DELIVERING BETTER ORAL HEALTH
IN CARDIFF & VALE

Local Oral Health Plan 2013-2018

An Oral Health and Dental Service Improvement Plan for
Cardiff and Vale University Health Board

December 2013
Dental & Primary, Community and Intermediate Care Clinical Boards
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Forward

In March 2013, the Welsh Government published its plans for improving the oral health of Wales for the next five years, entitled *Together for Health: A National Oral Health Plan for Wales 2013-18*. This plan ties dentistry and oral health into the overall vision of the Welsh Government for the NHS outlined in *Together for Health: A Five Year Vision For The NHS In Wales*.

This Local Oral Health Plan outlines how the health community in Cardiff and the Vale of Glamorgan plans to respond to the challenges outlined in these documents. Oral health and the provision of dental treatment are vital to the quality of life of our citizens and it requires the involvement of all parts of NHS dentistry and broader health services to see significant changes both in terms of lifestyle changes which will prevent disease and treatment options to provide the most appropriate care locally.

By ensuring the involvement of primary care dentists in the development and provision of patient centred care, this will ensure that patients are being treated in the most appropriate location. The development of the very fruitful Designed To Smile programme will ensure that the next generation grow up understanding the importance of looking after their teeth and will, hopefully, start to reduce the level of demand on treatment services.

Alongside this, Cardiff and Vale UHB play a vital role in training the coming generations of dentists and dental care professionals through the Cardiff University School of Dentistry based in the University Dental Hospital. This crucial link between the University and the Health Board ensures that, not only is Wales provided with high quality new dental professionals, but also our patients are provided with additional high quality care from leading Consultants in dental specialities.

It is vital that prevention is at the heart of this plan, helping our population understand the key messages which will improve not only their oral health, but also their general health. As David Thomas, the Chief Dental Officer for Wales, outlined in his foreword to the national plan, “Reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.” Cardiff & Vale UHB are committed to this journey which is more challenging for us, than for many, as we maintain our commitment to providing high quality training in the School of Dentistry.

By working with Health, Social Care, Education and Third Sector partners across the spectrum and our citizens, we hope that we can help people understand the importance of taking responsibility for their own oral health and seeing the improvements we all long for.

We commend to you the Cardiff & Vale UHB Local Oral Health Plan for 2013-18.

Professor Michael Lewis  
Board Director  
Dental Clinical Board

Dr Brendan Boylan  
Board Director  
Primary, Community & Intermediate Care Clinical Board
1. Development of Local Oral Health Plan and Good Governance Arrangements

**Welsh Government (WG) Action 1:**

Develop a Local Oral Health Plan to address the oral health needs of their residents, and clearly describe how they will ensure good governance in commissioning and delivery of all dental services.

**Where we are**

A key function of Local Health Boards set up in Wales on 1st April 2006, included the commissioning of NHS dentistry in response to local health needs. In addition, each Local Health Board (LHB) has a responsibility to improve the health of its local community, including oral health. In March 2013, the Welsh Government published ‘Together For Health: National Oral Health Plan For Wales 2013-18’ (NOHP), setting out the Government priorities for dental provision and oral health prevention. One of the priorities of the NOHP is for each LHB to develop and implement its own Local Oral Health Plan.

This Local Oral Health Plan is therefore set in the context of relevant national and local strategies, takes account of the current Cardiff & Vale picture of health needs and local service delivery and identifies key priorities for action over the next 5 years. Developed through the Oral Health Action Group, which includes all locally relevant stakeholders, it represents the locally agreed strategy for achieving good oral health in the local population and ensuring access to high quality NHS dental care across the city and region.

The Plan raises some significant long term aims and objectives. However, it is vital that it also has a strong short term focus in order to begin these developments. The Plan is an evolving plan and will be subject to regular review and revision, to ensure that it is reactive to changes in service and population need.

To achieve the aims of this plan, change is required. The skills, experience and dedication of the entire dental workforce are, and will remain, a vital resource upon which we will need to draw to achieve this change. Oral health is an intrinsic part of general health, and it is the responsibility of everyone involved in delivering health services to play a role in helping to deliver the oral health improvement necessary. Prevention is at the core of this plan and reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.

Working with colleagues across the health and social care professions to support people in taking responsibility for ensuring their own good oral health must become one of our major goals.

**The Strategic Framework**

The Local Oral Health Plan (LOHP) for Cardiff has been shaped by and is developed as the local response to the key strategic national and local strategies.

The fundamental document driving the expectations of the Welsh Government in relation to healthcare is *Together For Health – A Five Year Vision For The NHS* (published in 2011). This sets out the Government’s expectations for health care and services and all other plans draw from it. Therefore, in 2013, *Together For Health – A National Oral Health Plan for Wales 2013-18* was published to outline how the Government’s vision for health would apply to oral health and dental problems. With these key documents, the UHB are also expected to ensure compliance with other key WG strategic documents and plans which include:
• Setting the Direction: Primary & Community Services Strategic Delivery Programme (February 2010)
• Together For Health – A Five Year Vision For The NHS (February 2012)
• Together For Health – A National Oral Health Plan for Wales 2013-18 (March 2013)
• Delivering Local Health Care – Accelerating The Pace Of Change (June 2013)

Alongside these core plans and strategies, there are also a number of other guidance and strategy documents, developed both nationally and locally, which impact upon oral health and the development of dental services. These include:

• Designed to Smile – A National Child Oral Health Improvement Programme; Promoting Better Oral Health and Delivering a Fluoride Supplementation Programme (WHC(2008)008)
  National Child Oral Health Improvement Programme, initially targeted at areas of greatest need.
• Dental Services For Vulnerable People and the Role of the Community Dental Service – (Ministerial Letter EH/ML/014/08)
  Outlines the role of the Community Dental Service in Wales and the priorities for the service.
• Doing Well, Doing Better – Standards For Health Services In Wales
  Gives the standards for healthcare provision in Wales.
• Cardiff: 'What Matters' 2010-2020 – The 10 year Strategy
  The integrated partnership strategy produced jointly by numerous agencies including Cardiff Council and the UHB. Incorporates the previous Health, Social Care & Wellbeing Strategy.
• Vale of Glamorgan Community Strategy 2011-21
  The integrated partnership strategy produced jointly by numerous agencies including Vale of Glamorgan Council and the UHB. Incorporates the previous Health, Social Care & Wellbeing Strategy.

In order to deliver this LOHP effectively and extensively, the UHB will need to work with a wide range of users of dental services (through the Community Health Council), the dental workforce (from all parts of the dental service), other health professionals (especially GPs, Health Visitors, District Nurses etc), other Local Health Boards, Public Health Wales, the Department of Dental Postgraduate Education, the NHS Business Services Authority (Dental Services) and other partners including Local Authority Education Services and Social Services.

Commissioning Framework

The Plan also takes account of the Local Health Board’s responsibilities regarding the management of the dental contract, issued in 2006. These new arrangements meant for the first time the LHB:

• Has a duty to secure or provide primary care dental services
• Manages the financial resources for dental services
• Has the responsibility for commissioning primary care dental services to meet local health needs from dental practices
• Has the ability to commission suitable high street specialist dental services more cost effectively, closer to where patients live
• Has resources which follow patients rather than dentists so that if a provider ceases to provide primary dental services, or reduces their commitment to the NHS, the LHB retains the funding to commission services from an alternative provider

Having considered the above, the Local Health Board has identified the eight strategic priorities
1. Reduce the prevalence of dental decay, especially in young children
2. Ensure that consistent, key preventative messages and interventions are delivered
3. Reduce inequalities in accessing primary dental care services
4. Ensure that high quality, appropriate dental services are planned and provided for at risk groups
5. Ensure the delivery of specialist NHS services responsive to need
6. Maintain arrangements to ensure the planning and provision of high quality primary and community dental care services
7. Ensure access to unscheduled, out-of-hours and elective dental care is available to all
8. Work with the dental profession to ensure that the dental workforce is properly prepared and equipped to provide high quality patient centred care

A series of key research documents have provided vital support to the production of the LOHP and will continue to help direct the implementation of it. These include:

- **Primary Dental Care Service Use and Provision in Relation to Need 2012-13.** NHS Business Services Authority (Rob Wise) – August 2013
- **Oral Health Profile 2012** – Public Health Wales/Welsh Oral Health Information Unit (Maria Morgan) – March 2012
- **NHS Primary Dental Care Provision in Wales** – Exploring current service use and the distribution of services in relation to need. Public Health Wales/Cardiff University (Nigel Blewitt) – July 2011
- **Implementing the New Dental Contract** – Studies to inform the planning of NHS General Dental Services in Wales. Cardiff University (Ivor Chestnutt) – May 2008

**Structure of UHB and Dental Provision in Cardiff & Vale**

It is vital that the structures and the governance arrangements for dentistry are fully fit for purpose to ensure the safe and effective commissioning and provision of services for everyone in the Health Board area. It is necessary for these structures and systems to be assessed regularly for effectiveness and to ensure that they do not block the efficient integration of services.

The Cardiff & Vale UHB provides dental services through the following:

- General Dental Services (GDS) contracts for routine (mandatory) dental services from 73 practices (holding 90 contracts)
- Personal Dental Services (PDS) agreements for specialist dental services (currently orthodontics (4 specialist practices, 3 Dentists with Enhanced Skills), high need patients (currently 4 practices) & emergency treatment (currently 3 practices))
- Community Dental Services for vulnerable groups within community settings (through 8 clinics and mobile dental units plus the Designed To Smile and Dental Epidemiology programmes)
- Oral Medicine through consultant led services*
- Oral & Maxillofacial dentistry through consultant led services*
- Orthodontics through consultant led services*
- Restorative Dentistry through consultant led services*
- Oral Cancer services through consultant led services*
- Special Care Dentistry through consultant led services in UDH* and CDS specialists
- Tertiary care, providing leadership and expertise for Wales*

*These consultant led services are delivered from the University Dental Hospital which incorporates the Cardiff University, School of Dentistry. Many of the patients seen will be treated by students as part of their training, under consultant supervision

The University Dental Hospital houses the only Dental school in Wales and is responsible for the provision of teaching for undergraduates, postgraduates and other dental professionals. The service is funded by the Welsh Government via the Service Increment For Teaching
(SIFT) and as such provides primary dental care for patients who meet the required teaching criteria. Patients are assessed for suitability for treatment by undergraduate student and those that are unsuitable will be advised to seek care from a General Dental Practitioner (GDP).

There is an element of specialist care in a wide range of dental specialties provided for patients who are referred by General Dental Practitioners. Referrals are also accepted for advice only. Some of these referrals may qualify for treatment by postgraduate student in training in areas such as Endodontics, Orthodontics, Implantology and Sedation. The number of patients required for this element of teaching is however limited and those unsuitable will be referred back to their GDP.

The Dental Hospital works closely with the General Dental Services and the Community Dental Services in developing and delivering care pathways for patients locally in order to improve oral health in Cardiff and Vale and support the ongoing education of dental professionals across Wales. More specific details are included in various sections of this plan.

UDH’s role as a centre for tertiary care is dependent upon appropriate development of expertise and specialism across all LHBs in Wales. In the short term, Managed Clinical Networks are likely to be a key resource required to support the development of community based expertise and specialism. Therefore, the staff at the School of Dentistry, UDH and the CDS have a potential key role in supporting the early stages of development of these networks in and beyond Cardiff and the Vale of Glamorgan.

Cardiff & Vale UHB are currently moving to a structure which has devolved financial and service responsibility in Clinical Boards. The Clinical Board structure is designed to give great freedom to each part of the UHB to develop the services necessary to meet the needs of their patients and to take responsibility for the funds associated with this provision.

The purpose of the Clinical Boards is to:

- Make sure we are clinically led
- Power up the directorates and localities where patients and users are seen to take charge of their services and make sure they are well run, safe and of good quality
- Push further down, and speed up decision-making by placing authority to make decisions much closer to the front line
- Drive change and improvement in our services.

The Clinical Boards will enable us to change:

- From managing services ... To governing service delivery
- From managing directorates ... To developing, supporting and enabling directorate capacity and capability
- From referring decisions upwards ... To taking good quality decisions as close to the patient/user as possible
- From acting out of self-interest ... To doing the right thing
- From emphasising the management line ... To working collaboratively
- From blaming others (headquarters, other agencies, other parts of the UHB) ... To accepting responsibility

These new ways of working will enable us to:

- Liberate the people whose roles are to care for and keep well those we serve.
- Create a mechanism for integrating what we do around those we serve.
- Fuel staff engagement.
- Power up clinical leadership and engagement.
- Drive more localised decision making.
- Create manageable sized chunks of our organisation.
- Provide the basis of good accountability.
• Ensure we have strong and effective leadership and management.
• Drive better use of resources, and greater collaboration to make this happen.
• Drive pathway improvement and collaborative working.

There are two Clinical Boards who are responsible for the provision of dentistry within the Cardiff and Vale UHB area:

• The **Primary, Community and Intermediate Care (PCIC) Clinical Board** has responsibility for commissioning the GDS and PDS contracts as well as the management/financial responsibility for a number of other services including emergency dental care, prison dental services, primary care orthodontic services, the Dental Helpline (and other Communications Hub services) as well as supporting the oral health message within non-dental clinical staff (GPs, Community Pharmacies, Health Visitors, District Nurses, Community Dietetics Service etc).

• The **Dental Clinical Board** has responsibility for the planning and provision of the salaried dental services (CDS) in both the Cardiff & Vale and Cwm Taf Health Board areas as well as the management and running of the University Dental Hospital (in coordination with the Cardiff University, School of Dentistry).

There are opportunities associated with having two Clinical Boards responsible for dental provision in the area and the UHB needs to ensure that robust systems are in place to encourage integrated collaborative planning and management of services and pathways so that ‘silo’ thinking does not prevent the correct redesigning of services for patients.

The current structure of responsibilities within the UHB are shown in Diagram 1 below.

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**Diagram 1 – UHB Structures Linked To Dental Provision**

The current dental contracting arrangements which were introduced in 2006 introduced a greater emphasis on locally commissioned dental care, which gives Health Boards the opportunity to develop services with greater flexibility and in line with the Health Needs of the population. The UHB ensures that best use is made of the available population and needs
data in designing the most appropriate pathways and services models to meet the needs of the population.

It should be noted, however, that these planning and commissioning opportunities are restricted by the availability of ongoing funding within a number of ring-fenced budgets, including the Primary Care Dental Allocation, Designed To Smile Funding Allocation and the educational SIFT funding. To ensure that best use is made of the funding available, the UHB has ensured robust management of all dental provision is in place. This is overseen by the Cardiff & Vale Oral Health Action Group (OHAG).

This OHAG is multi-agency and comprises representation of all local stakeholders including:

- UHB Primary Care Contract Management Team (Primary, Community & Intermediate Care (PCIC) Clinical Board)
- UHB Community Dental Service (CDS) (Dental Clinical Board)
- UHB Hospital Dental Service (HDS) (Dental Clinical Board)
- Public Health Wales (PHW)
- Bro Taf Local Dental Committee (LDC)
- Designed To Smile (Dental Clinical Board)
- NHS Wales Shared Services Partnership (NW-SSP)
- Cardiff & Vale Community Health Council (CHC)
- Cardiff University School of Dentistry
- Postgraduate Deanery for Dental Foundation Training

A number of subgroups also feed into the OHAG in a formal way and have representation on the group. These are:

- SE Wales Orthodontic Managed Clinical Network
- SE Wales Special Care Dentistry Managed Clinical Network
- C&V Emergency Dental Service Advisory Group
- C&V Dental Quality & Safety Group (formally Dental Clinical Governance Advisory Group)

The LHB see the development of Managed Clinical Networks as umbrellas which provide a forum for cross service work on care pathways, clinical leadership for integrated service development and a framework from within which Dentists with Enhanced Skills can be developed and supported. The University Dental Hospital and School of Dentistry are key players in supporting the development of Managed Clinical Networks across the LHB and beyond. Where appropriate, and in liaison with neighbouring LHBs, the UHB will seek to develop additional Managed Clinical Networks as appropriate to ensure that the development of Integrated Care Pathways for as many services as possible are created.

In addition to the strategic OHAG group and in recognition of the opportunities associated with having responsibilities shared between more than one Clinical Board, the UHB operates a Dental Integrated Planning Team which draws together the operational managers of Primary Care, CDS and the University Dental Hospital on a monthly basis to look at better ways of working together and ensuring that plans being considered by each element of the service are developed in a collaborative and integrated manner.

**Local Service Delivery**

*Cardiff & Vale Primary & Community Services*

For the provision of primary care and community services, the area which Cardiff & Vale UHB provides services to is divided into three localities and nine neighbourhoods. The localities have UHB management teams and determine the services and levels to be provided in these areas. Historically, due to the non-geographic nature of dental services, dentistry (both primary care and community dental services) have not been part of these structures. As the
localities have become more established, it is planned that both primary care and community dental services will become more involved with the locality set up of the UHB.

Planning for the Future - Issues

In providing a framework to develop services and to ensure that service delivery is responsive to needs, there are many issues which have been identified and need to be considered. Whilst there are a number of issues which cut across the three localities, there are some key issues which particularly impact each locality which means that service provision and design may need tailored to the requirements of each locality. Overall, the localities are in the process of developing these key issues as part of the Clinical Board's Integrated Business Plan.

The key issues are:

**Vale of Glamorgan Locality:** Ageing population and rural issues

**Cardiff (North & West) Locality:** Significant population increase in new developments and ageing population

**Cardiff (South & East) Locality:** Demands of High Levels of Deprivation and significant numbers of asylum seekers and immigrant populations

There may be other cross-over issues or important general challenges which have not been outlined above, but these are the key issues.

**Demographics – The changes to the population of Cardiff & the Vale**

The population of Wales has been gradually increasing over many years to approximately 3 million people. In general, Wales has seen a decrease in the number of people aged under 35, whilst there has been an increase in the number of people aged 65 and over. Whilst some parts of the UHB area have seen this similar trend, others have seen and continue to see a very different trend, especially in the City and County of Cardiff. Cardiff saw a 15% population increase between 2001 and 2011 against an increase of 5% in Wales as a whole. The number of young adults is increasing and the projections for growth, supported by the Council's draft Local Development Plan, project a potential further increase in the population of 26% by 2026. This massive level of increase will put huge pressures on all health resources, especially the fixed (non-capitation) dental allocations (Primary Care & Designed To Smile). The impact of this projected growth, without additional funding, on the ability to provide core dental services let alone develop new services cannot be underestimated.
The growth of the population, especially in Cardiff, is fuelled by economic development and regeneration of the City, supported by its role as a regional economic centre. In addition, population growth is also linked to the growth in the City as a University site and the role the City has played since 2001 as a dispersal centre for Asylum Seekers, adding to an already diverse multi-cultural mix, and as a centre for economic migrants chiefly from the EU.

Within the current draft Cardiff Local Development Plan, the following are the key strategic sites within the Cardiff area with proposed housing allocations.

![Housing Allocations](image)

The plans for the Vale of Glamorgan do not currently predict as significant an increase in population as do the Cardiff plans, although there is still a population increase and additional building work. The Local Development Plan for the Vale is still in very early stages of development and so the potential impact is not fully known.

### Deprivation & Dental Provision

The Cardiff and Vale of Glamorgan area is one of huge differences in terms of deprivation and oral health need. It contains some of the most and least deprived areas in Wales which means that the provision of health care needs to be adjusted and targeted to meet the needs of individual areas. Deprivation in the Vale of Glamorgan is largely centred on the urban areas, especially Barry. Within Cardiff, the West Cardiff area and the Southern Arc have the highest levels of deprivation. The provision of GDS dental practices largely mirrors these areas of deprivation with lower levels of provision in the less deprived areas.
In order to develop the work of this plan further, more in depth analysis of the oral health needs of the individual areas needs to be undertaken and will form part of the developing work of this plan.

**Summary of Health Board Actions**

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<thead>
<tr>
<th>Action</th>
<th>By</th>
<th>When</th>
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<tbody>
<tr>
<td>a. Local Oral Health Plan to be in place by 31st December 2013</td>
<td>31st</td>
<td>December 2013</td>
</tr>
<tr>
<td>b. A full and detailed Oral Health Needs Analysis to be produced to</td>
<td>31st</td>
<td>March 2014</td>
</tr>
<tr>
<td>direct service redesign and planning.</td>
<td>March</td>
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2. Development of Local Oral Health Plan & Collaboration

**Welsh Government (WG) Action 2:**

Health Boards will be expected to work with dentists and their teams, and all other relevant stakeholders to develop and support delivery of Local Oral Health Plans.

The development of the Local Oral Health Plan has taken place under the responsibility of the Oral Health Action Group, the details of which are listed in Section 1. The specific oversight of the LOHP development rested with two groups, a Steering Group, with senior representation from both Clinical Boards responsible for dental provision as follows:

- **Prof Mike Lewis (Chair)**  
  Board Director, Dental Clinical Board & Dean, School of Dentistry
- **Mr Steve Davies**  
  Operational Director of Primary Care
- **Mr David Oliver**  
  Primary Care Support Manager (Dental & Optometry)
- **Mr Nigel Monaghan**  
  Consultant in Dental Public Health (PHW)
- **Mrs Karen Elcock**  
  Head of Operations & Delivery, Dental Clinical Board
- **Mr Paul Stockford**  
  Chair, Bro Taf Local Dental Committee

The practical outworking of the recommendations was delegated to a Working Group which consisted of the following representatives:

- **Mr David Oliver (Chair)**  
  Primary Care Support Manager (Dental & Optometry)
- **Mrs Hayley Dixon**  
  Directorate Manager, Community Dental Service
- **Mr James Gillespie**  
  Clinical Director, Community Dental Service
- **Mr Jon Ayres**  
  General Dental Practitioner (representing Bro Taf LDC)
- **Mr Chris Pryde**  
  General Dental Practitioner (operating WG new contract pilot)
- **Mr Will McLaughlin**  
  Consultant in Restorative Dentistry
- **Mrs Helen Robertson**  
  Directorate Manager, University Dental Hospital
- **Mr Nigel Monaghan**  
  Consultant in Dental Public Health (PHW)
- **Mrs Dinah Channing**  
  Designed To Smile Manager (CDS)

The Local Oral Health Plan is an evolving document and will be reviewed annually, with an annual plan produced with specific actions for the coming year. This plan would be approved by the Oral Health Action Group, with the full involvement of and scrutiny by the Local Dental Committee and the Community Health Council. These Annual Plans will also form the basis of the LHB’s performance report to Welsh Government.

**Summary of Health Board Actions**

<table>
<thead>
<tr>
<th>Action Description</th>
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</tr>
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<tbody>
<tr>
<td>a. Local Oral Health Plan to be approved by LHB and submitted to WG by 31st December 2013</td>
<td>31st December 2013</td>
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</tbody>
</table>
3. Improving Oral Health: Oral Health Promotion & Designed To Smile

**Welsh Government (WG) Action 3:**

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

**Background**

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.” (Page 4)

In recognition of the significant problems being faced by many of our population, especially the young, the Welsh Government set up Designed To Smile, the National Oral Health Programme in 2008. Cardiff and Vale UHB, along with Betsi Cadwaladr UHB in north Wales were selected as pilot sites for the new programme and so have had the greatest experience in developing and running Designed To Smile.

**Where we are**

The experience of having inequalities in health funding and then being one of the pilot sites for Designed To Smile has allowed Cardiff & Vale UHB the opportunity to shape the service and develop best practice and to start to see some of the outcomes with children. Currently, the management of the Designed To Smile programme sits with the UHB’s Community Dental Service, although it provides reports into the quarterly Oral Health Action Group meetings which provides input from other dental stakeholders. The Designed To Smile programme manager also sits on the Flying Start group for each area.

The Designed To Smile programme currently works with schools across the Cardiff and Vale of Glamorgan areas. There has, historically, been a focus on the most deprived parts of the area, especially schools within the Flying Start and Sure Start areas. Once the programme was rolled out nationally, however, the Designed To Smile team have started to approach a much greater range of schools across all parts of the area.

The analysis of Designed To Smile, produced by the Dental Public Health Unit of Cardiff University suggests that there are initial signs that Designed To Smile has started to make an impact on the level of decay in young children who have been through the scheme.

The UHB Community Dental Service are fully committed to the continued delivery of the Designed To Smile programme. Work continues on ensuring that a consistent message is delivered to all residents across schools and CDS clinics. The team continue to build on the close working relationships which have already been established with the Healthy Schools and Health Pre-schools programmes. The ability to provide a consistent oral health message in all settings is key to being able to educate a generation on how to improve their dental and general health.

We are working to ensure that the dental health messages given to health and education colleagues are consistent and will continue to develop this. The UHB will work closely with colleagues in the School of Dentistry to ensure that all students graduating from both dental and DCP courses have been trained on the importance of oral health education and the messages of Designed To Smile.
Where we need to be

As with many parts of health service provision, there is a growing need to shift from being purely treatment focussed to a much greater priority for disease prevention which will in due course reduce the demands on our treatment services. It is often much easier to design and commission treatment services than it is to engage with the population and specific groups to support them in making wise choices with regard to their health. It is, however, a culture change which must be pursued if we are going to make a significant impact on the oral health of this and future generations.

In respect of oral health improvement it is, therefore, vital for the LHB to engage with professionals well beyond the realm of dentistry to improve the understanding of our population with regard to oral health issues. If 58% of the population access NHS primary care dentistry (and these will generally be the more motivated people), then we will need to find ways of engaging the remaining 42% of the population with the key messages and opportunities to improve oral health. These will include Private Dentists, General Medical Practitioners, Community Pharmacists, Health Visitors, District Nurses, Community Dieticians, Teachers, Educational Support Workers, Social Workers, Flying Start & SureStart workers and many others. The work of Designed To Smile has started to develop this but much more can and should be done to ensure that the key oral health messages are communicated through many and various channels.

It is important to engage fully with the schools and local education authorities so that Designed To Smile becomes a fully embedded programme within all schools and not simply those who choose to engage with the process. It is vitally important that all aspects of the Designed To Smile programme are implemented by schools in order to have the maximum impact on child health. There is also scope for GDPs to work in partnership with Designed To Smile to access schools which may not need as intensive engagement as some within Flying Start/Sure Start areas. The provision of education on diet, toothbrushing and attending the dentist can be given by GDPs or members of their practice team but the LHB should work with practices to ensure a consistent message which is part of Designed To Smile. There is potential scope within the possible new GDS contract model to be able to enhance this work but the UHB should investigate ways of using the current contract model to support this without impacting on treatment capacity. The UHB will work with providers currently providing education in schools on a ‘private’ and ad hoc basis to see if this can be formalised and that training can be provided by the Designed To Smile team on consistent messages. This could then be rolled out more widely, if successful.

It is also important that all members of dental teams (both GDS and CDS) are trained and equipped to educate patients on the core community health promotion initiatives and where to gain support and advice. These should include smoking cessation, alcohol awareness and nutrition advice (both in terms of healthy eating and also weight awareness). The UHB will work with both GDPs and CDS teams to ensure a consistent message is given and that correct signposting happens.

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<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Evidence that CDS Designed to Smile Teams are fulfilling the</td>
<td>Establish Task &amp; Finish group</td>
</tr>
<tr>
<td>standards in the Designed to Smile quality framework.</td>
<td>by 31st March 2014 to report by 31st December</td>
</tr>
<tr>
<td>b. Investigate and propose ways of integrating Designed to Smile</td>
<td>December 2014</td>
</tr>
<tr>
<td>programme and principles into General Dental Practice</td>
<td>Establish Task &amp; Finish group</td>
</tr>
<tr>
<td>c. Investigate ways of ensuring that the Designed to Smile</td>
<td>by 31st March 2014 to report by 31st December</td>
</tr>
<tr>
<td>principles are extended to every child in the area.</td>
<td>December 2014</td>
</tr>
<tr>
<td>d. Participation in evidence based community health promotion</td>
<td>First plan for 2014-15 available by 31st</td>
</tr>
<tr>
<td>initiatives (smoking cessation, alcohol &amp; nutrition). The</td>
<td>March 2014</td>
</tr>
<tr>
<td>UHB will produce an annual Oral Health Plan</td>
<td></td>
</tr>
</tbody>
</table>

Cardiff & Vale University Health Board
Local Oral Health Plan: December 2013
Promotion Plan outlining oral/general health promotion initiatives throughout the year, involvement of PC/CDS, training available.

e. Documentation to be produced to show the alignment of oral health teaching to students in the School of Dentistry with the messages of Designed To Smile.  
By 31st March 2015
4. Oral Cancer Services

Welsh Government (WG) Action 4:

Liaise with the Cancer Networks and the Head and Neck Cancer National Specialist Advisory Group to ensure that the Welsh Cancer standards (2005) are implemented. Health Boards to work together to ensure evidence based, multi-disciplinary care is available to all their patients diagnosed with oral cancer. We will seek assurance that any identified variation in treatment outcomes is addressed by the Cancer Networks.

Background

Oral cancer treatment is a complex area with various treatment modes, therapy professionals and medical specialities involved; it spans from prevention, diagnosis, treatment services and rehabilitation. As outlined in the NOHP, the main causes of oral cancer have long been known and prevention is key to helping reduce the incidences of this disease. It is vital that the preventative messages around smoking cessation and alcohol reduction along with the other key health promotion messages are provided to residents in order to start to reduce the prevalence of this disease. Alongside this, work needs to be done to help improve early diagnosis and so improve the prognosis of patients.

Where we are

The UHB currently provides input to the Head and Neck Cancer National Steering Group and is working with this group to provide a comprehensive service to Head and Neck oncology patients. The UHB have a comprehensive multi-disciplinary team for Head and Neck cancer patients, including clinics involving Oral and Maxillofacial Surgery; Ear, Nose and Throat; Oncologist (Radiologist); and Restorative Dentistry rehabilitation services; with access to hyperbaric oxygen services as required.

The University Dental Hospital fully participates in the National Head and Neck Cancer Audit and has delivery plans in place which are compliant with the 10 day rule and 42 day treatment pathway.

The UHB completely agrees with the desire to reduce the percentage of oral cancer patients presenting at stage 3 & 4 but realises this is dependent on patients and referrers being adequately and appropriately aware of the condition and trained in its recognition. Part of this will involve promotion of Oral Cancer awareness month.

Where we need to be

The UHB will continue to engage with the National Steering Group and take a lead in the provision of diagnosis and treatment of oral cancers, ensuring that patients have access to high quality multi-disciplinary treatment to improve their chances of survival and cure. The UHB will work with neighbouring LHBs on the feasibility and potential for the development of a Managed Clinical Network for Oral Cancer in South East Wales to help ensure consistency of services across the region.

Details on addressing oral cancer will be included the UHB’s Cancer Delivery Plan to ensure that oral cancer remains a priority for the organisation.

A key to seeing a reduction in the prevalence of oral cancers involves better education and awareness for the population along with targeting of high risk groups such as older men who are smokers or heavy drinkers along with other high risk groups. To this end, the UHB will develop an action plan which brings together departments of UDH, the CDS and Primary Care contractors. This plan will look at improving awareness of the symptoms amongst the
wider population and the UHB will liaise with Welsh Government on better ways of highlighting the contributory factors.

### Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Investigate the possibilities for the development of a South Wales Managed Clinical Network for Oral Cancer</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>b. Ensure oral cancer is part of the UHB Cancer Delivery Plan</td>
<td>31st December 2014</td>
</tr>
<tr>
<td>c. Develop and implement a care pathway for suspected oral cancer to ensure that patients are referred, seen, diagnosed and treated promptly.</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>d. The UHB will train the dentists on the Emergency Dental Service rota on enhanced skills for spotting the signs of Oral Cancer to improve diagnosis rates.</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>e. Improve awareness and training of OOHs GMS staff (triage and centre staff) to better understand the signs of possible oral cancer</td>
<td>31st March 2016</td>
</tr>
<tr>
<td>f. Engagement of all parts of the UHB in the promotion of Mouth Cancer Awareness Month – development of annual Action Plan</td>
<td>31st July each year</td>
</tr>
</tbody>
</table>
5. Special Care Dentistry

**Welsh Government (WG) Action 5:**

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

**Background**

A strategic approach is required to develop effective services for ALL vulnerable people in Wales. It is sometimes challenging to define the concept of ‘vulnerable’ people and this is deliberate to allow the flexibility to be responsive to new and changing needs. Some of the groups usually included are:

- Frail elderly
- People with Impairment and Disability
- People with Mental Health Problems
- People with physical and learning disabilities
- People with Medical Problems
- People with Anxiety and Phobia
- Prisoners
- Homeless Population
- ‘Bariatric’ Patients
- Looked After Children

Following the publishing of the SCD implementation plan in November 2011, a national Implementation Group was set up and LHBs were instructed to group together regionally to form Managed Clinical Networks for SCD to take forward the recommendations.

**Where we are**

Cardiff and Vale UHB have accepted the Implementation Panel report and guidance and, through the OHAG, committed to working as part of the MCN to develop service models and Integrated Care Pathways for SCD. The UHB recognises the pivotal role of the CDS in the provision of services to SCD patients but also supports the improvement of awareness and skills for SCD patients within the GDS and also the vital role of the Hospital in some of the care and treatment of patients.

The UHB has been at the centre of the work to develop the MCN for SCD in South East Wales. There is a commitment to significant managerial and clinical engagement with the MCN to both shape the proposals of the group and also to commit to implement the recommendations. The group, therefore, has membership from the managers of the CDS, University Dental Hospital and Primary Care Contracts, along with the Clinical Director of the CDS. There are representatives from Special Care Dentists in the CDS and Hospitals as well as representation from the Local Dental Committees. The involvement of Cardiff & Vale UHB covers all of these areas along with representatives from Aneurin Bevan and Cwm Taf HBs.

**Where we need to be**

The MCN are currently working through two main workstreams in addition to a general pathway for Special Care Dentistry. These are domiciliary dental care and adult patients requiring advanced techniques (conscious sedation and GA). Both of these workstreams aim to produce a model pathway and framework to be implemented locally.

In addition Cardiff & Vale UHB are specifically also looking at the development of appropriate pathways and service models relating to the provision of services to ‘bariatric’ patients, prisoners and illegal immigrants (those without paperwork).

The UHB will investigate the possibility of explicitly outlining an expectation of one intermediate bariatric chair (up to 31 stone) for clinic refurbishments in UDH or practice
refurbishment/new practice in CDS/GDS. This will be included in the relevant UHB capital strategies. Due to the fact that Primary Care premises are not owned by the NHS, the UHB will work with Welsh Government to investigate ways of either encouraging or expecting GDS practices to include the bariatric capacity in practice developments.

With all of the Healthcare services in HMP Cardiff now being carried out internally by the UHB’s Primary Care Service Development Unit, a review is underway into the current arrangements for dental care, being provided by the CDS, to reflect the major changes to the prison population and status which have taken place over recent years, such that Cardiff prison now mainly houses remand prisoners for very short stay. The implementation of actions for the provision of prison dental care will also draw on lessons emerging from the Prison Needs Assessment currently being undertaken in Wales.

All of the work relating to service redesign is based on the premise of integrated working across GDS, CDS and HDS as far as possible with the most appropriate teams carrying out the most appropriate work and following a single coordinated care pathway. It is envisaged that appropriate integration with the GDS will allow some patients to be treated within routine dentistry, freeing up capacity within the CDS to see more complex patients and thus also reducing demand on UDH, allowing them to see the most severe patients.

The UHB is committed to the continued support of training roles to future proof the service and also to explore whether there are other vulnerable groups where their oral health needs are not being met. The CDS will establish the possibility of linking into to the Health Visitors IT system to establish a more coherent approach to the management of vulnerable groups to include electronic referral. The UHB will take every opportunity to engage in Health Fairs where opportunities arise in order to break down barriers with specific vulnerable groups. It is the UHB’s aim to reduce inequalities and improve access to dentistry for all.

The establishment of Dentists with Enhanced Skills (DwES) will be an important phase of evolving improved special care dental services. Experience over the last few years has been that Dentists with Special Interest (DwSI) were not appointed in any significant volume across the UK. Alongside development of a competency framework and training and quality assurance, arrangements to commission such services need to be developed. Some research on barriers and enabling factors for the establishment of DwES posts/contracts could help to provide a development framework and accelerate this process.

### Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>a. Continued full engagement with the development and success of the Managed Clinical Network for SCD in South East Wales including the implementation of recommendations where possible (engagement from Primary Care, CDS and UDH)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>b. Implementation of Integrated Care Pathway for Conscious Sedation &amp; GA Treatment, including the development of Dentists with Enhanced Skills (DES) in Conscious Sedation within primary care</td>
<td>31st March 2016 (this action is funding dependent)</td>
</tr>
<tr>
<td>c. Implementation of new Domiciliary Dental Care pathway, including new contractual model for commissioning domiciliary dental care from GDS providers.</td>
<td>31st March 2015 (this action is funding dependent)</td>
</tr>
<tr>
<td>d. Implementation of pilot integrated care pathway for bariatric patients. Commissioning of GDS provider to work alongside CDS provider, both operating out of the ‘Blue Room’ in UDH</td>
<td>31st March 2014</td>
</tr>
<tr>
<td>e. Investigate the possibility of including an expectation of at least one intermediate bariatric chair (up to 31 stone) in each clinic/practice upgrade or new practice in UDH, CDS or Primary Care.</td>
<td>31st December 2014</td>
</tr>
<tr>
<td>f. Undertake a full review of the service model for the provision of dental care to the prisoners at HMP Cardiff and to design</td>
<td>Review: 31st March 2014 New Model: 1st October</td>
</tr>
</tbody>
</table>
and implement the outcomes.

| g. Draw up Action Plan for involvement in Health Fairs, especially the annual BME Community Health Fair. | 2014 Annual Plan |
| h. Working collaboratively between Primary Care and CDS to ensure each service element is seeing the correct patient groups and to free CDS to see the most vulnerable patients. | 31st March 2015 |
6. Paediatric Dental General Anaesthesia

Welsh Government (WG) Action 6:

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

Background

The provision of dental GA in Wales by general dental practitioners ceased in 2001 following the publication of ‘A Conscious Decision’ (supported by the publication of Welsh Health Circulars). In Cardiff & the Vale of Glamorgan, two providers of dental GA services were established. One was the University Dental Hospital (funded through Dental SIFT) and the other was a dental clinic operating under the independent hospital regulations (funded through the Primary Care Dental Allocation). In 2009, following an extensive procurement exercise, the former Cardiff LHB transferred the cases being seen in the private clinic to the University Dental Hospital. Therefore, all paediatric dental GA treatment is carried out within the University Dental Hospital. As part of the tender to carry out the activity, UDH committed to the development of alternative care pathways, including conscious sedation.

Where we are

Currently, approximately 1,200 patients are treated under GA per year at UDH and the National Oral Health Plan recognises that, in general, too many children are undergoing GA for dental treatment. One of the key outcomes of ‘A Conscious Decision’ was that GA should no longer be a routine treatment modality but that it should be the treatment of last resort. Children with high needs should have access to high quality preventative care as well as alternative treatment techniques which will aid their rehabilitation into standard routine dental care. It is unacceptable that patients who do require GA for treatment (such as those with severe learning disability, physical impairment etc) have to wait for long periods to be seen.

Treatment is provided within UDH and the Children’s Hospital for Wales on both a day stay and in-patient basis. Data, collected on a sessional basis, is coordinated by the Dental Theatre Admission Team within UDH and is managed via a monthly performance management meeting. Activity data is available for immediate access on request.

There is recognition that the availability of alternative treatment methods within the NHS is very limited in Cardiff & Vale and is currently restricted to services available at UDH and a limited number of CDS personnel. There are no alternative techniques explicitly commissioned/funded in Cardiff & Vale.

Where we need to be

Alongside the work being undertaken in the South East Wales Managed Clinical Network for Special Care Dentistry, Cardiff & Vale UHB also recognises the need to develop alternative treatment options in both primary care and CDS settings and that the whole issue of accessing care for those unable to cope with routine dental treatment needs to be part of an Integrated Care Pathway, so that GA is not a stand alone treatment option but is the treatment of last resort on a spectrum of treatment modalities.

One of the keys to reducing anxiety amongst children requiring a GA is to ensure that both the staff and clinical environment are ‘child friendly.’ To that end, the UHB are committed to transferring the provision of paediatric dental GAs to Phase 2 of the Noah’s Ark Children’s Hospital For Wales upon completion. This will provide the most appropriate setting for treating these patients.
Alongside the treatment options which should be available to patients, it is also recognised that there is a vital need to ensure that these patients and their families gain access to high quality oral health improvement, including all of the core elements of the Designed to Smile programme, in order to maintain remaining and permanent teeth and reduce the risk to siblings. Repeat GAs and multiple GAs within families should trigger more focussed intervention, perhaps with the support of other external agencies.

**Areas of good practice**

- The quality of the GA provision within the UDH is of a consistently high standard with brand new high quality, children-focussed facilities being built.
- The School of Dentistry is centre of excellence for the training of alternative treatment techniques, such as Conscious Sedation (both IHS and IV) and Behavioural Management techniques, meaning that training for primary care and CDS dentists is available very locally, as are support and quality assurance.

### Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>a. The development of an Integrated Care Pathway for Children</td>
<td>31st March 2014</td>
</tr>
<tr>
<td>Requiring Alternative Treatment Techniques. This pathway will include</td>
<td></td>
</tr>
<tr>
<td>the following principles:</td>
<td></td>
</tr>
<tr>
<td>• The principle of the treatment of least intervention (using a</td>
<td></td>
</tr>
<tr>
<td>scoring system such as the Indicator Of Sedation Need (IOSN))</td>
<td></td>
</tr>
<tr>
<td>• Development of basic behavioural management training for all</td>
<td></td>
</tr>
<tr>
<td>GDPs/CDS dentists</td>
<td></td>
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<tr>
<td>• Investigate the possibilities of developing advanced behavioural</td>
<td></td>
</tr>
<tr>
<td>management techniques for more complex scenarios</td>
<td></td>
</tr>
<tr>
<td>• Make Conscious Sedation provision more widely available</td>
<td></td>
</tr>
<tr>
<td>• Centralised referral management and assessment</td>
<td></td>
</tr>
<tr>
<td>b. Develop the provision of Conscious Sedation services in both</td>
<td>31st March 2015 (this action is</td>
</tr>
<tr>
<td>primary care and CDS using the model of a Dentist with Enhanced Skills</td>
<td>funding dependent)</td>
</tr>
<tr>
<td>(DwES) in Conscious Sedation</td>
<td></td>
</tr>
<tr>
<td>c. Ensure that all appropriate staff providing Conscious Sedation</td>
<td>31st December 2014</td>
</tr>
<tr>
<td>and General Anaesthesia treatment are fully trained on the principles</td>
<td></td>
</tr>
<tr>
<td>and techniques of Designed To Smile and that all children undergoing</td>
<td></td>
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<tr>
<td>these treatments and their parents receive extensive oral health</td>
<td></td>
</tr>
<tr>
<td>education.</td>
<td></td>
</tr>
<tr>
<td>d. Performance data on the number of children receiving GAs to</td>
<td>From 1st April 2014</td>
</tr>
<tr>
<td>be submitted to the C&amp;V OHAG on a quarterly basis and/or other</td>
<td></td>
</tr>
<tr>
<td>appropriate committees for assessment, plus Completion of the Annual</td>
<td></td>
</tr>
<tr>
<td>Return to WG</td>
<td></td>
</tr>
<tr>
<td>e. Transfer paediatric dental GA activity to the completed</td>
<td>31st October 2014 (or when</td>
</tr>
<tr>
<td>Noah’s Ark Children’s Hospital For Wales when Phase 2 is completed.</td>
<td>complete)</td>
</tr>
</tbody>
</table>
7. Vulnerable Adults requiring Dental General Anaesthesia

Welsh Government (WG) Action 7:

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

Background

It is often difficult to define ‘vulnerable’ groups and, as a patient group, they can very easily be overlooked and their specific needs not taken into account. It is, therefore, necessary to ensure that specific reference is made to these groups in the planning of services so that appropriate and sufficient treatment is provided for them and they are given access to oral health information in a way which they are able to understand.

It is not acceptable that patients are made to wait extremely long times for treatment and so action needs to be put in place which will ensure access to specialised care for these patients.

Many groups of vulnerable people are adversely affected by the pressures on the current system of GA provision across the whole system. The overall systemic pressures mean that the lists for Special Care patients can be lost within the demands.

Where we are

A Multi-Disciplinary Team has been established at UDH involving the dental team, anaesthetics, social services, learning disabilities groups and third sector providers to arrange appropriate care. Treatment for this cohort of patients is provided in UDH, SSSU and on an in-patient basis as appropriate. Currently, there is a Special Care Dentistry list at the UHW, although it does not have guaranteed access to theatre time and so can be affected by pressures elsewhere in the system. Waiting list records are recorded by the Health Records section of UDH and reviewed on a weekly basis by the operational team to monitor compliance with Welsh Government targets. Alongside this, the Children’s Clinic at UDH liaises with relevant and appropriate partners to ensure full access to GA services for vulnerable children seeking to achieve compliance with Welsh Government waiting time guidelines.

Where we need to be

Key to establishing stability in the Special Care Dentistry GA list is the reduction in GA demand from other patient groups. These reductions in demand elsewhere, will allow dedicated time for SCD patients.

As with other patient groups, there is also a need to increase the supply of alternative techniques for vulnerable adults so that only those who would gain the most from being treated under GA, do so. This will require the CDS especially to assess the degree to which additional sedation clinics need to be provided with staff trained in both sedation and special care dentistry. The development of this provision may take some time depending upon the skill sets available at any given time.

Areas of good practice

a. Due to the links with the School of Dentistry, the UHB already benefits from highly trained staff who understand the needs of special care patients very well. Recent appointments at a consultant level in Special Care Dentistry help provide support and leadership in this area.
### Summary of Health Board Actions

<table>
<thead>
<tr>
<th></th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>• Link with the Actions in Section 6 to reduce demand on overall service and especially theatre time and space. • Link with the Actions in Section 5 in relation to the development of services/pathways for SCD patients.</td>
<td></td>
</tr>
<tr>
<td>a. Review of alternative techniques used with Special Care patients to ensure sufficient capacity is available and reduces GA waiting time.</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>b. Monitoring of Vulnerable Groups GA lists and waiting time as part of overall GA monitoring.</td>
<td>1st April 2014</td>
</tr>
</tbody>
</table>
8. Integrated Care Pathways

**Welsh Government (WG) Action 8:**

Work together to develop regionally agreed referral and care pathways which will promote efficient patient care and better working across GDS, CDS and HDS

**Background**

Prior to 2006, GDPs were able to locate their practices wherever they chose and to provide services to that cohort of patients. This meant that there were often gaps in provision geographically, where GDPs did not feel that it was financially viable to set up a practice and so the CDS were asked to step into these situations and to provide GDS services in these, often high need, areas. This changed in 2006, when LHBs were given the ability to commission services where the need was greatest and to define how this would be costed to enable GDPs to tender for the provision, allowing the UHB to achieve value for money whilst also ensuring dental capacity was located where it was most needed. The need for a CDS-GDS service has therefore been removed.

The same is also true for the provision of services for specific patient groups whereby the LHB are now able to commission specific services from providers for specific patient groups, whether that be particular treatment requirements (orthodontics, endodontics etc) or specific patient groups (domiciliary care, nursing homes, children etc). Historically, there has been a demand for UDH to accept many of these treatment requirements and patient groups, which increases pressure on their services and reduces the effectiveness of their undergraduate and postgraduate training as they try to cope with the demands of service provision.

Now that the post-2006 changes are embedded in the UHB, there is much scope for integrated service planning, which will allow a patient to be seen by the right professional, in the right location at the right time.

Development of care pathways affords an opportunity to develop formal arrangements which allow different services to work well together and deliver care in line with expected standards. The process of improvement provides an opportunity to both simplify and improve care increasing the ability of patients accessing the right elements of care at the right time.

**Where we are**

As Cardiff & Vale UHB move more deeply into separate Clinical Boards to cover dentistry, it is vital to ensure that there is robust unified oversight of dental provision and oral health care and that the planning of services does not take place in any of the service areas in isolation. The UHB is committed to make the best use of the most appropriate service provider to provide care for patients recognising that the increase use of salaried services up through the CDS into UDH and their specialist tertiary services, increases the cost of providing services and so should only be used when needed rather than in place of other more appropriate service provision.

The UHB has provided new streamlined referral criteria for UDH which outline clearly which services are provided as part of their secondary care commitment. On top of this the Hospital is also able to provide additional care for restricted numbers of patients in certain specialities in order to support the training of students, which comes out of SIFT funding.

The ability to direct funding to the areas most at need of it, has allowed the UHB to use GDS contract underperformance to target additional capacity at specific areas of access need, relieving pressure on these areas.
The establishment of Managed Clinical Networks provides an appropriate forum to develop draft care pathways and referral pathways with access to expert advice and clinical leadership. Ideally the outcomes empower front line primary care staff to do what they can and to call on assistance when needed.

Where we need to be

The greatest challenge to being able to provide appropriate and targeted treatment and increase provision of dentistry is the ring-fenced allocations which take no account of population numbers or needs. The UHB needs to make clear that there are significant restrictions on being able to provide the levels of care expected within the financial envelopes available.

Having said this, the UHB are working to ensure that having separate Clinical Boards does not interfere with the development of fully integrated pathways for patients. The work of both the Dental and PCIC Clinical Boards are overseen by the Oral Health Action Group to ensure that everything possible is done to work together to design and develop integrated services. The establishment of an Integrated Planning Team which draws together UDH, CDS and Primary Care is designed to ensure that all service developments are undertaken having reviewed the most suitable and appropriate provider(s) of these services.

The Primary Care team are committed to ensuring that all underspend or funds released from the Dental Allocation will be used to provide either core or specialist dental service in primary care. The CDS are also committed to ensuring that all ring-fenced funding released to the service is used for the provision of services.

As various Managed Clinical Networks are established we need to identify the service pressures and incidents which provide evidence that care pathways and referral pathways are required and act on that evidence to draft pathways. Experience with the Managed Clinical Networks in Special Care Dentistry and Orthodontics to date suggests this approach is appropriate.

Areas of good practice

- Following capacity problems within both the CDS and UDH, a new integrated Emergency Dental Service was developed in 2011 which brought together UDH Exam & Emergency Clinic, CDS emergency provision along with some new GDP-based emergency slots. The service is coordinated by the UHB’s internal Communications Hub which provides a 24-7-365 Dental Helpline service. Once triaged, appropriate patients are booked into the most relevant emergency slot, either in Primary Care, CDS or UDH. This allows a coordinated approach with the most appropriate clinician treating the patient. This has reduced the numbers trying to access the service, along with reducing the demand on the CDS clinics and ensuring that the student-led E&E Clinic in UDH is not swamped and sees the correct patients for student education.
Summary of Health Board Actions

<table>
<thead>
<tr>
<th>By When</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing – Reporting as appropriate into OHAG</td>
<td>a. All service developments are developed via the Integrated Planning Team to ensure the most appropriate service provider develops services.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>c. Working with the UHB finance teams, all ring-fenced budgets are used effectively for the purposes for which they are allocated</td>
</tr>
<tr>
<td>31st March 2015</td>
<td>d. Embed new UDH Referral Criteria with GDS, CDS and GPs to ensure appropriate patients are referred.</td>
</tr>
<tr>
<td>Review requirements as part of Annual LOHP Action Plan</td>
<td>e. Ensure development of Integrated Care Pathways for specialities and service areas as appropriate (eg endodontics, minor oral surgery etc).</td>
</tr>
</tbody>
</table>
9. Oral Cancer Prevention

**Welsh Government (WG) Action 9:**

Work with PGMDE to ensure dental teams have access to high quality postgraduate training to address educational needs in oral cancer, including information on appropriate Third Sector organisations and websites which patients can access for evidence based advice and support.

**Background**

As with many other cancers, smoking and unhealthy eating contribute to oral cancer risk. Additional risks are associated with chewing tobacco, drinking alcohol (especially in conjunction with smoking) and exposure to Human Papilloma Virus Strains 16 and 18.

As identified in Section 4, it is vital to ensure that primary care providers receive sufficient training in identifying and diagnosing oral cancer but also training in the key preventative steps people can take to reduce their risk of developing oral cancer. All dental teams need to understand how and where to refer patients looking to reduce their risk factors especially in terms of smoking cessation and alcohol reduction.

**Where we are**

Across the UK the population incidence of oral cancer is rising, especially among younger women. This probably reflects changes in smoking behaviour, drinking habits and exposure to HPV strains through sexual behaviour. Potentially the most effective action which could be taken is vaccination against Human Papilloma Virus prior to young people becoming sexually active. Currently girls receive this vaccine to prevent cervical cancer, but boys, who are at greater risk of developing oral cancer than girls, do not. The UHB understand that the Joint Council for Vaccination and Immunisations are about to consider vaccinating boys to protect them from oral and other HPV associated cancers.

Across Wales the Stop Smoking Wales service provides support to smokers ready to stop. One referral route in is via dental practices. Currently the Post Graduate Deanery is providing brief intervention advice training to dentists as part of the dental actions in the Tobacco Control Action Plan (see section 10).

Dentists are also being offered brief intervention training regarding patients who drink alcohol.

To this end UDH is working in association with the dental postgraduate section of Cardiff University Wales Deanery School of Postgraduate Medical and Dental Education to provide training courses for the dental team and medical colleagues in the recognition and management of head and neck oncology in compliance with core CPD recommendations by the General Dental Council.

**Where we need to be**

The UHB will also work with primary care and community clinicians (CDS dentists, GDPs and GPs) to improve awareness and diagnosis skills to help spot concerns early and understand the route for referral. The UHB will work with the Postgraduate Deanery in their development and implementation of core CPD training on oral cancer.

The UHB will also work with Primary Care and CDS dentists to improve their awareness of and engagement with smoking cessation and alcohol reduction programmes.

Should HPV vaccination for boys be recommended the LHB will need to ensure it is provided.
The LHB will request that the dental QAS enquires whether dental staff have received brief intervention training regarding alcohol and smoking.

The LHB will ensure dental practices are aware of annual public health campaigns encouraging smokers to quit.

### Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link with the Actions in Section 4 to improve understanding of and training in oral cancer and how to reduce incidences.</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Development of web-based information and education tools</td>
<td>For 2014 submission – released Autumn 2014</td>
</tr>
<tr>
<td>Include information on oral cancer, smoking cessation and alcohol reduction training undertaken by GDS performers in QAS</td>
<td></td>
</tr>
<tr>
<td>Audit Primary Care dental team trained in smoking cessation and alcohol advice</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Training expectations for all GDPs/CDS dentists to ensure understanding of:</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2016</td>
</tr>
<tr>
<td>• Oral Cancer</td>
<td></td>
</tr>
<tr>
<td>• Smoking Cessation</td>
<td></td>
</tr>
<tr>
<td>• Alcohol Reduction</td>
<td></td>
</tr>
</tbody>
</table>
10. Tobacco Control Action Plan

Welsh Government (WG) Action 10:
Work with PGMDE to ensure that the dental actions contained within the Tobacco Control Action Plan (TCAP) are taken forward

Background

Reduction in the number people smoking is a key target of Welsh Government for the NHS overall and dental teams can play their role in encouraging people to stop smoking and supporting them in access the best services to help them achieve this.

Where we are

Currently, practices are made aware of how and where to direct patients who have decided that they wish to stop smoking. This is normally be means of signposting patients to the correct service, although a small number of practices have undertaken brief intervention training to give a more level of interaction.

Where we need to be

Going forward, the Primary Care team will ensure that discussions around smoking cessation advice and information are included in their contract negotiations with new and existing contract holders and will ensure that practices take seriously their role in helping people stop smoking.

There is a need to work with the Postgraduate Deanery on rolling out Brief Intervention training to all practices and the UHB will work with colleagues in other LHBs to design a system of brief intervention training and rolling it out to all providers.

Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Link with the Actions in Section 4 to improve understanding of oral cancer and how to reduce incidences.</td>
<td>31st December 2014</td>
</tr>
<tr>
<td>• Link with the Actions in Section 9 to improve training with regard to oral cancer.</td>
<td></td>
</tr>
<tr>
<td>a. Invite PGMDE to All-Wales Dental Leads meeting to discuss possible training for providers (esp Brief Intervention training)</td>
<td>30th June 2014</td>
</tr>
<tr>
<td>b. Include smoking cessation assessment into End of Year performance packs and annual review meetings.</td>
<td></td>
</tr>
</tbody>
</table>
11. Improving Mouth Care for Adult Patients in Hospital

**Welsh Government (WG) Action 11:**

Take account of and participate in the 1000 Lives Plus programme to Improve Mouth Care for Adult Patients in Hospital

**Background**

For patients who are in hospital, it is important to help support them in maintaining their oral health and to ensure they have access to the most appropriate care possible. The experience of the 1000 Lives Plus programme to Improve Mouth Care for Adult Patients in Hospital has shown that training general nursing teams on the key oral health messages can help patients maintain their oral health.

**Where we are**

The CDS Oral Health Promotion teams have been involved in the initial pilot programme for Improving Mouth Care for Adult Patients in Hospital with great success. The teams will continue to roll out and provide the necessary training to ensure that the general nursing teams have the necessary skills to carry out and promote good oral health and hygiene, preventing oral discomfort and inadequate nutrition, and helping to improve outcomes for hospital adult inpatients. The training provides the general nursing team with the skills to ensure that when patients are unable to carry out their own daily mouth care, ward staff will feel confident in assisting or undertaking mouth care for them.

**Where we need to be**

The UHB will continue to build on the success of this initial pilot by training more nursing staff throughout the year.

**Summary of Health Board Actions**

<table>
<thead>
<tr>
<th>a. Training continues to be rolled out to ward nursing staff</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing programme</td>
</tr>
</tbody>
</table>
12. Quality Reporting Mechanisms

Welsh Government (WG) Action 12:

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

Background

In an environment of independent contractors, it is important to ensure that performance management is strong to safeguard both the quality of the treatment provided but also to deliver value for money for the public purse. LHBs have developed, since 2006, increasingly appropriate and sensitive performance management tools using the significant amounts of data available to them.

Where we are

The UHB has year on year increased the level of data interrogation which takes place for GDS contract holders, recognising the need to work with the profession to ensure a fair but robust performance management system. Increasingly, the UHB is identifying outlying practices and either supporting them to change how they operate or challenging them to change or risk contract sanctions. The UHB has worked closely with the Bro Taf Local Dental Committee to ensure the system is fair but robust.

The UHB have implemented the Dental Governance Framework for General Dental Services provided by Local Health Boards (PHW, January 2012) as well the governance arrangements outlined in the WG’s guidance on the management dentists on the Performers List. The use of the annual Quality Assurance System (QAS) with primary care dental practices allows practices to act directly on issues at the time of completing their returns. The UHB, supported by the PHW Dental Practice Advisors can feed back to practices on areas for action. In addition, both WG and the LHBs can request new items to be added to the QAS in response to concerns which emerge.

Equally the CDS have ensured that their data is collated and submitted on their Annual Quality Statement and this data is used to improve service provision.

Where we need to be

The UHB will work closely with the LDC and the Community Health Council to look at robust ways of measuring patient satisfaction, utilising data from NHS Dental Services and other sources.

Summary of Health Board Actions

| Summary of Health Board Actions | By When | | |
|---------------------------------|---------|---------|
| a. Include patient satisfaction on dental services as part of the Annual Primary Care Report and Annual Quality Statement. | 31st March 2014 |
| b. Work with LDC & CHC to ensure robust reporting of patient satisfaction. | 31st March 2015 |
| c. Maintain central GDS Contract Management Team whilst improving links with the Localities for both GDS and CDS | Ongoing |
| d. Review and further develop Emergency Dental Service (both in hours and out of hours) to ensure it meets demand and continues to model best practice. | 31st March 2015 |
13. Occupational Health Support

**Welsh Government (WG) Action 13:**

Work with LDCs to review the occupational support they provide, and develop an occupational health programme for all members of the dental team in general dental practice

**Background**

Occupational Health encompasses work related staff vaccination, plus support for staff to assist them in managing work related illness and return to work post-illness. As independent contractors, GDPs are responsible for their own staff but as core but small NHS contractors, the UHB recognises that the ability to provide a full range of occupational health support is often challenging given the limited resources available to each practice.

**Where we are**

Following a review of the requirements for general dental practitioners undertaken by the Primary Care Team in coordination with the LDC, the Team were able to work with the UHB’s Occupational Health Team to design and implement a universal Occupational Health Service for all GDPs and their staff holding an NHS contract.

From the 1st January 2013, all staff at NHS dental practices are entitled to the following occupational health support:

- Pre-employment assessment
- Health evaluation
- Sickness absence assessment
- Lung function testing (in appropriate cases)
- Immunisations and vaccinations
- Blood tests (in appropriate cases)
- Needlestick/sharps injury service
- Counselling (at additional cost - sessions to be agreed with UHB in advance)
- Musculo-skeletal physiotherapy service (at additional cost - sessions to be agreed with UHB in advance)

The agreement is for the service to be available 9am to 5pm Monday to Friday.

The UHB has also offered the seasonal flu vaccination to dental practices for the last two years and continues to do so but the uptake by practices has been very low.

**Where we need to be**

The UHB will monitor and evaluate the Occupational Health service once it has been in place for 18 months to ensure it is being effective and has been utilised by practices.

Following the removal of Primary Care Support Services and the fact that the replacement service does not cover dentist, the UHB will work with colleagues in other LHBs, PHW and Welsh Government to look at ways of supporting dentists and dental practices who are undergoing significant stress or struggles.

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Occupational Health Service</td>
<td>30th June 2014</td>
</tr>
<tr>
<td>- In place – Will be reviewed</td>
<td></td>
</tr>
<tr>
<td>after 18 months</td>
<td></td>
</tr>
<tr>
<td>b. Replacement for Primary Care</td>
<td>31st December</td>
</tr>
<tr>
<td>Care Support Services for</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
</tr>
</tbody>
</table>
14. Oral Health Training For Pre-Registration Nurses

Welsh Government (WG) Action 14:

Support the CDS to work with educational providers to ensure consistent evidence based oral health input to all pre-registration nurse courses in Wales, and to address training for Health Care Support Workers

Where we are

The Community Dental Service are working collaboratively with the further education providers to ensure all future Cardiff and Vale pre-reg general nurse trainees as part of the curriculum receive the necessary oral health education training.

Where we need to be

The CDS will continue to develop and strengthen the links with the pre-reg nurse and Health Care Support Workers training teams to ensure that consistent and full oral health education training is given to trainees.

Summary of Health Board Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>By When</th>
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<tbody>
<tr>
<td>Link with the Actions in Section 11 to improve Mouth Care for Adult Patients in Hospital.</td>
<td></td>
</tr>
<tr>
<td>a. Oral Health education to be on curriculum of pre-registration nurse courses</td>
<td>31st March 2014</td>
</tr>
</tbody>
</table>
15. National Prevention Campaigns

Welsh Government (WG) Action 15:
Ensure that high risk groups are targeted by national campaigns (e.g. Mouth Cancer Awareness and National Smile months)

Background

High profile national campaigns provide an important tool in raising awareness amongst the population of key health messages. Helping to train people on the keys issues facing them in protecting their oral health is an important part of our public health message.

Where we are

The UHB has raised the awareness with GDPs of both Mouth Cancer Awareness Month and National Smile Month and the key messages involved in both campaigns.

The CDS will provide oral health promotion and link, where possible, into these national events.

Where we need to be

The UHB would like to incorporate more training on key oral health messages into the general health provision and to use these two key national campaigns to improve training. The Primary Care Team will work together with the Designed To Smile to look at opportunities for training GDPs, GPs, Health Visitors, District Nurses etc as part of their ongoing continuing professional development so that they are aware of and understand the key messages of these campaigns.

The UHB will also look to work with specific community groups who may struggle historically with accessing dentistry to see if there are ways of helping them understand the messages of these national campaigns.

There is a recognition that many of the patients who are at highest risk of dental disease will also be those who will choose not to regularly attend the dentist and, as such will only come into contact with dentistry through the Emergency Dental Service when they are in pain. It is therefore vital that all of the EDS dentists understand the key messages and issues to look out for.

Summary of Health Board Actions

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<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
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<tbody>
<tr>
<td>• Link with the Actions in Section 4 and 9 with regard to Oral Cancer.</td>
<td></td>
</tr>
<tr>
<td>a. Link Primary Care training needs with Designed To Smile</td>
<td>31st March 2014</td>
</tr>
<tr>
<td>b. Training EDS dentists on oral cancer detection and preventative messages (Linked with Mouth Cancer Awareness Month)</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>c. Training GPs, Community Pharmacists etc on Oral Health messages (Linked with National Smile Month)</td>
<td>31st March 2016</td>
</tr>
</tbody>
</table>

Cardiff & Vale University Health Board
Local Oral Health Plan: December 2013
16. Oral Care For Patients With Complex Medical & Social Needs

Welsh Government (WG) Action 16:

In partnership with the Local Authority and the Third Sector, ensure oral care is integrated into the general health and social care plans/pathways of patients with complex medical and social problems.

Background and where we are

Historically, oral health messages have not been widely incorporated into wider general health plans but the move of the UHB towards Localities and the planning of services in localities, allows this to change. Some of the groups who would have complex medical and social needs include …

- Looked After Children
- Frail older people
- People with learning disability
- Asylum seekers

but this list is not exhaustive and will need to be reviewed regularly to ensure patient groups are not being excluded.

As an example of the interface between social and medical problems we can consider looked after children. A large proportion of looked after children are put into care because of neglect and associated with that neglect often have poor dental health, little or no experience of dental care complicated by issues of trust. Children in care often move between placements, making regular dental care from the same trusted provider the exception rather than the rule. Appropriate links between dental and other key staff could improve this.

Where we need to be

The UHB are investigating how to incorporate both Primary Care and Special Care dentistry into the Locality planning structures to ensure they form part of locality plans for the development of care plans and pathways. All three of the Cardiff & Vale localities have operational groups and the dental team (both primary care and CDS) are investigating with the management of the localities, the most appropriate way of engaging with these teams to ensure the core oral health messages are given as wide an audience as possible.

Dentists in Paediatric Dentistry and Special Care Dentistry often provide care for many in these groups, although in some cases with appropriate support care may be appropriate from a general dental practitioner.

The establishment of managed clinical networks in Special Care Dentistry and Paediatric Dentistry provide an appropriate opportunity to organise dental care pathways. External engagement of others involved in care for these vulnerable groups will enable such pathways to dovetail with other health and social care plans and pathways. The work of the MCN in Special Care Dentistry will also provide an overarching view on the level of provision of services to people with complex medical and social problems.

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>Mapping of Special Care provision (by SE Wales MCN in Special Care Dentistry)</td>
<td>31st March 2015</td>
</tr>
<tr>
<td>Design, with Locality management, ways of drawing dentistry (esp special care dentistry) into the locality management structures.</td>
<td>31st March 2015</td>
</tr>
</tbody>
</table>
17. Performance Management Of General Dental Services (GDS)

Welsh Government (WG) Action 17:

Plans must contain specific actions regarding the management of the current GDS contract:
- enhance contract monitoring and reviews on GDS/PDS contracts with high value Units of Dental Activity (UDA);
- ensure better compliance with NICE guidelines on recall intervals;
- monitor “splitting” courses of treatment;
- work to the interim Guidance of NHS Orthodontics in Primary Care, particularly during contract renewal

Background

The new contractual arrangements with primary care were introduced in 2006 and the UHB have adapted and improved their performance management of the GDS/PDS contracts, in cooperation with the LDC, to take into account the key performance issues which can highlight both poor and good performance.

Implementation of any new contract introduces the possibility of the contract not being operated the way which was intended when the contract was drafted. The providers of care and the commissioners are both on a learning curve, thus it can take some time for the “perverse” behaviour to emerge and then the responses to that behaviour to be thought through and influence performance management of the contract.

Where we are

The UHB Primary Care Team have developed a robust set of core data for performance management of practices which picks up outlying practices for further investigation. These practices can be subject (depending on the seriousness of the data) to anything from informal visit to help support the practice in improving through to a full Counterfraud investigation and possible recovery of funds. The UHB has worked with the LDC to ensure that the performance management is both fair and robust.

When the UHB’s Orthodontic PDS Agreements were renewed in 2012 for five years, they incorporated Welsh Government ‘Guidance on NHS Orthodontics in Primary Care’ into the new agreements and the UHB are developing a template for performance managing these contracts within this Guidance.

Where we need to be

The UHB plan to formalise the performance management data into a Balanced Scorecard to help provide a robust but easy to understand assessment of a practice’s performance. This will also form part of an increased focus on high value UDA contracts to ensure that the UHB is getting value for money in their contracts.

Working closely with the LDC, the UHB will investigate better ways of assessing quality and value for money, in advance of the introduction of any possible new GDS contract.

Alongside the current arrangements which
- identify potential access to dentistry problems,
- ensure the quality of premises and staff (e.g. follow up of Quality Assurance System findings),
- monitor treatment provision for signs of split courses of treatment and evidence of compliance with NICE recall guidance
the Health Board intend to strengthen the communication and feedback to providers to better ensure that information influences future action and that contracts which under-perform are addressed sooner.

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
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<tbody>
<tr>
<td>a. Based on current reporting, develop fully into a Balanced Scorecard approach to managing the GDS contracts</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2016</td>
</tr>
<tr>
<td>b. Work with Counterfraud on targeting outlying practices for “splitting” of treatment</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2014 and ongoing</td>
</tr>
<tr>
<td>c. Guidance on NHS Orthodontics in Primary Care now part of PDS Agreements. Develop monitoring strategy</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2015</td>
</tr>
<tr>
<td>d. Meet with all “high value UDA” contracts to look at enhanced performance management systems</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; December 2014</td>
</tr>
</tbody>
</table>
18. Domiciliary Dental Care

**Welsh Government (WG) Action 18:**
Use BSDH guidelines in developing plans for the delivery of domiciliary care

**Background**

Since 2006, almost all GDPs stopped providing domiciliary care as there did not appear to be an appropriate mechanism for payment. Therefore, the CDS has stepped in to provide domiciliary care for all residents of Cardiff & Vale, although this has led to a significant wait for treatment at times.

**Where we are**

The UHB, as part of the SE Wales MCN in Special Care Dentistry, has committed to developing an integrated domiciliary dental service which utilises the skills of both GDS and CDS as appropriate. The service being designed is using the BSDH Guidelines as a basis.

A central referral system will be introduced and all providers will operate to the standards set out in the BSDH Guidelines.

**Where we need to be**

The current CDS providers will provide evidence of compliance with the BSDH Guidelines and any new GDS providers will be expected to meet BSDH Guidelines from the start of their contracts. New performance management systems will be introduced to allow the UHB to show that the service is structured correctly and the correct providers are delivering the service.

**Summary of Health Board Actions**

<table>
<thead>
<tr>
<th>Action Description</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>a. Ensure all current providers achieve BSDH guidelines</td>
<td>31st March 2014</td>
</tr>
<tr>
<td>b. Implement new Domiciliary Dental Service, as designed by SCD MCN</td>
<td>31st March 2016</td>
</tr>
</tbody>
</table>
19. Alternative Patterns Of Care

Welsh Government (WG) Action 19:
Develop alternative patterns of care e.g increasing the specialist dental paediatric services and dental paediatric DwES (formerly known as DwSI) workforce, and building the capacity of alternative treatments such as sedation where feasible

_The development of sedation services is outlined in Section 6_

Where we are

As mentioned previously, the UHB are working within MCN structures to develop Dentists with Enhanced Skills (DwES) for appropriate services and will look to establish the relevant services as and when pathways have been developed and funding has been released for the development of the appropriate service. The UHB has been reluctant to raise the expectations of GDPs by developing DwESs without the guarantee of funding to implement the relevant services.

Where we need to be

As and when specific service areas are identified as requiring a primary care specialist, the UHB will work as part of an MCN to develop services models, care pathways and standards regionally, ensuring a consistent service for all patients. The relevant MCN will then also develop the standards and accreditation of DwES. A key part of the development of MCNs and DwES are the needs and requirements of Special Care Dentistry and Specialist Paediatric dental services.

The CDS have established specialist dental paediatric services and plan to continue to support and develop this part of the service with an StR post.

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
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<tbody>
<tr>
<td>• Links with other Actions 5, 6, 8 and 16</td>
<td></td>
</tr>
<tr>
<td>a. All DwES’s to be designed and implemented via a relevant MCN. Strategy for the development of MCNs and DwESs.</td>
<td>31st March 2017</td>
</tr>
</tbody>
</table>
20. Access To Specialist Dental Services

**Welsh Government (WG) Action 20:**

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

*The development of DwES is outlined in Section 19*
*The development of new Referral Criteria for secondary care is outlined in Section 8*
*The development of an Integrated Approach to Delivery of Services is outlined in Section 8*

**Where we are**

The development of Clinical Boards provides a framework to build integrated working on. The leadership of both Clinical Boards involved in the provision of dentistry are committed to ensuring that there is an integrated approach to the design and delivery of these services.

Increasingly, the development of services is being undertaken in a collaborative way involving Primary Care, CDS and UDH as appropriate.

**Where we need to be**

Over many years, the CDS has absorbed a number of services and treatment provisions and so it would be useful to be able to assess the strengths and the weaknesses of the current CDS structure and service provision and to ensure that they are providing treatment to their core service users, which should be primarily vulnerable groups and special care patients. Where possible, GDS may be able to support CDS by taking on routine patients.

The UHB should also ensure that innovative approaches to the provision of CDS care are investigated, including the possible co-location of CDS clinics within GDS practices and other possible integration of service delivery. This would allow the CDS to strengthen its core and improve the service provided to those who are often in most need.

Out of this review should come a robust set of referral and access criteria for GDS, GDS Specialist, CDS and UDH services ensuring that the best professional treats each patient.

**Summary of Health Board Actions**

<table>
<thead>
<tr>
<th>Summary of Health Board Actions</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>Links with Actions 8 &amp; 19 a. Undertake a full review of CDS provision in Cardiff &amp; Vale to look at strengths and weaknesses of the service and areas which can be developed both within the CDS and in partnership with GDS</td>
<td>31st March 2017</td>
</tr>
</tbody>
</table>
Appendix 1 – Dental Provision in Each Locality (2013)
Appendix 2 – Oral Health Profile 2012

From Next Page…
Key messages

- Dental decay is preventable
- Approximately two fifths of five and twelve year olds living in Cardiff and Vale UHB have experience of dental decay.
- There are wide inequalities in oral health experience associated with pockets of deprivation.
- Designed to Smile is working to address poor oral health in children from deprived areas within the LHB.
- Plans need to be made to meet the oral health needs of people living in Cardiff and Vale University Health Board more effectively.

Introduction

March 2012

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’.

Oral health is integral to general health and should not be considered in isolation. Oral disease has detrimental effects on an individual’s physical and psychological well-being and reduces quality of life. A range of conditions are classified as oral diseases. The main oral disease of childhood is dental caries (or tooth decay).

Among adults other important conditions are periodontal (gum) disease and oral cancers.

Figure 1 Changes in mean decayed, missing and filled permanent or primary teeth (DMFT or dmft) for children in Wales, 1983-2003

Trends in oral disease

The main surveys that provide information on trends in oral disease are the national decennial Adult Dental Health Survey and Children’s Dental Health Survey, and the local surveys that are coordinated by the British Association for the Study of Community Dentistry (BASCD).

Caries trends in children

The UK Child Dental Health surveys have reported improvements in Welsh children’s caries experience during the years previous to 1993 (Figure 1); this is thought to be mainly due to the widespread use of fluoride toothpaste. Since 1993 the oral health of Welsh 5 year olds has worsened and the rate of improvement in the dental health of 12 and 15 year olds has decreased.
Figure 2
Average dmft for 5 year olds, 1999-2006, Wales compared with England and Scotland

Figure 3
Mean decayed, missing and filled primary teeth (dmft) of five year olds in unitary authorities within Cardiff and Vale University Health Board, 2007-8

Figure 4
Percentage of 5 year olds with caries experience (%dmft>0) in unitary authorities within Cardiff and Vale University Health Board, 2007-8

Figure 5
Mean decayed, missing and filled permanent teeth (DMFT) of 12 year olds in unitary authorities within Cardiff and Vale University Health Board, 2008-9
FIVE YEAR OLDS
The decennial Child Dental Health surveys showed that there was a small improvement in the decay experience of Welsh 5 year olds between 1983 and 1993, but caries experience seems to have worsened since then (Figure 1).

GB country comparison
Local data on this age group are more regularly collected via the NHS Dental Epidemiology programme. Wales is now ranked third when average dmft, collected via these local surveys, is compared across the countries of Great Britain (Figure 2). In 2005–6, for the first time since these local surveys began in the mid 1980s, the average dmft for 5 year olds in Wales was significantly higher than in Scotland.

Most recent local survey, 2007–8 Health Board data
In Cardiff and Vale UHB the average dmft for all children aged 5, surveyed in 2007–8 was 1.45 and the average dmft for those with experience of caries was 3.73. These averages were significantly lower than the Welsh averages (1.98 and 4.16). Approximately two fifths (38.9%) of five year olds living in the LHB have at least one decayed, missing (due to caries) or filled tooth; this was lower than the figure for Wales, 47.6%.

Unitary Authority data
Dental caries is a preventable disease, Cardiff 5 year olds, for example, have on average one and a half teeth affected by dental caries and for those with the disease an average of just under four teeth are affected (Figure 3).

The percentages having at least one decayed, missing or filled tooth ranged from 28.3% in the Vale of Glamorgan to 41.7% in Cardiff (Figure 4).

Upper Super Output Area data
The range in average dmft is more marked when considering USOA level data; with The Vale of Glamorgan U001 having an average dmft of 0.78 compared with 2.52 in Cardiff U010 (Table 3). For the percentage with caries experience, this ranged from 23.3% of 5 year olds in the Vale U004 to 54.3% in Cardiff U008 (Table 3).

TWELVE YEAR OLDS
Decennial Child Dental Health surveys have shown that the oral health of 12 year olds has improved considerably.

The percentage of children in Wales with tooth decay has fallen from 83% in 1983 to 43% in 20032. The average DMFT has also fallen for this age-group, from 3.3 in 1983 to 1.0 in 2003 (Figure 1).

The oral health of Welsh 12 year olds is now among some of the best in Europe2.

Most recent local survey, 2008–9 Health Board data
The average DMFT for Cardiff and Vale (collected via the NHS Epidemiology programme) was 0.90 which was lower than the Welsh average of 0.98, but still within average range, as it did not differ significantly from the Welsh experience.

Unitary Authority data
Figure 5 shows average DMFT for 12 year olds by unitary authority. This ranged from 0.89 in Cardiff to 0.93 for the Vale of Glamorgan; both were within average range and did not differ significantly from Welsh experience.

Similarly the percentage with caries experience were within average range for both unitary authorities within Cardiff and Vale University Health Board (Figure 6).
Inequalities in children’s oral health

Although children’s oral health has improved on average, inequalities remain. Caries, like many other diseases increases with social deprivation.

Child poverty targets

Recent Welsh Government policy aims to eradicate the wider effects of childhood poverty; to that end the Deputy Minister for Social Justice and Regeneration proposed targets on infant mortality, low birth weight, childhood injuries, teenage conceptions and dental caries.

These Welsh targets use data from the NHS surveys to help address the widening gap between the oral health of children from the least well off and the most well off families in Wales. There are Wales level targets for 5 and 12 year olds which focus on the average dmft and the percentage with caries. It is important to note that these are Welsh targets; to date there are no Health Board targets.

Table 1: Indicators of caries prevalence in 5 year olds, 2007-08, for Upper Super Output Areas in Cardiff and Vale University Health Board

<table>
<thead>
<tr>
<th>Upper Super Output Area</th>
<th>average dmft</th>
<th>average dmft of those with dmft</th>
<th>%dmft0</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Vale of Glamorgan U001</td>
<td>0.78</td>
<td>2.70</td>
<td>29.1</td>
</tr>
<tr>
<td>The Vale of Glamorgan U004</td>
<td>0.84</td>
<td>3.59</td>
<td>23.3</td>
</tr>
<tr>
<td>Cardiff U009</td>
<td>0.87</td>
<td>3.67</td>
<td>23.7</td>
</tr>
<tr>
<td>The Vale of Glamorgan U002</td>
<td>0.88</td>
<td>3.33</td>
<td>26.4</td>
</tr>
<tr>
<td>Cardiff U003</td>
<td>0.90</td>
<td>3.19</td>
<td>28.2</td>
</tr>
<tr>
<td>Cardiff U001</td>
<td>0.92</td>
<td>3.63</td>
<td>25.3</td>
</tr>
<tr>
<td>Cardiff U002</td>
<td>1.07</td>
<td>2.81</td>
<td>38.1</td>
</tr>
<tr>
<td>Cardiff U007</td>
<td>1.40</td>
<td>3.50</td>
<td>40.0</td>
</tr>
<tr>
<td>Cardiff U006</td>
<td>1.49</td>
<td>3.54</td>
<td>42.2</td>
</tr>
<tr>
<td>The Vale of Glamorgan U003</td>
<td>1.50</td>
<td>3.75</td>
<td>40.0</td>
</tr>
<tr>
<td>Cardiff U005</td>
<td>1.59</td>
<td>3.88</td>
<td>41.0</td>
</tr>
<tr>
<td>Cardiff U004</td>
<td>1.65</td>
<td>3.30</td>
<td>50.0</td>
</tr>
<tr>
<td>Cardiff U008</td>
<td>1.96</td>
<td>3.61</td>
<td>54.3</td>
</tr>
<tr>
<td>Cardiff U010</td>
<td>2.52</td>
<td>4.93</td>
<td>51.2</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>1.45</td>
<td>3.73</td>
<td>38.9</td>
</tr>
<tr>
<td>Wales</td>
<td>1.98</td>
<td>4.16</td>
<td>47.6</td>
</tr>
</tbody>
</table>

Table 2: Indicators of caries prevalence in 5 year olds, 2007-08, for Upper Super Output Areas in Cardiff and Vale University Health Board

<table>
<thead>
<tr>
<th>12 year olds 2004-05</th>
<th>Cardif and Vale</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean DMFT</td>
<td>%DMFT0</td>
<td>mean DMFT</td>
</tr>
<tr>
<td>Least deprived</td>
<td>0.78</td>
<td>35.5</td>
</tr>
<tr>
<td>Second least deprived</td>
<td>0.96</td>
<td>41.4</td>
</tr>
<tr>
<td>Middle deprived</td>
<td>1.12</td>
<td>45.5</td>
</tr>
<tr>
<td>Most deprived</td>
<td>1.35</td>
<td>53.8</td>
</tr>
<tr>
<td>All within area</td>
<td>1.09</td>
<td>45.1</td>
</tr>
<tr>
<td>Ratio - most deprived: middle deprived</td>
<td>1.21</td>
<td>1.18</td>
</tr>
</tbody>
</table>

Table 3: Mean DMFT & %DMFT=0 for 12 year olds by quintiles of deprivation index, Wales and Cardiff and Vale UHB

<table>
<thead>
<tr>
<th>12 year olds 2008-09</th>
<th>Cardif and Vale</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean DMFT</td>
<td>%DMFT0</td>
<td>mean DMFT</td>
</tr>
<tr>
<td>Least deprived</td>
<td>0.58</td>
<td>30.5</td>
</tr>
<tr>
<td>Second least deprived</td>
<td>0.74</td>
<td>34.5</td>
</tr>
<tr>
<td>Middle deprived</td>
<td>0.95</td>
<td>42.1</td>
</tr>
<tr>
<td>Most deprived</td>
<td>1.11</td>
<td>45.5</td>
</tr>
<tr>
<td>All within area</td>
<td>1.09</td>
<td>42.9</td>
</tr>
<tr>
<td>Ratio - most deprived: middle deprived</td>
<td>1.21</td>
<td>1.18</td>
</tr>
</tbody>
</table>

In 2008-9 the average DMFT for 12 year olds for Cardiff and Vale UHB was 0.90 and for the most deprived group it was 1.25 (Table 3); There is room to improve if the 2020 national target is to be met.

In 2008-9 3 of the 14 USOAs in Cardiff and Vale UHB had an average DMFT in excess of 1.12 (The Vale of Glamorgan U003 - 1.23; Cardiff U008 - 1.24; Cardiff U100 - 1.28) There is room for improvement in these areas.

A map of USOAs can be found on the Welsh Oral Health Information Unit website: http://www.cardiff.ac.uk/dent/research/themes/appliedclinicalresearch/epidemiology/oralhealth/index.html
Reducing inequalities in oral health — Designed to Smile

Designed to Smile is a national Oral Health Improvement programme to improve the dental health of children in Wales; its overall aim is to reduce inequalities in oral health. It is funded by the Welsh Government and was initially launched on the 30th January 2009 in both North and South Wales as a three year pilot.

Due to the successful implementation of the programme, Edwina Hart, Minister for Health and Social Services announced in October 2009 that it would be enhanced and expanded to cover the whole of Wales. Currently Designed to Smile takes place in 515 schools and nurseries throughout Wales with in excess of 30,000 children taking part.

What does Designed to Smile involve?
Designed to Smile adopts a multi-agency approach using nursery and schools settings. Schools and nurseries that participate in Designed to Smile take part in preventive programmes such as twice yearly fluoride varnishing. Toothbrushing activities are also offered in addition to health promoting policies such as healthy food and drinks.

Toothbrushing: this includes supervised tooth brushing in school and nursery for young children and the promotion of good oral hygiene practices at home too.

Healthy eating and drinking:
Advice emphasises that sugar consumption should be limited and kept to mealtimes only. Milk and water are the only safe drinks for children and snacks should be sugar free.

Dental Screening: annual dental checks help to highlight problems early. The dental check will also indicate whether children are suitable for fissure Sealants or fluoride varnish or supervised tooth brushing.

For more detailed information about Designed to Smile please go to: www.designedtositme.co.uk

Health Minister enjoys miles of smiles at a Cardiff Primary School

The Minister for Health and Social Services Lesley Griffiths has seen how well a Welsh Government programme tackling tooth decay is working amongst primary school children.

The Health Minister was met by Year 6 school ambassadors when she visited Ninian Park Primary in Cardiff, on the 18th January 2012, to watch a Designed to Smile (D2S) session in action.

The D2S programme is a National Oral Health Improvement scheme to improve the oral health of children in Wales. Funded by the Welsh Government and delivered by the Community Dental Service.

The targeted programme has been running in Wales since its pilot in 2008 and its wider roll-out to all children in areas of greatest need in 2009.

During her visit, the Minister was on hand to see a Dental Health Educator demonstrate the importance or oral hygiene through the use of puppets and mouth models.

After the puppet shows the children were encouraged to clean their teeth themselves, a habit promoted by all schools taking part in the D2S programme.

Health Minister Lesley Griffiths said:
“The Welsh Government is determined to tackle oral health inequalities. Recent figures show over 50% of 5 year olds in Wales have experienced tooth decay. This is unacceptable when dental decay is avoidable simply by improving diet and nutrition and encouraging young children to develop the habit of brushing their teeth twice a day with fluoride toothpaste.”

“The Designed to Smile Programme continues to expand with some 62,000 children participating in the scheme, delivered through 954 schools and nurseries, improving their oral health and preventing tooth decay.”

“We have made significant progress across Wales with more children taking part in tooth brushing schemes, providing young people with the tools they need to develop and maintain good oral health from an early age.”
Figure 8
The proportion of adults with no natural teeth in Wales, 1978-2009

Table 4 Total numbers of cases registered with oral cancers by Local Health Board in Wales 2001-2010

<table>
<thead>
<tr>
<th>Unitary Authority</th>
<th>Total</th>
<th>EASR 95% Confidence Interval</th>
<th>Unitary Authority</th>
<th>Total</th>
<th>EASR 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglesey</td>
<td>60</td>
<td>6.7 (5.1, 9.0)</td>
<td>Neath &amp; Port Talbot</td>
<td>94</td>
<td>5.8 (4.7, 7.3)</td>
</tr>
<tr>
<td>Gwynedd</td>
<td>82</td>
<td>5.5 (4.3, 7.0)</td>
<td>Bridgend</td>
<td>94</td>
<td>5.9 (4.7, 7.4)</td>
</tr>
<tr>
<td>Conwy</td>
<td>101</td>
<td>5.6 (4.5, 7.1)</td>
<td>The Vale of Glamorgan</td>
<td>74</td>
<td>5.0 (3.9, 6.4)</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>74</td>
<td>6.0 (4.7, 7.9)</td>
<td>Cardiff</td>
<td>181</td>
<td>5.7 (4.9, 6.7)</td>
</tr>
<tr>
<td>Flintshire</td>
<td>103</td>
<td>5.7 (4.6, 7.0)</td>
<td>Rhondda Cynon Taff</td>
<td>140</td>
<td>4.9 (4.1, 5.9)</td>
</tr>
<tr>
<td>Wrexham</td>
<td>83</td>
<td>5.2 (4.1, 6.6)</td>
<td>Merthyr Tydfil</td>
<td>31</td>
<td>5.0 (3.4, 7.5)</td>
</tr>
<tr>
<td>Powys</td>
<td>71</td>
<td>3.4 (2.6, 4.5)</td>
<td>Caerphilly</td>
<td>92</td>
<td>4.7 (3.8, 5.8)</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>42</td>
<td>3.9 (2.8, 5.9)</td>
<td>Blaenau Gwent</td>
<td>35</td>
<td>4.3 (3.0, 6.4)</td>
</tr>
<tr>
<td>Pembrokeshire</td>
<td>69</td>
<td>4.3 (3.4, 5.7)</td>
<td>Torfaen</td>
<td>54</td>
<td>4.7 (3.5, 6.4)</td>
</tr>
<tr>
<td>Carmarthenshire</td>
<td>122</td>
<td>5.0 (4.1, 6.1)</td>
<td>Monmouthshire</td>
<td>44</td>
<td>3.5 (2.6, 5.2)</td>
</tr>
<tr>
<td>Swansea</td>
<td>165</td>
<td>5.1 (2.5, 7.2)</td>
<td>Newport</td>
<td>76</td>
<td>5.0 (4.0, 6.4)</td>
</tr>
</tbody>
</table>

Source: Welsh Cancer Intelligence and Surveillance Unit

Oral health in adults

Decennial Adult Dental Health surveys have reported that the dental health of most adults has improved dramatically during the past 50 years. During the post war years, the nation’s oral health was poor and dental disease was widespread. People did not expect their natural teeth to last a lifetime. This expectation has now changed nowadays more adults keep their teeth for life. In 1978 as many as 37% of adults in Wales had no natural teeth; by 2009 this figure had fallen to 10% (Figure 8). But, the number of adults with no teeth is still high when compared with England (where 6% had no teeth in 2009).

Caries

Tooth decay still affects a large proportion of the population and a significant proportion of people over the age of 75 are still without any natural teeth. Although more middle aged people have their own teeth, many of these teeth have been filled and these fillings need maintenance and repeated repair. This changing pattern in the demand for dental services needs to be taken into account in future workforce planning.

Periodontal condition

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

Oral Cancer

Oral cancer is more common in people who are over 50 years old, and is twice as common in men as in women. However, the gender difference is becoming less pronounced and prevalence is also increasing in younger adults. Almost all oral cancers are thought to be preventable. An estimated 80% are caused by tobacco smoking, alcohol consumption or a combination of the two. In Wales, data on oral cancer are collected via the Welsh Cancer Intelligence and Surveillance Unit. Table 4 shows the total number of cancers of the mouth, lip and oral cavity for the ten year period 2001-2010 for unitary authorities in Wales along with European Age Standardised Rates (EASR) per 100,000 population and 95% confidence intervals. The EASR takes into account the differing age structure in Wales compared with the European population. Only totals by persons are shown here due to the small number of cases by LHB for various head and neck cancers. The lowest EASR per 100,000 population of mouth, lip and oral cavity cancer is located in Powys with the highest EASR being in the Isle of Anglesey. It is also worth noting that the three unitary authorities within Abertawe Bro Morgannwg University health board all have EASRs which rank them in the worst fifth of Wales’ unitary authorities.
Care Home Residents

Older people now make up a larger proportion of the population and maintaining their dental health will be an increasing challenge. In 2007 a survey of Wales care home managers identified weaknesses in arrangements for ensuring that all residents have suitable assessments on admission; difficulty in accessing both routine and emergency dental care; training issues for staff who assist residents with oral hygiene; and assumptions made about the ability of residents to chew food which is affecting the range of food offered. Experience ranged across Wales, in Flintshire for example, the majority of care homes had well established systems for accessing oral health care; this was associated with local Community Dental Service initiatives working with care homes in the area. A link to this report can be found on the Welsh Oral Health Information Unit website (see Websites, page 8). More recently in 2011, an oral health survey of care home residents was carried out, the results will be available by the end of 2012, and will be used to facilitate planning processes within Local Health Boards.

Map 1 Indication of Relative Adequacy of Provision to Meet Need by MSOA
(The higher the score, the less well need is being met)

Researchers at Cardiff University have been carrying out a project Modelling NHS Primary Dental Care Provision in Wales. They have reported on the use of non-orthodontic GDS and PDS NHS dental services for the period April 2008 to March 2010.

The dental attendance rates (defined as the percentage of the population that made at least one visit to a dentist during the period) for Wales and Cardiff and the Vale UHB were virtually identical at were 56.1% and 56% respectively. Within Cardiff and the Vale this ranged from 55.3% in Cardiff to 57.9% in the Vale of Glamorgan. Middle Super Output Area-level, attendance rates varied from 18.2% to 78.6%, with 19 of the Health Board’s 62 MSOAs having an attendance rate above 60%. Whilst 8 MSOAs (all in the Cardiff locality) had an attendance rate below 40%.

There was no clear relationship between area attendance rates and deprivation, as measured by the Income Domain of the Welsh Index of Multiple Deprivation 2008. The Cardiff based researchers constructed an indicator of the relative adequacy of provision to meet need which highlighted the areas where need is being less well met (Map 1). When constructing the indicator the following definitions were used:

Need
The Income Domain from the Welsh Index of Multiple Deprivation (2008) at Middle Super Output Area (MSOA) was used as a proxy for need.

Demand
This was defined as the percentage of the population attending an NHS dentist at least once in the 24 month period 1st April 2008 to 31st March 2010. NICE guidelines suggest that the maximum frequency between dental visits for adults should be 2 years. This maximum frequency only applies to individuals who are not considered to be at risk of oral disease. Many regular dental attenders will visit at more frequent intervals – traditionally every six months.

Provision
This was defined as the total number of Units of Dental Activity (UDAs) commissioned per 1,000 people per MSOA.

Summary indicator of relative adequacy to meet need
Need, Demand and Provision were allocated a numerical score of 1 to 5 by placing the MSOAs into quintiles, where 1 corresponds to low need, high demand and high provision. Scores were summed to provide an overall indication of the adequacy of provision to meet need – the higher the score (the maximum being 15), the less well need is being met. The overall indicator is also mapped in Map 1 – the darker shading indicating where the less need is being met. The areas where need is being less well met are primarily in the south of Cardiff and along the border with The Vale of Glamorgan (that is Splott, Ely, Butetown and Grangetown).
Challenges for the future

- Even though Cardiff and Vale University health board has levels of caries experience within the Welsh average range, these levels are worse than those experienced in England and Scotland. Also, there is wide range of caries experience at the small area level. The challenge for the health board is to address the problem of the disease burden amongst 5 year olds and the inequalities in oral health.

- The health board needs to follow through preventive action to stop caries from developing in the first place and to ensure that key services for priority groups, in particular children, are planned for and resourced.

- The health board should ensure that the oral health needs of care home residents are met using the recommendations from recent national surveys.

- The health board will need to meet the additional pressure on dental services as more adults retain more teeth for longer and require more complex restorative services.

- The health board has room for improvement in meeting the oral health needs of the local population (Map 1); the health board needs to ensure that access to affordable services are available and that their uptake is encouraged.

References


Useful websites

- Welsh Oral Health Information Unit website
- PHW observatory
- British Association for the Study of Community Dentistry
- Designed to Smile
- Child Dental Health survey data
- Adult Dental Health survey data
- Health Maps Wales
- Welsh Cancer Intelligence and Surveillance Unit (WCISU)