RESTORATION OF DENTAL SERVICES POST COVID-19: DE-ESCALATION OF RED ALERT PANDEMIC PLAN

The purpose of this paper is to provide a framework for the restoration of primary dental care services in Wales 2020/21. This is important given the need to de-escalate RED alert status of the dental pandemic plan, as and when it is safe to do so, in preparation for relaxation of lock-down measures and the likely uncertainties in the year ahead. Covid-19 pandemic has had an impact on many lives and businesses in Wales. There is much to do and for us in the dental community how we rebuild services in dentistry needs consideration; given the impact that the restriction on the production of Aerosol Generating Procedures (AGPs) has had on the provision of dentistry.

However, the 'interruption to normal' also presents an opportunity to use the de-escalation plan to deliver aspirations outlined in *The Oral Health and Dental Services Response to 'A Healthier Wales'*, forming a way forward that encourages access, evidence-based prevention and clinical *care* that is based on need, using the skills of the whole dental team. The uncertainty around the safety of providing AGPs in dentistry means that we have to consider radical changes in how we provide primary dental care in Wales. In this way, the restoration of NHS dental provision could also act as an opportunity and 'portal' for scaling up our learning from the established NHS dental contract reform programme and embed what we know works in dental services across Wales. It could also consign legacy problems with the 2006 NHS dental contract to the past, whilst ensuring we meet future challenges and changing population health need.

Situation

On the 17 March, the first Chief Dental Officer (CDO) COVID-19 letter, heralded routine dentistry 'as normal' was no longer sustainable, as AGPs, frequent daily occurrences in routine dental care, needed to be avoided in the delay phase of COVID-19 infection. In addition, dental teams and people from vulnerable groups (older people and those with underlying health conditions) were required to reduce close personal contact, which occurs extensively in waiting rooms and surgeries. Dental practices and services were also experiencing growing numbers of Did Not Attends (DNAs) and cancellations. Because of the AMBER notice, practices were required to limit service provision and focus on stabilising mouths to reduce the likelihood of patients experiencing problems in the coming weeks. Urgent Dental Centres (UDCs) established across Wales. UDCs staffed and equipped with fit tested FFP3 masks and enhanced personal protective equipment (PPE), for provision of emergency and urgent dental service provision in every health board.

Once establishment of UDCs was confirmed, on the 23 March 2020 a further CDO letter declaring a 'COVID19 Red Dental Alert Level, was published. The aim of escalation to this phase was to ensure delivery of core urgent/emergency dental services in each Health Board by centralising sites for AGP required in emergency and urgent care service delivery and minimising the risks of transmission associated with dental procedures; assumed risk with any clinical encounter.

To ensure business continuity, NHS dental contract holders received confirmation that they would receive 80% of their Annual Contract Value monthly payments from April to June 2020. This ensured that dental practices with NHS contracts were able to maintain cash flow and provide NHS dental delivery teams with protected income. This offer took account of the anticipated reduction in material costs, laboratory fees and

loss of patient charge revenue. Private dental practices and private income of mixed practices were able to access wider Welsh Government support as per other self-employed businesses.

The current situation in Wales is as follows:

- All routine patient contact has stopped;
- If urgent dental care is needed, NHS and private patients should contact their dentist and are referred to UDCs if an urgent treatment need is confirmed at triage (those without a dentist are referred to UDCs via NHS 111);
- Aerosol generating procedures (AGPs) are now only undertaken at UDCs;
- Dental practices with NHS contracts remain 'open' to telephone triage, the provision of advice and the issuing of prescriptions (analgesia & antimicrobials);
- Dentists can provide face-to-face assessments in practice and non-AGPs urgent care if absolutely necessary;
- Recommended PPE and decontamination (e.g. FFP3 masks) are available to dental teams providing treatment in the UDCs; and
- Dental team members can volunteer to support the UDCs and wider NHS effort if their capacity allows.

Activity in dental practices in Wales to date:

Period: 23rd March – 10th May 2020	**Number**
Referrals to Urgent Dental Centre	759
Prescriptions issued	15,486
Patients seen in the practices for urgent assessment & non AGPs	4,614
Telephone calls taken	68,468
Remote advice provided	31,161

(UDC data will be available soon)

As highlighted above, there is now a need to plan for the period from June/July 2020 to March 2021 and beyond. The transition to resumption of dental care requires a phased approach. A key consideration is to provide business continuity, given the impact that the restriction on the production of Aerosol Generating Procedures (AGPs) has, and will have, on the provision of dentistry. 'Opening up' dental services again will

depend on maintaining the reduction in community transmission of COVID-19 and in time, the development of an effective vaccination programme. Equally, the continued supply of level 3 PPE to UDCs and the availability of standard PPE to dental practices are key, alongside community testing and a greater understanding of transmission, both in the community and in the dental care setting. It is likely that significant levels of unmet need from delayed dental care will present, so priorities for available capacity in resumed dental services will need to be agreed and be set. Consideration must also be given to the dental care needs of vulnerable groups (including those who are currently shielded) going forward.

It is clear that 'normal' routine dental activity, as we understand it, cannot resume in the medium or even longer term. The uncertainty around the safety of providing AGPs in dentistry and the need to maintain social distancing, means that dental treatment, activity and patient through-put, at pre-COVID levels is not possible; we have to consider radical changes in how we provide primary dental care in Wales. There is a need to ensure the sustainability of the dental sector throughout this transitional period, both in clinical and economic terms. As a result, a robust needs-led NHS dental primary care service working in a more integrated way to deliver value based healthcare, could emerge from this situation. To achieve this, we can draw on learning and experience of the established dental contract reform programme, prudent healthcare and A Healthier Wales policy direction; and strategic planning in wider primary care contract reform in Wales.

Background

The vision for dentistry in Wales builds on the philosophy of Prudent Healthcare and recognises that system and contract change is required. This pandemic has not altered this vision and the interruption to routine dentistry 'as normal' provides a catalyst for change. This focus on transformation, innovation and needs-based *care* to address inequalities, is the foundation of the current NHS dental contact reform work. The values and design principles employed can assist us now during this de-escalation period, using the tools designed and tested by dental teams in Wales over the last three years. This will facilitate and support the transition of NHS service provision and a resumption of a 'more preventatively focussed' approach in Wales. There has been steady investment in the skill-mix and capabilities in dental teams who deliver NHS care and continuous engagement with clinical teams throughout the contract reform process. The Quality Assurance Self-Assessment (QAS) report published in March 2020 confirmed: number of dental nurses trained in prevention and the application of fluoride varnish was 107 in 2017, 182 in 2018 & 263 in 2019, 818 dental practice team members have completed IQT Bronze level up from 397 in 2017 and 196 practices have used the Maturity Matrix tool. Sharing the learning, tools and measures developed in the last three years with all Welsh dental practices & community dental services will support what is now required to happen, relatively quickly across the country. As almost half of our practices with NHS contracts are part of the reform programme, we have the opportunity to go further and faster, as we have a developed and tested solution, that we can and should exploit in transition to resumption of dental services, that will produce the change that is now required at pace and scale.

Principles underlying change

Population need has changed in recent decades and there have been significant improvements in oral health. However, too many children and adults that still experience the impact of poor oral health and there has been little or no change to activity-based contracting of dental services. Whilst our ambition is to step up effective prevention, the 2006 (and current) dental contract arrangements continues to reward treatment activity ('cure') ahead of prevention and 'Value-Based' outcomes ('care'). The rigidity of the target-driven culture, links Units of Dental Activity (UDA) to the investment made in practices (Annual Contract Value - ACV), which incentivises treatment-based activity over preventive interventions. Multiple courses of treatment (CoTs) are often delivered to an existing patient base, rather than annualised care planning for new and existing patients seen; stifling the effective use of skill-mix and personalised prevention.

The oral health and dental services response to A Healthier Wales set out priorities under three themes, namely: a step up in prevention; dental services fit for future generations; and developing dental teams and networks. These are more relevant than ever and can assist us in planning de-escalation and emergence from scaled back services. They will serve us well in making the unprecedented decisions now required.

The five key priorities for transforming dentistry also still apply:

1. Timely access to prevention focussed NHS dental care;
2. Sustained and whole system change underpinned by contract reform;
3. Dental teams that are trained, supported and delivering Value-Based quality care;
4. Oral health intelligence and evidence driving improvement; and
5. Improved population health and wellbeing.

These five priorities are relevant in transition from the current situation. They support a 'Value-Based' and 'Prudent Healthcare' approach to the restoration of dental care provision in Wales, based on the following principles:

1. The public and professionals are equal partners
2. We care for those with the greatest need first
3. We do what is needed and do no harm, and
4. We reduce inappropriate variation based on evidence.

The dental practices taking part in NHS contract reform have created tools to assist their practice teams to plan their work force and the approach to evidence-informed preventive care and service provision. These include standardised and measurable assessments of health need, risk and outcomes using the Oral Health Needs Assessment (OHNA) tool, the ACORN (See Appendix One), evidence-based prevention to ensure personalised care (and treatment) for those with the highest need and appropriate use of preventive care for all patients. 'The Expectations' for preventive intervention, patient information for personalised advice and planning are agreed. (See Appendix Two).

Process

Given the uncertainty around COVID (the virus spreads primarily through droplets) and the safety of providing AGPs in dentistry in the future, it is highly unlikely that we will return to a model of service provision that was in operation prior to its onset. Transitioning from the current RED alert phase to a 'new normal' needs to be driven by our underlying core values and can only be managed by acting conscientiously and cautiously, but also calmly and with preparation that includes working with clinical teams, Health Boards, Public Health Wales, British Dental Association Wales, patients and the public. Through a consensual and collaborative approach, we need to develop a care-based model under-pinned by the values highlighted in the previous section, which supports business continuity during this transitional period and beyond.
To reduce AGPs and maintain social distancing, the throughput of patients will have to remain low for months to come, and even wide spread testing or an effective vaccination programme will not solve all the issues in the provision of dental services in this coming year. Patients do value dentistry and dental treatment; it is necessary and not easily postponed indefinitely. Dentists and their teams need to feel and be safe in order to fulfil their duty of care towards their patients.

The first stage in this process is planning for the de-escalation from the current RED alert phase to a heightened AMBER phase in dentistry; this paper is part of that consideration. To support this phase there will need to be a continuation and strengthening of the provision in UDCs for those in need of AGPs. Many of these patients will have on going and definitive treatment need and will need re-assessing in their routine dental practice, receiving dental care and preventive interventions that do not involve an AGP.

The second stage will need to address the backlog of need for patients and those people who do not normally attend dentistry routinely. This will include provision of definitive care for those who have received urgent care in the UDCs, those who have contacted dental practices during the RED alert phase, because they have had a dental problem and/or pain or swelling and who have an on-going treatment need. It will in addition, include those who did not meet the strict criteria for urgent or emergency care, but who have dental problems or treatment need that has had to be delayed, postponed or self-managed during this period of service interruption.

The third stage would be to reinstate routine assessment and care. At each stage, we will use the opportunity to base our de-escalation process on the aspirations highlighted above and the lessons that we have learnt from dental contract reform programme to date.

Over-arching each of these stages will be the wider context of Covid-19, it will be important to maintain rigorous infection-control. As a result, Standard Operating Procedures are in development to promote:

1. Efficient use of appropriate PPE for both UDCs and practices;
2. Pre-appointment checks (by phone/videoconference);
3. Pre-treatment checks;
4. "Social distancing" (consideration to timing of appointments and reduction in the number of patients in the waiting areas); and

5. Spacing of clinical appointments (reduction of numbers of patients waiting and providing sufficient time in-between appointments needed for adequate disinfection of the surgical areas.

Supporting de-escalation and resumption of NHS dental services within the current contractual framework

The reduced through put of patients will allow a slower more considered care-based approach to dentistry, giving more time for the dental team to concentrate on prevention and personalised advice; as well as the provision of effective treatment. It has been clear for some time that dentists need to change from a 'surgical model' delivering 'cure' to a medical 'physician' model based on clinical leadership of dental care within a team. This would also promote better integration of dentistry within NHS primary care and promote the use of the skills of the wider dental team, aligning to the objectives outlined in a prudent healthcare approach. What will matter most in the transition period is that dental teams see those with the greatest needs first, that they use the time to transfer the responsibility for daily mouth care and maintenance of oral health to patients; using the investment made in dentistry by Welsh Government effectively and efficiently. Essentially, this is creating the conditions to support de-escalation and the environment for a preventive care approach, to be workable sooner, within the current contractual framework.

As highlighted in the previous section, there is a recognition that patient through-put would be severely reduced to allow social distancing and enhanced decontamination processes limiting the number of patients that can be seen in any given treatment or assessment session. Enhanced PPE considerations and decontamination process are also required. The collection of patient charge revenue (PCR) also requires review to protect staff and patients in order to reduce cross-infection. Invoicing and remote payment transactions could be explored in transition, wherever possible, to avoid clinical teams handling cash. A simpler one off (or staged payment) of a single cost for access to NHS dentistry per financial calendar year (for all adults who are eligible to pay) could be proposed, developed and consulted on in the coming year. Such an approach would align better with annual care planning rather than patients paying in bands for Courses of Treatments (CoTs). Remote payment methods would facilitate the opportunity to explore the removal of the collection of patient charge revenue from dental practices in future years. Such a change would require significant amendment to current regulations and monitoring processes, therefore, it is not something we can easily achieve in the transition period but there is merit in using the time available to discuss and explore. It would also have the additional advantage of removing the transactional payment and 'eligibility checking' from a health care setting. Something dental teams have been asking for repeatedly.

Value-Based health care encourages the assessment of needs and risks, whilst promoting outcomes that are based on the quality of care, rather than the quantity of cure; using the available resources to achieve the best value and outcomes for individuals and communities. Prudent healthcare is about looking after a practice population, understanding and meeting their needs and everyone in the team working to their full Scope of Practice ('skill-set'). To support implementing both of these complimentary approaches, to underpin the de-escalation phase and improve the future of NHS dental service provision, we need to address the use of Units of Dental Activity (UDAs) in current contracting

arrangements. Current regulations allow the number of UDAs assigned to a given annual contract value (ACV) to be adjusted; *variation in the number of UDAs assigned to a contract can be altered with mutual consent in current GDS regulations*.

If UDAs linked to individual patients and therefore measured the 'practice list', in a given financial year rather that treatment activity, it would facilitate annualised care planning of a dental practice population. Units of Dental Activity (UDAs) could become Units of Dental Assessment (UDAS) to 'assess' and meet need, address risk and maintain oral health, rather than just incentivise check-ups and treatment activity. Each unique patient seen in a practice, in a financial year, would generate one UDAS per annum. This would break the link between UDAs, 6 month check-up and treatment activity/bands/CoTs. As a result, the numbers of patients attending and receiving care in a dental practice or service, in a given financial year, their needs & risks, preventive intervention delivered (meeting preventive expectations) and the quality of care provision (outcomes) would be the link to the ACV. These aspects of care would then become the incentives that drive NHS dental team behaviour.

This would also offer the business continuity to deliver preventive needs led care to encourage capital investment and increase capacity for the NHS. They will also be meaningful measures for monitoring performance and reporting, allowing the Welsh Government and the local Health Boards to understand and address the national and local oral health needs of their communities. Through the existing processes with the NHS Business Services Authority (NHSBSA), we can measure the unique number of patients attending a practice in any given 24-month period – that would be used to calculate the number of UDAS assigned to a contract value. Using the modified FP17W (see appendix 3), the practice would utilise the existing assessment OHNA tool (ACORN), which is extensively used in contract reform practices and report the summary findings, the need (& modifiable risk) once for each patient via FP17W in a financial year. When the ACORN is completed and reported a year later, it effectively monitors the impact and outcomes of care. The findings of the ACORN, a detailed assessment and clinical examination of a patient, describes need and modifiable risk of individuals. It forms the basis for discussion with patients and it guides the annual care plan. The preventive interventions, the quality of preventive care, we expect to be delivered, for individuals in each need & risk category, and the use of skill mix in the delivery of the annual plan, can also be reported on the modified FP17W.

This approach shifts the focus of care provision away from the proxy treatment measure (Unit of Dental *Activity* UDAs). Monitoring 'cure-based' activity rather than needs-based care would not be appropriate for the de-escalation phase, given its focus on routine check-ups and courses of treatment that create AGPs. However, much of what could be provided, without AGPs, would make a real difference to oral health and would reduce risk, of disease progression for patients, and in delivery of dental care for staff in transition to a 'new normal' in primary dental care. UDAs as they are, targets, incentivise treatment activity, patient through put, travel to the practice and social contact, as it encourages dentists to see patients frequently, even if no dental treatment activity is required.

In any case, UDAs are widely discredited as a measure of performance and the dental community and their representatives have been asking for their removal and reform of the current contract arrangement since 2006. Although the change seems like a significant one, the removal of UDAs, has been tested in the original dental pilot programme in Wales. However, at the time, without the measures in the current contract reform programme, such as, practice population need, risk & outcomes, quality markers of preventive interventions delivered and the use of skill mix, the changes in activity that occurred could not be explained, or understood and the outcomes of care could not be captured.

Currently 40% of practices, with NHS contracts, are taking part in dental contract reform (174 of 431 practices). The Minister for Health and Social Services set a target of 50% of practices to be part of the reform programme by October 2020 with a clear timetable in 2021 for the remainder of practices to join. The current reform programme allows a reduction of 10-20% of UDAs but this modest flexibility in UDA numbers does not break the link with activity targets and does not allow practices to truly, transform the primary dental care offer or use skill mix innovatively. This transition period presents the opportunity to do that.

If practices with NHS contracts move to the proposed Unit of Dental Assessment UDAS model during this de-escalation phase (July 2020 to March 2021), we would calculate the number of UDAS to assign to a contract based on number of unique patients attending. That is the number of patients that attended in the twenty-four-month period between April 2018 and March 2020, with an additional uplift of five per-cent to allow for some movement and to capture those patients who attend practices sporadically. This ensures that we can promote a Value-Based de-escalation model within the current contractual framework. Effectively the UDAs will become a Unit of Dental Assessment UDAS and will link directly to individual patients. At mid and year-end contract review discussion, consideration can be given to, the number of patients cared for, their needs and preventive delivery for the ACV, with obvious caveats on the context of the post-acute phase of Covid-19. In essence, practices with a healthier practice population would care for more patients than a practice with a higher need population for the same ACV. Developing and agreeing annual costs per patient and a safe number of patients will be the work of contract reform programme going forward.

Each patient attending a practice would be entitled to have one thorough assessment (Oral Health Needs Assessment using the ACORN tool) per annum. The dental team will complete an ACORN (Appendix 1) and agree an annual plan that is personalised for each patient. The dental team will be expected to deliver the Expectations (Appendix 2 as set out in CR programme report pages 32-35) outlining the preventive interventions and evidence informed advice required and give each patient the patient facing plan. The summary ACORN data will be completed and reported on the FP17W (Appendix 3).

http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/GDS%20Reform%20Annual%20report%20Final%20Version%2011.pdf .

During the first phase of this transition period, any non-AGP dental treatment and preventive interventions required, can be provided in practices with standard PPE as per standing SOP. However, those patients requiring AGPs in the first phase of transition will have to continue to receive treatment in UDCs; albeit in a strengthened UDC network. Practices will be expected to contribute and be part of the UDCs network where staff capacity and facilities allows this to happen. Later this year, if COVID transmission is contained and enhanced PPE supply can be assured, fit tested FFP3 masks become more widely available, in practices with more than one surgery AGP delivery may resume with caveats on numbers that could be treated. Priorities on delivery of AGPs will need to be set. This will be an iterative process. Resuming AGPs outside of the UDCs will need ‘keeping under review’ in all phases of transition.

Consideration is also required regarding the resumption of orthodontic practice during this transition period and details on that will follow by mid-June 2020.

Empirical evidence under-pinning the proposed approach to de-escalation

Data collected from the NHSBSA highlights that the majority of adults attending NHS dental care in Wales re-attend every six to nine months and relatively few have active treatment. Sixty-percent of the Courses of Treatment claimed by practices with NHS contracts are for Band 1 care (1 UDA), representing most often, an examination and a scale and polish. Only a quarter of UDAs claimed are for patients who require active intervention and the most common treatment in Band 2 is for one restoration ('filling') or an extraction. Only 4.5% of clinical activity claims relates to Band 3 treatments (crowns, bridges and the provision of dentures), whilst less than one in ten (9%) of claims are for urgent/emergency appointments. However, use caution in interpretation as UDAs claimed do not relate to % time taken for care provision. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Dental-Services/Current-Contract. These data provide the point estimate (average) for practices across Wales and there is a variation, although many practices have a stable population of mainly healthy patients. Practices receive investment from the NHS called the Annual Contract Value (ACV) paid in twelve equal monthly payments net of PCR collected. The % of the 'target' number of UDAs claimed is used as a % 'performance' measure of contract delivery often in isolation to the number of patients seen and/or their needs. Many practices, including those who have not had interruption to services or recruitment difficulties, fail to reach their UDA target and a common complaint from dental teams is that they feel like they are on a 'treadmill' and remunerated only for activity. If they did not see well patients frequently, who turn up on time and pay on time, they risk having contract value 'claw back'.

Uncoupling the link between treatment activity and remuneration will address this problem. In addition, current UDAs have varying 'values' and this is deemed unfair. It will be sometime before we can collectively agree a 'fair' number of UDAS to assign to the ACV so we have to start with current practice list. It will depend on patient need and risk. Practices will not be penalised if patients do not engage and improve oral health however, we must find a mechanism to celebrate and reward improved outcomes and increased access so practices can grow.

Data submitted by reform practices indicate that a significant proportion of patients attending the General Dental Services in Wales have stable oral health and no identified treatment need (Appendix 4). Less than twenty-percent had active disease however when we include those with modifiable risk more than half would benefit from risk reduction. One per-cent of adults and 0.1% of children had active tooth decay and periodontitis as well as treatment need for 'other dental conditions'. There is a common misconception that new patients have high treatment need. The risks and needs profile of new patients seen by the contract reform dental practices in 2018/19 is presented in Figure 6 of the contract reform report. It is not surprising that a higher proportion of new patients have prevention and greater treatment needs compared to patients who attend dental practices on a regular basis but again the majority were 'active disease' free. Time taken, to address those with greater treatment need, could be off-set by the many patients at the practice that have good oral health attending less frequently, having

preventive interventions delivered by other registrants such as, dental nurses, without the context of the practice being under pressure to generate UDAs.

We are aware of the other work streams to return provision of other regular and essential services in the wider NHS; also planned on an incremental and considered basis with a focus of providing equitable provision across Wales. This paper is part of that work but focussed on dentistry. Making progress through the phases of this transitional plan for the resumption of dental services, as with other NHS services, depend on response to Covid-19 measures in Wales in general.

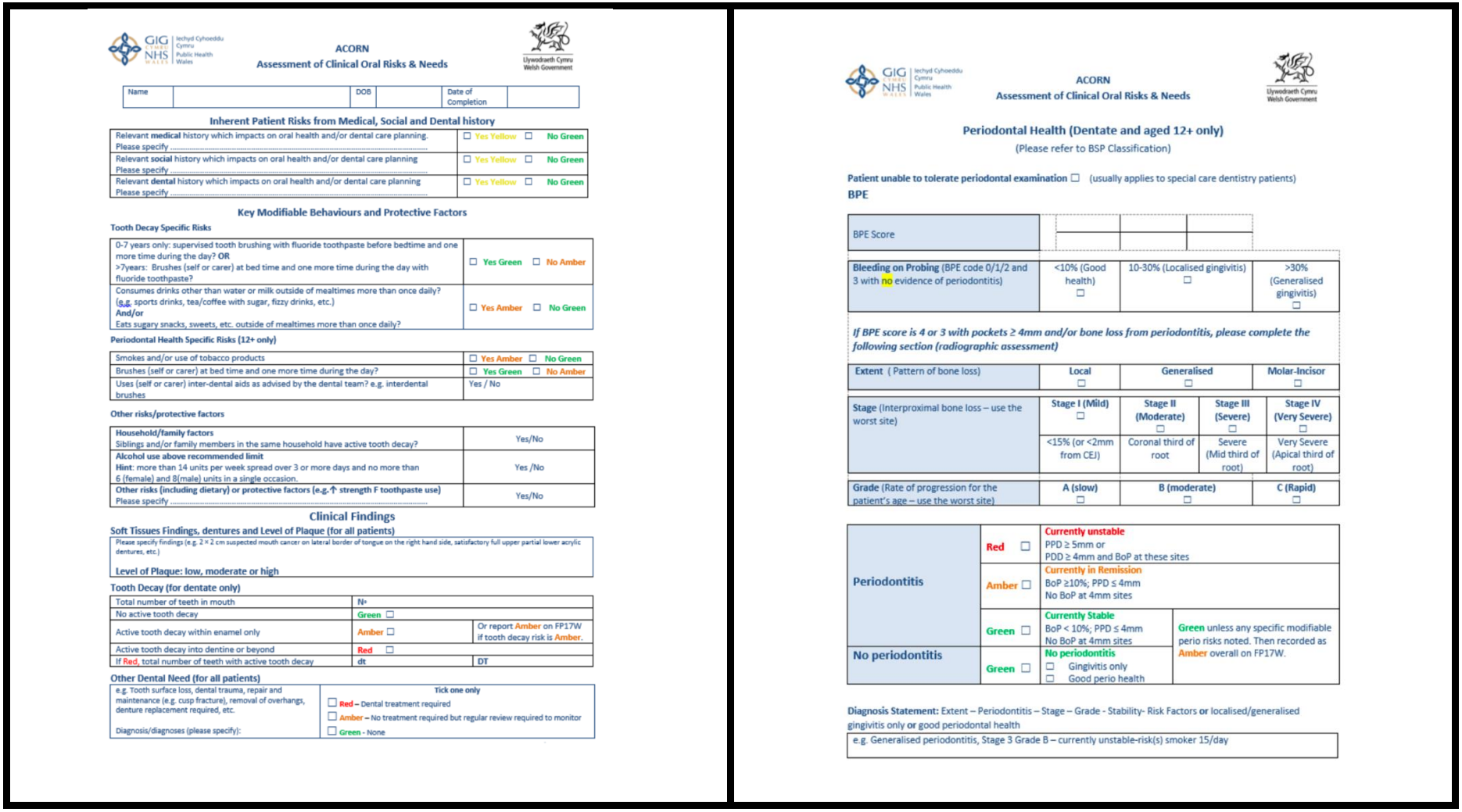
Recommendations

- Support and implement a phased restoration of dental services from June 2020 (see attached table 1)
- Socialise the proposals with clinical teams, health boards and representative bodies
- Contract reform team redeploy to offer training and support in the use of ACORN and Expectations tools and work on annualised care plans with all dental practices in June 2020
- Buddy current CR practices with new practices to support peers understand approach
- Explore new technology (attend anywhere) that will enable delivery such as digital/video consultations & pre-treatment checks
- Technology could also support practices to complete sections of ACORN prior to a patient attending the practice; reducing time in practice and F2F contact
- Expand ‘on-line’ learning in prevention (such as Making Prevention Work in Practice MPWiP) so dental teams prepare in June
- Work with NHS BSA and HBs to ensure UDAS assigned to contracts are calculated in a ‘Once for Wales’ approach and that FP17W monitoring can be altered to support change in UDA focus
- Complete detailed work on SOP to support clinical teams
- Ensure secondary care teams resume accepting USC referrals
- Use numbers of patients attending, ACORN findings / FP17W and KPIs of care delivered at mid-year contract review
- Reconcile costs of pathways, number of patients and practice population need at year end
- Work with representative bodies to take account of and explore changes to associate and self- employed DCPs T&Cs
- Assess risk to PCR, mixed contracts and impact on private practice delivery during transition period

EDT discussion and approval to proceed with proposed transition plan and necessary changes to contracts to facilitate implementation (see Table 1 below)

Table 1					
Covid-19 Dentistry	**Now Mar- June 20**	**Phase 1 July–Sept 20**	**Phase 2 Oct-Dec 20**	**Phase 3 Jan 21-Mar 21**	**Future Considerations**
Response	AMBER alert 17/03 & RED alert of pandemic plan 23/03 CDO letters No routine dental care Dental practices open for telephone contact and F2F assessment & urgent care no AGPs 15 UDCs established Emergency/urgent care AGPs in necessary	De-escalation, RED alert phase to heightened AMBER of pandemic plan in dentistry Continuation & strengthening of UDCs for urgent needs & AGPs definitive treatment need extend to practices Patients re-assessed in practices they normally attend, dental care and preventive interventions that do not involve an AGP	Address backlog of need Include people who attend dentistry routinely. Provision of definitive care for UDCs patients & those contacting dental practices since 23/03 with dental problems and/or pain or swelling who have on-going treatment need, include those not meeting strict criteria for urgent care who have treatment need delayed, postponed or self-managed.	Reinstate routine assessment and care. Use the opportunity to take lessons learnt from dental contract reform to inform the way of working and embed that NHS dentistry delivery	UG & PG issues DFT & DCT considerations
Purpose of Stage	Reduce community transmission Covid-19 Stop AGPs in practices Reduce travel and maintain social distancing protect staff and patients	Easement of lock down Resumption of dental care provision Consideration of orthodontic provision	Continuity and recovery	Return to 'new' normal	PPE supply in all stages
Practices **Health Boards** **CR Team & Dental branch**	Maintain telephone contact with patients collaborate with other practices standard PPE Report weekly to eRMS Volunteer to UDCs or wider NHS effort, no redundancies Ensure NHS staff receive average net income Prepare for restoration Monitor UDCs & practice returns, monitor adherence to CDO directions including finance prepare restoration Redeployed to Covid-19 response. In May and June need some staff to support implementation of restoration plan and mentor practices Introduction of guides and online learning etc.	Buddy CR practices with new practices to programme Ensure all have received training and ACORN guidance packs ACV restored ACV restoration and UDAS calculation Include practices in UDC network Support communications Support once for Wales calculations of UDAS & ACV proportional to performance and recruitment/service delivery to march 2020	Resume AGPs in practices that are part of UDC network **Attend anywhere implementation** **Continue to support CR implementation all practices** **Analysis of OHNA & KPIs**	**Review ACORN % completion** **Numbers of patients attending** **KPIs & access** **ACORN completion delivery** **Work on costed pathways**	
Other planning considerations	Secondary care USCs Orthodontics DFTs DCTs UGs & PGs HIW & HEIW & BDA liaison	Strengthen CR team £ & contract reform Attend Anywhere in dentistry Consultation on future changes to patient charges	**Prepare for PCR change proposal and consultation**	Prepare regulatory change	

Appendix 1 ACORN



ACORN
Assessment of Clinical Oral Risks & Needs

Name		DOB		Date of Completion	

Inherent Patient Risks from Medical, Social and Dental history

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

Key Modifiable Behaviours and Protective Factors

Tooth Decay Specific Risks

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

Periodontal Health Specific Risks (12+ only)

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

Other risks/protective factors

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

Clinical Findings

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

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

Level of Plaque: low, moderate or high

Tooth Decay (for dentate only)

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

Other Dental Need (for all patients)

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

ACORN
Assessment of Clinical Oral Risks & Needs

Periodontal Health (Dentate and aged 12+ only)

(Please refer to BSP Classification)

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

BPE

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

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

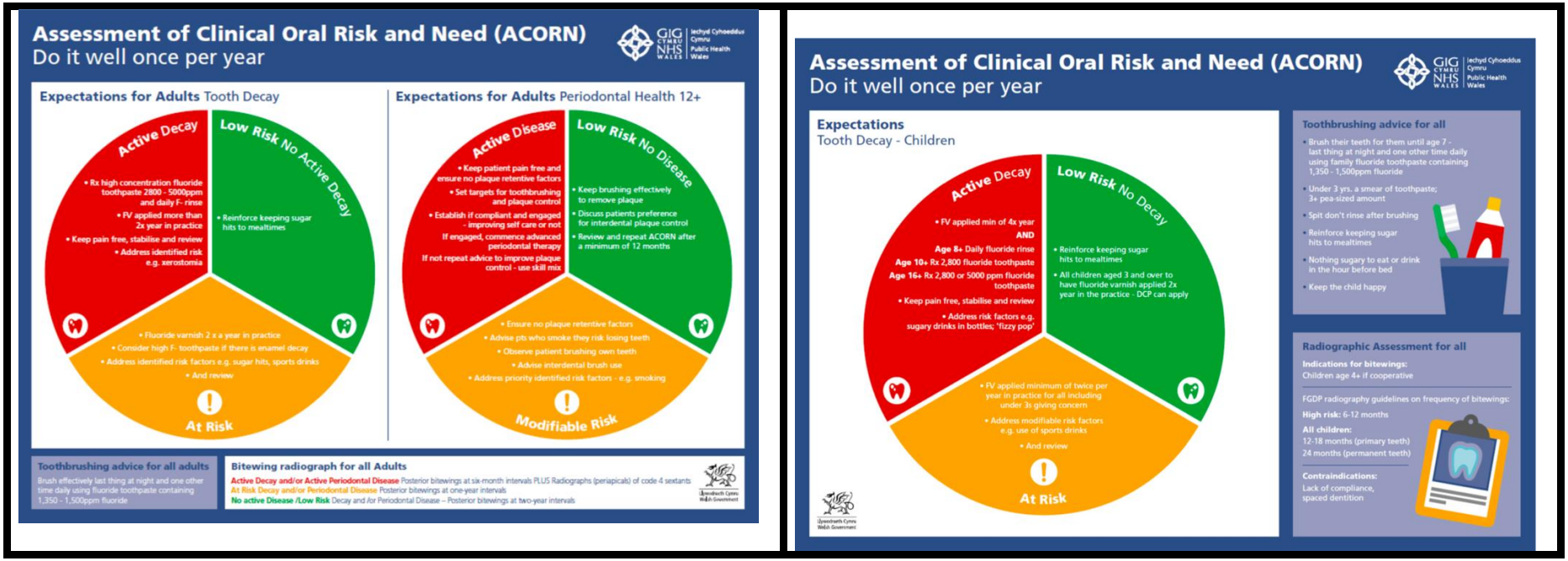
Extent (Pattern of bone loss)	**Local** ☐	**Generalised** ☐		**Molar-Incisor** ☐
Stage (Interproximal bone loss – use the worst site)	**Stage I (Mild)** ☐	**Stage II (Moderate)** ☐	**Stage III (Severe)** ☐	**Stage IV (Very Severe)** ☐
	<15% (or <2mm from CEJ)	Coronal third of root	Severe (Mid third of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

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

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

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

Appendix 2 Expectations



Your dental health

What you need to do:

Your next appointments

Date:	Time:
Date:	Time:
Date:	Time:

GIG CYMRU NHS WALES

Your Prevention Plan

Name:

Date:

Your dental health

Tooth decay	You have active tooth decay	You are at risk of needing a filling in the future	You have no active tooth decay
Gum health	You need treatment from us and better cleaning by you	Your gum health is stable but you need to follow our advice on cleaning	You have healthy gums! Keep doing what you are doing
Other problems of the mouth	You need dental treatment	You do not need additional treatment but we will review you regularly to monitor	You have no other dental need to be concerned about

What we will do for you

- ☐ Advice on what to eat or drink to improve your oral health
- ☐ Advice on cleaning your teeth
- ☐ Smoking cessation advice
- ☐ Apply fluoride varnish/fissure sealant
- ☐ Dental treatment as advised
- ☐ Prescription for a high fluoride toothpaste or rinse

What we expect you to do/continue doing

☐ 

Brush twice per day, at night and one other time. Spit don't rinse.

☐ 

Use a family fluoride toothpaste (1,350 – 1,500 ppm fluoride)

☐ 

Keep sugary food and drinks to mealtimes. Don't eat or drink anything sugary in the hour before bed.

☐ 

Contact Help Me Quit 0800 085 2219 www.helpmequit.wales

☐ 

Use interdental brushes.

☐ 

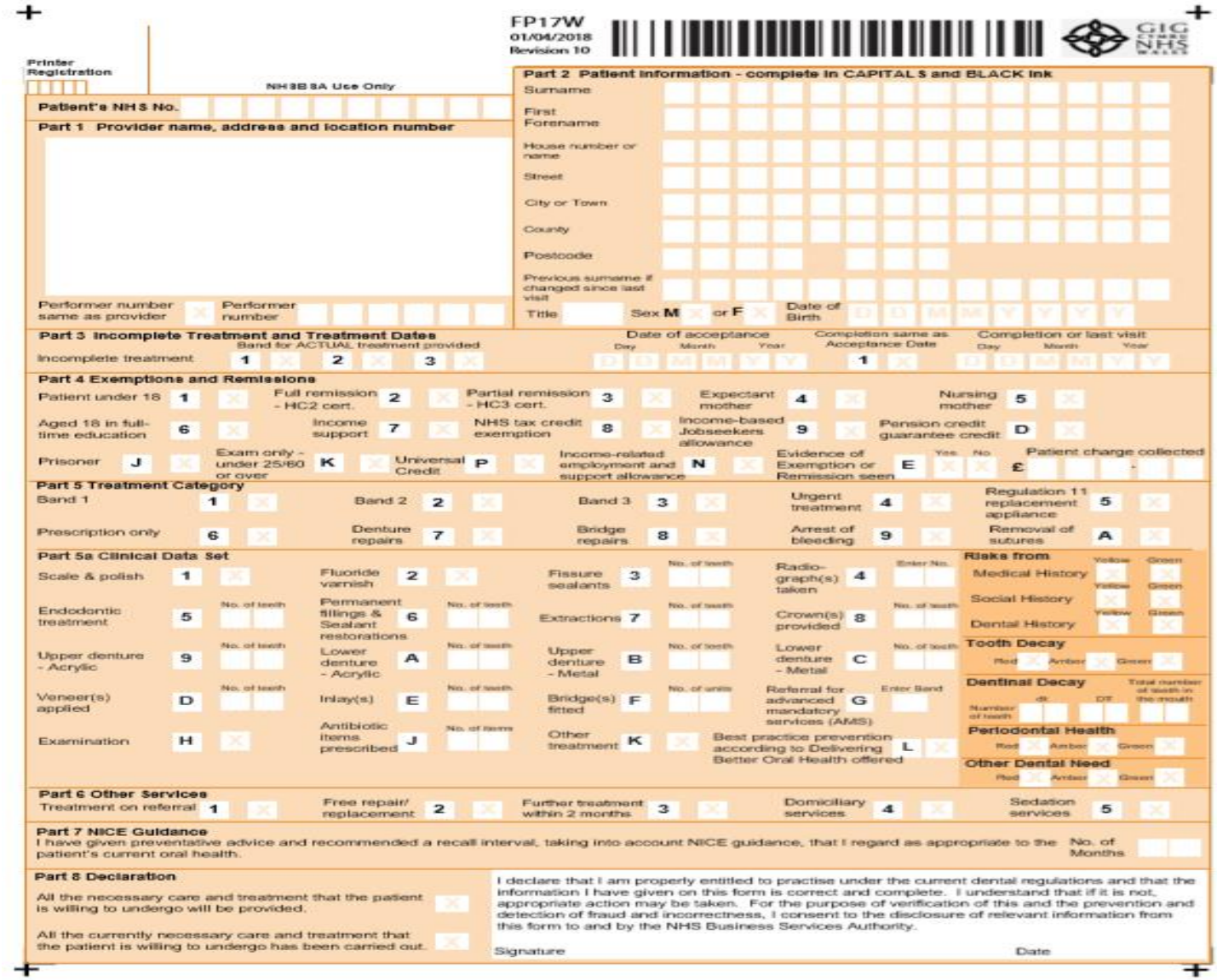
Attend your appointments when advised. Inform the practice if you cannot attend.

You will need a review in:

☐ 3 months ☐ 6 months ☐ 12 months ☐ Other_____

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

Appendix 3 - FP17W



FP17W
01/04/2018
Revision 10

Printer Registration

NHSBSA Use Only

Patient's NHS No.

Part 1 Provider name, address and location number

Performer number same as provider

Performer number

Part 2 Patient information - complete in CAPITALS and BLACK ink

Surname

First Forename

House number or name

Street

City or Town

County

Postcode

Previous surname if changed since last visit

Title

Sex M or F

Date of Birth D D M M Y Y Y Y

Part 3 Incomplete Treatment and Treatment Dates

Incomplete treatment — Band for ACTUAL treatment provided: 1 2 3

Date of acceptance D D M M Y Y

Completion same as Acceptance Date: 1

Completion or last visit D D M M Y Y

Part 4 Exemptions and Remissions

Patient under 18: 1 | Full remission - HC2 cert.: 2 | Partial remission - HC3 cert.: 3 | Expectant mother: 4 | Nursing mother: 5

Aged 18 in full-time education: 6 | Income support: 7 | NHS tax credit exemption: 8 | Income-based Jobseekers allowance: 9 | Pension credit guarantee credit: D

Prisoner: J | Exam only - under 25/60 or over: K | Universal Credit: P | Income-related employment and support allowance: N | Evidence of Exemption or Remission seen: E (Yes / No) | Patient charge collected £ .

Part 5 Treatment Category

Band 1: 1 | Band 2: 2 | Band 3: 3 | Urgent treatment: 4 | Regulation 11 replacement appliance: 5

Prescription only: 6 | Denture repairs: 7 | Bridge repairs: 8 | Arrest of bleeding: 9 | Removal of sutures: A

Part 5a Clinical Data Set

Scale & polish: 1 | Fluoride varnish: 2 | Fissure sealants: 3 (No. of teeth) | Radio-graph(s) taken: 4 (Enter No.)

Endodontic treatment: 5 (No. of teeth) | Permanent fillings & Sealant restorations: 6 (No. of teeth) | Extractions: 7 (No. of teeth) | Crown(s) provided: 8 (No. of teeth)

Upper denture - Acrylic: 9 (No. of teeth) | Lower denture - Acrylic: A (No. of teeth) | Upper denture - Metal: B (No. of teeth) | Lower denture - Metal: C (No. of teeth)

Veneer(s) applied: D (No. of teeth) | Inlay(s): E (No. of teeth) | Bridge(s) fitted: F (No. of units) | Referral for advanced mandatory services (AMS): G (Enter Band)

Examination: H | Antibiotic items prescribed: J (No. of items) | Other treatment: K | Best practice prevention according to Delivering Better Oral Health offered: L

Risks from

Medical History (Yellow / Green)

Social History (Yellow / Green)

Dental History (Yellow / Green)

Tooth Decay (Red / Amber / Green)

Dentinal Decay (Total number of teeth in the mouth) — Number of teeth: dt / DT

Periodontal Health (Red / Amber / Green)

Other Dental Need (Red / Amber / Green)

Part 6 Other Services

Treatment on referral: 1 | Free repair/ replacement: 2 | Further treatment within 2 months: 3 | Domiciliary services: 4 | Sedation services: 5

Part 7 NICE Guidance

I have given preventative advice and recommended a recall interval, taking into account NICE guidance, that I regard as appropriate to the patient's current oral health. No. of Months

Part 8 Declaration

All the necessary care and treatment that the patient is willing to undergo will be provided.

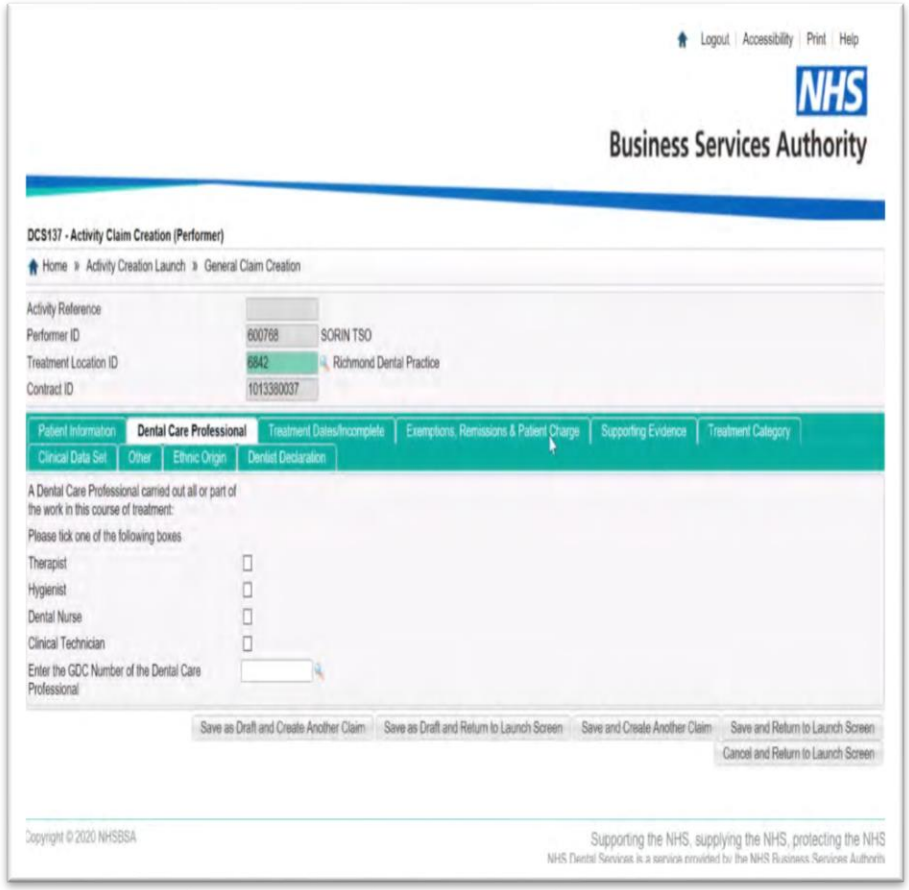
All the currently necessary care and treatment that the patient is willing to undergo has been carried out.

I declare that I am properly entitled to practise under the current dental regulations and that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. For the purpose of verification of this and the prevention and detection of fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by the NHS Business Services Authority.

Signature

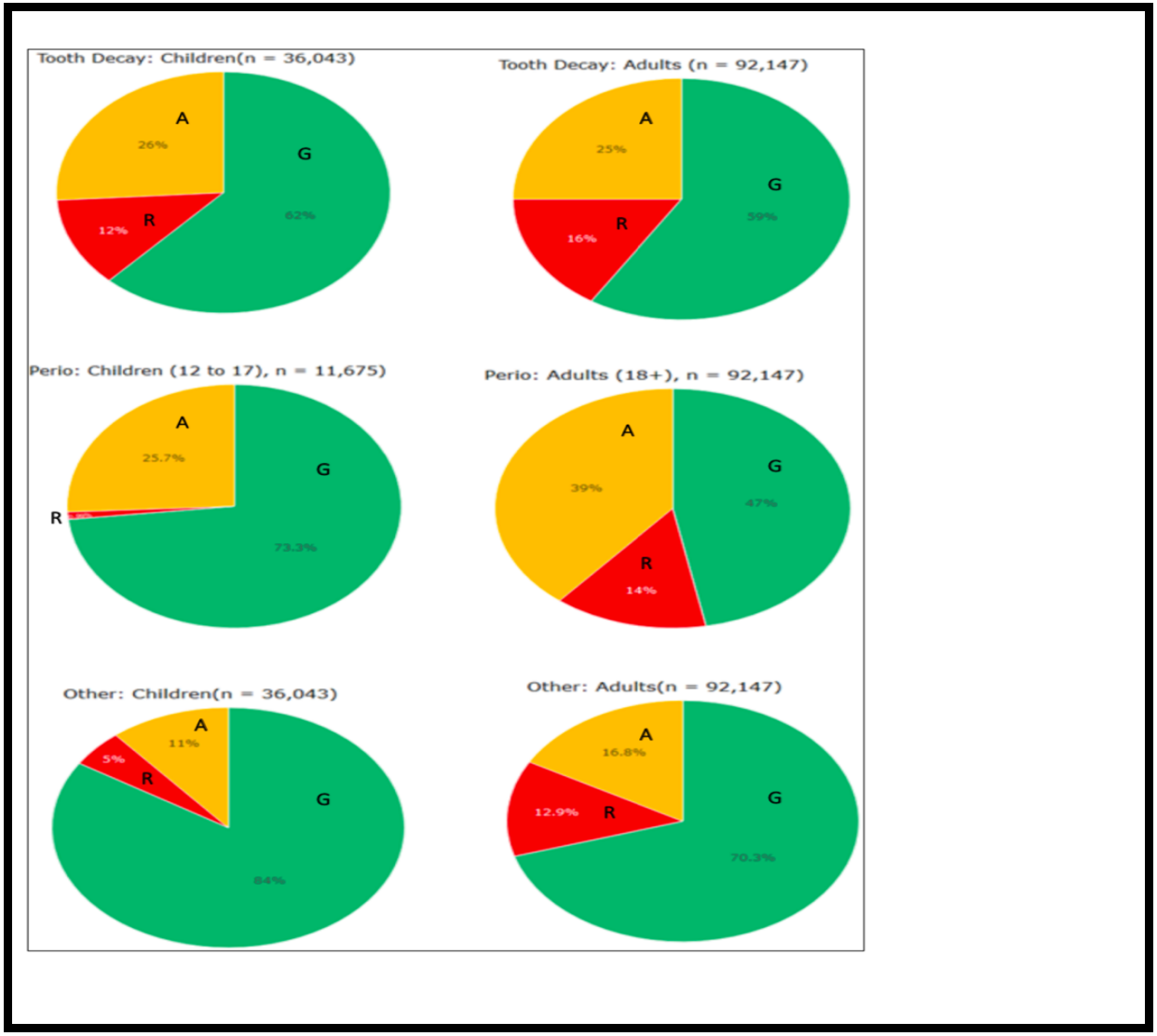
Date

Appendix 3 – Modifications made to the FP17W with effect from 1.4.20



Now allows submission of data by Dental Care Professionals. Clinical data set changes also better reflect contract reform principles (changes highlighted in yellow.

Appendix 4


Tooth Decay: Children(n = 36,043)
A
26%
G
62%
R
12%
Tooth Decay: Adults (n = 92,147)
A
25%
G
59%
R
16%
Perio: Children (12 to 17), n = 11,675)
A
25.7%
G
73.3%
R
Perio: Adults (18+), n = 92,147)
A
39%
G
47%
R
14%
Other: Children(n = 36,043)
A
11%
5%
R
G
84%
Other: Adults(n = 92,147)
A
16.8%
G
70.3%
12.9%
R