Local Oral Health Plan

2013 - 2018

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1. Health Boards will develop a Local Oral Health Plan to address the oral health needs of their 10

 residents and clearly describe how they will ensure good governance in commissioning

and delivery of all dental services.

2. Health Boards need to review processes to confirm they have adequate measures in place 17

 to ensure the provision of dental professional advice and access to a multi- professional

advisory structure, including that of a consultant/specialist in Dental Public Health Clinical

engagement. Partnership working and the development of integrated care will be

important principles of the new approach.

3. Health Boards should also focus on delivery, with the balance of care shifting away from 17

 secondary care towards primary care, or other non hospital locations wherever possible.

Health Boards should ensure that financial resources from both ring fenced and non

ring fenced allocations deliver effective and efficient services and that one off initiatives are

based upon need and are evidence based.

4. Health Boards will be expected to work with dentists and their teams and all other relevant 18

 stakeholders to develop and support delivery of Local Oral Health Plans.

PREVENTION 20

5. Health Boards will ensure the continued participation in evidence based community oral health 20

 promotion programmes particularly the Designed to Smile and Healthy Schools programmes.

DELIVERING EFFICIENT AND EFFECTIVE CARE 24

6. Health Boards will liaise with the Cancer Networks and the Head and Neck Cancer National 24

 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.

7. Health Boards should use the recommendations from the Special Care Dentistry 25

 Implementation Plan in ensuring that the needs of all vulnerable groups are addressed.

8. Health Boards following recommendations by the National Assembly Children and Young 29

 People Committee to collect annual data on the number of children who receive dental

treatment under General Anaesthesia (GA).

9. Health Boards must keep up to date information on waiting lists for vulnerable people who 31

 require dental treatment under GA and ensure that patients do not wait longer than

Welsh Government guidelines.

10. Health Boards must work together to develop regionally agreed referral and care 32

 pathways which will promote efficient patient care and better working across the

General Dental Service, Community Dental Service and Hospital Dental Service.

IMPROVING QUALITY & SAFETY 33

11. Health Boards must work with Postgraduate Medical and Dental Education (PGMDE) 33

 to ensure dental teams should 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.

12. Health Boards must work with PGMDE to ensure that the dental actions contained within the 33

 Tobacco Control Action Plan (TCAP) are taken forward.

13. Health Boards should take account of and participate in the 1000 Lives Plus programme to 35

 Improve Mouth Care for Adult Patients in Hospital.

14. Health Boards must include issues relating to primary dental care as part of their annual 37

 primary care reporting process and include them in their Annual Quality Statement.

LOHP must contain specific actions regarding the management of the current General

Dental Service 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

15. Health Boards must work with LDCs to review the occupational support they provide and 41

 develop an occupational health programme for all members of the dental team in general

dental practice.

16. Health Boards will support the Community Dental Service (CDS) to work with educational 41

 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.

17. Welsh Government, Public Health Wales (PHW) and Health Boards should ensure that high 42

 risk groups are targeted by national campaigns (e.g. Mouth Cancer Awareness and National

Smile months).

18. LOHP must include, in partnership with the Local Authority and the Third Sector, ensure oral 43

 care is integrated into the general health and social care plans/ pathways of patients with

complex medical and social problems.

19. LOHP must include use British Society of Disability and Oral Health (BSDH) guidelines in 44

 developing plans for the delivery of domiciliary services.

20. Develop alternative patterns of care e.g. increasing the specialist dental paediatric services 46

 and Dentists with Enhanced Skills (DwES) workforce and building the capacity of alternative

treatments such as sedation where feasible.

21. Develop clear plans on how residents will access specialist dental services in Primary Care 46

 (specialists/ DwES), the CDS and / or secondary care and ensure an integrated approach to

the delivery of these services.

22. Through their CDS, Health Boards should ensure: 49

· provision of facilities for a full range of treatment to children who have

experienced difficulty in obtaining primary care dental services, or for whom there is

evidence they would not otherwise seek treatment from such services

· provision of facilities for a full range of treatment to children and adults who,

due to their special circumstances, require special care dentistry and/or have

experienced difficulty in obtaining treatment from other services, or would not have

otherwise sought treatment from other services.

Abbreviations 53

APPENDIX 1 Précis of challenges and actions identified against which

progress will be measured.

APPENDIX 2 Oral Health Strategy Group Structure and Terms of Reference

APPENDIX 3 Oral Health Profile 2012

APPENDIX 4 Oral Health Profile 2013

APPENDIX 5 Business Services Authority Report

APPENDIX 6 Current Postgraduate Calendars

APPENDIX 7 Oral Health Needs Assessment

[Appendices available on Health Board members’ sharepoint site]

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FOREWORD BY ACTING CHIEF EXECUTIVE

‘Together for Health: A National Oral Health Plan for Wales’ provides a welcome steer for

improving the oral health of the people of Wales.

Professor Damien Walmsley, Scientific Adviser to the British Dental Association,

highlighted the unacceptable, growing chasm in the UK between those with good and

those with poor oral health. He stated, "There has been a significant improvement in the

nation's overall oral health over the last 30 years but despite that we still see a huge

disparity that is all-too-often related to social deprivation. It is completely unacceptable

that in Britain, in 2009, such a wide gap should exist." This statement is as relevant in

2013 as it was then.

The challenges facing North Wales relate largely to addressing these oral health

inequalities especially in the child and vulnerable adult populations within the unique

geography of the area.

The Chief Medical Officer for Wales has stressed that preventing disease and illness is

key to a healthy future generation and this message is reinforced by the Chief Dental

Officer in the foreword to the National Oral Health Plan stating that ‘Prevention is at the

core of the Plan’.

Additionally, a number of initiatives (Gwên am Byth, Child and Adult Learning Disability

Programmes) targeting some of our most vulnerable groups have already been

implemented in North Wales and we are proud that these have been cited in the National

Oral Health Plan as examples of good practice. We do however, recognise that access

to these programmes is not uniform across all Unitary Authority areas and our Local Oral

Health Plan seeks to address these inequalities. Every opportunity will need to be

pursued to extend evidence based good practice to ensure that there is equality in

access to all vulnerable people across North Wales. In these challenging times the focus

has also been on improving access to services cognisant of Welsh Government’s

strategy to shift the balance of care from Secondary to Primary Care where this is

feasible.

The establishment of our Oral Health Strategy Group with representation from all

branches of dentistry has facilitated an integrated strategic approach in the formulation of

this Local Oral Health Plan to achieve the aim of the National Oral Health Plan “…to

improve the oral health of the people of Wales so everyone can benefit from better oral

health throughout their whole life span.”

Signed

Geoff Lang

Acting Chief Executive

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INTRODUCTION

‘Together for Health: A National Oral Health Plan for Wales’ (NOHP) was issued by

Welsh Government following its launch by the Chief Dental Officer (CDO) on 18 March

2013.

The document identifies the main oral health challenges and sets out a five year plan to

improve the oral health of the people of Wales and requires Local Health Boards (LHBs)

to produce their own Local Oral Health Plans (LOHPs) to address the needs of their

populations. To assist with this exercise guidance has been issued identifying the

information which is expected to be included in the LOHP and the actions required by

LHBs.

Following an introduction on the demographic factors relating to North Wales, the LOHP

addresses each of the actions LHBs are required to address looking at the current

position, recognising where progress is required and identifying some short and medium

term goals. These will be addressed under the four headings identified within the NOHP:

· Key Strategic Actions

· Prevention

· Delivering Efficient and Effective Care

· Improving Quality and Safety

This LOHP is seen as an evolving document which will be revisited annually and

amended as appropriate. Appendix 1 is a précis of the challenges and actions identified

against which progress will be measured.

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DEMOGRAPHY

Mainly rural in character, North Wales is a geographical area of approximately 2,400

square miles (6,200 square kilometres) and a total resident population of approximately

682,000. It is anticipated that by 2026 the population will increase to 730,000 and by

2031 to 754,000. There is a significant concentration of the population along the

northern coastal strip (many of the coastal towns being popular tourist destinations which

can significantly increase the resident population during the summer months) and a few

inland towns; the main centres of population being located in the East. The region

consists of six Unitary Authorities (UA) (Figure 1) and 14 localities (Figure 2) as illustrated

below:

Figure 1: North Wales Unitary Authorities

Figure 2: Map of North Wales identifying localities

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North West Wales

Anglesey (Ynys Môn):

Located to the North West of the region, the Isle of Anglesey is connected to the

mainland by two bridges (the Menai Suspension Bridge and Britannia Bridge). It is a

rural county, consisting of several small scattered towns, villages and hamlets, its main

population centres are at Holyhead, LLangefni, Benllech, Menai Bridge, Amlwch and

Beaumaris. The county has a total area of 275 square miles (714 square kilometres).

The total population is approximately 69,000 (250 residents per sq/m or 96 per sq/km).

Approximately 57% of the resident population are Welsh speaking (fluent or able to

conduct a conversation in Welsh).

Gwynedd:

The county of Gwynedd is located on the West of North Wales and is by far the largest

geographical area. Both the Lleyn Peninsula and most of the Snowdonia National Park

fall within the county. Gwynedd is the second largest area in Wales but also the most

sparsely populated. Mostly rural in character, the population is spread across the main

towns of Bangor (a University town) and Caernarfon, as well as many smaller towns,

villages and hamlets. Gwynedd has an area of 983 square miles (2548 square

kilometres). The total population is approximately 119,000 (121 per sq/m or 47 per

sq/km). Approximately 65% of the population are Welsh speaking.

Central North Wales

Conwy (County Borough):

Largely rural in character its main population centres are the coastal towns of Llandudno,

Colwyn Bay and Conwy and inland, Llandudno Junction, Llanrwst, Betws-y-Coed

(another popular tourist destination), Abergele, Penmaenmawr and Llanfairfechan. The

geographic area is 436 square miles (1130 square kilometres). The total population is

approximately 114,000 (261 residents per sq/m or 100 per sq/km) with 27% of the

population speaking Welsh.

Denbighshire:

A rural county, with large areas of hilly moorland, the population is spread across the

main coastal towns of Rhyl and Prestatyn (popular tourist destinations) and inland at

Denbigh, Ruthin and St Asaph. Denbighshire covers 324 square miles (838 sq/km). The

total population is approximately 97,000 (299 per sq/m or 115 per sq/km). Approximately

24% of the population being Welsh speaking.

North East Wales

Flintshire:

Located to the East of North Wales and bordering on England, Flintshire is affected by

socio/economic activities of the Cheshire and North West region. Urban development is

concentrated in the coastal areas on the Dee Estuary, which has traditionally been a

location for industrial development.

In recent years the Deeside Industrial Park has been expanded and the county has

become a significant focus for sub-regional employment generation; the Air Bus Factory

in Broughton being one of the largest employers in Wales. Lower house prices attract

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families and individuals from across the border with England, which has contributed to

the expansion of the population.

Over several years there has been also been a significant influx of eastern Europeans

(particularly from Poland) to the area. Away from the urbanised coastal strip, the county

is rural in character, with market towns and village communities situated in rolling

countryside. The main towns are Mold, Buckley, Holywell, Flint, Shotton, Connahs Quay

and Saltney (bordering on Chester). The county covers 169 square miles (438 square

kilometres). Although the smallest county by size, Flintshire has the highest population in

North Wales with approximately 150,000 residents (887 per sq/m or 342 per sq/km).

Approximately 13% of the population speak Welsh.

Wrexham (County Borough):

Wrexham County Borough shares its name with its administrative centre and the largest

town in North Wales, Wrexham. The majority of the population are located in and around

Wrexham, with many of the outlying villages merging into an almost continuous urban

spread at the centre of the county. Beyond this central conurbation, the county is rural in

character.

The county borders on England and in common with Flintshire extensive housing

developments and often lower house prices than across the border has led to many

families relocating from the Chester / Cheshire area. The county has an area of 194

square miles (504 square kilometres). The total population is approximately 133,000

(690 per sq/m or 266 per sq/km), of which approximately 63,000 reside in the wider

urban areas of Wrexham town. Approximately 12% of the population are Welsh

speaking. There is also a large number of migrants from other EU countries, particularly

Poland as well as a number of Asylum Seekers.

Population

The population of North Wales was estimated at approximately 682,000 in 2013.

It is projected by 2026 that the overall population of North Wales will increase by 48,300;

an increase of 7% taking the total population to 730,300. The Welsh Government Local

Authority population projections estimate the following increases for 2018 and 2023.

(Table 1)

Table 1: Total Population by Local Authority

Total population by local authority, selected years

(2011 based projection)

2026

Principle

Projection

Ten year average

migration

 Anglesey 69,900 71,600

Gwynedd 127,600 128,500

Conwy 115,300 120,000

Denbighshire 99,700 102,300

Flintshire 156,200 156,400

Wrexham 153,400 151,500

Total 722,100 730,300

Source: Local Authority Populations Projections 2011 Based: Variant Projections Revised (Dec 2013)

 NB: For most authorities the projected population at mid-2026 is higher based on the ten-year average

migration variant than based on the principal projection.

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The General Fertility Rate (GFR) for North Wales is 61 per 1,000, slightly higher than the

Welsh average of 60 per 1,000. However, this figure can vary significantly within subpopulations;

within North Wales Wrexham Local Authority has the highest GFR at 64 per

1,000. At the electoral ward level there are rates of up to 93 per 1,000 within Cartrefle,

Queensway and Wynnstay.

In North Wales, 20.8% of the population is under the age of 18 years, compared with

21.2% in Wales as a whole. The highest proportion of under 18s fall within Flintshire

(21.6%) and Wrexham (21.3%) and the lowest proportion of under 18s reside in Conwy

(20%) and Gwynedd (20.5%).

The UK population is ageing and the demography of North Wales is predicted to change

over the next 20-30 years with a large growth in the numbers of older people.

The proportion of people aged over 75 in North Wales (9.2%) is higher than that in Wales

as a whole (8.6%) with variation across UAs. The highest proportion of over 75s reside

in Conwy (11.7%) and the lowest in Flintshire (7.3%). It is estimated that by 2025 the

number of people over the age of eighty is set to increase by almost a half and the

number of people over ninety will double.

Conwy also has the highest proportion in Wales of persons aged 85 years and over.

Denbighshire, Gwynedd and Anglesey are also among the top ten areas with the highest

proportion of the population over retirement age.

Of concern is the predicted increase in dementia. (Figure 3)

Figure 3: Estimated number of people in North Wales suffering with dementia,

2011-2030

Source: Welsh Government statistical Directorate (Daffodil)

Approximately 2700 people, predominantly older people, are living in care homes. The

distribution of care homes is illustrated in Figure 4.

8000

9000

10000

11000

12000

13000

14000

15000

16000

17000

18000

2011 2015 2020 2025 2030

Total population aged 65 and over

with dementia

Year

 Estimated

68% increase

in people with

dementia by

2030

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Figure 4: Community Dental Service with Nursing and Residential Homes

There are 81 nursing homes with a total of 2876 beds across North Wales (788 EMI

beds). This increasingly dentate aging population will pose significant challenges

regarding future dental treatment provision and will have an effect on the type of dental

services required impacting on the training and skills needed by health and social care

professionals.

In North Wales, the Black and Ethnic Minority population is approximately 1.0 percent,

which is lower than Wales at 2.1 percent.

Since 2004 North Wales has seen a significant number of people migrating into the area

from abroad. (Table 2)

Table 2: Immigration to North Wales 2004-2011

Immigration to North Wales 2004-2011

 Arrived

2004-2006

Arrived

2007-2009

Arrived

2010-2011

Total

Persons Persons Persons

Number Number Number

Anglesey 267 279 171 717

 Gwynedd 638 1,260 1,237 3,135

 Conwy 751 621 312 1,684

 Denbighshire 641 541 245 1,427

 Flintshire 1,304 1,173 401 2,878

 Wrexham 2,348 1,982 728 5,058

5,949 5,856 3,094 14,899

Source: Office for National Statistic ( 2010-11 reflects only a two year period up to the national census)

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The challenges to services posed by patients who are not Welsh/English speaking need

to be recognised. Access to language line is not without problems and ensuring that

patients are able to provide informed consent to proposed treatment can be difficult and

necessitate access to interpretation services both in hours and out of hours.

The number of people on a Local Authority registered with a physical/sensory disability is

25,108 for North Wales, However, this figure should be treated with caution as

registration is voluntary and the way that data is collected and recorded may vary

between local authority areas. The actual number of patients is likely to be significantly

higher. The need for clinical services to be Disability Discrimination Act compliant and to

improve facilities for those with sensory impairment is recognised.

Approximately 3000 adults registered with a General Practitioner Practice are identified

as having a learning disability. Many patients with a learning disability have special care

dental needs and require access to appropriate services.

Population - Health

A combination of lifestyle changes and improved healthcare can have a positive impact

on death rates as demonstrated by a reduction in mortality rates (all causes of death

under age 75) in North Wales between 1998 and 2007. The all-cause mortality rate for

North Wales is 617 per 100,000; lower than the all-Wales rate at 635 per 100,000.

Generally, the population is living longer and the anticipated life expectancy for men

across North Wales is 77.2 years and for women 81.5 years. The figures for some parts

of North Wales, however, show a marked contrast. The mortality rate for areas of

Wrexham (Gwersyllt North, Gwersyllt West) stood at 1,016 deaths per 100,000, whereas

other parts of Wrexham (Bronington, Overton) were much lower at 427 per 100,000

population. The National Public Health Service Profile of North Wales highlights the

effects of inequalities and this as a stark and unacceptable example. Oral health needs

mirror the pattern with poorer dental health in areas of greatest deprivation.

Smoking causes almost 90% of deaths from lung cancer, around 80% of deaths from

bronchitis and emphysema and around 17% of deaths from heart disease (ASH, 2007)

as will be evident later in the report, it is also one of the major causes of oral cancer. In

the most deprived areas of Wales 37% of the population smoke compared to 14% in the

least deprived area. Reducing smoking levels across Wales is a public health priority.

With regards to morbidity, there are various measures of ill-health (mental and physical)

and well-being. One measure is limiting long-term illness (LLTI), which is defined as

adults who report having any LLTI, health problem or disability which limits their daily

activities or the work they can do. This includes any problems due to old age. The

highest percentage of adults with LLTI in North Wales is on the Isle of Anglesey, 27%

and the lowest percentage in Conwy, 23%.

Individuals with diabetes are at greater risk of periodontal diseases. Animal and

population-based studies have demonstrated an association between periodontal

diseases and diabetes, cardiovascular disease, stroke, and adverse pregnancy

outcomes. Further research is needed to determine the extent to which these

associations are causal or coincidental.

In common with general health, oral health need is greatest in areas of deprivation. It

should be noted that almost one fifth of the population living within the most deprived

parts of Wales are located in North Wales. In 2008, the Welsh Index of Multiple

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Deprivation identified parts of Rhyl West as the most deprived in the whole of Wales, with

parts of Queensferry, Wrexham and other parts of Rhyl ranked 3rd, 4th and 5th

respectively.

Together for Health: A National Oral Health Action Plan highlights that:

· Many systemic diseases and conditions have oral manifestations. These

manifestations may be the initial sign of clinical disease and as such serve to

inform clinicians and individuals of the need for further assessment.

· The mouth is a portal of entry as well as the site of disease for microbial infections

that affect general health status.

· The mouth and its functions can be adversely affected by many pharmaceuticals

and other therapies commonly used in treating systemic conditions. The oral

complications of these therapies can compromise patient compliance with

treatment as well as putting patients at increased risk of oral disease.

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KEY STRATEGIC ACTIONS

1.

The Development of the Oral Health Plan for Betsi Cadwaladr University Health Board

(BCUHB) has been delegated to the Oral Health Strategy Group (OHSG) and is pending

ratification by the Executive Board. The Terms of Reference (ToR) and structure of the

OHSG is attached (Appendix 2).

Oral Health Needs

Oral Health was defined by the Department of Health in 1994 as the ‘standard of health

of the oral and related tissues which enables an individual to eat, speak and socialise

without active disease, discomfort or embarrassment and which contributes to general

well-being’. Appendices 3 and 4 present Local Oral Health Profiles which report results

of national decennial Adult and Child Dental Health Surveys and consider the results of

the local NHS Epidemiology Programmes which are conducted on a more regular basis.

Additionally, a report produced by the Business Services Authority (Appendix 5)

addresses uptake of NHS dental services by North Wales residents. The 2012-13 report

looks at Primary Dental Care use and provision applying indices of deprivation according

to postcodes of residents and excludes patients treated by dentists in North Wales but

who live outside the area.

The main oral diseases which are discussed in this LOHP are dental caries, periodontal

disease and oral cancer. The data relating to oral cancer are presented in the NOHP.

Possible preventative strategies that could be adopted in North Wales to reduce the

prevalence of this serious and debilitating disease are discussed in the relevant sections

of this document. This section concentrates on caries with some minimal reference to

periodontal health.

Where we are:

Child Dental Health - 5 year old children

The decennial National Child Dental Health Surveys suggest that caries experience in 5

year old children appears to have plateaued since 1993 following a small improvement in

the previous decade. Taking account of local surveys, the Welsh experience in 2005-06

was reported to be the worst in the UK. Welsh targets were subsequently set to reduce

inequalities in child dental health by 2020. These are described in the appendices

3 and 4.

Before 2007/08 surveys had utilised passive consent. The change to positive consent

has meant that comparisons with previous data cannot be considered as they are no

longer valid. Additionally, participation rates have fallen as a result of methodology

changes so that the data is likely to underestimate the disease levels in the population.

For example participation in Anglesey fell by 30% in 2007/08.

Local surveys provide greater detail regarding Wales and its UAs. Although North Wales

compared favourably with Wales as a whole, the differences between health board and

country level indicators were generally not statistically significant. Aggregated health

Health Boards will develop a Local Oral Health Plan to address the oral

health needs of their residents and clearly describe how they will

ensure good governance in commissioning and delivery of all dental

services.

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board indicators also masked marked variations between the most affluent and most

deprived areas in North Wales.

The results of the 2011/12 survey of 5 year old children allows for comparison with the

2007/08 data and early analysis suggests that the prevalence of dental caries is

improving. The headlines in the latest report from the Welsh Oral Health Information Unit

state:

· Preventable and active decay levels fell in Betsi Cadwaladr 5 year olds

· Health Board 2011/12 decay levels were lower than the Welsh averages

· Flintshire saw improvements in child oral health and has lower experience of

decay when compared with Wales

· Health inequalities in oral health appear to be reducing

These improvements are laudable. However, when small area statistics are examined,

even at Upper Super Output Area levels (with populations averaging 32,000), inequalities

are obvious (Figures 12 and 13 from the 2013 Oral Health Profile appendix 4)

Analysis of the 2005/06 survey, undertaken before positive consent was introduced,

illustrated the wide range of dmft (decayed, missing and filled teeth) in areas of Flintshire.

At that time Flintshire exhibited both the best and worst dmft values in North Wales;

Hawarden at 0.9 and Flint at 3.0.

Whilst it would be commendable if the improvements highlighted for Flintshire could be

attributed to this LHB being the earliest adopter of a preventive strategy other

explanations can be proffered such as sampling bias or reduced consent rates. The

hypothesis might however be worthy of further investigation.

It is acknowledged that Welsh Government has no current plans to fluoridate water

supplies in Wales. However, no Oral Health Plan for North Wales would be complete

without the mention of the effect of defluoridation on the dental health of Anglesey’s 5

year old children which is evident in Figure 5.

Figure 5: Caries Experience In 5-Year-Old Children: A Comparison Between

Anglesey And Mainland Gwynedd From 1987-2000

Source: BASCD Surveys

0.8

1.26

1.44

2.14

2.05 2.08

2.17

2.26 2.27

2.41

2.2

2.11

2.21

2.37

0

1

2

3

1987/88 1989/90 1991/92 1993/94 1995/96 1997/98 1999/00

dmf

Year

Anglesey

Gwynedd

12

Being able to observe the deterioration in the dental health of children following the

withdrawal of a water fluoridation scheme is possibly unique. Against a background of

little change in disease levels in un-fluoridated mainland Gwynedd in just five years there

was an increase in dmft of 5 year old children living on Anglesey from less than 1 tooth

per child to more than two.

In the absence of water fluoridation Welsh Government has funded a targeted national

programme, ‘Designed to Smile’ (D2S), which brings young children’s teeth into contact

with fluoride in the form of toothpaste and fluoride varnish. Other preventative strategies

such as fissure sealant applications are also included in the initiative. Initial analysis of

survey results appears promising although the non-participation of some schools in the

targeted areas is a cause for concern.

Child Dental Health - 12 year old children

Decennial Dental Child Dental Health surveys have shown a marked improvement in the

oral health of 12 year olds. In Wales the percentage of children with decay experience in

their permanent teeth fell from 83% in 1983 to 43% in 2003 with the average number of

decayed, missing and filled teeth (DMFT) reducing from 3.3 to 1.0 in the same period.

However although the oral health of 12 year old children has improved inequalities

remain, largely associated with social deprivation.

The last local reported survey was conducted in 2008/09 although a subsequent survey

has been carried out during 2012/13. The 2012 Oral Health Profile reports the results of

the 2008/09 survey. (Appendix 3) Gillick competent consent was utilised for these older

cohorts.

Although there has been a significant reduction in the prevalence of dental caries in 12

year old children in all Western European countries, over the last 30 years the

improvement in Eastern European member states is less striking. (Figure 6) Direct

comparisons of DMFT of 12 year old children in different countries are not reliable as

different methodologies are often adopted in the sampling and collection of data with

studies also being conducted in different years. The implications of the higher disease

experience are implicit for service provision and preventative strategies in those areas

where appreciable numbers of families have settled. Epidemiological surveys of children

will need to take account of nationality and preventative literature may need to be

produced in languages other than Welsh and English. In North Wales the impact is most

likely to be noted in Wrexham and in parts of Flintshire.

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Cyprus

Denmark

Germany

UK

Austria

Italy

France

Spain

Ireland

Romania

Poland

Lithuania

Figure 6: Changes in mean national Decayed Missing Filled Teeth (DMFT)

scores for 12 year olds from profiled Member States between the

1980s and first decade of 2000 (WHO 2012b)

5

4

DMFT Score in 1980-

1990

3

2

DMFT Score in 2000-

2009

1

0

Children with special needs

There are groups of children who have specific needs that make them worthy of special

consideration.

For some children dental disease or its treatment can pose difficulties or risk to their wellbeing.

For these children preventative strategies are of paramount importance.

Looked after children (LAC) tend to have greater health needs than their peers including

physical, mental and behavioural problems and a higher prevalence of health related risk

behaviours. They are also less likely to receive immunisation and health surveillance

checks and to receive routine dental care. There are in excess of 1200 LAC in North

Wales Local Health Boards have specific statutory responsibilities and must have robust

systems in place to ensure timely support and appropriate resources are in place to

deliver health plans for these children.

Similarly, children on Child Protection Registers (many of whom fall into the neglect

category) deserve special attention. The Welsh Government Statistical Bulletin,

November 2013, reports that 2,950 children (including unborn children) were on child

protection registers at 31 March 2013 with 45% being under the age of 5 and 43% falling

into the neglect category (registrations may state more than one category of abuse). Of

concern is that 545 children are on registers in North Wales and of the 22 Unitary

Authorities in Wales, 4 North Wales UAs are in the top 50%. The Isle of Anglesey has

the highest percentage of children on child protection registers with Denbighshire third,

Wrexham eighth, Conwy eleventh, Gwynedd sixteenth and Flintshire twenty first.

Oral Health - Adults

Decennial Adult Dental Health surveys have shown that the dental health of adults has

improved dramatically over the past 50 years. Between 1978 and 2009 the proportion of

adults in Wales having no natural teeth had decreased from 37% to 10%. Nevertheless

this still compared unfavourably with England where the figure was 6%.

14

A significant proportion of people aged over 75 are still edentulous (no natural teeth) but

more middle aged people have their own teeth. However, many of these will have

heavily restored dentitions which will require long term maintenance and repair. It is

likely that the improving oral health of younger cohorts will result in reducing restorative

demands.

In 2009, only 7% of dentate adults in Wales had excellent oral health. This was defined

as having 21 or more natural teeth present, 18 or more sound and untreated teeth, no

active decay at any site, no periodontal pocketing or loss of attachment above 4mm and

no plaque or calculus.

Oral Health - Older people

The demographics of North Wales demonstrate that older people now make up a larger

proportion of the population. Maintaining their oral health will be an increasing challenge.

In 2007 a survey of Wales care home managers identified weaknesses in arrangements

in relation to maintaining the oral health of their residents and ensuring that they received

dental care. It also emphasised that there was a dearth of oral health training for staff.

Flintshire was however highlighted as having well established systems for accessing oral

health care. This was attributed to a Flintshire LHB dental initiative in care homes. A

subsequent oral health survey of care home residents in 2011 found that the majority of

residents were aged over 75 with 54% being edentulous. Of the dentate residents 62%

had coronal caries with increased prevalence in deprived areas. Additionally, there was

gross inequality in access to dental care when compared with ‘free living’ adults as

reported in the Adult Dental Health Survey. Further analysis is being undertaken.

Where we need to be:

Treatment services will need to be commissioned to meet the differing dental needs of

younger, middle aged and older adults. Vulnerable children and adults have specific

needs and will pose specific challenges. These are discussed in the appropriate section

of the LOHP and actions suggested.

It has been proposed that a prison be built in Wrexham to accommodate 2000 inmates.

There will be a requirement to consider this population’s oral health needs.

The benefits of the regular use of appropriate strength fluoride toothpaste are well

documented. Vulnerable individuals and those with high caries rates (aged over 10)

would benefit from using suitable higher dose fluoride toothpastes which are only

available on prescription. The prescribing of these toothpastes should be encouraged for

patients where there is a demonstrated need. Similarly, Fluoride Varnish application has

been shown to yield benefits for younger children with caries and vulnerable adults

especially older adults with root caries.

Some populations remain geographically and socially disadvantaged with regards to

access to dental services. This needs to be considered in the planning process and

included in the strategies for the different branches of dental services.

There will be a requirement for Needs Assessment Documents produced by Public

Health Wales to be considered as produced and the LOHP modified as required.

15

Actions:

· Research of the oral health needs in prison populations will be undertaken by PHW,

with the pending report of a UK wide Prison Dental Health Review informing the

process. This will be utilised by the local planning group that has been established. A

time line is yet to be determined.

· Consideration will be given to the oral health needs of subgroups within the

population e.g. patients when first diagnosed with dementia. The priorities of this

agenda are likely to be determined at national level with input from local advisory

committees. This topic will be placed on the agenda of the OHSG on an annual

basis.

· A base line of current prescriptions for fluoride toothpaste (2800ppm + 5000ppm) will

be established by 31 March 2014 and regularly monitored by the PHW with annual

reports produced for the OHSG. This topic to be a subject for discussion at contract

review meetings.

· Access to disadvantaged populations will be improved as redistribution / reallocation of

resources permit. Applications will be made to access additional funding streams as

identified.

· The LOHP will be considered at least on an annual basis to determine progress

against identified actions and to consider any relevant needs assessments that have

been produced. This will be actioned by the OHSG by 31 March 2015.

Quality & Safety

Where we are:

BCUHB Executive Board is in the process of developing its Quality and Safety Strategy

taking account of the recommendations of the report produced following the Joint Review

conducted by Health Inspectorate Wales (HIW) and Wales Audit Office (June 2013).

Financial Governance compliance is the ultimate responsibility of the Finance Director.

Contract monitoring and probity checks, by means of reports produced by the NHS

Dental Services Division, Practice inspections and the involvement of Primary Care

Dental Practice Advisers (PCDPA), ensure a seamless approach.

All branches of dentistry within the Surgical and Dental Clinical Programme Group (CPG)

are committed to improve Quality & Safety by complying with extant guidance on dealing

with concerns outlined in 'Putting Things Right'. GDS/PDS practices are required to

comply with BCUHB clinical governance procedures including the completion and return

of a Quality Assurance Scheme document on an annual basis.

The Health Board utilises the Welsh Government (WG) guidance on a Model Operating

Procedure for the management of Dentists on the Performers' List whose performance is

of concern.

Patient satisfaction surveys are conducted within all three branches of the service. The

Business Services Authority carry out surveys of patients treated within General Dental

Services.

16

Where we need to be:

An annual quality statement will need to be produced to include all branches of dentistry.

A learning culture from concerns needs to be further developed to improve patient quality

and standards, with measures introduced initially offering support, whilst ensuring the

root causes of the problems are addressed.

The CPG is working towards harmonising the approach to dental governance across the

LHB to facilitate early identification of risk and poor or underperformance thereby

safeguarding patient safety.

To ensure the quality of service provision and patient safety, there is a need to further

develop the reporting framework with the Dental Contractor Services (GDS/PDS) in

liaison with PHW, HIW and PCDPAs. Outliers need to be identified and investigation

instigated as required.

It is the intention that as patients move between services Community Dental Service

(CDS)/General Dental Service (GDS)/Hospital Dental Service (HDS), in terms of quality

and safety their experiences are seamless. This will be achieved by linking governance

of all three services to the overall quality and safety policy of the Health Board.

Through continued dialogue with the Dental Postgraduate Department the use of audit

and adoption of the Maturity Matrix needs to be encouraged.

Actions:

· Full compliance with the annual Primary Care Quality and Safety programme will be

ensured by the deadline specified. The PCDPAs will action.

· In liaison with PHW/HIW a practice inspection protocol/clinical record check will be

developed, both targeted and random, to ensure regulatory/professional compliance

by 31 March 2015.

· The ongoing annual contract reviews will be supported by the PCDPAs with priority

given to those with poor/inadequate performance and/or non-compliance with

governance policies and processes.

· Consideration will be given to the introduction of Maturity Matrix as a tool which can

be utilised by all branches of Dentistry. OHSG by 31 March 2015.

· Production of an annual quality statement by individual disciplines by March 2015.

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2.

Where we are:

Professional advice is received through the Oral Health Strategy Review Group chaired

by the Director of Oral Health and through the various Managed Clinical Networks

(MCNs) and by liaising with the Local Dental Committee (LDC). The membership of the

OHSG is multi-professional with a Consultant/Specialist in Dental Public Health as a

member of the Group (Appendix 2). Proposed changes to BCUHB management

structure are not currently being progressed but are under review when a new Chief

Executive is in post.

Where we need to be:

Procedures need to be established to ensure that oral health professional advice is

considered and actioned at the appropriate level. Stronger links with other CPGs need to

be developed.

It is considered that MCNs for Restorative Dentistry and Oral Surgery need to be

developed but this is dependent on the Management Structure Review.

Action:

· MCNs to be developed for Oral Surgery and for Restorative Dentistry taking account

of ToRs developed with national guidance for Orthodontics and Special Care

Dentistry. This action will be progressed by the OHSG taking account of National

developments by 30 September 2014.

3.

Where we are:

The potential to address this guidance is being considered by the OHSG. The

Maxillofacial Surgery Department has already introduced outreach clinics at Deeside and

Colwyn Bay Community Hospitals and continue to provide a service at Llandudno

Hospital.

The department has also been proactive in participation with the development of an

Intermediate Tier service in oral surgery. A pilot has been conducted as an out of hours

service alongside Emergency Dental Service clinics. Following evaluation of the

scheme, a model for the future has been determined with the service being provided

within the CDS with a Consultant in Maxillofacial Surgery leading on the Quality and

Safety Agenda.

Health Boards need to review processes to confirm they have adequate

measures in place to ensure the provision of dental professional advice

and access to a multi- professional advisory structure, including that of

a consultant/specialist in Dental Public Health Clinical engagement.

Partnership working and the development of integrated care will be

important principles of the new approach.

Health Boards should also focus on delivery, with the balance of care

shifting away from secondary care towards primary care, or other non

hospital locations wherever possible. Health Boards should ensure

that financial resources from both ring fenced and non ring fenced

allocations deliver effective and efficient services and that one off

initiatives are based upon need and are evidence based.

18

Specialist orthodontic services in Primary Care have been developed over recent years

and have been subject to a tendering exercise during 2013.

Monitoring activity across all branches of dentistry is not harmonised at present but

clearly this must be an aspiration requiring agreement and implementation.

Where we need to be:

Any shift in service delivery needs to be undertaken without detriment to primary care

services and funding. Common monitoring arrangements for specific specialist activity

across the services need to be developed. There are specific issues relating to the

paucity of Consultant Specialist care in Restorative Dentistry that need to be urgently

addressed.

Actions:

· Recruitment to take place to the Intermediate Tier Oral Surgery sessions so that the

service can commence by 1 July 2014. The impact on Sedation and General

Anaesthetic (GA) service provision will be monitored.

· Referral protocols will be finalised in the same time frame.

· Standardised reporting mechanism from Secondary, Community and General Dental

Services will be developed by OHSG and MCNs by 31 December 2014 for

introduction 1 April 2015.

· Access to Consultant/Specialist Care in Restorative Dentistry needs to be resolved by

the CPG Surgery & Dentistry Board by 31 March 2014.

4.

Where we are:

Working with Dental Teams is facilitated through the OHSG, its sub-groups and the

MCNs. The Healthcare Professional Forum (HPF) is a conduit for informing other Health

Care Professional Groups. The Primary Care Support Unit (PCSU) and the three

PCDPAs are in contact with NHS general dental practices and are able to liaise to ensure

that all providers and their teams are aware of and able to contribute to this evolving

plan.

Where we need to be:

The strength of links with the six UAs (Social Services and Education) and the 14

Localities is varied and need to be strengthened through community networks.

Appropriate multidisciplinary groups will need to be consulted or established to address

the various issues raised in the Plan.

Actions:

· The LOHP will be brought to the attention of the Chair of the HPF by the Oral Health

Clinical Director/Dental Member by 31 March 2014.

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.

19

· The LOHP will be placed on the agenda of the Community Services Partnership

Forum by the dental member.

· The LOHP will be distributed to all Clinical teams in GDS, CDS and HDS by the Oral

Health Clinical Director by 31 March 2014.

· The LOHP will be made available by the 30 April 2014 to the Community Health

Council inviting contribution to the evolving plan.

· A summary of the LOHP will be placed on the BCHB website to inform the public by

30 June 2014.

20

PREVENTION

5.

The NOHP states:

“Having an unhealthy mouth can have a real impact on health and

wellbeing. This is particularly important in Wales where oral problems

are strongly linked to deprivation. However, there is much we can do to

tackle this important public health problem, as oral diseases are almost

entirely preventable.”

North Wales faces the challenge of many children from disadvantaged backgrounds

suffering poor dental health and as a consequence suffering tooth ache and requiring

extractions at a young age.

The Designed to Smile National Child Oral Health Improvement Programme promotes

better dental health and delivers a Fluoride Supplementation Programme. It commenced

as a Welsh Government funded Super-pilot in 2008. In the absence of Water

Fluoridation, Designed to Smile offers an evidence-based solution to putting young teeth

in regular contact with fluoride at the correct daily levels to promote better dental health.

Where we are:

North Wales was chosen as a Super-pilot area in 2008, alongside Cardiff and Vale and

due to the success of the Super-pilots, the initiative was rolled out across Wales. As a

super-pilot area the North Wales D2S Team was able to contribute to the development of

the programme, trial resources, recognise some areas of good practice, observe some

early successes and problem solve as the programme evolved. The details of the D2S

programme are available at www.designedtosmile.co.uk

An Example of Good Practice was recognised by the team. Following the lead of a large

Junior School in Flint a number of schools have now adopted a “whole school” approach,

with all school years brushing as well as participating in the fissure sealant and fluoride

varnish programmes. These have been identified as our ‘Flagship Schools’

The expansion of the D2S programme across North Wales is illustrated in Table 3.

Health Boards will ensure the continued participation in evidence based

community oral health promotion programmes particularly the

Designed to Smile and Healthy Schools programmes.

21

Table 3: The number of settings agreeing to take part in Designed to Smile (TB or

FV) in April 2012 -2013 compared with previous years, by reporting LHB

 \*settings originally targeted were for the supervised tooth brushing element of the programme

\*\*includes settings targeted for tooth brushing and fluoride varnish

Source: Welsh Oral health Information Unit (October 2013)

Of the 434 settings targeted 91% agreed to adopt the programme, which is well received

in participating schools by children and parents (95.9% consent rate). Of concern are the

19 schools refusing to adopt the scheme and 4 that have withdrawn.

In addition to the daily tooth brushing scheme, the D2S teams have commenced fluoride

varnish application at the "most needy" schools as an extension of the “clinical

prevention” work applying fissure sealants. Currently 74 schools are participating in this

clinical prevention aspect of the programme.

Complementing the Healthy Schools Programme, in D2S schools parents and children

receive advice about healthy eating and healthy snacking. Close working relationships

are well established with Sure Start Teams, Communities First Liaison Teams, Healthy

School coordinators and Healthy Sustainable Pre-school Steering Groups in all 6 UAs. A

multidisciplinary Designed to Smile Strategic Planning Group meets bi-annually.

Formal evaluation is undertaken annually by Cardiff University on behalf of Welsh

Government (WG) and produces an annual report of activity for all areas of Wales. The

impact of the D2S programme continues to be monitored through successive National

Child Dental Health Surveys. The Dental Public Health Unit of Cardiff University has

examined recent data and the results appear promising in relation to the impact on the

level of decay in young children participating in D2S initiative.

Where we need to be:

As the CDO states in the foreword to the NOHP, there needs to be greater emphasis on

prevention if we are to reduce demands on expensive treatment services.

There is a need to bring on board the targeted schools which have either declined to

participate in the initiative or have dropped out of the initiative. It is also necessary for

schools to adopt all aspects of the programme if the maximum benefits are to be reaped.

In the absence of compulsory participation, improved links with Education Departments

and Boards of Governors need to be developed.

2009-10\* 2010-11\* 2011-12\*\* 2012-13\*\*

Abertawe Bro Morgannwg 54 127 139 212

Aneurin Bevan 21 100 157 208

Betsi Cadwaladr 166 270 326 394

Cardiff and Vale 232 341 413 384

Hywel Dda 42 84 147 162

Powys 0 22 29 34

Wales 515 944 1211 1394

22

It is recognised that a regular update on the programme and school participation for all

GDS and CDS teams would be beneficial.

Vacancies in the team need to be filled in a timely fashion and the number of dental

nurses trained in Oral Health Education and in the application of fluoride varnish need to

be increased in anticipation of changes to the GDS/PDS contract.

There is evidence that maternal oral health; dental attendance; educational achievement;

social deprivation; anxiety; beliefs; attitudes and behaviour are factors that influence their

children’s oral health. The opportunities of influencing maternal behaviour needs to be

explored.

Arrangements need to be put in place to ensure that all LAC and children on Child

Protection Registers receive the benefits enjoyed by those children targeted by the D2S

programme.

Actions:

· Six monthly reports to be distributed to all GDS and CDS surgeries by D2S

managers. First update in new format to be issued by 30 April 2014.

· CDS to continue to deliver data required by the University of Wales for Annual

Monitoring in a timely fashion by the date specified.

· D2S Strategic Planning Group to determine an Action Plan to improve uptake and

compliance with all aspects of the D2S programme by 30 June 2014.

· Presentation to be delivered by D2S to LDC by 31 December 2014.

· Continue to train GDS nurses in the application of fluoride varnish as part of the D2S

initiative. Dental Health Promotion team to deliver training intervention(s) by

31 March 2015.

· The Dental Health Promotion team will continue to run a course(s) to prepare Dental

Nurses for the National Examination Board for Dental Nurses (NEBDN) post

certification exam in Oral Health Education. Frequency will be according to

demonstrated demand.

· Design a pilot utilising 1000 lives principles to bring new mothers and mothers of

young children into regular dental care. A Task & Finish Group to be formed to

design a study by 31 March 2015.

· Every LAC and child on the Child Protection Register will receive an oral health plan

and an input equivalent to the D2S programme. Specialist in Paediatric Dentistry to

produce a protocol by 30 April 2014.

· Child Learning Disability Programme to be introduced to all Special Schools and units

under the D2S umbrella and a modified D2S programme introduced in Special

School(s) for physical/medical compromised children by 31 March 2015.

· Explore opportunities for GDS involvement at national and local levels. This will be

actioned by PHW and OHSG by 31 August 2014.

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· Increase the number of fluoride varnish applications recorded in GDS by 31 March

2015.

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DELIVERING EFFICIENT AND EFFECTIVE CARE

6.

The most important aetiological factors, tobacco usage and excessive alcohol

consumption, account for about three-quarters of oral cancer cases in Europe. The

Human Papilloma Virus (HPV) is also implicated in some oropharyngeal cancers and a

link has been established between exposure to the sun and cancer of the lip.

The earlier the presentation the better the prognosis but often oral cancer patients are

diagnosed at a late stage in their illness. The majority of cases in the UK (87%) occur in

people aged 50 years or over and the incidence remains higher in the most deprived

cohort of our population. Although oral cancer continues to be more common in men

than women, the gender ratio in the UK has decreased from around 5:1 fifty years ago to

less than 2:1 today. The incidence of mouth and throat cancer in men aged 35-44 has

more than doubled in just over a decade. In the UK in 2007, 5,410 people were

diagnosed with an oral cancer with 385 in Wales. Throughout BCUHB there are

approximately 35-40 newly diagnosed cases of oral cancer per year.

Where we are:

All cases of oral cancer are discussed at a weekly multidisciplinary head and neck

meeting. Investigations, staging and treatment is discussed and the most appropriate

package of care for each individual formulated. All Surgical treatment is provided by two

designated Maxillofacial surgeons who are core members of the Multidisciplinary Team

(MDT). One of the Consultant Maxillofacial /Head and Neck Surgeon) is Vice Chair of

the Head and Neck MDT and Surgical representative to the all Wales Cancer National

Steering group.

Radiotherapy services are provided by the North Wales cancer centre located at Ysbyty

Glan Clwyd.

Once patients are registered with the MDT their data is entered on to the all Wales

Cancer Network Information System Cymru (CANISC) database and then on to the Data

for Head and Neck Oncology (DAHNO) national audit. Through the auspices of the

MDT, cancer standards are achieved and maintained. A retired Consultant in

Restorative Dentistry is a member of the Team, working on a part time basis, to ensure

that the team complies with required standards.

Initiatives that have evolved from the Local Cancer Development Plan include visiting all

secondary schools in North Wales to raise awareness of the causes and prevention of

cancers, including oral cancer.

Data which has been collated over the last 10 years has been analysed by the Welsh

Cancer Intelligence Surveillance Unit (WCISU). It demonstrates an increase in overall

survival of head and neck cancer patients treated in North Wales. (Table 4)

Health Boards will liaise with the Cancer Networks and the Head and

Neck Cancer National Specialist Advisory Group to ensure that the

Welsh Cancer standards (2005) are implemented. 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.

25

Table 4: Trends in 1 and 5 year mortality from oral cancer by Health Board area,

1995-2009

Source: Cancer in Wales 1995-2009: A comprehensive report Head and Neck cancer WCSIU (taken from NOHP)

Where we need to be:

Dentists should be encouraged to have a protocol in place to ensure that patients with

suspect lesion have been seen by the appropriate hospital department.

Action:

· Recognising the limitations and unsustainability of current arrangements the

recommendations of the Restorative Dentistry Review Group need to be finalised

cognisant of the need to retain compliance with the Head and Neck Cancer - Welsh

Cancer Standards 2005 and NICE Guidance 2004. 31 March 2014 by Restorative

Dentistry Review Group.

7.

Special Care Dentistry was recognised as a Dental Specialty by the General Dental

Council in 2008. The discipline relates to adults with impairment or disability. A Special

Care Dentistry in Wales Implementation Plan was published by Welsh Government in

November 2011 and a National Strategic Advisory Forum (SAF) established to ensure an

all Wales approach to the planning and delivery of Special Care Dentistry (SCD)

services. The SAF reports on an annual basis to the Chief Dental Officer. Regional

MCNs have been subsequently been created with common defined membership, remit

and accountabilities. An all Wales Special Interest Group, a sub-group of the CDS

Clinical Directors’ Group has existed for many years. There are 2 Consultants in SCD

working in the Community setting in Wales both in Aneurin Bevan LHB.

Where we are:

There is North Wales representation on the SAF (SCD) and on the all Wales Special

Interest Group. A North Wales and Powys MCN has been established. Membership of

key stakeholders provides a forum which supports a robust service framework and a

Health Boards should use the recommendations from the Special Care

Dentistry Implementation Plan in ensuring that the needs of all

vulnerable groups are addressed.

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focus around integrated dental care across North Wales and Powys. It reports to the

OHSGs as well as to the SAF.

A number of work streams have been identified which are being progressed through task

and finish groups. These include the formulation of integrated referral and care pathways

for cancer patients; stroke patients and those requiring domiciliary care.

Seven specialists in the discipline are employed within the CDS in North Wales; one of

whom is also a Specialist in Paediatric Dentistry.

A bottom up approach operates with most dentists and Dental Care Professionals

(DCPs) possessing varying special care skills and experience and contributing to overall

SCD service delivery. It is anticipated that a number of other CDS dentists will qualify for

Dentist with Enhanced Skills (DwES) status when the recognition process is established.

All CDS therapists/hygienists are skilled in treating children and adults with special

needs; one also having gained an additional qualification in SCD. A number of dental

nurses within the service hold the NEBDN Special Care Dental Nursing Certificate with

others having gained the Oral Health Education Certificate from the NEBDN. A number

of these are delivering Oral Health Promotion Programmes specifically designed for

Children or Adults with Learning Disability or are involved with the Older Persons’ Gwên

am Byth Programme. Additionally, most dentists provide Inhalation Sedation (IS) and

Intravenous Sedation (IVS) is offered at six sites across North Wales. An oral or

transmucosal sedation service is also available at two sites; Wrexham Dental Centre and

Ysbyty Glan Clwyd (formerly the Rhyl site). All therapists have recently successfully

completed training in IS.

North Wales is well known for the early development of its general anaesthetic service for

Adults with Special Needs. This has now relocated from Rhyl to Ysbyty Glan Clwyd.

Dedicated sessions for patients needing special care dentistry are available weekly from

the Glan Clwyd site and there is are separate sessions quarterly for patients who fall into

a higher medical risk category (ASA 4). Often multidisciplinary procedures will be

coordinated with other departments so that vulnerable patients, for whom cooperation is

challenging, can undergo all necessary investigations/ procedures under the same

anaesthetic. Adults for whom treatment under GA is the only option are also able to

receive comprehensive care at Llandudno Hospital where sessions operate on a monthly

basis. Extraction therapy and some oral surgery can be provided for these patients by

CDS teams at Ysbyty Glan Clwyd, Ysbyty Maelor and Llandudno Hospital. More

complex surgical procedures would be referred to the Maxillofacial Surgery Departments

at the three District General Hospitals (DGHs).

North Wales CDS is also a training provider for all members of the dental team. Dental

nurse training courses such the NEBDN accredited Oral Health and Conscious Sedation

courses are offered and generally attain higher than national pass rates. A Special Care

Dental Nursing Course, accredited in 2013 is currently running for the first time in a

number of years, with eight candidates being prepared to sit the examination in June

2014. The Service provides outreach training to all final year dental students from Cardiff

Dental School providing training and experience in IS and the management of children

and adults with special needs. At any one time there are also three Dental Core

Trainees (year 1) gaining experience within the CDS.

27

It has been requested and agreed that a CDS dentist will attend cleft palate clinics held in

all three DGHs to ensure continuity of care for these patients. One specialist also works

with the Consultant in Restorative Dentistry, on a sessional basis, serving as a link

between the cancer multi disciplinary team and the community dental service thereby

assisting in the facilitation of pre, peri and post operative oral care during radiotherapy

and chemotherapy.

As the CDS has been focussing on providing special care dentistry for many years there

are some well established links and referral networks in place. These vary by locality

and according to local need. Referrals are received frequently from general dental

practitioners, medical practitioners, learning disability and mental health teams,

residential and nursing homes, social services and community nurses.

Protection of Vulnerable Adults training, particularly important when delivering care to

vulnerable adults, has been delivered for CDS staff in 2009 and 2013.

A number of North Wales’ initiatives relating to Vulnerable Groups have been cited as

examples of good practice in the National Oral Health Plan:

Good practice: Betsi Cadwaladr University Health Board has recently

launched Gwên am Byth. North Wales Community Dental Service, in

liaison with PHW, has developed a new service aimed at improving oral

health and access to care for vulnerable older people living in residential

care. The service is provided by a dedicated team led by a Specialist in

Special Care Dentistry. The programme comprises training for care staff

and dental examinations for residents with the provision of individual oral

care plans. Dental treatment is also arranged as appropriate at either a

fixed site or from a newly commissioned purposely designed mobile dental

unit.

Good practice: Through Programmes for Children with Learning Disability, all

children in special schools in Flintshire and Denbighshire are offered the

opportunity to take part in a schools-based oral health improvement

programme. An experienced oral health educator and dental health care

support worker work in a multidisciplinary approach to support delivery of

the Children’s National Services Framework

There is also a Programme for Adults with Learning Disability through which

residents with learning disability can benefit from a comprehensive

programme of oral health promotion. A full time oral health educator leads

this programme with part time input from two community learning disability

link nurses seconded to the CDS. The programme has been locally funded

since 2004 and further supported and expanded in 2008.

Where we need to be:

There is a requirement for GA and sedation waiting times for adults with special needs to

be addressed.

It is recognised that information for service users and referrers to the Special Care Dental

service needs to be updated.

28

Although networking is strong in some localities community health, social services and

third sector links need to be further developed in other areas. Additionally, regionally

agreed referral and care pathways into the Special Care Service and for Domiciliary Care

need to be refined and a centrally managed referral database considered.

Given the age profile of the specialists and experienced workforce in SCD succession

planning is paramount and the development of a career pathway in the specialty in North

Wales needs to be implemented. A workforce training and development plan will assist

with this and application has already been made to convert a Band A Dental officer post

to a training grade in SCD. Discussions have taken place with the Director of

Postgraduate Dental Education in Wales and the Consultants in SCD at Liverpool Dental

School in order to progress this.

Actions:

· Task and Finish Group-Integrated referral and care pathway for Cancer Care to report

to the MCN by 31 March 2014.

· Task and Finish Group-Integrated referral and care pathway for Stroke patients to

report to MCN by 31 March 2014.

· Task and Finish Group- Integrated referral and care pathway for Domiciliary care to

report to MCN by 31 March 2014.

· On behalf of the SAF North Wales to develop a care pathway for Bariatric patients by

31 March 2014.

· Gwên am Byth to be expanded to include all nursing homes in Denbighshire and the

programme to be introduced into remaining UA areas using 1000 Lives principles as

funding allows 2014-18.

· Adult Learning Disability Programme to be gradually rolled out to other UA areas

2014-18.

· Child Learning Disability Programme to be expanded as an adjunct to D2S 2014-15.

· A North Wales and Powys SCD Training and Workforce plan to be developed by the

MCN by 30 April 2015.

· Meetings of MCN to be held within working hours in an attempt to improve attendance

by key stakeholders 20 March 2014.

· Progress post of Specialist Registrar by 30 June 2014.

· Vacant CDS post(s) to be filled to reduce waiting times for sedation and GA for adults

with special needs, by 31 December 2014.

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8.

The recent inquiry into Children’s Oral Health by the National Assembly for Wales

Children and Young People’s Committee recommended that:

The Welsh Government should ensure that data on the number of general

anaesthetics administered to children and young people for dental work in

Wales is collated and reported as part of the monitoring of Designed to Smile.

Where we are:

A total of 9129 dental GAs were performed in Wales for children under 18 years of age

during 2012-13 of which 1373 were carried out in North Wales. (Table 5) Some

additional cases would also have been conducted in England in the Countess of Chester

Hospital.

During the collection of the data for North Wales there was evidence of double counting

cases at some locations with cases being recorded for Oral and Maxillofacial data as well

as the CDS; the latter being the main service provider. However, the reported Welsh

Government data only takes account of information submitted by the CDS. It is a

requirement for accurate data to be provided on an annual basis to the Office of the Chief

Dental Officer.

Table 5: Prevalence of dental GAs amongst the under 18 population

 LHB

Number of children

aged under 18

Number of GAs by LHB of

patient’s residence

% prevalence

Powys 27,850 30 0.11

Cardiff & Vale 105,416 989 0.94

Betsi Cadwaladr 148,940 1,373 0.92

Aneurin Bevan 133,632 2,230 1.67

Cwm Taf 66,495 1,011 1.52

Hywel Dda 81,028 1,427 1.76

Abertawe Bro Morannwg 110,726 2,068 1.87

WALES 674,087 9,128 1.35

 \*2011 Census data (calculated from single year age groups)

The prevalence of dental GAs in the under 18 population is among the lowest of the

Health Boards in Wales with the exception of Powys where a GA service has only

recently been introduced. This is likely to reflect the extent of the Sedation Services that

has been developed in North Wales. It will be noted that the number of sedation cases

exceeds GA experience. (Table 6)

Table 6: GA and Sedation Activity 2011-12

Sedation General Anaesthetic Total GA &

Sedation

0/4 5/15 16/64 65+ Total 0/4 5/15 16/64 65+ Total

2012/13 7 941 1206 46 2200 171 1154 358 2 1685 3885

A comparison with the 2011-12 activity in Figure 7 shows a reduction in the number of

GA cases for children however, this cannot be interpreted as a reduction in need but

reflects a reduction in the availability of GA sessions and an increase in waiting times for

Health Boards following recommendations by the National Assembly

Children and Young People Committee to collect annual data on the

number of children who receive dental treatment under General

Anaesthesia (GA).

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the service during 2012-13. Contributing to this was the number of cancelled sessions

during the year due to the unavailability of Anaesthetist cover at some locations and a

temporary disruption in service during the transfer of service from the Royal Alexandra

Hospital to Ysbyty Glan Clwyd towards the end of 2013.

Figure 7: GA activity 2012-13 compared with baseline (2011-12)

A multidisciplinary GA Clinical Governance Group has produced a GA care pathway and

standardised documentation for use at all GA centres across North Wales. A

preventative intervention as part of the GA assessment is currently being piloted.

Referrals are triaged prior to assessment. Referrals to treatment times vary from 4-12

weeks, dependant on location, although urgent cases are accommodated and fitted into

an early GA session if this is the most appropriate mode of treatment. Many children

referred for GA are managed using IS or behavioural management. Wait from

assessment to treatment for routine extractions under GA varies from 6-12 weeks. For

those patients requiring comprehensive care under GA the wait from assessment to

treatment is 6-10 months at Ysbyty Gwynedd and 3-4 months at Ysbyty Glan Clwyd.

Two sessions a week are available for child exodontia at both Ysbyty Gwynedd and

Ysbyty Maelor with children accommodated at up to 5 sessions a week at Ysbyty Glan

Clwyd for both routine extractions and comprehensive treatment. At Ysbyty Gwynedd

comprehensive treatment under GA is available for 3 sessions a month.

Where we need to be:

A solution to the medium term problems in maintaining service delivery at Ysbyty Glan

Clwyd needs to be determined. Various options are being pursued.

It is essential that the facilities provided in the Ambulatory Quarter (AQ) at Ysbyty Glan

Clwyd meet the needs of the service and as a minimum equate to those vacated at Rhyl.

The MDT is represented on the AQ Outpatient and Therapies Design User group.

The long term strategy must be to reduce the number of GAs. However, in the short term

a reduction in waiting times for GA and an increase in employment of alternative

treatment modalities is desirable.

Parkway

Clinic

Morriston

Hospital (inc

PoW)

Kensington

Court

Aneurin

Bevan (inc

Royal Gwent)

CDS

Prince

Charles

UDH

Royal

Glamorgan

(C&V CDS via

SLA)

Parkway

Clinic

ABERTAWE BRO

MORGANNWG

ANEURIN BEVAN

BETSI

CADWALDAR

CWM TAF CARDIFF & VALE HYWEL DDA POWYS

2011-12 1997 308 1827 0 1547 284 1143 717 1368 0

2012-13 1903 128 1834 214 1373 385 1244 605 1343 1

0

500

1000

1500

2000

2500

Number of GAs

2011-12 2012-13

31

Actions:

· The MDT will continue to work with planning and estates to resolve the medium term

problem with a deadline of 31 March 2014 to be met.

· The AQ architect will visit the facility in Rhyl to familiarise himself with the

requirements of the service by 31 March 2014.

· The new time line for the relocation of the Community Dental Service provision to the

AQ (outpatient department) will be determined by 30 April 2014.

· Additional sessions will be provided by filling vacant funded posts to increase the

number of GA assessments sessions and therefore reduce waiting times for children

to facilitate their treatment using behavioural management, IS or GA, as appropriate

by 30 June 2014.

· The pilot for preventative interventions will be expanded to two sites and evaluated by

31 July 2014.

· Double counting of GA activity will be eliminated before reporting 2013/14 data to

Welsh Government. This will be progressed by IT with a report to CGP Surgical and

Dental Board by 31 March 2014.

9.

The CDS leads on the provision of GA for the dental treatment of adults who are unable

to receive treatment utilising Local Anaesthesia. Sedation techniques are also offered.

Dental General Anaesthetic and Sedation activity for adults (ages 16-64) receiving care

in the CDS is presented in Table 7 for 2012-13. (Data will be regrouped for adults 18-64)

Table 7: GA & Sedation Activity within the Community Dental Service for Adults

 16 - 64 65+

General Anaesthetic 358 2

Sedation 1206 46

Where we are:

Waiting times are presented in Table 8 below.

Table 8: North Wales Special Care Dentistry GA Waiting Time Data as end

November 2013

 0-3

months

4-6

months

7-9

months

10-12

months

13-15

months

16-18

months

Glan Clwyd (weekly sessions) 55 41 - - - -

Glan Clwyd (ASA4 list) approx 4 days pa 13 7 5 3 2 2

Llandundo (monthly) 15 11 5 - - -

Total 83 59 10 3 2 2

 Awaiting assessment Waiting Time

Glan Clwyd 90 3-4 months

Llandudno 27 1-11 months (triage for priority)

Health Boards must keep up to date information on waiting lists for

vulnerable people who require dental treatment under GA and ensure

that patients do not wait longer than Welsh Government guidelines.

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Where we need to be:

Additional assessment sessions are required to reduce the time between referral and

assessment as not all adult patients referred for GA will require this method for treatment.

By reducing the waiting time for assessment, treatment can be accelerated so that

patients can receive their care utilising the most appropriate treatment modality

(Behavioural Management Techniques, IS, IVS or GA) and the wait between referral and

treatment under GA thereby reduced. The provision of suitable facilities at Ysbyty Glan

Clwyd for this essential service is deemed a priority to ensure waiting times can be

maintained / improved until the AQ facilities are available.

Actions:

· Vacant funded CDS post(s) to be filled to reduce referral to assessment waiting times

by 30 June 2014.

· The system to monitor waiting times to be refined and centralisation of referrals to be

considered by 31 July 2014, with reports to CPG Surgical and Dental Board.

· Suitable alternative interim facilities will be identified and a timeline produced for the

transfer to the AQ by 30 April 2014.

10.

The Health Board is co-terminus with the North Wales Region although patients are also

referred from Powys and Ceredigion.

Where we are:

As part of the work being undertaken on service redesign relating to intermediate tier in

Oral Surgery care pathways are being reviewed.

The recent retendering exercise in relation to Specialist Orthodontic Services has

necessitated a review of the Orthodontic Care pathways by the Orthodontic MCN.

North Wales and Powys are working together with regards to the SCD agenda with

subgroups taking forward care pathways in domiciliary care, bariatric care, stroke and

cancer.

Where we need to be:

Care pathways are required for a number of patient groups and will be taken forward by

MCNs or subgroups of the OHSG. These are identified with their target dates in the

relevant sections of this report; iIncluding sections 7, 13 and 19.

Action:

· Work streams being undertaken by MCNs and subgroups/Task & Finish Groups will

report progress at OHSG meetings.

Health Boards must work together to develop regionally agreed referral

and care pathways which will promote efficient patient care and better

working across the General Dental Service, Community Dental Service

and Hospital Dental Service.

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IMPROVING QUALITY & SAFETY

11.

The GDC has confirmed that Oral Cancer: Improving Early Detection is to be included as

a ‘recommended topic’ in its Continuing Professional Development Scheme for all

members of the dental team. It is recognised that Dental Professionals have an ethical

obligation to educate their patients regarding the causes and the early signs of oral

cancer.

Where we are:

Consultants in secondary care are intimately involved in post graduate dental and

medical education. They provide annual teaching sessions organised by PGMDE in the

East, Central and West North Wales Post Graduate Departments.

Dental Teams already do have access to postgraduate training to address educational

needs regarding oral cancer. A number of courses have been scheduled in previous and

current postgraduate calendars. (Appendix 6)

Patients diagnosed with oral cancer are already provided with information and details of

Third Sector Organisations and websites so that they can access advice and support.

Where we need to be:

We need to continue to provide training locally so that all Dentists and DCPs are able to

access training in oral cancer training.

Dentists and DCPs in Primary and Community Dental Service should be made aware of

the information patients receive of Third Sector Organisations and of websites.

Action:

· Information issued to oral cancer patients to be issued to all Practices and the

Community Dental Service by Consultant(s) in Maxillofacial Surgery by 31 May 2014.

12.

At least three-quarters of oral cancers could be prevented by the elimination of tobacco

use and a reduction in alcohol consumption. Smoking cessation is associated with a

rapid reduction in the risk of oral cancers, with a 50% reduction in risk within three to five

years. Ten years after smoking cessation, the risk for ex-smokers approaches that for

life-long non-smokers.

The Tobacco Control Action plan (2012) identifies dentists as being key players and that

they should take all opportunities to encourage smokers to quit, advise on ‘quit strategies’

and give information on cessation support services and nicotine replacement therapy.

Health Boards must work with Postgraduate Medical and Dental

Education (PGMDE) to ensure dental teams should 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.

Health Boards must work with PGMDE to ensure that the dental actions

contained within the Tobacco Control Action Plan (TCAP) are taken

forward.

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The document highlights that most people now know of the dangers of smoking to their

general health but they are less aware of the damage of tobacco use to their mouth, from

gum disease to oral malignancies.

Specifications regarding actions that should be taken by LHBs in contract negotiations

and by the Dental Postgraduate Department are included in the NOHP.

NICE Guidance states that:

· Everyone who smokes should be advised to quit.

· People who smoke should be asked how interested they are in quitting.

· Those who want to stop should be offered a referral to an intensive

support service (NICE Guidance PH001: Brief Interventions and Referral

for Smoking

· Cessation in Primary Care and Other Settings, 2006).

The NOHP highlights the key role that all members of the dental team have in providing

smoking cessation to all patients who smoke (including those attending on an irregular

basis for emergency treatment). The Plan also underlines two key actions that relate to

dentistry and tobacco in the Tobacco Control Action Plan:

· Health Boards should discuss with dental providers the delivery of smoking

cessation advice as part of their Dental NHS Contract negotiations.

· The Dental Postgraduate Department will provide training in brief intervention

for smoking cessation to dental teams throughout Wales.

Where we are:

Brief Intervention Training is available from Stop Smoking Wales which offers an

accredited half day/day brief intervention training course or an E learning package NHS

e-Learning Package. They are free to teams and organisations and equip professionals

who come into contact with smokers on a regular basis with the appropriate knowledge to

deliver effective brief interventions in their everyday practice.

Discussions have already taken place with PHW staff as how best to introduce a referral

initiative in North Wales and a pilot will be introduced in the CDS.

Where we need to be:

There is a need to increase uptake of training available through the Dental Postgraduate

Department and raise awareness of other learning opportunities to dental teams.

Actions:

· Information regarding the e-learning packages available will be issued to all practices

by 31 March 2014.

· Brief Intervention Training will be delivered to Community Dental Service staff by

31 March 2015.

· A referral pilot will be organised in the Community Dental Service using 1000 Lives

methodology by 30 November 2014.

· The Health Board’s primary care staff will discuss this issue during contract meetings.

Ongoing.

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13.

Fundamentals of Care audits have shown that mouth-care is of high importance to

patients but that it has often been perceived as poorly performed in hospital settings in

Wales. Studies have shown show that up to 91% of adult patients have existing oral

health problems on admission to hospital. It has also been recognised that oral health

problems have the potential to impact on general health. An example is the increasing

evidence of poor oral hygiene being associated with an increase in incidence in Ventilator

Acquired Pneumonia (VAP).

As part of the 1000 Lives Plus programme, adult patients were identified as being in need

of improved support to maintain their oral health. An all Wales “mouth-care bundle” was

launched early in 2013.

Where we are:

It was necessary for ward staff to be familiar with the tools for assessing each patient’s

oral health status, on admission and at regular intervals thereafter in line with the all

Wales mouth-care bundle, if the programme was to be introduced successfully.

However, it was reported by nursing staff in North Wales that they felt they lacked the

knowledge, skills and confidence to use the bundle effectively. It was necessary for

these concerns to be addressed and to identify the learning needs.

An assessment of the need for training in implementing this care bundle was carried out

for nurses in acute and community settings across North Wales. The information

collected informed the design of a learning resource which was evaluated in use with a

variety of nursing and student nursing groups. These efforts were made possible through

collaborative working between nursing and Community Dental Service representatives.

Questionnaires were distributed on the wards in which the mouth-care bundle was due to

be introduced. These asked staff about their experiences of and attitudes to assessing

oral health status and providing the appropriate daily oral care.

Analysis of the results identified several training needs. These fell into four main

categories:

1. Lack of awareness of the nurse’s role in mouth-care of the patient.

2. Unsure about recognising signs that the mouth is unhealthy and not clear about

the processes needed to remedy various presenting mouth problems.

3. Little formal training in carrying out mouth-care, specifically in facilitating daily

tooth-brushing.

4. Not familiar with products available for oral hygiene and keeping patients’ mouths

comfortable.

A multidisciplinary collaborative was established to create a robust training package

which was interactive and incorporated a problem-based learning section. It was

delivered to a number of student nurses and qualified nurses across the LHB area as

part of a pilot study and a number of wards were selected to be early adopters of the

mouth-care bundle.

Health Boards should take account of and participate in the 1000 Lives

Plus programme to Improve Mouth Care for Adult Patients in Hospital.

36

An Oral Care Champion from each of these wards was encouraged to attend the training

and to roll the programme out via other ward staff. A ward “aide-memoire” resource has

also been developed and introduced to compliment the teaching session.

The efforts of the collaborative team resulted in them receiving a “highly commended”

award in the “evidence-based practice” category of the 2013 NHS Achievements Awards.

To date 353 nursing staff have received training in using the risk assessments and care

plans. Thirty wards are now using the tool out of a possible 103, with a further 16

planning to do so.

A triaging protocol has been developed for the onward referral of patients deemed to

require an opinion or urgent treatment and is being piloted. The impact on services is

being monitored.

Workshops are planned for early 2014 at each of the acute sites in North Wales.

Where we need to be:

The initiative needs to be introduced to more wards and rolled out to all hospitals across

North Wales in line with 1000 Lives principles. In the absence of identified funding and

other pressures it is likely to be a challenge to maintain the impetus and enthusiasm for

the scheme. However, the teams involved are determined that their objectives will be

met although a phased introduction is inevitable.

Specific challenges in providing oral health care to certain patient groups exist.

Examples include those with dementia or dysphasia and oncology patients where the

generic mouth-care bundle will need to be customised to meet their specific needs.

District Nurses, who are in contact with many vulnerable patients, often after discharge

from hospital, have not received any tailored training and this needs to be rectified.

The number of dentures lost in hospitals needs to be reduced as this increases workload

for clinicians, compromises outcome for patients and incurs unnecessary expense for the

LHB.

Support to implement the programme following training will be necessary in the first

phase.

Additional funding will be required to allow this programme to be rolled out within the

community setting, which will be required as patients are being discharged into the care

of the community at a much earlier stage in their recovery.

Actions:

· The broadening of the membership of the collaborative group to include

representatives from other disciplines will be explored with a view to developing

additional training resources for specific patient groups. These will be shared with the

all Wales Special Care Dentistry Special Interest Group.

· The results of the pilot for onward referral will be evaluated by 31 August 2014 for

consideration by the SCD MCN.

· Progress will be monitored and the programme will be reviewed annually to ensure

the documentation products etc conform to current best practice.

37

· Training needs of District Nurses to be determined by 31 March 2015.

· Lost dentures will be monitored by Hospital and Ward, all incidents will be recorded

on DATIX and a report produced for the OHSG by the DATIX system support team by

31 March 2015.

14.

General Dental Services

Where we are:

Primary care dental services are provided across the LHB via a network of 97 dental

practices. Each practice has a GDS or Personal Dental Service (PDS) contract with the

Health Board for the delivery of a specified level of annual activity (Figure 8).

Figure 8: Contracted UDA 2011-12

Primary care dental services provided at GDS/PDS practices within the HB area were

accessed by 51% of the resident population during the 24 months to June 2013. While

this rate shows a gradual improvement over recent years it is still some way short of the

All Wales average (see Figure 9).

Health Boards must include issues relating to primary dental care as

part of their annual primary care reporting process and include them in

their Annual Quality Statement.

LOHP must contain specific actions regarding the management of the

current General Dental Service 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

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Figure 9: 24 Month Patient Access Levels

The Health Board has developed and implemented a robust governance and

performance review framework identifying any contracts considered as being at risk

before prioritising them for action. Depending on the type and level of risk identified the

Health Board will work with the contractor to address the concerns utilising an

appropriate combination of practice visits, dental adviser support and DRS Case

Assessment. An action plan will be agreed with the contractor and improvements in

performance will be evidenced as part of the Health Board’s routine monitoring

procedures. Routine monitoring procedures include:

Performance monitoring - monthly

Performance review - 6 monthly

Practice risk assessment review - annually

Practice compliance visit - 3 yearly

In the event of potentially fraudulent activity being evidenced the case will be referred to

the Counter Fraud Team and funds recovered.

Where we need to be:

The Health Board will work toward ensure all dental funds are utilised optimally by:

· identifying underutilised or ineffectively utilised dental funds and reallocating in

accordance with commissioning priorities

· reviewing existing commissioned service levels and identifying where location,

quantity or restricted access is not in line with Health Board commissioning

priorities and adjusting those contracts accordingly, where this is possible

· working with contractors to ensure the effective application of NICE patient recall

guidelines to facilitate access to the optimum number of patients at each practice

The Health Board will work toward improving overall access levels to at least the All

Wales average by commissioning additional dental services, as and when budget

constraints allow. These will be targeted, where appropriate and possible, at addressing

areas where access is low, oral health is poor or there is inequity in the current dental

care provision.

24 Month Patient Access Levels

44.0

46.0

48.0

50.0

52.0

54.0

56.0

Mar-10

Jun-10

Sep-10

Dec-10

Mar-11

Jun-11

Sep-11

Dec-11

Mar-12

Jun-12

Sep-12

Dec-12

Mar-13

Jun-13

Quarter Ending

% Residents

All Wales

BCU HB

39

Service commissioning will consider practice provision of access to patients with a

sensory/physically disability.

The existing governance monitoring procedures will be reviewed and

amendments/improvements made to ensure satisfactory assurance is maintained on

aspects of contractor performance, clinical, financial, probity and quality.

Actions:

· Mechanisms to be reviewed to ensure effective monitoring and utilisation of funds and

where appropriate, their reallocation in line with Health Board access priorities by

30 June 2014.

· Review framework of priorities and criteria for commissioning additional services.

Commission services only from practices that satisfy these criteria and priorities.

OHSG by 30 June 2014.

· Monitor patient recall intervals and work with contractors to ensure NICE Guidelines

on recall intervals are complied with. PCSU ongoing.

· Regularly review governance monitoring procedures and ensure adequate assurance

is maintained on performance, clinical, financial, probity and quality aspects of

contractors work. PCSU ongoing.

Orthodontic Services

Where we are:

Primary care orthodontic services are currently commissioned by the Health Board at 5

Specialist practices and 11 general practices at which there is at least one dentist with

‘enhanced skills’. These practices are distributed reasonably evenly over the LHB relative

to the main centres of population. (Figure 10)

Figure 10: Contracted UOA 2011-12

40

A 2013 Public Health Wales report on the Orthodontic Needs Assessment for North

Wales (Appendix 7) states that between 26% (Flintshire) and 38% (Conwy and

Gwynedd) of 12 year olds has a significant orthodontic problem. The report estimates

that, on average, around 2,030 patients require treatment across the LHB on an annual

basis. This number includes those patients whose treatment is provided in secondary

care by the HDS and by the CDS.

Using the needs assessment report as a guide the LHB has recently completed a

procurement exercise restructuring and recommissioning specialist orthodontic services

at 4 sites across the LHB. The procurement exercise resulted in the award of 4

Specialist Orthodontic PDS contracts, which take effect from October 2014 and are

initially for 4 years with an option for the Health Board to extend for a further 6 years.

The new contracts specify the provision of services will be provided by or under the close

supervision of a registered orthodontist. The new contracts include the Key Performance

Indicators provided in the Interim Guidance on Management of NHS Orthodontic

Contracts in Primary Dental Care.

Any further commissioning/recommissioning of orthodontic services will reference the

needs assessment and be based upon maintaining a quality service, matched to need

and representing value for money.

Where we need to be:

The Health Board will continue to provide access to orthodontic services via a

combination of hospital based consultant, specialist orthodontic practices within primary

care and dentists with enhanced skills. Some orthodontic services will also continue to

be provided within Community Dental Services.

The rural nature of the Health Board and the potential long travel distances for patients

from some of the more remote locations will be addressed by the maintenance of

services with DwES in some general dental practices. Guidance of the MCN in

recognising and maintaining orthodontic DwES will be required.

Orthodontic treatment will be provided in a primary care setting wherever appropriate and

possible. Management and monitoring of primary care orthodontic services by the Health

Board will be carried out in accordance with the Interim Guidance of NHS Orthodontics in

Primary Care provided by Welsh Government.

Actions:

· Regularly review all contracts to ensure effective utilisation of funds. Reallocate funds

in line with Health Board access priorities where appropriate by PCSU ongoing.

· Work with the MCN to develop and implement effective recognition and monitoring

framework for orthodontic DwES, by 31 March 2015.

· MCNs to report to the OHSG on North Wales referral protocol by 30 June 2014.

· Manage all orthodontic contracts in accordance with the Interim Guidance of NHS

Orthodontics in Primary Care provided by Welsh Government. Ongoing action.

41

· Regularly review governance monitoring procedures and ensure adequate assurance

is maintained on performance, clinical, financial, probity and quality aspects of

contractors work. PCSU.

· The needs assessment report to be reviewed by DPH taking account of new

provision. 31 March 2015.

15.

Where we are:

The LDC, Primary Care Division and BCUHB’s Staff Health and Wellbeing Service have

agreed and introduced an Occupational Health Programme for dental teams working in

the General Dental Service. This comprises the following:-

Inclusive Services Provided For Retainer Fee Agreements:

· Employment health assessment

· Health/Sickness Absence consultation with Specialist Nurse Practitioner and/or

Physician

· Blood tests (e.g. Hepatitis B screening / HIV / Hepatitis C)

· Vaccination for work related preventable disease(e.g. Hepatitis B, MMR, TB)

· Flu vaccination (details will be circulated annually)

· Sharps / Body Fluid incidents

· Advice for contact or symptomatic of communicable diseases

Other services:

· May be provided as a cost per item of service e.g. counselling, Display Screen

Equipment Workstation assessments, retrospective vaccinations etc.

· Access to the service will be via management referral. No self referrals will be

accepted unless there is a prior agreement in writing.

Where we need to be:

Ideally, the service should provide a full occupational health service to include

counselling and other items that are currently chargeable. Self referrals should be

included.

Action:

· Implement an annual review of the take up and cost effectiveness of the service to

ensure that it maximises the services provided and that it provides value for money by

31 March 2015.

16.

Information gleaned from the 1000 Lives Plus project identified that nurses considered

that their undergraduate and continuing professional training could be enhanced by

Health Boards must 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.

Health Boards will support the Community Dental Service (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.

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including an evidence based oral health component. It has been agreed with the

University of Wales that there will be 9 hours of oral health training years scheduled into

the 3 year Undergraduate curriculum for nurses.

Where we are:

With the cooperation of the Universities of Bangor and Glyndwr an oral health module

has been included into the Undergraduate Curriculum for nurses. It is delivered by the

community dental team at Glyndwr. Lecturers at Bangor have attended the oral health

workshops and will deliver the training in house. This will be reviewed with them

annually to ensure that content meets current best practise.

To date 101 student nurses have received at least 3 hours oral health training and it is

planned to develop the training to include a practical aspect.

Qualified nurses and Health Care Support Workers (HCSWs) on wards have or will

receive training through the 1000 Lives plus initiative.

Gwên am Byth delivers a training package to Nurses and HCSWs caring for people living

in care homes in Flintshire and Denbighshire. These residents also have individual oral

care plans formulated to meet their specific needs.

Oral health care training has been introduced in the Induction Training that all HCSWs

working in hospitals receive.

Where we need to be:

The training needs of HCSWs in hospitals need to be explored to ensure that the

cascading of information by trained nursing champions is meeting their needs.

Actions:

· The outcomes of the undergraduate training package to be monitored at least

annually from 31 March 2014.

· The training package delivered to HCSWs will be monitored and evaluated by

31 August 2014.

17.

Patient delay has been cited as the main reason for late presentation and there is

evidence that the risk factors and symptoms of this disease are not well known by the ‘at

risk’ population or the general public.

Where we are:

To date, during Smile Month (May) attention has focused on children. There has been

very little input to Oral Cancer Month (November) outside of the DGHs.

A Head and Neck Cancer week (23 - 27 September 2014) is a pan European initiative

with 13 countries participating and discussions on how this can be implemented are

being considered nationally.

Welsh Government, Public Health Wales (PHW) and Health Boards

should ensure that high risk groups are targeted by national campaigns

(e.g. Mouth Cancer Awareness and National Smile months).

43

Cancer Awareness training is being delivered to all secondary schools in North Wales.

This initiative includes oral cancer.

Where we need to be:

Given that the incidence of oral cancer is increasing in younger cohorts there is a need to

increase the knowledge of oral cancer in the general population and in other professional

groups so participation in initiatives to raise awareness is deemed essential. We need to

determine how best North Wales can participate in the initiatives.

Actions:

· Seek input from the HPF as to how best to increase professional awareness of the

risk factors and symptoms of oral cancer. Dental member to take to HPF by 31 May

2014.

· The OHSG has delegated the planning and designing of the initiative to the Oral

Health Promotion Team which will pilot the initiative to raise public awareness of oral

cancer during National Smile Month (May 2014).

· The pilot will be evaluated by 30 June 2014 and adapted according to 1000 lives

principles in readiness for a campaign to be run during November 2014 (Mouth

Cancer Awareness Month).

· Consideration will be given as to the feasibility of North Wales participating in the

European Initiative by 30 June 2014.

18.

Where we are:

Local Authority and Third Sector representation is included in the MCN SCD.

All patients participating in Gwên am Byth and Adult Learning Disability Programme have

individual care plans.

Where we need to be:

Given the geographical area served and the wide remit and membership of the MCN

SCD, Task and finish Groups will be required to take forward this agenda. Members will

need to be co-opted relevant to the different patient groups.

Actions:

· Work streams will be determined by the MCN in SCD. (2013-18)

· Roll out Preventative Programmes identified as areas of good practice. (2013-18)

LOHP must include, 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.

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19.

A Ministerial Letter ‘Dental Services for Vulnerable People and the Role of the

Community Dental Service (EH/ML/014/08) was issued in October 2008 and is still

extant.

With regards to Domiciliary Dental care the guidance states:

Domiciliary care should reflect need in relation to the risk benefit to the

patient. The implementation of robust eligibility criteria will enable a

cohesive domiciliary service to be delivered, effectively, targeting finite

financial and human resources to the benefit of patients. The CDS is seen

as pivotal in the co-ordination of local services offering a single point of

access for a region or other defined geographical area. However, we

envisage the delivery of care as a cross service arrangement with patients

being assigned to the most appropriate provider be it GDS, PDS, CDS or

HDS.

A domiciliary setting is defined as any location which is not designated as a dental clinic

and includes areas such as private homes, residential homes, nursing homes, beds in

hospital settings etc. It does not include screening.

Where we are:

An exploratory paper on Domiciliary Care in North Wales was produced in August 2008

and a comprehensive report has subsequently been produced by the same author 2013.

Since the inception of the last Dental Contract in 2006 when all fees, including domiciliary

fees, were subsumed into a global sum based on earnings between October 2004 and

September 2005, the number of domiciliary visits carried out by GDPs under NHS

arrangements has reduced considerably.

The North Wales Community Dental Service operates domiciliary services within the

limitation of staffing. Figures for the last three reported years are given below in Table 9.

The figures can reliably be accepted as minimum figures.

Table 9: Domiciliary Visits Conducted by Community Dental Service Dentists

Year Total Number of

Domiciliary Visits

Number of CDS Dentists

Involved

 2010 / 11 1450 20

2011 / 12 1380 16

2012 / 13 1874 18

Currently a historic PDS contract is in existence in Gwynedd providing a limited number

of Domiciliary visits, this is shortly due for review.

The majority of patients requesting or being referred for domiciliary visits fall into the

housebound or bedridden category and fall into the over 65 age group. They tend to

have a variety of physical or mental problems that makes leaving the home or domiciliary

environment difficult.

As indicated in the demography of North Wales the proportion of the aging population

and the oldest cohorts are increasing with a corresponding predicted rise in dementia. It

LOHP must include use British Society of Disability and Oral Health

(BSDH) guidelines in developing plans for the delivery of domiciliary

services.

45

can therefore be concluded that the need and demand for dental care in the domiciliary

setting will increase over time.

Extrapolating from the population of retirement age, the greatest call on services is likely

to be in Conwy UA where almost a quarter of the population is aged over 65 (Table 10).

Of the 6 UAs in North Wales the percentage of the population over 65 is in excess of the

Welsh average (18%).

Table 10: Total Population and Population Aged >65 for Wales and North Wales

UAs

Area Population Percentage of population

aged over 65 years

 Wales 2,999,300 18

Anglesey 68,800 21

Gwynedd 118,800 20

Conwy 114,400 24

Denbighshire 96,700 21

Flintshire 149,900 17

Wrexham 133.200 17

North Wales 681,800 19.7 (134,000)

Provision of dental care under domiciliary arrangements to patients with a range of

disabilities, many of whom are medically compromised, is not without its challenges.

This is not only because of intrinsic problems caused by the non-surgery location and

circumstances in which treatment is attempted but in the light of new recommendations

and regulations regarding patient safety.

Guidelines for the Delivery of a Domiciliary Oral Health Care Service 2009 published by

the British Society for Disability and Oral Health have been utilised in the production of

the latest report for consideration by the MCN SCD.

www.bsdh.org.uk/guidelines/BSDH\_Domiciliary\_Guidelines\_August\_2009.pdf

It is important that resource intensive domiciliary care is only arranged when no

alternative treatment provision is possible. To avoid the service being abused a triaging

protocol has been formulated and is being piloted by the CDS.

A Task and Finish Group has been convened as a subgroup of the Special Care

Dentistry MCN to consider the report and its recommendations and will be reporting its

conclusions to the MCN and subsequently to the OHSG.

Where we need to be:

A cross service arrangement for the provision of Domiciliary Care in North Wales needs

to be agreed by the OHSG. The arrangement will need to take account of emergency

referrals. It is envisaged that the CDS will triage the patients contacting the service

requesting Domiciliary Care and refer to the most appropriate service provider (CDS,

GDS, PDS or HDS). In the case of GDS, separate contractor arrangements are likely to

be necessary. Following screening of care home residents by the CDS, referrals will also

to be made to the most appropriate service.

Actions:

· The Task and Finish group will report to the MCN by 31 March 2014.

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· A standard referral form will be designed and piloted along with a continuation of the

triaging system and care pathways finalised by the MCN by 31 July 2014.

20.

Where we are:

A Specialist in Paediatric Dentistry is employed within the CDS. Additionally, following a

lapse of 12-18 month, the service previously provided from Alder Hey Hospital has been

reinstated and a Consultant in Paediatric Dentistry from Alder Hey visits Holywell

Community Hospital on a quarterly basis. This facility benefits from having access to

OPG and Lateral Cephalometric radiography and a wheelchair recliner. Children who

would otherwise have been referred to Liverpool for advice are able to be seen in North

Wales. They are generally referred back to the referring dentist with a treatment plan;

treated locally within the CDS or for a small number of cases arrangements will be made

for them to receive treatment at Alder Hey.

Where we need to be:

Inhalation Sedation services are well developed and available at most CDS clinics

across North Wales with most dentists and all therapists trained in the delivery of this

treatment. Additionally IVS is available for older teenagers at 6 sites. Many CDS dental

nurses have received training in IS and a number have the National Examining Board for

Dental Nurses Post Certification Qualification in Conscious Sedation and are able to

assist with IVS.

Some sedation services are also provided under private arrangements in the GDS. All

training opportunities offered to CDS nurses are extended to nurses working in the other

branches of dentistry.

Developing criteria for DwES status in this discipline requires some further work on a

National basis in common with other disciplines to ensure some standardisation across

the LHBs.

Formalised training opportunities need to be explored with Liverpool/Alder Hey and the

possibility of establishing a Specialist Registrar (SpR) post in SCD explored.

Action:

· Discussions will be progressed with the Welsh Director of Postgraduate Dental

Education and Liverpool/Alder Hey depending on outcome of SpR post in SCD.

21.

The NOHP also requires Health Boards ‘to produce a strategy for specialist dental

services’. Although the majority of dentistry in the UK is delivered by dental generalists

there is evidence of increased referrals to specialist services which is predicted to rise.

Develop alternative patterns of care e.g. increasing the specialist dental

paediatric services and Dentists with Enhanced Skills (DwES)

workforce and building the capacity of alternative treatments such as

sedation where feasible.

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.

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A number of reasons have been suggested for this increasing trend including:

· changes in oral health with an increasing aging population who are retaining their

natural teeth (often heavily restored) and with associated complex periodontal,

endodontic, fixed or removable prosthetic problems

· more people with complex medical problems

· higher expectations of outcomes by patients

· availability of increasingly complex therapies

· insufficient time in the undergraduate curriculum to equip students to deliver

complex therapies

· differing expectations and experiences of a mobile dental workforce whose

undergraduate training within the European member states and experience of

specialties will be varied.

The changing needs and demands of patients, development of new treatments and an

increasing aging population will place growing demands on dentistry to provide more

complex care and treatment. It seems unlikely that the current undergraduate curriculum

can be expanded sufficiently to provide suitable training to meet these requirements.

There is thus a need to expand dental specialist training and to develop the process to

formally recognise DwES and thereby improve access to specialist treatments.

The generalist dentist has been compared to the conductor of an orchestra

(Prof A E Keaton) bringing in various sections of musicians (consultants, specialists,

DwES, DCPs) according to the musical score (patient need/treatment plan).

In younger age groups where preventative strategies have been produced, it is

anticipated that treatment needed for these cohorts will be reduced.

With the advent of Direct Access the roles of the Dental Therapist, Dental Hygienist,

expanded role Dental Nurse and Clinical Technician offer opportunities.

Where we are:

MCNs have been established in Orthodontics and Special Care Dentistry. They are

taking forward the WG and local agendas and reporting to the Oral Health Strategy

Group and to the respective Strategic Advisory Fora.

Consultant led specialist services in Orthodontics and Maxillofacial Surgery are provided

at all three District General Hospitals. The Maxillofacial Surgery Service, however, is a

pan North Wales Service with Ysbyty Glan Clwyd serving as the hub and other locations

as satellites.

Consultant Orthodontic Services waiting times have resulted in cases being transferred

to Chester but this is perceived to be temporary, interim arrangement as funding has

recently been secured for additional Consultant sessions.

A part time Consultant service in Restorative Dentistry continues to be provided to

ensure compliance with head and neck cancer standards whilst the recommendations of

the Restorative Dentistry Review Group are being considered. However, other aspects

of work of a Consultant in Restorative Service are not being provided. The limited

access and waiting times in relation to this service has resulted in solutions having to be

sought outside of Wales. Following an assessment of need and evaluation of the option

appraisal, the professional advice provided by the Restorative Dentistry Strategic Review

48

Group is that a minimum of 1.5 Consultants (supported in the longer term by Specialists

and DwES) is required to meet the needs of the North Wales population.

Within Primary Care the only NHS Specialist Service currently provided is Orthodontics.

This service has been the subject of a recent re-tendering exercise; the first of this size in

Wales. Procedures adopted and lessons learned from this work may be of benefit to

other HBs in Wales facing a similar challenge.

The CDS employed a Specialist Orthodontist who has recently retired. Succession

planning has been in place and a dentist has been supported through training who it is

anticipated will attain DwES status when the process is finalised by the Orthodontic

MCN/SAFO. This peripatetic post reduces inequalities in access to orthodontic care in

socially deprived or geographically isolated communities.

A Consultant/Specialist service is also offered in Paediatric Dentistry which is addressed

in another section of the Plan.

The CDS has a well developed Special Care Dentistry (SCD) service, which is also

described elsewhere in the Plan.

Additionally, a dentist with an additional qualification in endodontics has been employed

who focuses on the provision of care to patients with complex special needs or who have

been referred by Consultants in secondary care and for whom treatment requires a

multidisciplinary approach.

Care pathways for each discipline are being developed as service changes are

addressed to ensure an integrated approach.

North Wales Community Dental Service is one of two areas in Wales selected to pilot

Direct Access with Therapists.

Where we need to be:

The recommendations of the Restorative Dentistry Review Group need to be considered

as a matter of urgency. A short term solution to deal with long waiters has been agreed

for patients with periodontal problems. However, patients with complex restorative

problems, worn dentitions and other challenging oral health conditions cannot access

treatment which requires the input from Consultants/Specialists in other branches of

Restorative Dentistry.

Actions:

· A comprehensive strategy for Specialist Services to be developed by OHSG by

30 September 2014.

· A definitive solution regarding Restorative Dentistry to be determined by

31 March 2014.

· Direct Access Pilot to produce interim report for OHSG by 30 June 2014.

· MCNs for Oral Surgery and Restorative Dentistry to be developed in line with

principles adopted nationally and locally with regards to MCNs in Orthodontics and

Special Care Dentistry, by 31 March 2015.

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22.

The NOHP stresses WG continuing commitment to the provision of CDS in Wales. The

role and remit of the service is the Ministerial Letter EH/ML/014/08; Dental Services for

Vulnerable People and the Role of the Community Dental Service.

In addition to treatment provision the service has roles to fulfil with regards to

epidemiology, Dental Health Promotion and Prevention including D2S, screening and

training.

Over the last 20 years the remit of the CDS has changed considerably and its role has

developed to include services complementary to both General Dental Services and

Hospital Dental Services; including:

· Personal Dental Service Clinics - established in areas where patients may have

difficulty in accessing the services of a NHS high street dentist.

· Intermediate Care Services – providing specialist / specialised oral health care in a

community setting and reducing demand on secondary care services.

Where we are:

Within North Wales, the CDS has strategically placed dental centres in Wrexham, Rhyl

and Colwyn Bay (3-8 surgery facilities), with medium sized clinics in Holywell and

Llanfairfechan (incorporating two surgeries and a wheelchair recliner facility). Smaller

satellite clinics and mobile units serve other areas of need. The larger centres provide

some intermediate care service(s), e.g. sedation (intravenous and inhalation),

orthodontics, dento-alveolar surgery etc, as well as the core services. Some smaller

centres may also provide some intermediate care services depending upon the skills of

the clinicians available. CDS/PDS interface services are provided from Colwyn Bay,

Denbigh, Corwen, Bethesda, Blaenau Ffestiniog and Wrexham. General Anaesthetic

clinics are also provided at Llandudno Hospital, Ysbyty Gwynedd, Ysbyty Glan Clwyd

and Ysbyty Maelor.

National Statistics for Wales (SDR 2012-13) recognises that, in addition to the generic

role of the CDS each area has faced unique local challenges and in response has

developed “distinctive features of service provision to meet these needs”.

Table 11 presents contacts for the Community Dental Services across Wales.

Through their CDS, Health Boards should ensure:

· provision of facilities for a full range of treatment to children

who have experienced difficulty in obtaining primary care dental

services, or for whom there is evidence they would not

otherwise seek treatment from such services

· provision of facilities for a full range of treatment to children

and adults who, due to their special circumstances, require special

care dentistry and/or have experienced difficulty in obtaining

treatment from other services, or would not have otherwise

sought treatment from other services.

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Table 11: Community Dental Service Contacts across Wales

2011-2012 2012-2013

 CDS 0-4 5-15 16-64 65+ Total 0-4 5-15 16-64 65+ Total

Betsi

Cadwaladr

3326 24144 18658 4917 51045 2840 22072 18010 6339 49261

Powys

Teaching

839 4477 2448 842 8606 731 3856 2184 836 7607

Hywel Dda 3633 10173 3279 501 17586 1129 8019 3430 768 13346

Morgannwg 2408 9141 2307 784 14640 2451 10804 3661 1147 18063

Aneurin

Bevan

2673 12290 6613 4576 26152 2290 9916 5945 4420 22571

Cardiff &

Vale

3430 35020 9950 4700 53096 2720 34972 9934 4694 52320

WALES 16310 95250 43260 16320 171125 12161 89639 43164 18204 163168

NB: Cardiff & Vale and Wales estimated 2011-12

Welsh Government has expressed concern regarding reductions in clinical activity and

seeks explanations for this. It will be noted that for 2012-13 there was a reduction in

clinical contacts of 3.5% on the previous years, this largely attributable to delay in

appointing to vacant posts.

In addition to reporting the highest number of adult contacts (16 and over) of the 3,424

sedation contacts recorded for Wales, 2,200 were carried out in BCUHB. These factors

illustrate the different ways in which services have developed across Wales.

The service has also been proactive in the development of Intermediate Care:

· Special Care Dentistry

· Sedation and General Anaesthesia

· Endodontics

· Paediatric Dentistry

· Oral Surgery.

The services involved in the delivery of a number of programmes which have been

described elsewhere in this report:

· Designed to Smile

· Gwên am Byth (Flintshire and Denbighshire)

· Child Learning Disability (Flintshire and Denbighshire)

· Adult Learning Disability (Flintshire and Denbighshire)

· Mouthcare in Hospitals

· Undergraduate Nurse training.

Additionally, a programme for vulnerable residents of all ages is provided in Caia Park,

Wrexham.

The service provides or co-ordinates training for dental nurses preparing them for the

NEBDN diploma examination. All students are dental nurses from the General Dental

Service. Additionally, courses are organised for qualified dental nurses in Conscious

Sedation, Oral Health Education and Special care Dentistry. Training in Topical Varnish

Application for Dental Nurses and in Inhalation Sedation for Nurses and Therapists is

also offered.

51

The service was proactive in establishing a totally latex-free surgery at Rhyl about

10 years ago. It triages and treats patients with a variety of allergies of varying

severities, specifically aimed at those with documented adverse reactions. The CDS is

moving towards converting all sites to low or latex free environments where possible.

Members of staff participate in training for Foundation Trainees and at any one time there

are three Dental Core Trainees (year 1) gaining experience within the CDS.

The Out of Hours Emergency Dental Service, originally established in 1984, is organised

by the CDS on behalf of the LHB with clinical leadership provided by a Senior CDS

clinician. The out of hours service is available on a walk-in basis every Sunday at

strategic locations and in evenings and on Saturday mornings by appointment made via

NHS Direct and local help lines.

Where we need to be:

Looking ahead to the next five years there are challenges which the need to be

considered and addressed, including:-

· Ensuring capacity and skills are available to meet the oral health needs of an

increasing and aging population, with particular regard to vulnerable groups.

· In order to reduce demand on often over burdened secondary care services.

There is a need to introduce more intermediate oral health care services within a

community setting (GDS and CDS).

· Access to NHS dental services need to be improved in areas where patients have

difficulty in finding an NHS Dentist. The CDS/PDS model remains an option.

· Some clinics do not meet modern standards (for example, surgeries located on

the upper floor of a building with no lift available). A programme of modernisation

is required to upgrade outdated clinics to modern standards and replace mobile

units, being utilised as fixed clinics, with appropriate modern facilities. This will be

considered and addressed through the development of the CDS Strategy and

Implementation Plan. Some of the solutions could lead to more integration of

services.

It is understood that any potential service development is constrained by financial and

other resource limitations. However, a planned response must be prepared to address

these challenges and ways considered to address them and achieve the targets set by

the Welsh Government in its Together for Health documents. The CDS is therefore

considering all of these issues and potential ways to address them within its Strategy &

Implementation Plan, ‘Developing Community Dental Services 2013-2018’.

A new Information Data Set has been developed by WG in liaison with CDS and will

need to be introduced. An All Wales Screening Protocol has also been developed by an

All Wales Quality & Safety Task & Finish Group, which needs to be implemented

targeting the D2S schools and other areas that are geographically isolated or socially

disadvantaged.

Priority needs to be given to recruitment of funded vacant clinical posts and given the age

profile of clinicians, succession planning is considered a priority to ensure the

continuation of appropriate skill mix and clinical leadership.

To encourage career development and specialisation in Special Care Dentistry and

Paediatric Dentistry, there is a need to develop training grades in these specialties.

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Actions:

· Agree and implement a CDS strategy and implementation plan for 2014-2018 by

31 July 2014.

· Recruitment to vacant posts to be considered in a timely fashion and timelines for

these to be monitored. On-going.

· Information data to be reported in new format by 30 April 2015.

· New Screening protocol to be implemented according to Welsh Government

timescale.

· A vacant Dental officer post needs to be identified for conversion to a SpR in SCD

post by 30 April 2014.

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Abbreviations

AQ Ambulatory Quarter

BCUHB Betsi Cadwaladr University Health Board

CDO Chief Dental Officer

CDS Community Dental Service

CPG Clinical Programme Group

D2S Designed to Smile

DCPs Dental Care Professionals

DGH District General Hospital

DwES Dentists with Enhanced Skills

GA General Anaesthesia/Anaesthetic

GDS General Dental Service

GFR General Fertility Rate

HCSW Health Care Support Worker

HDS Hospital Dental Service

HIW Health Inspectorate Wales

HPF Healthcare Professional Forum

IS Inhalation Sedation

IVS Intravenous Sedation

LAC Looked After Child/Children

LDC Local Dental Committee

LHB Local Health Board

LLTI Limiting Long-Term Illness

LOHP Local Oral Health Plan

MCN Managed Clinical Network

MDT Multi-Disciplinary Team

NEBDN National Examination Board for Dental Nurses

NOHP National Oral Health Plan

OHSG Oral Health Strategy Group

PCDPA Primary Care Dental Practice Adviser

PCSU Primary Care Support Unit

PDS Personal Dental Service

PGMDE Postgraduate Medical and Dental Education

PHW Public Health Wales

SAF Special Care Advisory Forum

SAFO Special Care Advisory Forum on Orthodontics

SCD Special Care Dentistry

SpR Specialist Registrar

ToR Terms of Reference

UA Unitary Authority

WG Welsh Government