Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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Dental Branch
Annual Report

2003/2004

Foreword

This is the second Annual Report of Dental Branch.
Following comments from last year's Report, more detail has been incorporated into some of the sections. Generally these are work areas where Dental Services Group has the lead or holds the information. Increasingly, much dental data has been collected and we are aware that others are interested in this information.

Again, the Report is divided into the 3 work areas:

- Policy
- Referral Dental Service
- Prison service

The policy area has increased significantly over the past number of years. At the beginning of 2004 Michael Donaldson joined the Group, on secondment from QUB. This has strengthened and increased capacity to carry out reviews of services and contribute to the wider health agenda.

One of the highlights of the year was to joint host the meeting of the Council of European Chief Dental Officers (CEDCO). The CECDO moves around the European countries annually and an unexpected vacancy in host countries gave Ireland the opportunity to act as host. As there had been a meeting in Dublin several years ago, it was decided to hold a joint North/South meeting in Belfast. It was a very successful two-day meeting culminating in a dinner in Parliament Buildings.

The Referral Dental Service has experienced one of its busiest and most controversial years in attempting to run Positive Assurance on post-treatment claims. The complexity of the claims system and the diverse and poor record keeping of the profession has led to a rethink of the monitoring system.

The prison dental service continues to develop and modernise. The Magilligan site was contracted out to the independent sector and is working well. An evaluation of this contract will inform decisions on the future delivery of dental services at the other prison sites.

There is another full work programme planned for 2004/2005 which will take forward many of the projects detailed in the report.

Any comments on this annual report will be welcomed.

Doreen Wilson
Chief Dental Officer

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1. Background

Dental Branch is one of five Professional Groups within the Department. As the Chief Dental Officer, Mrs Doreen Wilson provides advice to the Minister, discharges functions on behalf of the Department, provides services for the wider NICS and delivers dental services to the Prison Service.

The main areas of work within Dental Branch are:

- Policy
- Dental Referral Service
- Prison Dental Service

The Chief Dental Officer (CDO) is a member of the Departmental Board and as such has a corporate role.
There is increasing multi disciplinary working throughout the Department and cross representation on all the major committees. Dental Branch endeavours to contribute to as many areas of health as appropriate and plays a full part in the corporate agenda of the Department.

Policy

Mrs Doreen Wilson (CDO), Mr Donncha O'Carolan (Policy Officer), Mrs Jennifer McAdams (PS), Mr Liam McGuckin (EO II, appointed 29 March 2004), Michael Donaldson (Specialist in Dental Public Health – on secondment).

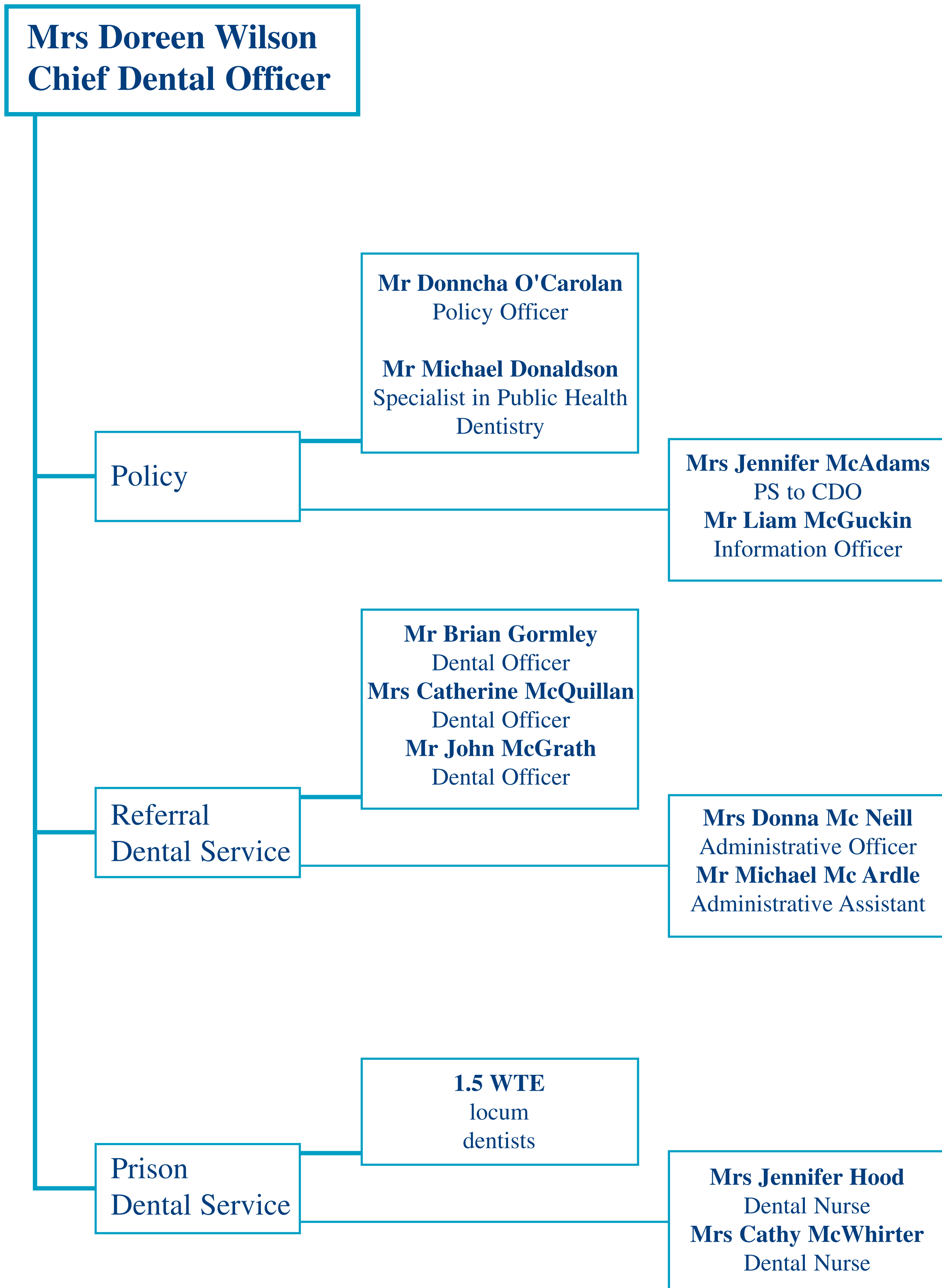
Referral Dental Service

Mr Brian Gormley (Dental Officer), Mr John McGrath (Dental Officer), Mrs Catherine McQuillan (Dental Officer, appointed February 2004), Mrs Donna McNeill (AO), Michael McCardle (AA) on loan from Personnel Branch.

Prison Dental Service

1.5 WTE locum dentists, Mrs Jennifer Hood (Dental Nurse), Mrs Cathy McWhirter (Dental Nurse).

Staffing Structure



2. Policy

CDS Review

The Review of the Community Dental Services was completed in May 2003. The final report was cleared for publication in September 2003. Owing to the purdah period during the assembly elections, consultation was delayed until December 2003 to March 2004.

The terms of reference of the Review required:
- An assessment to be made of the current status of the CDS
- The future role for the service to be set out
- An action plan to be drawn up to take the service forward.

Currently, the core functions of the CDS are:
- The provision of dental care for those individuals unable or unwilling to obtain care through the General Dental Services
- Screening of school children for dental decay
- Delivery of oral health promotion to groups with poor oral health.

The Review made 17 recommendations. The core recommendation of the Review is that a CDS Corporate Plan should be drawn up so that clear, quantifiable aims and objectives for the service are produced. The Review also recommended that special needs patients should be the focus for clinical activity in the future.

The 17 recommendations have been assigned to six action plans:

- Corporate Plan
- Information Management
- Staff Issues
- Research/Best Practice
- Clinical Governance
- Oral Health Promotion

It is envisaged that six working groups will take these forward following the end of the consultation. Around 500 review documents were sent out for consultation to a wide range of stakeholders. A proforma was enclosed with the Review document in order to focus the comments and observations of the respondents on the key areas of the Review.
The responses will be collated and it is proposed that working groups will be set up, in late 2004, to take forward the recommendations.

Oral Health Strategy (OHS)

Northern Ireland's first OHS was published in 1995 in the expectation that there would be fluoridation of the public water supply. When it was decided that fluoridation would not proceed, the initial targets were revised in 1998. A Mid Term Evaluation was published in 2001 and a further revision of some of the targets took place. Whilst there had been a demonstrable improvement in the overall standards of oral health the Mid Term Evaluation identified areas where there was little or no improvement in oral health. This was particularly

noticeable in primary school children and especially related to areas of social deprivation. The final evaluation of the 1995 OHS was due to take place in 2005 but several factors dictated that a new OHS needed to be developed before this date.

- The 1995 OHS was developed in the expectation that fluoridation of the public water supply would take place. A new OHS will need to meaningfully address the unacceptably high levels of oral disease and dental health inequalities that persist in our population.
- The development of a new OHS will provide the context for a new strategy for primary care dental services
- As there will be new contractual arrangements for the delivery of primary care dental services in England and Wales after April 2005, Northern Ireland, along with Scotland, will no longer be part of the national General Dental Services contract. New contractual arrangements for the GDS in Northern Ireland will need to be developed in the context of the levels of dental disease here.

In view of these factors, the CDO decided to adopt the following approach:

1. Bring forward the Evaluation of 1995 OHS
2. Develop a new OHS
3. Develop a strategy for the delivery of Primary Care Dental Services

1. Evaluation of 1995 OHS

The Steering Group from the Mid Term Evaluation was reconvened under the chairmanship of Heather Clarke, Consultant in Dental Public Health, SHSSB. This report will help support the scoping and baseline exercise for the new OHS.

2. New OHS:

The objectives of the new OHS are:

- Identify the oral health needs of the population
- Determine the desired outcomes for the next ten years
- Produce a dental public health plan for the next ten years.
- Identify target groups to address social need and oral health inequalities
- Identify groups with special needs

Areas to be covered by the new OHS

- Current state of oral health in Northern Ireland
- Fluoridation
- Epidemiology and demographic trends in Northern Ireland
- Needs of population groups

Timescale for the project is January to June 2004. A steering group, chaired by CDO, was convened in January 2004. A project manager has been seconded and it is planned that the final report will be available by June 2004.

To help inform the strategy, a survey of 1000 users was undertaken by an independent research company in January 2004 and produced a report in March 2004. In addition contact has been made with a wide range of user representative groups to further inform the project.
A series of workshops, aimed at the whole team were undertaken in March to garner the views of those in attendance.

Delivery of Dental Services

Initially it had been planned to develop a strategy for the delivery of dental services alongside the OHS. However, The Departmental Board recommended a sequential approach to the development of an OHS and the Strategy for the Delivery of Primary Care Dental Services. It argued that the OHS was much wider than the delivery of dental services and formed part of the public health agenda. The outputs from the Oral Health Strategy would subsequently inform the strategy for delivering dental care.
The drivers for a strategy for delivering dental services are:

- The effective implementation of the new OHS will be reliant on effective delivery mechanisms if the oral health needs in Northern Ireland are to be met
- New contractual arrangements come into force in 2005 for the delivery of General Dental Services (GDS) in England and Wales. This will be the first time since the inception of the NHS that Northern Ireland has not been part of a national GDS contract. It will be important, therefore, to have a strategy in place that can help inform the most appropriate method of delivering the necessary dental services to the public and for remunerating dentists in the future.

It is planned to start on the delivery strategy in the autumn of 2004.

PCD Review

September 2003 saw the commencement of the first ‘Review of Workforce Planning for the Professions Complementary to Dentistry’ to be carried out in Northern Ireland. Responsibility for the Review fell to the Human Resources Directorate within the Department but the steering group largely comprised dental team members from a variety of backgrounds. Capita Consulting were commissioned by the Department to conduct the Review.

The main objectives of the Review were:
- Provide an analysis of the current PCD staff in Northern Ireland
- Provide an analysis of current and future recruitment and retention issues
- Provide a prediction of future demand
- Provide recommendations whereby services could be commissioned and delivered optimally.

The proposed outcome of the project was to produce a report that would:
- Predict the number of PCD staff that will be required over the next 5-10 years
- Produce a model that can be applied to predict trends in the supply and demand of PCD staff
- Identify current and indicative future trends in the development of these services.

The project ran from September 2003 to January 2004 and the information gathering included desktop research, focus group meetings, postal questionnaires, face to face and telephone interviews. Publication of the final report is due in summer 2004.
This Review of the PCD workforce is both timely and strategically important given the impending mandatory registration of PCD's. Further work in relation to the provision of dental nurse training in Northern Ireland is currently underway in order to address the likely increase in demand which will follow on from the requirement for mandatory registration.

Update on Workforce Review

The first Dental Workforce Review in Northern Ireland was published in November 2002. While responsibility for the Review fell to Human Resources Directorate (HRD) within the Department, Dental Branch had a substantial input into the Review. Further work on the Review document was required in 2003. Firstly, in line with all the other workforce reviews recently undertaken by the Department, a condensed booklet version was drafted by Dental Branch and HRD staff and the ensuing publication was widely circulated to the profession and other key stakeholders. Secondly, again in line with the process of other workforce reviews, the workforce review steering group was reconvened in November 2003. The purpose of reconvening the group was to challenge the assumptions and predictions made in the initial review, to consider the recommendations made in the initial review and to look at additional issues affecting the dental workforce.

The main outcomes of the review meeting were:
- A recognition that the figures in relation to the workforce in general dental practice contained in the initial review were a 'first cut' and refinement was needed to improve the quality and accuracy of the data held for the workforce in this sector.
- There is a need to agree a formal method of collection of workforce data, standardised across the workforce, which is collated and analysed centrally.
- Provision of career pathways should be included as a recommendation in the report.
- Further work is required on the specialist workforce.

A working group is currently progressing the recommendations in the original report along with the actions that arose from the review meeting.
The steering group will continue to meet annually to monitor progress and further advise on dental workforce issues.

Priorities for Action

Dental Priorities for Action (PfA) were included in the Primary Care and Child Health priorities.

Within the Primary Care context the dental priorities were:
- Trusts should ensure the adoption and full implementation of regional guidelines on school dental inspections with effect from the school year beginning September 2003. First returns should be sent to the Department by March 2004 and thereafter quarterly.
- Boards and Trusts should work with general dental practitioners towards a target of 30% of 2 year olds and 68% of 3-5 year olds being registered with general dental practitioners by 31 December 2003.

Within the Child Health context the dental priority was:
- Boards and Trusts should ensure that any child experiencing dental pain who is referred for dental treatment under general anaesthetic should have their pain relieved, by the most appropriate method, within one week of referral.

Screening guidelines

In Northern Ireland it is a statutory requirement for children to receive a dental screening at least three times during their school years. Although Trusts always met and often exceeded this target, the screening methodology used varied widely. In recent years there has been a realisation that in order to maximise the usefulness of oral health data obtained from the school dental screening programme a standardised approach was needed. In 2001 and 2002 the Department, Boards and Trusts in collaboration produced guidelines for a standardised school dental screening programme. This was at least partially implemented by all Trusts in the 2002-3 school year and fully implemented in the 2003-4 school year. All Trusts sent returns for 2002-3 to the Department by March 2004.
Dental Services Group was able to use this data to produce Northern Ireland figures for:

- The average number of teeth per child affected by dental decay for P1, P2 and P7 classes.
- The proportion of P1, P2 and P7 children with decay experience.

These analyses of the school screening data has been sent down to each Trust to allow comparison of local oral health with the national figures.

Registration
The inclusion of this PfA was in response to recommendations 2 & 3 of the Mid Term Evaluation of the 1995 Oral Health strategy, which set these registration targets for the 0 –2 and 3 –5 age groups.

December 2003 Dental Registrations

Location	0 to 2 year olds						3 to 5 year olds					
	Medical Registrations	Dental Registrations	Registration Rate (target 30%)	No. needed to raise rate to target	Improvement In Rate	% of Unregistered needed to meet target	Medical Registrations	Dental Registrations	Registration Rate (target 68%	No. needed to raise rate to target	Improvement In Rate	% of Unregistered needed to meet target
EHSSB	21,481	5,906	27.5%	538	0.9%	3.5%	25,068	15,282	61.0%	1,764	2.5%	18.0%
NHSSB	14,814	4,104	27.7%	340	2.9%	3.2%	17,031	11,364	66.7%	217	1.1%	3.8%
SHSSB	12,390	3,127	25.2%	590	1.6%	6.4%	13,976	8,863	63.4%	641	3.8%	12.5%
WHSSB	10,756	2,567	23.9%	660	0.6%	8.1%	12,576	7,524	59.8%	1,028	2.9%	20.3%
ZZZZ	298	57					404	218				
N.IRELAND	59,739	15,761	26.4%	2,161	1.4%	4.9%	69,055	43,251	62.6%	3,706	2.5%	14.4%
EHSSB	21,481	5,906					25,068	15,282				
DOWN&LISBURN	6,290	1,746	27.8%	141	1.9%	3.1%	7,429	4,503	60.6%	549	2.3%	18.8%
N&W BELFAST	4,997	1,145	22.9%	354	2.3%	9.2%	5,844	3,189	54.6%	785	2.2%	29.6%
N. DOWN&ARDS	4,645	1,437	30.9%	0	-0.2%	0.0%	5,430	3,512	64.7%	180	5.1%	9.4%
S&E BELFAST	5,549	1,578	28.4%	87	-0.8%	2.2%	6,365	4,078	64.1%	250	0.6%	10.9%
NHSSB	14,814	4,104					17,031	11,364				
CAUSEWAY	3,260	836	25.6%	142	5.4%	5.9%	3,852	2,627	68.2%	0	1.9%	0.0%
HOMEFIRST	11,554	3,268	28.3%	198	2.1%	2.4%	13,179	8,737	66.3%	225	0.9%	5.1%
SHSSB	12,390	3,127					13,976	8,863				
ARMAGH & DUNGANNON	3,949	1,025	26.0%	160	-0.5%	5.5%	4,497	3,075	68.4%	0	1.9%	0.0%
CRAIGAVON & BANBRIDGE	4,522	1,175	26.0%	182	0.6%	5.4%	5,068	3,227	63.7%	219	4.7%	11.9%
NEWRY & MOURNE	3,919	927	23.7%	249	5.0%	8.3%	4,411	2,561	58.1%	438	4.5%	23.7%
WHSSB	10,756	2,567					12,576	7,524				
FOYLE	6,446	1,197	18.6%	737	0.6%	14.0%	7,564	4,115	54.4%	1,029	4.8%	29.8%
SPERRIN LAKELAND	4,310	1,370	31.8%	0	0.5%	0.0%	5,012	3,409	68.0%	0	-0.3%	0.0%
ZZZZ	298	57					404	218				

ZZZZ = unknown Health Board and/or Trust
Health Board is derived from the home address postcode of the patients. Local Government Districts are based on the 1992 boundaries.
Only Live Valid dental registrations where the patient also has a medical registration are considered.
A small number of dental only patients have been excluded from the results
Improvement in rate refers to change since February 2001

General Anaesthetic (GA) Action

The driver behind this PfA was new guidelines issued in July 2000 ('A Conscious Decision') following a review of the use of general anaesthesia and conscious sedation in primary dental care by the Chief Medical Officer and Chief Dental Officer in the Department of Health in England. This resulted in removal of general anaesthetic services from all clinical sites that did not have critical care facilities in December 2001.
The Department allocated £2M extra funding to the Boards to commission additional GA services. The vast majority of dental general anaesthetics provided in Northern Ireland are for extraction of teeth in young children. The Department was keen to ensure that patients who were referred with dental pain did not have to wait longer than one week for relief of their symptoms. While this requirement put the Community Dental Services under increased pressure, feedback from the Trusts indicates that this PfA has been substantially achieved.
The table below outlines the GA activity in Northern Ireland in 2003/04. Just under 8000 dental GA's were undertaken, with over 33,227 dental teeth extracted.

	NHSSB	**WHSSB**	**SHSSB**	**EHSSB**	**NI**
Total number of GA sessions carried out	AAH 72 MUH 46 COL 77	EH 48 TC 92 Foyle 123	C 44 DH 101 ST 46	RBHSC 79 UHD 142 DLT 86 MIH 90	
TOTAL	**195**	**263**	**191**	**397**	**1046**
Number of cases	AAH 387 MUH 241 COL 559	EH 195 TC 331 Foyle 985	C 379 DH 991 ST 274	RBHSC 987 UHD 1094 DLT 558 MIH 841	
TOTAL	**1187**	**1511**	**1644**	**3480**	**7822**
Average case/session	AAH 5.38 MUH 5.24 COL 7.26	EH 4.06 TC 3.59 Foyle 8.0	C 8.61 DH 9.81 ST 5.96	RBHSC 12.4 UHD 7.7 DLT 6.5 MIH 9.3	
Teeth extracted: Permanent	AAH 140 MUH 167 COL 196	EH 93 TC 104 Foyle 247	897	RBHSC 463 UHD 510 DLT 290 MIH 878	
Deciduous	AAH 1926 MUH 949 COL 2417	EH 720 TC 1259 Foyle 3801	5915	RBHSC 4019 UHD 4911 DLT 1979 MIH 3487	
TOTAL teeth extracted	**5795**	**6224**	**6812**	**14396**	**33227**
Average number of teeth per patient	AAH 5.34 MUH 4.63 COL 4.67	4.12	4.39	RBHSC 4.54 UHD 4.90 DLT 4.06 MIH 6.10	

AAH Antrim Area Hospital
MUH Muckamore Hospital
COL Coleraine Hospital
EH Erne Hospital
TC Tyrone County Hospital
Foyle Altnagelvin Hospital
C Craigavon Area Hospital
DH Daisy Hill
RBHSC Royal Belfast Hospital for Sick Children
UHD United Hospitals Dundonald
DLT Down & Lisburn Trust
MIH Mater Infirmorium Hospital

Dental Hospital

SUMDE

The Department continues to contract for analysis of the use of funding which is allocated to the Dental Hospital to enable undergraduate teaching to take place (Supplement for Undergraduate Medical and Dental Education).
The Belfast Dental Hospital is benchmarked with Glasgow and Dundee dental hospitals. The collection of data from the Dental Hospital is being refined each year and has led to a better understanding of the cost of undergraduate clinical teaching.

Management Restructuring

The previous management structure within the School of Dentistry reflected the dual roles of the establishment, namely clinical services and training of dental students. Thus, there was a Head of School on the University side and a Clinical Director on the Trust side. When the posts came up for renewal in September 2003 it was decided to combine the posts and Dr Donald Burden was appointed as joint Head of School/Clinical Director. He has set up a new senior management team within the Dental Hospital.

In January 2004 a new series of regular meetings was set up involving the Dental Hospital, the 4 HSSB Dental Directors and the Chief Dental Officer. This forum offers the opportunity for management from the Dental Hospital to discuss their current priorities with the HSSB's and Department, and for all concerned to work together to improve the service the Dental Hospital provides to Northern Ireland as a region.

Learning Disabled

One of the targets within the dental branch business plan is to develop a strategy for dental services for the learning disabled. With the development of the new OHS and the impending Delivery of Dental Services Strategy, it was decided to incorporate learning disabled issues into the relevant areas of these strategies in order to ensure full integration of the oral health needs and service delivery issues for this group of patients.
The Chief Dental Officer (CDO) convened a working group in January 2004, under the chairmanship of the Dental Director from EHSSB, of dental health care providers who have a key role in the provision of dental services for the learning disabled.

This working group has two main tasks:

1. Identify spare capacity within the HPSS throughout Northern Ireland in order that patients may be treated as soon as possible and waiting lists reduced.
2. Look at developing the service and plan for the future.

Dental care for the learning disabled is provided province-wide by the Community Dental Service (CDS), at Trust level, and more complex cases are treated by specialist staff in the dental hospital at the Royal Group of Hospitals (RGH). The working group has made progress on cleansing the waiting list at the Dental Hospital, improving linkages across Trust

boundaries in order that any spare capacity is quickly identified and made best use of, and is currently identifying sites outside the RGH which may be able to provide dental services for those learning disabled patients that require dental care in a hospital setting.
These short to medium term measures coupled with the long-term measures being developed in the various dental strategies (including those recommendations which fall out of the CDS Review) should ensure a much improved and efficient service for learning disabled patients in the future.

Away day Workshop

Following on from two successful workshops in 2002/03, The Chief Dental Officer organised a two-day workshop in the Manor House Hotel, Killadeas, County Fermanagh. The rationale behind these workshops is to discuss, in detail, priority areas of policy and to emphasise and encourage regional working among the key stakeholders.
Attending this workshop were Dental Branch DHSSPS policy staff, Referral Dental staff, HSSB Dental Directors, HSSB Dental Practice Advisers, CSA Dental Director, Primary Care Directorate Policy Staff.

The issues covered at this workshop included:
- CDS Review
- Final Evaluation of 1995 OHS
- New OHS
- Delivery of Dental Services Strategy
- Positive Assurance
- Quality Improvement Money
- Primary Care Strategy
- Regional Practice Inspection Protocols
- Sedation
- Record Cards
- Under Performing Dentist.

Celtic RDO/DPA Conference

January 2004 saw the first Celtic Referral Dental Service (RDS)/ Dental Practice Adviser (DPA) conference to be held in Northern Ireland. The conference was organised by Dental Branch DHSSPS as a follow up to the January 2002 conference held in Dunkeld, Scotland. The theme of the conference was ‘The Underperforming Dentist’ and had been identified by dental staff from the DHSSPS (NI) and Department of Health in Scotland as an area which merited further discussion.

The aims and objectives of the conference were:
- To define what we mean by under performance
- To identify appropriate indicators of under performance
- To provide an update on current methods of detection of under performance and make recommendations on how they can be improved
- To provide an update on systems for dealing with underperformance and produce an action plan for their implementation.

The conference was held on 15/16 January 2004 in the Templepatrick Hilton Hotel. 45 Delegates from Northern Ireland and Scotland took part including Referral Dental Officers, Dental Practice Advisers, Dental Directors, Dental Probity Officers and CSA Dental Officers. The Chief Dental Officer from Northern Ireland and the Deputy Chief Dental Officer from Scotland attended.

The conference format comprised a series of presentations and workshops given by representatives from Referral Dental Service, Dental Practice Advisers, Dental Probity Officers, Health Boards, General Dental Council (GDC), Medical and Dental Defence Union of Scotland, NHS Education Scotland and Queens University Belfast.

Two workshops were held. The first one looked at the definition of under performance, indicators used in detection of underperformance and interagency working. The second workshop looked at systems for dealing with under performance.

Among the outcomes from workshop one was an aspiration for centralised monitoring, enhanced early detection, improved communication (including IT linkages) across administrative/agency boundaries and across all branches of the profession and a requirement that patient protection is given the priority it deserves.

Some of the necessary elements of a model system for dealing with underperformance which emerged from workshop two were: a need to look at selection procedures for undergraduates and an exit strategy for poorly performing students; the system should allow for informal non-threatening contact where appropriate; a need for local schemes (such as PASS schemes) which are properly resourced and with appropriately trained staff; a filtering mechanism to deal with various aspects of underperformance and to refer on appropriately and a mechanism to provide patient support and a requirement that any system must have the support of the profession.

Evaluation of the conference was very favourable and a follow up report was produced and circulated to all delegates and professional representatives.

Newsletter

The Branch Newsletter, entitled ‘CDO News’, launched in December 2002 became an established quarterly publication in 2003. Distribution lists and channels were further developed to ensure wide dissemination throughout the profession and to other key stakeholders. Dental Branch has endeavoured to cover a wide range of issues throughout the year in order to reflect and maintain the interest of the wide target audience.

Feedback on the newsletter has been very positive and has, on occasion, generated constructive debate on some of the issues raised. It continues to be a valuable communication conduit to the profession.

It is hoped to make the publication available in electronic form as part of the development plans for our web site in the coming twelve months and to increase the circulation.

GDC

The GDC is the regulatory body of the dental profession. It registers dentists, hygienists & therapists; sets standards; quality assures dental education and monitors Continuing Professional Development.
The 4 UK Chief Dental Officers are non-voting associate members of the General Dental Council. They have a seat on various committees of the General Dental Council. The Northern Ireland Chief Dental Officer sits on the Governance Group, the Registration Committee and the Fitness to Practise Committee.

NICPMDE/NIMDTA

New Agency
During 2003/04 Human Resources Directorate within the Department facilitated the move of the Postgraduate Council from its' present status to that of a special agency. A working group was set up within the Department to oversee this change and dental branch provided professional input. The new Body will be called Northern Ireland Medical and Dental Training Agency (NIMDTA).
While the Agency will continue to undertake the postgraduate education and training of doctors and dentists in Northern Ireland, there will be significant changes to the structure of the Board of the Agency. The Board of NIMDTA will comprise a non-executive chair and five non-executive members. Of the five non-executive members, three will be lay, one will be from a medical background and one will be from a dental background.

Sub Committees
The CDO has provided professional input into the Committee on Vocational Training (CVT), General Dental Practice Committee and Hospital Committee of NICPMDE throughout the year. In addition, a series of regular meetings were held between the dental staff from NICPMDE, CDO and the Dental Directors.

General Professional Training
August 2003 saw the introduction of Northern Ireland's first General Professional Training (GPT) scheme for new dental graduates. The scheme is a two-year longitudinal scheme involving placements in general dental practice, community dental services and hospital dental services.

Other Committees Which Dental Branch Inputs Professional Advice

- Best practice Best Care Steering Group
- Care Standards sub group
- Clinical & Social Care Governance sub group
- Standards and Guidelines Unit sub group
- Safety in Health & Social Care Steering Group
- Records management Steering group
- Regional Decontamination Working Group
- Smoking Cessation Working Group
- Consent Working Group
- Departmental Emergency Management Group
- Central Dental Advisory Committee (CDAC) and Hospital Services sub committee

3. Referral Dental Service (RDS)

The RDS monitors the quality and probity of health service dentistry in Northern Ireland. This role is carried out on behalf of the four Health Boards who have contracted with dentists in their area to provide health service dentistry. The system of monitoring underwent a significant change in 2003/04 with the introduction of positive assurance.

Positive Assurance

Background

Health and Social Services Board Chief Executives are required to provide assurance regarding their spend on General Dental Services, in keeping with all other areas of Board expenditure. The issue of probity in family practitioner services was the subject of a report by Comptroller and Auditor General for Northern Ireland in the late 1990s. The need to strengthen monitoring was subsequently highlighted in a report by the Public Accounts Committee (PAC). It was on the back of this adverse PAC report that the need for post payment verification (PPV) in the general dental services (GDS) was necessary.
Guidance was issued to the four HSSB's and CSA in July 2000, HSS (F) 26/2000, from the Department in relation to the implementation of PPV. The Boards were to liaise with their local dental committees (LDC's) on agreed local arrangements for PPV including practice visits. Significant obstacles were encountered in negotiating acceptable arrangements and the issue returned to the Department in 2001. The Department then negotiated with the dental practice committee (DPC) which proposed an enhanced RDS. This proposal was discussed at length and after consideration it was decided to develop this model in order to have an acceptable regional system in place by April 2003.

Planning

In furtherance of developing a regional model for positive assurance, a dental positive assurance implementation group was set up in the Department in December 2002. The objective of this group was to develop an agreed regional approach to obtaining positive assurance on GDS payments, based on substantive testing of a random selection of claims for a practitioner and the calling in of all patient records and any other documentation necessary in order to substantiate those claims. The implementation group comprised the four dental directors, dental director CSA, finance staff from the four Boards along with finance and dental staff from the Department. The planning timetable was as follows:

i. **29/11/2002**; letter from Andrew Hamilton, Director of Finance DHSSPS, to Chief Executives of HSS Boards updating re proposed arrangements for gaining positive assurance on GDS expenditure and seeking nominations for membership of implementation group.

ii. **09/12/2002**; first meeting of positive assurance implementation group including discussion on draft terms of reference (TOR), substantive testing approach, roles of various stakeholders, sampling and evidence of service provision.

iii. **16/12/2002**; meeting of Finance Management Directorate with CSA Information and Research Unit to discuss sampling and trends and analysis of GDS spend.

iv. **13/01/2003**; second meeting of implementation group including discussion on sampling, proposed model for implementation and action plan

v. **24/01/2003**; draft list of items to secure evidence of service provision drafted by Ivan McCappin and emailed to four Board Dental Directors and Dental Services Group DHSSPS for comment.

vi. **29/01/2003**; meeting of Dental Services Group with Information and Analysis Directorate to discuss sampling

vii. **03/02/2003**; meeting of Dental Directors and dental policy officer (DHSSPS) to further develop list of items to secure evidence of service provision

viii. **13/02/2003**; Letter from Andrew Hamilton to Chief Executives of HSS Boards outlining implementation of positive assurance and requesting confirmation of Boards acceptance of the proposal by 21/02/2003

ix. **03/03/2003**; updated list of items to secure evidence of service emailed to all Board Dental Directors for final comment.

x. **07/03/2003**; Letter from Dental Services Group to four Board Dental Directors outlining list of items to secure evidence of service (in the absence of these items fee recovery may occur) along with a request for Dental Directors to arrange information evenings for their practitioners. Communication to the profession via CDO News and MDS 630 outlined the requirements of clinical records in relation to GDS regulations.

xi. **28/03/2003**; circular HSS (F) 2/2003, 'Securing Positive Assurance on HSS Board General Dental Services Expenditure' issued from Andrew Hamilton to HSS Boards and CSA (to be reviewed for 2004/05). This circular superseded HSS (F) 26/2000.

xii. **14/03/2003**; consolidated list of positive assurance verification data (items to secure evidence of service) and a more detailed list of frequently occurring Statement of Dental Remuneration (SDR) items sent to Board Dental Directors.

xiii. **15/05/2003**; DPC apprised of new arrangements for Positive Assurance. The main concern raised at the meeting was the issue of secure postage for transit of original patient records.

Communication with Profession

An important element in the introduction of the new system was communicating with the profession and this was achieved in the following way:

A. CDO News, Spring 2003, featured a two-page article on frequently asked questions on positive assurance. This Newsletter was posted to all general dental practitioners on the GDS list with the **March 2003** pay schedule.

B. MDS 630 ‘Clinical Records and GDS Regulations’ issued on **19/02/2003** and amended version issued on **20/03/2003**.

C. Letter from Chief Dental Officer to all GDPs on the GDS list issued on **24/03/2003**. Letter outlined the background to positive assurance and the obligations placed on the practitioner under the new system.

D. Information pack from the Referral Dental Service issued to all GDPs on the GDS list on **11/04/2003**. This correspondence detailed the operation of the positive assurance system and included a copy of MDS 630 (Clinical Records and GDS Regulations), a checklist of those items required by the RDS prior to patient examination and a copy of the new D 4T form. A contact telephone number was also supplied for those practitioners who required additional information. This information pack was also sent out to those practitioners who had patients called when the system became operational.

E. A consolidated table of positive assurance data (items to secure evidence of service) and a more detailed table of frequently occurring SDR items was sent to all LDC secretaries and chairman of DPC **(18/04/2003)**.

F. WHSSB Dental Director facilitated an information evening on positive assurance on **20/05/2003**. A presentation was given by one of the RDO’s and dental staff from the Department and CSA along with WHSSB Dental Director participated in a follow up Q&A session.

G. Presentation on positive assurance to the Eastern LDC meeting on **16/09/2003** by RDS.

H. Presentation on positive assurance to the new starts day on **19/09/2003** by RDS

I. Presentation on positive assurance to the Southern LDC on **23/10/03** by RDS

J. Presentation on positive assurance to the Northern LDC on **06/11/2003** by RDS

K. Articles in CDO News Autumn 2003, detailing the operational procedures involved with the new system, and Winter 2003, outlining frequently encountered problems with records submitted for positive assurance and outlining dentists’ obligations under GDS terms of service in relation to record keeping.

Implementation

Unlike the previous system, the new system would result in **all** claims generating a positive assurance report as well as an RDO report for those patients who attended for examination. In conjunction with the Information and Research Unit CSA, a form was developed which would contain all the information which appeared on the claim and would allow the RDO’s to record whether these items were present on the record cards and on examination if appropriate. These forms would then be forwarded to the relevant Dental Director who would, based on the information gathered, decide whether the claim could be positively assured.
In addition new D 4T forms and check list forms needed to be designed and printed. The Dental Referral IT system required an enhanced specification in order to trace record cards and record additional information.
As original patient record cards were to be submitted to the RDS, the whole issue of secure postage had to be addressed. Advice from the postal service was that their Special Delivery service was the most secure method of ensuring safe passage of patient records. A contract for prepaid special delivery was secured with the Royal Mail.

Operational Issues

The first requests for submission of dental records for the purpose of positive assurance were sent out in August 2003, the first clinical examinations taking place in early September 2003. The major difference with the new system was the more detailed scrutiny involved in examining the record cards for all claims sampled and reconciling these with the payment claims before the examination session. With the first tranche of record cards called, there were immediate problems identified and some of these persisted throughout the entire period of the project.

The following problems were encountered:

Record Keeping
The overall standard of record keeping was extremely poor. The main problems encountered were:

- Poor legibility
- Incomplete records
- Computerised records with insufficient information
- HS45 PR Forms either absent or inadequately completed (required to verify EDI claims)

With so much information missing from the records, the RDO's held several meetings with the Dental Directors to verify what they would deem as acceptable. This need for clarification resulted in record cards being held at the Department for a much longer period than expected in the initial months.

Workload
The increased workload involved in individually scrutinising each record card and reconciling these with the payment claims was much more than expected. This was primarily due to the very poor standard of the records (discussed below). To address this problem the number of clinical sessions had to be dramatically reduced.
In addition, every record card, form, claim and any other correspondence from the dental practices had to be photocopied in order that supporting documentation could be held at the Department and forwarded to the Boards, as the original records required to be returned to the dental practices.

Postage
Prepaid special delivery is not a common method of postage in Northern Ireland (postage of the Transfer Examination results is the only other time is has been used in Northern Ireland) and despite assurances from the Royal Mail, lack of familiarity with the system at certain post office counters led to practitioners being incorrectly charged for the service. Arrangements were made to reimburse those practitioners who were charged. Within the first few months of the system this problem was largely rectified (less than 40 cases were encountered during the 10 months of the scheme).

Ongoing Monitoring

Throughout the months September to March 2003, numerous meetings were held with the Board Dental Directors, CSA and Departmental Finance staff to facilitate refinement of the scheme to overcome the problems encountered.
Although negotiations on setting up the scheme had encouraged a regional approach by the Boards on taking action the reports, the 4 HSSB's acted on the positive assurance findings in a variety of ways.

End of Year Review

Ongoing monitoring of the scheme throughout the year had highlighted the following problems:

- The poor quality of the record keeping made it difficult to reconcile dental records with the claims and to adhere to the original criteria in circular HSS (F) 7/2003 ' For each claim selected, the corresponding dental records will be expected to contain all the necessary details to verify the claim. The necessary details are those defined in GDS Regulations and the Statement of Dental Remuneration'. This problem was compounded by the complexity of the SDR which contains almost 400 treatment items, the narrative of which can, at times, be ambiguous
- The style of the patient record card and the numerous forms used to claim payment allow many interpretations as to what constitutes a complete record.
- Dentists submitting electronic claims are required to complete a HS45 PR form. This was frequently not present or not completed
- The emphasis of the RDS shifted from a quality to a probity focus, which had an immediate impact on the assurance of patient quality of care
- The calling in of original patient records led to dentists being without their records for a minimum of 2 weeks. Once received at the Department, a strict protocol had to be followed to ensure the safe return of these records
- The work of the RDO's shifted from clinical examinations to desktop work.
- With the necessary drop off in clinical sessions (down 25%), the number of patients examined dropped off by 43%.
- There was no regional approach by the Boards leading to a variety of follow up actions.
- Follow up on the reports was slow, often taking over 6 months before a reply was received by the Boards/CSA
- Despite much communication before the introduction of the scheme, the inclusion of PA with the RDS led to confusion among the profession. This was particularly noticeable in the follow up where practitioners were unsure whether to reply to the CSA or Boards
- The new sampling technique at the CSA lead to a higher failure to attend rate at the examination sessions as many of the patients were very young, old or had no treatment carried out.
- A lack of a compatible database to transfer dentist/patient details between CSA, DHSSPS and the HSSB's led to an increased volume of paper work for all.

There were some advantages noted in the new system:

- The new sampling technique allowed a much wider spread of the GDS global sum to be assured
- A larger number of claims were examined and in greater depth than before
- Many areas of risk, not apparent under the old system, were identified; e.g. EDI submissions not verifiable, inappropriate claiming of items such as higher examination fees and periodontal treatments
- The poor standard of records led to region wide training for dentists in best practice in record keeping. Computerised records were a particular concern which, without PA, would not have been detected.
- Weaknesses in the follow up of problem claims have been identified and will require action by RDS, CSA and Boards to tighten procedures.

Data Analysis

Table 1.

PRE POSITIVE ASSURANCE Feb '03 to Aug '03	*POST POSITIVE ASSURANCE* Sept '03 to Mar '04	*% Change*
No. of Sessions of Clinical Examination		
112	**84**	**25% ↓**
No. of Patients called for Examination		
2607	**1900**	**27% ↓**
No. of Patients Examined		
1102	**632**	**43% ↓**
No. of Clinical Record Cards Examined		
0	**1900**	**190000% ↑**

This table shows how the work pattern of the RDS shifted from clinical examination to desk top in the first 7 months of PA compared to the previous 7 months under the old monitoring arrangements. The number of clinical examinations dropped by 43% while the examination of records rose dramatically.

Table 2.

CODE BY BOARD								
	PRE POSITIVE ASSURANCE Feb '03 to Aug '03				POST POSITIVE ASSURANCE Sept '03 to Mar '04			
	A/B	C	D	X	A/B	C	D	X
EASTERN	301 (66%)	136 (30%)	0	18 (4%)	50 (25%)	147 (74%)	0	1 (1%)
NORTHERN	234 (77.5%)	59 (19.5%)	0	9 (3%)	65 (38%)	104 (60%)	0	3 (2%)
SOUTHERN	116 (74%)	40 (25%)	0	1 (1%)	40 (30.5%)	90 (69%)	1 (0.5%)	0
WESTERN	129 (67%)	53 (28%)	0	6 (5%)	20 (15%)	107 (82%)	3 (2%)	1 (1%)

This table shows the effect on the RDO report codes that the PA scheme brought about. There was a dramatic shift in the proportion of C codes compared to the previous 7 months. Codes A & B require no follow up. Codes C, D, E & X do require follow up. This led to an increased volume of paperwork for the CSA to handle, as practitioners would have to engage in correspondence to clarify the queries.

Table 3.

Board	**E**	**N**	**S**	**W**	**Grand Total**
Total called	719	436	437	318	1910
Cancelled or exempted	177	98	112	73	460
Total attended for examination	208	171	140	98	617
Total failed to attend (FTA) for examination	334	167	185	147	833
Attended - PA=yes	47	57	28	21	153
FTA - PA=yes	109	85	50	43	287
Attended - PA=no	161	114	112	77	464
FTA - PA=no	225	82	135	104	546

Table 3 show an analysis of the desktop examinations and clinical examinations under taken by the RDO's during the PA scheme (up to May 2004). ***PA = Yes*** denotes cases where there were no discrepancies in the claim. ***PA = No*** denotes cases where there discrepancies and the relevant Board was required to make a decision. ***Attended*** denotes a clinical & desktop examination, ***FTA*** denotes a desktop only examination.

4. Prison Dental Service

Introduction

Dental services are provided at the three prison sites in Northern Ireland, HMP Maghaberry, HMP Magilligan and HMP Hydebank Young Offenders Centre (YOC).
Dental Branch at DHSSPS is responsible for providing staff for delivery of dental services while the Prison Services Directorate is responsible for provision of the clinics, equipment and all other facilities necessary to deliver the service.

Staffing

During 2003/2004 Dental Branch reviewed its staffing arrangements at the three prison sites. Following on from a recommendation in the first Moseley/Neale report it was decided to contract out services at Magilligan prison. The contract was put out to tender in July 2003 and the contract was subsequently awarded to a group of general dental practitioners. These practitioners took over the service at Magilligan in January 2004.
Locum dental practitioners currently provide dental services at Maghaberry prison and the YOC with support from two dental nurses employed by DHSSPS.

Prison Reviews

Two complementary reviews of prison dental services in Northern Ireland have been carried out in the past two years. Both reviews were undertaken by senior staff from the Dental Practice Board (DPB) in Eastbourne. The first Moseley/Neale report was published in May 2002 and the second report was released in January 2004. This second report took a detailed look at the quantity and quality of the clinical work carried out at the three sites along with further recommendations and follow up comments on the progress of the recommendations from the first report.
An implementation plan on the Review of Prison Healthcare Services (April 2002) was published by the Prison Services Directorate and looked at taking forward the recommendations in the original report.

Essence of Care Project

The Essence of Care project is a clinical governance tool which arose from the National Nursing, Midwifery and Health Visiting Strategy 'Making a Difference' and aims to benchmark standards of care.
A pilot study on the theme of 'Personal and Oral Hygiene' commenced in February 2004 at the YOC site. A wide range of stakeholders, including dental staff from the prison service and the Department, participated in the project. The project identified a number of action plans necessary to enhance the provision of oral care at the YOC. Follow up on the project has been delayed due to redeployment of the project manager

Future Developments

1) Fully integrate a new electronic management information system into the monitoring of prison dental services
2) Evaluate the contracted out services at Magilligan prison
3) Develop appropriate models of service delivery at the Maghaberry and YOC sites.

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