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Delivery Plan

Together for Health: A National Oral Health Plan
for Wales 2013-18

Date of issue: **18 March 2013**

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Foreword by the Chief Dental Officer for Wales



It gives me great pleasure to present the National Oral Health Plan for Wales. 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 the Welsh Government's 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.

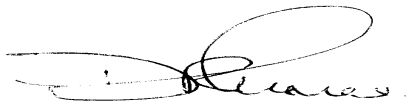
There remain sharp differences between individuals with the best and worst oral health in Wales and our performance lags behind similar countries in some important aspects. Sustainability lies at the heart of our agenda and good health is vital to the creation of a prosperous, successful and sustainable 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.

I would like to thank everyone who responded to the consultation. We have made a considerable effort to take account of all comments and suggestions in developing this final Plan.

Prevention is at the core of the 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. By working together, we believe we can make a real and sustainable difference to the oral health of our country.

Signed

A handwritten signature in black ink, appearing to read 'David Thomas', written in a cursive style.

David Thomas
Chief Dental Officer for Wales

A SUMMARY OF THE KEY ISSUES AND ACTIONS REQUIRED

What we need to do to improve oral health

Key Issues

- Inequalities in dental health in children;
- Differing needs of adult age cohorts;
- Geographical variation of oral cancer outcomes;
- People's awareness of their responsibility in taking care of their oral health.

Where we are

- Testing a new preventive orientated General Dental Services (GDS) contract;
- Designed to Smile programme in place nationally.

Where we need to be

To meet Programme for Government commitments and to improve oral health, the key actions to consider include:

- Health Boards to develop "Local Oral Health Plans";
- Develop awareness campaigns for groups with a high risk of dental decay;
- Provide each dental practice with "Delivering Better Oral Health" linked to Designed to Smile;
- Expand Designed to Smile to include other groups, if resources permit;
- In partnership with key programmes for health promotion, include oral health issues in public education programmes;
- Roll out integrated NHS IT systems to all NHS dental practices.

How we ensure effective and efficient dental services are in place

Key Issues

- Geographical and demographic challenges of the dental workforce;
- Need to review the way dentists are paid;
- Patchy access to services in some areas;
- Need to keep NHS dental services affordable;
- Variable access to specialist services delivered in primary and secondary care;
- Implementation of evidence based recall process and NICE guidance.

Where we are

- Piloting new ways of working in GDS;
- Guidance published on effective planning of services;
- National orthodontic review completed and published;
- Managed Clinical Networks (MCNs) developed for Orthodontics and Special Care Dentistry;
- Some pilot primary care specialist contracts in place.

Where we need to be

To ensure effective and efficient dental services, the key actions to consider include:

- Design new primary care service model, making effective 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 on clinical pathways;
- Improve access to NHS where patients are finding access difficult;
- Review activity profile of Community Dental Service (CDS);
- Ensure policy in place to develop alternative solutions to dental treatment using general anaesthesia.

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

Key Issues

- Access to high quality post graduate training;
- Access to specialist and academic staff;
- Ability to recruit to some posts (geographically);
- Inequitable access of dental nurse training.

Where we are

- New outreach teaching facilities for Dental Foundation Training (DFT) and undergraduates in place;
- Workforce analysis complete;
- Email pilot ongoing;
- HTM01-05 published (decontamination guidance);
- The Standards for Health Service are becoming embedded as part of NHS dental delivery;
- Plans are in place to ensure dental team contribution to the Quality Delivery Plan.

Where we need to be

To maintain and improve quality and safety, key actions include:

- Develop policy and guidance on referral pathways between primary and secondary care;
- Further develop Dentist with Special Interest (DwSI) accreditation process;
- Review private dentistry regulations;
- Implement the recommendations of the workforce analysis;
- Facilitate the development of a national dental nurse training framework;
- Promote the 1000 Lives Plus campaign to improve antibiotic prescribing and improve mouth care for adult patients in hospital;
- Develop an Audit of HTM01-05.

Setting the Scene

Having an unhealthy mouth can have a real impact on health and wellbeing. This is particularly important in Wales where 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 out 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.

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 the key aims and actions for improvement in our *Programme for Government* which translates the 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. In addition, *Achieving Excellence: The Quality Delivery Plan for the NHS in Wales for 2012-16* outlines actions for quality assurance and improvement to ensure we have quality-driven local services. We want local services which are safe, effective, accessible, affordable and sustainable and which provide an excellent experience for patients. On oral health and dentistry we specifically aim to deliver the manifesto commitments using the Programme for Government objectives:

- continue to increase access to NHS dentistry where there are localised problems;
- 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;
- prevent poor oral health and reduce inequalities through the continued implementation of Designed to Smile to improve the oral health of children;
- ensure dental charges remain affordable and in doing so help tackle oral health inequalities;
- require Health Boards to produce a strategy for specialist dental services;
- improve the results of Fundamentals of Care audits in relation to oral health and hygiene.

The Plan includes a number of sections that examine the issues in detail:

- Section 1 focuses on the inequalities in oral disease and who is particularly at risk. It also highlights some key areas for oral health promotion;
- Section 2 focuses on dental service delivery; 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 facilitate the continued delivery of high quality services; and

- 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 section makes recommendations for action. These are summarised and collated at the end of the document in an Action Chart. **The timeframe for delivery of this plan is 2013-2018¹.**

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.

By 2008, the population of Wales is projected to increase by 8% 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 gradually become older with the median age of the population rising from 41.1 years in 2008 to 42.5 years in 2023. A potential large scale population growth in Cardiff has recently been predicted by the city council and the size and speed of the proposals to meet this need would have major logistical effects on primary and secondary dental care delivery:

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

An increase in the population, with particular increases in the numbers of young children and the elderly will, over time, have major service delivery effects. Action will be required to meet the changing needs of the population. The effects of demographic change and the actions required to mitigate these changes are explained later in the document.

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>.

¹ All web links provided in this document are accurate at the time of publication.

The most common oral disease of childhood is dental caries (tooth decay) and children living in deprived communities in Wales have the poorest dental health in the United Kingdom (UK). Tooth decay is found in all population groups but is more common in deprived communities. Whilst many five year old children across Wales have no decayed teeth, over 40% experience a high disease burden and have, on average, four teeth decayed, 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. However, the 2011/12 dental survey of five year old children shows a 6% decrease in the proportion of children with experience of dental decay in Wales (47.6% in 2007/08 falling to 41.4%). Dental disease levels in children are improving in Wales across all social groups. There is no evidence of widening inequalities. This is in contrast with previous surveys when improved decay levels were associated with widening inequality.

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 continues to lag behind the rest of the UK.

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>

Over the next five years, we intend to vigorously address this inequality in experience of child tooth decay.

The role of fluoride in prevention

Put simply, dental decay results from the production of acids when bacterial plaque is provided with sugars in the food and drink we consume. Controlling the frequency of eating and drinking sugars is an important means to prevent dental decay, but we know that simply advising children not to have sugary snacks between meals is rarely effective. ***The scientific evidence suggests almost every proven method to prevent decay includes delivery of fluoride to teeth surfaces.*** Although most toothpaste contains fluoride some children do not brush their teeth at all. Currently there is almost no optimally fluoridated water supplied in Wales. The 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”.

We acknowledge the strength of feeling that was expressed as part of the consultation process in relation to water fluoridation, and the clinical benefits of doing this as a means of addressing high levels of dental decay in Wales. However, having reflected on the comments made; and taking account of the legal, political and financial implications associated with fluoridating water supplies in Wales, we believe the Welsh Government position should remain unaltered.

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.

Evidence for the effectiveness of preventive programmes

The 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. The Designed to Smile programme is targeted at younger children and seeks to establish patterns of behaviour with long term impact which should carry forward throughout life (see page 24 for details on Designed to Smile). We intend to examine whether Designed to Smile has influenced decay levels in 12 year olds by 2020. In 2012, those children were four years old.

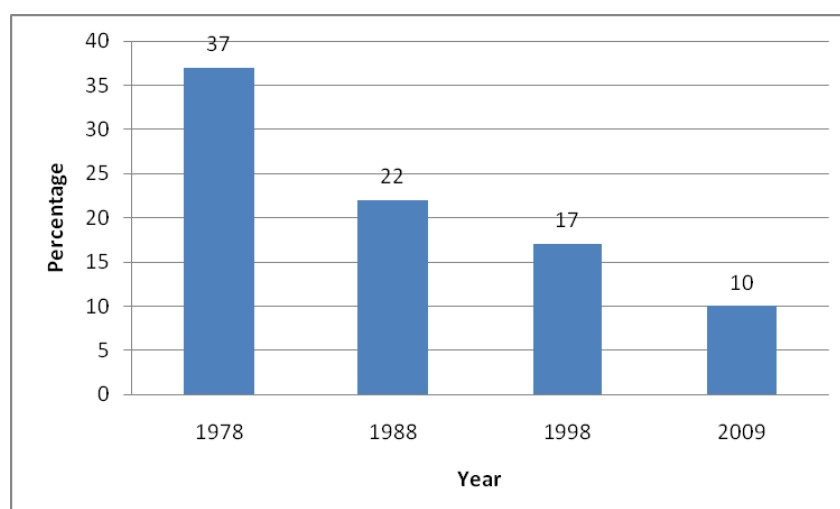
Designed to Smile is broadly based on Childsmile (a child dental health programme based in Scotland). Evidence has recently been published indicating links between improved child dental health in Scotland and the Childsmile initiative. Designed to Smile will continue to be evidenced based and evidence will be the central pillar of the programme. A study is currently underway in Wales to examine the cost effectiveness of fissure sealants and of fluoride varnish in preventing decay from age 6-7 in a community and school settings. Building capacity in deprived communities through Designed to Smile is critical. However, we believe it is justifiable to extend the scope of the programme to other target groups in order to further address oral health inequalities if resources permit.

Adult Dental Health

Oral health in adults

Decennial Adult Dental Health surveys report that the dental health of most adults has improved dramatically over the past 50 years. During the post war years, the nation's oral health was poor and dental disease was widespread. People did not expect their natural teeth to last a lifetime. This expectation has changed and today more adults keep their teeth for life. In 1978 as many as 37% of adults in Wales had no natural teeth; by 2009 this figure had fallen to 10% but the number of adults with no teeth is still high when compared with England (where 6% had no teeth in 2009). Figure 1 (The Health and Social Care Information Centre, 2011) refers. 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, rising to 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)

Dental decay

Tooth decay still affects a large proportion of the population and a significant proportion of people today over the age of 75 years have no natural teeth. Although more middle aged people have their own teeth, many of these teeth have been filled and these fillings need maintenance and repeated repair. This changing pattern in the demand for dental services needs to be taken into account in future workforce planning.

Periodontal (gum) condition

Periodontal disease is an important cause of tooth loss, particularly in older age. In 1998, 12% of all UK adults with their own teeth had moderate periodontal disease (gum pocketing of 4mm or more). Poor oral hygiene contributes to both tooth decay and gum disease. Many older patients suffer from long-term conditions such as diabetes, which increases the risk of developing periodontal disease. Smoking is also known to contribute significantly to the development of periodontal disease.

In 2009, 56% of dentate adults (i.e. those with teeth) in Wales had bleeding gums; 50% had pocketing of 4mm or more; 8% had pocketing of 6mm or more. 77% of dentate adults aged 55 years and over had loss of attachment (LOA) of 4mm or more; 33% had LOA of 6mm or more; and 3% had LOA of 9mm or more. Only 7% of dentate adults in Wales had excellent oral health - that is they had 21 or more teeth, 18 or more sound and untreated teeth, no active decay at any site, no periodontal pocketing or loss of attachment above 4mm, and no plaque or calculus.

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 not exceptional. Thankfully those times are past. 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 have an extraction.

Links between oral health and general health

There is a large amount of research evidence relating to this issue. A summary of the findings to date are reported below:

- Many systemic diseases and conditions have oral manifestations. These manifestations may be the initial sign of clinical disease and as such serve to inform clinicians and individuals of the need for further assessment;
- The mouth is a portal of entry as well as the site of disease for microbial infections that affect general health status;
- The mouth and its functions can be adversely affected by many pharmaceuticals and other therapies commonly used in treating systemic conditions. The oral complications of these therapies can compromise patient compliance with treatment, as well as putting patients at increased risk of oral disease;
- Individuals with diabetes are at greater risk of periodontal diseases. Animal and population-based studies have demonstrated an association between periodontal diseases and diabetes, cardiovascular disease, stroke, and adverse pregnancy outcomes. Further research is needed to determine the extent to which these associations are causal or coincidental:

<http://www.nidcr.nih.gov/datastatistics/surgeongeneral/sgr/chap5.htm>

The impact of changing demographic profiles on the delivery of dental services

The National Adult Dental Health Survey (2009) concluded that the changing prevalence of dental disease and the trends in service provision will greatly affect the prospects of adults of different ages. Generally, as long as risks are managed, younger adults (16-44 years) appear to have a good chance of retaining sound teeth in later life, whereas the future treatment needs for people over 45 years of age are likely to be much higher. This issue is likely to have an adverse affect on oral health outcomes in this group. The challenging variations in oral health are related not only to age but also to socio economic conditions, with an established relationship between poor oral health and deprivation.

- **Young adults (under 45 years)** – for the minority in this cohort with 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 are 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 treatment 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 (45- 65 years)** – this cohort poses the greatest challenge in the coming years as they grow older. The demographics of an aging population in Wales mean that over the coming decades not only will this cohort increase, but older people will have more of their own teeth and retain them for longer. These teeth will be heavily restored in many cases and require more care than dentures, both on the part of their owners and the dental profession. 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. In addition to the technical issues, it will be important to clarify where these services are going to be delivered, as more people with co-morbidity may require domiciliary services. It will again be necessary to make explicit use of the evidence base while developing 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 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. Older adults are increasingly likely to have a range of co-morbidities; these require the dental team to have particular knowledge, skills and technical support to provide patients with effective and safe care.

Oral Cancer

“Together Against Cancer: A Cancer Delivery Plan for Wales” has recently been published. In addition, the Welsh Government published the National Cancer Standards 2005 including standards for head and neck cancer (head and neck cancers include mouth, lip, tongue and pharyngeal cancers):

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=983&pid=54497>.

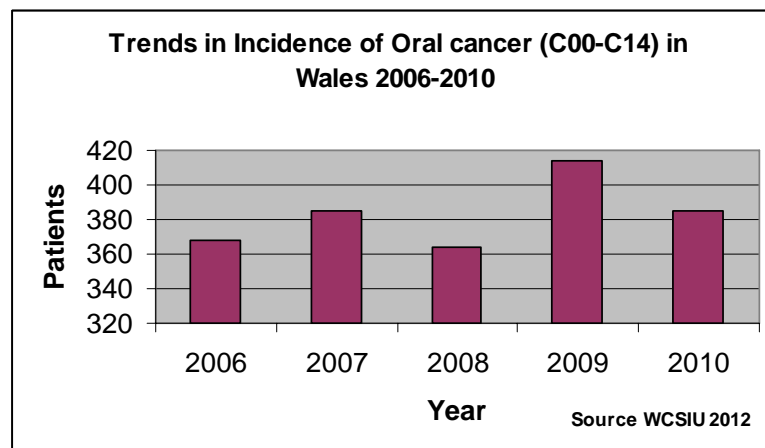
The main causes of oral cancer have long been known and many cases of the disease could be prevented. The most important aetiological factors are tobacco usage and excess consumption of alcohol and these factors together are thought to account for about three-quarters of oral cancer cases in Europe.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

role of HPV virus in certain oral cancers, as well as a link between exposure to the sun and cancer of the lip.

Most oral cancer patients are diagnosed at a late stage in their illness. The overall prognosis is considerably improved if patients are diagnosed at an early 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 area for treatment.

In the UK in 2007, 5,410 people were diagnosed with an oral cancer (385 in Wales Figure 2) with the highest incidence, for both males and females, in Scotland. In the UK and most other countries, oral cancer is more common in men than women. However, the gender 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 the majority of cases in the UK (87%) occur in people aged 50 years or over. Data for Welsh residents is shown below:

Figure 2: Trends in the incidence of oral cancer in Wales 2006-2010



“The incidence is still higher in the most deprived cohort of our population..... with Merthyr Tydfil becoming one of the most prevalent areas for head and neck cancer. There are slight reductions, however, in Neath Port Talbot/Swansea areas compared to ten years ago. The mortality figures accrued have also had slight changes with a general increase in the five year survival and one year survival. It is sad to say that in Wales approximately 23% of people still die within the first year of diagnosis (compared to 20% in England) and approximately 45% within five years of diagnosis. Although there are small changes in trends, I am glad to say the trend is up for survival and outcome” (Hodder – Cancer National Specialist Advisory Group).

The overall survival rates for head and neck cancer in Wales are shown below in Figure 3:

Figure 3: Trends in 1 and 5 year mortality from oral cancer by Health Board area, 1995-2009*

Local Health Board	One year			Five year	
	1995-1999	2000-2004	2005-2009	1995-1999	2000-2004
Betsi Cadwaladr University	72.1 (67.3,76.4)	80.5 (76.4,83.9)	79.9 (76.2,83.2)	50.3 (44.8,55.7)	57.3 (52.2,62.0)
Powys Teaching	75.7 (63.0,84.6)	68.7 (56.0,78.4)	74.6 (62.7,83.1)	51.7 (37.6,64.1)	53.4 (39.7,65.4)
Hywel Dda	75.8 (69.7,80.8)	75.9 (69.8,80.9)	73.5 (67.9,78.4)	51.3 (44.2,57.9)	52.4 (45.4,58.9)
Abertawe Bro Morgannwg University	82.2 (77.7,85.9)	72.1 (66.8,76.8)	78.6 (74.0,82.4)	59.5 (53.6,64.9)	55.0 (49.0,60.6)
Cwm Taf	74.3 (67.3,80.0)	71.1 (63.7,77.2)	69.9 (63.3,75.5)	51.5 (43.6,58.9)	46.8 (38.9,54.3)
Aneurin Bevan	70.6 (65.0,75.6)	78.1 (72.8,82.5)	75.1 (70.2,79.2)	46.6 (40.3,52.7)	53.5 (46.9,59.6)
Cardiff & Vale University	72.7 (66.4,78.1)	76.3 (70.3,81.2)	79.8 (74.5,84.1)	48.9 (41.9,55.5)	54.5 (47.3,61.0)

*Cancer in Wales 1995-2009: A comprehensive report Head and Neck cancer WCSIU

Prevention

At least three-quarters of oral cancers could be prevented by the elimination of tobacco smoking, use of tobacco in other forms such as paan and chewing tobacco, 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 three to five 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 General Dental Council (GDC) has recently recommended that training in oral cancer should be part of the Continuing Professional Development (CPD) programme for all members of the dental team. The dental section of Postgraduate Medical and Dental Education (PGMDE) is committed to increasing provision of relevant training to dental teams in Wales.

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 and dental team members have a key role in providing smoking cessation advice to all patients who smoke (including those attending on an

irregular basis for emergency treatment). The Tobacco Control Action Plan contains two key actions that relate to dentistry and tobacco. They are:

- *Health Boards should discuss with dental providers the delivery of smoking cessation advice as part of their Dental NHS Contract negotiations;*
- *The Dental Postgraduate Department will provide training in brief intervention for smoking cessation to dental teams throughout Wales.*
- All dental team members have a role to play in advising patients about the risks of drinking more than the recommended level of alcohol. At present this advice is not embedded in dental practice and we will work with PGMDE and the “Have a Word” team to address training needs for dental teams. The Welsh Government Dental Division team will liaise closely with colleagues within the Welsh Government to ensure the incorporation of oral health messages into relevant Government sponsored public awareness campaigns.

Action: Dental teams should have access to high quality postgraduate training to address educational needs in this area, including information on appropriate Third Sector organisations and websites, which patients can access for evidence based advice and support.

Welsh Government, Public Health Wales (PHW) and Health Boards should ensure that high risk groups are targeted by national campaigns (e.g. Mouth Cancer Awareness and National Smile months).

Health Boards and PGMDE should ensure that the dental actions contained within the Tobacco Control Action Plan are taken forward.

Treatment

Guidelines for improving services for head and neck cancer patients have been published (Welsh Government, 2005). One of the key recommendations of the report 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 that 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). This programme includes audit of head and neck cancers. 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: Health Boards will liaise with the Cancer Networks and the Head and Neck Cancer National Specialist Advisory Group to ensure that the Welsh cancer standards (2005) are implemented. We will expect Health Boards to work together to ensure evidence – based, multi-disciplinary care is available to all their patients diagnosed with oral cancer. We will seek assurance that any identified variation in treatment outcomes addressed by the Cancer Networks.

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 problems, physical and learning disabilities, 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. **Other groups that must be considered include prisoners and the homeless population.** Recent evidence from Scotland indicates that both prison inmates and the homeless population have poorer health than the rest of the population. They have a high prevalence of mental health problems including serious mental illness, drug and alcohol related problems, personality disorders and chronic stress. Data on the oral health status of these individuals is limited. In addition, increasing numbers of the population require access to bariatric care. Health Boards should consider how best to address the needs of these groups.

A strategic approach is required to develop effective services for ALL vulnerable people 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, with some patients waiting up to two years for treatment. Action must be taken to ensure these vulnerable people have access to specialised care.

The Welsh Dental Committee (WDC) carried out a review on special care dentistry (SCD) in Wales. Complementing this, PHW carried out a SCD needs assessment. In response to the 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>.

Good practice: Through Programmes for Children with Learning Disability, all children in special schools in Flintshire and Denbighshire are offered the opportunity to take part in a schools-based oral health improvement programme. An experienced oral health educator and dental health care support worker work in a multidisciplinary approach to support delivery of the Children’s National Services Framework.

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 oral health educator leads this programme with part time input from two community learning disability link nurses seconded to the CDS. The programme has been locally funded since 2004 and further supported and expanded in 2008.

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. As the group is chaired by the Director of Public Health there is a direct link to the Executive Board and this assists the decision making process.

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 needs 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 the general health and social care plans/pathways of patients with complex medical and social problems.

Action: Health Boards should respond to the SCD Implementation Plan by ensuring the needs of all vulnerable groups are met as part of the development of a Local Oral Health Plan.

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 gain a better understanding of their oral health status and needs:

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

The surveys showed many care 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 one in three homes staff were assisting residents in cleaning teeth or dentures, but they had not received any training in this activity.

As a direct result of the survey, we recommended adoption of written procedures and in May 2011 we published an advice leaflet for residential and nursing 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>

Good practice: Hywel Dda Community Dental Service with support from the Care Home Support Team, offers a comprehensive oral health training package to all nursing and care homes within the Health Board. It offers certificated training sessions. A champion is nominated in each home to oversee documentation and delivery of oral care to residents. Full support is given to carers delivering oral care and a box of resources is provided by the team. This is a rolling programme and assessments are regularly carried out by the Oral Health promoters and care home nursing assessors. The effectiveness of oral care is also monitored.

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 mouth care and oral hygiene for adult patients in hospital, particularly those who are long-stay, on Critical Care/IT units, in Palliative Care, receiving chemotherapy and radiotherapy. We will encourage services to build on the lessons learnt from this work in hospitals, to further address and improve mouth care for residents in care settings.

Action: Health Boards should take account of and participate in the 1000 Lives Plus programme to improve mouth care for adult patients in hospital.

Section 2: Dental Service Delivery

Strategic and Management developments relating to Dental Service Delivery

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 primary care dental services. All three NHS Dental Services are therefore essentially part of the same organisation.

The development of strategic planning and delivery for dentistry needs to be 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. This approach is 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 Group aims to provide effective and efficient dental services for the population served by the

Health Board within available resources, while 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 for all dental services in a strategic fashion within the allocated funding envelope.

Strategic Actions for Health Boards

By December 2013, Health Boards will **develop a specific Local Oral Health Plan** to address the oral health needs of their residents. The plan will highlight services to be provided or commissioned to meet the identified needs, and will clarify how the Health Board will ensure good governance in both commissioning and delivery (Annex 1 provides details of the issues that need to be addressed in the plan). It is recognised that some Health Boards have already developed Local Oral Health Action Plans. These should be reviewed to ensure they incorporate the required actions arising from the National Oral Health Plan.

Health Boards need to review processes to confirm they have adequate measures in place to ensure the provision of dental professional advice and access to a multi-professional advisory structure, including that of a consultant/specialist in Dental Public Health Clinical engagement. Partnership working and the development of integrated care will be important principles of the new approach.

Health Boards should also focus on delivery, with the balance of care shifting away from secondary care towards primary care, or other non hospital locations wherever possible. Health Boards should ensure that financial resources from both ring fenced and non ring fenced allocations deliver effective and efficient services and that one off initiatives are based upon need and are evidence based.

The Dental Workforce

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 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; 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 available data in relation to the dental workforce in Wales is variable, and there is a need to improve the quality of the information available.

The National Leadership and Innovation Agency for Healthcare (NLIAH) have carried out a comprehensive analysis of the dental workforce in Wales and reported their

findings in September 2012 –“Analysis of the Dental Workforce in Wales”. This publication provides a fuller picture about future service provision/workforce planning for all dental services and will allow Health Boards to plan accordingly. However, the report also highlights the need for more robust data. A summary of the information is set out below:

Dentists

- There is an overall total of 1,801 dentists working within in Wales* (as at autumn 2011);
- Almost three-quarters of Wales’ dentists who perform NHS work (“NHS dentists”) work predominantly in general dental services providing primary care dentistry;
- Approximately half of Wales’ NHS dentists are aged below 40, while around one-quarter are aged 50 or above;
- Almost 60% Wales’ NHS dentists are male;
- In broad terms a higher proportion of older dentists are male, while amongst younger dentists (and dental undergraduates) the gender ratio is close to 50:50;
- The Community Dental Service (CDS) has the highest proportion of female dentists (67%), while the GDS has the highest proportion of male dentists (60%).

* 105 of these dentists work entirely in the private sector, however, due to data availability issues they are excluded from the figures.

Dental Care Professionals (DCPs)

- Wales has a total of 2,842 registered DCPs (as at September 2011);
- 80% of DCPs are Dental Nurses, 10% are Dental Technicians, and 9% are Dental Hygienists and/or Therapists, while Orthodontic Therapists and Clinical Dental Technicians make up the remaining 1%;
- 91% of registered DCPs are female.

The report concludes that if the rate of growth in dentist numbers continues at historical rates, Wales is likely to have a broad balance between supply and demand. If there are increases in retirement age and/or dentists choose to retire in their mid 60s or later, or if the rate of growth in demand for treatments slows (e.g. due to economic factors), the supply of dentists is likely to outstrip demand. **Over the past 7-20 years, the average rate of growth in total dentist numbers (c.1.6%-3.5%p.a.) appears to have been significantly higher than the rate of growth in Wales’ population (0.5%p.a.).**

The modelling described in the analysis suggests that Wales is unlikely to face a Wales-wide shortfall of dentists during 2012-2020. The full report can be viewed at:

<http://www.wales.nhs.uk/sitesplus/829/document/201686>.

Skill Mix

The GDC states that “good dental care is delivered by the dental team” and that “all members of the team contribute to the patient’s experience of dental treatment.”

General Dental Practitioners (GDPs) and DCPs are the dental team, and they individually provide differing skills and attributes.

Reviews of the delivery of oral healthcare have been prompted by changing patterns in oral and dental disease and the needs of patients. There is a potential for dentists to focus on complex therapeutic activities if DCPs, such as dental hygienists and dental therapists were further facilitated to deliver preventive, educational and general health promotion services. The roles of DCPs are defined by the GDC and at present they must work to the prescription of a registered dentist.

Evidence suggests that a high proportion of a dentist's clinical time may be taken up by activities that could be delegated to dental hygienists and therapists. It is possible that dental therapists could increase the output of daily practice by 45% and likewise dental hygienists by 33%. However, the literature suggests that such delegation is not yet widespread within the UK.

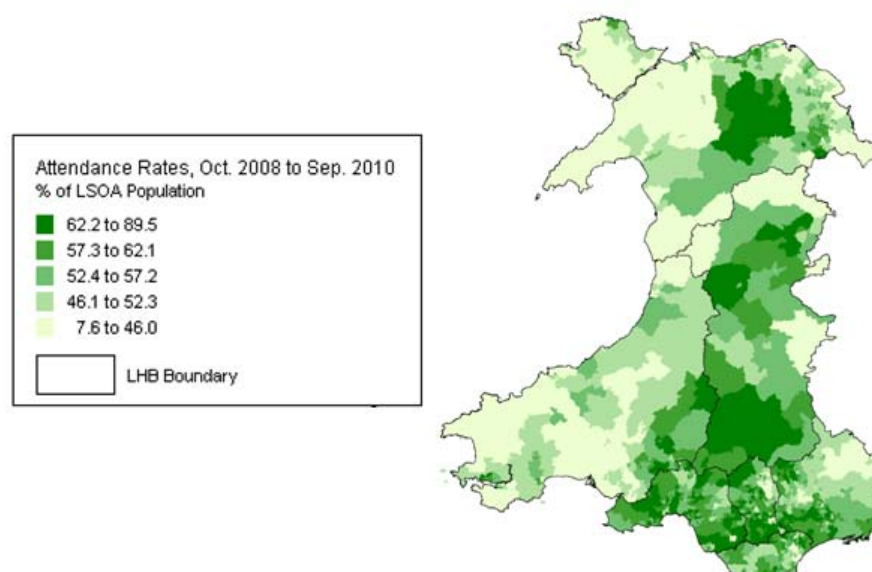
A recent survey of GDS dental teams in Wales by PGMDE shows GDPs are often willing to engage with the skill-mix agenda, and explore the possibility of more frequently delegating clinical activity to DCPs. However, further work is required to identify barriers to progress.

Access to General Dental Services (GDS)

In the 24 months preceding the end of September 2012, 1.67 million people attended an NHS dentist in Wales. That represents 54.6% of the total population and 52.1% of the adult population (Welsh Government, 2012). 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).

Figure 4: Attendance Rates in Wales, Oct 2008-Sept 2010



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 primary care dental services 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 primary care dental 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: Local Oral Health Plans should include actions to:-

- enhance contract monitoring and reviews on GDS/ PDS contracts that enjoy particularly high value Units of Dental Activity(UDA) and “splitting” courses of treatment - see Annex 1;
- ensure better compliance with NICE guidelines on recall intervals:
<http://www.nice.org.uk/Guidance/CG19>

Managing the GDS

We want Health Boards to maintain or develop an all Wales 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, facilitates the pooling of management/administration resources and utilises corporate knowledge e.g. through professional input to interpretation of reports from the NHS Business Services Authority, which is vital in effective operational handling of the GDS.

Action: Health Boards must include issues relating to primary dental care as part of their annual primary care reporting process and include them in their published Annual Quality Statement.

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 is 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 Review Task & Finish Group, the Welsh Government decided to test new systems of payment and delivery of primary care dental 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.

Two types of pilot programmes have been tested 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 and initial findings suggest the majority of the pilot sites have embraced the opportunity for innovation. Miller Research is undertaking the qualitative evaluation and has produced a baseline report identifying practices that have already made significant changes to skill mix and clinical procedures.

Action: Welsh Government 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.

The role of and access to Community Dental Services (CDS)

Role of the CDS

We remain committed to the provision of the CDS in Wales. Guidance on the role of the Community Services in Wales was issued in 2009, Ministerial Letter EH/ML/014/08: Dental Services for Vulnerable People and the Role of the Community Dental Service:

<http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/ministerial-letters/letter/?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 primary care dental services, or for whom there is evidence they would not otherwise seek treatment from such services; 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. This includes the Designed to Smile programme which is primarily delivered by the CDS and has helped revitalise the service in parts of Wales. The CDS also plays a key role in developing and delivering the 1000 Lives Plus programme to improve mouth care for adult patients in hospital, and in providing training for student nurses.

There is some anecdotal evidence to suggest that CDS and general dental practitioners have limited understanding of each others work. This barrier needs to be removed if each service is to be complementary to one another.

Access to the CDS

The remit of the CDS has changed over the last 20 years as it has responded to the need to provide a complementary service to general dental practitioners. The CDS

has adapted to meet the demands of patients with special needs, primarily those with complex clinical conditions and/or challenging behaviour. Consequently there has been a reduction in numbers of routine child patients treated by the CDS, the extent of which varies from area to area. There has been a rise in the number of adult patients treated, with a concentration on the client groups who have special needs. Activity data for the CDS has been collected directly by the Welsh Government for some years using form "CDSRW", which was introduced with the agreement of the CDS in 2008-09. However, there have been issues about the timeliness of reporting and questions about whether the information data set continues to provide the level of information Health Boards require to make strategic decisions about service delivery. The most recent data showed:

- There has been a gradual decrease in the number of contacts with the CDS in recent years. 71,400 patients (i.e. individuals) were seen by the CDS in 2011-12;
- Changes in the proportions of young to old patients seen by the individual services. The highest percentage of patients seen are aged between 5-15 years (Wales 2000/01 65% of total seen and 2011/12 57% of total seen). During 2000/01, 5% of the treatment workload was delivered to persons aged 65 and over however, this has increased to 10% in 2011/12. In the future, access to domiciliary care will become increasingly important and CDS could have a pivotal role to play by offering a single point of contact for a region, or other geographical area;
- A reduction in activity 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 require greater resources of clinical skills and time;
- There is emerging evidence questioning whether "traditional" dental screening of schoolchildren remains effective and/or efficient. Clearly there is a need to consider how to target the most vulnerable children who may not be attending school for a variety of reasons. Not to do so would mean that inequality in health remains and the most deprived children will continue to experience unacceptable levels of dental decay.

The system for the monitoring of clinical standards for each of the primary dental care services is different. Whilst the GDS is subject to the monitoring system applied to independent contractors, the CDS currently has no national standard provision.

Community Dental Services in Wales are well placed to facilitate the development of integrated dental services, as outlined in the consultation document "Together for Health - Delivering a Local Integrated Care Plan".

Action: Welsh Government will work with PHW to consider evidence regarding dental screening, review the current school screening programme in Wales, and update advice to CDS.

Welsh Government will work with Health Boards to review and improve the CDS information data set to ensure that it meets all stakeholder requirements, is consistent with the Annual Quality Statement and includes the need for electronic data collection.

Designed to Smile

Designed to Smile is a targeted National Oral Health Improvement Programme. Its primary focus is the improvement of the dental health of children in Wales. It is funded by Welsh Government and was initially launched in January 2008 in both North and South Wales as a pilot. In October 2009, the then Minister for Health and Social Services, Edwina Hart MBE OStJ AM, announced that due to the success of the pilots the programme would be enhanced and expanded to cover the whole of Wales. By March 2012, 78,350 children from 1,121 schools and nurseries in the most deprived parts of Wales were taking part.

A 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 has Designed to Smile as an integral component.

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 dental teams, parents, teachers and other health professionals. 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: Welsh Government will introduce a quality framework to benchmark the effectiveness and efficiency of individual Designed to Smile programmes.

Practice Based Prevention

Dentists and their teams have a duty to provide preventive advice where they judge it appropriate for their patients.

In April 2011, the Welsh Government instigated dental contract pilots in Wales. As explained earlier, 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. We recommend practice dental teams refer to:

Delivering Better Oral Health: An evidence based toolkit for prevention. 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: A Welsh edition of Delivering Better Oral Health with specific links to the Designed to Smile programme will be published in 2013.

Other Commissioned services

Unscheduled dental care

Health Boards should ensure that adequate access is available to both “in hours” and “out of hours” treatment of dental emergencies. “Out of hours” unscheduled care is accessed via telephone triage systems and the unscheduled care service is complementary to the “in hours” scheduled services provided in primary dental care. Service planning must include those groups who are hard to reach, including the vulnerable. To assist, Welsh Government has issued guidance on the role of dental services for vulnerable people, Ministerial Letter EH/ML/014/08: Dental Services for Vulnerable People and the Role of the Community Dental Service:

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

Domiciliary Services

Currently, approximately one third of the UK population of 60.2 million is aged over 50 years. People aged 75 years and over will account for more than 10% of the population by 2023 and the number of people aged 85 years and over will double in the next 25 years. Within Wales it is acknowledged that future decades will see an ageing population. In 25 years, there are likely to be more people of retirement age than there will be children. The biggest growth is expected in the ‘oldest old’ (i.e. those aged over 80). This has implications for the health care system as, generally, older people suffer more ill health, resulting in increased demand for health care.

Domiciliary dental care is defined as the provision of dental care in an environment where the person is resident (either permanently or temporarily), as opposed to dental care delivered in a fixed or mobile dental clinic. It will normally include dental care delivered in care homes, hospitals, day centres and the patient's own home (British Society for Dental Health (BSDH), 2009). It is most frequently, but not always, older people who require domiciliary dental care. It is important to note that the scope of dental treatment which can be provided under domiciliary arrangements is limited by the physical environment of the location. There is evidence that the delivery of, and access to domiciliary dental care has become patchy. Domiciliary care can be delivered by both general dental services and CDS providers. Clearly Health Boards have a responsibility for the development of a robust process to support local residents.

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, CDS and other stakeholders to develop an integrated domiciliary care system with central referral management.

Good practice: Betsi Cadwalwr University Health Board has recently launched **Gwên am Byth**. North Wales Community Dental Service, in liaison with PHW, has developed a new service aimed at improving oral health and access to care for vulnerable older people living in residential care. The service is provided by a dedicated team led by a Specialist in Special Care Dentistry. The programme comprises training for care staff and dental examinations for residents with the provision of individual oral care plans. Dental treatment is also arranged as appropriate at either a fixed site or from a newly commissioned purposely designed mobile dental unit.

Action: Health Boards should use BSDH guidelines in developing their plans for the delivery of domiciliary 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 primary care dental services. In addition, hospital based orthodontic care is provided to patients who require more complex orthodontics and/or surgical and multidisciplinary care.

Orthodontic services in Wales have been reviewed both at regional and national level. Regionally, PHW 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 these reports are 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 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 2013 in order to evaluate whether changes to services have occurred.

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. 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.

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: Hwyl Dda Health Board has pioneered the development 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>

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: Welsh Government will undertake a review of the GDS orthodontic contract in conjunction with colleagues in England by 2016.

Health Boards should work to the Welsh Government's Interim Guidance on Management of NHS Orthodontics in Primary Care (March 2011) particularly during contract renewal.

Dental treatment using general anaesthesia

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. Services need to be compliant with current guidance (WHC (2001) 056 and WHC (2001)077) which outline the experience, skills and qualifications required by staff and specify the facilities needed.

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 child’s general wellbeing, including disruption of schooling, and for parents and other family members having to cope with a child in pain.

PHW has indicated in a recent interim report that over 9,696 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 was one reason for the launch of Designed to Smile in 2008 and why we will continue to support the programme.

Certain groups of patients find it impossible to cope with dental treatment in the normal way. These may include people with severe learning disability, or physical impairment which mean they cannot control their movements. They may require all forms of dental treatment under GA. It is unacceptable for these patients to wait for long periods for treatment – particularly when they are in pain. There are instances of patients being prescribed repeated antibiotics in a bid to control dental pain and infection while they wait many months or years for treatment under GA. Provision of care for this cohort of patients requires specialist facilities and specially trained anaesthetic, nursing and dental teams.

Action: Following recommendations by the Children and Young People Committee, the Welsh Government will develop and publish data about the number of children receiving dental treatment under GA each year.

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;
- 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; and
- keep up to date information on waiting lists for vulnerable people who require dental treatment under GA, and ensure that patients do not wait longer than Welsh Government guidelines.

Hospital Dental Services (incorporating specialist dental services)

In dentistry, most care is provided by generalists and patients are rarely referred to specialists, though referral rates are reported to have risen greatly in recent years and are likely to continue to do so. Secondary care is more likely to be on an outpatient basis. A large amount of specialised (orthodontic) care is delivered within primary care by non consultant specialists.

In an ideal system the interface between primary and secondary dental care would be described as equitable, seamless, effective and efficient. However, an analysis of the geographical location of hospital based dental specialists working in Wales reveals service inequities. Whilst most areas have access to consultant led Oral and Maxillofacial and Orthodontic services there are few Restorative and Paediatric consultants based outside Cardiff. These specialities are extremely important in the management of the complex dental needs of medically compromised children and adults and the need to develop these services and specialties throughout Wales. In addition, so as to develop a seamless approach it is important that Health Boards consider using DWSIs in relation to dental specialties (oral surgery, periodontics and endodontics).

Training, development and offering contracts to this group could help improve access to specialist services in primary care. It is necessary in terms of overall service efficiency, development of specialities, training, clinical peer review and audit, that Hospital Dental Services (HDS) are centralised. However, it is also important that in a country like Wales, with contrasting urban and rural factors, central HDS are sensitive to the need to outreach wherever practical.

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.

Community Dental Services have employed specialist practitioners to provide endodontics (BCU) and oral surgery (Powys). They provide an intermediate level of care for those patients who do not need hospital services, but whose care is generally too complex for GPs.

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.

Health Boards need to develop clear plans on how their residents will access specialist dental services based in primary care (specialists/DwSIs), the CDS and/or secondary care, and, ensure an integrated approach to the delivery of the aforesaid services.

Section 3: Quality and Safety

Delivering and 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. Dentistry must be considered when Health Boards plan how to meet current and future quality and safety requirements, and dental teams must contribute appropriately to their delivery.

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 independent practice visits and reporting.

Action: PHW will continue to enhance the QAS to further embed the Standards for Health Services in GDS.

Regulation and Standards - Quality Delivery Plan

As outlined in Together for Health, Welsh Government published a Quality Delivery Plan (QDP) in 2012 which 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 and an Annual Quality Statement. The QDP highlights 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. Following publication of the QDP, Welsh Government worked with PGMDE to consider how best to ensure that dental teams contribute to its delivery.

Action: Welsh Government will work with PGMDE and stakeholders to address all QDP Actions which are relevant to dental teams.

PGMDE will support further development of audit for Dental Care Professionals.

Quality Improvement – 1000 Lives Plus

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

- reducing antimicrobial prescribing by dentists; and
- improving mouth care 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: PGMDE will support the dental profession to improve antimicrobial prescribing in general dental practice through the use of 1000 Lives plus practice based audits, and subsequent use of recognised improvement methodologies.

The CDS will work with educational providers to ensure consistent evidence based oral health input to all pre-registration nursing courses, and, to address training for Health Care Support Workers.

Quality Assurance System in primary dental care

Online Quality Assurance System (QAS)

The dental public health team of PHW manages the annual 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. Welsh Government and PHW are working together to modernise the QAS and further enhance it in line with Welsh Government quality and safety requirements. In Wales up until April 2013, the Dental Reference Service (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. Welsh Government is currently considering how to develop and introduce an effective and enhanced system of primary dental care appraisal for Wales.

The Maturity Matrix Dentistry

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 which 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: Welsh Government will work with all stakeholders and seek Ministerial approval to develop a new appraisal process for independent monitoring of primary dental care by October 2013. Health Boards will be in a position to report the outcomes in their Annual Quality Statement.

PGMDE 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/information/decontamination/?lang=en>

In May 2012, the Chief Dental Officer (CDO) issued further guidance to the profession on the essential requirements for compliance with HTM 01-05 Welsh Edition (CDO (2012) 2):

<http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/cdo-letters/compliance/?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 2013/14 the Welsh Government 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. The audit will be developed using recognised improvement methodologies.

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 11% 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 system. 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 GDP 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: Welsh Government will use the pilot into NHS connectivity and email in general dental practices to further develop ICT in dentistry.

During 2013, we will work with stakeholders to encourage and promote use of electronic data/claims transfer by all GDS practices in Wales.

Dealing with dentists whose performance causes 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 Welsh Government, Public Health Wales Dental Team, Health Boards, NHS Wales Shared Services Partnership, Department of Postgraduate Dental Education and NHS Dental Services. This is particularly beneficial to how we support and deal with practices and practitioners whose performance gives rise to concern. During 2012 we published revised guidance on dealing with dental performance:

<http://wales.gov.uk/topics/health/ocmo/professionals/dental/publication/information/guidance/?jsessionid=9F3C1EF9FA32FFB5D925CDCE2031ECF1?lang=en>

One specific area we need to focus on is the support provided for non UK qualified dentists commencing work with the NHS in Wales. This issue is considered further in the Analysis of the Dental Workforce in Wales.

Issues relating to occupational health

In 2006, as part of a package supporting the introduction of new dental contractual arrangements, the Welsh Government provided funding to each Health Board for occupational health and Hepatitis B vaccinations for general dental practitioners. Utilisation of this funding and the services available was variable across Health Boards. In August 2012, Health Boards were allocated £100,000 recurrent funding, ring fenced for the specific purpose of occupational health provision for members of the primary care dental team. Health Boards have been encouraged to develop broad 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 and develop an occupational health programme for all members of the dental team in general dental practice.

Training

All members of the dental team must comply with GDC requirements for Continuing 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 are covered by the Analysis of the Dental Workforce in Wales (see page 18).

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. These issues are considered in the Analysis of the Dental Workforce in 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 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.

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. 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: Welsh Government will discuss gaps in the evidence base associated with primary dental care with its academic partners and the profession, to identify priorities and how we can encourage primary care practitioners to participate in research and development of services.

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 (until April 2013) with the DRS to visit and report on private practices to the same standards as applied to NHS practices.

Action: Welsh Government will work with the dental profession to revisit the Private Dentistry regulations and in particular, consider whether and how dental practices – rather than individual dentists – can register to provide private dental care. In addition we will seek advice on how private dentistry can meet the *National Minimum Standards for Independent Healthcare* so that standards for private dentistry are consistent with NHS services.

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 oral disease 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, multi-sectoral working, 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.

National Oral Health Plan: Action Chart

Key Strategic Actions

ACTION	BY WHOM	BY WHEN
Provision of strategic leadership by developing a series of key outcome indicators and performance measures to support Health Boards' Local Oral Health Plans.	Welsh Government	October 2013
Health Boards will develop a Local Oral Health Plan to address the oral health needs of their residents, and clearly describe how they will ensure good governance in commissioning and delivery of all dental services (see Annex 1).	Health Boards	Core plans - December 2013
Provision of information and expert advice to inform the development and delivery of Local Oral Health Plans.	Dental Public Health team (PHW)	From April 2013
Health Boards will be expected to work with dentists and their teams, and all other relevant stakeholders to develop and support delivery of Local Oral Health Plans.	Health Boards; dental profession and dental teams; Local Authorities; Third sector	From April 2013
Commission, develop and deliver education and training programmes to appropriately support the delivery of Local Oral Health Plans.	PGMDE	From April 2013
Publish annual all Wales report based on Health Board reports against key outcome indicators and performance measures.	Welsh Government	Baseline report in April 2014, annually thereafter

Additional actions to support the development and delivery of Local Oral Health Plans

Prevention

Welsh Government

- Provide strategic support for national preventative campaigns e.g. during Mouth Cancer Awareness Month and National Smile Month;
- Publish, in 2013, a Welsh edition of “*Delivering Better Oral Health*” with specific links to the Designed to Smile programme.

Health Boards

- Health Boards will ensure the continued participation in evidence based community oral health promotion programmes particularly the Designed to Smile and Healthy Schools programmes.

Delivering Efficient and Effective Care

Welsh Government

- continue to pilot systems which move away from the current system of remuneration and delivery, towards a model which focuses on prevention, risk assessment and tailored patient care;
- work with Health Boards and PHW to consider evidence on dental screening, review the current school screening programme in Wales, and update advice to CDS;
- work with Health Boards to improve the CDS information data set to ensure it meets all stakeholder requirements, is consistent with the Annual Quality Statement and includes the need for electronic data collection;
- undertake a review, by 2016, of the GDS orthodontic contract in conjunction with colleagues in England;
- develop and publish data about the number of children that receive dental treatment under GA each year.

Health Boards

- will liaise with the Cancer Networks and the Head and Neck Cancer National Specialist Advisory Group to ensure that the Welsh Cancer standards (2005) are implemented. We will expect Health Boards to work together to ensure evidence – based, multi-disciplinary care is available to all their patients diagnosed with oral cancer. We will seek assurance that any identified variation in treatment outcomes is addressed by the Cancer Networks;
- should use the recommendations from the Special Care Dentistry Implementation Plan in ensuring that the needs of all vulnerable groups are addressed;
- following recommendations by the Children and Young People Committee, collect annual data on the number of children who receive dental treatment under GA;
- must keep up to date information on waiting lists for vulnerable people who require dental treatment under GA, and ensure that patients do not wait longer than Welsh Government guidelines;
- must work together to develop regionally agreed referral and care pathways which will promote efficient patient care and better working across GDS, CDS and HDS.

Improving quality and safety

Welsh Government

- work with stakeholders to develop and introduce an appraisal process for independent monitoring of primary dental care by October 2013. Health Boards will be in a position to report the outcomes in their Annual Quality Statement;
- introduce a quality framework to benchmark the effectiveness and efficiency of individual Designed to Smile programmes;

- during 2013/14 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 and the CDS. The audit will be developed using recognised improvement methodologies;
- work with PGMDE and stakeholders to address all QDP Actions which are relevant to dental teams;
- work with the dental profession and other stakeholders to revisit the Private Dentistry regulations;
- use the pilot into NHS connectivity and email in general dental practices to further develop ICT in dentistry;
- work with stakeholders to encourage and promote use of electronic data/claims transfer by all GDS practices in Wales;
- discuss gaps in the evidence base associated with primary dental care with its academic partners and the profession, to identify priorities and how primary care practitioners can be encouraged to participate in research and development of services.

Public Health Wales

- continue to enhance the QAS to further embed the Standards for Health Services in GDS.

PGMDE

- support further development of audit for Dental Care Professionals;
- work with 1000 Lives Plus programme to promote use of recognised improvement methodologies by dental teams;
- support the dental profession to improve antimicrobial prescribing in general dental practice through the 1000 Lives Plus practice based audit, and subsequent use of recognised improvement methodologies;
- continue to promote and facilitate use of MMD in GDS in Wales, particularly for practices where performance concerns have been identified.

Health Boards

- must work with PGMDE to ensure dental teams have access to high quality postgraduate training to address educational needs in oral cancer, including information on appropriate Third Sector organisations and websites which patients can access for evidence based advice and support;
- must work with PGMDE to ensure that the dental actions contained within the Tobacco Control Action Plan are taken forward;
- should take account of and participate in the 1000 Lives Plus programme to Improve Mouth Care for Adult Patients in Hospital;
- must include issues relating to primary dental care as part of their annual primary care reporting process, and include them in their Annual Quality Statement;
- must work with Local Dental Committees (LDCs) to review the occupational support they provide and develop an occupational health programme for all members of the dental team in general dental practice;
- will support the CDS to work with educational providers to ensure consistent evidence based oral health input to all pre-registration nurse courses in Wales, and to address training for Health Care Support Workers.

GUIDANCE FOR THE DEVELOPMENT OF LOCAL ORAL HEALTH PLANS

Local Oral Health Plans **must** include an up to date assessment of oral health needs and local service provision. Service planning must take account of the specific issues outlined below:

- plans for their residents to access specialist dental services based in primary care (specialists/DwSIs), the CDS and/or secondary care, and ensure an integrated approach to the delivery of these services;
- use of BSDH guidelines in developing their plans for the delivery of domiciliary services;
- develop alternative patterns of care e.g. increasing the specialist dental services and dental DwSI workforce, and building the capacity of alternative treatments such as sedation where feasible;
- in partnership with the Local Authority and the Third Sector ensure oral care is integrated into the general health and social care plans/pathways of patients with complex medical and social problems;

Plans **must** also contain specific actions regarding the management of the current GDS contract:

- enhance contract monitoring and reviews on GDS/PDS contracts with high value Units of Dental Activity(UDA);
- ensure better compliance with NICE guidelines on recall intervals (<http://www.nice.org.uk/Guidance/CG19>);
- monitor “splitting” courses of treatment;
- work to the Interim Guidance on Management of NHS Orthodontics in Primary Care, particularly during contract renewal.