GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Improving Oral Health Together

An Oral Health and Dental Service Improvement Plan for Abertawe Bro Morgannwg University Health Board

A five year vision

Contents:

Foreword

On 18 March 2013, the Welsh Government (WG) released a national Oral Health Plan for Wales. In response to this the Health Board must develop a local oral health plan, indicating how it will achieve the actions set by the Welsh Government.

This Local Oral Health Plan (LOHP) outlines an agenda for improving oral health and reducing oral health inequalities in Abertawe Bro Morgannwg University (ABMU) Health Board over the next five years. Prevention is at the heart of this plan. Reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.

Since the inception of ABMU Health Board in 2010 the Board has worked to bring together the three former Local Health Boards of Swansea, Neath Port Talbot and Bridgend, and considerable work has already been undertaken to bring together the service delivery for primary, secondary and community dental services. ABMU Health Board has established a number of Managed Clinical Networks and working groups to plan and deliver effective dental services.

We do however recognise that there is further work to be undertaken and to achieve our aims change is required. The skills, experience, and dedication of the dental workforce across primary, secondary and community services are, and will remain, a vital resource upon which we will need to work with to achieve that change. Oral health is an intrinsic part of general health and wellbeing. One of our major goals in implementing this plan must be to help people take responsibility for ensuring their own good oral health.

There remain significant differences between individuals with the best and worst oral health in ABMU. We must improve the health of everyone in our area and pay particular attention to the young and vulnerable groups and seek to reduce inequalities. Services must deliver modern prevention orientated NHS dental services resulting in high quality care being delivered in the most appropriate setting. We must also prioritise dental care for the most vulnerable.

In developing this plan we have consulted with professional groups, neighbouring Health Boards and Local Authority colleagues. And as part of the City and County of Swansea's designated Healthy City status an Integrated Impact Screening Assessment has been undertaken on the plan to ensure the actions identified are as robust as possible in meeting the needs of the resident population.

I commend to you the ABMU Health Board Oral Health Plan 2013 – 2018

Paul Stauber
Director of Planning

Executive Summary

In responding to the Welsh Government (WG) National Oral Health Plan for Wales, Abertawe Bro Morgannwg University (ABMU) Health Board has produced a Local Oral Health Plan which responds to the 20 actions set out by Welsh Government.

We recognise that we need to enable patients to take responsibility for their own oral health whilst supporting the most vulnerable groups to access high quality and effective services. Oral health is an intrinsic part of health and wellbeing.

Currently we know that:

- 64% of the ABMU resident population attended a NHS dentist at least once in the 24 month period between April 2011 and March 2013, compared to 53% across Wales.
- The average distance travelled to see a dentist was 5 kilometres
- 88% of 6 to 17 year olds attended the dentist at least once between April 2011 and March 2013
- We need to reduce the levels and burden of decay at ages 5 and 12 amongst the most deprived groups of patients by 2020
- In 2011/12 the children living in the most deprived areas of the Health Board had an average dmft (decayed, missing, filled teeth) of 2.48 and a %dmft of 58.3% which is higher than the Welsh targets for this group. Whilst the situation has been improving there remains considerable room for improvement
- On average across Wales in a class of 30 five year olds, four children would have experienced dental pain in the last 12 months

The Health Board, through developing the Oral Health Plan has identified a number of key priority areas to progress on over the next five years, which we hope will go some way to address the health inequalities and will enable the resident population to take responsibility for maintaining good oral health.

1. Access to urgent dental care during the working day
   We need to improve access to NHS dental services for patients who have an urgent dental need and who do not see a dentist on a regular basis for their ongoing dental care. Improved access for patients with an urgent need during the working day should reduce the patient contacts currently being reported by GPs, GP Out of Hours services and the Accident and Emergency Department.

2. Dental Out of Hours Services
   Work has already begun to look at a new model for dental Out of Hours services for those patients who have an urgent dental need. It is important for the Health Board to differentiate between an urgent dental need and a dental emergency where the patient needs to be seen in the Accident and Emergency Department. The new model will need to be supported by a patient education programme to ensure that patients are able to access the correct service.

3. Domiciliary Dental Services
   A review of domiciliary dental services has already been undertaken by Public Health Wales. The Health Board now needs to implement the revised service model to ensure that all patients requiring the service have access to a model of care delivered to a consistent standard, and that there is sufficient capacity in the service model to meet the clinical needs of patients.

4. Oral Cancer
   Due to the patient demographics of the Health Board area we already know that the incidence of oral cancer is forecast to continue to increase over the next 10 years. The Health Board needs to review the current service model for these patients to ensure that the Referral to Treatment Times (RTT) are adhered to and that the service model is capable of delivering against the short term anticipated growth in demand whilst planning a future service model.

5. Developing Dentists with Enhanced Skills
   Work has already begun to support the local recognition of dentists with enhanced skills in orthodontics and endodontics. In considering all of its service models and the associated workforce to deliver them, the Health Board will need to consider how dentists with enhanced skills can be appropriately supported to deliver against the organisations objectives for providing safe and effective dental services.

6. Orthodontics
   Considerable work has already been undertaken through the established Managed Clinical Network to develop a patient pathway that includes working with Dentists with Enhanced Skills (DES) and establishing a referral pathway. Demand for orthodontic services in specialist practices remains high and therefore the Health Board needs to continue to consider this as a priority area.

7. Children's General Anaesthetic (GA) Service Pathway
   A revised service model is being developed for implementation from January 2014. Work is ongoing to consider the ability to support the new model with a Paediatric DES which would include robust treatment planning of children referred into the service and to ensure an overall reduction in the number of general anaesthetics for children aged 3 – 17.

8. Designed to Smile (D2S) & Community Dental Services
   The Health Board will continue to support the D2S programme linking to data collected as part of the child GA service to identify schools within target areas. The development of the Community Dental Service will remain a priority for the Health Board to ensure that the outcomes of the Public Health Wales review are implemented.

9. Prison Dental Services
   The Health Board has the responsibility for the provision of dental services at Her Majesty's Prison Swansea. The current contract was established prior to the prison becoming a remand prison which has seen an increased demand in dental services.

10. Quality & Safety
    Underpinning all of the work undertaken in dental services across primary, community and secondary care, quality and safety is paramount in giving assurance to the Board that all of our dental services are fit for purpose. There is already a significant governance framework in place which we will continue to review to ensure that all services meet local and national standards, regardless of the setting in which they are delivered.

Glossary of Terms

A
ABMU - Abertawe Bro Morgannwg University Health Board
AMD – Associate Medical Director

C
CDS – Community Dental Service
CS – Conscious Sedation

D
D2S – Designed to Smile
Dmft – decayed, missing, filled teeth
DES – Dentist with Enhanced Skills
DSPG – Dental Strategy and Planning Group
DCT – Dental Core Training
DDC – Domiciliary Dental Care

G
GDS - General Dental Services
GA – General Anaesthetic
GDP – General Dental Practitioner

H
HDS – Hospital Dental Services

L
LA – Local Anaesthetic
LHB – Local Health Board
LDC – Local Dental Committee
LOC – Local Orthodontic Committee

M
MAH – Mouth care for Adults in Hospital
MCN – Managed Clinical Network

N
NICE – National Institute for Health and Care Excellence

P
PDS – Personal Dental Services
PHW – Public Health Wales

R
RD – restorative dentistry

S
SCD – Special Care Dentistry

W
WG – Welsh Government

Action 1

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.

Key Issues for ABMU Health Board

- By 2020 to reduce the levels and burden of decay at age 5 among the most deprived quintile of the population to that recorded for the middle deprived quintile
- By 2020 to reduce the levels and burden of decay at age 12 among the most deprived quintile of the population to that recorded for the middle deprived quintile
- To continue to support the Designed to Smile Programme
- To ensure that any new contracted dental activity is in line with the need of the resident population
- To continue to support and develop on effective clinical governance arrangements
- Ensure that recall attendances are in line with national guidance and meet the clinical needs of individual patients
- Increase access to patients needing urgent dental care during "normal" working hours and remodelling the dental out of hours service to ensure that it is delivering accessible and effective patient care.
- To ensure that members of the public are supported to take responsibility for ensuring their own good oral health

Where we are

The current primary care dental contracting arrangements were introduced in Wales in April 2006, with a greater emphasis on locally commissioned dental care. A consequence of this is that Local Health Boards have greater flexibility in planning and providing dental services in line with addressing dental health needs. ABMU Health Board is committed to commissioning any new dental activity in line with the needs of the resident population; however this is moderated by the inflexibilities within the ring-fenced budget. Work is also ongoing through the Dental Strategy Planning Group (DSPG) to ensure that there is alignment between primary, community and secondary care dental services to ensure that patients have access to timely services in the most appropriate clinical setting.

A strong focus has already been placed on the governance mechanisms used to ensure that safe and effective services are delivered across the Health Board. These will continue to be reviewed to ensure that they remain appropriate and take into account any changes in national/local policy.

ABMU Health Board provides dental services through the following:

- General Dental Services (GDS) contracts for urgent and routine dental services
- Personal Dental Services (PDS) agreements for specialist dental services e.g. orthodontics, intermediate oral surgery
- Community Dental Services for vulnerable groups within the community setting
- Oral and Maxillo Facial surgery through consultant led services
- Orthodontics through consultant led services
- Restorative dentistry through consultant led services

ABMU Health Board delivers a number of consultant led secondary care services to Hywel Dda Health Board and as a result has established a number of working groups and managed clinical networks to ensure engagement from management and professionals across both Health Boards.

The reporting mechanisms for the various groups are detailed in the table below:

The Dental Strategy and Planning Group is chaired by the Director of Planning for the Health Board who has the executive responsibility for dental services. Membership of the group includes the clinical leads of each of the working groups/MCNs, as well as colleagues from across the Health Board who deliver dental services, Public Health Wales, the LDC and Hywel Dda Health Board.

In addition to the conventional access streams to NHS dental services ABMU Health Board also facilitates innovative access through the Dental Training Unit (DTU), based in the Port Talbot Resource Centre. Patients attending the DTU are, in the main, treated by Dental Core Training Post Year 1 dentists (DCT1), who are recruited on an annual basis. The DTU also has two senior supervising dentists, a trainee therapist and a team of qualified and trainee dental nurses.

A 'High Need' referral scheme has been established which enables local dental practices to refer high need patients e.g. those patients who need a significant amount of dentistry to enable them to become dentally fit, to the DTU for a course of treatment, thereby releasing capacity for general dental practitioners. When treatment is completed, the patient is referred back to the general practice for any future care.

This scheme has already improved local access to NHS dentistry across the Health Board and been offered to all practices in the Neath Port Talbot area and has been extended to some to practices in Swansea and Bridgend. When capacity increases, the scheme will be offered more widely across ABMU.

The DTU was expanded in early 2013 to include three surgeries and a laboratory facility for the provision of restorative dentistry that was previously undertaken at Princess of Wales Hospital and Neath Port Talbot Hospitals. A proposed service model to integrate dental services operating at the Port Talbot Resource Centre is currently being explored. The model includes the integration of the DTU, Community Dental Service, Restorative Dentistry and elements of Minor Oral Surgery working in collaboration where possible and a single point referral system to manage dental activity. Furthermore, the development of a two-year longitudinal DCT Training Scheme, building on the success of the current DFT scheme and

also ensure that numbers of trainees are consistent year on year. This development would provide the opportunity for broader postgraduate training experience and produce dentists with experience in several dental specialties.

ABMU Health Board is also fortunate to have two dental practices in Swansea who are participating in the Welsh Government Dental Contract Quality and Outcome Pilots established to look at new ways of providing care for patients that link to access, quality of services and disease prevention in adults and children.

The Health Board has also recently awarded contracts for the provision of intermediate oral surgery services (patients requiring more complex dental extractions under local anaesthetic) from two community based practices in Swansea. Both practices accept referrals from all dental practices across ABMU. It is anticipated that this new service model will see a reduction in the number of patients referred into secondary care for procedures that can be safely undertaken in a primary/community setting.

Deprivation, Primary Care Dental Servicer Use and Provision in Relation to Need 2012/13

The Welsh Index of Multiple Deprivation (WIMD) 2011 is the official measure of relative deprivation for small areas in Wales. It was produced by the Welsh Government as a tool to identify and understand deprivation in Wales.

"*Deprivation is a wider concept than poverty. Poverty is usually considered to be a lack of money, whereas deprivation includes a lack of opportunities and resources to which we might expect to have access in our society, for example good health, protection from crime, a clean and safe environment. "Multiple" deprivation therefore refers to the different types of deprivation that might occur. Eight types of deprivation, or domains, are included in the Index. These are: employment, income, education, health, community safety, geographical access to services, housing and physical area. Ranks are a relative system of measurement; we can know which areas are more (or less) deprived than others, but not by how much."*

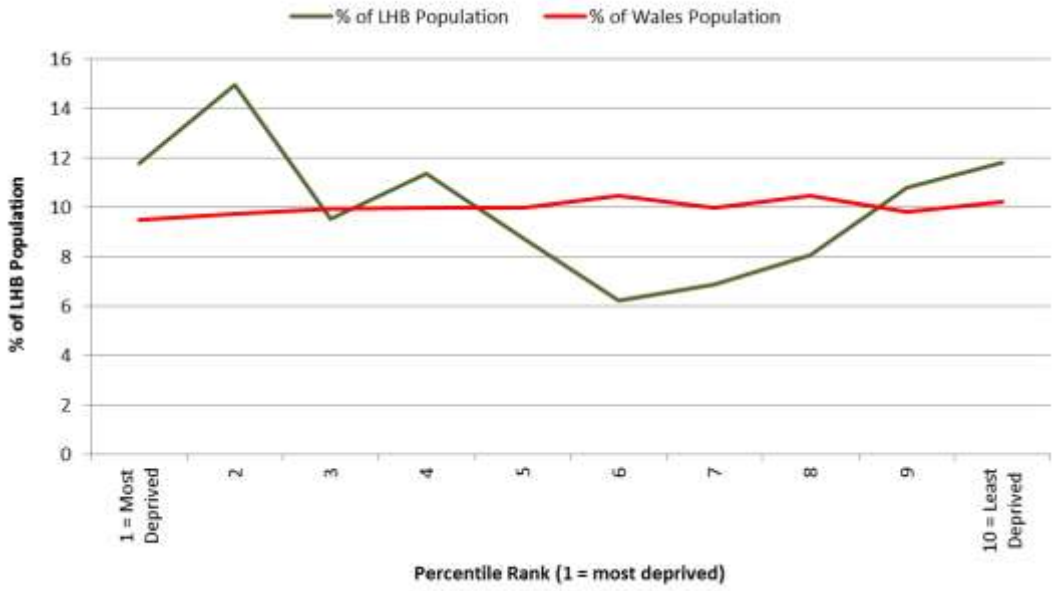
WIMD is produced at lower layer super output areas (LSOAs), the geographical size of these small areas varies quite widely, and depends on the local population density, the populations are intended to be the same in each LSOA, with an average population of 1,500 people. LSOAs were designed by the Office of National Statistics to have consistent population sizes and stable geographies, so that statistical comparisons of small areas over time can be carried out.

Within each Local Health Board the distribution of deprivation varies. In this report the deprivation score for individual LSOAs are ranked on an All Wales basis. *Table 1* below shows the size and proportion of the LHBs population that falls within each WIMD 2011 quartile. *Chart 1* shows the proportion by percentile.

Table 1: Population within WIMD 2011 Quartiles

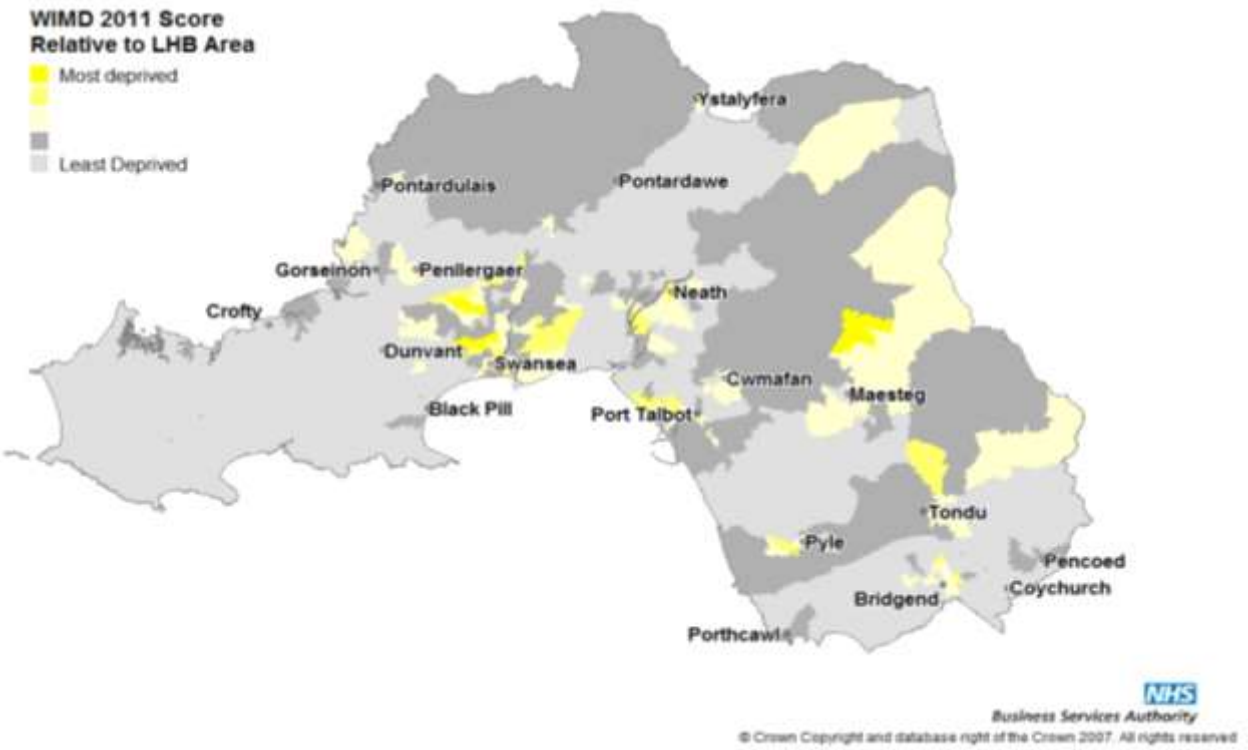
Quartiles Rank	LHB Population	% of LHB Population	% of Wales Population
25% Most deprived	149,870	29.8	24.2
25-50% Most deprived	133,413	26.5	25.0
50-75% Least deprived	82,181	16.3	25.7
25% Least deprived	137,512	27.3	25.2
Total	502,976	100.0	100.0

Chart 1: Population within WIMD 2011 Percentiles

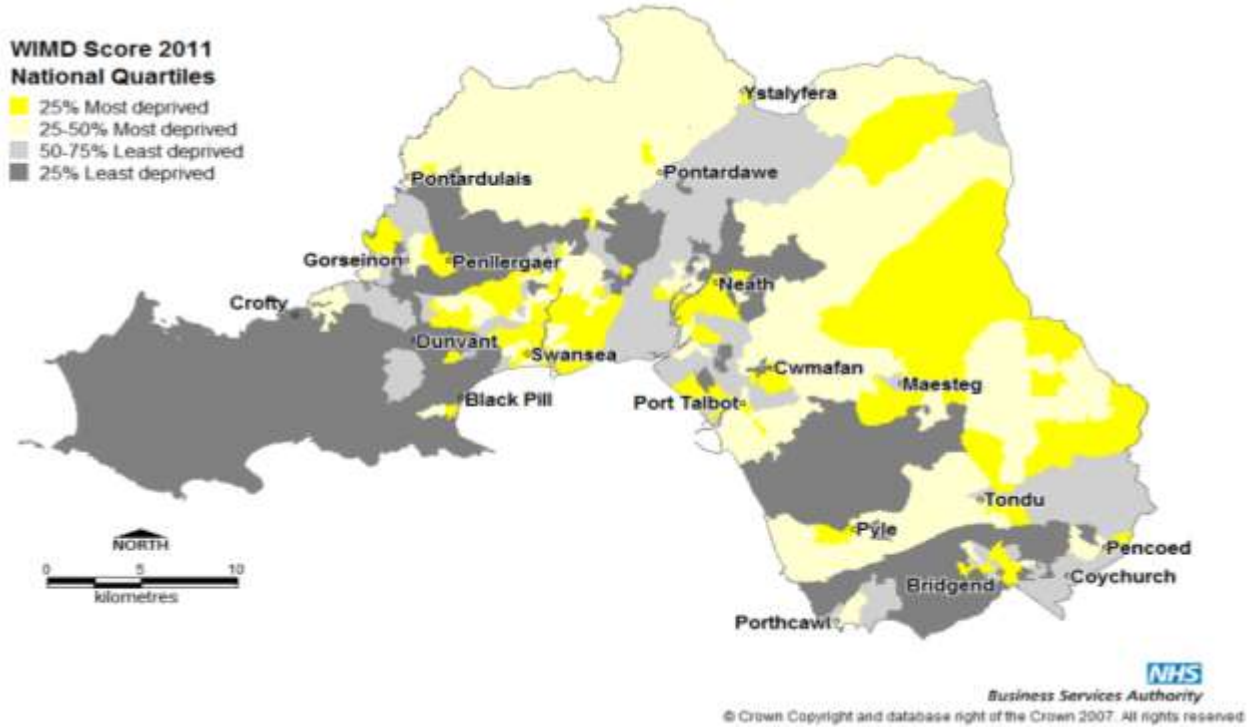


This information shows that the LHBs population is over-represented in the most deprived areas and to a lesser extent the least deprived areas. The LHBs population is considerably under-represented within the median deprived communities compared with Wales as a whole, particularly those area in the 60 to 80% least deprived areas.

Map 1 (below) shows the WIMD 2011 score relative to the LHB area only, i.e. ranking only LSOAs in the LHB. Those areas shaded yellow are the most deprived relative to the LHB area. Main towns or cities are shown for geographical reference.



Map 2 (below) shows LSOAs in the area which fall into national WIMD 2011 quartiles i.e. the 25% most deprived to 25% least deprived nationally. Main towns and cities are shown for geographical reference.



Based on the needs analysis ABMU Health Board undertook a tender exercise in 2012/13 to commission additional dental activity in the areas of highest need, with new contracts being awarded in Sketty/Uplands (Swansea), Pontardawe (Neath Port Talbot) and Maesteg

(Bridgend). The average distance travelled by patients from their home to a dentist was 5km. 64% of the ABMU resident population attended a NHS dentist at least once in the 24 month period between April 2011 and March 2013, compared to 58% across Wales; with a greater proportion of females (67%) attending compared to males (61%). Attendance rates were highest in children with 88% of 6 to 17 year olds attending the dentist at least once during the same period. However, attendance rates are closely related to levels of deprivation with children resident in the least deprived areas consistently attending a NHS dentist compared to those in most deprived areas. This pattern is however reversed in adults with higher rates attending a NHS dentist in the most deprived areas.

The National Institute for Health and Clinical Excellence (NICE) published guidance in October 2004 sets out to help dentists assign recall intervals between oral health reviews that are appropriate to the needs of individual patients which can range between 6 and 24 months. From the 2012/13 data the most common re-attendance interval for adult patients is 6 to 8 months, which suggests that a significant number of patients and their dentists are continuing with the long established pattern of twice yearly attendance whilst the recall interval for patients living in the most deprived areas was shorter (e.g. 3 months).

Children's Oral Health

Dental health targets were set for Wales in *Eradicating Child Poverty in Wales – Measuring Success* (2006):

In summary:

- By 2020 to reduce the levels and burden of decay at age 5 among the most deprived quintile of the population to that recorded for the middle deprived quintile
- By 2020 to reduce the levels and burden of decay at age 12 among the most deprived quintile of the population to that recorded for the middle deprived quintile

Whilst there are no specific Local Health Board targets, we can use the Welsh targets as a benchmark. There has been an improvement in both the average DMFT and the %DMFT>0 for children living in the ABMU area between 2007/08 and 2011/12.

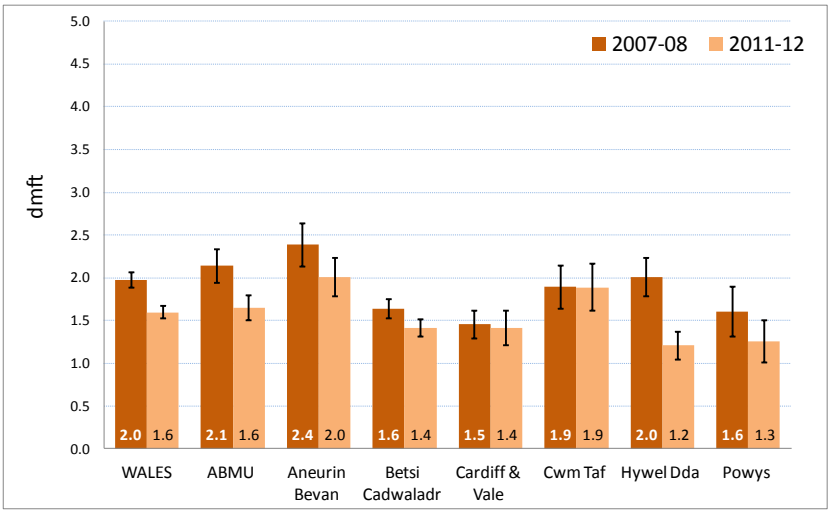
ABMU Health Board will continue to address this inequality in experience of child tooth decay over the next five years.

For the most deprived fifth of 5 year old children in Wales, the average DMFT (decayed, missing due to caries and filled index) was 2.65 in 2007/08 when the baseline was set. The national child poverty target is to bring this average down to 1.77 by 2020. In 2011/12 the average dmft for the most deprived group was 2.16; half a tooth reduction when compared with 2007/08 and good progress towards the 2020 target. The results of the Wales 2011/12 survey of 5 year olds suggest that prevalence of dental caries is improving but this needs to be confirmed by reviewing the results of future surveys, the next being scheduled for 2015/16. It is important to note that these are Welsh targets as to date there are no Health Board targets.

The sum of decayed, missing and filled teeth is a measure of the decay experience of the average child. It is the burden of disease which theoretically could have been prevented.

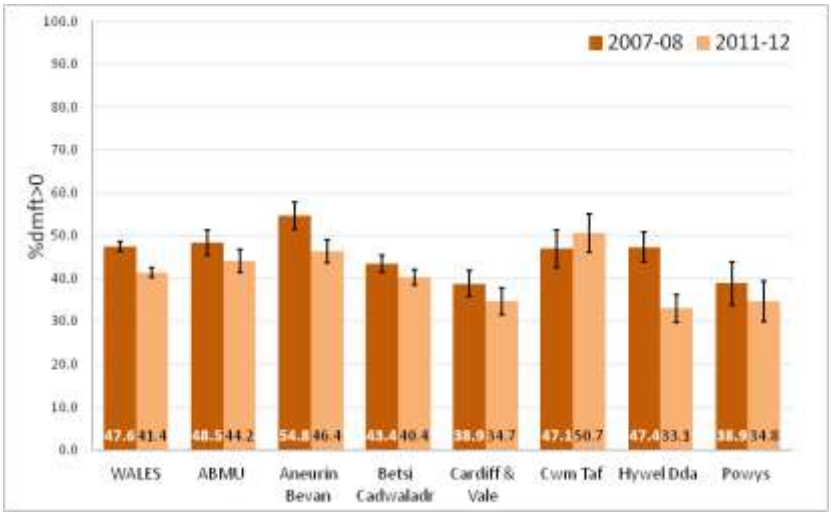
Average dmft scores for Welsh Local Health Boards in 2007/08 and 2011/12 are presented in the table below. ABMU Health Board experienced a statistically significant reduction, with the averages being 2.1 and 6.1, with the mean being similar to the Welsh average for both.

Average dmft for 5 year olds, Welsh Local Health Boards 2007/08 compared with 2011/12



The table below illustrates the proportion of children with at least one decayed tooth (%dmft>0) by LHB in 2007/08 and 2011/12. Although there appears to be a general tendency (except in Cwm Taf) for a reduction in the proportion of children with decay experience, the changes only reach statistical significance in Aneurin Bevan and Hywel Dda LHB areas.

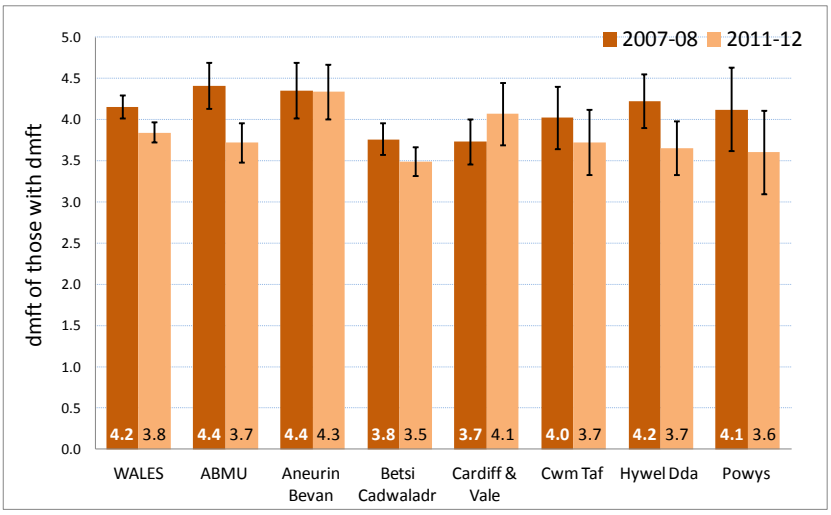
Percentage of 5 year olds with caries experience (%dmft>0), Welsh Local Health Boards, 2007/08 compared with 20011/12



The %dmft>0 for ABMU Health Board in 2011/12 was 44.2% which was within the average range when compared with the Welsh average of 41.4%

The average number of children with decayed teeth among the children with at least one decayed tooth is shown in the table below. There is a general tendency for a reduction in the mean scores; the only change shown which reaches statistical significance is in ABMU where the averages for 2007/08 and 2011/12 were 4.4 and 3.7 respectively.

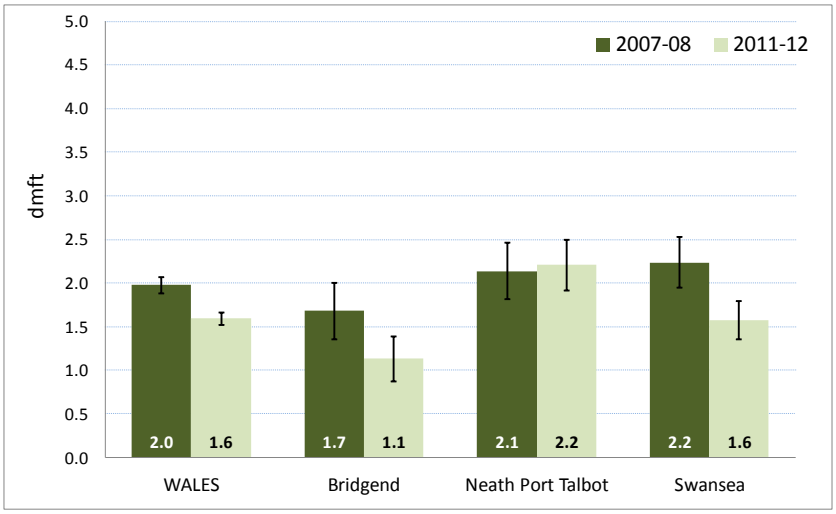
Average dmft of those with caries experience for 5 year olds, Welsh Local Health Boards 2007/08 compared with 2011/12



The decayed teeth component of preventable decay (dmft) measures active decay. This puts the child at risk of pain, infection and suggests risk of decay of permanent successor teeth. In the past it has been called untreated diseased.

The concept of treating all decay in teeth which will be shed later by providing fillings/extractions is being questioned. Many of these children need measures to empower control sugar in the diet, improve access of teeth to fluoride and ensure removal of dental plaque, as opposed to operative dental procedures. This decayed teeth data is now regarded as a marker for children who need support in managing this chronic dental disease.

Between 2007/08 and 2011/12 there was a statistically significant reduction in averaged dmft for Wales with the values being 2.0 and 1.6 respectively. During 2007/08 the average dmft values for all three ABMU unitary authorities (UA) were within the average range when compared with Wales for the same year.



For Bridgend UA there was a notable reduction in average dmft between 2007/08 and 2011/12, from 1.7 to 1.1, but this difference was not statistically significant. However, the

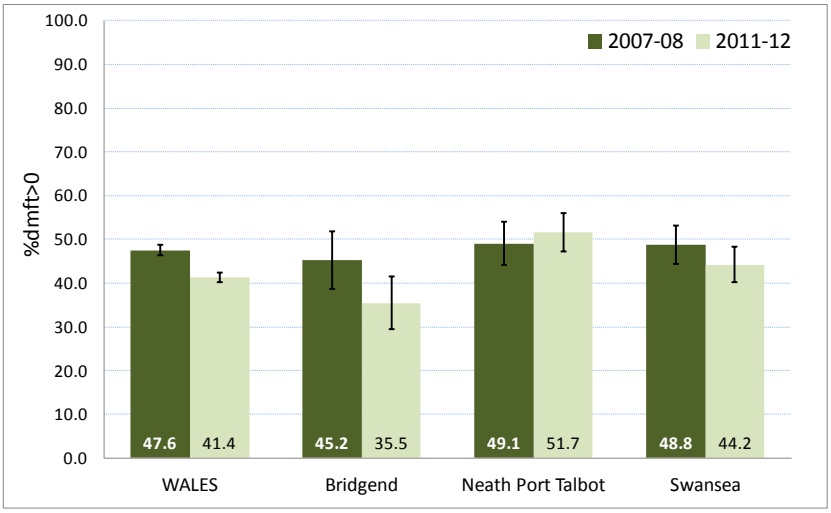
average dmft for the UA in 2011/12 was statistically lower that the Welsh average for the same year.

Between survey years the average dmft for Neath Port Talbot showed little change (2007/08: 2.1 compared to 2011/12 2.2). The dmft for the UA in 2011/12 of 2.2 was statistically higher than the Welsh average for the same year.

Swansea UA experienced a significant reduction in average dmft between 2007/08 (2.2) and 2011/12 (1.6). The dmft for both surveys was within the average range when comapred with the Welsh value for the same survey.

The %dmft>0 for Bridgend fell by almost 10% between 2007/08 and 2011/12, from 45.2% to 35.5%; because of the wide confidence intervals linked to smaller sample sizes, this change was not statistically significant. The %dmft>0 for Bridgend for both surveys fell within the average for Wales (table below)

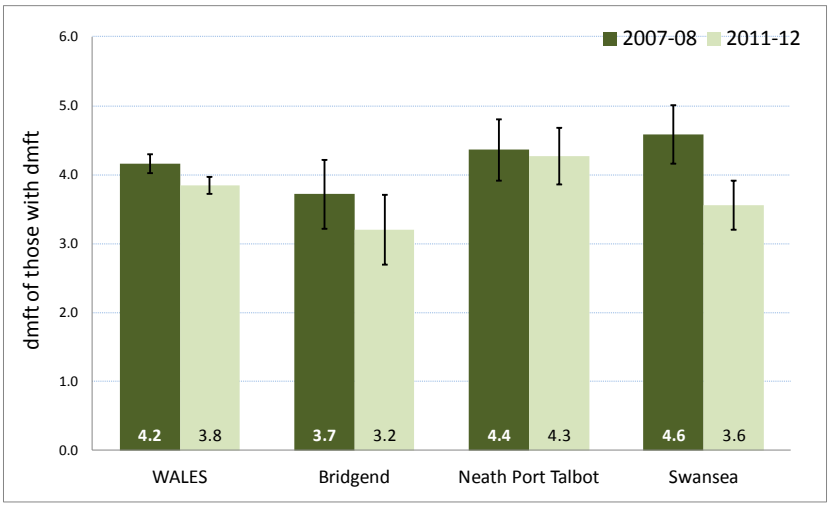
Percentage of 5 year olds with caries experience (%dmft>0) in unitary authorities within ABMU Health Board 2007/08 compared with 2011/12.



The %dmft>0 for Neath Port Talbot showed little change over the two surveys 2007/08 (49.1%) and 2011/12 (52.6%). The %dmft>0 for the UA in 2011/12 was 52.6% statistically higher than the Welsh percentage for the same year.

The %dmft>0 for Swansea showed little change little change over the two surveys 2007/08 (48.8%) and 2011/12 (44.2%); also it fell within the average range for Wales at both time points.

Looking at those children who have at least one decayed, missing or filled tooth illustrates the stark differences between children with decay and those without. The average dmft for a child with dmft is shown in the table below.



For Wales overall, the reduction from 4.2 in 2007/08 to 3.8 in 2011/12 does suggest an improving position.

In Bridgend there was a reduction in average dmft of those with dmft between the two surveys from 3.7 to 3.2 but this difference was not statistically significant. However the average dmft for the UA in 2011/12 was statistically lower that the Welsh average for the same year.

Between survey years the average dmft for those with dmft in Neath Port Talbot showed little change 2007/08 (4.4) to 2011/12 (4.3). This variable fell within the average range for Wales for both surveys.

The average decayed tooth (dt) of children who have at least one decayed, missing or filled tooth for Wales fell between 2007/08 and 2011/12 from 2.9 to 2.6. This statistically significant improvement represented a reduction of almost 1/3rd of a tooth. The dt experience of those with decay in Bridgend was lower than that of all Welsh 5 year olds for both surveys 2.2 in 2007/08 and 1.9 in 2011/12, this however is not considered to be statistically significant. In Neath Port Talbot the average dt of those with decay almost plateaued between the two surveys, 3.1 and 3.1 in 2007/08 and 2011/12 respectively. Similarly the average dt in Swansea showed little change between the two survey dates 3.0 in 2007/08 and 2.8 in 2011/12; on both occasions these fell within the average rates for Wales.

The overall picture is one of improvement in the unitary authority breakdown of the data for Bridgend and to a lesser extent in Swansea; however this is not evident in the data for Neath Port Talbot. Efforts need to be focussed on Neath Port Talbot to ensure that inequalities do not widen.

The consequences of poor child oral health are multiple and all the more concerning because they affect the youngest members of our society. Tooth decay commonly results in pain and infection, often resulting in sleepless nights, time off school and possibly the need for effective treatment under General Anaesthesia. On average across Wales in a class of thirty five year olds, four children would have experienced dental pain in the last 12 months.

The Welsh Government launched the *Expansion of Designed to Smile – A National Oral Health Improvement Programme* in 2009, which is Wales' national child oral health programme. The programme sets out to improve the oral health in children by a targeted,

preventative approach in the areas of greatest need. The local D2S programme is described under Action 3 on page 19.

ABMU Governance Arrangements for GDS/PDS Contract Management

The Associate Medical Director (AMD) for Dentistry holds the responsibility for ensuring that robust governance arrangements are in place for primary care dental services, this is underpinned through a number of key mechanisms:

Clinical Governance Committee for Dentistry
Chaired by the AMD for Dental, this group meets on a quarterly basis and reviews governance issues with representation from Localities, Community Dental Service, Chairs of dental managed clinical networks, Public Health Wales and the Deanery. The remit of this group is to oversee clinical governance in dental services contracted to or directly provided by the Health Board.

Public Health Wales Quality Assurance System (QAS)
All contracted dental services through General Dental Services (GDS) contracts or Personal Dental Services (PDS) agreements have a requirement under Part 10, Paragraph 79 of the Regulations to:

The contractor shall comply with such clinical governance arrangements as the Primary Care Trust may establish in respect of contractors providing services under a contract.

The contractor shall nominate a person who manages services under the contract to have responsibility for ensuring compliance with clinical governance arrangements.

In this paragraph, "clinical governance arrangements" means arrangements through which the contractor endeavors to continuously improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish.

All general dental contractors in ABMU participate in the annual on line QAS self assessment process managed by Public Health Wales on behalf of the Health Board, which satisfies this section of the Regulations. The self assessment tool covers a number of domains including compliance with HTM01-05 (decontamination), IRMER regulations, child protection training etc.

Exception Reporting
The Health Board has an agreed policy with the Local Dental Committee on the management of contract performance information on a quarterly basis which identifies any "exceptions" within a contract. These are normally exceptions that are known to the locality teams e.g. a contract that has a high level of urgent treatments recorded could provide a number of "access" sessions for patients who do not have a regular dentist and present with urgent dental needs. There has however through the management of this process been recognition that in larger dental practices it is more difficult to identify where there are issues of exception that need investigation. An addendum to the policy has been developed for localities to review multiple claims per patient from the electronically transferred data from dental practices to the Dental Practice Division on a quarterly basis. Where there appears to be a high level of attendance rates for patients; practices will be asked to review these in line with the exception reporting policy.

Contract Monitoring Process
Where dental contracts are achieving less than 30% of their contracted activity at the midyear point, practices are engaged in discussions over their ability to achieve their contracted level of activity for that year. Where necessary, contract adjustments are made on a temporary or permanent basis. Once the Health Board has received the end of year data however, all practices are subject to a visiting programme where a standard agenda is discussed and the details of the visit are documented. This is managed on a consistent basis across all three localities, and will include ensuring that any outstanding from the QAS process have been completed, actions from any Dental Reference Officer visits have been undertaken, updates on changes in legislation etc.

Dental Performance Scorecard
Recently introduced, the localities are using a scorecard mechanism to review all known data about their dental practices to flag where there are potential areas for concern using a number of key indicators. High level discussions about these practices are conducted with a small group that includes locality representatives, Dental Practice Advisors from PHW and the Associate Medical Director for Dentistry prior to the Clinical Governance Committee for Dentistry to ensure that the correct actions are undertaken in relation to the concerns that are being raised.

Primary Care Performance Procedures
A high level performance team has been established pan-ABMU to consider performance issues and is being led by the Associate Medical Director for Dentistry. Underpinning the primary care performance process are The National Health Services (Performers List Regulations) Wales (2004) under which Part 2, Regulation 10 sets out the reasons why a Health Board may chose to remove a performer from the Performers List.

As with all other primary care contractors, NHS dental contractors are also subject to the All Wales Primary Care Performance Procedures, where concerns over an individual's performance is managed through a national framework. The Welsh Government "*Updated Guidance on a Model Operating Procedure for the Management of Dentists on the Dental Performers List whose Performance is of Concern*" (October 2012) sets out the revised process for managing concerns to ensure that the safety and wellbeing of patients is protected; that a response is given to expressions of concern about practitioner performance at the earliest stage; a structured framework for the review and/or investigation of concerns; to ensure any review or investigation is open, transparent and fair to all parties; provides an accurate assessment and report upon which to base decisions and appropriate action and focuses on good practice and improved performance.

Management of NHS dental complaints
All dental practices are required under the Regulations Part 7 Paragraphs 47 to 52 set out the process dental practices need to have in place to manage complaints and investigations in a timely manner.

The NHS Business Services Authority Clinical Advisors are qualified dentists who are able to undertake impartial case reviews of complainants where there is a dispute over the clinical treatment provided.

The Dental Reference Service

In addition to offering patient examinations the NHS Business Services Authority currently provide Health Boards with support in a number of areas:

- Dental Practice Inspections
- Clinical Record Reviews
- Patient questionnaires

The service also undertakes a rolling visiting programme of dental practices whereby a random sample of clinical records are reviewed and reports highlighting any areas of concern are sent to the Health Board which are then addressed through the annual contract monitoring visiting programme as well as being fed into the dental performance scorecard.

Where we need to be

Consideration and approval has been given from the DSPG for the development of a single point of access for all dental referrals received into the Health Board. To support this work a task and finish group has been established to look at the development of robust referral guidelines and referral templates to assist in better referral management.

The DSPG has also agreed a proposal to appoint a dedicated project manager to take forward the development and integration of dental services provided out of the Dental Training Unit.

There is recognition also that the Health Board needs to have improved access for urgent dental care during the working day, which will be managed in parallel with a review of the dental out of hours service, to ensure that patients have timely access to appropriate services.

In addition, Her Majesty's Prison in Swansea has a waiting list for dental appointments which has resulted in 26 complaints between April 2012 and March 2013, additional investment was put into the prison dental service in 2012/13 following the recalculation of the Patient Charge Revenue by Welsh Government and the directive that Health Boards use this funding to support access issues. However this is not recurrent funding and there is the potential for the waiting list to continue to grow.

Further work needs to be undertaken with the Operative Dentistry and Oral Surgery Working Groups to refine them into Managed Clinical Networks.

Areas of good practice

- Development of multi-faceted approach to governance for contract management
- DTU pilot scheme, supporting patients with high need for dental treatment to enable them to become dentally fit
- A review of the child GA service provision to ensure that it remains fit for purpose and meets national guidance
- Development of the MCN for Orthodontics working across ABMU and Hywel Dda Health Boards
- Requests to Public Health Wales to undertake independent reviews of dental services

Risks

- A lesser reduction in the DMFT rates than anticipated to meet the 2020 target
- Availability of appropriate financial resources to deliver revised models of care
- Isolated management teams not facilitating integrated planning and delivery of dental services
- Current contractual arrangements do not easily enable a preventative oral health promotion approach
- Difficulty in accessing public transport to ensure that children are accessing regular dental care
- Implementation of a new contract during the Oral Health Plan period could impact on the ability of the Health Board to deliver against some of the identified actions

Summary of Health Board Actions:

- Continue to support the D2S programme and remain committed to child dental health improvement and a reduction in child dental general anaesthetics
- Work with Swansea Poverty Forum to review data on children's oral health to fit with the Target Area work that is being undertaken
- Ensure that the management structure for dental services across ABMU remains fit for purpose and ensures that resources are targeted appropriately to meet patient need
- Management and deployment of appropriate resources to ensure that effective service changes are enacted
- Support the further development of the DTU pilot to enable more patients to have access to the service
- Take forward the integration of dental services and development of care pathways across the Health Board
- Take forward the integration of dental services and dental training model provided at Port Talbot Resource Centre
- Develop a central referral management system for all dental referrals ensuring that referral pathways and templates are robust and fit for purpose

Action 2

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

Key Issues for ABMU Health Board

- Ensuring contributions are sought from service and clinical leads across ABMU, including Public Health Wales
- Ensuring effective engagement with a wide variety of stakeholders on the development of the ABMU Oral Health Plan, including
    - All members of the Community Dental Service
    - The Local Dental Committee
    - LHB/LDC Liaison Group
    - Local Authorities
    - Designed to Smile steering group
    - Study day for all NHS dentists and their teams
    - Hospital dental teams
    - The management teams of Swansea, Neath Port Talbot and Bridgend localities
    - Cancer Network
    - Hywel Dda Health Board
    - Cardiff and Vale Health Board
    - Dental Strategy and Planning Group
- Developing a five year plan that sets clear objectives and milestones that can be signed up to by the Board

Where we are

A programme of engagement has been developed to support the full development and ownership of the ABMU Oral Health Plan. The LDC, Hospital dental teams, Public Health Wales and the Community Dental Service have been included in the drafting of the initial plan to ensure that there is ownership for the actions identified to facilitate successful implementation of a five year plan that will set out the strategic direction for the delivery of dental services in ABMU.

Where we need to be

During September we need to be undertaking an engagement exercise both internal within the Health Board but with external partners and agencies, before finalising the draft document during October 2013. ABMU Health Board will be presented with the final plan in November 2013 with it being ready for submission to Welsh Government by the December 2013 deadline.

Areas of good practice

We already have a number of existing forums where we can take the document for discussion, and have planned a number of other meetings and events to ensure that all members of the dental profession are engaged in the process.

Risks

- We were working within a tight timescale leading off the summer holiday period which meant that some individuals were late in joining the development process

Summary of Health Board Actions:

- A set programme of engagement to ensure wide ranging views are sought on the draft document
- Finalisation of the draft plan during October 2013 to enable Board sign off in November 2013
- Submission to Welsh Government by 31 December 2013

Action 3

Ensure the continued participation in evidence based community oral health promotion programmes particularly the Designed to Smile and Healthy Schools programmes.

Key Issues for ABMU Health Board

- Remain committed to the Designed to Smile (D2S) programme
- Support the D2S Steering Group and ensure the Designed to Smile Programme remains effective and cost efficient.
- Build stronger links and partnership working between health and other agencies, and strengthen working with education and GDP's.

Where we are

Scientific evidence suggests almost every proven method to prevent decay includes delivery of fluoride to teeth surfaces. We recognise that water fluoridation would have the greatest benefit to dental health, however due to legal, political and financial implications associated with fluoridating water supplies in Wales the message the Welsh Government has continued to convey in relation to fluoridation is important to note:

"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."

In the absence of water fluoridation, ABMU Health Board continued to support the national and local D2S programmes as a means of improving the oral health of children in the area.

An established and multidisciplinary D2S steering group with representatives from:

- Community Dental Service,
- Local Dental Committee,
- ABMU HB Health Visiting
- Finance,
- Public Health Wales,
- A Dental Practice Manager,
- Healthy Schools and Pre-school Schemes from the three local Authorities.

Designed to Smile has robust reporting processes; through the annual submission of monitoring data to the Welsh Oral Health Information Unit (WOHIU) and to ABMU Health Board via the Dental Services Strategy and Planning Group. Evaluation of the programme at local and national level is conducted by the Dental Public Health Department at Cardiff Dental School, and the BASCD national annual child dental health surveys funded by the Welsh Government.

Data from the 2011/12 child dental survey showed an overall improvement (6%) in the dental health of 5 year olds in Wales, although it is too early to confirm if this is predominantly down to D2S. The survey has also indicated a 17% improvement in children attending schools participating in D2S but this data has to be treated with caution, the next surveys will hopefully confirm an improving trend.

The local D2S team has forged strong working relationships with the Healthy School and Pre School Schemes within the Health Board. Healthy and Pre-school co-ordinators help recruit schools/settings to the programme and also provide D2S with additional support should issues arise, e.g. schools selling inappropriate snacks, or consider withdrawal from the programme. The local D2S programme provides financial support to the Healthy School and Pre-school schemes to cover supply costs to enable staff to attend training sessions around oral health and well being.

The fissure sealant programme has been established using the new mobile dental unit and the fluoride varnish programme is underway following completion of staff training.

In April 2012 the management of the Community Dental Service and the Designed to Smile programme in Bridgend transferred to Abertawe Bro Morganwwg University Health Board from Cardiff and Vale Health Board. Following this transfer, and the disparity in programme delivery identified, the focus has been to work towards an equitable D2S programme across the Health Board. This entailed the recruitment of additional staff and the procurement and refurbishment of suitable office and storage spaces in the Bridgend area.

Oral health education training and awareness raising of the Designed to Smile programme is offered to a range of professionals and local agencies such as School Health Nurses, Health Visitors, Dieticians, GDPs, Community Drugs and Alcohol Team and the Voluntary Sector.

Where we need to be

We must ensure the D2S be maintained as the key component of our strategic approach to oral health improvement. We will ensure it is embedded in to the fabric of schools, settings and professional practice.

The Steering Group will engage with head teachers to improve knowledge of the programme and address issues such as non compliance with daily brushing and the opting out of schools.

The Welsh Government has recently published A Quality Standards Framework for the Designed to Smile Programme in Wales. The framework has been designed to benchmark individual Designed to Smile Schemes and ensure that the service remains both effective and cost efficient. In response the D2S Steering Group is required to produce an annual report to the Chief Dental officer detailing compliance with the standards. To do so requires delivery of the core programme which includes the supervised tooth brushing programme for the 3-5 age group; the fissure sealant programme where clinically appropriate and the fluoride varnish program for 3-5 year olds. This academic year the fluoride varnish programme will be implemented by D2S team members using domiciliary kits in schools.

The links between D2S and GDS needs to be improved. We need to work with Public Health Wales to use the child dental health survey and child general anaesthetic data to better target D2S resources. In addition we need to work with LDC to develop a policy for ensuring that children who have a dental GA, and thus by default are high risk, have extended preventative care.

There are potential opportunities for D2S to extend its brief into health promotion initiatives like smoking cessation, but this is to a degree dependant on additional resources or Welsh Government redirecting part of the existing programme.

Areas of good practice

The development of a multiagency steering group identified within the Quality Standards Framework for the Designed to Smile Programme.

The establishment of strong partnership working with the local Healthy Schools and Pre-School Schemes and a range of other stakeholders.

Risks

- Schools opting to withdraw from programme.
- Assumption that there will be no changes to D2S funding following the outcome of the Health Improvement Review conducted earlier this year.
- Commitment to funding beyond 2014/15.

Summary of Health Board Actions:

- To comply with the Quality Standards Framework for the Designed to Smile Programme
- To deliver the Designed to Smile Programme in accordance with WG requirements including fissure sealant and fluoride varnish application programmes
- Submit robust annual monitoring data to the Welsh Oral Health Information Unit
- Establish links and develop working relationships with GDP's
- To review child dental health survey and child dental GA data to inform the delivery of the local D2S programme
- We need to work with the LDC to develop a policy for ensuring that children who have had a dental GA and thus by default are high risk, have extended preventative care

Action 4

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. Health Boards to work together to ensure evidence based multi-disciplinary care is available to all of their patients diagnosed with oral cancer. We will seek assurance that any identified variation in treatment outcomes is addressed by the Cancer Networks.

Key Issues for ABMU Health Board

Where we are

The Data for Head and Neck Oncology (DAHNO) produced an Information Pack for Head and Neck Cancer MDTs in Wales in August 2012, which set out the data collection requirements for the annual audit (November 2012), and captured activity relating to patients diagnosed between 1 November 2011 and 31 October 2012.

Whilst recognising that it is one of the Welsh Governments longer term outcomes to have a reduction in the percentage of oral cancer patients presenting at stage 3 or 4 and an increase in the percentage of patients presenting with stage 1 or 2, due to the demographics of the ABMU and Hywel Dda Health Board areas the trend is forecast to continue to increase over the next decade. The incidence of oral cancer is increasing in women which is considered to be directly related to an increase in smoking and the consumption of Alco-pops. The presenting age of patients with oral cancer is also decreasing.

The Welsh Cancer Intelligence Surveillance Unit (WCISU) Triennial report 2011 *(table below)* demonstrated the incidence of head and neck cancer survival rates after one and five years.

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

The report also identified the incidence of oral cancer by Local Authority area set out in *table 2* below.

Local Authority	1995-1999			2000-2004			2005-2009		
	Total cases	Wales ASR (95% CI)	EASR (95% CI)	Total cases	Wales ASR (95% CI)	EASR (95% CI)	Total cases	Wales ASR (95% CI)	EASR (95% CI)
Isle of Anglesey	43	11.9 (8.7, 16.5)	9.2 (6.6, 13.2)	67	18.3 (14.3, 23.6)	14.5 (11.2, 19.2)	73	19.3 (15.2, 24.7)	16.1 (12.6, 21.1)
Gwynedd	90	14.8 (11.9, 18.3)	12.0 (9.6, 15.2)	104	17.2 (14.1, 21.1)	14.8 (12.0, 18.3)	116	18.8 (15.6, 22.7)	14.6 (12.0, 18.0)
Conwy	108	16.6 (13.6, 20.4)	13.5 (11.0, 17.0)	109	17.1 (14.0, 20.9)	14.1 (11.5, 17.6)	118	18.0 (14.9, 21.9)	13.6 (11.1, 17.0)
Denbighshire	95	19.0 (15.4, 23.5)	16.0 (12.8, 20.2)	76	14.8 (11.7, 18.9)	12.0 (9.4, 15.7)	102	19.5 (15.9, 24.0)	15.6 (12.7, 19.6)
Flintshire	90	13.5 (10.9, 16.8)	11.1 (8.9, 13.9)	106	15.1 (12.4, 18.4)	12.1 (9.9, 14.9)	141	19.2 (16.2, 22.8)	15.4 (12.9, 18.4)
Wrexham	88	14.6 (11.8, 18.2)	12.2 (9.8, 15.4)	95	15.4 (12.5, 19.0)	13.0 (10.5, 16.2)	107	16.9 (13.9, 20.6)	13.2 (10.8, 16.3)
Powys	87	12.6 (10.1, 15.8)	10.3 (8.2, 13.2)	87	11.9 (9.6, 15.1)	9.6 (7.7, 12.4)	91	11.8 (9.5, 14.8)	8.5 (6.8, 11.0)
Ceredigion	75	19.7 (15.6, 25.1)	16.3 (12.8, 21.3)	62	15.3 (11.8, 20.0)	12.6 (9.7, 17.1)	65	15.5 (12.1, 20.3)	11.7 (8.9, 16.1)
Pembrokeshire	97	16.6 (13.5, 20.5)	13.8 (11.2, 17.4)	96	15.5 (12.6, 19.1)	12.7 (10.2, 16.0)	107	16.4 (13.5, 20.1)	13.2 (10.8, 16.5)
Carmarthenshire	141	15.2 (12.8, 18.0)	12.9 (10.8, 15.6)	139	14.7 (12.4, 17.5)	11.8 (9.9, 14.3)	163	16.8 (14.3, 19.7)	13.2 (11.2, 15.7)
Swansea	251	22.0 (19.4, 24.9)	18.1 (15.9, 20.7)	178	15.8 (13.6, 18.4)	12.8 (11.0, 15.1)	202	18.2 (15.8, 21.0)	15.0 (13.0, 17.5)
Neath Port Talbot	150	21.5 (18.3, 25.4)	18.3 (15.4, 21.8)	104	15.2 (12.5, 18.6)	12.5 (10.2, 15.5)	125	18.0 (15.0, 21.6)	14.8 (12.3, 17.9)
Bridgend	100	16.1 (13.2, 19.8)	13.7 (11.1, 16.9)	105	16.8 (13.8, 20.5)	14.0 (11.4, 17.3)	115	17.6 (14.6, 21.3)	14.5 (12.0, 17.8)
Vale of Glamorgan	86	15.0 (12.0, 18.7)	12.9 (10.3, 16.3)	94	15.9 (12.9, 19.7)	12.9 (10.4, 16.2)	98	16.1 (13.1, 19.8)	12.4 (10.0, 15.5)
Rhondda Cynon Taff	186	16.8 (14.5, 19.5)	14.3 (12.3, 16.7)	190	17.5 (15.2, 20.3)	14.1 (12.1, 16.4)	217	19.7 (17.2, 22.6)	15.5 (13.5, 17.9)
Merthyr Tydfil	50	18.5 (13.9, 25.0)	16.0 (11.9, 21.9)	36	13.8 (9.8, 19.6)	11.1 (7.8, 16.1)	59	22.9 (17.5, 30.0)	17.8 (13.6, 23.7)
Caerphilly	127	16.5 (13.8, 19.8)	13.6 (11.3, 16.4)	104	13.4 (11.0, 16.4)	10.8 (8.8, 13.3)	137	17.2 (14.5, 20.5)	13.6 (11.4, 16.3)
Blaenau Gwent	54	15.4 (11.6, 20.4)	13.6 (10.2, 18.3)	56	16.4 (12.5, 21.6)	14.0 (10.6, 18.8)	51	14.9 (11.2, 20.0)	11.6 (8.7, 16.1)
Torfaen	54	12.6 (9.5, 16.7)	10.5 (7.9, 14.1)	67	15.2 (11.8, 19.5)	12.5 (9.7, 16.3)	66	14.7 (11.4, 18.9)	11.4 (8.8, 15.0)
Monmouthshire	47	10.7 (7.9, 14.6)	8.4 (6.2, 11.9)	43	9.6 (7.0, 13.5)	7.4 (5.3, 10.8)	66	13.9 (10.8, 18.2)	10.7 (8.2, 14.5)
Newport	93	14.7 (11.9, 18.2)	12.3 (9.9, 15.4)	82	12.9 (10.3, 16.1)	10.5 (8.4, 13.4)	129	20.3 (17.0, 24.2)	16.3 (13.6, 19.7)
Cardiff	215	16.6 (14.5, 19.1)	14.4 (12.5, 16.7)	209	16.4 (14.3, 18.9)	13.6 (11.8, 15.7)	263	21.2 (18.7, 24.0)	16.7 (14.7, 19.0)
WALES	2327	16.3 (15.6, 16.9)	13.6 (13.1, 14.2)	2209	15.3 (14.7, 15.9)	12.5 (12.0, 13.1)	2611	17.7 (17.0, 18.4)	14.0 (13.4, 14.6)

Where we need to be

Whilst there is a forecast increase of the incidence of oral cancer by 17% in the next 5 years; there has already been an increase of 100% in incidence in the past 10 years due to a 50% increase in case incidence in Wales and a centralisation of cases in the Swansea's Multi-Disciplinary Team with the cases being brought in from West Wales. Evidence that screening and follow up after 3 years is negligible.

Developing an awareness raising campaign targeted at the public in order to increase the number of patients who identify oral cancer at an early stage that sets out the key risk factors for patients, and the symptoms they should be presenting with. It is important to understand the demographics of this group when considering how publicity campaigns should be used to target the "at risk" groups of patients.

We also need to raise awareness and understanding that the prevalence of HPV is on the increase and the associated risks of oral cancer.

Areas of good practice

Multi-Disciplinary Team meetings in South West Wales are held on a regular basis and are delivering against most of the Welsh and national standards for head and neck standards.

Follow up clinics have been reviewed and as a result have been streamlined and are working more effectively.

The Health Board has a planned education for GDPs in December 2013 and the agenda will include a session on the early identification of oral cancer.

Risk

- Increase in number of patients presenting with stage 3 and 4 due to the demography of the area
- Insufficient resource to deal with the growing demand that has been estimated
- Low percentage of regular attendees for routine dental care increases the risk for those patients not being screened

- Delay in treatment following outpatient assessment is a risk linked to resource issue with beds
- Lack of access to regular dental care for post operative oral cancer patients for ongoing dental care
- HPV immunisation may change prevalence of oral cancer in females, immunisation of males may reduce the number of cases of oral cancer (long term control)

Summary of Health Board Actions:

- Review of the communications strategy needed to target the "at risk" groups of developing oral cancer
- Planning services, both in the short and longer term to meet the anticipated need for the service, whilst ensuring that waiting times are managed with the RTT guidelines
- Continue to have regular input into the MDT meetings, to ensure excellence of clinical practice

Action 5

Use the recommendations from the Special Care Dentistry Implementation Plan in ensuring that the needs of all vulnerable groups are addressed

Key Issues for ABMU Health Board

- Oral care should be integrated into the general health and social care plans and/or pathways of patients with special care needs e.g. those with complex medical and social problems
- Implement the recommendations from the Special Care Dentistry Implementation Plan in ensuring that the needs of all vulnerable groups are addressed
- Development of regionally agreed referral and care pathways through ABMU and Hywel Dda Health Board Special Care Dentistry Managed Clinical Network (MCN)

Where we are

ABMU Health Board has recognised the guidance provided by the SCD Implementation Plan. A MCN in Special Care Dentistry (SCD) for ABMU and Hywel Dda Health Boards has been established which meets on a quarterly basis and has membership that includes the clinical leads of ABMU and Hywel Dda Community Dental Services, Specialists in Special Care Dentistry, Hospital representation in Special Care Dentistry, General Dental Service (GDS) representatives from ABMU and Hywel Dda Health Boards, Public Health Wales representation, ABMU Health Board AMD (Dentistry), Welsh Postgraduate Deanery representation, management representation from ABMU and Hywel Dda Health Boards and DCP and Oral Health Promotion representation from both Health Boards.

The SCD MCN is developing a work programme that is initially based upon an audit of what SCD type and level of services is currently being provided, where and by whom. Service specifications and referral and acceptance criteria provided by SCD providers are being collected and will be used to inform the development of referral pathways for SCD across ABMU and Hywel Dda Heath Boards.

The MCN recognises the important role of the GDS in the provision of SCD in both Health Boards and seeks to work with GDS representatives to not only develop SCD service provision but also to improve professional links between the GDS the other SCD service providers.

Other current work programmes include the development of individual care pathways such as the pathway for patients about to undergo Intravenous Bisphosphonate therapy, support for the Mouth Care for Adults in Hospital programme, an integrated Domiciliary Dental Care service in ABMU Health Board and the development of Conscious Sedation as an alternative to general anaesthesia for vulnerable people.

Where we need to be

The SCD MCN needs to continue its development work and ensure that the recommendations from the Special Care Dentistry Implementation Plan are addressed. This work will include:

- Establishing service specifications and referral and acceptance criteria for SCD providers in ABMU and Hywel Dda Health Boards

- Ensuring that referral pathways and contact details for SCD providers are published and accessible to those seeking care and that care provided meets currently accepted guidelines in SCD
- Specific pathways for care are developed (e.g. Bisphosphonate Related Osteonecrosis of the Jaws referral pathway and Patients about to undergo Radiotherapy to the Head and Neck referral pathway) including a pathway for bariatric dental patients
- Support for the Mouthcare in Hospital programme is developed
- Development of SCD GA facilities and compliance with the Implementation Pathway for Adults with a Learning Disability
- Conscious sedation services are developed as an alternative to general anaesthesia. This will include the development of transmucosal sedation
- The development of links with support groups for vulnerable people to enhance SCD service provision (e.g. care for people resident in nursing homes)
- Helping to improve training in SCD and the development of Dentists with Enhanced Skills, Clinical attachments and training posts in SCD
- Developing the role of DCP's in SCD
- Developing an integrated DDC policy in ABMU HB

The role of management in ABMU and Hywel Dda Health Boards should not be forgotten as they will have an important part to play in supporting the role of the SCD MCN in developing care for vulnerable people.

Areas of good practice

The development of a SCD MCN which is working across ABMU and Hywel Dda Health Board with Public Health Wales support and representation from both Local Dental Committees. The group continues to meet on a quarterly basis and has made considerable headway in the development of referral criteria and referral guidelines.

Improvements are being made to the ABMU Health Board SCD GA list with a proposed move to better facilities in the Prince of Wales Hospital in Bridgend.

A Joint Clinic in SCD exists in ABMU Health Board staffed by members of the Department of Restorative Dentistry and the Community Dental Service. It is planned to further enhance this service by including members of the Hywel Dda Community Dental Service in the near future.

Conscious sedation services are being developed in ABMU and Hywel Dda Health Boards and additional Community Dental Service staff members are currently being trained in the use of conscious sedation in a primary care environment. This will not only enhance conscious sedation services but also reduce the need for treatment under GA.

Risks

- There is a need to be applied observed across ABMU and Hywel Dda Health Boards.
- Ideally one system of data collection on the provision of SCD is required, carried out in a consistent manner by all SCD providers. This is a challenge because ICT is lacking in certain areas.
- Lack of training of special care dentistry training courses for dentists could have an impact on developing the service model

Summary of Health Board Actions:

- To continue development of the MCN in SCD for ABMU and Hywel Dda Health Boards
- To ensure that the MCN includes representation from the GDS, CDS and HDS and works together across service boundaries to develop dental care for vulnerable people
- To continue the development of regionally agreed referral and care pathways through the ABMU and Hywel Dda Health Board Special Care Dentistry MCN operating with professional guidance

Action 6

Following recommendations by the National Assembly Children and Young People Committee collect annual data on the number of children who receive dental treatment under GA

Key Issues for ABMU Health Board

- Approximately half (48.5%) of five year olds living in the ABMU area have at least one decayed, missing (due to caries) or filled tooth. The percentages range from 45.2% in Bridgend to 49.1% in Neath Port Talbot. *Cardiff University & Public Health Wales* (March 2012)
- The national child poverty target for 2020 is to bring down the average dmft from 2.65 in 2007/08 to 1.77. The average dmft for 5 year olds during this period in ABMU was 2.14, with 12 of the 17 Upper Super Output Areas (USOAs) being higher than 1.77, ranging from 1.81 (Bridgend U003) to 4.54 (Swansea U005). *Cardiff University & Public Health Wales* (March 2012)
- While seeking to reduce the number of dental GAs performed we need to ensure that the Health Board has safe and sustainable GA/conscious sedation services available for children aged 3 to 17 years of age.
- The need to review the referral data on an ongoing basis to assess the ability to further target the D2S programme to schools where there are a high number of children being referred for extraction/restoration.
- To ensure that the current service model evolves to include a joint assessment with the service provider and a specialist paediatric dentist.
- To ensure that all children who are treated under GA/conscious sedation have their treatment plans tailored to ensure that repeat GAs are unnecessary.

Where we are

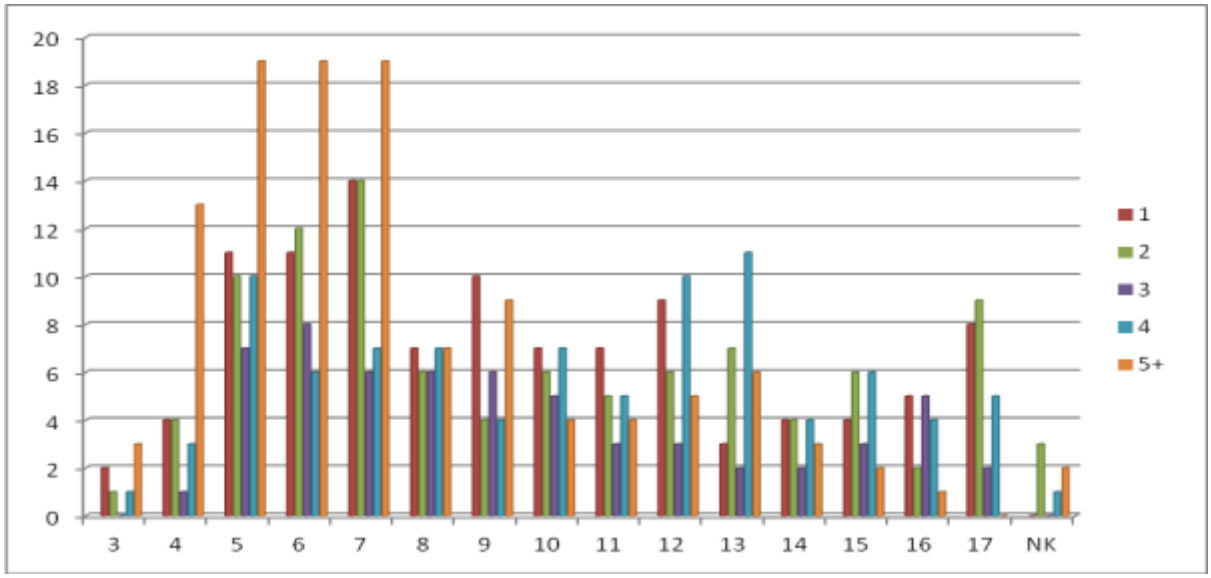
ABMU Health Board currently commissions a GA/conscious sedation service from Parkway Clinic to provide care for an approximate number of 1,017 cases annually. The current Service Level Agreement is due to end on 30 September 2013 and a tender process to appoint a service provider for the new model of care from the beginning of October 2013.

The service aims have been set to ensure that ABMU's contracted dental position for children aged 3 to 17 years of age, who require treatment under general anaesthetic is driven by the children's needs, their best long term interests and minimises risks to them as individuals. The Health Board also seeks to ensure that care is consistent to national standards, local guidelines and policies and that recognised best practice is followed. The service must be provided in a safe environment, by individuals who are competent to deliver the needs of the child and assess their best long term interests.

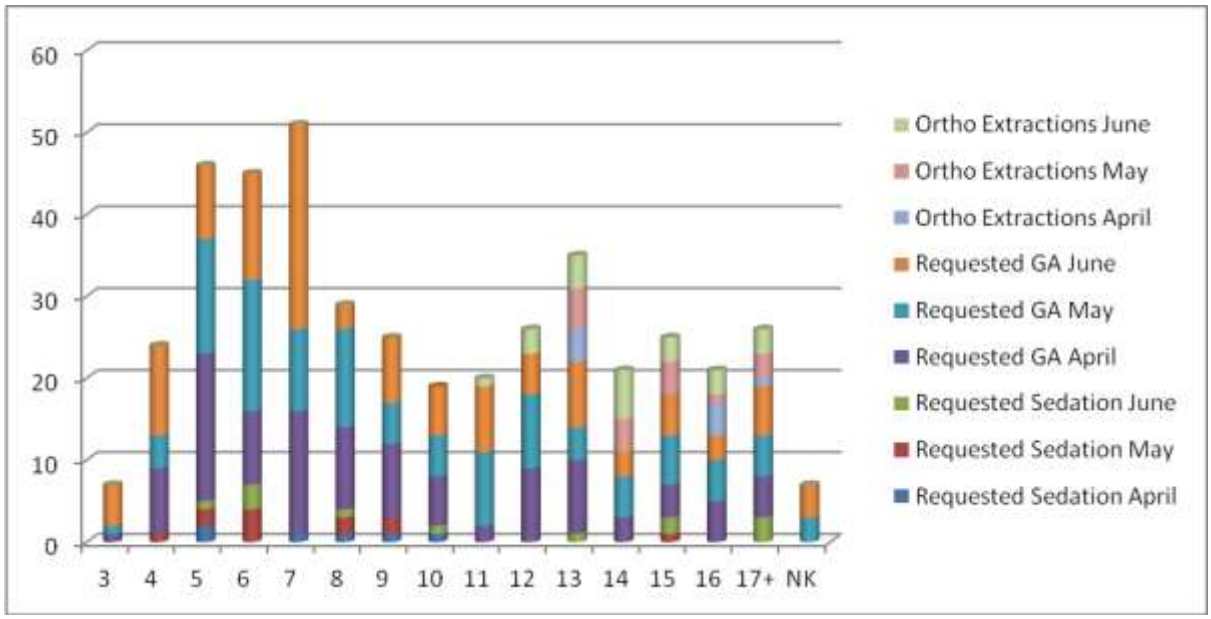
The service provided offers urgent care to patients (e.g. those with an acute and significant dental infection and associated symptoms, requiring treatment under GA/Conscious Sedation) within 48 hours of the receipt of the referral.

Parkway Clinic provides the Health Board with monthly activity information. Data collected for the first quarter of 2013/14 (April – June 2013) has identified an average number of 157

referrals into the service each month. The graph below breaks down the referrals into age bands and the number of teeth extracted:



The following graph breaks down the above information to identify whether or not the referring dentists requested extraction under GA or conscious sedation; it also includes those patients where it was identified that they were being referred for extraction prior to the commencement of orthodontic treatment.



The number of referrals requesting that treatment is undertaken under conscious sedation is significantly lower than those requesting treatment under General Anaesthetic.

The Health Board has developed in conjunction with Parkway Clinic a revised referral form which will be implemented in October 2013 *(Appendix 6A).* The new referral form will hopefully provide the Health Board with additional information on the demographics of the

children being referred into the service; as well as asking for the GDPs to confirm at the time of referral that they have or will undertake oral health advice and necessary interventions (e.g. fluoride varnish); and similarly the parents/carers will have to confirm that this has been discussed and offered.

Where we need to be

- A new service pathway developed for children needing to access dental care under GA or conscious sedation, with a joint assessment process supported by a specialist paediatric dentist working in conjunction with the Health Boards commissioned service provider.
- Patients having an assessment with a "cooling off" period prior to treatment taking place.
- Using demographic information on the referral forms to use a targeted approach to the D2S programme in schools.
- Seeing a reduction in the dmft.

Areas of good practice

- Development of an agreed referral form and implementation of a referral management system which will enable improved data collection and the ability to target the D2S programme to schools where there are consistently high numbers of referrals.
- A service that is able to provide a quick response to the needs of children

Risks

- Limited reduction in the number of children currently being referred for treatment under GA/conscious sedation

Summary of Health Board Actions:

- Implementation of a new service model for child GA/conscious sedation services, which enables patients to have an assessment prior to the date of treatment through an integrated assessment, negating the need for any further treatment under GA.
- Ensuring the continuation of a robust service that is able to deliver care to children with an urgent dental need that can only be met through treatment under GA/conscious sedation
- Regular review of referral information to signpost D2S programme to schools where there are consistently high numbers of referrals for children to receive treatment under GA/conscious sedation

Action 7

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.

Key Issues for ABMU Health Board

- There is a need to improve the facility for special care patients in need of dental treatment under General Anaesthesia (GA)
- The existing Special Care Dentistry (SCD) GA list does not have a ring-fenced bed provision that is predictably available in the past this has led to patient cancellations in the past and greater waiting list times for these vulnerable patients
- There is no designated room for a vulnerable special care patient to wait in private. This can lead to patient distress and treatment not being completed
- The existing SCD GA list can see only 2 patients per session, an improved GA facility could increase this number to 3 patients per session
- There is currently no hospital emergency facility for special care patients to receive restorative treatment and exodontia at the same time
- Data on SCD GA referrals is already being collected. This data does not include the nature of the disability of the special care patients seen

Where we are

The Department of Restorative Dentistry in ABMU Health Board currently has a Special Care GA list at Morriston Hospital which it operates together with the Community Dental Service. This list currently operates on a Wednesday morning each week.

There is no dedicated bed available on patient admission for care on this list. This has led to patient cancellation on more than one occasion in the past. There is also no dedicated quiet area for patients to wait before their treatment. We recognise that this has led to anxiety and distress for some vulnerable people. These issues have led to treatment not being completed and longer patient waiting list times.

There is no facility for emergency admissions on to this list at present. This can lead to people with a severe disability, including a learning disability, waiting for long periods for treatment.

ABMU Health Board are currently looking at the relocation of the SCD GA list to the Short Stay Unit at the Prince of Wales Hospital in Bridgend where improved facilities will be available.

Where we need to be

If the SCD GA list is relocated at the Prince of Wales Hospital as planned, this should result in an improved service with a dedicated private room be predictable of bed availability for patients prior to their admission. It will also mean that any patient who needs to remain in hospital overnight following treatment will have consultant cover available.

Designated anaesthetic support will be available and the improved facilities should enable the numbers of patients seen on the list to be increased, thus reducing the waiting list times for GA on this list. There should also be improved access for emergency referrals to this list. Data on SCD GA referrals to this list is already being collected and it should be possible to include data on the category of special care groups seen on this list.

The SCD GA list complies with many of the recommendations of the ABMU Health Board Learning Disability Implementation Pathway. This Pathway makes several recommendations for the care of adults with a learning disability who are about to be admitted to a hospital. The SCD GA list compliance has been evaluated and recommendations made to improve the pathway for the SCD GA patients seen. This work is in progress.

Areas of good practice

Patients tend to be referred to this list from a jointly managed clinic staffed by members of the Department of Restorative Dentistry and Community Dental Service. This provides a good opportunity for joint working between the two services.

Following the SCD GA list move to the Prince of Wales Hospital in Bridgend, it will be possible to hold the Joint Clinic on the afternoon of the SCD GA list; anaesthetic assessment may also be possible. It is hoped that this service change will reduce the numbers of visits required by individual patients to be seen on the SCD GA list.

Alternative techniques to reduce the need of GA are currently being developed including the use of conscious sedation and the development of the use of intranasal midazolam.

Risks

- Cancellations due to other service pressures which may result in greater waiting list times
- Insufficient resources to provide a hospital based emergency facility for special care patients to receive restorative treatment and exodontia at the same time

Summary of Health Board Actions:

- Improved SCD GA facilities and designated anaesthetic support
- Improved the timeliness of emergency admissions onto SCD GA list
- Increased numbers of patients seen through the joint clinic to relieve pressures on waiting lists
- Monitoring and reporting of waiting lists with more comprehensive information
- Improved compliance with WG waiting time guidelines
- Improved compliance with the Learning Disability Implementation Pathway

Action 8

Work together to develop regionally agreed referral and care pathways which will promote efficient patient care and better working across General Dental Service, Community Dental Service and Hospital Dental Service

Key Issues for ABMU Health Board

- Centralised referral management centre across GDS, CDS and HDS to ensure referrals are directed to the most appropriate setting, and allow inappropriate referrals to be returned to the referrer and in doing such influence change in referral practice
- Need to review access to hospital GA/sedation service due to capacity constraints with access to beds resulting in patient complaints
- Need to maximise use of facility at Port Talbot Resource Centre
- Development of Dentist with Enhanced Skills (DES) model in restorative dentistry to provide alternative solutions for referrals currently sent into secondary care for routine endodontic treatment

Where we are

Orthodontic referral protocols and guidelines establishing access criteria for primary care intermediate specialist, DES services and secondary care.

A tender for provision of intermediate level oral surgery was awarded and implemented in April 2013. General Dental Practitioners (GDP's) are able to direct referrals previously sent to the Hospital Dental Service (HDS) into two separate providers and this is expected to reduce referrals into secondary care. However, secondary care providers continue to receive referral for intermediate level services with no current mechanism for re-direction of these referrals to appropriate providers. Referral management protocols and referrer education are needed to support this service.

Difficulties with access to the weekly inpatient session that provides a GA service for restorative dentistry patients with special needs/learning disabilities has resulted in increased patient complaints. Access to hospital beds as a result of increased emergency care pressures and the environment on the acute hospital site is insufficient to meet the needs of this specific patient group.

A state of the art facility was commissioned in early 2013 at the Port Talbot Resource Centre. The centre already provided Community Dental Services (CDS) and a Dental Training Unit (DTU), and this has been expanded to include three surgeries and a laboratory facility. The transfer of restorative dentistry services previously held at the Princess of Wales and Neath Port Talbot hospitals took place in June 2013, but this does not make full use of the facilities available.

A secondary care waiting list in excess of two years exists for patients with routine endodontics. A proposal has been developed to provide DES training and contracting within the Port Talbot Resource Centre.

Where we need to be

The Dental Services Strategy and Planning Group (DSSPG) agreed at its meeting in March 2013 that work should be undertaken to progress the development of a Referral Management Centre (RMC) to act as a single point of contact for general dental practitioners to refer into specialist primary, community and secondary care dental services. The aim of the RMC will:-

- Ensure that referral guidance is adhered to and that referral forms are fully completed and have any necessary radiographs attached
- Return any incomplete referrals to the referring GDP or where there is information missing that is necessary within the referral guidance to encourage best practice
- Log all referrals by speciality and dental practice
- Provide referral information by dental practice for contract performance
- Provide information to dental contractors on waiting times by speciality/service
- Have a set of performance standards to ensure timely dissemination of referrals to the relevant department/service provider
- Act as a point of contact for patients/GDPs on waiting times for individual referrals
- Assist in the management of any patient complaints

A task and finish group has been developed across primary and secondary care to carry out of a review of all referral forms and guidance, agree the appropriate clinical management of referrals including a quality assurance mechanism and a set of performance standards to ensure timely and appropriate management of all referrals received. It is expected that the centre will manage all referrals for the following services:-

- Child GA/CS referrals
- Dental Training Unit Referrals
- Oral Surgery
- Restorative Dentistry
- Community Dental Service
- Orthodontics

A review has been carried out to determine the benefits of transferring the weekly GA inpatient list from Morriston hospital to the Princess of Wales hospital in Bridgend. Representatives from the Learning Disabilities directorate, theatres and clinicians have been involved in the development of a revised pathway for patients. The new All Wales pre-assessment guidelines, pre and post op care plan for daycase surgery and nursing care plan for children and young people have been reviewed in order to ensure the needs of this patient group are met. A booklet is being developed for patients that will include picture boards and the provision of appropriate information to smooth the patient journey. A walk-through with existing patients is being undertaken prior to a pilot in September to test the revised pathway.

The Dental Strategy and Planning group has approved the proposal to appoint a dedicated project manager to take forward the development of the Port Talbot Resource Centre and the planned Referral Management Centre. The postholder will lead a project that streamlines pathways across GDS, CDS and HDS, by developing an integrated management structure for the dental services based at the Port Talbot Resource centre, combining and sharing resources where practicable, and streamlining the referral and access systems. There will be a need to include the views of patients and seek feedback via patient questionnaires.

A proposal has been agreed by the DSPG to tender for the provision of endodontics through a Personal Dental Services Agreement for a pilot of one year to assess the feasibility of an integrated primary/secondary care service which will operate out of Port Talbot Resource Centre for two sessions each week.

An outline proposal has been made to recruit a Clinical Dental Technologist into the Restorative Department who will undertake treatment for patients requiring removable prosthetic options and who are under consultant care; It is however recognised that there could be alternative models to delivering this service which need to be scoped to develop an integrated service model between primary and secondary care.

Areas of good practice

Orthodontics

The Health Board has a joint Orthodontic Managed Clinical Network (MCN) with Hywel Dda Health Board which meets on a quarterly basis and has membership that includes consultant orthodontists; specialist orthodontists working in practices; members of the Local Orthodontic Committees (LOCs), as well as management support from the Health Boards and Public Health Wales. The group has made considerable headway in the development of referral criteria and referral guidelines; as well as a referral management process. In addition, a patient satisfaction questionnaire has been developed for implementation in September 2013 and will be given to the last twenty patients who have completed a course of orthodontic treatment. In conjunction the practitioners will be asked to undertake a PAR audit on each of the patients completing the questionnaire. The survey will be run by performer and across primary and secondary care; the results of which will be considered by the MCN later in the year.

Risks

- Timescales to deliver the above and impact on delays for patients
- Ensuring appropriate education for referrers
- Appropriate financial resource to deliver revised models of care

Summary of Health Board Actions:

- Appointment of Project Manager post to maximise use of Port Talbot Resource Centre and development of Referral Management Centre
- Ensure appropriate transfer of GA list to Princess of Wales hospital and improved pathway for patients
- Implementation of DES model for Restorative Dentistry
- Consideration of developing a model to support the development of a removable prosthetic service to patients under the care of the Restorative Department
- Scoping exercise to identify the specialist skills of GDPs who would be able to work with the Health Board in developing DES models of care

Action 9

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.

Key Issues for ABMU Health Board

- Ensuring that an appropriate referral pathway is in place to ensure that patients with suspected oral cancer are accessing high quality treatment within an appropriate timescale
- Evidence of a lower number of patients being referred for oral cancers, but a higher number of early referrals for those patients that need to be seen and treated
- Ensuring that all members of the Primary Care Dental Teams are aware of and have undergone training in identifying oral cancer
- Identifying relevant Third Sector organisations who can support patients with oral cancer and their families

Where we are

Data has been sought from PGDME on the numbers and percentages of the primary care dental team to inform the Health Board of the current levels of training. In addition further consideration has been given to how we will work in partnership with PGDME over the five year period, and beyond, to ensure that training and education is continuous.

The current referral pathways are direct into Oral Maxillo Facial Surgery (OMFS); this service is provided out of Morriston Hospital for patients resident in ABMU and Hywel Dda Health Boards. *Table 1* below identifies the number of referrals received into the department by year from 2010 to 2013 for oral surgery. The 2012/2013 figure is a projected outcome; and the increase is partly due to a service change; *Table 2* demonstrates the total number of referrals based on residency of the patient from 2009/10 to 2012/13 for oral surgery and max fax.

Table 1

	2010/2011	2011/2012	2012/2013
ABMU	6273	8483	9358
Hywel Dda	600	1978	2978

Table 2

	Total Referrals for Oral Surgery & Max Fax				
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
BRIDGEND	1882	1939	2071	2125	675
NEATH PORT TALBOT	1397	1354	1593	1797	526
SWANSEA	2146	2011	2397	2599	792
ABMU LHB	**5425**	**5304**	**6061**	**6521**	**1993**
ANEURIN BEVAN LHB	54	52	94	65	21
BETSI CADWALADR LHB	3	1	8	7	0
CARDIFF & VALE LHB	183	149	197	167	63
CWM TAF LHB	72	63	74	95	28
HYWEL DDA LHB	840	600	1977	3020	692
POWYS LHB	93	79	87	106	25
ENGLISH PCT	8	5	12	15	7
UNKNOWN	14	18	10	8	2
Total	**6692**	**6271**	**8520**	**10004**	**2831**

Where we need to be

The Health Board needs to have an assurance and supporting evidence that all members of dental teams have undertaken training and/or updating in the risks that will lead to oral cancer and the recognition of oral cancer.

Areas of good practice

- Planned education day for all General Dental Practitioners and Dental Care Professionals before the end of 2013 to raise awareness of oral cancer.

Risks

- Limited reduction in the number of early referrals for oral cancer

Summary of Health Board Actions:

- Education for general dental practitioners on raising awareness of early identification of oral cancers
- Actively reviewing the numbers of patients being referred for oral cancers to see a reduction in the overall numbers of patients being referred but with an increase in the number of early identification of oral cancers being referred
- Continue to work with PGDME to ensure that robust information on the numbers of dentists accessing training is captured in a meaningful format
- Continue to work with Third Sector organisations wherever appropriate to ensure that support and information is accessible to patients and their families

Action 10

Work with PGMDE to ensure that the dental actions contained within the Tobacco Control Action Plan (TCAP) are taken forward

Key Issues for ABMU Health Board

- Tobacco and smoking causes serious harm to the health of smokers and to non smokers who are exposed to second hand smoke. It continues to be the largest single preventable cause of ill health and premature death in ABMU.

Where we are

ABMU Health Board has an extant Tobacco Control Action Plan and we plan to implement the actions and provide opportunities and focus during 2014 to develop pathways from dental practitioners that support smoking cessation.

Where we need to be

- Working with PGDME to make available training for all GDPs on brief intervention for Smoking Cessation
- Developing robust links with Public Health Wales with regard to providing information and resources on the Stop Smoking Wales Service
- Discuss with dental practitioners the need to deliver smoking cessation advice linked to Community Pharmacy Enhanced Services

Areas of good practice

Risks

- Capacity to deliver training to all GDPs and their teams during 2014 due to the design of the current dental contract and the pressures it exerts on practice time

Summary of Health Board Actions:

- Work with PGDME to understand the numbers of dentists who have undertaken brief intervention training
- Provide training on an ABMU wide basis linked to PGDME to ensure the increase in numbers of dentists who have received training in brief intervention
- Include a review of smoking cessation advice in the annual contract monitoring visits

Action 11

Participation in 1000 Lives Plus Programme to Improve Mouth Care for Adult Patients in Hospital:

- *Work within a multi disciplinary team to deliver MAH programme*
- *Develop and deliver in-house educational training programme to comply with MAH recommendations*
- *Ensure better compliance with MAH documentation via nurse metrics*
- *Ensure correct oral health care consumables are available at ward level*
- *Support and deliver E Learning programme for in-house training on MAH programme*
- *Develop appropriate referral pathways*

Key Issues for ABMU Health Board

- Ensuring a consistent approach to delivery of the Improving mouth care for adult patients in hospital (MAH) programme
- Visible leadership and support from executive nurse team for multi disciplinary working
- CDS leadership and support for the MAH programme
- Care pathway for urgent dental referrals identified during MAH implementation
- Development of MAH programme links with the MCN in Special Care Dentistry and the Integrated Domiciliary Dental Care initiative in ABMU Health Board
- MAH programme roll out, implementation and evaluation of effectiveness.

Where we are

An ABMU Health Board Community Dental Service (CDS) Oral Health Promotion Officer, seconded to 1000 Lives Plus as the National Programme Manager, has been responsible for the development of the Improving Mouth Care for Adults Patients in Hospital Programme in ABMU Health Board and across Wales. This development has been fully supported by the ABMU Health Board CDS.

1000 Lives Plus is a National Improvement programme, supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. This is achieved by engaging frontline staff and leaders in developing evidence based interventions, spreading good practice and ensuring patient driven care is at the centre of all improvement work.

The CDS is working closely with the deputy director of nursing, quality and safety, and nurse clinical leads in supporting and delivering the programme. Key stakeholders and priority test areas have been identified. These include Elderly Care, Rehabilitation, Palliative Care, Oncology, Haematology, ITU / CCU / HDU units and Head and neck / ENT surgery.

All wards participating in the MAH programme have had a commencement plan, are using a PDSA approach and where possible capture data on nurse metrics.

An urgent dental referral form and triage form for hospital in-patient referral to the CDS has been developed. This is currently being tested.

Continuous work with procurement to ensure safe mouth care resources at ward level is ongoing. Other current work focuses on the development of patient group directives as

regards the need to be able to supply and/or administer appropriate medicines involved in the MAH programme.

An oral health training programme has been developed by ABMU Health Board CDS and is being delivered to priority areas within the Health Board. In addition, the Dental Postgraduate section of the Wales Deanery in collaboration with 1000 Lives+ have developed an antimicrobial prescribing audit for general dental practitioners. Professional bodies agree that all prescribers need to improve antimicrobial prescribing. The aims of the audit are to support the most effective clinical use of antimicrobials and to reduce the number of unnecessary prescriptions. The Health Board will be promoting the use of this audit.

Where we need to be

The 1000 Lives+ MAH programme should be rolled out across ABMU Health Board alongside existing service priorities. This will necessitate continuing support for the MAH National Programme Manager and continuing CDS and nursing team support to not only develop the programme but also improve partnership working across the Health Board.

Oral health champions should be identified in areas of MAH programme implementation to cascade 1000 lives mouth care training programme to other staff.

Adequate resources should be available to support the MAH E-Learning programme for Health Board staff. This will help develop a workforce that is better informed in oral health care. Mouth care processes should be included into nurse metrics.

An evidence based approach should be used to develop a quality assurance system to evaluate the MAH programme development. This should include staff feedback and evaluation.

Areas of good practice

The MAH programme was developed as a result of the work of ABMU Health Board CDS and clinical leads from hospital departments including palliative care, elderly care and mental care nursing teams. This joint working involved the development of a programme of care to improve oral health for adult patients in hospital, based on established 1000 Lives Plus Quality Improvement methodology.

The MAH programme was officially recognised for implementation across Wales by the Health Minister for Wales in 2012.

The ABMU Health Board CDS Oral Health Promotion Officer responsible for developing this programme has subsequently presented her work in the UK and Europe to inform other health care organisations of oral care for vulnerable people in hospital.

Educational resources have been developed to complement the MAH programme. These include patient information leaflets on the effects and management of dysphagia, enteral feeding, xerostomia and oncology on oral health.

Procurement processes within the MAH programme have been refined so that resources are provided in such a manner to facilitate the smooth running and roll out of the programme.

Risks

- Insufficient CDS staff and resources to support the rollout of the programme across the Health Board
- Lack of focus on programme delivery and other pressing service demands may result in the programme not being given the priority it deserves and appropriate mouth care may not be delivered across the Health Board
- Inadequate monitoring and quality assurance systems being observed to ensure adequate compliance with the MAH programme

Summary of Health Board Actions:

- To provide continued support for the MAH programme and its roll out across the Board
- To ensure support for the CDS to enable it to support the MAH programme delivery
- Support from the Executive Nurse team to deliver the programme

Action 12

Include issues relating to primary dental care as part of their annual primary care reporting process, and include them in their Annual Quality Statement

Key Issues for ABMU Health Board

- Ensuring that the Quality Delivery Plan is inclusive of Action 5 of the Quality Delivery Plan in relation to measuring patient satisfaction
- Ensuring that the ABMU Primary Care Annual Plan is expanded to include dentistry in all priority areas.

Where we are

ABMU Health Board has received an annual report on primary care services including dental services. This report sets out progress made in the previous twelve months and actions agreed for the future twelve months, of eight priority areas the following three had a focus on dental services.

Access & Out of Hours
Locally, there has been a key driver to improve access to NHS dentistry in areas of highest need (General Dental Services) however access to dentist appointments in ABM compares well with other Health Boards across Wales. Local review of public health data recognised that access could be further improved in the areas of highest need by directing additional dental activity to those areas. In 2012/13 a Health Board tendering exercise identified providers of general dental services in these areas and consequently additional activity has been awarded to the value of £1.5 million. In addition, the Health Board has ensured that access is increased for those patients requiring minor oral surgery under local anaesthetic and orthodontic treatment.

The core function of DTU, based at Port Talbot Resource Centre is to develop well trained dental staff who will be encouraged to practice in Wales. As a developing centre of excellence, 2012 has also seen it facilitate increased access to local dentistry by enabling practices to refer high need patients for treatment, thereby freeing up capacity for general dental practitioners in the community to provide routine treatment to new patients.

Governance & Performance
The QAS process was referred to in Action 1.

ABMU monitors primary care contractors' performance and compliance with their contractual obligations. Performance frameworks for primary care providers bring together data from a range of sources trying to create a balance between self reporting, reviews of statistical data and subsequent in depth reviews of contracts identified as needing further intervention. Where this concerns management of a practitioner's performance the national guidance and regulations are followed.

Primary Care Contract Management
The budgets for General Dental Services are ring fenced by Welsh Government are managed through national contracts introduced in 2006.

Continual engagement with the contractors' representative bodies ABMU Local Dental Committee (LDC) is required to ensure effective contract management.

Where we need to be

The ABMU Primary Care Annual Report 2012/13 set out eight priority areas, and discussed the dental position in some of those areas. There are however a number of areas where dental services were not included within the report and therefore we will consider the expansion the 2013/14 Primary Care Annual Plan to be inclusive of Workforce, Revalidation, Infrastructure and Service Development in relation to primary and community dental services, if these remain Health Board priorities.

Areas of good practice

The development of a patient satisfaction survey in orthodontics which will run concurrent to PAR audits on the same cases during September 2013**.**

The development of a patient satisfaction survey for use in the Community Dental Service which has already been piloted and will be rolled out to all CDS clinical sites in September 2013.

Risks

- Quality and Risk arrangements within the Health Board are currently under review and therefore there is a possibility that revised arrangements for dental quality and risk management may be required.

Summary of Health Board Actions:

- Include patient satisfaction on dental services as a key component of the Quality Delivery Plan
- Implement additional capacity arrangements that have now been commissioned to improve dental access in areas of highest need
- Refresh emergency dental access and Out of Hours arrangements with exploration of a fixed site model for out of hours dental care
- Further development of the Port Talbot Resource Centre in delivering integrated dental services to include the DTU, Community Dental Service, Restorative Dentistry and elements of Minor Oral Surgery, working in collaboration where possible
- Development of a single point referral system to manage dental activity to improve management of demand and enable integration of referral pathways and performance management
- Develop an extended two year DCT 1 training, capitalising on the success of the current DCT 1 scheme and ensuring that trainee numbers are consistent year on year
- Introduction of a governance scorecard for general medical and general dental service contract holders, monitored via the performance management framework for the Health Board.
- Continued attention to active management of performance cases. All cases will be managed in line with national guidance and regulations.

- Develop clinical governance forum arrangements to promote learning from events.
- Continue to focus on contract reviews and visits where needed to monitor contract performance and governance issues.

Action 13

Work with 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

Key Issues for ABMU Health Board

- The need to have an established Occupational Health Service for GDPs and their dental teams, which links to the Well Being at Work initiative to ensure that comprehensive support is available that includes:
    - New employment checks
    - TB vaccinations
    - Flu immunisations (to be inclusive of Pneumococcal)
    - Advice for contact of symptomatic communicable diseases
    - Sharps/body fluid incidents
    - Vaccination for work preventable diseases (Hepatitis B, Hepatitis C, HIV)

Where we are

ABMU Health Board is in the process of establishing an Occupational Health Service for primary care dental contractors, and has a draft service specification *(Appendix 13A).*

Where we need to be

To have an operational Occupational Health Service in place by December 2013, that has a referral mechanism that supports direct referrals from practices and provides high level data on access to the service; and is accessible across a number of sites across ABMU to facilitate good access.

To ensure appropriate and effective use of the service the Health Board needs to ensure that communication to general dental practices over the service is clear and accessible and that supporting services such as Well Being at Work are also available and should be accessed.

Areas of good practice

Well Being At Work service provides support to individuals working and living in the ABMU area and is available as direct access.

Ad Hoc assessments are currently provided by Occupational Health based individual referrals where there are health concerns for general dental practitioners.

Ad Hoc arrangements are in place for Hep B immunisations for indivudals working in dental practices.

Risks

- Insufficient funding to support a fully operational occupational health service for all members of the dental team working across practices in ABMU

Summary of Health Board Actions:

- Finalise and agree a service specification with Occupational Health Department
- Finalise and agree funding with Welsh Government and ABMU Finance
- Advise practitioners jointly with the LDC on the new service model and the pathways for access to it
- Establish a system to monitor the use of the service

Action 14

Support for educational providers: pre–registration nurse course (University of Swansea) and Health Care Support Workers employed within the Health Board.

- *Pre-registration course (University of Swansea)*
- *Deliver evidence based oral health training*
- *Ensure practical competencies in the delivery of appropriate mouth care*
- *Deliver training to ensure competencies in completing All Wales mouth care risk assessment*
- *Work within the All Wales Nurse Curriculum*
- *Health Care Support Workers*
- *Deliver evidence based oral health training*
- *Ensure practical competencies in the delivery of appropriate mouth care*
- *Deliver training to ensure competencies when supporting registered nurses who complete the All Wales mouth care risk assessment*
- *Work within the Clinical Care Competency For Health Care Support Workers developed by ABMU Health Board*

Key Issues for ABMU Health Board

- Ensuring a consistent approach to the delivery of evidence based oral health training throughout the Health Board
- Liaison between the nurse team and the CDS on all aspects of oral health care when developing 'care' policies and pathways
- Provision of ongoing support from University of Swansea in evaluating programmes
- Ensure adequate funding to continue and further develop programmes

Where we are

Pre-registered nurse training:
The CDS delivers training on oral health and appropriate mouth care for pre registered nurses at Swansea University. There are two cohorts with approximately 200 - 350 students per annum. Oral health care practice is delivered to students in the first year of their 3 year curriculum.

Enhanced and updated programme which incorporates the All Wales Mouth Care Risk Assessment (WG 2013) and 1000 Lives Plus Mouth Care for Adult Patients in Hospital programme is currently being developed and training will commence in 2013.

Health Care Support Workers
In addition to the pre-registered nurse training programme there is a need to train the existing health and care work force in ABMU Health Board. There are significant gaps in the knowledge and skills care providers possess when carrying out mouth care practice for patients, both in the acute and primary care setting.

In response to this need, the CDS have developed a training programme that supports the 1000 lives plus programme. The CDS is developing an oral health educational programme that will be incorporated into the Clinical Care Competency Framework for health care support workers. This will help to:

- Improve oral health knowledge and skills for health care professionals who support patients in hospital/community settings and those living with complex medical conditions and advanced illness.
- Enable health care professionals to provide and deliver a high standard of mouth care.
- Support person centred training, to suit individual needs and local circumstances.
- Support training and teaching in practical mouth care support for health and care professionals who find it difficult to clean a patient's mouth
- Staff training for both registered and non registered staff within ABMU Health Board has been carried out in various locations across the health board including Princess of Wales, Cefn Coed and Neath Port Talbot Hospitals.
- Due to the high volume of staff, this work is on going and is supported by the Executive Nurse Director.

Where we need to be

1000 Lives+ Mouth Care for Adult Patients in Hospital programme has identified an inconsistent approach to oral health education across Wales. Subsequently the Chair of the All Wales Pre-Registration Nursing and Midwifery Group has agreed further development in oral health care training for student nurses. The training will be evidence based, consistent across Wales and in line with the National Curriculum.

To ensure comprehensive competencies in oral health care for newly qualified and registered nursing staff across ABMU Health Board, further education modules will need to be developed and incorporated into the nurse curriculum.

An increase of time allowance in the curriculum is essential to meet the standards in Fundamentals of Care (WG 2003) for Nurse Training. An oral health education policy must be developed. This may help address inequalities in oral health standards, throughout ABMU Health Board and have the potential to raise standards of care and save on budgetary spending when unified clinically evaluated resources are used.

The Health Board will seek to ensure that there are adequate CDS staff who are trained and available to support delivery and of these programmes.

Areas of good practice

The CDS has worked with the University of Swansea for many years to incorporate and deliver oral health education/training into the nurse based curriculum. To date this has been delivered to 1st year students. Significant joint working with Hywel Dda CDS in delivering the programme into University of Wales Trinity Saint David has ensured a consistent approach for student nurses across South West Wales. Work is underway in developing this programme to meet enhanced educational requirements as agreed at an All Wales level.

Partnership working with a multi disciplinary team of clinical leads in the Health Board has resulted in the development and dissemination of an oral care programme that includes training on oral risk assessment and care planning for adult patients admitted to hospital. The programme has been accepted as a national standard across nursing practice in Wales.

Risks

- Inconsistencies in knowledge and skills of the workforce
- CDS capacity and resources to deliver programmes
- Adequate funding for further development of the programmes
- Adequate time within the nurse curriculum needs to standardise training and practice.

Summary of Health Board Actions:

- To support the development and provision of educational initiatives in oral care for pre-registration nurses and health care support workers
- To recognise and support the CDS in the formulation and delivery of this training

Action 15

Ensure that high risk groups are targeted by national campaigns (e.g. Mouth Cancer Awareness and National Smile months

Key Issues for ABMU Health Board

- National campaigns form an important part of the awareness raising and oral health knowledge of the population of Wales
- ABMU HB has an active Communications Team that support national campaigns by looking for a local angle and using a variety of communication tools to publicise e.g. Facebook, Twitter, ABMU HB website

Where we are

All national campaign material is distributed out to all GDPs with NHS contracts in ABMU and relevant partner organisations.

ABMU HB is in the process of finalising a patient information leaflet on all aspects of NHS dental services including a timetable of national campaigns to raise awareness. The leaflet will, when finalised, be available in all dental practices as well as in all relevant health care and partnership agencies. The leaflet will be available bilingually.

Where we need to be

There is a need to be more proactive in using the Health Board Communications Team to ensure that key messages are cascaded to the public via Twitter and Facebook as well as the Health Boards internet and intranet sites, as well as more traditional communication methods to ensure those individuals who do not access social media have access to the same key messages.

Areas of good practice

The Designed to Smile team's promotion of National Smile Month was held between May and June 2013. To support the campaign the team attended events hosted by schools, charities and children's organisations. A link to the press article is below.
http://abm.cymru.nhs.uk/bulletins/bulletin.php?bulletin_id=6581

Risks

- Ability to identify resources from ring-fenced budgets to support all relevant health promotional campaigns
- Closer working with Public Health Wales to ensure joint communication strategies to underpin delivery of campaigns

Summary of Health Board Actions:

- To take a more proactive approach in communicating key oral health messages linked to national campaigns to the resident population of ABMU Health Board in a variety of media to ensure information is accessible to all.

Action 16

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

Key Issues for ABMU Health Board

- Ensuring that oral health is a key component of the funded nursing care and continuing health care assessments.
- Ensure that patients in receipt of funded nursing care and continuing health care are in receipt of regular reviews which includes their oral health status
- Appropriate links with the Community Dental Service to ensure that vulnerable patients have timely access to services that meets their needs

Where we are

Oral health is a component of the funded nursing care and continuing health care assessments which are used to identify and plan to meet the needs of patients with complex medical and social care challenges.

The current assessment criteria sees patients being re-assessed at 6 weeks and three months and for those in receipt of continuing health care a further assessment will be undertaken on an annual basis. Patients in receipt of funded nursing care are reviewed annually. These reviews can be brought forward if there is a matter of concern.

Any dental problems identified during the process are currently referred into the Community Dental Service or a contracted specialist domiciliary service for treatment.

The Community Dental Service provides works with a number of agencies to ensure that vulnerable groups, including Travellers have access to NHS dental services.

Where we need to be

In renegotiating contracts with the Local Authorities, Nursing and Residential Homes, ABMU Health Board will include oral health as a quality marker for care packages of patients.

Areas of good practice

The Community Dental Service (CDS) provides oral health care training and advice for carers and support groups of vulnerable people including adults with a learning disability. A CDS Oral Health Promotion Officer has developed an educational package and training for various groups in the community including adult domiciliary support organisations such as Walsingham and the Community Lives Consortium. The CDS also works with closely Swansea People First (SPF) which is a Peer Advocacy Group project that seeks to look after adults with a learning disability. Amongst other initiatives the CDS has made a DVD jointly with SPF to explain what happens when adults with a learning disability go to the dentist.

The CDS works with the Cyrenians Charity Organisation to provide care for homeless people in Swansea which has the highest number of homeless people in Wales. Working together, the Cyrenians and the CDS provide dental care for homeless people using a Mobile Dental unit which visits the Dragon Art Project Centre in the Strand, Swansea on a regular basis. Homeless people in Swansea would otherwise experience great difficulty in obtaining dental care if this service was not available.

The CDS works closely with mental health teams and carers and support groups who look after adults with mental health problems living in the community, and has strong links with Social Services departments to try to ensure that oral care is provided for vulnerable children.

As well as working with child support groups, the Designed to Smile initiative provides support and oral health educational packages and advice for adults who look after children including parents and ethnic minority groups.

Risks

- Patients who have had an assessment and have been in receipt of continuing health care or funded nursing care can be in placements for periods of time during which their oral health needs may have changed. Without a re-assessment their oral health needs may not be identified.

Summary of Health Board Actions:

- Ensuring that oral health is a key component of the funded nursing care and continuing health care assessments.
- Ensure that patients in receipt of funded nursing care and continuing health care are in receipt of regular reviews which includes their oral health status
- Continue to provide access to dental services to patients with complex medical and social problems through the Community Dental Service

Action 17

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

- *Enhance contract monitoring reviews on GDS/PDS contracts with high values Units of Dental Activity (UDA);*
- *Ensure better compliance with NICE guidelines on recall intervals;*
- *Monitor "splitting" courses of treatment;*
- *Work to the interim Guidance of NHS Orthodontics in Primary Care, particularly during contract renewal*

Key Issues for ABMU Health Board

- Ongoing review of multiple FP17 reports to ensure that "splitting" courses of treatment is eradicated across all contracts
- Ensuring value for money in relation to all GDS/PDS contracts by reinforcing the need for dental contractors to ensure the appropriate implementation of NICE guidelines relating to recall periods
- Need to ensure that a consistent UOA rate is applied to all PDS Agreements for Orthodontic services and that all contracts issued contain the revised clauses following the interim Guidance on Orthodontic Services (*March 2011*)
- Ongoing validation of the orthodontic waiting lists and a review of the new patient waiting list
- Review of the referral management process for orthodontic referrals in consideration with bringing in line with other dental specialities across ABMU
- Education for dentists to ensure that IOTN criteria is being adhered to on referral and to ensure that wherever possible early referrals are minimised if being used as a mechanism to secure patients a place on the waiting list

Where we are

ABMU Health Board currently undertakes an annual contract monitoring visit once the end of year data has been published by the Dental Practice Board. All dental practices are scheduled to have a visit within the July to September period; and a standardised set agenda is used to stimulate discussion and to ensure that consistent messages and guidance are given. All contract activity data is reviewed again at the mid-year point with meetings offered to those dental practices that are falling short of the 30% contract achievement. That said, given the length of time that existing contractual arrangements have been in place, the number of practices failing to demonstrate that they are making steady progress to increase their contract activity has decreased because the Health Board now takes a pro-active approach in working with practices to ensure that they have contracted activity that is achievable on a sustainable basis.

The Health Board has an Exception Reporting policy in place that ensures the circulation of quarterly exception reports to practices asking them to respond to any areas of concern. During 2013, it has been noticed, from contractual reviews that the exception reports are not always flagging issues of concern where there are a number of providers working under a single performers contract. The Health Board has therefore implemented an addendum to the exception reporting policy that has the support of the Local Dental Committee to agree that any dental contract where there are three or more dentists working to a single contract number will have multiple FP17 reports run on a quarterly basis to assist in identifying any areas of concern e.g. splitting courses of treatment through multiple FP17 claims.

The dental contract monitoring visits are also an opportunity to discuss with the dentists their recall attendances and to reiterate NICE guidelines. This is however a challenging area for the Health Board to address as not only are some patient expectations that they should have an appointment for a check-up every six months; given the need for clinical discretion it is often difficult to challenge whether or not the interim period between appointments has been based on the oral health of the patient and their clinical need.

ABMU Health Board has fully taken on board the interim guidance on the management of orthodontic services which was issued in March 2011.

The Health Board has a joint Orthodontic Managed Clinical Network (MCN) with Hywel Dda Health Board which meets on a quarterly basis and has membership that includes consultant orthodontists; orthodontists working in specialist practices; members of the Local Orthodontic Committees (LOCs), as well as management support from the Health Boards and Public Health Wales.

Through the MCN the Health Board has developed a patient satisfaction questionnaire which will be implemented in September 2013, and will be given to the last twenty patients who have completed a course of orthodontic treatment. In conjunction the practitioners will be asked to undertake a PAR audit on each of the patients completing the questionnaire. The survey will be run by performer and across primary and secondary care; the results of which will be considered by the MCN later in the year.

The Health Board has also revised the Personal Dental Services (PDS) Agreement contract clauses to include that each patient must only have one assessment claimed for during the course of their treatment. The Health Board also embraces a robust procurement process which has been used to award General Dental Services (GDS) contracts and will ensure that this open and transparent process is used when the existing PDS Agreements for Orthodontics are due to end to ensure a continuous evaluation of the service model to ensure it is providing value for money care for patients within safe and equitable service provision.

ABMU Health Board in 2012/13 has implemented referral guidelines and a referral template for all orthodontic referrals into specialist practices, locally accredited Dentists with Enhanced Skills (DwES) and Hospital Dental Services (HDS). This information is managed by each individual service provider and submitted to the Health Board on a quarterly basis, which is then analysed and shared with local dental contractors.

ABMU Health Board had formerly agreed and signed up to the Hywel Dda process for Dentist with Specialist Interest (DwSI) accreditation (now known as DwES), and will continue to use this process where necessary.

Where we need to be

Whilst we are almost there, ABMU Health Board needs to have a full assurance that all dental practices are providing care in the best interests of their patients and that the "splitting" of courses of treatment is eradicated. It is anticipated that this will be reinforced by the addendum to the exception reporting policy with localities taking responsibility for closely reviewing the activity of their larger practices and engaging with their allocated Public Health Wales Dental Practice Advisors (DPAs) on a regular basis to discuss any concerns that may arise from this process.

Further work is needed to be undertaken with GDPs supported by the LDC to get greater assurance of adherence to NICE guidelines on recall intervals for patients and/or a better understanding of current practice and why this sits outside of the guidance.

Ensure that any future commissioning of orthodontic services is managed through an open and transparent tender process ensuring that the same UOA rate is applied across ABMU.

Ongoing review of the referral management process for orthodontics to ensure that it can be brought in line with ABMU wide discussions on referral management for dental referrals per se; consideration to a single point of access for all dental referrals is work in progress at present.

Areas of good practice

The development of an Orthodontic MCN which is working across ABMU and Hywel Dda Health Board with Public Health Wales support and representation from both Local Orthodontic Committees. The group continues to meet on a quarterly basis and has made considerable headway in the development of referral criteria and referral guidelines; as well as a referral management process. The next piece of work will be the patient satisfaction survey and an audit of PAR scores for the same group of patients.

The inclusion of additional clauses in PDS Agreements for Orthodontic services with regard to one assessment per patient.

The development of a patient satisfaction survey in orthodontics which will run concurrent to PAR audits on the same cases.

The implementation of the Addendum to the Exception Reporting policy to ensure that any potential issues of “splitting” courses of treatment can be reviewed by the Health Board.

Risks

- Consistent implementation of NICE guidelines in relation to recall attendances. Patients have come to rely on six monthly recalls and often challenge the decision to extend the recall period. The Health Board needs to secure LDC support in actively challenging practitioners where there appears to be a pattern of routine recall rates outside of NICE guidelines to ascertain the appropriateness of the decision.
- The review of multiple FP17 reports may highlight performance concerns within dental practices which will need to be addressed through the All Wales Performance Procedures for Dentists

Summary of Health Board Actions:

- To agree the process of and undertake an orthodontic waiting list validation exercise to ensure that those patients referred prior to the implementation of the orthodontic referral guidance and referral forms are assessed as being appropriate for referral into a DwES/Specialist practice and that any patients identified as having an urgent treatment need are signposted to the most appropriate service provider
- To move to a single value for UOAs across all specialist orthodontic PDS agreements
- Implementing quarterly reviews of multiple FP17 reports for practices where there are more than three dentists working to a single contract, and ensuring that a high level report on this information is submitted to the Dental Clinical Governance Committee on a regular basis.

Action 18

Health Boards should use BSDH guidelines in developing their plans for the delivery of domiciliary services.

Key Issues for ABMU Health Board

- There is a need for a revised, cross-service strategy towards the planning and contracting/provision of Domicilliary Dental Care (DDC) across ABMU Health Board based upon BSDH 2009 guidelines
- There is a need for a single guidance document setting out ABMU wide requirements in DDC including clinical governance, referral criteria, monitoring procedures, clinical activity and financial outcome indicators and a definition of the difference between screening and DDC. This should be based upon BSDH 2009 guidelines
- There is variance across the Health Board in referral and acceptance criteria. It is also unclear what types of treatments are being provided during DDC and what standards of care are being applied. The outcome of treatments provided during DDC, particularly in the GDS, also appear to be largely unknown. Clinical governance arrangements need to be reviewed as there is currently no assurance that all providers carrying out DDC are observing BDSH 2009 guidelines
- There needs to be a review of DDC contract provision mechanisms and remuneration system for DDC service provision by GDS practitioners
- The dental care for patients in elderly residential homes and long stay institutions in the AMBU Health Board area is disorganised and needs to be reviewed.

Where we are

A Review of DDC in the Community Dental Service (CDS) in ABMU Health Board was carried out in 2008. This review revealed several concerns in the provision of DDC by the CDS which have been addressed following the Review of the CDS in ABMU Health Board Wales in 2010.

Following a proposal for an integrated approach to DDC within ABMU Health Board a Task and Finish Group was established lead by PHW to set out the protocol and service design for DDC across the dental specialities in ABMU Health Board. The Group submitted a report and recommendations to ABMU Health Board in 2012. The report recommended an integrated approach to the provision of DDC across the dental specialties in ABMU Health Board and improved clinical governance and monitoring procedures.

A further Task and Finish Group has subsequently been established in ABMU Health Board in 2013 to look at the development of a single point of access for referrals for dental treatment including DDC. This work is currently in progress.

A Managed Clinical Network (MCN) in Special Care Dentistry (SCD) for ABMU and Hywel Dda Health Boards has been established in 2012. The SCD MCN will oversee all aspects of SCD service provision including DDC. The MCN includes representation for the General Dental Services, CDS and Hospital Dental Services and representatives from Primary Care Management from both Health Boards. MCN work includes the development of patient referral pathways in SCD including DDC. It is also hoped to develop Dentists with Enhanced Skills in SCD including DDC in ABMU Health Board.

ABMU Health Board CDS is also developing a continuing Patient Satisfaction Survey to evaluate patient satisfaction with the services it provides. This will include DDC.

Where we need to be

There needs to be a single integrated pathway for DDC. This can be established as part of the single access point for referrals for dental care within ABMU Health Board.

There needs to be a clear list of DDC providers in ABMU Health Board. Once in place, this list can be advertised and publicised across the stakeholder organisations along with guidance for referrals.

Clear referral and acceptance criteria need to be provided for DDC. All referrals for DDC should be assessed for suitability according to these criteria. Referrals that are accepted can then be passed on to the most appropriate DDC provider in the GDS, CDS or HDS. BSDH 2009 guidelines should be followed during assessment.

Appropriate arrangements need to be made to accommodate emergency requests for DDC including hospital referrals and the Mouthcare for Adults in Hospital programme.

Patients should be able to expect a consistently high standard of care and service from DDC providers. Providers of DDC should all meet agreed standards of training and quality (BSDH 2009). Appropriate records of care including quality assurance returns should be completed for all providers of domiciliary dental care services. Evidence to support these returns should be supplied to the Health Board upon request. Providers should provide evidence Contracts should be reviewed for all providers who fail to meet the ABMU Health Board DDC quality standards.

DDC providers should carry and maintain the necessary equipment as outlined in BSDH 2009 for each procedure provided to patients. Risk assessment procedures should be followed and recorded for each case of DDC.

DDC monitoring will be appropriate to the DDC pathways. Data sources collected during this process should be used for monitoring service provision.

Areas of good practice

The development of a MCN in SCD which is working across ABMU and Hywel Dda Health Boards with Management, CDS, Hospital Dental Service, Public Health Wales, and Local Dental Committee representation will help to develop the provision of DDC. The MCN continues to meet on a quarterly basis and has made headway in the development of referral criteria and referral guidelines.

ABMU Health Board CDS also participates in a Health Board/Local Dental Committee Liaison Group. This Group provides a good opportunity for the development of improved working relations between the CDS and the GDS. This includes DDC.

Clear updated guidelines in the provision of DDC have been provided by BSDH 2009. These guidelines for DDC are widely accepted by the dental profession.

Risks

- There needs to be consistent compliance with BSDH 2009 guidelines in DDC
- There needs to be an effective central referral mechanism for DDC with appropriate support from management
- A robust monitoring mechanism should be introduced that is acceptable for DDC providers
- A clear clinical governance process for DDC needs to be introduced for all providers.

Summary of Health Board Actions:

- To develop a central referral mechanism for Domiciliary Dental Care (DCC)
- Provide clear referral and acceptance criteria for DDC with a clear list of DDC providers
- Establish requirements for DDC monitoring, QAS and compliance with BSDH 2009 guidelines in DDC
- Provide an effective clinical governance policy for DDC

Action 19

Develop alternative patterns of care e.g. increasing the specialist dental paediatric services and dental paediatric DwES (formerly known as DwSI) workforce, and building the capacity of alternative treatments such as sedation where feasible

Key Issues for ABMU Health Board

- Service pressures in secondary care waiting lists which could be supported by alternative care pathways
- Challenges in making changes to the general dental contracts to enable service change due to Regulations
- Lack of a referral management system that underpins all dental referrals into the Health Board
- Co-ordinated domiciliary service across GDS and CDS ensuring quality and safety of service provision

Where we are

A review of paediatric dental services was commissioned from Public Health Wales in 2011, which set out five recommendations for the Health Board to support the development of a robust service model.

Significant work has been undertaken in relation to the evaluation of community paediatric dental services during 2013, with a new service model being established for the ongoing provision of child GA/conscious sedation services.

Following a tendering exercise the Health Board has awarded two PDS Agreements with two different service providers for an adult intermediate oral surgery under Local Anaesthetic service. Whilst both centres for this service are within the Swansea Locality, both service providers accept referrals from General Dental Practitioners across ABMU Health Board.

A service specification for a pilot for a Dentist with Enhanced Skills in Endodontics has been developed and agreed through the Dental Services Planning Group and is attached at *Appendix 19A*.

Where we need to be

Re-considering the actions set out in the review of specialist paediatric dentistry to ensure that an integrated approach to service delivery is achieved.

Potential for development of a DwES in paediatric dentistry based within the Community Dental Service working conterminously with the commissioned GA/conscious sedation service.
Considering additional investment into the Community Dental Service to equip a greater number of community sites with the necessary equipment to deliver conscious sedation services.

Further consideration needs to be given to the ability of the Health Board to fund the pilot for the Endodontic DES for a 12 month period to ascertain if it would be successful in not only reducing the waiting list for patients requiring molar endodontic treatment but to develop a broader multi-disciplinary approach to the provision of restorative dentistry.

Areas of good practice

The commissioning of the two intermediate oral surgery PDS agreements for adults requiring dental extractions under Local Anaesthetic; it is anticipated that the revision to this service model, along with revised referral guidance and referral templates will help to refine the pathway for patients.

Risks

- Potential financial impact with no additional resources to support changes to service delivery. May need to consider service change in line with "invest to save" models to redirect the care of patients from secondary to primary care/community services.
- Increased demand on secondary care waiting lists despite new service models in primary care
- Workforce pressures; self funding of development for training and education to enable different service models by General Dental Practitioners could see a paucity in the number of individuals who are suitably skilled to deliver new models of care.

Summary of Health Board Actions:

- Pilot of Endo DES to be operating out of Port Talbot Resource Centre in 2014/15 to include an audit of patient outcomes
- Review of current minor oral surgery arrangements to ensure appropriate access to services for patients which will include the development of a new referral form, criteria and pathway for the service
- Review of the recommendations in the Specialist Paediatric Dental Services in ABMU report (2011)

Action 20

Develop clear plans on how residents will access specialist dental services in Primary Care (specialists/ DwES), the CDS and / or secondary care, and ensure an integrated approach to the delivery of these

Key Issues for ABMU Health Board

- Completion of pathway work that commenced during 2012/13 to develop referral guidelines and templates for all dental sub-specialities
- Establishment of a referral management system across all dental specialties

Where we are

Orthodontic Dentists with Enhanced Skills
Across the ABMU area there are currently three Orthodontic DES's working in conjunction with the Orthodontic Department at Morriston Hospital. All three dentists were assessed as being competent for the ongoing provision of this service through a joint assessment with the former Carmarthenshire Local Health Board (now Hywel Dda Health Board). Referral guidelines and a referral template have been established and are in use; and a flow chart (Appendix 20A) describes how the current system works for patients being redirected into the DES service.

Endodontics DwES
A service specification for a pilot for a Dentist with Enhanced Skills in Endodontics has been developed and agreed through the Dental Services Planning Group and is attached at *Appendix 19A*. Whilst the agreement in principle has been taken to establish this service model, further work needs to be undertaken to identify the associated funding to run this pilot for a 12 month period. The proposed service model would seek expressions of interest from general dental practitioners to work within the Restorative Department at Port Talbot Resource Centre.

Special Care Dentistry General Anaesthetic list
The establishment of a joint assessment clinic between the Restorative Dentistry department and the Community Dental Service for special care adults requiring treatment under general anaesthetic is currently operating out of Princess of Wales Hospital for one month's trial (September 2013) and if successful this will become the established service model.

Child GA service
ABMU Health Board currently contracts with Parkway Clinic for the provision of extractions under general anaesthetic or conscious sedation for children who are dentally phobic, have special health needs or require multiple extractions. Following a service review, a tender exercise was concluded at the end of August 2013, for a new service model to be established from January 2014. The revised service specification is attached at Appendix 20A.

Intermediate Oral Surgery Service
ABMU Health Board commissioned two specialist intermediate oral surgery services through PDS agreements for adults requiring dental extractions under local anaesthetic in 2012/13. It is anticipated that this new service model, coupled with new referral guidelines and a

referral template will see a reduction in the number of patients being referred into secondary care for dental extractions.

Where we need to be

Greater integration of all dental services across the Health Board, to ensure that care pathways are streamlined and enable access to specialist services in the primary and/or community setting; this could include the associated general management functions as well as the service delivery models.

Continuously reviewing data and waiting times to ensure that intermediate oral surgery services are sufficient for the current levels of demand and the types of patients accessing the service. Consideration may be given to the potential to expand the current intermediate oral surgery services to include treatment under conscious sedation for patients who are dentally phobic.

Expanding the joint assessment of patients accessing the special care dentistry GA list to include a consultant anaesthetist at the time of assessment and treatment planning.

Areas of good practice

Orthodontic Dentists with Enhanced Skills
Across the ABMU area there are currently three Orthodontic DwES's working in conjunction with the Orthodontic Department at Morriston Hospital. All three dentists were assessed as being competent for the ongoing provision of this service through a joint assessment with the former Carmarthenshire Local Health Board (now Hywel Dda Health Board). The Health Board commissions 3,956 of Units of Orthodontic Activity from Orthodontic DwES's each year, which equates to approximately 188 patients.

Special Care Dentistry General Anaesthetic list
The joint working between the Restorative Department and the Community Dental Service has enabled a more streamlined service model to be established taking into account the specialist skills of clinicians.

Risks

- Waiting list demands for special needs adults for GA extractions can increase especially due to winter pressures on beds
- Waiting list demands for children referred for orthodontic treatment at specialist orthodontic practices
- Financial resource implications to establish new models of care on a sustainable basis within a ring fenced dental budget
- Clinical expertise and competency. The Health Board needs to be assured that any DES model is delivered by individuals who have the appropriate skills and training needed to provide the service and to work as part of the broader dental team

Summary of Health Board Actions:

- Ongoing review of the referral pathway for Orthodontic DES service to ensure that it remains effective and ensures appropriate service delivery for patients
- Develop an agreed pathway for referrals into the Endo DES service using information from the pilot to support a robust model
- Review of procedure for joint clinics for special care adult dentistry to ensure timely access for patients and recognition of individual clinicians skills and areas of expertise
- Establish new service model for Child GA service, supported by referral template and criteria
- Finalisation of referral template and guidance for adult oral surgery services to be provided in both primary and secondary care to ensure all referrals are considered against the same Health Board criteria, streamlining the patient pathway
- Consideration of remodelling management arrangements to support service pathway changes

Conclusion

Whilst the Health Board has made significant achievements in the bringing together of the three former Local Health Boards, Hospital and Community services; aligning systems and processes, there still remains a lot of work to do to refine existing patient pathways and to align service development and change to meet the needs of the resident population; and the population of neighbouring Health Boards that receive dental services from ABMU Health Board.

In reviewing the actions set out throughout the plan, there are 10 key areas that the Health Board will focus on achieving for the duration of this plan, which have been summarised in the Executive Summary at the start of this document.

In setting out to undertake the development of services that will bring changes to how patients access and receive care through these key areas; there are a number of risks facing the Health Board which could impede their achievement, these include:

- The implementation of new contracting arrangements for NHS primary care dental services
- Insufficient financial resources to deliver new models of care based on current budgetary position
- Clinical expertise and competence to be able to deliver on DES models
- Increasing demand for some services e.g. orthodontics
- Capacity and resources within the existing workforce to be able to deliver revised service models to ensure appropriate pathways are in place for patients

We are however confident that despite the challenges facing the Health Board in delivering against this Oral Health Plan, we have a dedicated workforce that will support service change and are dedicated to improving the oral health of the resident population in ABMU Health Board area.

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
1. 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 (p17)	Local Oral Health Plans to be in place by 31 December 2013 Information provided by Cardiff University and NHS DS on service use in relation to need, to be used to inform local plans, thereby ensuring a consistent national approach.	Local Oral Health Plan agreed by Board and Published.	Issue plan for document preparation Draft document with key stakeholders: - CDS - D2S - DTU - Local LDC - HDS - Local Authority - Localities - Cancer Network - Hywel Dda HB - Cardiff and Vale HB Engagement with PHW Engagement with wider stakeholders Sign off by Locality Management Teams, Directorates, LDC & DSPG Submission to Board Submission to WG	Production of an agreed plan for the Health Board	July 2013 July 2013 August 2013 August 2013 September 2013 November 2013 December 2013	CR/RB

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
2. 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 (p 36)	WG will seek assurance that this action point is being addressed, how it is being achieved, and specifically that structures are in place to receive multi-professional dental advice, including that of a consultant specialist in Dental Public Health	For dentists at their teams to have led and contributed to the drafting of the plans and wider engagement during September 2013.	Engagement with LDC Engagement with the whole CDS team Engagement through D2S session GDP study day Engagement with DTU team Engagement with HDS team	All stakeholders to have signed off on the plan in advance of completion and submission	September 2013	CR/RB
3. Ensure the continued participation in evidence based community oral health promotion programmes particularly the Designed to Smile and Healthy Schools programmes (p 28).	Evidence that CDS Designed to Smile Teams are fulfilling the standards in the Designed to Smile quality framework. WG will seek assurance from HBs, including the CDS, of participation in evidence based community health promotion initiatives which may include smoking cessation, alcohol and nutrition.	Local D2S team involved in drafting the LOHAP Local D2S team fulfilling the standards in the D2S quality framework Plans to include CDS participation in community HP initiatives which may include smoking cessation, alcohol and nutrition	Production of an annual report to the Chief Dental Officer detailing compliance as laid out in the quality standards framework. D2S team to support schools and nurseries to continue participating in the programme and to encourage daily brushing. Recruitment of additional schools and nurseries Increase provision of clinical interventions e.g. fissure sealant and fluoride varnish through mobile dental unit and domiciliary kit	Progress against the 11 standards. Annual report to WG Number of schools & nurseries participating in the programme (number withdrawing) and brushing daily Numbers sustained/increased year on year Number of children receiving FS & FV	2013/14 Ongoing 2013-2014 ongoing In progress 2013-14 annually	CT/MS/DD

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
Action 3 continued			Continue strong working links and financial support to health schools and pre-school schemes	Number of staff trained to contribute to improve child oral health (nutrition, smoking, alcohol, breast feeding)	2013-14 annually as budget permits	
			Engage with head teachers to improve knowledge and understanding the programme	Meetings with head teachers groups across ABMU. Number of schools participating	2013-2014	
			Strengthened working with GDPs and LDC	Increased knowledge and awareness of the programme, consistent messages and practice. Referrals to CDS	2014-2018	
			Provision of training for health professionals including Health Visitors, school nurses, community drug and alcohol teams	Numbers attending training/consistent messages and practice	2014-2018	
			Contribute to the objectives of the HB obesity strategic delivery plan and extend input into community programmes and initiatives and work programmes e.g. Community First, Big Lottery, third sector organisations	D2S embedded in wider health initiatives/programmes	2014-2018	

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
Action 3 continued			CDS staff trained and involved in health promotion initiatives including smoking cessation and healthy eating advice. Work with GDPs and LDC to agree prevention and care pathway for high risk children following general anaesthetic for caries extractions	Contacts with patients and advice given recorded in patient notes. Patient satisfaction surveys Reduction in number of GA and repeat GA	2014-2018 2014 - 2018	
4. 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. 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 (page 14).	Evidence of (i) cross border discussions on oral cancer services and (ii) liaison with Head and Neck Cancer National Steering Group. Cancer Delivery Plans include details on addressing oral cancer. Full participation in National Head and Neck Cancer Audit as required under the NCAORP. Long term outcome: reduction in the percentage of oral cancer patients presenting at stage 3 or 4 and an increase in the percentage of patients presenting with Stage 1 or 2.	Continue to deliver effective, evidence based audited services with links where necessary to Hywel Dda and Cardiff and Vale Health Boards. Local reporting and benchmarking against the national audit	Review of current arrangements. Ongoing review as and when necessary of managed system for USC referrals Weekly ABMU Cancer performance meetings held	Reconstitution of Head and Neck national group. Timely management of USCs Effective communication of meeting outcomes to teams	2014-2015 Ongoing Ongoing	KP

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
5. Use the recommendations from the Special Care Dentistry Implementation Plan in ensuring that the needs of all vulnerable groups are addressed (page 15).	Regionally agreed referral and care pathways are in place for patients who require advice from, or treatment in, specialist dental services. WG will review LOHPs to ensure the recommendations have been taken into account in developing services for people with special needs.	Development of regionally agreed referral and care pathways through ABMU and Hywel Dda Health Board Special Care Dentistry MCN	Establish MCN in Special Care Dentistry for ABMU and Hywel Dda HB's. Determine SCD provision in ABMU and HD HB's and available workforce. Establish clear referral and acceptance criteria for SCD. Establish referral and care pathways and publish pathways. Improved SCD GA list facility. Improved availability of conscious sedation. Support for Mouth care for Adults in Hospital Programme. SCD data collection. CD workforce development. Improved links with SCD patient support groups.	MCN meetings and action points. TOR's Service specifications available. Referral and acceptance criteria available. BRONJ and radiotherapy pathways. Bariatric patient pathway. Improved service operational. Sedation referrals. Transmucosal techniques used. Enhanced clinical support available. Data collection for SCD referrals and patients seen. Improved training in SCD available. Involvement in MCN	2013-14 2013-14 2013-14 2014-15 2014-15 2014-15 2014-15 2015-16 2015-16 2015-16	DD/JO/LD Directorate

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
Action 5 continued			SCD joint clinic in Hywel Dda Integrated DDC policy in ABMU HB Development of Dentists with Enhanced Skills in SCD Clinical attachments in SCD Training posts in SCD	Participation in joint SCD clinics in Hywel Dda Policy in operation DES in SCD and DDC Attachments with CDS and/or HDS Posts in place	2016-2017 2016-2017 2017-2018 2017-2018 2017-2018	
6. Following recommendations by the National Assembly Children and Young People Committee collect annual data on the number of children who receive dental treatment under GA (p 36).	Data collated and reported on a quarterly basis to the Board / responsible Committee on numbers of children receiving dental treatment under GA. Each HB will be required to complete an annual return to WG for this issue.	Referral management process in place for child GA referrals and new service model in place Quarterly submission to DSPG of referral and outcome activity Annual review of service including clinical audit Annual report to Board Annual submission to WG delivered	Implement a new referral management process Establish regular data collection for consideration at DSPG & DCGC Finalisation of the service SLA Implementation of a revised service model that is fit for purpose; which is reviewed and adjusted to meet the needs of the population.	Development of a robust service that is able to meet the needs of the children accessing their service ensuring that their best long term interests are considered and that any risk to them is minimised.	August 2013 April 2014 April 2014 July 2014	RB/SW

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
7. 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 (page 28).	Data collated and reported on a quarterly basis to the Board / responsible Committee on waiting lists and times for vulnerable people who require dental treatment under GA. Patients do not wait longer than WG waiting time guidelines.	A robust system for collecting and reporting data on patient referral for treatment UGA and waiting list times. Examine compliance with WG guidance on waiting times. Identification of patients waiting more than the advised waiting time limit. Facilitation of waiting list management times. Improved compliance with the Learning Disability Implementation Pathway.	Designated special care GA list to move to POW. Data collection system and data entry. Reporting system developed. Improved compliance with the Learning Disability Implementation Pathway. GA waiting list down to 3 months over 5 years	Improved SCD GA facilities and designated anaesthetic support. Improved patient flow on SCD GA pathway. 3 patients/session Reduced waiting times. Improved emergency admissions onto list. Numbers of patients referred to Special Care GA list. Areas referred from and by whom. Times on the waiting list. Improved compliance with WG waiting time guidelines. Full compliance with the Learning Disability Implementation Pathway. Time on waiting list	2013-14 2013-14 2014-15 2014-15 2013-14 2013-14 2014-15 2015-16 2017-18	DD/JO

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
8. Work together to develop regionally agreed referral and care pathways which will promote efficient patient care and better working across GDS, CDS and HDS (page 30).	Action is taken to identify areas where there is limited access to both primary and secondary NHS dental services and to improve access where there are localised problems (access includes geographical / specialist services / provision for children and vulnerable groups). There is effective and proper use of ring-fenced dental budgets against the specific services to which they are allocated.	To have an established single point of access for all dental referrals across GDS/CDS/HDS; with a review of existing service models to ensure patient pathways are streamlined and alternative methods of services delivery are considered and where appropriate piloted.	Agreed referral guidelines and templates for all dental sub-specialities. Establishment of a single point of access for all dental referrals Review of existing service models where there are blockages affecting delivery of patient care. Consideration of alternative models of care with DwES's/primary/community services Review capacity at PTRC	Development of effective patient pathways that enable the patient to be seen by the right service provider in the most appropriate care setting.		SW/CR/ PG

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
9. 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 (page 13).	Collect the number and percentage of primary care dental team members who have received training in risks for patients associated with smoking and alcohol. Identify the number and percentage of primary care dental team members who have received core training in recognition of oral cancer, understanding associated risks factors and local referral pathways.	To have developed robust links with PGDME and to ensure that CPD is supported appropriately.	Data collected from PGMDE Local training in oral cancer awareness for GDPs and DCPs	Increased levels of training on a local level for dentists and their teams to participate in.	August 2013 November 2013	Localities
10. Work with PGMDE to ensure that the dental actions contained within the Tobacco Control Action Plan (TCAP) are taken forward (page 13).	WG will seek assurance that this is being achieved.	To have developed robust relationships with PGDME to gain a better understanding of the training available and the attendance rates; to have an increased number of dentists who have undertaken brief intervention training	Work with PGDME to understand the numbers of dentists who have undertaken brief intervention training Provide training on an ABMU wide basis linked to PGDME to ensure the increase in numbers of dentists who have received training in brief intervention Include a review of smoking cessation advice in the annual contract monitoring visits	An increased number of dentists providing brief intervention therapy and an overall increase in the numbers of patients who stop smoking and remain smoke free.	August 2013 October 2014	Localities

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
11. Take account of and participate in the 1000 Lives Plus programme to Improve Mouth Care for Adult Patients in Hospital (page 16).	Participation in 1000 Lives Plus programme to Improve Mouth Care for Adult Patients in Hospital as evidenced by active mini collaborative in place, and data reported to dental programme manager.	Full implementation of 1000 Lives Plus Programme 'Improving Mouth Care for Adult Patients in Hospital' into identified priority areas.	Identification of priority hospital wards. Identification of Oral Health Champions. Implementation and delivery of training for Oral Champions. Mouth care processes implemented in nurse care metrics. Health board spread plan identified by executive team. Implementation of electronic learning programme to support training. Development of CDS to support programme.	Evidence of wards programme implementation. Number of Oral Health Champions. Number of staff trained in evidenced based oral health care. Data input onto nurse metrics. Evidence of health board spread plan. Number of staff accessing electronic learning training. CDS staff accessing electronic learning programme.	2013 – 2014 2013 – 2014 2014 – 2015 2014 – 2015 2014 – 2015 2016 – 2018 2013 – 2018 on-going programme	DD

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
12. Include issues relating to primary dental care as part of their annual primary care reporting process, and include them in their Annual Quality Statement (page 21).	WG will seek assurance that actions in the Quality Delivery Plan (QDP) are being addressed in relation to dentistry and dental patients, including Action 5 of the QDP on measuring patient satisfaction.	That members of the Board are fully briefed and aware of issues relating to primary care dental services and their interface with community and secondary care, and that these are included in the Annual Quality Statement where appropriate.	Board approval of the ABMU Health Board Oral Health Plan Reports on achievement of actions to Dental Strategy and Planning Group Review of the actions within the QDP to ensure that dental services are included.	Joined up plans and communication across the Health Board on the delivery of effective and efficient dental services. Ensuring inclusion in all major plans for service delivery.	November 2013 Ongoing	Localities
13. Work with 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 (page 34).	An NHS GDS dental team occupational health service is in place, has been agreed with the LDC and publicised to GDS dental teams.	To have an effective and efficient direct access occupational health service in place for all GDPs and their associated clinical staff	Agreement of a Service Level Agreement within the Health Board for the delivery of the service Advising GDPs of the service availability and of the Well Being at Work service	A fully functioning, direct access occupational health service running across multiple sites in ABMU	September 2013 November 2013	Localities

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
14. 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 (page 31).	WG will seek assurance from CDS services that they are working appropriately with local nurse education providers, and that the training requirements of Health Care Support Workers have been identified and addressed.	Development and use of an evidenced based oral health education framework for: 1. Pre – registered nurses 2. Health Care Support Workers 3. Other appropriate staff groups identified for inclusion into training	*Pre-registered nurses* Develop 1st, 2nd and 3rd year pre – registered nurse framework to comply with Nurse Curriculum. Present, test and evaluate using Quality Improvement methodology. Review framework for service development. Alignment and integration of oral health education policy for pre-registered nurses *Health Care Support Workers* Establish and develop oral health education framework to comply with Clinical Care Competency for Health Care Support Workers Deliver, test and continuous evaluation of framework for best practice Review framework for service development. Alignment and integration of oral health education policy for Health Care Support Workers	Evidence of framework for pre-registered nurses. Number of pre-registered nurses trained in evidenced based oral health care. Service delivery policy and specification in operation. Improved Oral Health Education Policy for pre-registered nurses. Evidence of educational framework for Health Care Support Workers. Number of Health Care Support Workers trained in evidenced based oral health care. Service delivery policy and specification in operation. Improved Oral Health Education Policy for Health Care Support	2013 – 2014 2013 – 2014 – 1st year students 2014 – 2015 – 1st & 2nd year students 2015 – 2016 – 1st, 2nd & 3rd year students 2016 - 2017 2017 – 2018 2013 – 2014 2013 – 2014 – year 1	DD

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
Action 14 continued				Workers	2014-15 year 2 2015-16 year 3	
			Deliver, test and continuous evaluation of framework for best practice	Number of HCSWs trained in evidence based oral health care		
			Review framework for service development	Service delivery policy and specification in operation	2016-17	
			Alignment and integration of oral health education policy for HCSWs	Improved oral health education policy for HCSWs	2017-18	
			CDS involvement in programme	Number and skill mix of CDS staff to deliver the programmes	2013-18 ongoing programme	
15. Ensure that high risk groups are targeted by national campaigns (e.g. Mouth Cancer Awareness and National Smile months (page 13).	WG will seek assurance that LHBs take a proactive approach to target local high risk groups in suitable national campaigns e.g. clarification of plans to link National Smile Month (May/June) with delivery of Designed to Smile and Oral Cancer Awareness month (October).	That a more proactive approach is taken to the awareness raising of key oral health messages linked to oral health campaigns	Ensuring that national campaigns are publicised via the Health Board Communications Team	Greater public awareness of oral health campaigns and how they link to local initiatives and dental services.	Ongoing	Localities PHW
			That links are made between national campaigns and local awareness raising		Ongoing	
			Identify resources from ring-fenced budgets to support all relevant health promotion campaigns		Ongoing	

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
16. 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 (page 15).	WG will seek assurance that this is being taken forward and evidence as to how partnership arrangements are being/will be developed, together with the relevant timeframes.					Nursing
17. Plans must 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; - monitor "splitting" courses of treatment; - work to the interim Guidance of NHS Orthodontics in Primary Care, particularly during contract renewal (pages 41 and 27).	WG will seek assurance that LOHP commitments are progressed and achieved. HBs to ensure that providers of NHS orthodontic services have separate PDS agreements and established that staff are appropriately skilled and qualified. HBs should be mindful of advice of their local orthodontic Managed Clinical Network.	To have consistent and robust contract management arrangements across the three localities. Standardised agreed policies for the management of contractual issues Locality representation on all HB dental MCNs and working groups	Agreed timescales for mid-year reviews Agreed standard agenda for end of year reviews Regular dental team meetings	Standardised approach with seamless contract monitoring across the three localities ensuring a collaborative approach to the management of dental contracts and a seamless interface with community and secondary care dentistry.	Ongoing	Localities

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
18. Use BSDH guidelines in developing plans for the delivery of domiciliary care (page 26).	WG will seek assurance that the guidelines are used and a monitoring process is in place.	An integrated policy for Domiciliary Dental Care (DDC) across ABMU Health Board with a robust quality assurance mechanism and clinical governance process	Clear referral and acceptance criteria for DDC ABMU Health Board based on BSDH 2009. Designated DDC service providers in ABMUHB. Accepted patient referral pathways in DDC. Integrated DDC policy and clear guidelines for service provision based on BSDH 2009. Standards and clinical governance policy for DDC. Central referral system. Central referral system DDC service operational. Evaluation and robust monitoring mechanisms and QAS to evaluate provider compliance with recognised guidelines by BSDH 2009.	Criteria available. Provider list established. Funding established. Pathways developed. Policy document. Policy document. Single point of access for DDC referrals. Data on patient referrals/service provision. QAS. Patient satisfaction surveys.	2013-14 2014-15 2014-15 2014-15 2014-15 2015-16 2015-16 2016-17	DD/ Localities

Actions for Health Boards	WG expected outcome	HB expected outcome	The defined process to deliver the action in stages	Measurable outcomes	Timeline over 5 years	Lead
19. Develop alternative patterns of care e.g. increasing the specialist dental paediatric services and dental paediatric DwES (formerly known as DwSI) workforce, and building the capacity of alternative treatments such as sedation where feasible (page 28).	This action links with No's 5, 8 and 16 in terms of developing regionally agreed referral care pathways. Recognising that this action will require longer term planning, WG will seek assurance that plans are in place to identify and address local needs.	To have established alternative models of service delivery that include the use of DwES's in a number of speciality areas e.g. Endodontics and paediatric dental	Agreed model for delivery of endodontic DwES Pilot of Endo DwES model for 12 months Evaluation of Endo DwES model Continued investment into model if considered successful Discussions on developing the assessment process for child GA services Implementation of new model of child GA pathway Ongoing review of DwES model	A service model that operates across primary, community and secondary care utilising specialist skills as part of a managed clinical network response for the delivery of NHS dental services.	September 2013 April 2014 Jan/Feb 2014 April 2015 October 2013 January 2014 Ongoing	Localities
20. Develop clear plans on how residents will access specialist dental services in Primary Care (specialists/ DwES), the CDS and / or secondary care, and ensure an integrated approach to the delivery of these services (page 30).	This action links with No's 5, 8 and 16 in terms of developing regionally agreed referral care pathways. Recognising that this action will require longer term planning, WG will seek assurance that plans are in place to identify and address local needs		During contract negotiations with Local Authority care providers need to include oral health as a quality marker Referral guidelines and forms developed during 2013-14 for all dental sub specialties Establishment of a single point of access for all dental referrals across the Health Board to streamline systems and processes; links to in hours access, dental out of hours and domiciliary dental care.			Localities

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Referral Form for Children requiring treatment under General Anaesthesia or Conscious Sedation in Parkway Clinic

SECTION ONE: Patient Details

Patient Name:	Address:
Date of Birth:	
Contact Tel(s):	
e-mail:	Postcode:
School:	Parent/next of kin:
	Language spoken:

SECTION TWO: Referral Details

Name of Referrer	Practice Stamp (Address and Contact Tel):
Signature	
Date of referral:	
Has this patient been referred before for GA extractions and/or treatment?	Yes ☐ **If Yes**, please specify where and date No ☐

SECTION THREE: Reason for Referral

☐ Dental/needle phobic

☐ Special Needs patient

☐ Other

☐ Problems with LA (please detail below)

☐ Un co-operative

SECTION FOUR: Treatment Requested

☐ General Anaesthesia

☐ Conscious Sedation

Restorative:	
Extraction:	
Other treatment:	**Please specify:**

Presenting complaint / history of complaint

Medical History including allergies:	tick if N/A ☐

Medication:	tick if N/A ☐

Social History:

Special care requirements:	tick if N/A ☐

SECTION FIVE:

The risks of general anaesthesia and conscious sedation have been explained to me. Alternative treatments under sedation have also been explained		Signature of patient/guardian and date
I have been given /or offered oral health advice and treatment to support improved oral health e.g. fluoride varnish		Signature of patient/guardian and date
I have explained the risks of general anaesthesia to the patient and discussed alternatives (e.g. LA/ sedation)		Signature of referring dentist and date
Oral health advice and necessary interventions e.g. fluoride varnish have been/will be provided		Signature of referring dentist and date

To be completed by Parkway Clinic post treatment

☐ **Procedure undertaken under GA** ☐ **Procedure undertaken under conscious sedation**

Service Specification for Dentists Enhanced Skills (DwES) in Endodontics

Background & Introduction

Endodontics is concerned with the study of the form, function and health of, injuries to and diseases of the dental pulp and periradicular region, their prevention and treatment. The aetiology and diagnosis of dental pain and diseases are integral parts of endodontic practice. (European Society of Endodontology 1992).

ABMU Health Board is seeking to deliver the provision of molar and other endodontics through a Personal Dental Services Agreement for a pilot of one year to assess the feasibility of an integrated primary/secondary care service which will operate out of Port Talbot Resource Centre for two sessions each week. Nursing support and consumables will be provided within the department.

All referrals to the service will be triaged by clinicians within the Restorative Department as per the flowchart attached at *Appendix 1.*

Direct supervision of the dentists will not be provided however there will be opportunities for professional advice and opinion from an on-site consultant/specialist during the sessions. Continuing Professional Development (CPD) opportunities will be available through the Restorative Department.

Costings

Using the ABMU common UDA rate of £22.50 the following procedures will attract the associated number of UDAs:

- Molar endodontics 8 UDAs per completed case (£180)
- Other endodontics 4-5 UDAs per completed case (£90 - £112.50)

It is anticipated that each molar case will take three visits per patient and all other endodontics will generate two visits to complete the treatment.

Definition of a DES in Endodontics

A DES in endodontics is a primary care general dental practitioner who:

- Is able to demonstrate a continuing level of competence in their generalist activity
- Is able to demonstrate an agreed level of competence in endodontics
- Is contracted to the Health Board through a PDS agreement to manage a number of patients requiring endodontic treatment of moderate difficulty

Whilst not offering the same breadth of activity in terms of the complexity of cases treated; he/she will be required to practice to a standard consistent with that expected from established specialists who cover this area of clinical expertise.

Department of Health/Faculty of General Dental Practice (UK): *Guidelines for the appointment of Dentists with Specialist Interests (DwSIs) in Endodontics* (April 2006)

Competencies

A system of assessment will be put in place to assess each individual who expresses an interest in being considered as being locally recognised as a Dentist with Enhanced Skills in Endodontics.

All applicants will be required to submit:

a. A full curriculum vitae; which should contain information on the following:

- Details of primary qualification including date, university and state LDS/BDS or overseas equivalent
- Details of postgraduate qualifications held including clinical and non clinical. Include details of the awarding institute and date obtained
- Other education with details of when, where and qualifications(s) received; in particular any postgraduate training in clinical endodontics which has or is leading to a diploma or other qualification
- Employment history with details of posts and dates
- Clinical training and experience including observerships, attachments and other consultant-led training opportunities
- Further professional development in terms of courses attended with details of topic, nature of instruction, and learning outcomes
- Membership of professional bodies/specialist societies

Other information may include details of the following areas, but undue weight should not necessarily be given to these:

- Research activity
- Grants awarded with details of amount, funding body and study
- Teaching experience
- Prizes and awards

b. A reflective portfolio; which should contain the following:

- A reflection on previous education, training and employment that outlines knowledge and competencies achieved, range of clinical activities undertaken and profile of current practice.

- Evidence of performance in primary care setting through the submission of structured case reports that map against the competencies expected of a DES in endodontics (*Appendix 2*)

- Evidence of professional activities such as work with local dental committees, BDA etc.

- Testimonials from patients, colleagues and former employees

- Documented evidence of relevant audit either carried out personally or in association with others.

Process for assessment of competencies

The process will be an evaluation of the evidence presented in the applicant's reflective portfolio.

The evaluation will be undertaken by a local accreditation panel which will include:

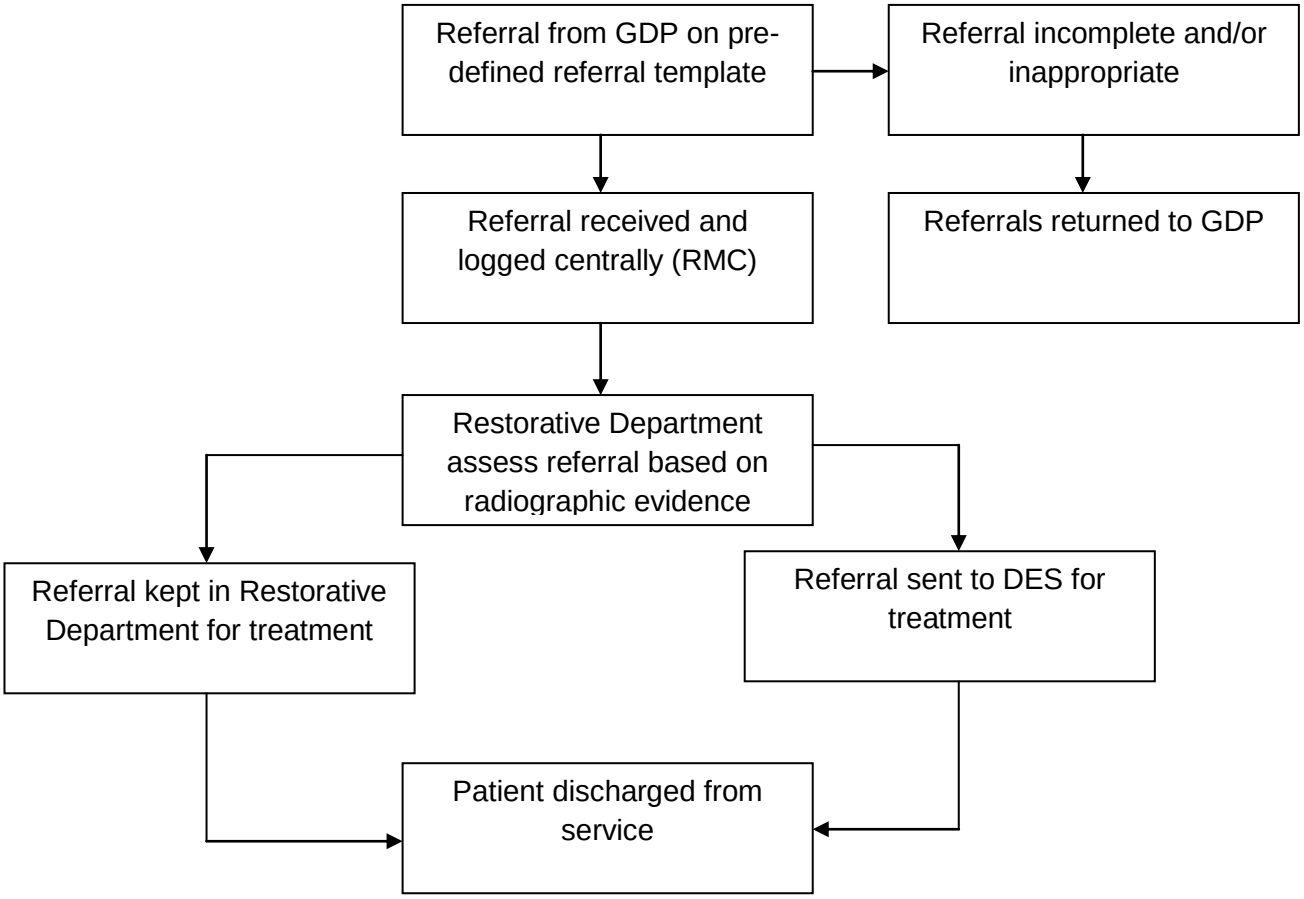
- Consultant(s) in Restorative Dentistry
- LDC representative
- Health Board representative(s)
- Dental Postgraduate Department

ABMU Health Board will interview all potential candidates prior to awarding any contractual agreements.

Appendix 1

Referral Management

It is anticipated that with the introduction of a DES model a new way of managing referrals to limit the patient waiting time would also be introduced.



Specification Required for Directly Contracted General Anaesthesia/Conscious Sedation Services for Children

1. Aims

To ensure that ABMU LHB's contracted dental services for children (3 - 17) requiring care under general anaesthetic is driven by the children's' needs, their best long term interests, and minimizes risks to them as individuals.

To ensure care is consistent with relevant national and ABMU guidelines and policies and recognised best practice and is provided:

- in a safe environment
- by individuals who are competent to deliver the needs of the child and assess their best long term interests

2. Underpinning Principles and Objectives of the Service

2.1 To provide a service that integrates a dental examination, referral, clinical assessment and consent prior to the appointment for treatment all ASA (American Society of Anaesthetists) I or II cases.

2.2 All children referred into the service for extractions or extractions and limited restorative treatment should be free from dental disease following their treatment in this service and should not require further immediate treatment, except in *exceptional* cases.

2.3 The referrer must confirm that appropriate oral health promotion advice and preventative treatment has/or will be given in line with agreed best practice such as in *Delivering Better Oral Health: An evidence-based toolkit for prevention – second edition.*

2.4 Each case must be considered on its own merits as to the ability and suitability to provide care under general anaesthesia, conscious sedation or behavioural management with local anaesthesia.

2.5 Services will be commissioned from either a NHS hospital or an organisation with premises registered under the Registered Homes Act 1984 as amended by Section 39 of the Care Standards Act 2000.

3. Overview of Service Pathway

3.1 In most cases the patient pathway will start with a referral from a general dental practitioner (GDP) who has appropriately used the standardised referral form (*Appendix 1*). All referrals will be collated at a central point, recorded and then passed on to the most appropriate provider within the agreed service pathway.

3.2 The service provider will engage with other providers involved in the care pathway to provide a seamless and integrated service.

3.3 The service provider must offer an assessment to clinically assess the patient and to ensure that the patient is fit for GA or other appropriate treatment method, and that the parents/guardians are fully aware of the treatment options and the agreed treatment plan. For the majority of cases this part of the pathway should not coincide with the start date for the treatment. This provides a "cooling off" period prior to the treatment taking place and must be factored into the service model except in urgent cases.

3.4 All urgent patients e.g. with an acute and significant dental infection and associated symptoms, requiring extraction under GA/conscious sedation should be offered an appointment for assessment and treatment within 48 hours of the date of receipt of the referral. All elective patients should be offered an assessment and a date for start of treatment within 10 working days.

3.5 Where treatment under conventional local anaesthetic is considered inappropriate or has failed the following criteria may be used as indicators to consider a paediatric patient for urgent dental treatment under the service:

- Significant and worsening ora-facial swelling is present and where systemic illness or pyrexia may also be evident
- Severe acute dental pain not controlled by over the counter medication

4. Acceptance Criteria

The Provider will ensure that the service is provided in strict adherence to the agreed LHB policies on the relevant care pathways.

4.1 Cases Suitable for GA treatment:

- ASA 1 or 2
- BMI less than 30
- Single or multiple extractions in children aged 3 to 17 years of age where treatment under local anaesthetic or LA with conscious sedation has failed, is impractical, is not in the best interest of the child or is contra-indicated.
- Acute and significant soft tissue swelling requiring removal of the infected tooth/teeth under a GA
- Surgical drainage of an acute infected swelling

- Simple direct restorative treatments in permanent teeth in limited cases where it is considered that the tooth following restoration would have a good long term prognosis and a GA is necessary for other dental care.
- Surgical exposure of erupted or partially erupted tooth/teeth under the specific and explicit prescription of a specialist orthodontist and where the complexity of the case is consistent with the service model.

Cases Suitable for CS treatment:

Children assessed as amenable to conscious sedation including those who are needle phobic and where the following care is required:

- simple restorative treatment excluding endodontics
- simple tooth extractions limited to a single tooth per quadrant

Cases Not Suitable for Treatment by the GA Service Include:

- Orthodontic extractions of primary canines and secondary pre molars
- Complex surgical extractions
- Complex restorative care such as indirect restorations and endodontic treatment.

5. Referral Forms

Referral forms will be expected to be appropriately completed by the referring GDP. The service provider will be expected to return an incomplete referral letter/form with a request for the missing information.

6. Clinical Records and Investigations

- Standard dental examination including extra oral and intra-oral examination and soft tissue assessment will be carried out by the referrer. This will involve recording a full dental charting using a grid.
- Pulpally involved and unrestorable teeth should be clearly identified in the clinical record.
- The service provider must also carry out a full dental examination to confirm the referrer's diagnosis etc.
- Appropriate, valid, written consent must be sought prior to the commencement of treatment.

Radiographs

- To ensure that all carious teeth are identified and the patient is appropriately treatment planned; radiographs are usually required for the majority of co-operative patients.
- The referrer should provide appropriate radiographs, which should only be obtained after a medical history has been taken and a clinical examination has been performed. These should be provided with the completed referral form
- A radiographic report must be written in all associated clinical records

- DPTs are required when first permanent molars are being extracted, otherwise periapical radiographs are appropriate for extractions.
- Bitewing radiographs (or lateral obliques in younger patients) are also indicated unless open contacts allow direct view of all proximal surfaces to assess the caries status of all patients prior to any referral into the service or construction of a definitive treatment plan.

Medical History

- It is the responsibility of the referring clinician to supply a full medical history for each patient at the time of referral, but this must be checked by the service provider
- The service provider will ensure that the dental operator and other staff as appropriate also assess the patient's medical history at the time of assessment
- The patients height and weight will be recorded and their BMI calculated.

Treatment Planning

- If a child is to be referred all pulpally involved and unrestorable teeth will be planned for extraction
- In teeth that are to be retained, all dentinal caries must be removed and the relevant teeth restored by the referrer prior to the GA taking place unless it is intended and agreed that this care will be provided under a course of CS by the provider or as part of an agreed integrated treatment plan.
- At the end of any episode of care under GA or CS within the service, the child should be caries free and all pulpally involved teeth should have been extracted.

Exceptions

- Arrested caries in primary incisors may be left where the tooth is close to exfoliation. The parents/guardians need to be advised of the risk of leaving the tooth untreated.
- Teeth with enamel white spot lesions may be left. The parents/guardians should be given advice on how to prevent caries.

Orthodontic Extractions

- If a permanent molar is to be considered for extraction under general anaesthesia or conscious sedation, the orthodontic implications should be considered, and the need for loss of further teeth discussed with the child and parents/guardians.

- If the decision is not straightforward an orthodontic/paediatric specialist opinion should be sought prior to the finalisation of the treatment plan.

Records and Audit

All records pertaining to treatment plans, investigation, medical history forms, GA risk and referral forms should be stored together in the patients file and entered onto computerised records as appropriate.

Audit should be undertaken on forty randomly selected patient records on a quarterly basis for the first 12 months of the contract to assess the degree of compliance with the service specification. The aim will be to move to bi-annual audits for subsequent years.

7. Explanation of risk and Consent

The pre-anaesthetic/operative assessment provides the opportunity for explanation of the pathway of a child through the GA/conscious sedation service and of the risks the procedures carry.

Once the decision has been taken to use GA, it should be explained to the parent(s)/guardian(s) that the anaesthetic is not administered by the dentist, but by a consultant anaesthetist who has undergone specialist training in paediatric anaesthesia.

7.1 It should be explained that the procedure will be undertaken in an operating theatre with a team trained in the care of children.

7.2 The potentially serious nature of the treatment should be clearly explained to the parent(s)/guardian(s) and where appropriate, the patient.

- Specific written consent must be obtained at the time of treatment planning and updated on the day of treatment.
- Care should be taken to ensure that the parent/guardian understands whether primary, permanent or both teeth are included in the treatment plan.
- It is good practice to obtain written consent from the child where it is thought that they have sufficient understanding and emotional maturity.
- Interpreting services must be used if it is through that the parent(s)/guardian(s) may not understand the nature of the proposed treatment. This should be further reinforced by asking that the parent read the consent form carefully with an interpreter or through the use of Language Line, who is able to explain the medical/dental terms in the parent/guardian's own language. It is not uncommon for a young child to have better English language skills than their parents however in these circumstances it is not acceptable to use the child as an interpreter.
- Blanket consent such as "extractions necessary" is totally inappropriate except where it is agreed that an examination under anaesthesia (EUA) is necessary before treatment planning can be completed. It should be explained that the decision about the number of extractions can sometimes only be made when the child is anaesthetised and that this decision is left to the judgement of the operating clinician, if agreement cannot be achieved, further referral to a colleague should be offered for specialist advice.

8. Post-op discharge patient information

- Written post operative advice must be given to the child and/or parent(s)/guardian(s)
- A discharge letter back to the referring GDP and GP must be made within 24 hours
- It is the responsibility of the referring GDP to undertake a post operative review and to provide oral health promotion advice and preventive treatment.

9. Workforce

The provider must engage or employ appropriately qualified and registered staff to provide routine general dental services under GA and CS.

Specific requirements of the staff employed:-

- Anaesthetists should be on the anaesthetic specialist register of the General Medical Council as per Welsh Health Circular 2001 (056)
- Dental operators should have the necessary skills to treatment plan and deliver the appropriate care for this group of patients. They should be able to respond to any potential changes in treatment plan whilst the child is anaesthetised or under conscious sedation.
- Dental operators should have access to appropriate dental surgery facilities to undertake examinations and treatment planning.
- The anaesthetist and the dentist should each have appropriately trained and competent dedicated DCPs who are able to support treatment under GA and Conscious Sedation
- All service staff must be trained and certified in Advanced Life Support (ALS). All clinical staff must be skilled and trained in Advanced Paediatric Life Support (APLS) or (PALS), in addition to Advanced Life Support
- All members of the service team must practice resuscitation together at regular intervals, consistent with Resuscitation Council (UK) Guidance for Team Training and the practice must maintain a record of this training
- All staff involved in direct patient care should be fully compliant with the requirements of their regulatory body extent at the time
- All staff must be trained specifically as a team with the necessary skills, experience, drugs and equipment to manage life-threatening situations. Service staff must be trained and equipped to the current standards to deal with emergencies or collapse of a patient.

10. Performance Management, Reporting and Data Requirements

Performance management reports using the template attached at *Appendix 2* will be required to be submitted quarterly with an annual review of the service. Monitoring of the service is required to ensure that a quality service is provided which conforms to current clinical governance guidelines and the agreed terms of the

specification and contract. Data collected will also be used to inform future service planning.

11. Clinical Governance, Quality & Safety

11.1 The Provider is expected to have clear policies, practices and procedures for clinical governance in line with the requirements of the Health Inspectorate Wales, Welsh Government, the LHB and relevant professional guidance and best practice.

11.2 The core standards are mandatory requirements for all organisations providing NHS care e.g. Health Care Standards for Wales. The Provider must be in a position to demonstrate that it meets any or all the relevant core standards if requested to do so including information governance to ensure the safety and security of patient information and compliance with the Data Protection Act.

The underpinning guidance for the service is:-

1. Guidelines For The Management Of Children Referred For Dental Extractions under General Anaesthesia
2. UK National Clinical Guidelines in Paediatric Dentistry. Guideline for the Use of General Anaesthesia (GA) in Paediatric Dentistry, 2008.
3. Maintaining Standards; Guidance to Dentists on Professional and Personal conduct – General Anaesthesia and Resuscitation (November 1998 & May 1999)
4. The Royal College of Anaesthetists Standards and Guidelines for General Anaesthesia for Dentistry (February 1999)
5. A Conscious Decision – A review of the use of general anaesthesia and conscious sedation in primary dental care CMO/CDO England Report (1999)
6. Dental General Anaesthesia – Report of the Clinical Standards Advisory Group Committee on General Anaesthesia for Dentistry (July 1995)
7. General Anaesthesia for Dental Treatment – amendment to the National Health Services GDS Regulations 1992 WHC (01) 39
8. Private Provision of General Anaesthesia for Dental Treatment WHC (2001) 56
9. General Anaesthesia for Dental Treatment in a Hospital Setting with facilities for the provision of critical care (WHC) (2001) 077
10. Conscious Sedation In The Provision of Dental Care. Report of an Expert Group on Sedation for Dentistry. Commissioned by the Department of Health 2003.
11. Conscious sedation in Dentistry – Dental Clinical Guidance. 2nd Edition. Scottish Dental Clinical Effectiveness Programme, 2012.
12. Welsh Health Circular 2001 (056)

Review

The service and service specification will normally be subject to an annual review, or more frequently if appropriate.