Special Care Dentistry in Wales; an assessment of need

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To inform the work of the Welsh Government’s Special Care Dentistry Implementation Group

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SPECIAL CARE DENTISTRY IN WALES; AN ASSESSMENT OF NEED

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Executive Summary

Introduction

Special Care Dentistry was established as a new Speciality with the General Dental Council (GDC) in 2008. This Speciality deals with disabled, medically compromised and vulnerable adults; specialists were adopted onto the GDC register between 2008 and 2010. In 2008, the Minister for Health and Social Care requested a review of services for vulnerable adults in Wales by the Welsh Dental Committee (WDC). The review was reported in 2010 and its recommendations accepted by the Welsh Government.

This needs assessment provides additional information to inform the work for the Special Care Dentistry Implementation Group for Wales.

Key Findings

- Inequalities in access to and uptake of dental services exist for people with Special Care Dentistry needs in Wales; these inequalities are greater for older people where there is a difference in uptake of dental care of over 10%.
- Some patients who need Special Care may not be identified and may not receive care as a result of the current infrastructure.
- Data relating to Special Care Dentistry are poor, and are insufficient for robust planning and monitoring.
- Consultant expertise and specialist training in Special Care Dentistry is concentrated in the South East of Wales.
- In some areas, there are no dedicated vulnerable adult general anaesthetic lists, and Special Care patients can face unacceptable waiting times.
- The funding for, availability of and uptake of additional training in Special Care Dentistry by general dentists or dental care professionals is not related to population needs.
Conclusions

Multidisciplinary Strategies for Special Care Dentistry

A strategic approach is required in the development of Special Care Dentistry in order to address the inequalities in access to, and uptake of services. This is best achieved through joint working between the stakeholders, which include the providers of dental services, public health teams, social care teams, the Welsh Government, patients and patient representatives.

Referral and treatment pathways need to be as simple and unambiguous as possible to ensure that the clinical needs of patients are dealt with promptly and effectively. The development of all-Wales level referral and acceptance guidelines would assist this objective.

Defined processes to enable the transfer of information between authorities must to be established to ensure patient needs are met.

Infrastructure planning at a strategic level is needed to overcome access barriers and to ensure improved services to deprived rural communities. Examples include overcoming transport problems that prevent Special Care patients from reaching services.

When the delivery of Special Care Dentistry is provided across different health services, clear lines of responsibility and accountability are required. This is particularly important for general anaesthetic care provided for Special Care patients within hospitals.

Workforce and Service Development for Special Care Dentistry

During these early days within the development of their Speciality the newly appointed Consultants and Listed Specialists in Special Care Dentistry are in a unique position to lead the development of an integrated service approach to Special Care Dentistry. In order to achieve this, appropriate capacity has to be built up within all three of the dental services.

Managed clinical networks should be developed for Special Care Dentistry. Strategically placed “Centres of Special Care Dentistry Excellence” with leadership from a Consultant, could be set up in Wales to provide Consultant level expertise for this network and should function across Health Board boundaries.

Services delivering care to Special Care dental patients should meet clinical needs effectively, using skill mix to optimise specialist resources e.g. if a patient requires sedation, but has no other physical or mental problems requiring additional care, then a dentist without broader Special Care skills, but capable in sedation, could provide treatment, even if that has to be within a wider Special Care plan. Using skill mix appropriately will ensure better access to and best
use of specialist resources. Payment systems to reward dental teams using additional skills are necessary to maximise skill mix.

**Technology and Data for Special Care Dentistry**

Indicators for Special Care Dentistry and data sets for recording Special Care Dentistry activity need to be agreed.

Methods to use technology to improve access to Special Care Dentistry expertise and the effectiveness of care delivery need to be considered.

**Workforce Development**

Courses and programmes for the development of the Special Care Dentistry Workforce need ongoing development and support to meet the changing needs of the populations they serve. Teams from centres of Special Care Dentistry Excellence will need to support the planning, ongoing development and delivery of knowledge, training and experience to the dental workforce.

Many patients with Special Care needs may have some or all of their dental treatment in general practice and it is estimated that around three quarters of patients with Special Care needs who do see a dentist, are seen in general dental practice; a proportion of these patients may be referred for treatment when additional expertise is required. Special Care Dentistry courses, training and placements should be planned and implemented to meet the needs of the general dental teams and the communities they serve. Participation should be supported and encouraged.

A consultant or specialist with the necessary management expertise will be needed to lead each Centre of Special Care Expertise. This will enable specialist training and the development of Dentists with Special Interests to meet oral health needs across Wales. In the short term, Specialist training and the development of dentists with Special Interests will also need to be planned to replace outgoing staff with Special Care expertise and to meet patient care needs.
1. Special Care Dentistry in Wales

1.1 Background
A review of Special Care Dentistry in Wales by a Working Group of the Welsh Dental Committee was commenced in 2009 at the request of the Minister for Health and Social Services\(^1\)\(^2\). The purpose of the review was to enhance the provision of dental care for vulnerable groups served by Community Dental Services and other service providers.

Special Care Dentistry is a new speciality of dentistry with expertise specific to the health needs of vulnerable groups. The evidence for establishing this Speciality was outlined in the 2003 document, "A case for need-proposal for a speciality in Special Care Dentistry"\(^3\). The Speciality was established by the General Dental Council in 2008, and individuals with the knowledge and expertise to become a specialist were adopted to the register between 2008 and 2010\(^4\)\(^5\). A specialist training programme is being developed to train the next generation of Specialists in this area of care\(^6\). The case for need document described pathways of Special Care Dentistry. These pathways included consultants, specialists and dentists with a special interest; patients with varying complexity or severity of need would be cared for at the most appropriate stages within pathways.

The Welsh Dental Committee (WDC) Review of Special Care Dentistry in Wales, June 2010\(^7\), highlighted the urgent need to review the provision and future development of Special Care Dentistry services in Wales. The review report emphasised the inequalities in Special Care Dentistry provision. The report also highlighted the need to train and nurture a new generation of Specialists in Special Care Dentistry. The recommendations included the need to establish training posts and specialist posts. In addition, the report also described the development of contracts for dentists with a special interest in Special Care.

The planning and delivery of Special Care Dentistry is underpinned by legislation, most notably the Disability Discrimination Act\(^8\) and the Equality Act 2010\(^9\). Furthermore, there are a number of key national strategy, policy and guidance documents relevant to this type of care including: One Wales\(^10\), Designed for Life\(^11\), National Service Framework (NSF) for Older People in Wales\(^12\), NSF for Diabetes\(^13\), NSF for Mental Illness\(^14\) and the Learning Disability Wales Strategy.
1.2 Purpose of this report

The purpose of this needs assessment is to provide additional information to inform the Special Care Dentistry Implementation Group for Wales.

1.3 Objectives

- Develop a working definition and scope for a Special Care Dentistry needs assessment in Wales
- Identify the need groups within this definition
- Locate and collect data relating to patients with Special Care Dentistry needs
- Explore the met and unmet needs for Special Care Dentistry patients

1.4 Definition and scope

Special Care Dentistry has been defined as being, “concerned with providing and enabling the delivery of oral care for people with an impairment or disability”, where this terminology is defined in the broadest terms. It is concerned with the improvement of oral health of individuals and groups in society who have the physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, or more often a combination of a number of these factors. The Speciality is defined by a diverse client group with a range of disabilities and complex additional needs. This includes people living at home, in long-stay residential care, in long-stay hospital care and homeless people\(^3\). This definition will be used for this needs assessment.

1.4.1 Special Care Need Groups

People within the definition of Special Care Dentistry have varying levels of disability and ill-health, and there is a spectrum of need and disability across this population. Disability may not necessarily confer need; while some patients may be able to have some treatment delivered in general dental practices, others may require more specialised care services. Unlike other dental specialities, the need for Special Care Dentistry is based on the patient’s wider health needs rather than specific oral conditions. This means that Special Care needs can exist beyond the traditional hospital centred specialist delivery of dental treatment care including multidisciplinary community level interaction with stakeholders, agencies and patients. Identifying populations as defined in 1.4 is made more complex because many patients with special needs have multiple disabilities and illnesses. As a result, the oral health needs of vulnerable populations can be difficult to identify. Populations who need Special Care
Dentistry have been categorised into the following groups, which will be used to describe the population needs in this report:

- Learning disability
- Mental illness
- Medically compromised
- Frail older people
- Anxious patients
- Vulnerable groups (including prisoners, homeless, travellers)

### 1.5 Threshold of definition of Special Care

Special Care Dentistry, as defined by the General dental Council, pertains to adolescents or adults. Younger patients from birth through to adolescence are cared for by Specialists in Paediatric Dentistry. In order to define the threshold between Paediatric Dentistry and Special Care Dentistry, discussions were held with both Paediatric and Special Care dentists and it was agreed that the threshold should be the age of 16 years. It should be noted that the dental payment system in the NHS general dental services uses a different age threshold, with patients up to the age of 18 considered as children.

For the purpose of this needs assessment, adolescents and adults aged 16 or over will be included. Children and adolescents below the age of 16 will be considered to be within the Speciality of Paediatric dentistry as a result the oral health needs of the under 16's with Special Care needs should be considered as a separate needs assessment exercise.

### 2 Method

The 2003 Speciality proposal document for the GDC and the Special Care Dentistry Dentistry review in Wales were used to define the overall scope of Special Care Dentistry. In addition, discussions were held with both Paediatric and Special Care Dentistry consultants and their statements were used to confirm the working definition within this needs assessment. Meetings were also held with Consultants in Special Care Dentistry and the leads of the Community Dental Services. Descriptive accounts of Special Care Dentistry were obtained though these meetings which were used as evidence within this needs assessment.

Existing sources of data for describing the epidemiology of the groups within Special Care Dentistry were identified from the Public Health Wales Observatory, The Welsh Hospitals and general dental data sources. Information was sourced from Special Care Dentistry Special Interest groups and from public health teams of Public Health Wales working with specific needs groups. A number of organisations and charities with
expertise and interests in the health and care of specific Special Care groups were also consulted.
3 Overview of the Demography of Wales

3.1.1 Population of Wales
The overall population of Wales is just under 3 million; 60% of this population reside in the Southern and Eastern areas Wales. The West and North of Wales are less densely populated with more rural areas as illustrated in Figure (i) below.

Figure (i): Map showing population density in Wales 2007

Population density key

number of persons per km\(^2\)

- 4.72 - 176.97
- 176.98 - 748.02
- 748.03 - 2,036.92
- 2,036.93 - 3,958.82
- 3,958.83 - 19,680.00
3.1.2 Health Service Areas

Wales covers an area of 20,780 square kilometres. In terms of the organisational structure of health services, NHS Wales is divided into seven health board areas. These areas are:

- Betsi Cadwaladr University
- Hywel Dda
- Powys
- Abertawe Bro Morgannwg University
- Cwm Taf
- Cardiff & Vale University
- Aneurin Bevan

Each of the seven health board areas is distinct in terms of its geographical size; terrain and population (see Figure A Annex).

Betsi Cadwaladr University Health board covers a wide geographic area and has urban areas with wide expanses of less densely populated rural areas. Powys Teaching Health Board is also predominantly rural with a comparatively a small population but large land mass. The majority of the population of Wales live in the South. Cardiff and Vale University LHB Cym Taf and Aneurin Bevan LHB are in the South East of Wales, these have a larger more densely populated population. Both have a number of urban areas, of which Cardiff is the most densely populated. Abertawe Bro Morgannwg University LHB is in West Wales and has a mixture of dense urban and rural areas. Hywel Dda is further west, mostly rural but with several urban concentrations. The population density of across Wales is illustrated in Figure (i) overleaf.

The boundaries and populations for Health Board Areas are different when compared to Local Authority Areas and this should be considered when examining data presented in this report.

3.1.3 Changes to the population in Wales

The population of Wales, like other areas of the UK, is ageing. The number of people living beyond 75 years old is increasing. The age profile of the population in Wales is illustrated in Figure B (Annex). Additionally, according to the Office for National Statistics the proportion of the population of over 75’s in each area is illustrated in Figure C (Annex). Many health conditions become more common in old age and so, as the age profile of the population changes, so do the health care needs of the population.
Populations with Special Care Dentistry Needs in Wales

The definition of Special Care Dentistry (section 1.1) is broad and encompasses many health conditions and states. The presence of a condition or health state does not necessarily mean that an individual needs to access Special Care Dentistry Services for care. It is difficult to determine the need, uptake and demand for Special Care Dentistry Services in the population because no specific data are collected for this purpose. As a result of this, current data will be used to illustrate the demographics of the relevant population groups and compare this to the uptake in Wales.

3.2 Disability

3.2.1 Special Care Dentistry and Disability

Disability is often defined in terms of the Disability Discrimination Act (1995) as ‘a physical or mental impairment which has substantial and long-term adverse effects on [the] ability to carry out normal day to day activities’. Many physical, sensory or mental impairments do not prevent routine dental care being undertaken in general dental practice, however there are many patients who do need the additional care and support Special Care Dentistry can provide because of the range and severity of their health problems and impairments.

3.2.2 Disability in Wales

In Wales, in 2009 there were 33500 people of working age registered as having a disability as defined by the disability discrimination act. A total of 101700 adults of working age in Wales were defined as having a physical disability as their main disability in 2009; 68900 had respiratory or heart problems, 47700 had longstanding progressive illness and 116700 were described as having “other” problems as their main disability.

Physical disability is not the main cause of disability in adults of working age in Wales; health problems have a more significant contribution to disability in Wales. The distribution of people affected by disability varies from area to area; the numbers of people with each main cause of disability are outlined in Figure (ii) overleaf.
Disability in older adults will be dealt with in section 3.5.

Although, there are figures for numbers of people in each local authority area with disabilities, there are no data sources available that explicitly demonstrate the numbers of individuals with disability that require Special Care Dentistry services.

Community Dental services, general dental services and hospitals do not record disability data in a consistent way. Different services in Wales use different IT systems and recording; some do not use computers and have very little recorded data that can be easily and consistently retrieved. Returns of dental activity are sent to the Welsh from each Community Dental service, but these data have limited Special Care Dentistry information. At present, there are no “all Wales” routine data collected for the purpose of monitoring uptake or use of dental services by people with specific disabilities or Special Care needs.

In the absence of direct data recording uptake and use of dental care services by people with disabilities, alternative data sources were
identified. Self reported limited function and limiting illness are established as measures for the effects of conditions on daily activities; these may be a useful indicator for disabilities that affect a person’s ability to receive dental treatment. The Welsh Health Survey 2009/10 questions included self reported health and the findings were that; eleven percent of over 65’s reported poor health and 7 per cent of 45-64 year olds reported poor health (Table (i) below). Using these figures, it is estimated that approximately 114054 people across Wales have poor self reported health. In the 2009/10 survey, the sample excluded individuals in hospitals or residential care. Therefore, because these figures excluded individuals in residential care and hospitals, who have poor health and wellbeing status, this figure may be much higher.

Table (i) Self Reported Health from the Welsh Health Survey 2009/10 by age in Wales

<table>
<thead>
<tr>
<th>Welsh Health Survey 2009/10 Self reported Health</th>
<th>2010 Mid Year Estimated population of Wales for each age group</th>
<th>Estimated poor health in Wales (%poor health applied to the midyear population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Very good</td>
<td>Good</td>
</tr>
<tr>
<td>16-44 (6,410)</td>
<td>25</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1108752</td>
<td>(2% of 1108752)</td>
</tr>
<tr>
<td></td>
<td>22175</td>
<td></td>
</tr>
<tr>
<td>45-64 (5,569)</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>792149</td>
<td>(7% of 792149)</td>
</tr>
<tr>
<td></td>
<td>55450</td>
<td></td>
</tr>
<tr>
<td>65+ (3,893)</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>548270</td>
<td>(11% of 548270)</td>
</tr>
<tr>
<td></td>
<td>60309</td>
<td></td>
</tr>
<tr>
<td>All aged 16+ (15,872)</td>
<td>16</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>2449171</td>
<td>(6% of 2449171)</td>
</tr>
<tr>
<td></td>
<td>146950</td>
<td></td>
</tr>
</tbody>
</table>

Survey Data from data request from Welsh Welsh Health Survey 2009/10
Population data from StatsWales

(Older adults in residential care and hospital will be discussed in 3.5.)

3.2.3 Uptake of Dental Services
In the 2009/10 Welsh Health Survey, individuals reporting a limiting long term illness were 11% less likely to have been seen by a dentist in the previous 12 months than those without a limiting long term illness (Table 1 Annex). How often a patient should attend for dental appointments during a 24-month period can vary from patient to patient, depending on their individual oral health needs. This 12-month attendance figure does not provide an accurate measure of need, but does provide an indication of differential uptake of services over the course of one year.

Dental attendance in dentate adults in Wales was reported to be 69%25, and a lower rate of attendance is likely amongst edentulous individuals. Across Wales, according to the Welsh Health Survey, individuals who
reported more than one life limiting illness were less likely to have seen a
dentist in the previous 12 months than individuals with one or less life
limiting illnesses (Table 2 Annex). This may be as a result of increased
edentulousness amongst those with the poorest health or as a result of
the age distribution of health conditions. Irrespective of the reasons,
these data trends indicate inequalities in the uptake of dental care.

In total 22845 adults (age 16+) were seen by the Community Dental
service across Wales in 2009/10\textsuperscript{26}; this represents around a quarter of the
147000 people estimated to have poor self reported health (6% of the
adult population in the Welsh Health Survey) who reported attending the
dentist in the previous 12 months (using an attendance rate of 66%).
However, uptake of Community Dental services is higher in younger
adults; 32% of younger adults (age 16-64) and 16% of older adult (age
65+) dental attendees with poor self reported health are seen by
Community Dental Services. It is likely that the remaining three quarters
of patients with poor self reported health who do attend the dentist are
seen in General Practice during the course of a year. However, it is not
possible to tell from these data how extensive the Special Care Dentistry
needs are in this population or how many of people seen in general dental
practice each year have been seen as a Community Dental service patient
in the past.

The Welsh Health Survey findings also indicated that there were
differences in the uptake of dental care between areas (Table 2 Annex).
In Hywel Dda, individuals with a limiting long term illness were 2% less
likely to see a dentist than individuals without limiting long term illness.
In Cwm Taf, individuals with a long term illness were 7% less likely to see
a dentist than those without a long term illness.

Inequalities in access to dental services in different geographic areas may
exist as a result of differences in services, referral criteria, and
approaches to engaging with the population, local geographical factors
and differences in the overall composition of populations.

The Welsh Government and other stakeholders need to identify and
develop policy to overcome inequalities in uptake of services. Specialists
in Special Care Dentistry will need to continue to work with Disability
groups, Public Health teams, Social Care, and Dental Public Health teams.
3.3 Mental Health

Mental health problems are common, and it is estimated that 1 in 6 adults are suffering from mental health problems at any one point in time\textsuperscript{27}. Special Care dentists receive referrals for patients with mental health problems because of anxiety problems relating to dental care, or because of the disabling severity of some mental health conditions. Furthermore, many individuals with drug and alcohol dependency, who are also Special Care patients, often have underlying mental health problems, these patients are discussed in more detail in 3.4.7.

Mental health problems can have an effect on self esteem, self care, diet and health\textsuperscript{28}. Because of co-morbidity of mental health conditions with other health problems and associations with issues such as smoking\textsuperscript{29}, it is likely that the risk of oral health problems will be greater for these individuals than for the general population. Additionally, some of the medications for mental health problems can cause oral problems such as xerostomia. People with mental health problems can therefore be vulnerable to dental health problems. Although the majority of people with mental health problems can be cared for in general dental practice, there are individuals who do need to be seen by a dentist with Special Care expertise.

3.3.1 Mental health illness in Wales

The majority of people with mental health problems are cared for within primary care and according to the QoF data (Table 3 Annex)\textsuperscript{30}, 25069 people in Wales registered with a General Medical Practitioner as having mental health problems. This figure is much lower than 1 in 6 and so many people with problems may not be identified within general practices or mild cases may not be registered.

Specialist mental health services receive referrals for one in every ten people with mental health problems. Referrals are usually made for the most severe mental health conditions and in Wales, as of 31\textsuperscript{st} March 2010, there were 1820 people receiving treatment in hospital or a residential unit for their mental health conditions (Table 4 Annex); of these 33% were detained under the Mental Health Act 1983\textsuperscript{31}.

There are no systems in Wales to collect all-Wales level data that detail access to dental services specifically for patients with mental health problems. However, mental health is often poorly reported and people with mental health problems do not necessarily seek medical health, and therefore the quality of the data for this population can be poor.

Half of the patients being treated in for mental health conditions in hospitals and residential units in Wales are 65 years of age or more.
(Table 3 annex). It should therefore be considered that many of these patients may have a number of concurrent health problems, increasing the need for oral health care.

In Cardiff and Vale there were a reported 2485 contacts with patients with mental illness, as a result of referrals. There is also dental expertise available to a hospital unit which deals with patients with mental health problems. In Aneurin Bevan area, mobile dental units have been provided to address the needs of 2 secure units, additionally referrals are taken from hospital wards. The Community Dental service in Betsi Cadwaladr reported treating 354 patients with mental health problems over the same 08/09 time period, and 150 people were seen in Abertawe Bro Morgannwg Health Board area. There are wide differences between areas, which may reflect both attendance and the way that these conditions are recorded.

Not only may individuals with mental health complaints fail to seek dental care when they need it, they may also not attend for dental appointments that have been made. Dental service providers, including general dental practitioners, hospitals and Community Dental services operate policies for non attendance, and many do not offer further appointments for patients who do not attend for their appointments. Although such policies are necessary for the optimal use of NHS resources, this means that patients with mental health problems may have poorer access to dental care.

Consultants in Special Care will need to work with social care and other stakeholders to ensure patients with mental health problems are identified and referred when required. Mechanisms to ensure ongoing support and care may also need to be considered, this may include working to ensure that non attendance policies do not create an additional barrier to care.

3.4 Medically Compromised

3.4.1 Medically Compromised People and Dental Care

Medical health problems have an important role in disability in Wales (3.2) and a large number of people with a Disability Discrimination Act defined disability have medical health problems.

The delivery of dental care can become more complex for patients with medical health problems. Some conditions, and the treatment for some conditions can increase the risk of dental disease e.g. some autoimmune diseases cause xerostomia (dry mouth) and medications also can also induce a dry mouth. A reduced amount of saliva can predispose an individual to dental caries.
Although many people have medical conditions, a large proportion of these conditions can be well managed medically, and as a result these patients can be treated in general dental practice. However, although many patients with medical health conditions can be managed by general dental practices, some patients do require some or all of their care to be delivered by dentists with Special Care Dental expertise.

General health declines with age and the majority of people over the age of 75 take one or more medication. Having a medical condition does not confer a need for Special Care Dentistry however it is difficult to define and measure the threshold where a patient would need additional services.

Consultants in Special Care Dentistry and Dental Public Health will need to work to identify data that would best indicate oral health needs, uptake and provision for medically compromised patients. Mechanisms to record consistent and useful data within and referred from general dental practice should also be considered. This would enable better monitoring of the uptake of care for the patients and help improve the care for patients with Special Care Dentistry needs.

3.4.2 Medically Compromised People in Wales

Table 6 (Annex) shows the numbers of people on the QoF registers across Wales with a range of health complaints. These figures, illustrate the range of health problems seen by medical practitioners, but do not provide any indication of severity, co-morbidity or age.

From the analysis of the QoF data, it is evident that a great number of people have medical health problems that are relevant to dental care such as diabetes and coronary heart disease. When comparing these data to the general practice and community attendance data (Table 7 Annex), it is evident that many patients with medical problems are being seen in general dental practice. QoF datasets do not provide any indication of the severity of conditions. Additionally, the QoF system is used for monitoring medical practice performance which may compromise the integrity of these data for the purposes of understanding the prevalence of conditions in population.

General medical practitioners have many patients with Special Care needs on their registers. There is considerable scope for developing referral pathways and mechanisms to identify the most vulnerable through the general medical practice computer systems in order to ensure that these patients are offered dental care.
3.4.3 Medically Compromised Care Provision

According to the Welsh Health Survey findings, people who have suffered a stroke, or who have arthritis, diabetes, eyesight or hearing problems are less likely to have attended the dentist in the previous 12 months. The over 65’s with these conditions are less likely to attend the dentist than the under 65’s (Table (ii) Self reported health conditions and dental attendance reported in the Welsh Health Survey 2010).

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Survey Response</th>
<th>Percentage of people who reported seeing a dentist in the previous 12 months (Welsh Health Survey 2010)</th>
<th>All people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>16-64</td>
<td>65+</td>
</tr>
<tr>
<td>Ever had stroke (a)</td>
<td>No</td>
<td>73</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>65</td>
<td>50</td>
</tr>
<tr>
<td>Currently treated for arthritis</td>
<td>No</td>
<td>73</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>70</td>
<td>56</td>
</tr>
<tr>
<td>Currently treated for diabetes</td>
<td>No</td>
<td>73</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>67</td>
<td>57</td>
</tr>
<tr>
<td>Eyesight difficulty</td>
<td>No</td>
<td>73</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>64</td>
<td>50</td>
</tr>
<tr>
<td>Difficulty with hearing</td>
<td>No</td>
<td>73</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>72</td>
<td>59</td>
</tr>
</tbody>
</table>

Data from the Welsh Health Survey

The figures in Table 9 are not age adjusted and so the differences in access may also relate to the age of the respondents. Many disabilities can affect access to information and ease of transport. The dental impact of physical and medical disabilities that do not require special ramps or wheelchair access should not be underestimated.
There is a considerable amount of engagement with many special needs groups in existence in Wales; however improvements will need to continue, as health services develop and change.

3.4.4 Medically Compromised Patients in Hospital

In Wales there are approximately 12868 available hospital beds, of which on average, 10451 are occupied daily\(^3\). Hospitals have the responsibility for the oral health of their patients for the duration of their stay; oral care essential is a fundamental and essential part of good care\(^3\). The evidence provided by the Community Health Council and from the enquiries to Public Health Wales, indicates that the extent and availability of these services can vary.

It is recommended in a number of guidelines that oral care and multidisciplinary working for oral health is established for in-patient care\(^3\),\(^4\),\(^5\),\(^6\). Examples where this is established include longstay hospital care facilities such as Rookwood in Cardiff, where comprehensive care is delivered by a dental team at the hospital; these modes of care delivery are important for these patients. Dental patients at Rookwood will be moving to Llandough once a dental facility is established. Although many good systems are in place, multidisciplinary communication can be strengthened. The equity of and mechanisms for the delivery of oral health care in hospitals may need further investigation to ensure a consistently high quality service across Wales. Furthermore, many patients, particularly elderly ones are often discharged to care establishments and so in addition, it is equally important to ensure communication between providers during the transitions.

There are ongoing projects and many opportunities to strategically incorporate oral care and multidisciplinary working with Special Care Dentistry to improve oral health for patients with Special Care needs in hospitals.

3.4.5 Specific facilities for Medically Compromised Patients

The 2009/10 QoF data (Table 6 Annex) show 318606 people registered with GPs who are listed as obese. Although the majority of these patients will not be severely obese, there are patients in Wales who are severely obese.

Obesity is an issue for dentistry, as there is a weight limit for conventional dental chairs. This means that patients who are severely overweight cannot be treated sitting in most dental chairs. Special facilities, including hoists, reinforced floors and specialist chairs are needed for these patients to receive dental care in a surgery. Ground floor facilities are required for these patients to enable emergency evacuation, in the event of a fire. In
addition, transporting these patients for care requires specialist transport facilities.

Treating these patients in an operating theatre can be an alternative for severely obese patients, but it be physically challenging for a dentist and the dental team members to carry out. Physically treating severely obese patients can pose a risk to the health of members of the dental team, and it is possible to incur injuries from posture or the movement of patients.

Furthermore, severely obese patients often suffer from a range of medical conditions which means that they may require dentists with specialist expertise for their care.

Specifically designed facilities and dental teams with expertise and training in bariatric dental care would be most appropriate for the management of severely obese patients.

According to anecdotal evidence from Special Care, community and hospital dentists, there are limited facilities in Wales for the treatment of severely obese patients, but many discussions have taken place in different areas about developing facilities. At present there are few severely obese patients who are receiving dental treatment and some Community Dental services are managing the care of these patients with domiciliary care or treatment in the Blue Room at the Dental School in Cardiff. However, most areas have limited access to facilities specifically catering for such patients.

Transporting severely obese patients over long distances may pose a risk to their health. Therefore, the location of services is important and should be considered from the perspective of distance to travel. However, travel across Local Health Authority borders is an issue; Service Level Agreements and agreed pathways are needed to ensure the necessary care and transport to care for these patients are achieved without unnecessary expenditure of resources in trying to obtain and make arrangements for this care.

Where such opportunities and funding become available, it may be possible to agree a Wales level strategic approach for the placement of these facilities. With a planned approach, funding from across a number of local health boards could be used for the development of facilities and transport for obese patients. Centres of expertise in the management of these patients can be developed and service level agreements can underpin these arrangements.

3.4.6 Bleeding Disorders
Patients with Haemophilia require access to Special Care Dentistry. Dental procedures such as extractions carry the risk of bleeding and for Haemophilia patients, where clotting factors are reduced or missing, dental procedures pose a risk to their health and well-being. Some dental procedures and check-ups can be carried out in a general dental practice by non-specialists. Patients with Haemophilia may choose to have the majority of their care delivered within general practice. However, some patients may prefer or require all or some of their care delivered by Special Care dentists with expertise in the care of haemophiliac patients. Because the greatest risk for Haemophilia patients is for surgical procedures or extractions, many of these patients may need to have some of their specialist care through Oral Surgery or Maxillofacial Surgery.

There were approximately 22,000 people with Haemophilia across the UK in 2009/10. People in Wales are less likely to have Haemophilia compared to other areas of the UK. According to hospital episode statistics for 2009/10 there were 637 admissions for Haemophilia or coagulation defects across Wales.17

There are specialist centres for Haemophilia in Bangor, Cardiff, Swansea and Newport and these are linked to dental services. Community and hospital dental staff have reported seeing these patients when referred as needed or as ongoing patients.

It is essential to ensure that haemophiliac patients have appropriate and timely assessments of oral health needs and access to oral care. As there are small numbers of these patients in Wales, centres of expertise for the dental treatment of these patients linked to the specialist haemophilia centres should be maintained for these patients. In addition, consideration may be given to the use of DWSI dentists to provide timely and more convenient general care for these patients on a local area level.

3.4.7 Drugs and alcohol misuse

In Wales in 2010, there were 16052 people referred to services for alcohol misuse (Table 8 Annex). In addition, there were also 11698 people referred for drug misuse. Common features of alcohol problems include a chaotic lifestyle and poor self care. Patients with drug and alcohol problems are vulnerable to a range of general and dental health problems. Many of these patients may also have mental health problems (section 3.3) and some may be homeless (section 3.8.2).

Patients with drug and alcohol problems can have a number of conditions that can make receiving dental care more difficult and complex. Chronic alcohol use can cause liver damage, which can mean that patients are more prone to bleeding and they cannot process as much local
anaesthetic. Liver damage can also mean that a person can take a reduced amount of medication; the type of medication that a person can take may also be affected. Chronic drug abuse can also cause a variety of relevant health problems and mean that patients are more likely to have blood borne infectious diseases. Issues of access to general dental care for patients with blood borne diseases do arise and where a patient is seriously unwell with a compromised immune system, a patient may be best treated in a hospital environment.

Patients with drug and alcohol problems may find accessing and receiving care difficult. Targeting services at this group can also be challenging because of the chaotic lifestyles.

Where patients are referred for drug and alcohol problems and are under care, there may be opportunities for joint working with social and health services across Wales to create a strategy to promote oral health and ensure access to dental care

### 3.5 Care of the frail and homebound

There are a number of health conditions and disabilities which result in individuals having difficulty in physically receiving some or all of their routine dental services in a dental surgery. Some dental practices are more accessible for patients with disability than others. Some dentists have no choice but to refer patients who cannot physically access their services.

One method of delivering dental care, particularly for those who live in their own homes, is through domiciliary care. For individuals who are resident in care homes, where it is difficult to transport patients to dental care services, mobile dental units can also be used to provide care for patients.

It is difficult to define the population who need domiciliary dental care and there are no routine data collected that relate to the numbers of individuals who need domiciliary dental care services. However, social care services provide home care for individuals who are homebound, frail and dependent. Social care services in Wales only deliver these services to individuals who have a critical need for help, and although the thresholds in each local authority area are not well defined Figure 6 (annex); these data provide a proxy indicator for homebound and dependent individuals who may need some of their care delivered through domiciliary services.

**People who are in care**
In addition to individuals living in their own homes, there are also 13643 adults aged over 16+ receiving residential care services. The majority of these individuals are over the age of 65. (Figure E Annex, Table 9 Annex)

The total number of adults receiving home care provides an indication of the numbers with limiting disabilities and the overall figures for each local authority figure are illustrated on Table 12 (Annex). However the amount of care given to each client can vary and is likely to relate to the physical needs of the individuals. Approximately half of the people receiving care receive more than 10 hours of home care per day, although this does vary by area and some areas appear to provide more home care than others (Table 10 Annex). These figures may be useful in helping to determine domiciliary care needs in local areas.

In addition to social services care, there are also 9262 carers identified across Wales who are providing home care to people on an unpaid basis; this number is likely to be an underestimate of real care provision as many family carers are not identified. Individuals providing care may be exclusively providing that care or be sharing care with social care providers. Therefore, it is likely that the number of people who may need additional help to get to a dentist, or receive domiciliary care may be higher than indicated by the social care figures.

Some Community Dental Services provide more domiciliary care than others. Additionally some of the domiciliary care is provided by general practitioners. (Table 11 Annex) illustrates the numbers of patients seen by the GDS and CDS domiciliary visits. It is not possible to identify the true extent of and the type of care from these data. It is likely that a significant proportion of care would have been for the provision of dentures, which does not require specialist expertise and can be delivered by a competent general practitioner. However, delivering fillings and other dental treatments at home involves additional expertise and equipment.

It should also be considered that mobile dental units are also used to deliver care to some of the patients who would otherwise require domiciliary care.

The workload undertaken for domiciliary provision by the Community Dental service does vary in different areas of Wales. In Betsi Cadwaladr area, the majority of domiciliary care is provided for adults over the age of 65, in Aneurin Bevan and Cardiff areas a considerable amount of domiciliary care is provided for children aged between the ages of 0-15, (Figure (iii)1 Community Dental service contacts as mobile or domiciliary visits by age and area 2010).
From the data, it is evident that there are more people who may be eligible for domiciliary care than the numbers than those who receive care, although many of these may be cared for with the use of mobile dental units. What these data do provide is an indication of the current dental capacity to deliver domiciliary dental care. As domiciliary care can be more costly to deliver than routine “in surgery” care, this resource should be targeted at those who could not receive care in another way.

Domiciliary care is necessary for some patients who cannot access services, and Special Care dentists will need to work to ensure that dentists in the GDS and CDS are trained and encouraged to provide these services.

Although the majority of domiciliary care can be provided by competent general dental practitioners, since the advent of the new contract in 2006, domiciliary care cannot be provided by dentist, unless they have an agreement to do so. This may mean that the patterns of domiciliary care in the general dental services are based on historic provision and not on patient need. Additionally, domiciliary care is a more expensive service to
provide than fixed location care, (when excluding the costs of staff to accompany clients and transport facilities by NHS providers).

Special Care Dentistry Specialists will need to work with LHBs and other stakeholders to develop a strategic approach to ensure that domiciliary care is available to those who need it and that the necessary resources are employed effectively.

3.5.1 Oral and Dental Health in Care Homes

A survey of dental care provision in care homes was carried out across Wales in 2006/7\(^37\). This had included responses from 957 of the 1185 homes caring for older people in Wales. Approximately 40% of care home managers responding stated that they sought dental care for their clients through the Community Dental Service, and a further 40% sought routine care through the General Dental Service (Table 12 Annex). These differences in the chosen providers for dental care may be as a result of a variety of reasons including local geography and access or the client needs. These data do provide evidence to show that the responsibility for oral care of vulnerable older adults is not necessarily clear.

Care homes also reported some problems in accessing services for their clients. Over 30% of care home managers reported experiencing some difficulties in access to emergency dental care and just fewer than 40% had experienced problems accessing routine care (Table 13 Annex).

All Wales information leaflets have now been developed by the Welsh Oral Health Information Unit as part of its work for the Welsh Government. These help Local Health Boards signpost care home managers to the appropriate dental care for their residents. This work will be evaluated at a later date.

The initial findings of an oral care epidemiological survey across care homes in Wales are expected at the end of 2011/beginning of 2012. This survey will provide information about the oral health need, as diagnosed by clinicians in care homes. The amount of Special Care Dentistry care needed within this population may then be easier to quantify.

The 2010 care home epidemiological dental survey results and the results of the 2006/7 care home survey should be used by multidisciplinary teams to develop and plan services to meet the needs of care home residents.
3.6 Learning Disability

3.6.1 Special Care Dentistry and People with Learning Disability

People with moderate to severe learning disabilities have a range of dental health needs that may be best managed by dentists who have trained in Special Care Dentistry. This is because of a range of health and behavioural issues in this population, for example, many people with Learning Disabilities are needle phobic. General Practice dentists who have had additional training in the management of these patients may also be able to provide the majority of some patients care, referring for Specialist help when needed.

3.6.2 Learning Disability in Wales

The Welsh Government holds a register of individuals with moderate and severe learning disabilities. These registers provide information about the population of residents in Wales with learning disabilities. However, although these lists provide useful information it should be considered that there may be variations in the entry criteria for different areas. Entry to the register may also depend on the availability and access to local area assessments.

The 2009/10 register of people with learning disabilities in Wales shows that there are 10,647 adults between the ages of 16 to 64 registered in Wales there are also 931 adults over the age of 65. 105 adults aged 16 to 64 and 16 adults age 65+ respectively resided in National Health Service hospitals. Additionally, 103 adults aged 16 to 64 and 42 adults aged over 65 were resident in Local authority accommodation. The majority of adults with learning disabilities live in family homes or supported living community placements.

3.6.3 Learning Disability dental care provision

A questionnaire was administered to all of the Community Dental service providers in Wales by the Special Care Dentistry Review group to identify the current level of services provided in 2009 this included data relating to individuals with learning disabilities. When comparing the results of this questionnaire against registrations for learning disabilities it is evident that there are considerably more individuals on the learning disability register in each area than have been seen by the Community Dental Service (Table 14 Annex). The numbers seen by the Community Dental service may also include individuals who have less severe learning disabilities and who may not be eligible for the register. As there have been few training opportunities for general dentists in Wales, this means that many of these patients are not seen by a dentist or are being seen
by dentists with no additional training or skills in the care of these patients.

3.7 Systems to ensure that patients receive care

Community Dental Service teams in Wales are working to improve access to dental care for learning disability groups. Difficulties have been reported as a result of continual changes to the NHS infrastructure. This means that Community Dental staff need to spend time to maintain and establish contacts with learning disability groups and teams. The NHS dental IT systems, at present do not identify individuals with Learning Disabilities and there is no method of cross checking across NHS systems to make sure that patients have access to care.

Individuals with learning disabilities are more likely to suffer from health problems than individuals without learning disabilities. A primary care Learning Disability Directed Enhanced Service (DES) was introduced in Wales in 2006 to reduce these health inequalities. Annual Health Checks (medical health checks) for individuals with learning disability were introduced as part of this work. This piece of work may be useful when considering dental needs. It should be noted, that at present these health check questionnaires do not include dental health but this is currently being revised.

Through this work it has been noted that individuals who are most dependent are more likely to attend for checks than those who are more independent, as carers for the dependent enable their clients to access care. Less dependent individuals reportedly have haphazard lifestyles, meaning that they do not always manage to keep appointments. In terms of dentistry, many hospitals, Community Dental services and hospital dental services often remove patients who fail to attend from their lists, meaning that some of these patients may not receive regular dental care.

Joint working between the Welsh and Local Health Boards has been important for improving the uptake of annual health checks. The Welsh provides the Local Health Board with a list of individuals in the area with Learning Disabilities, local doctors are then provided with lists of individuals in their local area in order to ensure that these patients receive care.

In West Wales the Community Dental Service asked to be provided with a list of people in their area of people with learning disabilities in order to offer these people dental care, this request was refused.

The Health Checks have shown that communication is important for improving access to care for individuals with learning disabilities, and there are established methods of communication that are not being made available to improve oral health.
Special Care dental provision should be facilitated by Local Health Boards and the Welsh. Defined processes need to be established to enable the transfer of information between authorities to ensure that the patients with specific health needs are met.

3.7.1 Engagement with Local Area Groups

Like other areas of Wales, Community Dental teams in Abertawe Bro Morgannwg University Health Board have been working with learning disability groups to improve the accessibility of dental care. This work has included the development of a video of tooth brushing and visiting the dentist to improve oral health for people with learning disabilities. This work has been well received by learning disability groups.

In discussions with such groups there has been considerable interest in developing and improving the existing infrastructure for dental care for these groups. Working with Special Care groups is a fundamental component of the development of services to meet needs. Through this, there are further opportunities available to improve accessibility of dental health and care for learning disability groups adapted to meet the needs of the people with learning disabilities; representatives from Learning Disability Wales would be happy to facilitate an Easy Read Survey for people with learning disabilities to underpin a needs based planning process. These opportunities to develop services with should also be applied to other special needs groups.

Specialists in Special Care Dentistry will need to continue to use their expertise and work with experts in public health promotion and lay groups to ensure equitable access to care through the development of appropriate information.

Individual specialists could take the lead for the improvement of oral health information and access for specific need groups across Wales in partnership with special needs groups. This could also involve training and workforce development; this would ensure that DWSI dentists with special interests in learning disability groups are available in each area.
3.8 Vulnerable Groups

In the population there are groups that have additional health needs and experience poorer outcomes when these needs are not met, these groups are considered to be vulnerable. Gypsies, travellers, homeless people and prisoners are examples. These groups have greater health needs and poorer health outcomes.

One issue when dealing with vulnerable groups is that individuals are often “below the radar”. They do not use health services as regularly as other groups in the population, and they are often missed in statistical figures for example Gypsy and Travellers because they move from place to place, (Table 15).

In terms of the distribution of travelling populations, the local authorities maintain a list of the sites for each area. These lists give an indication of the location of the populations. Because of the movement from place to place, it is difficult from a health perspective to maintain engagement with the travelling community.

There is a considerable amount of ongoing work within Community Dental departments to deal with the oral health needs of vulnerable populations. Opportunities may exist to improve the oral health of these groups through multidisciplinary working with Public Health and Social Care Services to help Special Care Dentists best work with these communities.

3.8.1 Prisoners

The oral health of individuals in prisons is poorer than the oral health of the general population. Individuals who are in prisons are more likely to be from a deprived background, they are more likely to smoke and to have other health related problems.

Prisoners often have limited access to oral hygiene equipment. Prisoners may not be allowed dental floss or any items that may pose a potential risk in the prison. Basic toothbrushes are available, but options can be limited and in some prisons, toothpaste and toothbrushes are “purchased”, from prisoners weekly allocations; these allocations are often used for cigarettes. Oral hygiene equipment can be less of a priority for prisoners.

The head count of male prisoners in Wales 2814 as of the 31\textsuperscript{st} August 2008, however, this figure is a point in time, and the overall number of men who have been in prison in one year is far greater. There are four Welsh prisons but there are no female prisoners in Wales.
Dental care is an important issue, as there are only limited numbers of dental treatment sessions available to deal with dental problems.

Oral health in prisons will need consideration and may require a specific needs assessment for the planning of dental care services and oral health promotion.

3.8.2 Homelessness

The health and oral health of homeless populations is poor. In Wales between October and December 2010, there were 1529 individuals identified by the Welsh Government as being homeless. Of these cases, 113 involved mental illnesses, 95 involved disabilities, 146 were young people between the ages of 16 and 21 who were at risk, 33 involved a vulnerable adult of old age and 574 were cases involving dependent children.

The Welsh has released standards relating to homeless people, this included recommendations for the improvement of access to dental care for the homeless. Health professionals and social care services are expected to work together to improve the health and wellbeing of the homeless. In each Local health board, a named Director is expected to support the homelessness agenda. Work is being undertaken in many areas to improve the oral health of homeless people. The dental needs of this group are different to that of the general practice population and there are opportunities for to develop services to meet oral health needs though jointworking with health and social teams for homeless people.

There are ongoing opportunities for Working with and developing links with the teams working with the homeless.

3.9 Dental Anxiety

3.9.1 Dental anxiety and Special Care Dentistry

Special Care dentists manage patients who have been referred because of an inability to receive dental treatment as a consequence of anxiety issues towards dental care. Some patients are referred for anxiety issues and have no other health problems, but some patients have other health issues in addition to anxiety.

Anecdotal evidence highlighted a number of needle phobia problems and healthcare anxiety issues amongst people from learning disability groups. Further to this, individuals with mental health problems can also have a number of anxiety issues in relation to dental care. Medically complex patients can benefit from anxiety management as a part of their dental care e.g. patients with angina can benefit from relative analgesia for
anxiety provoking procedures, as the techniques involved relaxation of the patient but provide continued oxygen thereby reducing the risk of an angina attack.

There are a number of methods of dealing with anxiety issues. These include using behavioural management techniques, pharmacological sedation techniques and general anaesthetic or a combination of these.

3.9.2 Dental Anxiety in Wales

According to the latest adult dental health survey 1 in 10 of the population suffers from severe dental anxiety (using a validated scale for dental anxiety). This would mean, using midyear population estimates, that approximately 190090 people in Wales would suffer with severe dental anxiety.

3.9.3 Dental Anxiety care provision

It is not possible to identify how many adults receive behavioural interventions or hypnosis for dental care as these data are not recorded in hospital, community or general dental datasets. However, those individuals receiving behavioural interventions are likely to have less severe anxieties than those requiring pharmacological interventions for the management of dental anxiety.

The number of people receiving pharmacological treatment in Wales is different in each area (Table 16 Annex) at present work is being undertaken in some areas to develop sedation services. From these figures, it is clear to see that the majority of patients estimated to have anxiety issues do not receive sedation for their dental care and in some areas of Wales, it is unlikely that patients will receive any sedation care.

In addition to the figures above, hospitals provide some dental care with sedation, but it is not possible to identify the precise numbers from generally available hospital episode statistics.

The dental hospital in Cardiff provides a specific sedation service based on the teaching of undergraduate and postgraduate dental students; there were approximately 1800 referrals to the Sedation Suite in the University Dental Hospital Service between April 2010 and March 2011. The numbers receiving intravenous and Relative Analgesia sedation care as a result of these referrals have been collected for analysis. These data show that half of the patients meeting the criteria for treatment receive intravenous sedation and half are treated with inhalational sedation. On average, it takes four treatment visits per patient. Between 1 and 7 of the patients seen each month have additional complex special needs.
Although the numbers of patients receiving sedation services across Wales are illustrated (Table 16 Annex), the number of visits per patient is not clear. Furthermore the type of sedation used is not indicated within the data. Certainly, of all of the CDS providers in Wales, only 6 locations provide intravenous sedation. Therefore, it is likely that a good proportion of the sedation care provided in the CDS is relative analgesia sedation. It is not possible to identify the precise amount and type of sedation provision in Wales and these figures are an only an indicator. Some of the sedation figures may also reflect uptake in relation to geographic availability of sedation care, which is greater in some parts of Wales as illustrated in Figure G (Annex). Where sedation services are limited or are unavailable, it is possible that very anxious patients may be treated with general anaesthesia, with additional risks to patient health and additional cost to the health service.

Many patients who suffer from severe dental anxiety have no health problems and are classified as ASA class 1, there are also a number who have less serious and minor health complaints and are classified as ASA 2. Many of these patients ASA 1 and 2 patients do not need to see specialist in Special Care Dentistry in order to receive dental care. These patients could be treated in general dental practice or in a facility delivering sedation services.

Referrals to the School of Dentistry in Cardiff are classified into three categories, the first is simple, which is a case that could be carried out by a student, the second is moderate which could be carried out by a postgraduate or a middle grade member of staff and the third is complex, which would be carried out by a consultant or Specialist. In the dental hospital, this mix of patients is necessary to deliver teaching in sedation. However, as a proportion of the referrals, half of the cases were simple ASA 1 and 2 cases, and approximately half were moderate. Only a handful of referrals were severe. Using these crude figures, it may be suggested that at least half of the patients referred with dental anxiety issues could be treated in general dental practice. This is a more efficient method of providing care than community or hospital services.

| Delivering sedation to simple cases in general dental practice would remove non-specialist cases from Specialist Care pathways thereby optimising the specialist resources for those who need them. |

At present, there are only a small number of dental practices offering sedation services to patients. According to QAS data from 2009, there were 22 providers of dental care using sedation across Wales. Of these, 4 reported using inhalational sedation, and a further 3 reported offering inhalational sedation and either IV or oral sedation. Ten practices offered only IV sedation and a further five reported offering IV or oral sedation for patients.
Dental care with sedation is contracted from general practice providers as an “additional” service. This budget is considered separately from the CDS budget and the hospital budget. As a result, it is up to the individual Health Board Dental Care Leads to explicitly provide contracts for general dentists to provide these services. However, the purchase of such services is from the same funding stream as general dental services. As a result, access to other general dental services could be reduced by the provision of funding for sedation services in practices, even though it could provide a more efficient model of care delivery for some of the sedation care.

In some areas of Wales, the development of sedation services may also be hindered by a lack of understanding amongst non dentists about dental sedation services. This is a barrier to care.

Encouragement and information to help develop an understanding of dental sedation amongst non dentists involved in management, strategy and planning of dental services may be necessary to overcome barriers to patient care.

LHBs need to be persuaded to strategically plan and deliver sedation care including that from general practices to enable more equitable care for anxious patients in Wales. This may involve working in partnership to convince dentists to train and develop services.

3.9.4 General anaesthetic

Although not recommended or indicated for the majority of routine dental patients, there are some patients with Special Care Dentistry needs who do require some or all of their treatment carried out under general anaesthesia.

The delivery of general anaesthetic services to these patients varies by area, according to anecdotal evidence. Some of the patients with Special Care needs are seen by oral surgery teams who do not usually carry out restorative treatment under general anaesthesia. In other areas, Special Care patients are treated on restorative lists. However, few areas have a dedicated Special Care general anaesthetic operating list. The number of sessions of general anaesthetic care (a session being of a 3 and a half hour time period) in 2009/10 as recorded on the CDS returns is illustrated on (Table 17).

There are no targets that relate to Special Care patients and when these patients require restorative work, a considerable amount of operating theatre time and resources are needed to deliver care. Some special needs patients are “slotted in” for dental extractions as emergencies but in West Wales, where an operating list where this work has been stopped, there have been reports of Special Care patients waiting for 6 months for emergency dental treatment and up to 18 months for more extensive
work. Other areas report long waiting times, because of a lack of dedicated vulnerable adults lists. This is a considerable length of time for any patient to be in pain and may compromise the health and wellbeing of patients with medical problems or learning disabilities.

Clear lines of responsibility for the provision of timely general anaesthetic care for Special Care patients need to be established within the hospitals. Joint working is needed between community located Special Care Dentistry and the Hospital Services to ensure effective and timely referral to treatment is established and maintained.

4 Special Care Dentistry Infrastructure

The majority of people with a Special Care need are seen by general dental practices (3.2.3) for care at some point, although the extent of the care needs and treatment received may vary. The Special Care needs of patients seen exclusively or though shared care with the GDS may be less complex than those seen by the CDS; the bottom tier of Special Care needs. Patients who cannot be cared for within general dental practice are, at present looked after by the Community Dental Service. These services are different in different areas of Wales and have evolved to meet the changing demands and expectations placed upon the service. Many community sites were originally children’s dental services and some have retained this historic profile. In addition to the Community Dental Services, hospitals have also provided care to special needs patients through restorative and oral surgery departments for specific dental conditions.

The age range of patients seen within the different Community Dental services is illustrated in Figure (iv) overleaf.

Services have concentrated on children and many of the patients seen by the Community Dental service have, also been through the involvement in the National Designed to Smile campaign. However, Abertawe Bro Morgannwg area had a particularly low proportion of care aimed at older people and adults and a considerable amount of work is being done by the Community Dental Service Senior Dentist to improve access to care for Special Care patients. Although it is important for the Community Dental service to see children for prevention and care, wherever it is possible to do so, care should undertaken in general practice, referring and joint working with the Community Dental service as required. Ongoing work may be possible to improve joint working between community and general dental services, and making best use of the dental resources available.
Clinic locations in Wales predominate in the southern and northern peripheries. There is a wide geographic expanse in rural mid Wales between service sites. Community Dental services clinic sites are located in areas of greater population density as illustrated in Figure I (Annex). The most rural areas have sparse and more widely distributed populations. Delivering Special Care Dentistry services to these populations effectively is challenging because of the travelling distances between sites and the workload per site; the care needs of these populations should be considered in service planning.

Deprivation is associated with poorer oral health. Dental clinic sites in Wales are well located in locations within or accessible to the most deprived areas of Wales (Figure J Annex). However, within the more affluent rural population areas, there will be individuals who are more deprived. These people will be vulnerable to rural access deprivation and their needs may be greater as a result of geographic barriers to care. The rural access barriers to care may also be compounded by policies which do not permit the transport of patients to dental surgeries for dental care.
Transport to dental care services needs to reach the policy agenda locally. Strategic planning to overcome these barriers and to deliver Special Care Dentistry services to deprived rural communities should also be considered.

5 Workforce

The workforce, including consultants, specialists, dentists with a special interest in Special Care Dentistry, dental nurses, therapists, hygienists and oral health educators, needs ongoing development in line with the current and future needs of vulnerable patients in Wales.

The Platt norms suggest a consultant to population ratio of 250,000, for most dental specialities. The ratio for orthodontic consultant expertise in this formula was one for every 500,000 of the population. These formulae only provide guidance on the numbers of consultants in relation to the population and do not take account of geography and population density in an area. Additionally, the Platt formulae, having been developed a number of years ago, do not fully take into account the role of specialists and dentists with special interests.

Consultants and Specialists for each of the specialities can be employed by hospitals, Community Dental units, universities or a combination of each. Additionally, some consultants and specialists provide sessions of private care and NHS care within the dental practice environment.

Consultant roles and services vary by area and many have been developed historically and in response to local needs and political demands. Some restorative consultants provide a considerable amount of care to Special Care patients. Restorative consultants have always provided care to some of these patients as some medical conditions and syndromes are related to specific restorative dental problems including hypodontia. In areas where the Community Dental service has historically provided children’s care, restorative consultants have provided dentistry to Special Care patients as required.

There are differences in the amount of time spent on clinical care for different types of consultants. Academic consultants provide less direct clinical care than NHS consultants, due to their extensive teaching commitments, which include supervising undergraduate students and postgraduate dentists.

5.1.1 Workforce in Wales

Each of the dental specialities in Wales has a different workforce profile. There are a small number of restorative specialists in Wales. A number of
academic restorative consultants teach in Cardiff University (Table 18 Annexe.)

The total number of restorative consultants in Wales is approximately 12 WTE, which would mean a consultant to population ratio of approximately 1: 250,000. Although this figure seems to fit the Platt formulae, the figures are affected by the number of academic consultants, who, as previously discussed, have a high teaching commitment and a different workload when compared to NHS consultants.

Additionally, the Platt formulae, when applied across Wales does not take into consideration the distribution of consultants, which is 1 in 678,000 for North Wales; There are no restorative consultants in some areas, although, as previously discussed, where consultants are available, patients are seen from neighbouring areas.

There are few consultants in paediatric dentistry in Wales. The British Society for Paediatric estimated from referral data that 1% of children (0-16 years of age) needed to see a paediatric dentist in any one year. In view of this, the report recommended a specialist to population ratio of one specialist to every 20,000 children. This estimate excludes the contribution of Dentists with Special Interests and this ratio would be reduced by the application of skill mix; the number of registered specialists in Paediatric Dentistry falls well below the ratio.

Similarly to the restorative specialities, the majority of consultant expertise is based in Cardiff (Table 19 Annex) of which two consultants are academic appointments. In a recent draft Public Health review, a recommendation was made for the appointment of an additional specialist in paediatric dentistry in the West of Wales, and additional sessions of consultant time.

The workforce of the specialities of oral surgery and orthodontics are more difficult to compare to Special Care than restorative and paediatric dentistry. Oral surgery services can be delivered in part by both the medical speciality of oral and maxillofacial surgery and the dental speciality of oral surgery. As a result of this, it is difficult to directly compare the workforce. Orthodontics is another speciality that is different in terms of its delivery; most of the orthodontic care is delivered to children below the age of 18 and treatment is usually delivered over a year or more. As little comparison can be drawn between these specialities and Special Care Dentistry, these specialities will not be compared in this needs assessment.

Dental Specialists can work outside of hospital environments and a proportion of the Special Care Dentistry specialist workforce work in Community Dental Settings.
According to the GDC register, 10 of the 258 GDC registered specialists in Special Care Dentistry are registered in Wales in Wales, an additional 3 will be added to the register in due course and there are more who are awaiting a verdict regarding registration. Three of these are additionally on either the restorative or paediatric dentistry register. The clinical time that these specialists devote to Special Care Dentistry may vary and so a more relevant number may be the number of clinical sessions in each area. There are 231 specialists in paediatric dentistry in the UK, of whom 11 are registered at an address in Wales. Although it is not possible to compare the sessions worked by these specialists, this number of Special Care Dentistry specialists compares favourably to the current paediatric workforce in West and North Wales.

According to anecdotal evidence, a number of restorative consultants and senior dental officers across Wales have been treating and managing patients with Special Care Dentistry needs for many years. While some individuals have applied for positions on the specialist lists, there are many who have chosen not to apply for consultant or specialist status.

In addition to the registered specialists, there are dentists who are awaiting the outcome of their applications to the specialist list and dentists who have not applied. This represents an additional body of expertise in the speciality across Wales that should be considered within the workforce planning, as specialist appointments may need to be made to replace these posts in the future. The Special Care Dentistry workforce, as outlined in the review of Special Care is illustrated in Table 20 (Annex).

Consultants in Special Care Dentistry in Wales are predominantly based in the South East of Wales but there are specialists in the South West and North of Wales. This is a similar geographical pattern of distribution, compared to the other dental specialities.

As, discussed previously, only a small proportion of the referrals to the Cardiff School of Dentistry are categorised as needing consultant only expertise; it is likely that only small numbers of patients in other geographical areas will have a need for all of their care to be delivered by a consultant in Special Care Dentistry. Patients who are not seen by a consultant at the school of dentistry are often seen by a specialist or a dentist working in the speciality at a centre with consultant expertise available.

Some areas of Wales are very rural, with lower density populations, so the numbers of patients with these needs and the travelling between areas to meet these needs may mean that the appointment of a consultant in each area is not a viable option. Historically the recruitment of Consultants to these geographically distributed posts has been difficult.
In view of the rurality and travel issues in Wales, complex patients may be better cared for, when required, within a centre of excellence for Special Care Dentistry, where the numbers of patients and the complexity of patients seen may ensure an optimum outcome for the patient. Dental care for Special Care patients could be managed by Dentists with Special Interests and Specialists, with upwards referrals to consultants where needed ensuring better geographic provision of care and expertise.

5.1.2 Training workforce

In addition to the consultant and non training grade workforce, there are also a number of speciality registrars and trainees who are undertaking consultant training in Wales (Table 21 Annex). Of the trainees in Wales, the majority are located in the South East; one orthodontic trainee is located in the North. Three trainees, one in Dental Public Health, one in restorative dentistry and one in orthodontics were sites in West Wales. Three trainees in Maxillofacial surgery had no location given for their respective training number.

Trainees in Special Care Dentistry have been appointed to South East Wales locations. Trainees can only be appointed to locations where consultants are available for training and may affect the distribution of the training workforce creating a less even distribution of the workforce.

Although there are 3 specialists training in paediatric dentistry at present, there is only ongoing funding for one trainee.

5.2 Postgraduate training in Wales

5.2.1 Postgraduate deanery

The postgraduate deanery in Wales provides a variety of training opportunities for the dental team.

5.2.2 Dentists with Special Interests

There is a comprehensive programme for the development of specialists in Special Care Dentistry however, programmes for the training of dentists with special interests (DWSI) will require development as the speciality becomes more established.

The courses and programmes for the development of Dentists with Special Interests will need ongoing development and support. Strategically delivered training courses to deliver experience, knowledge and skills across Wales for hygienists, therapists, nurses and managers are required for the Special Care workforce.
5.2.3 Skills recognition and top up training

As previously discussed, some dentists have not applied to become specialists, this has included dentists who have not had the necessary breadth of experience to become a specialist and some who have made the decision not to apply to become specialists; these dentists do have a considerable amount of expertise to add to the skill mix available in the workforce. Training specialists without previous expertise takes a considerable amount of time and resources. One way to increase the number of trained specialists would be to develop a system to “add the skills” to the experienced dentists in order to become specialists or training posts where the training time is adjusted for previously gained competencies.

5.2.4 Developing skills across the dental team

Dental hygienists, nurses and therapists play an important role in the Special Care workforce. There are clinical procedures that can be carried out by a suitably trained and experienced hygienist or therapist. Workforce development planning needs would be appropriate for hygienists and therapists. Suitable training should be developed for these important members of the dental team and extension of DWSI training courses to include the wider team may improve communication, training and skill mix across teams.

The practice environment and staff are important for enabling and facilitating care. DWSIs need to be supported by a suitably trained team. Training for managers and reception staff may also need to be considered if practices are to enable care for Special Care patients in practices.

The deanery run Special Care dental nurse training courses, these train around 20 nurses per year. These courses can be expensive to run and dental nurses in Wales can incur considerable costs in terms of travelling and time, which are borne by the employer or the nurses themselves. The location of and number of nurses training in this area of care needs to be considered as part of the workforce planning.

The development of the workforce to support delivery of care through DWSIs needs to be planned strategically.

5.2.5 Sedation

In Wales, an annual revalidation update sedation training is offered by the postgraduate deanery for the dental team whilst the Certificate in Sedation Dental Nursing programme can only be offered when there are sufficient students to make the course economically viable. This sedation training is offered by staff within the Sedation Suite in the dental school together with the postgraduate deanery.
There is a diploma/MSc sedation course run by the school of dentistry for dentists. The initial 2 years of training are for the diploma and a further year is necessary for the master’s degree. This course has been running since 2009; 7 dentists were admitted to the course in the first year 2009/10; only 4 were admitted in the second year of the course 2010/11. A new cohort of 6 students have been recruited for 2011-2012. Of the first year cohort, 3 completed the diploma course, of whom, 2 continue to work in Wales. The remaining 4 dentists from the first year of the diploma sedation course have continued and are in the process of completing their master’s degrees. Sedation training is also offered in other parts of the UK.

Comprehensive training in sedation for dentists is an expensive undertaking costing £5700 per year. A few Community Dental services and hospitals have funded candidates for this training to enable the development of services. Some funding for the training of dentists in this area has also been shared by dentists and Local Health Boards/hospitals/Community Dental units.

Dental nurse training in sedation has also been offered in Cardiff. This course had insufficient interest to run the course last year but may run this year. This training costs approximately £700, which is competitively priced, but may be perceived as a considerable amount to be borne by a general practice or nurse.

For sedation facilities to be developed and maintained, dentists and nurses will need to be trained in sedation. Within the strategic plans for the development of services, the mechanisms and funding models for training should be considered.

5.2.6 Smoking cessation training

Twenty five percent of the adult population in Wales smoke. Patients who smoke are more likely to have medical health problems and some patients with mental health problems, drug and alcohol dependency are also more likely to smoke than other individuals in the population.

Oral health is affected by smoking and smokers are more vulnerable to a range of oral health related problems such as periodontal disease and oral cancer. Some of the dental care workforce have received cessation training, but in many areas this has been an ad hoc rather than planned approach to this service. Furthermore, there is a lack of a joined up approach to wider smoking cessation in dentistry in some areas.

There are opportunities to help improve Special Care Dentistry patients’ oral health through smoking cessation. Although some areas have made some progress in these areas, there are many opportunities for the Special Care Dentistry team to develop skills in smoking cessation and to
develop links to smoking cessation services locally. This would contribute to the health and oral health of Special Care patients.

A strategic, planned and joined up approach to smoking cessation training and for dental teams caring for Special Care patients should be developed across Wales.

5.2.7 Workforce Development
Many patients with Special Care Dentistry needs are being seen in the general dental service. Patients with more complex dental and health needs can take longer to treat and the current general practice system does not have different rates of remuneration for cases that take longer. There are also no incentives for dentists to treat patients with Special Care needs and could discourage dentists from taking on patients with Special Care needs.

At present there are no financial incentives for a dentist to develop skills and become a dentist with special interest (DWSI). Furthermore, once accredited, DWSI’s are expected to undertake a considerable amount of ongoing professional development training.

With many rural areas of Wales needing Special Care Dentistry provision, the DWSI dentist could provide opportunities for cost effective, locally delivered care to Special Care patients.

Mechanisms for encouraging and rewarding dentists for developing skills and taking on patients will need to be considered during the development of the speciality.

5.2.8 Special Care Speciality Expertise

There is a Specialist Interest Group for Special Care Dentistry. As the role of consultants in Special Care develop in Wales, there may be possible opportunities for individuals to take leading roles in Wales for specific Special Care groups across Wales on a strategic level. On a more local level, managed clinical networks may also integrate and improve the planning of care delivery mechanisms.

Currently there is only one consultant in Special Care Dentistry with a specialist interest in older people’s care, AND one who is also on the specialist register for paediatric dentistry.

Managed clinical networks may provide a mechanism to include the necessary expertise for the planning and delivery of Special Care Dentistry.
Additionally, consideration should be given to identifying individual Special Care consultants as leads for specific patient groups across Wales. This would enable lead roles for training that are specific to the expertise of the consultants who could facilitate and develop the adoption of best practice for specific patient groups in Wales.

6 Information Systems

6.1 IT infrastructure

Anecdotal evidence relating to the Information Systems in each area was collected. Though this, it is clear that information systems and data collection systems are not universal or consistent across Wales. Services in West Wales are not using computer systems. This makes it difficult and time consuming to collect specific data relating to Special Care patients or monitor clinical service provision. Community Dental service IT systems have been further developed in some areas of Wales but at present, it is not possible to profile the needs of the patients across Wales with the current IT infrastructure. This makes planning for current and future needs or identifying individuals with Special Care Dentistry needs who are not being seen very difficult. North Wales have reported that with current developments, needs specific reporting will be available in the near future.

6.1.1 Data returns

Computer systems for the submission of data returns have been developed in the Community Dental Services in South East and North Wales. Some Community Dental Services in Wales do not yet have the information technology infrastructure to electronically collect Special Care data.

Where Community Dental Services collect Special Care Dentistry data, submissions are based on the British Dental Association Case mix tool. This tool has been developed to measure some of the complexity of Special Care patients needs. The quality of data produced from this system needs to be assessed in terms of usefulness in the planning of services and the time taken to retrieve data from the systems. Data to describe the profile of the population attending services and to contribute to the development and planning of services on an all Wales level could be agreed.

It is necessary for services dealing with the dental needs of Special Care patients across Wales to use consistent data. In order to do this a common Special Care dataset for planning and services needs to be agreed.
The Dental Practice Board computer system is inadequate in terms of collecting data relating to Special Care Needs of patients and there is no way to identify how many individuals are seen in general practice. Mechanisms to pay dentists working under general practice contracts may need to be considered as part of the development of the workforce; with this there will be an opportunity for Special Care Dentists help to data collection that will be useful for planning for the care needs of patients.

Data submissions for the payment and monitoring of dental care services for patients with special needs are necessary to enable the development and integration of Dentists with Special Interests in Special Care Dentistry in general dental practices.

6.1.2 Examples of additional data collection

Medical health checks for learning Disability groups follow a structured toolkit and now use “read coded” forms. This means that health data relating to individuals with learning disability are now consistent and are collected through an organised system. This allows the completeness of the health checks to be checked. It may also allow a developed understanding allowing health services to plan for the health needs of these patients.

6.2 Referrals

Effective allocation of the workload of Special Care Dentistry requires appropriate referrals and allocation of patients. At present, although there is a recommended structure for Special Care Dentistry, there are no set criteria outlining the patients who should be seen by a consultant, specialist or dentist with a special interest. Recommendation 1 of the Standing Advisory Committee Review of the Dentally based Specialities and Specialist Lists in 2004 stated that, “Clear guidelines should be set down to assist patients, practitioners, employing authorities and the Department of Health in differentiating appropriate levels of specialist expertise”. Further to this, recommendation 4 stated that “The delineation of roles in Special Care Dentistry will need to be communicated to health care professionals and the general public.”

6.2.1 Guidelines for referrals

At present, there are referral guidelines for services relating to Special Care Dentistry in Wales, however according to anecdotal evidence; many referring dentists do not consistently use these criteria, despite some services sending dentists referral information. Medical doctors and other health service professionals also reportedly refer some patients inappropriately or do not refer some patients who need care. Although evidence was not explicitly collected from medical doctors or other health
care professionals, it is likely that non dental professionals are unaware of when to refer and the criteria for referral for each Special Care Dentistry services.

From the anecdotal evidence collected, it is evident that are different services provided and different referral criteria used in different areas of Wales. Most of the Community Dental services receive inappropriate referrals, some of whom do not fit into the referral criteria of other specialist dental services but are beyond the competence of many General Practitioners. These patients can become passed between different specialists, non specialist dental service providers and the Community Dental services; the Community Dental services reportedly often take on these patients to minimise the impact of being passed from service to service. A shared understanding and criteria for treatment thresholds between the other dental specialities and Special Care Dentistry is necessary to improve the experience of these patients.

From the anecdotal evidence collected, there is some support amongst dentists for a central point of referral for Special Care Dentistry, with referrals being triaged to the required level of expertise. There is some divergence in views towards the direction of referrals in relation to consultants or specialists in Special Care. Some consultants expressed a wish to lead the process of triage, whereas some dentists favoured a process of upwards referral for patients as necessary.

Special Care Dentistry consultants need to develop consistent criteria for referrals based on local population need. An agreed approach to referrals may provide greater opportunities for appropriate care. However, consideration also needs to be made towards the management of patients who do not fit referral criteria. When the opportunity becomes available, this may include the future development of computerised referral systems.

6.2.2 Paediatric dentistry

Many patients with acquired and developmental Special Care Dentistry needs are cared for by paediatric dental services or by community dentists with expertise in the care of paediatric Special Care needs. These patients will become Special Care Dentistry patients at the age of 16; at this stage they may transition to a different service or continue within the same service, possibly with the same team of dentists. The transitions for these patients are important, particularly for patients with Learning Disabilities, who need to be well supported through changes.

Consultants will need to work with paediatric dental consultants in order to ensure optimal dental care before the age of 16, and to ensure smooth and complete transitions for these patients into adult services.
Referral and advice technology

Information Technology is advancing and the future use of technology to support Special Care Dentistry should be considered. Technology could be used to improve care services for patients and dentists seeing Special Care could use technological applications for referrals, advice and for joint consultation processes. Technology could be used to overcome some of the access issues of rurality in some areas and the costs incurred by patients, health services, social services and ambulance transport services by reducing the number of visits to Special Care services and reducing unnecessary referrals.
7 Key Findings

- Inequalities in access to and uptake of dental services exist for people with Special Care Dentistry needs in Wales; these inequalities are greater for older people
- Some patients who need Special Care may not be identified and may not receive care as a result of the current infrastructure.
- Data relating to Special Care Dentistry are poor, and are insufficient for robust planning and monitoring
- Consultant expertise and specialist training in Special Care Dentistry is concentrated in the South East of Wales
- In some areas, there are no dedicated vulnerable adult general anaesthetic lists, and Special Care patients can face unacceptable waiting times
- The funding for, availability of and uptake of additional training in Special Care Dentistry by general dentists or dental care professionals is not related to population needs

8 Conclusions

8.1 Multidisciplinary Strategies for Special Care Dentistry

A strategic approach is required in the development of Special Care Dentistry in order to address the inequalities in access to, and uptake of services. This is best achieved through joint working between the stakeholders, which include the providers of dental services, public health teams, social care teams, the Welsh Government, patients and patient representatives.

Referral and treatment pathways need to be as simple and unambiguous as possible to ensure that the clinical needs of patients are dealt with promptly and effectively. The development of all-Wales level referral and acceptance guidelines would assist this objective.

Defined processes to enable the transfer of information between authorities must to be established to ensure patient needs are met.

Planning a strategic level is needed to overcome access barriers and to ensure improved services to deprived rural communities. Examples include overcoming transport problems that prevent Special Care patients reaching services.

When the delivery of Special Care Dentistry is provided across different health services clear lines of responsibility and accountability are required. This is particularly important for general anaesthetic care provided for Special Care patients within hospitals.
8.2 Workforce and Service Development for Special Care Dentistry

During these early days within the development of their Speciality the newly appointed Consultants and Listed Specialists in Special Care Dentistry are in a unique position to lead the development of an integrated service approach to Special Care Dentistry. In order to achieve this, appropriate capacity has to be built up within all three of the dental services.

Managed clinical networks should be developed for Special Care Dentistry. Strategically placed “Centres of Special Care Dentistry Excellence” with leadership from a Consultant, could be set up in Wales to provide Consultant level expertise for this network and should function across Health Board boundaries.

Services delivering care to Special Care dental patients should meet clinical needs effectively using skill mix to optimise specialist resources e.g. if a patient requires sedation, but has no other physical or mental problems requiring additional care, then a dentist without broader Special Care skills, but capable in sedation, could provide treatment, even if that has to be within a wider Special Care plan. Using skill mix appropriately will ensure better access to and best use of specialist resources. Payment systems to reward dental teams using additional skills are necessary to maximise skill mix.

8.3 Technology and Data for Special Care Dentistry

Indicators for Special Care Dentistry and data sets for recording Special Care Dentistry activity need to be agreed.

Methods to use technology to improve access to Special Care Dentistry expertise and the effectiveness of care delivery need to be considered.

8.4 Workforce Development

Courses and programmes for the development of the Special Care Dentistry Workforce need ongoing development and support to meet the changing needs of the populations they serve. Teams from centres of Special Care Dentistry Excellence will need to support the planning, ongoing development and delivery of knowledge, training and experience to the dental workforce.

Many patients with Special Care needs may have some or all of their dental treatment in general practice and it is estimated that around three quarters of patients with Special Care needs who do see a dentist, are seen in practice. These patients in general practice may be referred for treatment when additional expertise is required. Special Care Dentistry courses, training and placements should be planned and implemented to meet the needs of the general dental teams and the communities they serve. Participation should be supported and encouraged.
A consultant or specialist with the necessary management expertise will be needed for each Centre of Special Care Expertise. This will enable specialist training and the development of Dentists with Special Interests to meet oral health needs across Wales. In the short term, Specialist training and the development of dentists with Special Interests will also need to be planned to replace outgoing staff with Special Care expertise and to meet patient care needs.
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