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A Review Of The Community Dental Service

A Consultation Document

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Produced by: Department of Health, Social Services & Public Safety
Castle Building, Belfast BT4 3SQ
Telephone: (028) 90522 710
Textphone: (028) 9052 7668
www.dhsspsni.gov.uk
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EXECUTIVE SUMMARY

The Community Dental Service (CDS) is the salaried arm of the primary dental services and employs 189WTE staff across Northern Ireland's 11 community and mixed Trusts. There are 64WTE dentists working within the CDS which equates to approximately 10% of the Province's dentists. The CDS annual budget in 2001/2 was £5.4m or approximately 8% of the total spend on primary dental care.
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.

These functions reflect the relatively high proportion of individuals with special health care needs in our society and the low uptake of General Dental Services among the NI population. The CDS offers a high quality service with recognition of this coming from the Charter Mark Scheme and national dental awards in clinical excellence. However, the service is fragmented and lacks clarity in its key aims. There is wide variation in the activities undertaken across Trusts and in how these are measured and recorded. This makes regional comparison and performance management an arduous task.

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. A working group will take on this task and should link in with other groups developing a standard information collection system and performance indicators. This will allow meaningful Clinical Governance of the CDS.

The CDS has always had a remit for special needs patients and the Review found that this client group should be the focus for clinical activity in the future. Formal training programmes need to be put in place to assure quality care for these patients who often have complex treatment requirements. A working group should be established to examine the number of staff to be trained, the level of training required and the associated costs.

The mechanism to achieve harmonisation among the disparate CDS units proposed here is clear Service aims and objectives generating regional Service standards which are monitored through an effective information collection system.

SUMMARY OF RECOMMENDATIONS

1. A working group with responsibility for the formulation of a Corporate Plan for the CDS should be established. The Corporate Plan should outline, in both the short and long term, the role of the service. It should also produce quantifiable aims and objectives for the service.

2. (a) The requirements of special needs patients should be prioritised. An agreed definition of what groups are covered by the term special needs should be laid out in the Corporate Plan.

   (b) A working group should be set up to examine how the community-based dental consultants and clinical attachment training schemes should be organised and the likely costs involved in each.

3. The CDS within each Trust should nominate a liaison person who will be responsible for highlighting to the LHSCG ways in which the CDS may link in with the Primary Care Investment Plan.

4. Representatives of the CDS should continue to monitor developments and initiatives undertaken in the rest of the UK.

5. While it is not necessary for regional epidemiological studies to be undertaken every year, dental surveys should still be carried out locally or regionally when the need arises.

6. Needs assessment should be guided by a core set of standard indicators but the methodology should be sufficiently flexible to provide information on local issues.

7. Boards and Trusts should make every effort to agree and implement regional school screening guidelines as soon as possible.

8. A register should be compiled of all CDS staff with an interest in research. A formal CDS research policy document should be developed which addresses funding, the relationship between training and research and CDS research links with local and non-local research institutions.

9. Regional guidance on OHP policy should be developed with a focus on how OHP and the HPA can work together. The Regional Health Promotion Planning Group should have an oral health representative.

10. (a) A Dental Information and ICT Systems Project should be established with the initial aim of agreeing and developing standard definitions for the collection of activity data.

    (b) All CDS units need to be suitably equipped, and CDS staff adequately trained, to permit efficient use of the Health and Care Number.

    (c) IT links should be developed between CDS areas, and in the long-term links should be extended to include GDS and HDS.

    (d) A working group made up of CDS and DHSSPS personnel should undertake the Dental Information and ICT Systems Project.

11. (a) The measurable aims and objectives contained within the Corporate Plan need to be developed into standard, regional performance indicators.
    (b) The Clinical Governance working group should examine different monitoring possibilities for performance indicators so that the most effective, most efficient and least bureaucratic system is put in place.

12. A clinical and service environment should be put in place which supports the delivery of high quality dental care. Service quality should be assured through; peer review with GDS and HDS, evidence based dental practice, user surveys, and systems which recognise and act upon poor performance.

13. A job evaluation exercise is required to ensure job standardisation and equality of opportunity for staff. A skills survey should be undertaken to identify any gaps in expertise within the service. Individual staff appraisal should be introduced which will link directly to the strategic aims and objectives of the CDS

14. Training sessions for PCDs should be provided in all skill areas identified as being deficient in the skills survey.

15. Appropriate educational activities need to be available to CDS dentists that will allow them to fulfil the GDC's CPD requirements.

16. The role of the CDS in campaigns that utilise the common risk factor approach should be recognised and further developed in strategic plans.

17. A dedicated project manager should be appointed to organise and chair the project groups that will take forward the recommendations above.

INTRODUCTION

The Community Dental Services (CDS) along with the General Dental Services (GDS) are the providers of primary dental care in Northern Ireland. While the GDS is made up of independent contractors paid largely on a fee-per-item basis and located on the high street, the CDS consists of salaried dentists working within Community Trusts.

The CDS proper was established as part of the 1974 reorganisation of public services. Prior to this there existed a School Dental Service whose remit was largely limited to the treatment of children found to have a dental health need at the annual school dental screenings. However, since this time the range of client groups seen by the CDS has widened considerably.

The impetus for the current Review of the Community Dental Services (CDS) came from the Mid-term Evaluation of the 1995 NI Oral Health Strategy (DHSSPS, 2001). This document recommended that, *"the overall aims and objectives of the Community Dental Service should be reviewed in the light of changing dental practice and the general oral health background"*.

In August 2002 Capita Business Services Ltd were contracted to carry out the CDS Review under the direction of a steering group chaired by the Chief Dental Officer. The objectives of the Review were to:

1 Assess the current performance of the service.
2 Decide upon the future role and structure of the CDS.
3 Devise an action plan to move the service from the current position to the desired position.

The full terms of reference for the Review can be found in appendix 1.

THE CDS IN NORTHERN IRELAND

The CDS in Northern Ireland provides a range of services which are officially defined in HSS (CH) 2/89 (DHSS, 1989), Guidance on the Community Dental Service. The circular outlines that the service should provide:

- Monitoring of the dental health of all age groups in the population and the planning of local dental services;
- Dental health education and prevention programmes;
- Facilities for a full range of treatment to patients for whom there is evidence that they could not seek treatment from the GDS (safety net);
- Dental screening in state funded schools at least three times in each child's school life.

The current service has developed, in both form and function, in response to changes in the environment in which the health service operates and in response to local need. The service responds to changes in policy, e.g. the shift of dental general anaesthetics away from the GDS, under the leadership of the Department and Board Directors.

The CDS in Northern Ireland is a salaried service provided by 189 WTEs across 4 Boards and 11 Trusts (appendix 2). The CDS employs 64 WTE dentists, 117 WTE Professions Complimentary to Dentistry (PCD) staff and 8 WTE clerical staff. Staffing levels relative to Trust population vary slightly across the province (appendix 3). There are three Board Directors of Dental Services and one Consultant in Dental Public Health based across Northern Ireland. Within each Board, there are a number of Trusts, of which the Community and mixed Acute/Community Trusts each have a Clinical Director. The SHSSB CDS is structured differently and acts as a single Board-wide service. There is therefore just one Clinical Director covering this Board's three Trusts (appendix 4).

The budget for the service throughout Northern Ireland, based on information received for 2001/2002, is approximately £5,407,849 of which £4,792,849 (88.6%) can be attributed to salaries and wages and £615,000 (11.4%) to goods and services. Financial systems vary from Trust to Trust and in some cases CDS Clinical Directors do not have responsibility for their goods and services budget. The proportion that each CDS unit spends on goods and services ranges from 6.0% to 17.2% (appendix 5). This disparity may be explained by the wide variation in CDS staff numbers across Trusts (economies of scale) and by different Trust activity levels (see section on service remit).

METHODOLOGY

The Review was conducted in three phases, each of which mirrors the three key objectives above.

Phase 1 - Where are we now?

Stage 1 - Project Initiation
Stage 2 - Strategy/Policy Context and Desktop Research
Stage 3 - Information Gathering - Trusts
Stage 4 - Information Gathering - Other Stakeholders
Stage 5 - Comparative Analysis of Best Practice
Stage 6 - Development of Interim Findings and Interim Report.

Phase 2 - Where do we want to be?

Stage 7 - Future Position of the Community Dental Service
Stage 8 - Assessment of Future Options.

Phase 3 - How do we get there?

Stage 9 - Action Plan and Draft and Final Reports.

Phase 1 generated a series of core issues for the service, now and in the future. Phase 2 looked at what sort of a CDS would be required to address these issues and phase 3 examined the processes that need to be put in place to achieve the desired new service.

FINDINGS OF THE REVIEW

Sixteen core issues requiring action were identified and these are grouped under three key headings; the future role of the CDS, the public health function and support systems. Recommendations have been made to address each issue, in some cases an issue merits more than one recommendation.

1. The Future Role of the CDS

(i) Aims and Objectives of the Service

Issue 1: The specific policy within which the CDS operates and which primarily dictates its general aims and objectives is outlined in HSS (CH) 2/89 (DHSS, 1989). This document is now 14 years old. Dentistry, the health service in general, and Northern Ireland society has experienced significant changes over this time. During consultation many staff felt that the CDS in Northern Ireland did not have a clear long-term direction and was reacting to a steady stream of policy documents without having an overall strategic vision in which to frame these.

Recommendation 1: In order that the roles and functions of the CDS are clearly defined and consistent across Trusts, the aims and objectives of the service need to be agreed at a regional level. These should act as high level goals against which the development of local services may be measured. The aims and objectives should flow from the new CDS mission statement:

'To improve people's health and social wellbeing by providing oral health services to the highest standards.'

A working group with responsibility for the formulation of a Corporate Plan for the CDS should be established. The Corporate Plan should outline the roles, aims and objectives of the service in both the short and long term.

Standard setting and performance management are dealt with in section 3 (ii).

(ii) Service Remit

Issue 2: Currently the CDS provides the following services:

- Treatment
  - Of special needs patients[1]
  - Of patients without special needs who, for various reasons, have difficulty accessing general dental services (hereafter termed the 'safety net function')
  - Of patients requiring dental treatment under general anaesthesia or sedation
- Screening
- Oral Health Promotion
- Undergraduate and Postgraduate teaching
- Research
- Needs Assessment
- Epidemiology

The CDS may be viewed as being part of an integrated oral care system along with the GDS and Hospital Dental Service (HDS). However, the lack of guidance on which services the CDS should provide in complimenting the other dental services has led, at least in part, to the wide variation in Programme of Care activity levels observed between Trusts (appendix 6). Furthermore, the lack of clarity surrounding the role of the CDS has contributed, in some instances, to the service receiving inappropriate referrals from the GDS.

1 Patients who have medical, social, psychological or physical conditions that make it necessary to modify the normal course of dental treatment. (Glassman and Miller, 1998)

Recommendation 2a: The requirements of special needs patients should be prioritised. An agreed definition of what groups are covered by the term special needs should be laid out in the Corporate Plan. The Corporate Plan should also detail circumstances in which other patient groups may be seen by the CDS.

Recommendation 2b: It will be necessary to improve specialised treatment services to meet the requirements of special needs patients and those with complex medical problems. In order for staff to develop the skills necessary to undertake these roles there is a need for formal training programmes and opportunities to develop competencies under clinical supervision. At present within the CDS there are no dental consultants based within the community. A training programme designed to produce dedicated community based dental consultants with expertise in the required areas needs to be established. Arrangements that allow staff to develop competencies through clinical attachments should be put on a more formal footing. A working group should be set up to examine how these distinct training schemes should be organised and the likely costs involved in each. See also recommendation 13.

(iii) Changes within the wider Health Service

Issue 3: The new arrangements for Local Health and Social Care Groups (LHSCGs) have been in effect since 1 April 2002. LHSCGs will allow front line health service staff to be part of the commissioning process. They will be able to make decisions about what health services are offered in their area and how they are delivered. At present, the CDS does not have direct representation on LHSCGs, but some Trusts do provide information informally to the groups on oral health promotion issues through their integration with other groups of professionals, e.g. health visitors and district nurses.

Recommendation 3: It is essential that LHSCGs are well informed of the role that the CDS plays in relation to both service delivery and health promotion. This should ensure that CDS issues are adequately reflected in LHSCG deliberations. The CDS within each Trust should nominate a liaison person who will be responsible for highlighting to the LHSCG ways in which the CDS may link in with the Primary Care Investment Plan.This will permit the profession to further develop links with other health care workers, facilitate multidisciplinary working and ensure that dentistry has an input into the development and commissioning of local health services.

Issue 4: At a national level the implementation of Options for Change[2] will offer the CDS in Northern Ireland the opportunity to learn from developments throughout the rest of the UK and to identify areas of best practice in order that improvements can be made in service provision. In addition, a review of the salaried primary care dental service, is soon to be undertaken in England which may influence developments in the CDS in Northern Ireland.

Recommendation 4: Representatives of the CDS should continue to monitor developments and initiatives undertaken in the rest of the UK and should provide feedback in order that informed decisions can be made in developing the service in the future.

2. The Public Health Function of the CDS

According to The Tripartite Steering Group for Standards in Public Health (2001) the purpose of public health is to:

- Improve the health and wellbeing of the population

[2] Options for Change (DoH, 2002) outlines alternatives models for the future delivery of General Dental Services in England. The alternative GDS models are currently being tested in 26 field sites.

- Prevent disease and minimise its consequences
- Prolong valued life
- Reduce inequalities in health

No other branch of dentistry makes as much of a contribution to public health as the CDS. It does this through its epidemiology, needs assessment, screening, research and health promotion functions.

(i) Epidemiology

Issue 5: Almost all individuals in the developed world will be affected by dental decay or periodontal disease at some stage in their life. Levels of oral disease must be assessed in order to develop programmes and plan services appropriate to the community's needs. Epidemiological surveys form one of the key elements of the oral health care needs assessment process. However, these surveys are expensive and time consuming to carry out. Until recently, Northern Ireland took part in the UK wide NHS Dental Epidemiology Programme but low consent rates and competing service demands have caused the province's participation in this programme to be suspended.

Recommendation 5: Periodic regional epidemiological studies will continue to be necessary in the future. However, the value of carrying out annual province-wide dental surveys is questionable, particularly with less than optimal participation rates and virtually static oral health levels. Every effort should be made to improve the validity of data obtained from the current school screening programme so that it may in future be used to inform the needs assessment process. Occasional local dental surveys should be used:

- When baseline data on a particular client group are inadequate
- To investigate the effectiveness of dental health improvement initiatives
- When there is concern that local oral health differs markedly from regional oral health

(ii) Needs assessment

Issue 6: Needs assessment within the CDS is carried out at individual Board and Trust level. The benefit of carrying out local needs assessment is that locally sensitive information is provided. This allows resources to be targeted at the areas were they will have the greatest effect. Local needs assessment will also influence the development of local services and allows an assessment of staff skills and numbers required to deliver these services. However, if service developments or health improvement initiatives are to be funded from a regional source it is important that the information contained within the local needs assessments is robust and comparable across Trusts.

Recommendation 6: Needs assessment should be guided regionally but it may be appropriate that it is linked to the requirements of individual LHSCGs. Any needs assessment carried out should be standardised across the region to ensure comparable information is collected. Needs assessments should focus on the target groups for the service as set out in the Corporate Plan.

(iii) School Dental Screening

Issue 7: All Trusts currently screen children at least three times during their school years, as required by circular HC (89) 2 (DoH, 1989). Many Trusts see children more frequently than this. However, there is considerable variation across the province in relation to the age groups seen, the equipment used, links with the Child Health System and consent procedures used. The Mid-term Evaluation of the Oral Health Strategy recommended that "a consistent approach to school dental screening should be adopted across all Trusts". A rolling programme of training has been established and a direct data entry system is under development. However, discussions continue on the exact wording of the guidelines and it appears that the timetable may be slipping.

Recommendation 7: While the primary aim of school screening will remain the identification of previously unrecognised treatment need the new system should also yield caries data comparable both across Trusts and with data from epidemiological surveys. A regionally standardised school dental screening programme using criteria compatible with other UK surveys will, for the first time, allow valid comparisons of caries severity to be made at the small area level within Northern Ireland. This will facilitate needs assessment for LHSCGs. Boards and Trusts should make every effort to agree and implement regional school screening guidelines as soon as possible.

(iv) Research undertaken in the CDS.

Issue 8: Research related to the treatment and public health functions of the CDS is an essential element of service improvement. Research helps in the evaluation of health promotion programmes and in the generation of evidence-based clinical guidelines. Participation in research is an important feature of staff development and clinical governance. While some members of the CDS are involved in research projects in collaboration with both local and non-local universities, these arrangements have developed in the absence of any formal CDS research policy.

Recommendation 8: A register should be compiled of all CDS staff with an interest in research. This should list the topics in which the staff member has an interest, what experience of research they have and any projects they are currently involved with. A formal CDS research policy document is required. Research should be undertaken with the aid of dedicated funding, linked to specific areas of work or training and with formal channels being developed through which research can be supervised and co-ordinated. While links currently exist these need to continue to be developed through:

- Closer links with local universities
- Extended North/South and East/West links
- European relationships

(v) Oral Health Promotion

Issue 9: Virtually all of the Oral Health Promotion (OHP) carried out in Northern Ireland involves CDS or Health Board staff. OHP is a function currently undertaken by all community Trusts. The focus is on improving oral health through intervention programmes and through educating the public on the importance of oral health and the connection between oral and general health. OHP takes place through various initiatives across Northern Ireland, examples of which have been highlighted in appendix 7. While there is a regional OHP group, there are no regional OHP schemes. In fact, it is not unusual for different Boards and Trusts to run very similar campaigns without any co-operation taking place between the organisations.

Recommendation 9: OHP in Northern Ireland is a key area to be developed for future service delivery. It is also a facet of CDS work where staff should be able to formally link up in a regional network with relative ease. A concrete OHP resource sharing agreement between Trusts will ensure more effective and efficient use of knowledge, experience and materials. In order for this to occur:

- Regional guidance should be developed on oral health promotion policy and, in particular, how OHP and general health promotion compliment each other. The Regional Health Promotion Planning Group should therefore have a dental representative to ensure that oral health issues are considered and included in the formulation of policy;

- The Health Promotion Agency could take a co-ordinating role in this area while the implementation of this guidance should continue to take place at a local level;

- Continuous evaluation of health improvement initiatives should take place at a regional and local level to help build the evidence base for OHP. The results of the evaluations should be made available to all Trusts and Boards;

- Dedicated staff resources need to be identified to provide continuous focus, and a nominated senior manager appointed to ensure that objectives and targets are met; and

- Educating other professionals (for example, nursing staff and health visitors) regarding the services that can be provided and the importance of oral health in the provision of complete patient care needs to take place.

3. Support Systems for the Future Role of the CDS

(i) Information Management

Issue 10: There is considerable variation between Trusts on both the type of information recorded and method of collection. Some Trusts have paper based collection systems, some use a computerised method. While all Trusts record activity data (e.g. patient contacts), differences exist in how a unit of activity is defined. Computerisation has in many cases enhanced the amount and type of information that can be collected and analysed. The information collected is used to chart progress towards targets over specific time periods and to analyse changes in service provision. In turn this information may be used by Trusts to identify local need and to plan services accordingly.

Many CDS staff view the collection of information as being time consuming and inefficient. Often information is recorded in duplicate so that collection systems which use different formats can be completed. The variations that exist in the interpretation of Programme of Care definitions mean that information is often produced in a manner that makes comparison across Trusts and Boards difficult (appendix 6).

Recommendation 10a: It should be a priority that a Dental Information and ICT Systems Project is established with the initial aim of agreeing and developing standard definitions for the collection of activity data. Following this, a business case should be prepared for a Dental Information System to collate information so that patterns of treatment can be studied on a regional basis. This project will ensure that the information collected is comparable across Northern Ireland and will provide accurate data for performance management, needs assessment and planning purposes.

Recommendation 10b: Current developments with regard to the Unique Patient Client Identifier (UPCI)/Health and Social Care Number Project will facilitate the collection of standard information. The introduction of the UPCI/Health and Social Care Number provides the essential building block for the creation of Electronic Patient Records and ultimately, Electronic Health Records. The availability of the UPCI/Health and Social Care Number will also provide commissioners of health and social care with increased opportunities for access to patient/client related information on a cross-sectoral and multi-agency basis. All CDS units need to be suitably equipped, and CDS staff adequately trained, to permit efficient use of UPCI.

Recommendation 10c: In conjunction with the development of an information system IT links should be developed between CDS areas, and in the long term links should be extended to include GDS and HDS. This will encourage communication between all areas and will facilitate the dissemination of best practice procedures, for example, through teledentistry, management information and standardised patient information. Other likely benefits will include teledentistry and on-line booking of patient appointments.

Recommendation 10d: The Dental Information and ICT Systems Project should be undertaken by a working group made up of CDS and DHSSPS personnel, with ownership and leadership of the project coming from within the dental profession. In view of the technical and procurement issues which will arise during the course of the project, it may also be necessary for expertise to be drawn in from DIS and from external consultants.

(ii) Performance Management

Issue 11: The subjects of performance management and information management are strongly linked. Data on how well a service is functioning and the capabilities of that service are essential to the target setting process. However, performance management should be about much more than sets of figures. It has been said that if you only count what you can measure, then eventually, what you measure becomes all that counts.

Performance management systems need to provide a clear sense of direction, boundaries that define what is and what is not permissible, space in which to innovate and permission to take risks not micro-management (NHS Confederation. 2002). The sense of direction will come from the Corporate Plan but there is a need for performance standards to be set and for these standards to be monitored.

Recommendation 11a: The Corporate Plan should produce measurable aims and objectives for the service on a regional basis. These need to be developed into standard, regional indicators which should:

- Relate to the outputs of the Dental Information and ICT Systems Project:
- Be quantitative and qualitative in nature;
- Link to indicators of other professions;
- Demonstrate the achievements of the CDS and how these have been met

Recommendation 11b: These performance indicators must be monitored. The clinical governance working group (see the Action Plan) should examine different monitoring possibilities so that the most effective, most efficient and least bureaucratic system is put in place.

(iii) Clinical Governance

Issue 12. Effective performance management is considered to be an essential element of clinical governance. Quality service is only delivered when the performance of the system meets the standards that have been set. Within the CDS clinical governance should be seen as a positive concept that supports the continuous improvement of quality in clinical dental practice. The current requirements placed on Trusts and Boards, as well as those placed upon individual clinicians in relation to clinical governance will help to drive up quality.

Recommendation 12: In order that the new mission statement of the service is fulfilled some areas may require attention. These are:

- A clinical and service environment should be in place which supports the delivery of high quality dental care;
- The development of peer review with GDS and HDS;
- Evidence based dental practice in day-to-day use within a supportive infrastructure;
- User surveys;
- Systems which recognise and act upon poor performance.

A Northern Ireland quality manual has recently been released to all GDPs. The manual was designed in conjunction with all 4 HSS Boards and essentially is a guide to meeting the regulations relating to dental practice. This manual could be shared with the CDS to facilitate integration between these two branches of dentistry, provide guidance on standards and allow the development of a common system of clinical governance.

(iv) Staff Development (general)

Issue 13: Within any service area staff are fundamental to the successful delivery of the service to clients. It has been highlighted that the CDS is currently operating under increasingly difficult circumstances. This has led in some cases to morale being low and sickness absence levels increasing. A perceived lack of control, e.g. when external factors affect how the service operates, can exacerbate these problems.

Recommendation 13: To support any changes the following work needs to be undertaken in the first instance:

- A job evaluation exercise is required to establish the tasks and duties carried out by individual professionals across each Trust to ensure standardisation and equality of opportunity for staff;
- A skills survey should be undertaken to identify any gaps in expertise within the service. Any deficiencies found should be assessed and rectified through appropriate training and development. In some cases staff recruitment may be required. See also recommendation 2b.
- Individual staff appraisal should be introduced which will link directly to the strategic aims and objectives of the CDS;

(v) Continuing Professional Development (CPD) for PCDs

Issue 14: To provide better standards of care for patients and a better career pathway for PCDs, the GDC has agreed that all groups of PCDs should be trained, qualified and statutorily registered. The registration of dental nurses, dental technicians, clinical dental technicians, maxillofacial prosthetists and technologists and orthodontic therapists will start during 2004.

With effect from 1 July 2002 dental hygienists and dental therapists were able to carry out a range of extended duties. Currently these are the only two classes of Professionals Complementary to Dentistry (PCDs) required by law to be registered with the GDC. For these individuals sound and relevant training is essential so that all members of the dental team provide patients with good care and treatment. Extended duties can only be undertaken by these PCDs once the necessary training has been received. Dentists, as leaders of the dental team will be responsible for ensuring that this is the case. Training in the extended duties can be provided in Dental Schools and hospitals or postgraduate centres. The Schools of Dental Hygiene have already been working on developing training programmes for new duties.

Recommendation 14: Training sessions for PCDs should be provided in all skill areas identified as being deficient in the skills survey. Once skills have been acquired staff should be encouraged to use skills on a regular basis. For this to occur facilities need to be available and adequate staff in place to cover all duties and responsibilities.

(vi) Continuing Professional Development (CPD) for Dentists

Issue 15: On 1 January 2002 the General Dental Council introduced ***Lifelong Learning*** - a programme of mandatory CDP for dentists (GDC, 2001). This scheme applies to all registered dentists and it requires them to keep their knowledge and skills up to date throughout their careers. The scheme offers an opportunity for professional development, greater public protection, formalises existing good practice and is in line with Government policy. For Lifelong Learning to work, sufficient numbers of relevant, accessible, quality learning events must be provided.

Recommendation 15: Appropriate educational activities need to be available to CDS dentists to allow them to fulfil the GDC's CPD requirements.

(vii) Multidisciplinary Working

Issue 16: Multidisciplinary working is undertaken throughout the CDS and has been facilitated in many ways through the development of Trusts and multidisciplinary teams of care professionals. Many recent Northern Ireland policy documents advocate and encourage the continuation of multidisciplinary working. It is NHS policy to promote the integration of dental health professionals with other members of the primary care team. However, the extent of multidisciplinary working undertaken by dental professionals is rarely recognised in regional health policy documents, particularly in relation to health promotion activities.

Recommendation 16: The role of the CDS in campaigns that utilise the common risk factor approach[3] should be recognised and further developed in strategic plans.

Multidisciplinary working involving the CDS should receive focus in the future through:

- Working with and advising LHSCGs on the oral health needs of the local population. Local networks already established will therefore be utilised to develop this area further;
- Multidisciplinary audits;
- Links with the GDS;
- Integration throughout the system, for example, attachments to acute settings.

[3] A method of maximising the effectiveness of health promotion resources from different disciplines by focusing on disease risk factors which are common to two or more conditions. Examples include school-based healthy diet schemes which help to reduce dental decay as well as childhood obesity.

TAKING THE RECOMMENDATIONS FORWARD

The most effective and expeditious way to move the CDS from its current position to the delivery of the recommendations is to appoint a dedicated project manager to organise and chair the six project groups detailed in the Action Plan below. An individual committed solely to this task would be able to devote the considerable amount of time and effort required to implement the action plans. Furthermore, having a single individual moving between concurrent project groups will help harmonise outcomes. The final recommendation is therefore:

Recommendation 17: A project manager should be appointed to co-ordinate and ensure delivery of the six projects which make up the Action Plan.

An alternative method of progressing the recommendations above is to assign functional responsibility for key areas to the Board Dental Directors, who may then lead the specific project teams. The Board Directors may be supported by Clinical Directors at Trust level who can be given executive responsibility and accountability for delivering defined outputs.

Under this model in the Board Directors will become 'champions' in specific areas and will provide focus and expertise that will be disseminated across the CDS. As outlined, Board Directors will not be expected to take on the above roles in isolation but rather will work closely with the Trust Clinical Directors. At present, the Clinical Directors at Trust level meet on a regular basis and have identified individual areas of expertise and interest. It is therefore appropriate that this expertise is further developed and used at a regional level to support Board Directors in their roles.

In examining how these various tasks may best be allocated functions have been grouped together in a manner which reflects natural organisational and service relationships. A suggested structure is shown below. Specific directors have not been assigned specific tasks at this stage. If this approach is to be pursued, it will

be a matter for discussion between the Chief Dental Officer, the Board Directors and Trust Clinical Directors.

Lead	Responsibilities	Action Plan
Director 1	Treatment Services ICT	Corporate Plan (1) and Information Management (2)
Director 2	Staff Development and Training CPD Multidisciplinary working	Staff Issues (3)
Director 3	Research Best Practice Guidelines OHP Epidemiology	Research (4) and OHP (6)
Director 4	Clinical Governance Performance Management	Clinical Governance (5)

These initiatives will place the service in a position that defines the future aims, objectives, roles and functions of the CDS and will ensure that better communication and collaboration take place. The CDS will therefore be in a position to deliver services against the backdrop of more cohesive planning and resourcing, particularly in terms of having availability of adequate numbers of staff who are appropriately skilled and trained. Services will be delivered in areas of most need which will have been identified through local needs assessment supported by standard information which has been gathered locally and compared regionally.

At an operational level, no major structural change can take place while Boards and Trusts exist. Clinical Directors will continue to be in place supported by senior dental officers, dental officers and PCD staff.

ACTION PLANS

This section of the report collates the recommendations made and, where appropriate, groups them into action plans. There are six plans each presented in the same tabular format which details:

- The title;
- The terms of reference;
- The processes/stages of the project;
- The time scales for completion;
- The resources (manpower and capital investment);
- Any associated project dependencies.

1. The Corporate Plan

Title	**Corporate Plan**
Terms of Reference	To clarify the roles and functions, aims and objectives of the CDS on a regional basis.
Process/Stages	Stage 1 - Develop regional aims and objectives, based on current policy drivers and outcomes from epidemiological and needs assessment work, to define the roles and functions of the CDS.
	Stage 2 - Develop clear definitions of those to be treated especially surrounding interpretation of the 'safety net' function and special needs patients. To determine procedures for dealing with patients not within the CDS remit.

Title	**Corporate Plan** Stage 3 - Development of key performance indicators.
Timescale	Completed within 4 months of the end of the review.
Resources	Dedicated personnel to assume responsibility for this area supported by a steering group which should include departmental representation. No associated capital costs.
Dependencies	Availability of staff resources.

2. Information Management

Title	**Information Management**
Terms of Reference	To ensure that information collected is standardised across Trusts and that it meets the requirements of those commissioning and planning services. This information should be both qualitative and quantitative in nature and should reflect the aims and objectives of the CDS. To explore the alternatives methods for delivering a Dental Information System and develop a business case.
Process/Stages	Stage 1 - Develop and agree definitions surrounding information categories. Stage 2 - Specification, procurement and implementation of new information management arrangements and systems. Stage 3 - Preparation of a business case for a Dental Information System to collate standardised activity data across Trusts. Stage 4 - IT links developed between CDS units and in the long term between the CDS, GDS and HDS.

Title	**Information Management**
Timescale	To begin within 3 months of the end of the review.
Resources	Formation of a project group with a designated leader to follow the stages of the developing new information management arrangements.
Dependencies	These projects are dependent upon staff availability and developing links with a range of external stakeholders. This area is also dependent upon linking systems already in place to any new system.

3. Staff Development and CPD

Title	Staff Issues
Terms of Reference	To identify the staff numbers and skills required, for both dentists and PCDs, to ensure delivery of a quality service in the future. To draw up a costed plan on how to address any shortfall in staff numbers or training.
Process/Stages	Stage 1 - Job evaluation exercise. Stage 2 - Skills survey. Stage 3 - Assessment of staff numbers and training required to meet the future needs of the service. Particular attention should be paid to the specialised training requirements of those who will deliver care to special needs patients. Stage 4 - Calculation of the costs involved in undertaking the required staff training and recruitment. Stage 5 - Development of appropriate training programmes to address skill gaps and to meet the needs of CPD.
Timescale	To begin within 3 months of the end of the review.

Title	Staff Issues
Resources	Dedicated individual to drive projects forward supported by a representative number of staff across all grades and areas. Costs of developing and implementing training will vary depending on the gaps identified and the urgency of filling the gaps. Capital costs may be incurred if extra clinics are required to provide training.
Dependencies	Availability of staff resources and outcomes of external reviews. This area will also be dependent upon the availability of mechanisms to support training pathways. Review of Primary Dental Care in England which may impact upon staff terms and conditions in Northern Ireland. The Review of PCDs in Northern Ireland

4. Research and Identification of Best Practice

Title	Research/Best Practice
Terms of Reference	To identify and disseminate best practice within the CDS. To develop a CDS research policy.
Process/Stages	Stage 1 - Collation of information on adequately evaluated Trust-based initiatives to establish areas of good practice. Stage 2 - Development of a policy for sharing best practice between Trusts. Stage 3 - Compilation of a register of CDS staff with a research interest Stage 4 - Identification of areas where research by CDS staff is required, feasible and likely to be productive. Stage 5 - Development of a formal CDS research policy addressing university links (local, North-South and East-West), funding, and the relationship between training and research. Stage 6- Formation of a primary dental care research network.

Title	Research/Best Practice
Timescale	Stage 1 - To begin immediately with areas of best practice identified within 6 months of the review. Stage 2 - Process to begin immediately. Stages 3 to 6 - To begin as soon as possible with stage 6 complete within 1 year.
Resources	Internal and external staff, as appropriate. Availability of specific funding.
Dependencies	These projects are dependent upon staff availability and developing links with a range of external stakeholders.

5. Clinical Governance

Title	**Clinical Governance**
Terms of Reference	To develop a system of governance that sets and monitors standards in an efficient and effective way. To ensure that any new Dental Information System allows high quality performance management. To establish clear lines of responsibility and accountability through the CDS up to the DHSSPS.
Process/ Stages	Stage 1 - Develop regional guidance on health and safety, risk management and quality improvement processes. Stage 2 - Develop peer review with GDS and HDS. Stage 3 - To develop appropriate performance indicators linked with the new Dental Information System. Stage 4 - To develop an effective and efficient system of performance management with reference to the roles of the DHSSPS, the Boards and the Trusts. Stage 5 - Creation of a scheme of user surveys or linking in with an established user survey programme so that valid data are provided on stakeholders' views of the service.

Title	Clinical Governance
	Stage 6 - A survey of CDS premises and equipment to ensure that they support the delivery of high quality dental care.
Timescale	Stage 1 - Complete within 6 months of end of review. Stage 2 - Trusts to draw up proposals for next round of funding. Stage 3 - To be carried out in conjunction with ICT project. To begin within 3 months of end of Review. Stage 4 - To begin within 3 months of end of Review. Stage 5 and 6 - To be complete within 1 year.
Resources	Dedicated personnel to assume responsibility for this area supported by a steering group which should include departmental representation. The NI quality manual recently issued to GDPs may facilitate development in this area. Cost of setting up and maintaining a user survey or buying into an existing user survey.
Dependencies	Availability of staff resources.

6. Oral Health Promotion

Title	**Oral Health Promotion**
Terms of Reference	To develop a common approach to address oral health problems across different Boards and Trusts. To, as much as current structures allow, share materials and best practice. To further develop collaborative working with general health promotion, including the Health Promotion Agency.
Process/ Stages	Stage 1 - Development of regional guidance on oral health promotion and the tools to be used to carry out these functions. Guidance should be developed in conjunction with the Health Promotion Agency with existing initiatives being considered. Stage 2 - Regional guidance should be implemented by locally based health promotion teams. Stage 3 - Dental representation on the Regional Health Promotion Planning group to ensure dental views are incorporated in the development of health promotion policies and initiatives. Stage 4 - Identification of key CDS, Board and university staff who are willing and capable of offering advice on the planning and evaluation of OHP initiatives.

Title	**Oral Health Promotion** Stage 5 - Setting up of a training programme for relevant staff so that future schemes are properly designed, evaluated and the results disseminated.
Timescale	Stage 1 - Complete within 1 year of the end of the Review. Stage 2 - Complete within 3 months of completion of stage 1. Stage 3 - Immediate. Stage 4 - Complete within 1 month of the end of the Review. Stage 5 - To begin within 6 months of completion of stage 4.
Resources	Dedicated staff to be involved in the development of guidance and the identification of current Trust based initiatives.
Dependencies	Agreement of the Health Promotion Agency to be involved in the development of guidance. Availability to recruit staff to develop local health promotion teams.

LIST OF ABBREVIATIONS USED

CDS - Community Dental Service

CPD - Continuing Professional Development

DIS - Directorate of Information Systems

GDC - General Dental Council

GDS - General Dental Service

HDS - Hospital Dental Service

HPA - Health Promotion Agency

ICT - Information and Communications Technology

LHSCG - Local Health and Social Care Group

PCD - Professions Complimentary to Dentistry

WTE - Whole Time Equivalent

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APPENDICES

APPENDIX 1

MEMBERSHIP OF STEERING GROUP

Doreen Wilson	Chief Dental Officer	Chair
Michael Donaldson	Specialist Registrar in Dental Public Health	Project Manager
Greg Campbell	DHSSPS	
Ruth Freeman	Professor of Dental Public Health, QUB	
John Finnerty	Clinical Director, Causeway HSS Trust	
Brian Gaffney	Chief Executive, Health Promotion Agency	
Basil Gibson	DHSSPS	
Julia Kirk	Clinical Director, Armagh & Dungannon HSS Trust	
Paul Maguire	Dental Practice Committee	
Judi McGaffin	Director of Dental Services, WHSSB	
Robbie Saulters	DHSSPS	
Aideen Sweeney	Clinical Director, S&E Belfast Trust	

APPENDIX 1

CDS REVIEW: TERMS OF REFERENCE

1. The Community Dental Service (CDS) in Northern Ireland has been in operation for over 20 years and evolved out of the old school dental service. It is generally agreed that the core role of the CDS is to provide oral health care for individuals who:
   (a) Would not otherwise seek treatment from the General Dental Services (GDS).
   (b) Are unable to obtain treatment from the GDS.
   (c) Require treatment not generally available in the GDS.

In addition the CDS is responsible for oral screening of school children and other client groups, epidemiological fieldwork and oral health promotion.

2. In 2001 the DHSSPS published the Mid-term Evaluation of the 1995 NI Oral Health Strategy. This document recommended that, *"the overall aims and objectives of the Community Dental Service should be reviewed in the light of changing dental practice and the general oral health background".*

   In response to this recommendation the DHSSPS have engaged a firm of business consultants to carry out a review of the CDS. The business consultants will report to, and be guided by, a Steering Group chaired by the Chief Dental Officer. The Review will follow the appropriate guidelines as laid down by the DHSSPS.

3. There will be three phases to the Review:

   Phase 1. An evaluation of the current performance of the service.
   Phase 2. Proposals for the future positioning of the CDS.
   Phase 3. Production of an Action Plan and draft and final reports.

APPENDIX 1

Staff within the CDS will have an opportunity for input to the Review through focus groups, face-to-face interviews and written questionnaires.

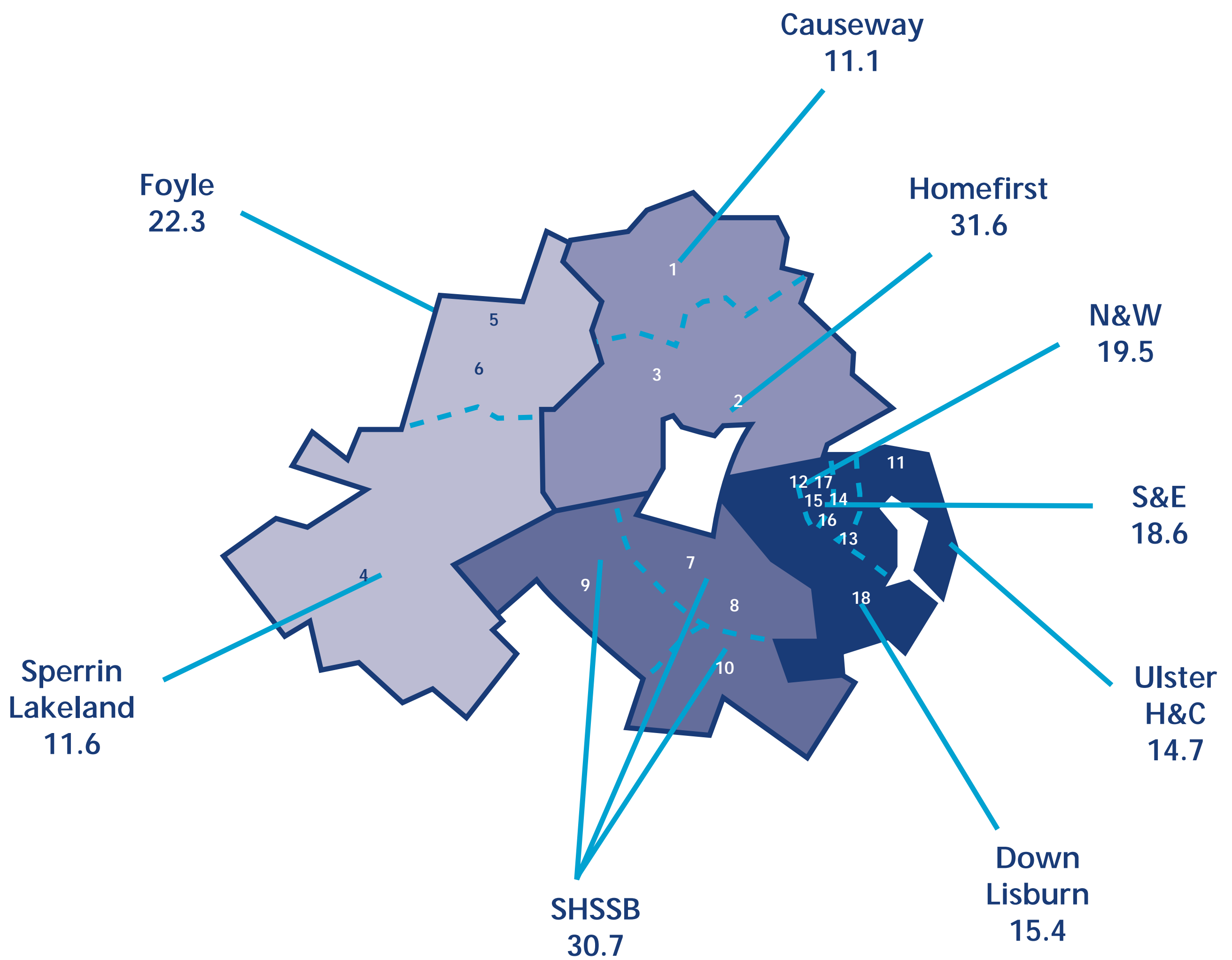
4. Information required for the Review process will include:
   Policy context within which the CDS operates
   Staffing levels and structures within the 11 community Trusts
   Summary of overall service costs per Trust per annum
   Levels of health care need across the 11 Trusts
   Breakdown of service delivery by Trusts
   Views of CDS staff
   Views of dental and non-dental stakeholders

5. The purposes of the Review are:
   (a) To evaluate the current performance of the CDS.
   (b) To make recommendations on the future role and organisation of the CDS.

6. The draft report will be produced by the end of January 2003, with the final report due by the end of February 2003. The Steering Group will be given the opportunity to comment on the draft report and their views will inform the final report. The Final Report will be presented to the Departmental Board for approval to go to the Minister, who will then decide if the Report goes out for consultation. Both the Minister and the Health Committee have been informed that a Review of the Community Dental Service is being undertaken.

APPENDIX 2

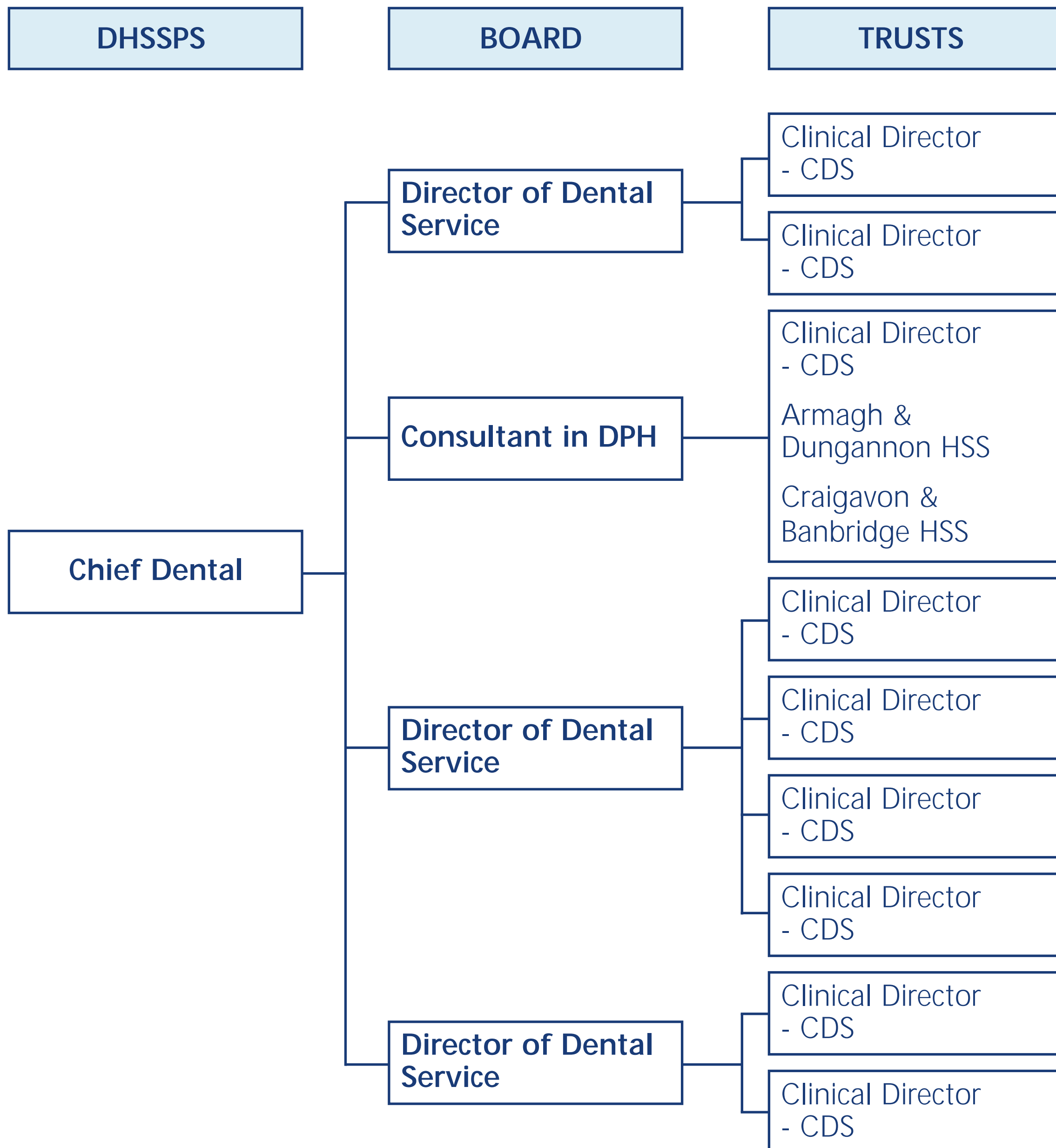
Numbers of Whole Time Equivalent CDS Staff in each Community Trust (clerical staff excluded)



APPENDIX 3

Trust	Population	% GDP registration	Deprivation ranking (1= most deprived)	WTE dentists/ 100,000 popn	WTE PcDs/ 100,000 popn
Causeway	100,000	69.49	5	4.29	6.76
Down Lisburn	170,000	64.48	8	3.53	5.51
Foyle	163,600	59.36	2	3.91	9.72
Homefirst	320,000	67.83	6	4.13	5.76
North & West Belfast	160,000	57.62	1	4.71	7.48
SHSSB - all Trusts	312,000	64.61	4	3.11	6.73
South & East Belfast	205,000	65.25	7	3.07	6.00
Sperrin Lakeland	115,000	68.85	3	4.17	10.26
Ulster C&H	147,095	65.27	9	3.74	6.27

APPENDIX 4

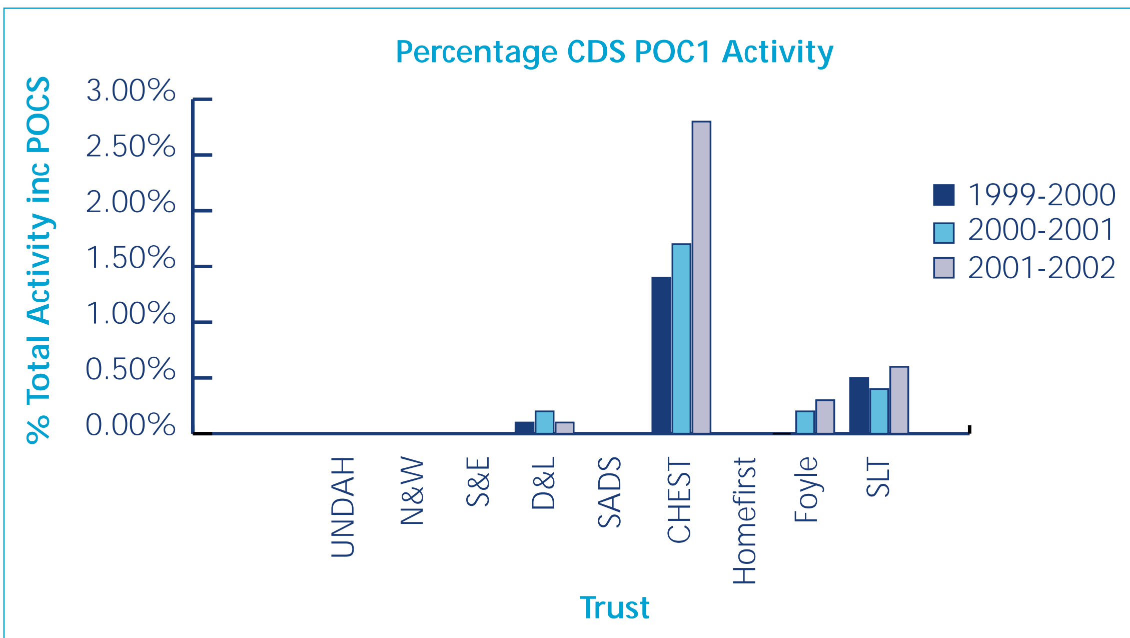


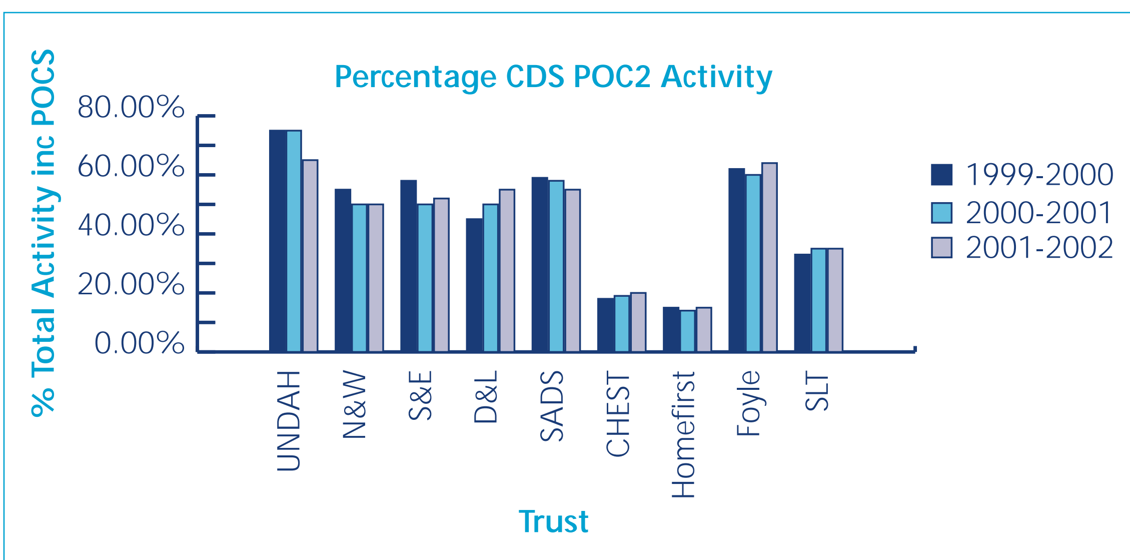
APPENDIX 5

Total	Salaries and Wages £	% of budget on salaries & wages	Goods and Services £	% of budget on goods & services
South & East Belfast	482,549	88.4	63,540	11.6
North & West Belfast	620,000	unknown	unknown	unknown
Down Lisburn	469,941	90.3	50,500	9.7
Ulster Community & Hospitals	125,030	85.0	22,064	15.0
Homefirst	738,647	85.0	130,349	15.0
Causeway	418,449	82.8	86,878	17.2
Sperrin Lakeland	426,678	89.5	50,000	10.5
SHSSB - all Trusts	845,131	94.0	53,838	6.0
Foyle	520,876	91.6	48,000	8.4

APPENDIX 6

CDS Review; Trust Activity Figures 2001-2002; Relative % weighted activity across all Programmes of Care.



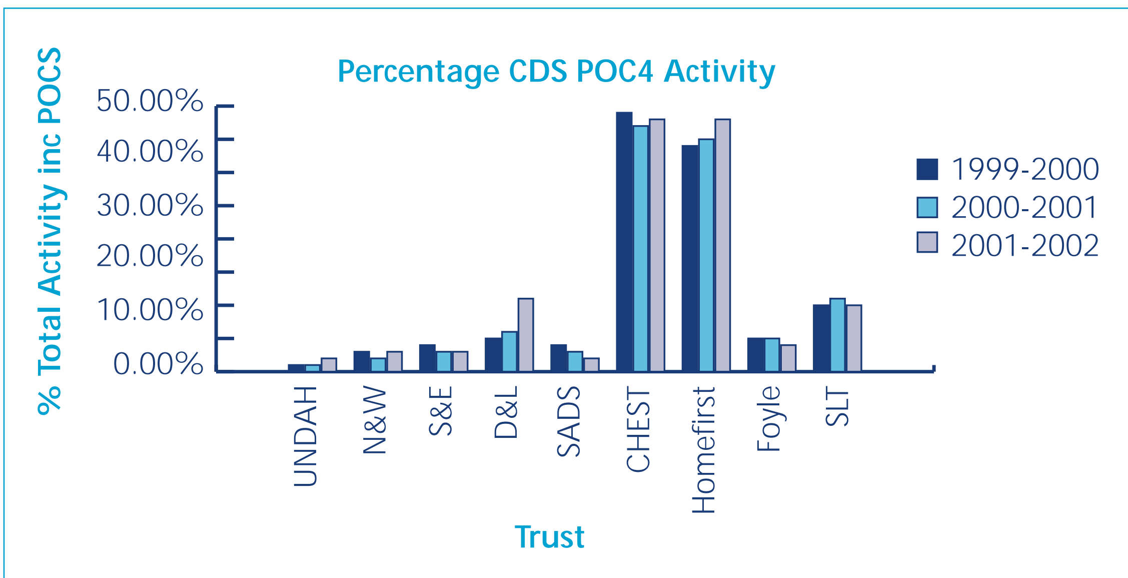


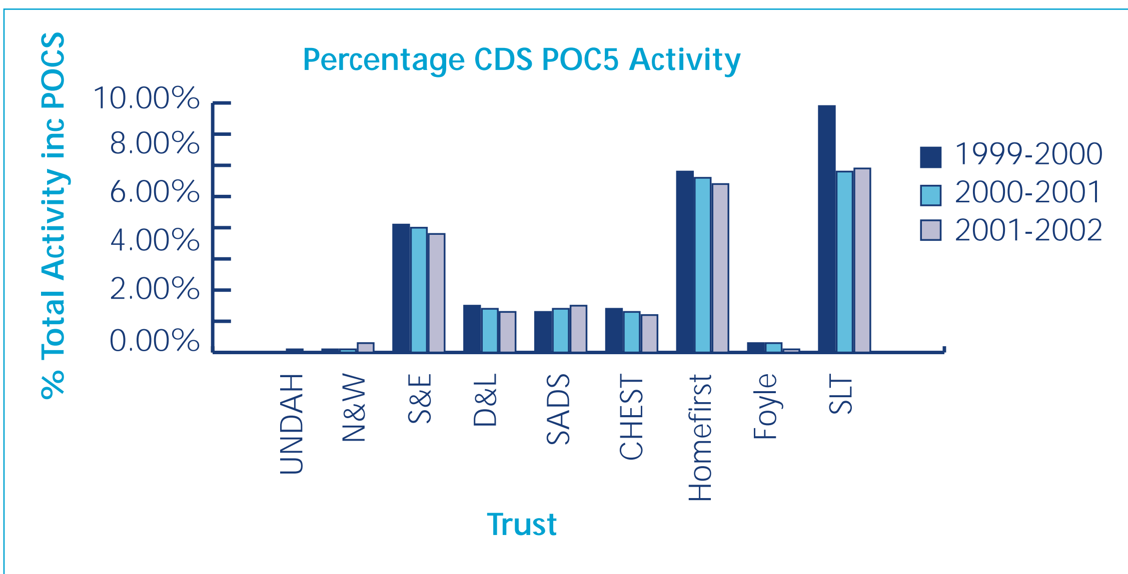
POC 1 = Acute contacts

POC 2 = Maternity & Child Health

APPENDIX 6

CDS Review; Trust Activity Figures 2001-2002; Relative % weighted activity across all Programmes of Care.





POC 4 = Elderly

POC 5 = Mental Illness

APPENDIX 6

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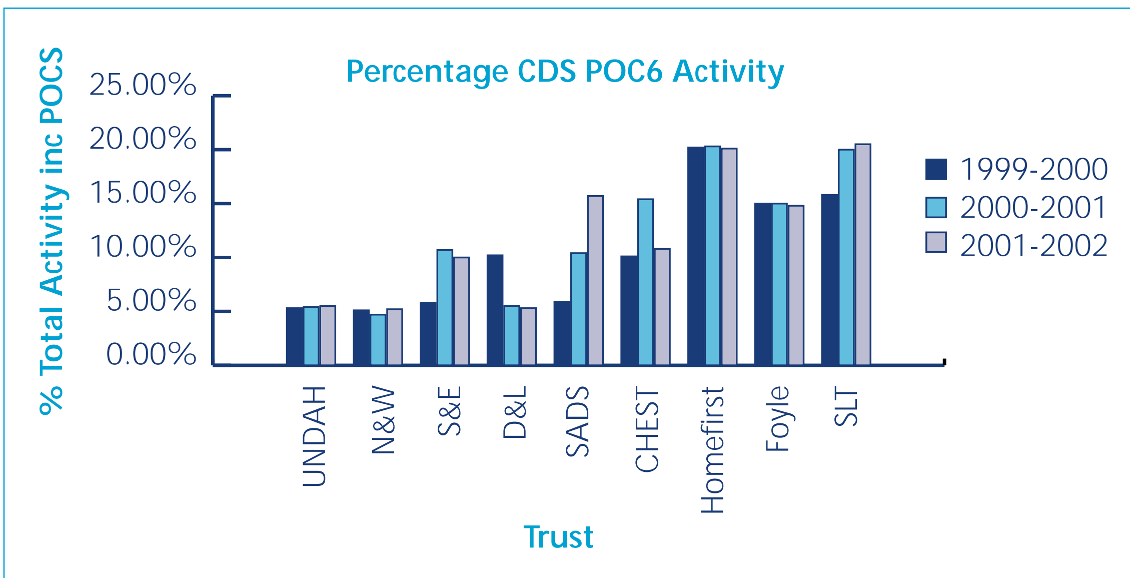
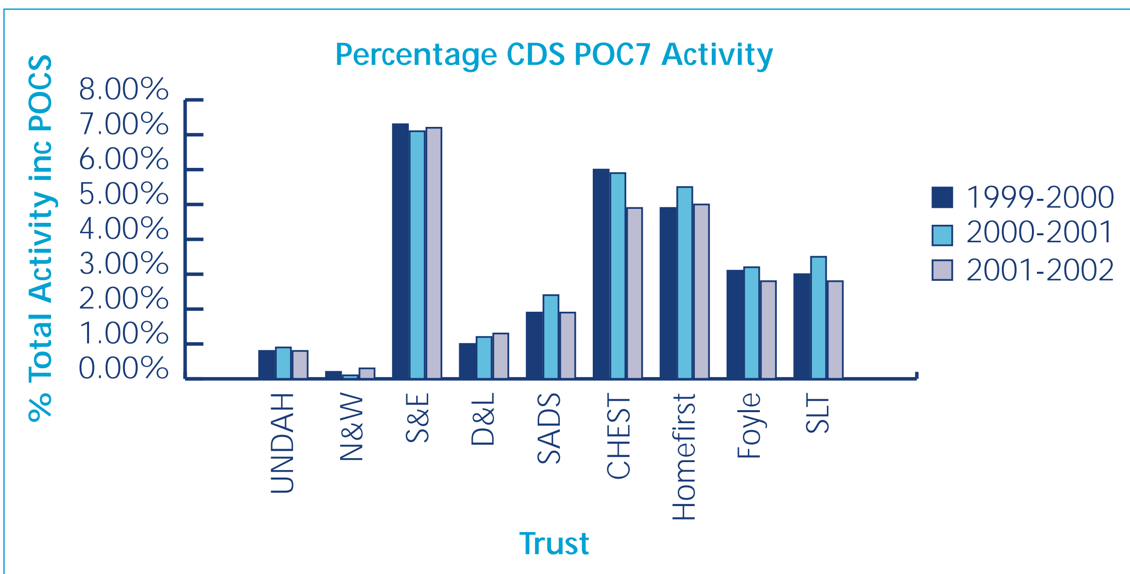


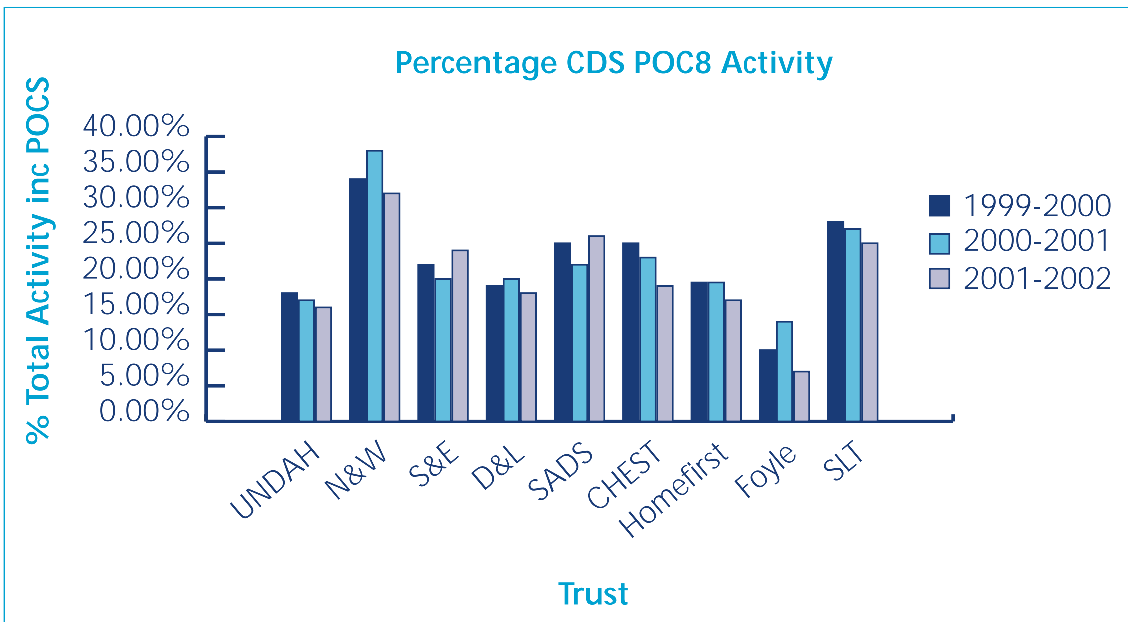


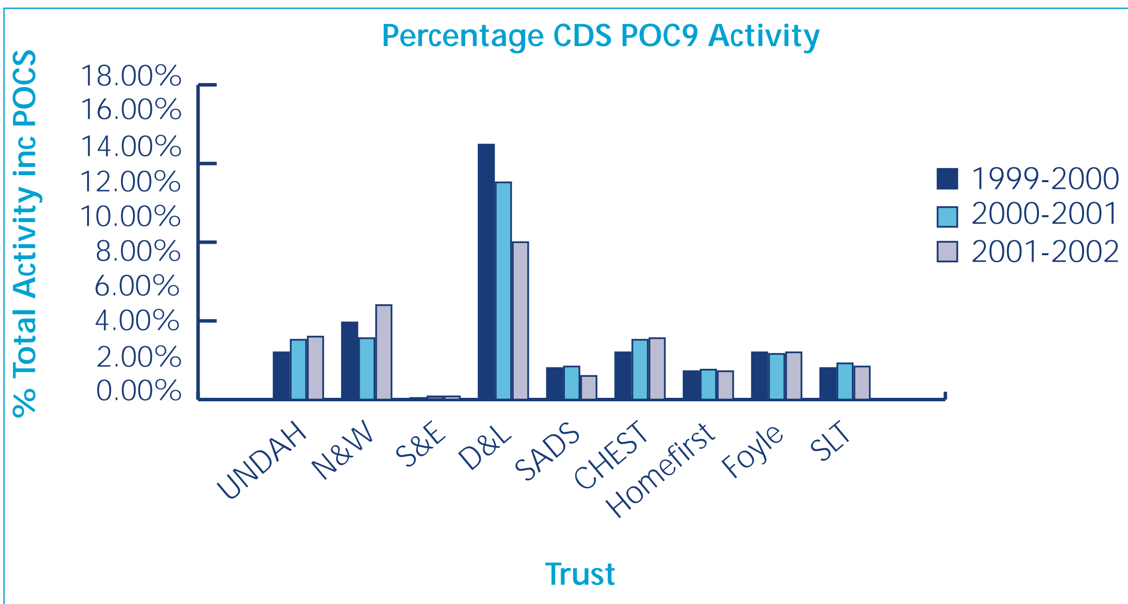
POC 6 = Learning Disability

POC 7 = Physical Disability

APPENDIX 6

CDS Review; Trust Activity Figures 2001-2002; Relative % weighted activity across all Programmes of Care.





POC 8 = Health Promotion/Screening POC 9 = General Population (Adults)

APPENDIX 7

A Sample of CDS Health Promotion Programmes

- Launch of oral health promotion pack for use with young children;
- Participation in a bid for the Sure Start Scheme.
- Early registration scheme;
- Educating carers in oral health promotion; and
- Increasing dental awareness with general practice.
- Oral health guidelines for 0-4 years a multidisciplinary approach for professionals;
- Video and information leaflet - Get a life-Get a Mouthguard.
- Healthy break time;
- Fresh fruit for schools pilot;
- Trauma pack;
- Health Visitor workshops for SureStart and Homestart;
- Smoking cessation;
- Water is cool in schools.
- Smile for the Millennium Project;
- Crest Program;
- Use of a home care pack for learning disabled adults in their own home;
- Smart Snacks Award in local schools;
- Involvement with SureStart schemes;
- Sportsguard scheme;

APPENDIX 7

A Sample of CDS Health Promotion Programmes

- Feeding cup scheme with GDPs and Health visitors;
- CREST programme school evaluation - questionnaires carried out in schools to determine if the programme was beneficial to schools;
- Dental Prevention by early and Active intervention - project aimed at improving the dental health of 6 year old children in the Creggan area of Derry.

Produced by: Department of Health, Social Services & Public Safety
Castle Building, Belfast BT4 3SQ
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Textphone: (028) 9052 7668
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A Review Of The Community Dental Service

A Consultation Document

December 2003