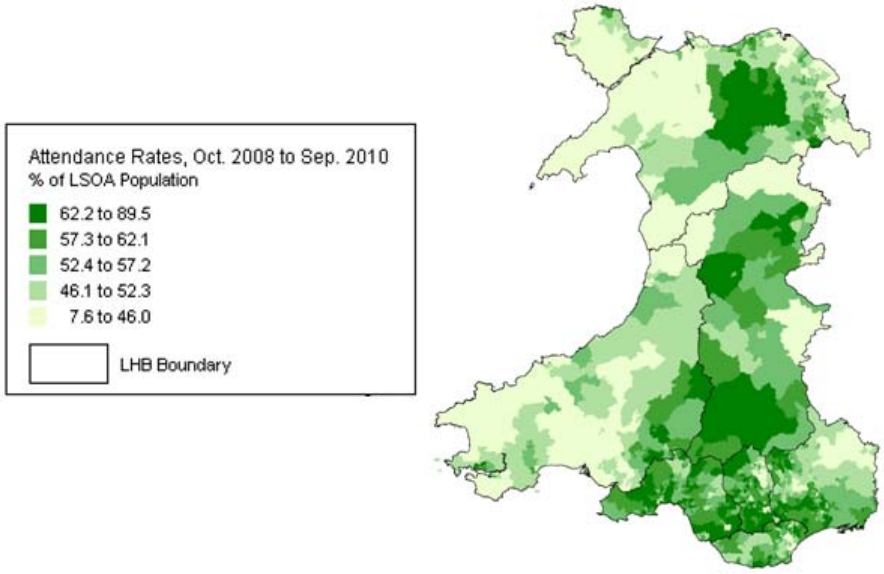
Section 2: Dental Service provision

Access to General Dental Services (GDS)

In the 24 months preceding the end of March 2010, 1.7 million people attended an NHS dentist in Wales. That represents 55.3% of the total population and 52.5% of the adult population (Welsh Government, 2011). Across the whole of Wales the average distance travelled to access dental care was 4.3 miles. However, half of all attendees attended a dentist within 2.3 miles of their home. Only 5% attended a dentist more than 15 miles from home (Blewitt et al, 2011). A survey of citizens’ views of dental practices showed 95% of NHS dental service users were positive

about the quality of care received (Welsh Government, 2011). This data does not include patients who accessed dental care totally independently of the NHS.

It is not possible to collect data centrally on the number of patients who have their dental care on a private basis each year. However, the Adult Dental Health Survey 2009 asked about the payment arrangements for patients' last course of treatment. This reported 29% of adults had their last course of dental care on a totally private basis. This contrasts with the 37% who had NHS dental care and made a co-payment and 33% who had NHS care without a patient charge. None claimed to have had a combination of NHS and private care *(Blewitt et al, 2011).* The map below shows attendance rates across Wales. The darker areas (high attendance rates) contrast with the light areas (low attendance rates).



While overall access appears to have improved some inequalities persist. We intend to work with Health Boards to ensure action is taken to improve access in areas where there are localised problems. We believe there are inefficiencies in the system of GDS service planning and delivery. We also encourage Health Board incentives to assist the setting up/longer term support of practices in areas of low access and high need.

Good Practice: Abertawe Bro Morgannwg University, Betsi Cadwaladr University and Cardiff and Vale Health Boards utilised the data from the report "*NHS Primary Dental Care Provision in Wales ABMU Health Board - Final Report Exploring Current Service Use and the Distribution of Services in relation to need Cardiff University Dental School",June 2011** to inform their plans for contracting GDS services into 2013. This provided assurance that limited GDS funding would be directed at need, and practices where the need was highest, and not towards demand or GDS practices that "shouted loudest".

*****similar reports have been sent to every Health Board.

Action: Health Boards should:

- ensure better compliance with NICE guidelines on recall intervals and information to patients, to ensure that patients do not attend more frequently than necessary; http://www.nice.org.uk/Guidance/CG19
- develop closer monitoring of "splitting" courses of treatment;
- focus contract monitoring and reviews on GDS/PDS contracts that enjoy particularly high value Units of Dental Activity(UDA), to ensure best value for public funding;
- work to the Interim Guidance on Management of NHS Orthodontics in Primary Care;
- support better integration of GDS with other dental services; and
- ensure that one off funding initiatives are based upon need (rather than demand), are evidence based and have a high probability of health gain.

Managing the GDS

We want Health Boards to maintain or develop a pan Health Board approach to management of the GDS budget and contracting of GDS services as part of their integrated service planning. Avoiding fragmentation into small geographical/ management units ensures that the distribution of resources can be determined through a needs based approach. It also facilitates consistent application of contracting arrangements and management policy.

In addition, such an approach cuts out duplication and allows the pooling of management/administration resources and corporate knowledge e.g. through professional input to interpretation of reports from the Dental Services/Business Services Authority which is vital in effective operational handling of the GDS.

Action: We have asked Pubic Health Wales to develop a GDS Governance Framework and a high level annual Reporting Matrix. We will publish the Framework in 2012, and will require Health Boards to complete the Matrix as part of their annual primary care reporting process.

GDS Finance

The Programme for Government outlines the need to ensure that that dental charges remain affordable and in doing so help tackle oral health inequalities. In addition dental budgets will be ring fenced to ensure equitable access.

Action: We have extended the ring-fencing of the dental contract budget until 2015.

Health Board Dental Advisory Structures

The Chief Executive of the NHS in Wales emphasised the need for Health Boards to consult widely with the profession when developing services (September 2009) and stressed the importance of ensuring effective links between the Boards and its dental advisory structures. The response by Health Boards has been variable, indeed we judge some as poor. In addition, we consider it vital Health Boards have processes in place to fulfil their statutory requirements with regard to their Local Dental Committee.

Action: We will seek assurances Health Boards have adequate measures in place to ensure dental professional advice, and access to a multi-professional advisory structure including that of a consultant/specialist in Dental Public Health.

Welsh Dental Pilots

The experience of grappling with the current system often leaves patients feeling disempowered and dentists disengaged. We have a vision of change where innovation is first tested and evaluated in selected areas.

We are looking to develop an NHS dental service which should be available to everyone who needs it - a universal system, one capable of meeting the needs of particular groups in the population, with referral to specialist dental services as necessary. Furthermore, the service should allow the dental team to increasingly focus on preventive measures to combat dental disease and to tackle the oral health inequalities that exist, particularly in the child population.

Subsequent to recommendations of the Dental Contract Task & Finish Group, we decided to test new systems of payment and delivery of GDS services in Wales to find a system that will work better for patients, dental providers and health boards alike. This will be underpinned by evidence based guidelines for patients and dental professionals on just what can be expected and delivered under the auspices of NHS dentistry.

There are two types of pilot programmes in Wales:

1. *Preventive Dental Care for Children and Young People Pilot* - this aims to give incentive to prevention in care of the primary and mixed dentition, complement Designed to Smile and test the introduction of Quality and Access indicators.
2. *Quality and Outcome Utility Pilot- this* tests a new way of working, to address issues of access, quality and prevention.

Eight pilot sites have been running since 1 April 2011. It is early days, but initial indications are that the majority of the pilot sites have embraced the opportunities for

innovation. Miller Research are undertaking the qualitative evaluation and have produced a baseline report identifying that some practices have already made significant changes to skill mix and clinical procedures.

Action: We will continue to pilot systems which move away from the current system of remuneration and delivery, towards a model which focuses on tailored patient care based prevention and/or on risk assessment.

Community Dental Services (CDS)

We remain committed to the provision of the CDS in Wales. New guidance on the role of the Community Services in Wales was issued in 2009.

http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/ministerial-letters/?lang=en

In summary, through their CDS, Health Boards should ensure:

- provision of facilities for a full range of treatment to children who have experienced difficulty in obtaining treatment in the GDS, or for whom there is evidence they would not otherwise seek treatment from the GDS; and
- provision of facilities for a full range of treatment to children and adults who, due to their special circumstances, require special care dentistry and/or have experienced difficulty in obtaining treatment from other services, or would not have otherwise sought treatment from other services.

In addition, the CDS performs other important roles e.g. screening, epidemiology and health promotion.

Recent trends in dental activity: Community Dental Service

As a demonstration of our commitment to development of the CDS, Designed to Smile - our National Oral Health Improvement Programme - is primarily delivered by the CDS and this has helped revitalise that service in parts of Wales where it was in decline. However, although the CDS has risen to the challenge of delivering Designed to Smile, there has been over several years, with the exception of 2010/11, a gradual decrease in the number of patient treatment contacts, individual patients seen and total numbers of people screened.

In summary, activity data for the CDS has been collected directly by the Welsh Government for some years, most recently using a form called “CDSRW” which was introduced with the agreement of the CDS in 2008-09. The most recent data showed:

- there has been a gradual decrease in the number of contacts with the CDS in recent years;
- 78,000 patients (i.e. individuals) were seen by the CDS in 2009-10;

- there were 20,900 patients screened by the 5 CDSs in Wales who were able to provide data in 2009-10. 91% of the patients screened were children.

This may partly be explained by the changing focus of the work within the CDS i.e. towards caring for an increased proportion of special needs and vulnerable patients who need and require greater resources of clinical skills and time. In addition, there is emerging evidence questioning the role of "traditional" dental screening of schoolchildren. We need to understand more about the reasons behind these activity trends.

Action: We will request, through the Welsh Dental Committee and in the strict context of the extant national guidance of the role of the CDS in Wales, the CDS Clinical Directors Group inquire and report into the reasons behind the changing trends in reported CDS activity, and report to Welsh Government by September 2013.

We will request, through the Welsh Dental Committee and in the strict context of the extant national guidance of the role of the CDS in Wales, that Public Health Wales inquire and report on the emerging evidence regarding dental screening and its relevance to Wales, and report back by September 2013.

Designed to Smile

Designed to Smile is a targeted National Programme. Its primary focus is the improvement of the dental health of children in Wales. It is funded by the Welsh Government and was initially launched on the 30th January 2008 in both North and South Wales as a pilot. In October 2009, due to the successful implementation of the pilots, we announced the programme would be enhanced and expanded to cover the whole of Wales. At the present time, 61,524 children from 920 schools and nurseries in the most deprived parts of Wales are participating.

The recent report of the National Assembly for Wales Children and Young People Committee Inquiry into children's oral health (February 2012), examined the effectiveness of the programme in improving the oral health of children in Wales, particularly in deprived areas. Many of the Committee's recommendations supported the current policy direction and also recognised the progress made to date, including the importance of the development of a National Oral Health Plan which will have Designed to Smile at its centre.

Designed to Smile is underpinned by an evidence based review conducted by the Dental Public Health Department at the Cardiff University Dental School, and by guidance set out in Welsh Health Circular (008) 2008 and Ministerial Letter EH/ML/032-09 Expansion of Designed to Smile – A National Oral Health Improvement Programme.

http://new.wales.gov.uk/topics/health/ocmo/professionals/dental/publication/ministerial-letters/smile/?lang=en

The website http://www.designedtosmile.co.uk provides a useful national resource for dentists, parents, teachers and other health professionals. It also provides information on the local programmes. It is important to retain the evidenced based core of the current programme as the central pillar of the initiative.

It will be critical to maintain the emphasis in two areas:

- strong linkage and partnership working between health and other agencies and services i.e. education; and
- the use of local multidisciplinary steering groups that are able to feed into a National Forum in order to share best practice and for maintaining the recognisable national "brand" that Designed to Smile has become.

Action: Consideration will be given to extending the scope of the programme to other target groups.

Practice Based Prevention

Dentists have a duty to provide preventive advice where they judge it appropriate for patients who attend for dental treatment.

In April 2011 we instigated dental contract pilots in Wales. As explained above, one type of pilot focuses on the delivery of preventive care to children based on caries risk. What we learn from the pilot will inform us about the practicalities of introducing evidence based preventive programmes tailored to individual patient risk factors.

In the meantime, we recommend practice dental teams refer to:

Delivering Better Oral Health: An evidence based toolkit for prevention, that although intended for practices in England, the toolkit provides good general practice advice applicable to most practice situations.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102331

Action: In order to develop an integrated preventive approach we will publish, in Autumn 2012, a Welsh edition of Delivering Better Oral Health with specific links to the Designed to Smile programme.

The Dental Workforce

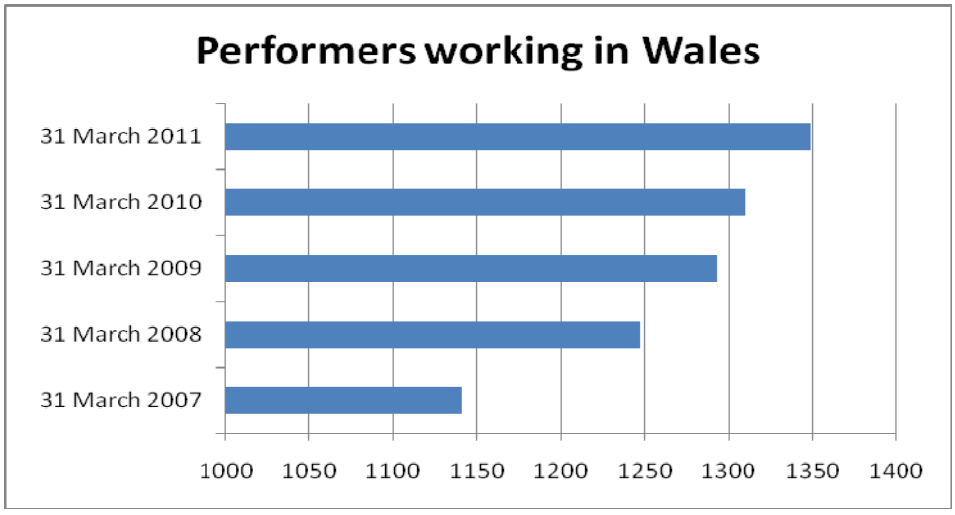
In April 2006, the Welsh Government undertook the first major reform of primary care NHS dentistry since 1948. This was of particular significance to the demand side of the equation. Under the previous system, dentists could set up practice where they wished and carry out as much or as little NHS dentistry as they wanted. This gave the NHS little control over how much dentistry was provided in different areas of the country. Under the new system Local Health Boards hold local budgets for dentistry

and use these resources to commission an agreed annual level of service from local dentists. These developments, which have resulted in more capacity and closer control over the use of resources, have had major implications for dental workforce planning.

Each Health Board should monitor its dental workforce in relation to current and future needs. There has been a major expansion in the training of dental care professionals which, together with the regulatory changes undertaken by the General Dental Council(GDC), have greatly increased the scope for skill mix within the dental team.

Health Boards need to have regard to succession planning; skill mix reviews; education and training; recruitment and retention; continuing professional development (CPD); and career development. Clearly, local planning of dental services allows the NHS to develop the most appropriate services and target resources to where they are most needed. Currently there is patchy data available about the dental workforce in Wales. There is a need to improve the quality of the information available.

Performers working in Wales across 4 year period 2007-2011:



(Source StatsWales 2011)

Includes some dentists working in the Emergency Dental service and some CDS staff working on a PDS contract.

Whole time equivalent dentists, hygienists and therapists working in CDS in Wales for April 2008-March 2009

	Dentists	Therapists	Hygienists	DHE	Dental Health support
Mid and West Wales	22.81	3.48	0.10	1.51	0.42
North Wales	19.35	4.02	0.86	2.10	3.84
South East Wales	43.02	9.58	1.31	15.70	4.72
WALES	**85.18**	**17.08**	**2.27**	**19.31**	**8.98**

The National Leadership and Innovation Agency for Healthcare (NLIAH) have carried out a comprehensive review of the dental workforce and were due to report their findings in June 2012. The publication of the Dental Workforce review will provide a fuller picture about future service provision/workforce planning for all dental services and will allow Health Boards to plan accordingly.

Action: Welsh Government will publish the results of a review of the dental workforce in Wales and use this to further inform policy on oral health.

Other Commissioned services

Orthodontic Services

The majority of orthodontic services in Wales are provided to children by dentists working in primary care. NHS Wales spends around £13 million pounds annually on these services; approximately 10% of the primary care dental budget and 40% of the total spend on children's dentistry in the GDS. In addition, hospital based orthodontic care is provided to patients who require more complex orthodontics and/or surgical and multidisciplinary care.

Demand for orthodontic services has been rising for many years, however we believe NHS orthodontics must be strictly provided in terms of need rather than demand. It is important Health Boards make provision for orthodontic services based on assessment of need, as defined by the current NHS acceptance criteria.

We intend to move towards a position where all primary care orthodontics is provided by specialists and/or Dentists with Special Interest (DwSI). We need to develop an orthodontic workforce led by Specialist Orthodontists and supported by orthodontic therapists, DwSIs, orthodontic nurses and orthodontic technicians. As the skill mix and services change there will be a need to review the funding of such services and the specialist orthodontic training numbers.

Good Practice: Hwyel Dda Health Board has pioneered the setting out of a policy for DwSI accreditation. The Health Board's aim is to ensure all Orthodontics is provided by practitioners who have shown orthodontic qualification, relevant continuing professional development and experience, and good outcomes for their patient cases. This process has not been without its problems but the lessons learnt will be valuable for other Health Boards who should now move towards a similar policy.

http://www.dh.gov.uk/en/Healthcare/Primarycare/Dental/DentistswithSpecialInterestsDwSIs/index.htm

In Wales, orthodontic services have been reviewed both at regional and national level. Regionally, Public Health Wales has carried out overviews/needs assessments. Nationally, the Welsh Government set up an independent Task &

Finish Group to review orthodontics in Wales, and the National Assembly for Wales, Health Wellbeing and Local Government Committee carried out a separate inquiry. The recommendations of both reports were broadly similar, highlighting the pressing requirement for Health Boards to develop more effective planning and management of these services and improvement in the efficiency and effectiveness of the orthodontic services delivered in Wales.

http://wales.gov.uk/docs/phhs/publications/101109reporten.pdf

http://cymru.gov.uk/about/cabinet/cabinetstatements/2010/101020ort/?lang=en

Welsh Government has broadly accepted the recommendations. With effective procurement and contracting, improvement in the appropriateness of referrals and performance management, there appears to be sufficient resources to meet the orthodontic need of the population and to ensure that limited resources are not wasted. It will be useful to revisit the review data in Spring 2013 in order to evaluate whether changes to services have occurred.

The provision of NHS orthodontics in Wales must be focused on health gain, and not correcting the aesthetic cases that do not fall under the current NHS acceptance criteria.

Good Practice Cardiff & Vale, Aneurin Bevan and Cwm Taf Health Boards have worked together with the profession and Public Health Wales to develop an Orthodontic Managed Clinical Network. It is still early days but these stakeholders have recognised that orthodontics as a specialty service is best planned on a regional basis, with organisations and the profession agreeing a joint approach.

Action: We have issued Interim Guidance on Management of NHS Orthodontics in Primary Care, and further guidance will follow.

Health Boards must ensure public funding for orthodontics, including one off non-recurrent initiatives, is based on need and not demand, and any additional orthodontic funding must be justified in the face of other pressing oral health improvement and dental service priorities. In addition, one off non-recurrent initiatives must have a high likelihood of positive health gain for patients.

General Anaesthesia Services

As highlighted previously, the relatively poor dental health of children in Wales results in a high need for extractions under general anaesthesia (GAs).The provision of dental GA in Wales by general dental practitioners from traditional “High Street” dental practices ceased in 2001 with the publication of WHC (2001) 039. Dental GA activity is now carried out under a variety of contractual or provider agreements in secondary and intermediate care. The experience, skills and qualifications of staff and the specifications of the facilities used need to be compliant with WHC (2001) 056 and WHC (2001)077.

The consequences of poor oral health are multiple and all the more concerning because they affect the youngest in our society. Tooth decay commonly results in pain and infection, often resulting in sleepless nights, time off school and possible need for general anaesthesia to treat effectively. There is an impact on the childs general wellbeing, including disruption of schooling, and for parents and other family members having to cope with a child in pain.

Public Health Wales indicated in a recent interim report that over 9696 children underwent a general anaesthetic for tooth extraction in 2010-11. This is unacceptable for what is an almost totally preventable disease. It is a risk to child health and wellbeing that would not be tolerated in other diseases. This is one reason for the launch of Designed to Smile in 2008 and why we will continue to support the programme.

Action: Health Boards must:

- ensure the continued development of community based programmes promoting better oral health using initiatives e.g. the Designed to Smile and Healthy Schools programmes; and
- develop alternative patterns of care e.g. increasing the specialist dental paediatric services and dental paediatric DwSI workforce, and building the capacity of alternative treatments such as sedation where feasible.

Hospital Dental Services

The Hospital Dental Service (HDS) should only be provided for those patients who require hospital care.

There are areas of Wales where it has been historically difficult to recruit dental specialists into the HDS, notably the western rural areas such as Hywel Dda. Taking the Hywel Dda example further, its Health Board has become largely dependent on accessing the HDS services for its population through service agreements with Abertawe Bro Morgannwg University Health Board.

It is necessary in terms of overall service efficiency, development of specialities, training, clinical peer review and audit, that hospital dental services are centralised. However, it is also important that in a country like Wales, with contrasting urban and rural factors, the hub HDS services are sensitive to the need to outreach wherever practical.

Not only is there inequitable location of HDS services, but there are also gaps in the types of dental specialities provided by some HDS services e.g. specialist paediatric dental services and restorative dentistry.

Action: Health Boards must work closely together to develop regionally agreed referral and care pathways which will allow GDS, CDS and HDS to better work together.

The publication of the Dental Workforce review will provide a fuller picture about future service provision and workforce planning for all specialist dental services and will allow Health Boards to plan accordingly.

The development and management of Strategic Delivery Programmes for Dental Services

In the Welsh Labour 2011 Manifesto we set out *Access* and addressing *Oral Health Inequalities* amongst our priorities and confirmed this in our *Programme for Government*.

Under the current organisational structures Health Boards directly provide Community and Hospital Dental Services and contract with general dental practitioners/dental bodies corporate to provide GDS services. Therefore, all three NHS Dental Services currently come under the wing of the same organisation.

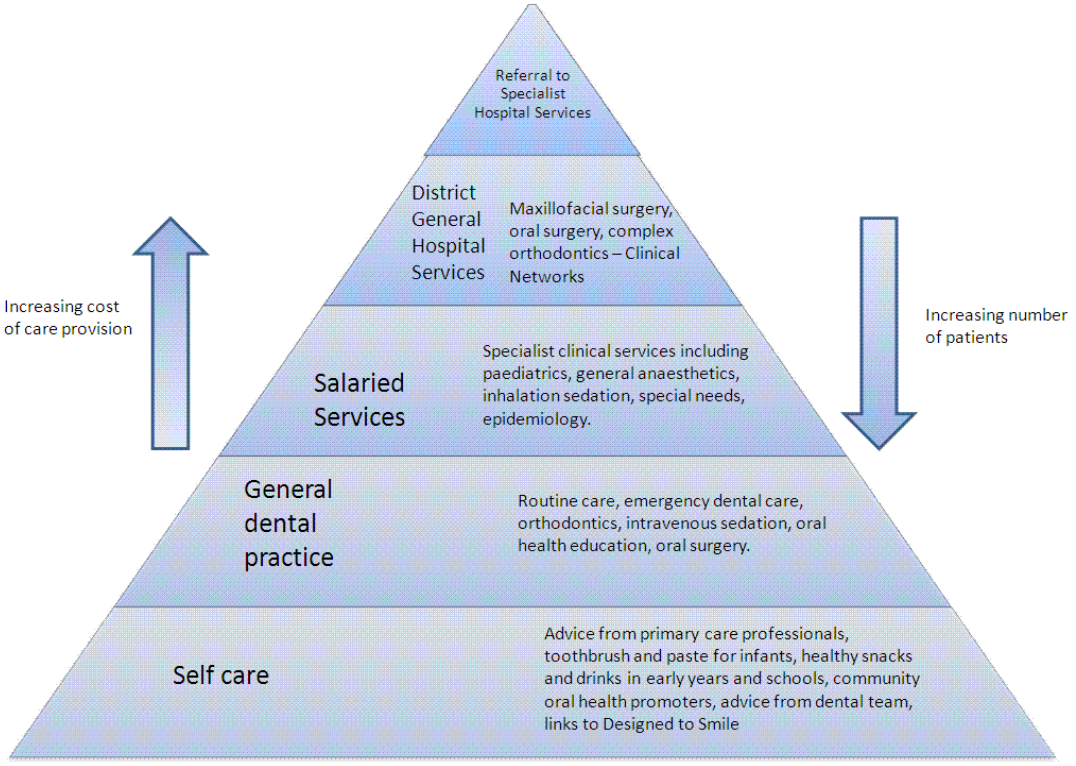
We wish to see the development of Strategic Planning and Delivery Programmes for dentistry as an integral part of each Health Board's overall planning process. These processes will include citizen engagement, as well as integrated working with dental professionals. We view this as vital if we are to improve delivery of dental services and improve oral health outcomes.

Good Practice: Abertawe Bro Morgannwg University Health Board has established a Strategic Dental Services Planning Group, Chaired by an Executive Director. The aim is to ensure provision of effective and efficient dental services for the population served by the Health Board within available resources, meeting required targets set by the Welsh Government. In summary, the objectives of the Group are to:

- develop channels for communication and partnership working;
- develop integration of service through the planning process;
- encourage a patient journey/pathway approach, breaking down Primary/Secondary distinctions;
- ensure clinical work is carried out in the most appropriate environment by the most appropriate service;
- ensure a system-wide approach is taken to implementation of service plans;
- ensure all operational targets are met; and
- manage financial resources within the allocated funding envelope.

Planning must involve dentists and their teams working with other public service partners through a delivery framework, see figure 1 below.

Figure 1



Health Boards should ensure that Out of Hours unscheduled care is accessed via telephone triage systems and the unscheduled care service is complementary to the "in hours" scheduled services that are provided in primary dental care.

Service planning must include those groups who are hard to reach and vulnerable. We have issued guidance on the role of dental services for vulnerable people.

http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/ministerial-letters/?lang=en

The focus is on delivery, with the balance of care shifting away from secondary care towards primary care, or other non hospital locations wherever possible. Clinical engagement, partnership working and developing integrated care will be important principles of the new approach.

Good practice: Abertawe Bro Morgannwg University Health Board has taken the decision to relocate some of its Consultant Restorative Dentistry services out of Morriston Hospital into the community setting of the Port Talbot Resource Centre. This will improve integrated working and understanding of the specialist services.

In the future, within the Port Talbot Resource Centre, Consultant Restorative Dentistry will be located alongside Community Dental Services and an extensive postgraduate training establishment. This provides an innovative and almost unique arrangement in the UK opening a real opportunity for better integration and joint working to be tested.

Section 3: Quality and Safety

Assuring High Quality and Safe Dental Services

Quality and Safety must be integral to all aspects of dental care. Health Boards must support and promote quality and safety in all dental services, and seek and provide assurance on this.

Regulation and Standards-Quality Delivery Plan

Together for Health outlines Welsh Government commitment to publish a Quality Delivery Plan (QDP) and sets out how quality assurance and improvement arrangements will operate in future. Health Boards will need to assure themselves that all services, including primary care, meet required standards and they must produce an annual primary care report. The QDP will highlight participation in National Audits and the need for Health Boards/Trusts to have robust audit plans. Dental teams in all services should participate in well conducted clinical audit and be supported to use recognised improvement methodologies to embed sustained improvements in care.

Action: Department of Postgraduate Dental Education will support further development of audit for Dental care professionals.

We will work with the 1000 Lives Plus programme dental lead and the Department of Postgraduate Dental Education to promote use of recognised improvement methodologies by dental teams.

Private Dentistry

The Private Dentistry (Wales) Regulations 2008 came into force on 1 January 2009 and were revised in January 2012. These regulations require all dentists who practice any private dentistry in Wales to be registered with Healthcare Inspectorate Wales (HIW). HIW have an arrangement with the Dental Reference Service (DRS) to visit and report on private practices to the same standards as applied to NHS practices.

Action: We will consider publication of National Minimum Standards for Private Dentistry.

We will work with the dental profession to consider whether and how dental practices – rather than individual dentists – can register with HIW to provide private dental care.

The Standards for Health Services

'Doing Well, Doing Better – Standards for Health Services in Wales'(April 2010), sets out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. The Standards are incorporated into a number of key assurance systems in dental care, including the Self Assessment Quality Assurance System (QAS) in GDS and Dental Reference Service practice visits and reporting.

Action: We will publish National Minimum Standards for NHS Dentistry. Health Boards will work with their dental services, patients and Department of Postgraduate Dental Education to further address these aspects of the Standards for Health Services.

Quality Improvement – 1000 Lives Plus

Dentistry is embracing the 1000 Lives Plus programme. At present there are 2 dental programmes:

- reducing antimicrobial prescribing by dentists; and
- mouthcare for adult patients in hospital. This aims to address findings from Fundamentals of Care audit, and is integrated with Free to Lead, Free to Care programme.

Both programmes are integrated into the 1000 Lives Plus programme and will seek to promote use of recognised improvement methodologies in dental care.

Action: We will support and work with the dental profession to improve antimicrobial prescribing in general dental practice through the introduction of practice based audits.

We will support and work with the nursing and dental professions to improve oral health risk assessment and mouth care for adults in hospital.

Quality Assurance System and Maturity Matrix Dentistry

The dental public health team of Public Health Wales manages the annual Quality Assurance System (QAS) process on behalf of Health Boards, whereby every contracted practice is requested to complete a self assessment quality return. The returns are collated and reported on to the Health Boards. In Wales the DRS visit, inspect and report on every practice with a GDS or PDS contract on a three year cycle. The inspection reports are scrutinised in conjunction with the QAS returns.

The "Maturity Matrix" was originally developed in Wales for use in General Medical Practice, and has now been developed for use in General Dental Practice. The Maturity Matrix Dentistry (MMD) is a straightforward, practice based team development/clinical governance tool that allows the dental team to focus on how they work. Using MMD enables everyone in the practice to consider the quality of care provided in twelve areas or "dimensions" including safe use of X-rays, cross infection control and reducing clinical risks.

www.walesdeanery.org/dentistry/mmd

Action: Public Health Wales will review and revise the QAS to ensure that all relevant aspects of the Standards for Health Services are incorporated into the QAS.

Department of Postgraduate Dental Education will continue to promote and facilitate use of MMD in GDS in Wales, particularly for practices where performance concerns have been identified.

Infection Prevention and Control

The control of cross-infection and healthcare acquired infections are vital to patients and all members of the dental team. This cornerstone of quality and safety is included in a number of quality assurance systems in dentistry.

In Wales, Health Technical Memorandum 01-05 (Welsh Edition) was issued in April 2011. It is intended to progressively raise the quality of decontamination work in primary care dental services.

http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/cdo-letters/decontamination1/?lang=en

The document introduces specific benchmarks for dental practices to achieve and demonstrate, including compliance with essential quality requirements and best practice.

Action: During 2012/13 we will use the 1000 Lives Plus methodologies for improvement. We will work with the dental profession to develop an audit of compliance with the essential requirements of HTM 01-05 for all dental practices in Wales.

By the end of 2012, Health Boards must ensure that all GDS, CDS and any other directly employed primary dental care services comply with essential requirements of HTM01-05 as a minimum.

ICT developments

General Dental Services – the extent to which dental practices utilise information technology varies widely. Dental practices can transmit claims directly by electronic transfer to NHS Dental Services of the NHS Business Services Authority. On the other hand, some practices barely make use of information technology. Since 2002 the percentage of practices transmitting claims by electronic transfer has increased but approximately 13% of FP17 forms submitted are still paper claims.

Community Dental Services – since 2002 there has been development of IT infrastructure within most of the CDS across Wales. This is a major improvement, despite more than one system being used. However, it is of concern that some CDS in Wales still do not have a coordinated ICT infrastructure as having such an infrastructure should be a reasonable expectation of any modern, directly provided, NHS dental service.

Developing and enhancing the information and technology infrastructure within community and primary care dentistry is important for the future effectiveness and efficiency of these services. It is also vital if they are to function in an integrated way with the wider "NHS family". A system to allow GDS teams to access Health Board on-line training and educational resources is being piloted in Aneurin Bevan Health Board and if successful it should prove possible to adopt the system for primary care practice across Wales.

Action: We will use the pilot into NHS connectivity and email in general dental practices to further develop ICT in dentistry.

Health Boards should review the IT infrastructure within their CDS and work to address inadequacies identified.

During 2012 we will work with stakeholders to encourage and promote use of electronic data/claims transfer by all GDS practices in Wales.

Dealing with performance causing concern

It is vital Health Boards have systems in place to identify, recognise and act upon performance that causes concern. In Wales we are fortunate to benefit from strong working links between the Office of the Chief Dental Officer for Wales, Public Health Wales Dental Team, Health Boards, the NHS Wales Shared Services Partnership, the Department of Postgraduate Dental Education and the Dental Reference Service. This is particularly beneficial to how we support and deal with practices and practitioners whose performance gives rise to concern.

One specific area we need to focus on is the support provided for non UK qualified dentists commencing work with the NHS GDS in Wales.

Action: Working with Public Health Wales we will publish revised guidance on dealing with dental performance that causes concern.

We will work with the Department of Health and the GDC to identify and implement systems to support non UK graduates who want to work in the NHS in Wales.

Issues relating to occupational health

In 2006, as part of a package supporting the introduction of new dental contractual arrangements, we provided funding to each Health Board for occupational health and Hepatitis B vaccinations for general dental practitioners. Utilisation of this funding is variable across Health Boards. Therefore, we would encourage Health Boards to utilise this to develop broader based occupational health support for general dental practice.

Good Practice Powys Health Board offers primary care dental teams, who undertake exposure prone procedures; consultant led occupational health support including the following:

- recommended vaccinations including Hepatitis B;
- routine testing for Hepatitis B antibody levels;
- confidential storage of information;
- advice and treatment for needle stick injuries; and
- annual flu vaccinations.

Action: Working with Local Dental Committees (LDCs) Health Boards should review the occupational support they provide to general dental practice.

Training

All members of the dental team must comply with GDC requirements for Continued Professional Development (CPD). Dental teams in Wales can access a wide range of CPD which encompass different learning styles. Health Boards should ensure that all dental staff are appropriately trained and knowledgeable to enable them to have the skills and competencies to deliver the care needed.

Undergraduate/Foundation/specialist

Issues relating to these groups of dentists will be covered by the ongoing review of the dental workforce in Wales.

Dental nurse Training

The GDC requires all dental nurses to be qualified and registered, although student dental nurses can work in practice if they are enrolled on a course or on a waiting list for an approved course. Dental nurses must comply with the GDC requirements for CPD. It is essential that Wales has sufficient dental nurses to support delivery of dental care in all settings. In Wales there are currently a number of approved routes for training, but they are clustered in the South and student dental nurses in North Wales may have to travel considerable distances to access training.

Action: We will work with all education providers to develop sufficient and equitable provision of basic and advanced dental nurse training across Wales.

Research issues

The Dental School, University of Cardiff, has an active and internationally regarded dental research base. Work ranges from basic dental sciences aimed at improving knowledge of that aetiology and management of oral disease, to patient and public focused projects. How knowledge is transferred to chairside delivery and fills the evidence gaps in the context of NHS dental care organisation and delivery is an important objective.

The Dental School in Cardiff has been selected as the sole European dental school to participate in the World Health Organisation patient safety programme, which is aligned with 1000 Lives Plus.

As an example, within Wales there is a study currently underway to examine the cost and effectiveness of fissure sealants and of fluoride varnish in preventing decay over three years, commencing from age 6-7, in a community and school settings.

Currently, Designed to Smile is targeted at younger children and seeking to establish patterns of behaviour with long term impact, which should carry forward throughout life. It is intended to examine whether it can influence decay levels in those who will be 12 years old in 2020.

There is a need to facilitate the involvement of interested general dental practitioners in primary care based research in order to develop an evidence base of relevance to NHS Wales e.g. frequency of recalled dental attendance, whether multiple courses of treatment reflect inadequacies in the current contract arrangements and whether alternative arrangements should be made for patients with particularly high treatment needs.

Action: We will discuss gaps in the evidence base associated with primary dental care with our academic partners and the profession, to identify priorities and how we can encourage primary care practitioners to participate in research and development of services and use recognised improvement methodologies.

Conclusions

At a glance, the problem of oral disease seems straightforward and simple to solve. The causes of oral diseases are understood, they are almost entirely preventable and many people now experience good oral health. Yet this continues to place a significant burden on society and the NHS and have multiple impacts on individuals.

It has become clear that improvement of oral health at a population level is much more challenging than might initially appear. The focus of oral health improvement should be on creating healthy public policies, supportive environments, strengthening community action, developing personal skills and reorienting health services towards prevention.

This report has summarised the inequalities experienced by Wales' population in terms of experience of oral diseases and access to services. It has given an overview of the action needed to improve oral health, access to oral health services and quality of these services. It is vital these recommendations are adopted so the unacceptable burden of preventable oral diseases on our residents can be reduced.

Action Chart

Responsibility	Action
Welsh Government	• Government and Health Board sponsored innovative awareness campaigns are required (in prevention), especially targeted at the high risk groups. • We will ask the Welsh Dental Committee to set up an expert working group to review oral cancer audit findings in the context of service structures in Wales and report by 2013. • The dental budget will be ring fenced until at least 2015. • We will seek assurance that Health Boards have adequate measures in place to ensure dental professional advice, including access to a multi-professional advisory structure including that of a Consultant in Dental Public Health. • We will continue to pilot systems which move away from the current GDS system of remuneration and delivery, towards a model which focuses on tailored patient care based prevention and/or on risk assessment. • We will request that, through the Welsh Dental Committee, and in the strict context of the extant national guidance of the role of the CDS in Wales, the CDS Clinical Directors Group inquire and report into the reasons behind the changing trends in reported CDS activity and report back by 2013. • We will request that, through the Welsh Dental Committee, and in the strict context of the extant national guidance of the role of the CDS in Wales, that Public Health Wales inquire and report on the emerging evidence regarding dental screening and its relevance to Wales and report back by 2013. • Consideration will be given to extend the scope of the Designed to Smile programme to other target groups. • In order to develop an integrated preventive approach we will publish a Welsh version of Delivering Better Oral Health with specific links to the Designed to Smile programme. • We have issued Interim Guidance on Management of NHS Orthodontics in Primary Care, further guidance will follow.

Responsibility	Action
	• During 2012/13 we will use the 1000 Lives Plus methodologies for improvement and we will work with the dental profession to develop an audit of compliance with the essential requirements of HTM 01-05 for all dental practices in Wales. • We will publish Department of Dental Education National Minimum Standards for NHS Dentistry. Health Boards will work with their dental services, patients and the Department of Post Graduate Dental Education to further address these aspects of the Standards for Health Services. • We will support and work with the dental profession to improve antimicrobial prescribing in general dental practice through the introduction of practice based audits. • We will work with all education providers to develop sufficient and equitable provision of basic and advanced dental nurse training across Wales. • We will discuss gaps in the evidence base associated with primary dental care with our academic partners and the profession, to identify priorities and how we can encourage primary care practitioners to participate in research and development of services, and use recognised improvement methodologies. • We will publish the results of a review of the dental workforce in Wales and use this to further inform policy on oral health. • We will consider publication of National Minimum Standards for Private Dentistry. • We will work with the dental profession to consider whether and how dental practices – rather than individual dentists – can register with HIW to provide private dental care. • During 2012 we will work with stakeholders to encourage and promote use of electronic data/claims transfer by all GDS practices in Wales. • We will work with the Department of Health and the GDC to identify and implement systems to support non UK graduates who want to work in the NHS in Wales.

Responsibility	Action
	• We will use the pilot into NHS connectivity and email in general dental practices to further develop ICT in dentistry. • We will work with the Department of Post Graduate Dental Education to roll out the 1000 Lives Plus antimicrobial audit, and to develop an audit of compliance with HTM 01-05 (see Infection control and prevention). • We will work with 1000 Lives Plus programme dental lead and the Department of Postgraduate Dental Education to promote use of recognised improvement methodologies by dental teams. • We will support and work with the nursing and dental professions to improve oral health risk assessment and mouth care for adults in hospital.
Department of Postgraduate Dental Education	• Will support further development of audit for DCPs. • Dental teams should have access to high quality postgraduate training to address educational needs in prevention. • Will continue to promote and facilitate use of Maturity Matrix Dental in GDS in Wales, particularly for practices where performance concerns have been identified.
Health Board, Local Dental Committee, Local Authority and Third Sector	• Health Boards should work with LDC to review the occupational health support they provide to general dental practice. • Health Boards, in partnership with the Local Authority and voluntary sector, should ensure that oral care is integrated into general health and social care plans/pathways of patients with complex medical and social problems. • Health Boards should take account and implement the guidance published by the 1000 Lives Plus programme “Mouthcare for Adults in Hospital”. • Following the overall approach laid out in this Plan it will be a requirement for Health Boards to develop

Responsibility	Action
	Local Oral Health Plans for financial years 2012-16 working jointly with other Health Boards and key stakeholders as appropriate. Oral health improvement and the development of dental services must be included in Health Board corporate objectives and local delivery plans. • Ensure better compliance with NICE guidelines on recall intervals and information to patients to ensure that patients do not attend more frequently than necessary – http://www.nice.org.uk/Guidance/CG19 • Closer monitoring of "splitting" courses of treatment. • Health Boards should respond to the SCD Implementation Plan within their future planning of dental services as part of the development of a local oral health plan. • Focusing contract monitoring and reviews on GDS/PDS contracts that enjoy particularly high value Units of Dental Activity (UDA) to ensure best value for public funding. • Work to the Interim Guidance on Management of NHS Orthodontics in Primary Care. • Health Boards must ensure that public funding for orthodontics is based on need and not demand. • Health Boards must ensure the continued development of community based programmes promoting better oral health using initiatives e.g. the Designed to Smile and Healthy Schools programmes. • By the end of 2012, Health Boards must ensure that all GDS, CDS and other directly employed dental services comply with essential requirements of HTM01-05 as a minimum. • Health Boards should review the ICT infrastructure within their CDS and work to address inadequacies identified. • Health Boards should develop alternative patterns of care e.g. increasing the Specialist Dental Paediatric services and Dental Paediatric DwSI workforce, and building the capacity of alternative treatments such as sedation wherever feasible. • Health Boards must work closely together.

Responsibility	Action
	• Health Boards must work to develop “regionally agreed”, referral and care pathways which will allow GDS/CDS/HDS to better work together to provide the right care in the right place at the right time. • Health Boards should support better integration of GDS with other dental services. • Health Boards must ensure that one off funding initiatives are based upon need (rather than demand), and are evidence based and have a high probability of health gain.