Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Annual Report

General Dental Services Reform Programme

2019

Contents

A. Background

The General Dental Services (GDS) Reform Programme is developing, in partnership with the Welsh Government, within the context described in the following key strategic documents:

- Taking Oral Health and Dental Services Forward in Wales
- A Healthier Wales: Our Plan for Health and Social Care
- Oral Health and Dental Services' Response to A Healthier Wales.

The current GDS Reform Programme commenced in September 2017 with engagement with key stakeholders especially Health Boards and dental services. General dental practices were invited to join the programme and twenty-one practices from across Wales joined between September 2017 and April 2018. Currently 132 general dental practices across Wales are participating in the programme (Appendix 1).

B. Objectives of the Programme

1. Involve key dental stakeholders to develop an NHS GDS Reform Programme and adopt an Action Learning Approach.
2. Ensure dental services undertake an assessment of the oral health risks and needs of individual patients once a year using a standardised toolkit (ACORN) and utilise the information to:
   2.1. Understand what matters to patients.
   2.2. Effectively communicate level of risks and needs to patients (or their carers) and work with patients in making them understand changes they can make to prevent dental diseases and maintain oral health.
   2.3. Agree on the oral health outcomes patients want to achieve over a period of time or after a course of dental treatment.
   2.4. Utilise the principles of Shared Decision Making in formulating a preventive dental care plan.
   2.5. Monitor changes in the risks and needs of patients who receive ongoing care from the service.
3. Improve and increase the delivery of evidence-based prevention and treatment.
4. Support the implementation of dental recall intervals based on oral health risks and needs.
5. Increase the use of skill-mix in NHS General Dental Services in Wales.
6. Encourage clinical teams to develop a culture of continuous quality improvement to ensure enhanced service quality and safety.
7. Test the changes that are required to reduce inequity in dental care use and improve dental access for individuals who have dental need but currently cannot/do not access dental care.
8. Encourage dental teams to establish productive working relationships with other primary and social care services to improve overall patient care.
9. Inform any changes required in the relevant programmes (e.g. workforce planning, training and planning) and information systems in place to facilitate ongoing improvement.
10. Inform any changes required in national dental contracts, associated legislations, other related work with partner organisations and Health Boards adopting a 'once for Wales' approach to contract monitoring.
11. Evaluate to understand the changes in key activities, quality indicators and oral health outcomes and establish quality indicators to inform ongoing improvement of primary dental care.

C. Action Learning Approach

Complex system changes require a learning approach and building cultures that support collaborative inquiry and learning. Action Learning Approach supports participative solutions to entrenched problems. It requires all stakeholders to adapt and respond to changes from their experimental and experiential learning. Considering the complexity of the GDS system, the GDS Reform Programme takes an Action Learning Approach. It brings together Welsh Government, Public Health Wales, Health Boards, Health Education and Improvement Wales, NHS Business Services Authority, independent dental service providers (and their teams)and academia, amongst others, to find solutions to complex problems.

Fig 1 Why use Action Learning adapted from (https://www.actionlearningcentre.com/about-action-learning Sept 2019

This approach brings with it many advantages including some highlighted in Figure 1. 'Why use Action Learning'. Our early experience of using the Action Learning Approach for the GDS Reform Programme has been positive. Involvement of multiple stakeholders itself is a learning process. It has provided insights often not available in linear change models. However, it is not easy to explain and implement an Action Learning Approach when expectation and culture of linear model of change is prevalent. Our interactions with key stakeholders tell us that understanding of the Action Learning Approach is increasing. However, we need multimodal communication actions, ongoing platforms for interactions, project management skills and clarity in distributed responsibilities to support and build trust between key stakeholders to fully embed the Action Learning Approach.

D. Engagement

Solutions to problems are likely to be sustained if those affected by them have been involved in their creation. Recognising the importance of communication and engagement in a change process, the GDS Reform Programme started with formal and informal engagement with key stakeholders. We organised formal engagement events and meetings to engage, listen and develop various aspects of the programme.

The first output produced from the early participatory approach in 2017/18 was a 'Risks and Needs Assessment' toolkit called ACORN. Dental teams with input from others developed this toolkit, which has been a catalyst for change.

We have held many formal engagement events over the last two years. The latest

(three across Wales) were held in September 2019 and were organised with close support from the Welsh Government. Many dental practices, relevant teams from Health Boards, members of Local Dental Committees, Welsh Dental Committee and others attended, making them successful platforms for information sharing, interactions and feedback.

Recent engagement events also included a Continuing Professional Development (CPD) session run by Health Education and Improvement Wales (HEIW) on Shared Decision Making, a key area for improvement for the GDS in Wales.

Alongside the formal engagement events, which were open for all stakeholders, we also organised meetings for Health Boards' Primary Care management teams to understand local adaptation used in testing changes, their experience and challenges in implementing change. These meetings also provided opportunities for Health Boards to share learning.

GDS reform has also been a key area of discussion in annual meetings between Welsh Government (Chief Dental Officer and Head of Dental Policy) and Health Boards.

Locally many Health Boards have also organised interactive meetings or engagement sessions for reform practices to provide platforms for discussion and the opportunities to share learning. We have provided input to these local sessions when requested and possible.

We will improve on our engagement to increase the reach and tailor our engagement to different groups of dental practices at different stages of the improvement journey. We will continue to facilitate Primary Care management teams in seven Health Boards to collaborate more closely and share learning. We will use a project management approach especially to improve our communication with stakeholders using different channels. We will continue to offer our support and input to local engagement sessions at Health Boards and emerging Quality Improvement (QI) groups.

Continuing with our Action Learning Approach, we will regularly reflect on all processes to capture insights to inform our next steps i.e. actions.

E. Dental Symposium

The second Welsh Dental Symposium, 'Transforming Dental Services in Wales' was held on 21st March 2019 at the Principality Stadium in Cardiff.

The aim of the event was to give those working in dentistry in Wales an opportunity to understand the transformation context, the Welsh Government's relevant strategies, existing national programmes in dentistry including the GDS Reform Programme and local initiatives. There was dedicated time and space for attendees to provide feedback, which provided useful insights for the GDS Reform Programme. The event also provided an opportunity for all attendees to network and share learning. The programme for the day included an introduction to Shared Decision Making, behaviour change skills and understanding dental quality and safety system in Wales including QI support available for dental practices. The symposium provided an opportunity for Continuous Professional Development (CPD) for dental teams.

Slightly over 250 delegates attended the symposium. Representation from all areas of primary care dentistry was evident (Figure 2).

Figure 2: Breakdown of delegates who attended the dental symposium.

Feedbacks were positive and it was clear that the dental profession would welcome the continuation of the annual dental symposiums.

We will find a new venue to accommodate the higher number of delegates who want to attend the symposium. We will avoid March for future symposium as feedback tells us that many prefer to avoid dates near financial year-end.

F. Joining the GDS Reform Programme

Health Boards invite dental practices in their area to join the programme. Health Boards have used local selection criteria and insights to choose practices to join the programme. Practices join the programme on either 1st of April or 1st of October each year.

On joining the programme, practices start using a standardised risks and needs assessment toolkit, called ACORN (**A**ssessment of **C**linical **O**ral **R**isks & **N**eeds) (Appendix 2) and move away from the traditional model of dental check-ups.

Practices carry out risks and needs assessment once a year instead of dental check-ups every 6 months. We have outlined the intended outcomes from the use of the toolkit within the programme objectives (see Appendix 2 above). These intended outcomes from the toolkit have been re-iterated during our engagements events and meetings. Practices are also expected to improve their delivery of personalised evidence-based prevention such as brief intervention on smoking cessation and referral, application of fluoride varnish on teeth, etc.

Participating practices submit a summary risks and needs status for each patient via the amended FP17W, the claim form dental practices submit to the NHS Business Services Authority.

We have provided a document explaining the GDS Reform Programme principles, expectations and criteria (Appendix 3) to the practices and health boards. This document outlines the changes we expect the practices and Health Boards to make and criteria practices need to meet to progress from stage one to stage two.

Currently there are 120 practices in Stage 1 and 12 practices have progressed to Stage 2 (Table 1).

Table 1: Number of practices in different stages of the programme across seven Health Boards (November 2019).

Health Boards	Stage 1	Stage 2
ABUHB	28	0
BCUHB	17	4
C&VUHB	22	2
CTMUHB	20	2
HDUHB	14	0
SBUHB	14	4
PTHB	5	0

G. Monitoring Reports

The NHS Business Services Authority (NHSBSA) has a crucial role in the GDS Reform Programme to create an information system and outputs that are aligned with the principles of the reform.

The number of patients receiving an ACORN instead of a traditional dental 'check-up' is increasing. The addition of risks and needs data to the existing GDS activity database provides an opportunity to develop new quality indicators and provide reports to practices and health boards that includes risks and needs profile of population that use NHS dental services. The information system being developed within the NHSBSA will also allow us to understand outcomes of dental care and share the best practices.

Welsh Government has funded two senior information analyst posts within the NHSBSA. The two data analysts are currently working for the GDS Reform Programme to produce regular monitoring reports and answer any information queries from the Health Boards and dental practices.

We have supported the NHSBSA in producing monitoring reports by sharing our expertise in data analytics and the objectives of the reform programme.

The NHSBSA has produced the monitoring reports, which are essentially feedbacks to practices on the changes they have made since joining the programme. Public Health Wales, Health Boards, Welsh Government and dental practices have provided feedback to the NHSBSA to ensure monitoring reports continue to improve in line with the expectations of the programme and its stakeholders.

The NHSBSA will produce monitoring reports every quarter for practices and Health Boards, which should inform their local discussions to identify areas for improvement and co-create an improvement plan.

Table 2: Schedule of producing monitoring reports

Reports	Expected availability
Quarter 1 report	July
Mid-year report	October
Quarter 3 report	January
End of year report	August

Further improvements are required in the information system to capture preventive interventions and treatment activities currently not captured via the FP17Ws. Although this report is concerned with GDS Reform Programme, Community Dental Services (CDSs) in Wales now also use ACORN toolkit and submit FP17Ws. We will share learning with the CDSs including the interpretation of the quality indicators included in the monitoring reports. We are working closely with the NHSBSA and Welsh Government so that plans are in place to amend the claim form FP17W and produce meaningful outputs to support the reform. It has also been agreed that the system, including legislations, will be changed so that Dental Care Professionals (DCPs) who currently cannot submit FP17W (without an examination by a dentist) can do so to capture the dental prevention and care they provide to patients between risks and needs assessments. It is expected that these changes will be made in early 2020.

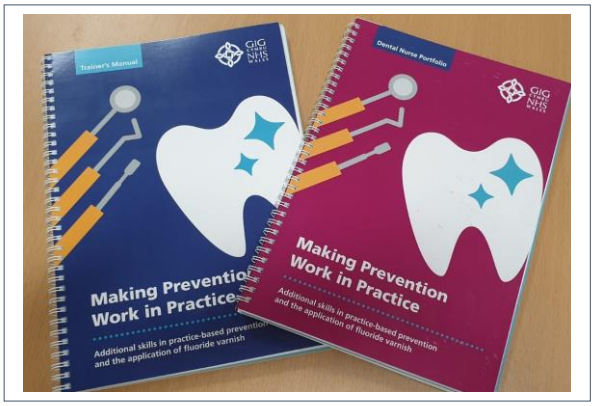
The NHSBSA is also developing a new reporting platform called eDen. This provides opportunities to present GDS and

CDS service delivery including information on quality indicators in a new way that supports continuous quality improvement. Health Boards and dental practices should be able to access the information as frequently as they wish rather than waiting for quarterly monitoring reports.

H. Workforce Development

Workforce development and planning is crucial for success of the GDS Reform Programme.

We are working closely with the dental section of Health Education and Improvement Wales (HEIW) to develop training and resources for dental teams that support the objectives of the GDS Reform Programme. HEIW, working with the programme and Primary Care Commissioning (PCC), has developed the Making Prevention Work in Practice (MPWiP) course, which supports practices to integrate a comprehensive preventive approach into dental practice. Dental educators in HEIW have been trained to deliver this training to their peers working in dental practices.



MPWiP uses the 'Train the Trainer' Model. Five 'Train the Trainer' Events have taken place between March – September 2019 and four more have been organised within the 2019/20 financial year. So far, 69 dentists have received MPWiP training who will train 113 dental nurses working in their practices.

Work is underway to establish Local Quality Improvement Groups (LoQIG) in each Health Board. HEIW Quality Improvement (QI) educators, working closely with colleagues from the Health Boards will support the development of these groups providing a platform for sharing learning, peer review and joint QI projects.

We have worked closely with the dental section of the HEIW to develop QI support available for the dental practices. We have provided input to the development of many QI toolkits, projects and audits. QI resources are free to NHS dental practices and funding is available for practices to participate in most QI initiatives available through the HEIW, which should help to embed QI into dental practice. We will continue to work with the HEIW to ensure dental practices understand the value of quality improvement methodologies and develop a culture of continuous quality improvement in the GDS.

I. Public Survey

We have awarded a grant to the Public Health Collaborating Unit at Bangor University for a national public engagement survey related to the GDS Reform Programme. A report is expected in January 2020. Findings from this public survey will provide valuable insights to improve different elements of the programme.

J. Research

We collaborated with the Dental Public Health Unit at Cardiff University to support their recent research funding applications.

Health Care Research Wales has provided funding for two studies under the Research for Patients and Public Benefit (RfPPB) scheme. Both studies will inform the GDS Reform Programme.

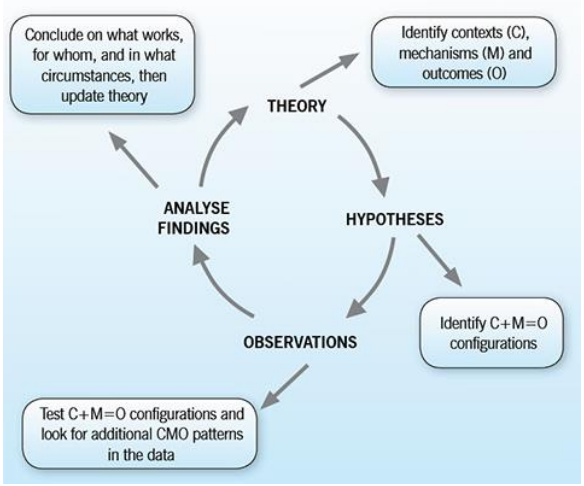
- PRIDA – Patient Recall Interval Decision Aid Study
- Optimising value-based, preventive care delivery in NHS GDS.

Both RfPPB research projects are led by Professor Ivor Chestnut, Cardiff University and Dr Anwen Cope, Specialty Trainee in Dental Public Health.

K. Realist Evaluation

Based on the service specification provided by the programme, Welsh Government has procured a Realist Evaluation of the programme from Bangor University. The evaluation team has already started their work.

Fig 3 – Realist evaluation



The realist evaluation (Fig 3) aligns well with the Action Learning Approach adopted by the GDS Reform Programme. Regular interim reports provided by the evaluation team will guide further development and improvement of the programme.

L. Steering Group

We formed the GDS Reform Programme Steering Group as soon as the programme commenced in September 2017. The Chief Dental Officer (CDO) chairs the Steering Group with membership from the British Dental Association (BDA), Welsh General Dental Practice Committee (WGDPC), Welsh Dental Committee (WDC), Public Health Wales (PHW), Welsh Government (WG), Community Health Council (CHCs), seven Health Boards (HBs) and Health Education and Improvement Wales (HEIW). Dental team members from dental practices are also invited and attend the meetings to provide their valuable insights.

The Steering Group meetings provide opportunities for all stakeholders to discuss key challenges, influence the Welsh Government's strategic direction, provide feedback and input to the programme. The group also monitors progress in different areas of the programme. This group has a dual role of advising and supporting the programme but also holding PHW and other stakeholders accountable for progress against the agreed deliverables.

The Steering Group has met three times so far in 2019, with the next meeting agreed to be held in November 2019. We have received positive feedback on the Action Learning Approach and the changes dental teams are making to integrate prevention

into practice. However, there are different challenges for all stakeholders involved. The pace and number of changes will need to take account of capacity and capabilities of all teams involved in the programme.

M. Programme Update Reports

We provide regular programme updates to our key stakeholders. The programme updates are sent to all practices in the programme, relevant teams within the seven HBs, Local Dental Committees (LDCs) and the Steering Group members with a request to further disseminate within their networks. Appendix 4 provides an example of the programme updates.

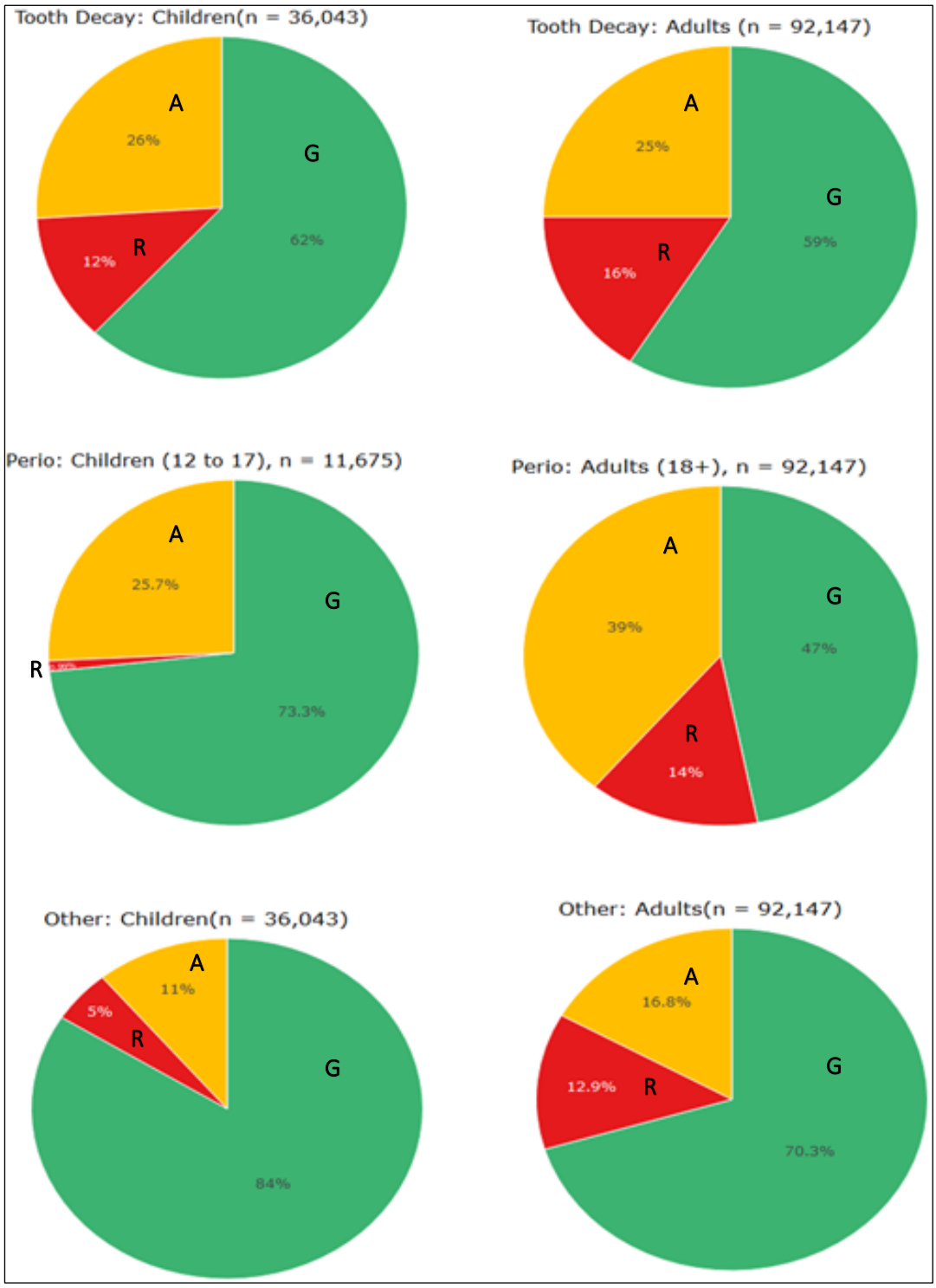
N. Early Insights from the Database (2018/19)

There were 55 dental practices participating in the programme during the 2018/19 financial year. Of these, 21 practices were in the programme for the whole year while 34 joined the programme in October 2018. Practices were able to submit additional data on 'risks and needs' via the amended FP17Ws from June 2018. Hence, all risks and needs data presented in this report relates to data submitted by practices from 1st June 2018 - 31st March 2019. Given that the findings are based on a relatively small number of practices over a limited period, information presented here should be interpreted with caution.

Risks and Needs Profile

Data submitted by reform practices indicate that a significant proportion of patients attending the GDS in Wales have stable oral health and no identified treatment need (Figure 4).

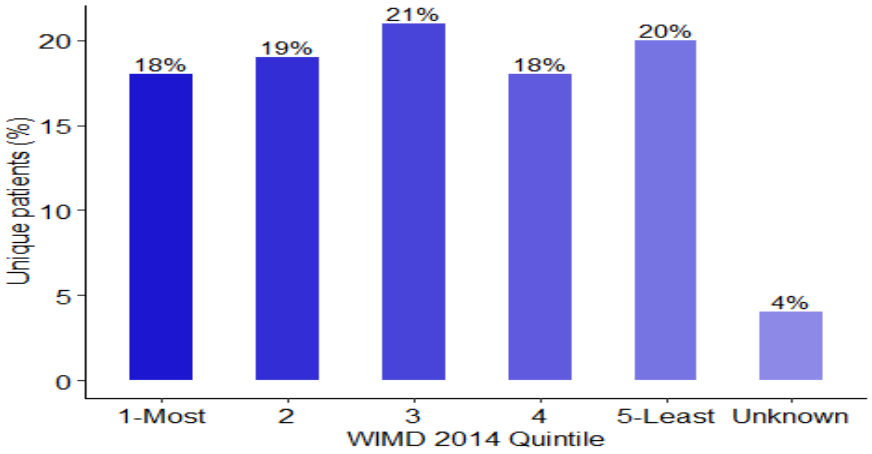
Figure 4: Risks and Needs profile of patients who attended the reform practices in 2018/19. (Red= treatment need, Amber= risks for disease or early/stable disease, Green= no treatment need)



27% of adults and 51% of children assessed between 1st June 2018 - 31st March 2019 did not have any treatment need for any dental conditions. 1% of adults and 0.1% of children had active tooth decay and periodontitis as well as treatment need for 'other dental conditions'.

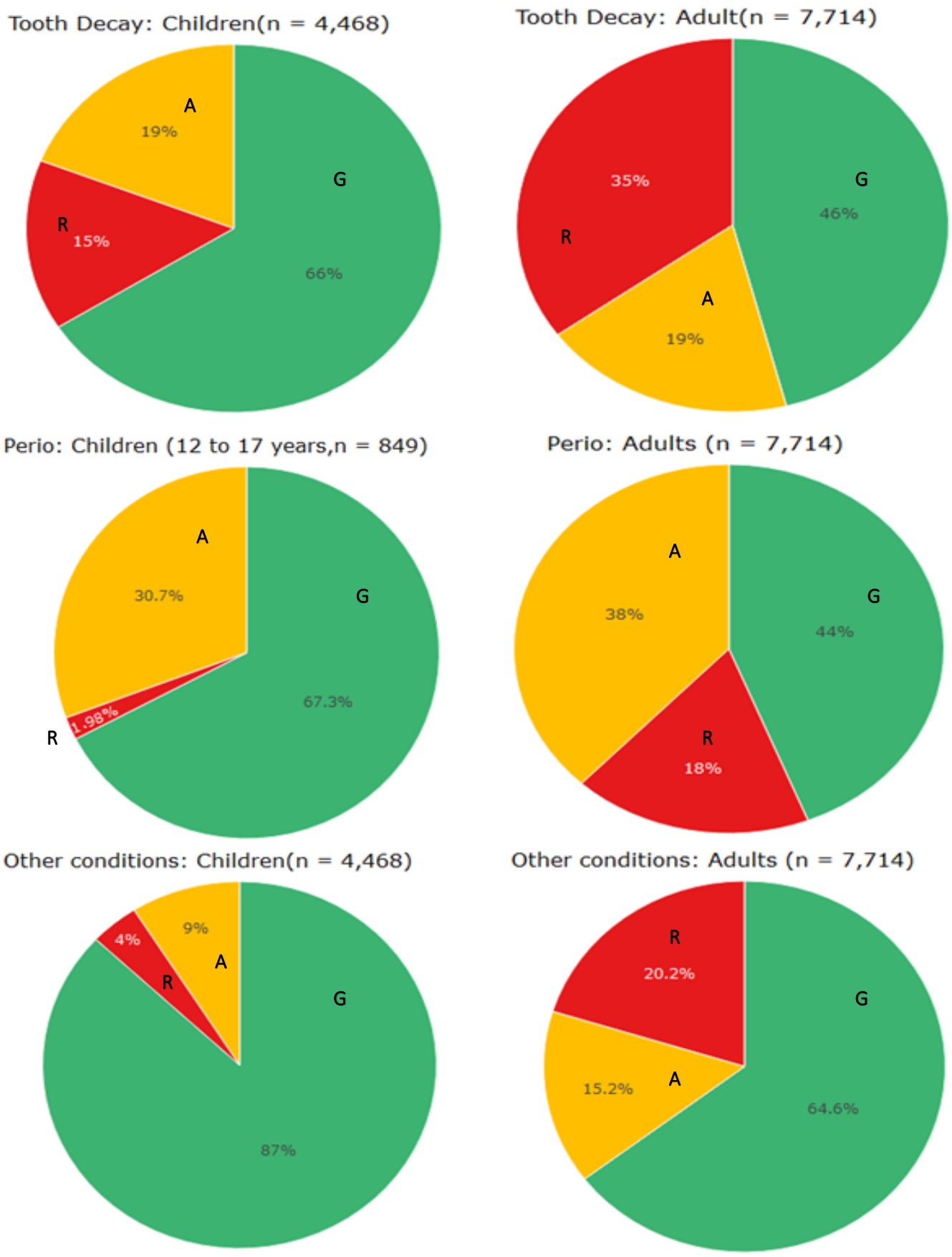
Figure 5 shows that patients who received ACORN in 2018/19 lived in areas across all the deprivation quintiles. The spread of assessments across the deprivation quintiles indicate representativeness of the profile presented on Figure 4.

Figure 5: Spread of patients across Welsh Index of Multiple Deprivation (WIMD, 2014) who received ACORN in 2018/19.



There is a common perception that all new patients have high treatment need. The risks and needs profile of new patients seen by dental practices in 2018/19 has been presented in Figure 6. It is not surprising that the higher proportion of new patients have prevention and treatment needs compared to patients who attend dental practices on a regular basis.

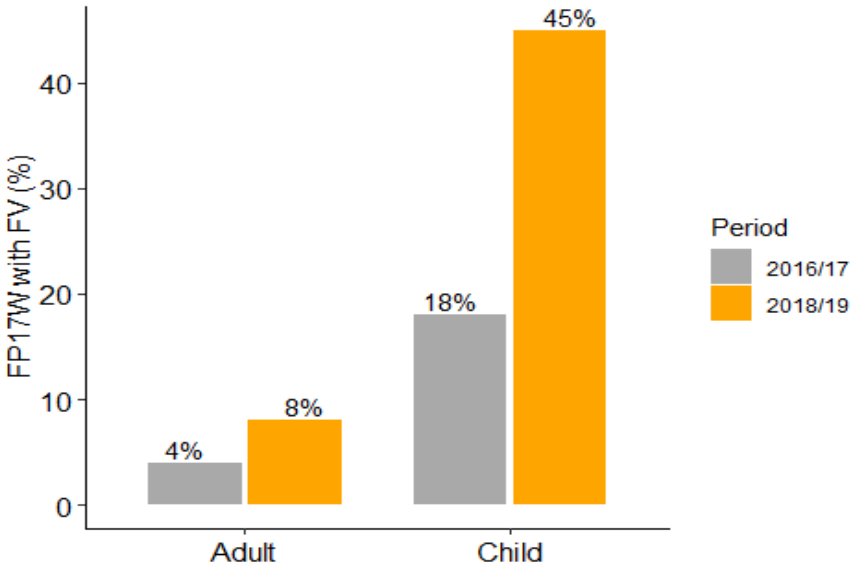
Figure 6: Risks and needs profile of new patients seen by reform practices in 2018/19.



Fluoride Varnish Applications

Fluoride Varnish (FV) is effective in preventing tooth decay. It should be applied at least twice a year but it can be applied up to four times a year for those patients at risk of developing tooth decay. Delivery of FV applications within GDS has been very low for many years. The practices in the programme are expected to increase FV applications. Figure 7 shows increase in FV applications in 2018/19 compared to 2016/17 (baseline year).

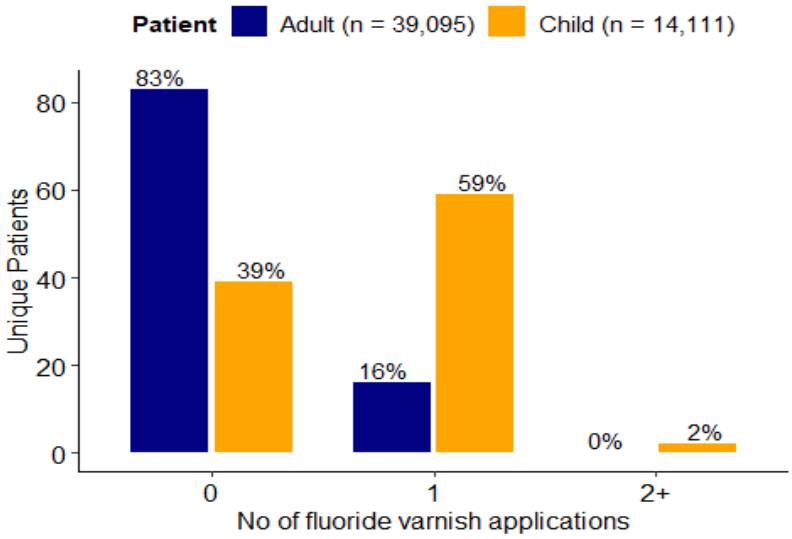
Figure 7: Percentage of Courses of Treatment (FP17Ws) that included FV applications (2016/17: n = 357,338, 2018/19: n = 367,836).



In 2018/19, 61% of children and 16% of adults who were categorised as Red or Amber for tooth decay received at least one application of FV. The proportion of patients categorised as Red or Amber for tooth decay who were reported as receiving at least two applications of FV in a year is still low (Figure 8).

The delivery and reporting of FV applications needs to improve to ensure effectiveness of the intervention.

Figure 8: Number of patients categorised as Red or Amber for tooth decay and number of applications fluoride varnish in 2018/19.



50% of Courses of Treatment (FP17Ws) submitted by practices for 6-17 year olds in 2018/19 included neither fissure sealant nor FV. There is plenty of room for improvement in the delivery of prevention, particularly for FV applications and fissure sealants; two simple but evidence based effective preventive interventions that can be delivered by Dental Care Professionals (DCPs).

Dental Access

Practices are expected to ensure that the annual number of patients seen in their practices should not decrease unless there are genuine reasons for such a decrease, e.g. reduction in Annual Contract Value (ACV), significant staff changes or the practice profile indicates that patients, especially new patients, seen by the practice have higher treatment need etc.

Fifty-two out of fifty-five practices participating in the programme were in operation during 2016/17 (baseline year) and during 2018/19. Fifty-two practices saw 212,368 unique patients in 2018/19 compared with 224,074 unique patients in 2016/17. Looking at just the 12 months dataset there appears to be 5% drop in number of patients seen by these 52 practices in 2018/19 compared with 2016/17 (4% and 6% drop in children and adults respectively, Figure 9). There seems to be a variation between dental practices participating in the programme in change in access in 2018/19 when compared to the baseline year (2016/17). Some practices have managed to increase access while others have seen fewer patients in 2018/19 compared to 2016/17. This change is not always explained by change in ACV. There may be many other reasons why reform practices have seen less or more patients in 2018/19 (programme year) compared to 2016/17 (baseline year). Dental access comparison presented here should be interpreted with caution because dental access is usually analysed over 24-months rather than 12-months timeframe. In addition, other factors need to be taken into account in understanding increase or decrease in dental access.

Early findings indicate that is important for Health Boards and practices to monitor dental access trend closely using the quarterly monitoring reports provided by the NHSBSA and more frequently if required using the eDen, when available. Health Boards will need to take account of a number of factors to understand increase/decrease in dental access in practices participating in the programme.

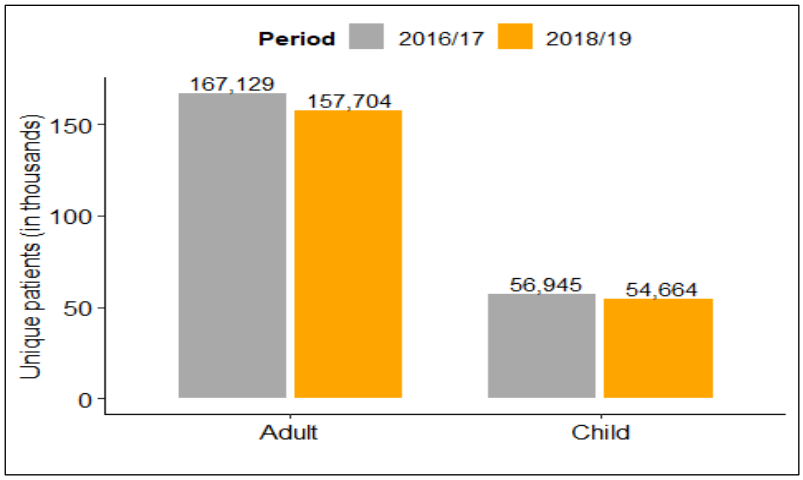
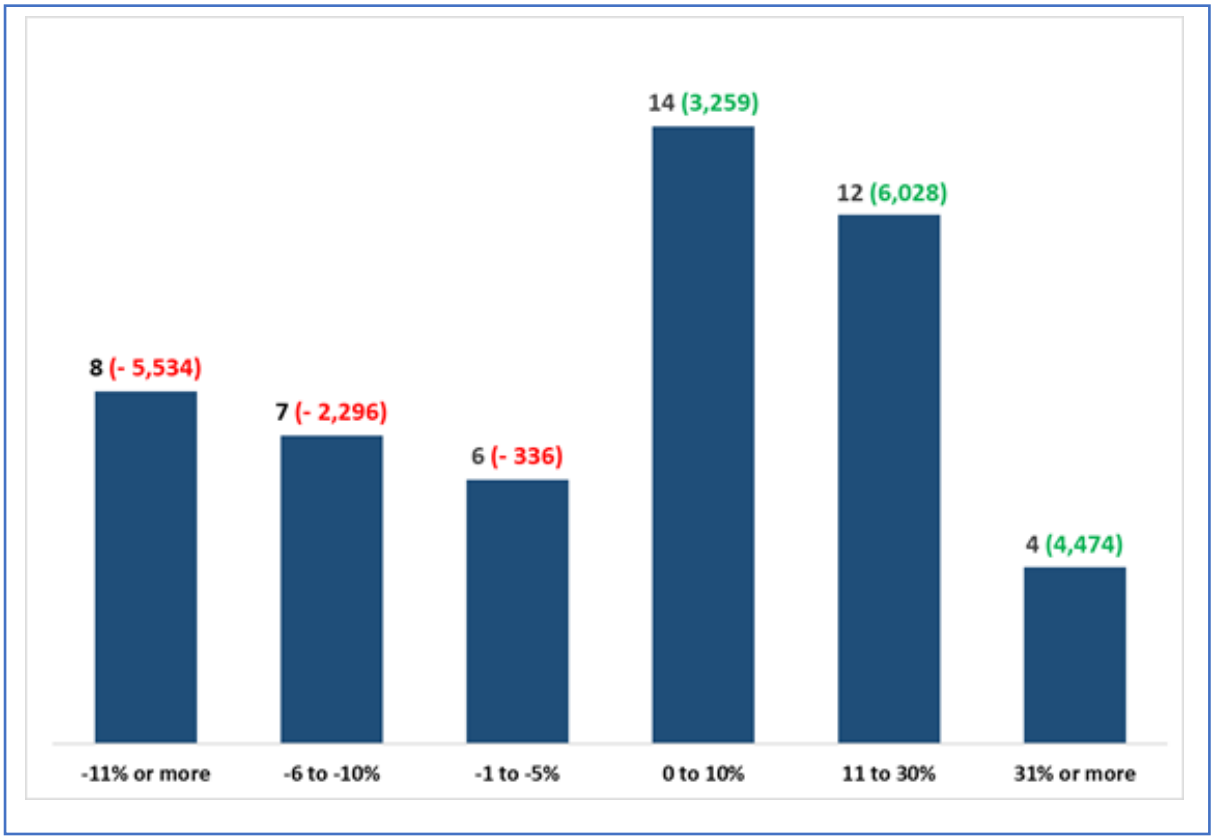


Figure 9: Number of patients seen by 52 practices in the programme in 2018/19 compared with 2016/17 (baseline year).

Fig 10 Practices in the programme categorised by percentage change in number of patients seen in 2016/17 vs 2018/19 (includes number of practices and change in number of patients in each group)



O. Next Steps

With more than 130 practices now participating in the programme, we need to adopt a formal programme management approach to improve our communication with all stakeholders including meeting the information need of practices that would like to join the programme. We will work more closely with practices and Health Boards to tailor our engagement to understand the local nuances, progress being made by existing practices and examples of best practices. We will also systematically collect feedback and insights from stakeholders to improve the programme including supporting products produced by the programme (Appendix 5) and to inform other relevant local and national actions.

We recognise that Health Boards' Primary Care teams will need support and guidance in adopting an Action Learning Approach in managing the change and ensuring that robust risk management processes are in place to ensure quality and patient safety. Health Boards and dental practices will also need support in interpreting information including the new data and reports. Emerging insights from local practices and other information sources including monitoring reports will inform further innovation and changes. We will continue to encourage all stakeholders to be proactive in providing us with feedbacks and insights.

We will continue to advise the NHSBSA in analyses and production of monitoring reports for practices. In addition to practice level reports, we have requested the NHSBSA to produce programme level monitoring reports. We will also utilise insights from these programme reports to improve the programme and inform any related actions.

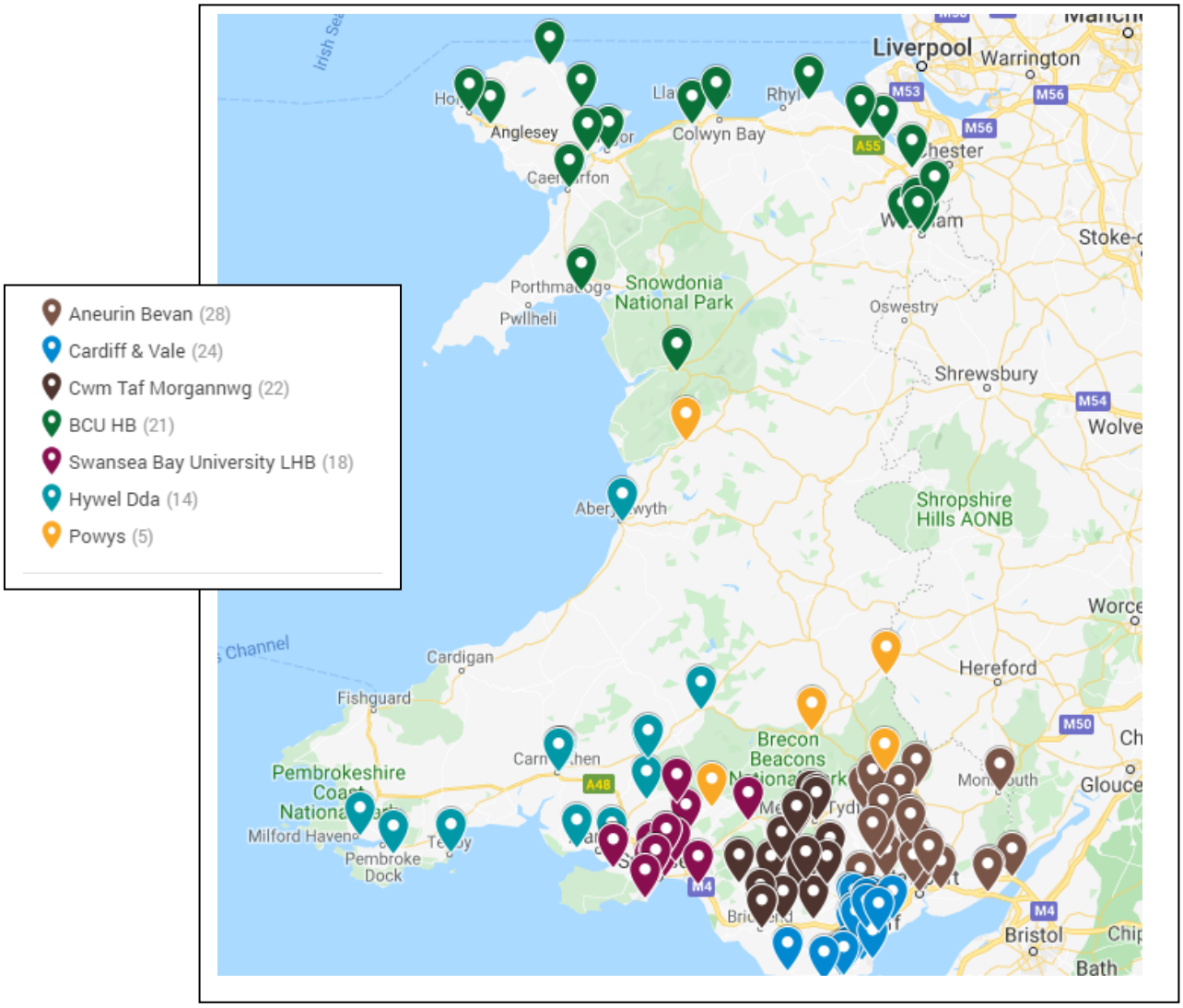
Monitoring of dental access and dental care, including prevention (e.g. FV applications) provided to patients with different risks and needs categories will help us to understand any variation in outcomes achieved by practices. We should also be able to monitor the proportion of dental resources used by patients who have excellent dental health and how that shifts compared to the baseline year (2018/19). Overall, we need to create an information system that allows us to understand the value of NHS dental care delivered in Wales and improvement actions to optimise the value.

We are working in partnership with Welsh Government on changes required to secondary legislation (regulations) to support the GDS Reform Programme. Amendments to secondary legislation will provide a different context and opportunity for ongoing reform. We will work with all stakeholders to reflect and improve the programme accordingly.

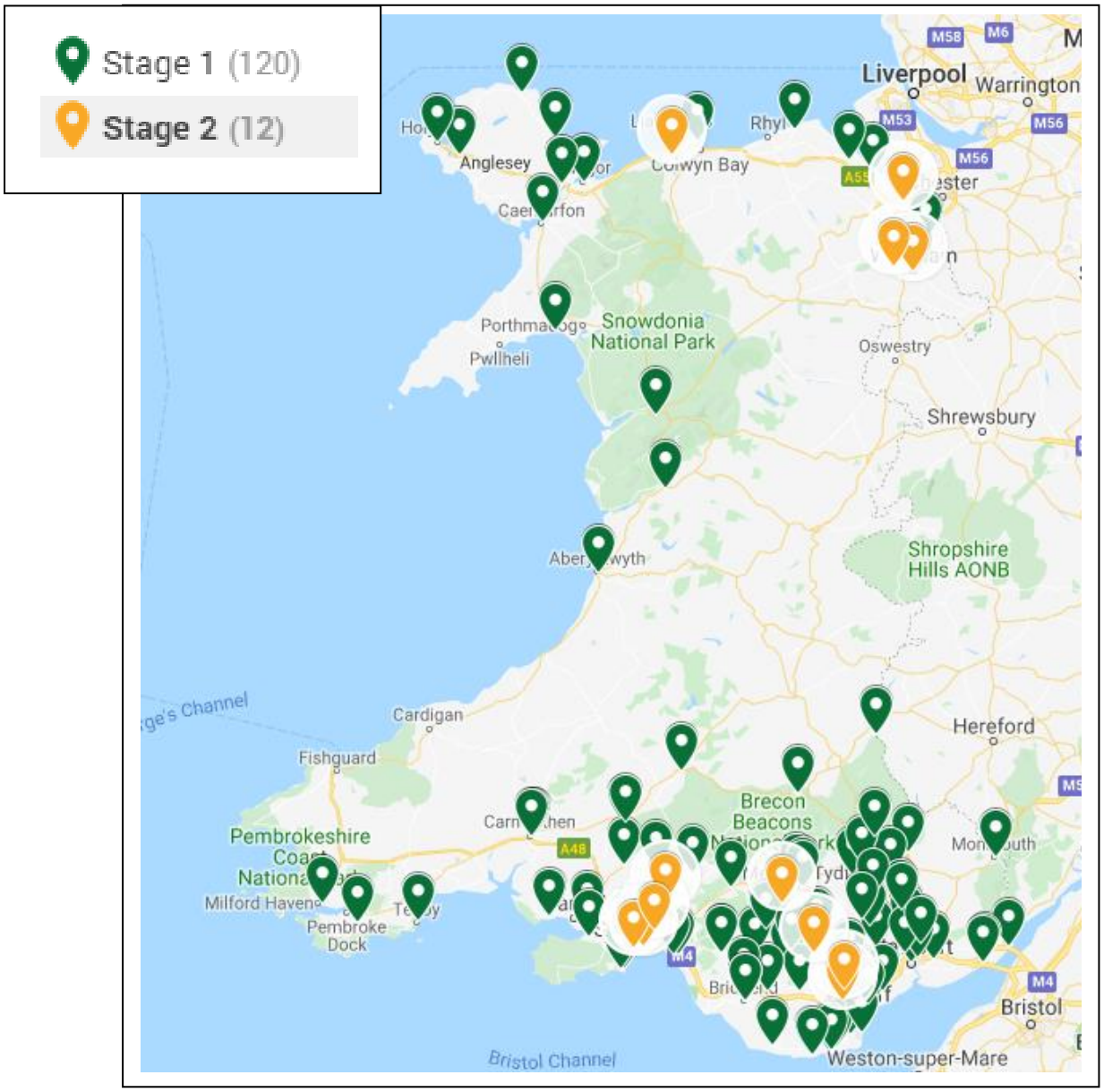
It is everyone's responsibility to improve the NHS dental system in Wales. Hence, we encourage active involvement of all stakeholders in this improvement journey.

Appendix 1

1.1 Location of the GDS Reform Practices across Wales (October 2019).



1.2 GDS Reform Stage 1 and Stage 2 Sites across Wales.



Appendix 2: Assessment of Clinical Oral Risks and Needs (ACORN) Toolkit

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Llywodraeth Cymru Welsh Government

ACORN

Assessment of Clinical Oral Risks & Needs

Name		DOB		Date of Completion	

Inherent Patient Risks from Medical, Social and Dental history

Relevant **medical** history which impacts on oral health and/or dental care planning. Please specify	☐ Yes Yellow ☐ No Green
Relevant **social** history which impacts on oral health and/or dental care planning Please specify	☐ Yes Yellow ☐ No Green
Relevant **dental** history which impacts on oral health and/or dental care planning Please specify	☐ Yes Yellow ☐ No Green

Key Modifiable Behaviours and Protective Factors

Tooth Decay Specific Risks

0-7 years only: supervised tooth brushing with fluoride toothpaste before bedtime and one more time during the day? **OR** >7years: Brushes (self or carer) at bed time and one more time during the day with fluoride toothpaste?	☐ Yes Green ☐ No Amber
Consumes drinks other than water or milk outside of mealtimes more than once daily? (e.g. sports drinks, tea/coffee with sugar, fizzy drinks, etc.) **And/or** Eats sugary snacks, sweets, etc. outside of mealtimes more than once daily?	☐ Yes Amber ☐ No Green

Periodontal Health Specific Risks (12+ only)

Smokes and/or use of tobacco products	☐ Yes Amber ☐ No Green
Brushes (self or carer) at bed time and one more time during the day?	☐ Yes Green ☐ No Amber
Uses (self or carer) inter-dental aids as advised by the dental team? e.g. interdental brushes	Yes / No

Other risks/protective factors

Household/family factors Siblings and/or family members in the same household have active tooth decay?	Yes/No
Alcohol use above recommended limit **Hint**: more than 14 units per week spread over 3 or more days and no more than 6 (female) and 8(male) units in a single occasion.	Yes /No
Other risks (including dietary) or protective factors (e.g.↑ strength F toothpaste use) Please specify	Yes/No

Clinical Findings

Soft Tissues Findings, dentures and Level of Plaque (for all patients)

Please specify findings (e.g. 2 × 2 cm suspected mouth cancer on lateral border of tongue on the right hand side, satisfactory full upper partial lower acrylic dentures, etc.)

Level of Plaque: low, moderate or high

Tooth Decay (for dentate only)

Total number of teeth in mouth	N=	
No active tooth decay	Green ☐	
Active tooth decay within enamel only	Amber ☐	Or report Amber on FP17W if tooth decay risk is Amber.
Active tooth decay into dentine or beyond	Red ☐	
If Red, total number of teeth with active tooth decay	dt	DT

Other Dental Need (for all patients)

e.g. Tooth surface loss, dental trauma, repair and maintenance (e.g. cusp fracture), removal of overhangs, denture replacement required, etc. Diagnosis/diagnoses (please specify):	**Tick one only** ☐ Red – Dental treatment required ☐ Amber – No treatment required but regular review required to monitor ☐ Green - None

Periodontal Health (Dentate and aged 12+ only)

(Please refer to BSP Classification)

Patient unable to tolerate periodontal examination ☐ (usually applies to special care dentistry patients)

BPE

BPE Score			
Bleeding on Probing (BPE code 0/1/2 and 3 with no evidence of periodontitis)	<10% (Good health) ☐	10-30% (Localised gingivitis) ☐	>30% (Generalised gingivitis) ☐

If BPE score is 4 or 3 with pockets ≥ 4mm and/or bone loss from periodontitis, please complete the following section (radiographic assessment)

Extent (Pattern of bone loss)	**Local** ☐	**Generalised** ☐		**Molar-Incisor** ☐
Stage (Interproximal bone loss – use the worst site)	**Stage I (Mild)** ☐	**Stage II (Moderate)** ☐	**Stage III (Severe)** ☐	**Stage IV (Very Severe)** ☐
	<15% (or <2mm from CEJ)	Coronal third of root	Severe (Mid third of root)	Very Severe (Apical third of root)
Grade (Rate of progression for the patient's age – use the worst site)	**A (slow)** ☐	**B (moderate)** ☐		**C (Rapid)** ☐

Periodontitis	**Red** ☐	**Currently unstable** PPD ≥ 5mm or PDD ≥ 4mm and BoP at these sites	
	Amber ☐	**Currently in Remission** BoP ≥10%; PPD ≤ 4mm No BoP at 4mm sites	
	Green ☐	**Currently Stable** BoP < 10%; PPD ≤ 4mm No BoP at 4mm sites	**Green** unless any specific modifiable perio risks noted. Then recorded as **Amber** overall on FP17W.
No periodontitis	**Green** ☐	**No periodontitis** ☐ Gingivitis only ☐ Good perio health	

Diagnosis Statement: Extent – Periodontitis – Stage – Grade - Stability- Risk Factors **or** localised/generalised gingivitis only **or** good periodontal health

e.g. Generalised periodontitis, Stage 3 Grade B – currently unstable-risk(s) smoker 15/day

Appendix 3: General Dental Services (GDS) Reform Programme Principles, Expectations and Criteria

Programme approach - Involve key dental stakeholders to develop a NHS GDS Dental Reform Programme for Wales and adopt a continual improvement model. Although the programme takes an Action Learning Approach, this is a National programme and as such there should be no variation between Health Boards in implementation of the programme. This applies to all practices engaged in the GDS Reform Programme.

	Programme objectives
ACORN TOOLKIT AND ITS UTILITIES	Ensure participating practices undertake an assessment of the oral health risks and needs of individual patients once a year using the standardised toolkit and utilise the information to: ✓ Understand what matters to patients; ✓ Effectively communicate level of risk and need to patients (or their carers) and work with patients in making them understand changes they can make to prevent dental diseases and maintain oral health; ✓ Agree on the oral health outcomes patients want to achieve; ✓ Utilise the principles of shared decision making in formulating a preventive dental care and treatment plan' ✓ Monitor changes in the risk and need of patients who receive ongoing care from the service.
QUALITY	Improve the delivery of evidence-based prevention and treatment: EVIDENCE BASED PREVENTION AND TREATMENT
	Encourage clinical teams to develop a culture of continuous quality improvement to ensure enhanced patient quality and safety: CULTURE OF CONTINUOUS QUALITY IMPROVEMENT (shifting the balance; currently excessive focus and reliance on 'inspections')
ACCESS	Support the implementation of dental recall intervals based on oral health risk and need: RISK and NEED BASED RECALL
	Test the changes that are required to reduce inequity in dental care use, and improve dental access amongst individuals who have high dental need but currently cannot/do not access dental care (ADDRESS INEQUITY IN DENTAL ACCESS)
ACCESS & QUALITY	Encourage dental teams to establish productive working relationships with other primary and social care services :PROACTIVE, PREVENTIVE & CO-ORDINATED CARE
VOLUME, QUALITY & OUTCOME MEASURES	Evaluate and understand the changes in key activities, outcomes, and establish quality indicators to inform improvement in quality and value of primary dental care: DEVELOPMENT OF VOLUME/ACTIVITIES, QUALITY & OUTCOME MEASURES.
SKILL-MIX	Increase the use of skill-mix in NHS General Dental Services in Wales - IMPROVED ACCESS & VALUE BASED CARE WITH USE OF SKILL-MIX
INFORM CHANGES	Inform any changes in National dental contracts, associated legislations and others: INFORM CHANGES REQUIRED IN THE DIFFERENT PARTS OF THE SYSTEM.
	Inform any changes required in the relevant programmes and activities (e.g. workforce planning, skills development and planning) and information systems in place to facilitate ongoing improvement: INFORM CHANGES REQUIRED IN THE DIFFERENT PARTS OF THE SYSTEM.

Expectations

In line with the Welsh Government Policy[1], Unit of Dental Activity (UDA) rate for GDS practices to be set at a minimum of £25. If a reform practice is below this rate, their UDA rate should be uplifted to £25 (by removing a number of UDAs assigned to ACV OR by uplifting ACV) **THEN** the reduction in annual UDA target applied. Health Boards should make this adjustment by 1st April 2019. **Stage One: A practice joins the programme**

Support to the practice to join the reform programme: Uplift UDA rate to £25/UDA (if current UDA rate is below £25/UDA) & 10% reduction of annual UDA target (or equivalent contract uplift without any additional UDA target)

	What? - Expectations	Monitoring
1	Risks and Needs Assessment (ACORN) – Do it well once a year and deliver utilities of the toolkit (see above under the programme objectives). Make use of resources provided by the programme: Prevention Expectations, Your Prevention Plan, Practice Profiles (6 month and end of year profile)	Reform practice to monitor within their practice; peer review and learning Qualitative evaluation will explore this area especially if utilities of the ACORN toolkit were delivered and intended outcome achieved.
2	Submit full ACORN dataset via electronic FP17W	Health Board and NHSBSA - Quarterly (Also monitored centrally by programme team 6-monthly at first and then moving to once a year)
3	Deliver evidence based prevention & treatment (including reform practices to start referring to Help Me Quit: https://www.helpmequit.wales/professional-referral-form/)	Monitored centrally based on data submitted via FP17Ws (Indicator used: Fluoride varnish (FV) applications on children and adults) FV applications and other prevention activities (e.g. brief intervention on smoking cessation) delivered by Dental Care Professionals (DCPs) and not transmitted via FP17Ws should be captured by practices and submitted if requested by Health Boards and programme team. (Note: Further changes on FP17Ws have been requested to capture activities delivered by DCPs)
4	Upskill workforce –Making Prevention Work in Practice (MPWiP) – training dental nurses in prevention and FV application	Uptake of training offered by the Health Education and Improvement Wales (HEIW)
5	Participate in evaluation, engagement events, workshops/Local Quality Improvement Groups, provide feedback to the programme etc.	Monitored centrally by the programme team
6	Overall number of patients seen per year should not decrease (and if many patients found to have low risk and need it is likely to increase)	Practice and Health Boards to monitor quarterly (support from the NHSBSA) Practices should monitor and capture DNAs Monitored centrally by programme team annually as part of the evaluation

[1] Welsh Government, Oral Health and Dental Services Response to Healthier Wales, 2018

Criteria to move to Stage Two:

Meet all of the above expectations in stage one AND

	Criteria	Monitoring
1	Minimum of 6 months full good quality data submitted via electronic FP17Ws (ACORN dataset)	Dental practice and their health board with support from the NHSBSA
2	Fluoride Varnish (FV) applications in children: Minimum of 50 per 100 FP17W in previous 6 months	Dental practice and their Health Board – with support from NHSBSA (centrally by programme team as a part of producing programme reports annually)
3	FV applications in adults: Minimum in line with active tooth decay (Red) reported on FP17W. e.g. if 20% of adults are classified as 'Red' for tooth decay, minimum of 20 FV/100 FP17W in the previous 6 months	Dental practice and their Health Board – with support from the NHSBSA (centrally by programme team as a part of producing programme reports annually)
4	Dental access should not have dropped compared with baseline year, and 'need and risk' practice profiles and additional investment may suggest it should be increasing. Dental access -> unique number of patients seen in previous 12 months for children and 24 months for adults.	Dental practice and their Health Board – with support from the NHSBSA (centrally by programme team as a part of producing programme reports annually)
5	Clear signage showing the practice is a NHS dental service provider (Practice buildings/website, etc.).	Health Boards to monitor
6	Proportionate UDA reduction (and uplifted UDA rate if applicable) has been passed on to the associates (i.e. performers) working in the practice so that all performers can fully implement the changes expected. Exact % of UDA target reduction and other incentives for performers to be agreed between the performer and the GDS/PDS contract holder.	Health Boards receiving feedback from the performers and/or providers

Stage Two: Having met the stage one expectations and criteria, a reform practice moves to Stage Two

Support to reform practices:

Year 1: 20% reduction of UDAs (or equivalent uplift without any additional UDA target); No 'clawback' on not meeting the remaining UDA target if all of the other expectations outlined below have been met (please see below for support in Year 2) and there has been no significant change in service availability.

Year 1 of stage 2 - However if following expectations are not met, health boards can clawback on practices not meeting the remaining 80% of the UDA target.

All of the expectations under Stage One above AND

	Additional expectations	Monitoring
1	At least one dental nurse in practice trained in prevention and FV application and running clinics offering follow up preventive intervention clinics.	Evidence of training certificates on request by Health Board
2	Recall Interval – 'Green' adults (Green for caries, periodontal disease and other dental conditions moved to 12 month recall (or longer if agreed by patient)	Dental practice and their Health Board – with support from the NHSBSA
3	New Access -- Number of access sessions open for new patients should reflect size of the contract and be agreed with health board - access must be open to new adults (exempt and not exempt) and child patients – consider links with OOH, Health Visiting/Flying Start/Social Care teams, GMS/Local Clusters, D2S, etc. these are not urgent access sessions – any patient should be welcome - routine and/or those with problems. See clinical guidance for expected care approach and a reminder of needs led recall intervals.	Monitored locally by the Health Boards – When care pathways have been established, practices and HBs to monitor DNAs. Data analysed by NHSBSA to ascertain number of 'new patients' (urgent dental care only, for ACORN and any prevention and dental care required) seen by the practice HB to use the number of new patients seen and practice profile to individualise % UDA reduction in Year 2 of Stage 2 (see page 5).
4	Practice set up for smoking cessation referrals to Help me Quit (HMQ) and referrals are being made	Monitored locally by the Health Boards, working with the Local HMQ team member/local public health team
5	Active participation in Local Quality Improvement Groups sharing best practice and learning, Quality improvement projects (e.g. peer review of ACORN, audit of patient outcomes, implementation of Shared Decision Making etc.) CPD and participation in activities related to evaluation of the programme	Feedback from the HEIW QI Educators/Local Quality Improvement Groups, Health Boards, programme, evaluation team, etc.
6	FV applications in children: Upward trend from minimum of 50/100 FP17Ws criteria for Stage 1 practices (high proportion of children who attend the practice two or more times a year should receive FV twice per year)	Dental practice and their Health Board – with support from the NHSBSA Quarterly monitoring reports
7	FV applications in adults in line with need	
8	Benefits of UDA reduction (or UDA rate uplift) has been passed on to any associates/performers and DCPs	Health Boards to monitor

9	Number of new patients seen reflects the need and risk and resources of practice.	Dental practice and their Health Board – with support from the NHSBSA (centrally by programme team as a part of producing programme reports annually)
10	Reliably transmitting good quality accurate data including DT/dt and new data items added on the FP17Ws to the NHSBSA	Monitored by the NHSBSA working closely with the programme team 'Feedback loop' – reform practice and health boards
11	Development of workforce – Uptake of training on leadership, risk communication, motivational interviewing, brief interventions, Shared Decision Making, ongoing quality improvement projects, etc.	Feedback from HEIW, practices and other course providers Annual QAS – Quality Improvement section; HEIW QI projects – Uptake from reform practices

If all of the above expectations are achieved by the reform practices then there should be an agreement between the practice and their Health Board that there will be no clawback on not meeting the expected UDA target assuming there have been no significant changes in service availability or loss of staff. A Health Board's concern, if any, on Patient Charge Revenue (PCR) due to changes made by reform practices will be discussed in a meeting between the Health Board and the Welsh Government.

Year 2 of Stage 2

Review and adjustments:

Close monitoring of delivery expectations by Stage Two practices and any variations is vital. As outlined in the table above, Health Boards should monitor and review reform practices' data (and any additional information) quarterly as a minimum. Health Boards' Primary Care Management teams should set up a network to share good practice and learning especially monitoring and change management. They can also seek advice and support from the programme team. Health Boards can request the programme team to facilitate a workshop where all Health Boards' Primary Care teams will meet to discuss and agree adjustments in the Service Level Agreement (SLA) for the following year.

After a reform practice has been on Stage Two for 12 months, their Health Board should review data and adjust the practice's SLA for the following year.

Year 2 SLA: 15-30% of Annual Contract Value (ACV) to be released to continue delivering the expectations under Stage Two. The actual % of ACV released will vary between practices based on a practice's 'risk and need' profile, UDA rate, agreement on access for new patients , expected UDA loss due to use of skill-mix (DCPs not being able to submit FP17Ws); receipt of any additional funding without UDA target (e.g. innovation fund) etc.

If you have any query about this document or any other query related to the GDS Reform Programme, please contact Raylene Roper, Project Manager at Raylene.Roper@wales.nhs.uk

New practices opening/commissioning:

New GDS services must be commissioned to meet the objectives of the GDS Reform Programme rather than just annual UDA target.

Support to new practices/contracts that provide access to 'new' patients and are building a patient list:

New practices/contracts set up under the GDS Reform agenda should not have UDA rate less than £25/UDA as per the Welsh Government policy. In the first 12 months, a new dental practice/contract set up to accept new NHS dental patients and is building up a 'practice list' should be guaranteed no clawback in the first year. These practices should be set up to utilise skill-mix right from the start. New dental practices should match this high trust of 'no clawback' in the first 12 months by meeting expectations outlined in the table below which includes expectations on 'Dental Access' and service availability.

Close monitoring (monthly/quarterly), feedback and support by Health Boards is required to ensure the new practice meets expectations on use of skill-mix, providing dental access to an expected number of patients and dental recall intervals based on 'risk and need'. After 12 months, annual data (submitted via FP17Ws and additional data, e.g. activities delivered by DCPs but not submitted via FP17Ws and collected by the practice) needs to be analysed, discussed and a new SLA agreed outlining expected number of UDAs to be delivered and continuing implementation of the GDS programme objectives. Health Boards can seek advice and support from the programme team and the NHSBSA for monitoring.

All the expectations under the stage 2 above AND:

	Additional Expectations	Monitoring
1	Skill-mix use optimised from the start: Upskilling and use of dental therapists, hygienists, extended duty dental nurse and running their own clinics	Prevention and activities delivered by DCPs Initially captured within practices and submitted via FP17Ws when such mechanism is in place
2	Total number of annual patients expected to be seen by the practice (Dental Access) in the first year to be similar to reform practices of a similar contract and location	Monitored locally by HBs with support from the NHSBSA (centrally by programme team as a part of producing programme reports annually)
3	Service availability and Dental Access to new patients and patients referred by Health Board's primary care team – Adults and Children	Monitored locally by HBs with support from the NHSBSA (centrally by programme team as a part of producing programme reports annually)
4	Dental nurse trained in prevention, FV application - paid in line with equivalent staff employed by Health Boards under Agenda for Change	Voluntary feedback from Dental Nurses
5	Practice continuously working on at least one project for improvement (e.g. improvement in delivery of preformed crowns on deciduous teeth, antibiotic prescribing, referral to smoking cessation services, access to high need/vulnerable groups, learning from incidents/near misses/never events, etc.)	Feedback from HEIW, Local Dental Networks, Health Boards Report on the annual QAS
6	Dental team members training in: Risk communication, Shared Decision making principles, motivational interviewing, etc.	Feedback from HEIW, practices, health boards – impact captured through qualitative evaluation and ultimately via patients (when developed).

New dental practices that are set up to provide dental access to new NHS dental patients should reach a steady state in around 12 months. After 12 months, a new SLA should outline delivery of agreed programme objectives and annual UDA target (70-80% of ACV at minimum of £25/UDA). In effect a new practice, after 12 months or so should align closely with a Stage Two practice in Year 2 as described above which is:

Year 2 SLA: 15-30% of ACV to be released to continue delivering the expectations under Stage Two. The actual % of ACV released will vary between practices based on a practice's 'risk and need' profile, UDA rate, agreement on access for new patients , expected UDA loss due to use of skill-mix (DCPs not being able to submit FP17Ws); receipt of any additional funding without UDA target (e.g. innovation fund), etc.

Expectations and monitoring will be reviewed and clarified. Clawback for not meeting expectations will also be outlined and agreed.

(Note: In future, annual UDA target may be replaced by another volume/activity target developed through the GDS Reform programme.)

Stage One reform practices successful in receiving Welsh Government's Innovation Fund

Reform practices may have received additional funds from WG Innovation Fund or HBs without any UDA target to be delivered. Reform practices are expected to deliver additional expectations (e.g. increased access) which will be clarified in SLAs/contract variation letters to practices by their Health Boards. Health Boards and practices should regularly monitor delivery of these additional expectations.

Risk Management by Health Boards

It is essential for Health Boards to set up a monitoring mechanism to ensure reform practices are delivering expectations outlined in the SLA. Health Boards should also ensure that reform practices are included in their Dental Services Governance processes to ensure patient safety.

Ongoing engagement, feedback to reform practices is required. NHSBSA and programme team are working closely for the NHSBSA to set up a 'feedback loop' to Health Boards and reform practices. The programme team/Dental Public Health consultant can provide advice and support to the health boards' Primary Care Management Team to interpret information collected via FP17Ws. Health Boards' dental practice advisors may also require training in interpretation of the GDS reform practice reports/data to ensure their interpretation is in line with the GDS reform programme objectives.

Although further changes on FP17Ws have been requested, e.g. capture activities delivered by Dental Care Professionals (DCPs), it may take time to affect those changes. Hence, it is important that Health Boards and practices collect and monitor additional activities delivered but not captured via FP17Ws.

At this stage of the programme, Health Boards and the practices can agree for the practice to exit the programme i.e. return to 100% UDA contract OR drop back from Stage 2 to Stage 1 OR stay in Stage 1 for longer period if a reform practice:

- does not meet 'expectations' on implementation of changes and achieve criteria set above (and outlined on the annual SLA);

  OR

- is found not to be fully engaged in the reform agenda.

Health Boards and reform practices should discuss any plan for reform practices with the National GDS Reform programme team. They should also keep a record of reasons for a practice exiting the programme or a practice dropping from Stage Two back to Stage One or a practice remaining in Stage One for more than one year. This information is vital for ongoing monitoring and evaluation of the programme.

Appendix 4 – An Example of the Programme Update

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

General Dental Services Reform Programme Status Report

September 2019

Programme Update

- Engagement sessions held in Cardiff, Swansea and Llandudno.
- Shared Decision Making run by HEIW CPD session held for clinicians and time spent with each HB running through the end of year monitoring report.
- 42 new practices joining the programme from October 2019 have been confirmed (see breakdown below).
- Information shared with Health Boards to agree the practices moving to Stage 2.
- ACORN and the guidance has been updated and shared with all GDS reform practices. GDS practices becoming familiar with 'need and risk' assessment of their practice population. Teams using ACORN findings to guide prevention, treatment and use of the skills of the whole team in care delivery.
- 1st Quarter and end of year monitoring reports available from NHS BSA.

Key Reports and Dates

Annual programme report will be produced by the programme team by end of October 2019

Quarterly monitoring reports will be provided directly from NHS BSA via the usual route.

Date expected	Reporting period	For who
Nov-19	Mid-Year Report 2019/20	All GDS reform practices and HBs
Jan-20	Quarterly Report 2019/20	All GDS reform practices – including new sites who join in October 2019 and HBs

Risks, Issues & Decisions

Further FP17W changes have been requested and agreed with NHSBSA for 2019-20, including ability to report all activities carried out by DCPs via FP17Ws. There has been some delay in implementing these changes. Awaiting date from NHSBSA for completion/roll-out.

Activities for the Next Reporting Period

- Work has started on reviewing current dental legislation and identifying changes to support the GDS Reform Programme.
- GDS Q&S group meeting in October with NHS BSA colleagues who will share with DPAs how to ensure correct interpretation of the new monitoring reports.
- Work with HBs in supporting practices to move to stage 2 - confirm with HB the practices who will be moving by Oct 1st.
- Welsh Government 1st round Innovation Fund distributed - recruitment and increase in DCPs realised. Round 2 new investment information to be circulated by October – focus on access for adults
- Feedback received on quarterly and end of year reports will be provided to the NHSBSA.
- Scope venues and dates for Dental Symposium 2020.
- Steering group meeting due to be held on 30th September 2019.

Programme Engagement Opportunities

Further engagement sessions will be arranged in 2020

If Health Boards are planning to arrange any meetings or workshops in addition to the ones organised by the programme team for practices who are interested in joining the programme please get in touch. Wherever possible a member of the programme team would try to be there to answer any questions.

If you have any queries, comments or would like to provide input into ongoing work please contact the Project Manager Raylene.Roper@wales.nhs.uk

GDS Reform Practices by Health Board

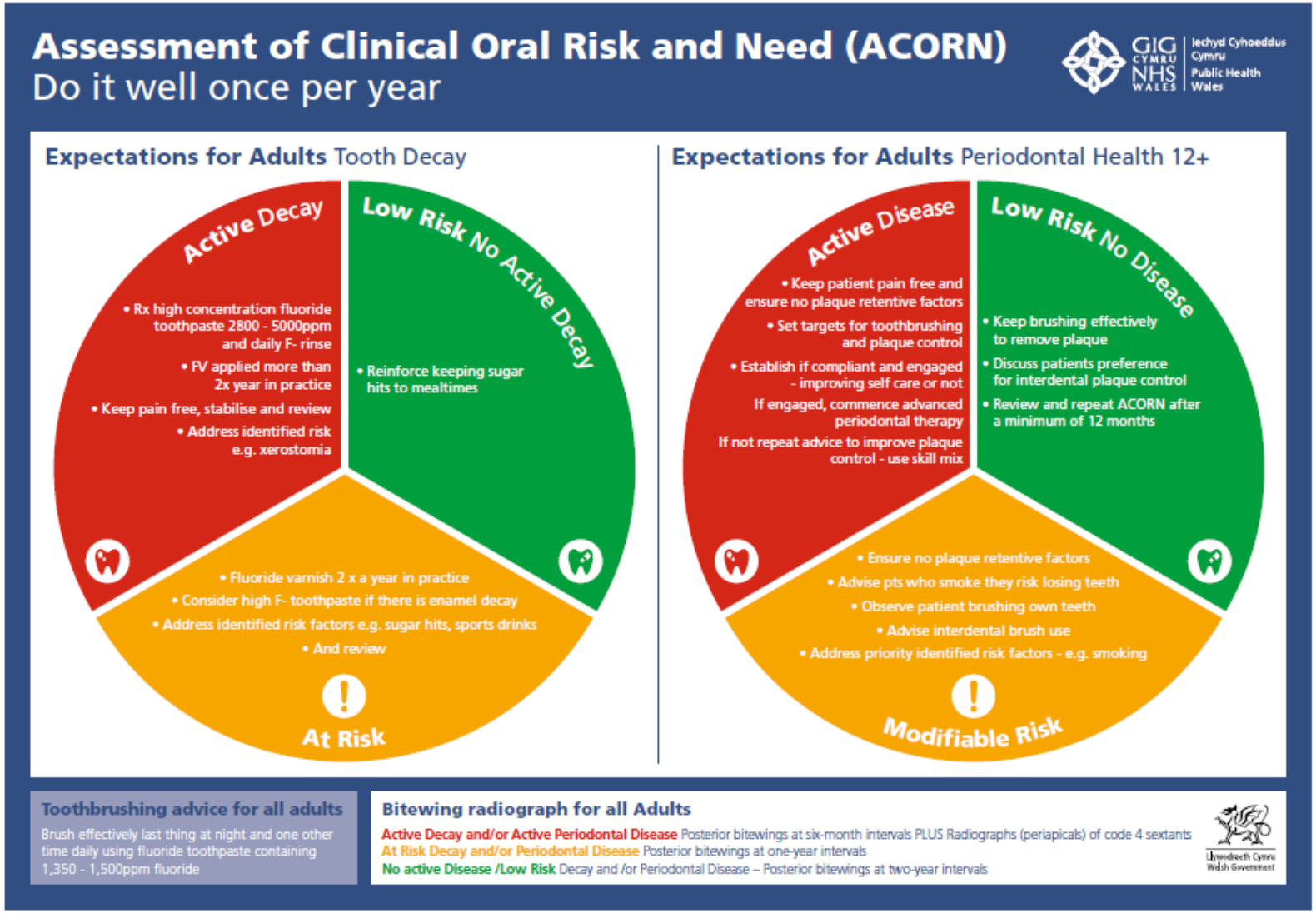
Health Board	New practices joining as of Oct 1st 2019	Total practices from Oct 1st.
Cwm Taf Morgannwg	4	22
Aneurin Bevan	9	29
Cardiff & Vale	9	24
Hywel Dda	4	14
Swansea Bay	5	18
Betsi Cadwaladr	11	24
Powys	0	5

The next report will be produced in November 2019

Appendix 5

5.1 Patient Prevention Plan

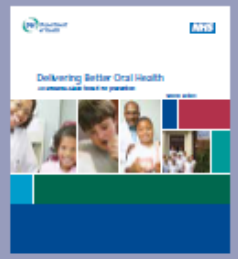
5.2 Prevention Expectations for Adults



Key Principles

Remember, brushing is a practical skill – witness and demonstrate

- Spit don't rinse after brushing
- Nothing after brushing



Prevention intervention and advice as per Welsh DBOH

- Reinforce keeping sugar hits to mealtimes
- Nothing sugary to eat or drink in the hour before bed

- Prioritise risks and concentrate on one change at a time to assist patients look after and improve their own oral health – transfer responsibility to patients
- Layer advice and intervention adding more the higher the risk and need

- Identify key modifiable risk taking behaviour, discuss with patient what they might want to change and agree an achievable action plan
- Work together to agree a personal plan

- Risk and Need status communicated to patient
- Utilise the whole team to deliver what is expected
- Interval for recall must reflect need and risk

Support patients to value and maintain their oral health

5.3 Prevention Expectations for Children