

## Greater Glasgow NHS Board

### Board Meeting

Tuesday 17 August 2004

Board Paper No. [04/50]

Director of Planning and Community Care

### Oral Health Strategy 2004-2009: Consultative Draft

#### Recommendation:

Members are asked :

- (a) to approve the draft strategy for consultation
- (b) to agree to receive a final report based on consultation at the Board's December meeting

#### 1 Introduction

The attached oral health strategy has been prepared by the Oral Health Planning and Implementation Group. The group has representation from the Board, Primary Care Dental Directorate, Area Dental Committee, Community Dental Service, Glasgow Dental Hospital and School and North and South operating divisions. It is intended that the strategy is issued for a three month consultation period.

The strategy follows on from earlier oral health plans previously approved by the Board, namely the Oral Health Strategy of 1997 and the Community Dental Review of 1999.

#### 2 Key Pressures

The need for an oral health strategy is timely.

##### Need

Greater Glasgow's oral health is poor. For all the principal age groups, Greater Glasgow exhibits poorer oral health than almost anywhere else in Scotland, which in turn has one of the poorest oral health records in Western Europe. This has been a longstanding pattern which shows little sign of change. While there are some signs of improvement, these are occurring at a slower rate than in other areas. The prevalence of dental caries amongst 5 year olds in Greater Glasgow continued to be ranked as a red light indicator at the recent Accountability Review. Based on current circumstances, our chances of meeting Scottish Executive targets for oral health for young and older children are poor..

##### Inequality

Within Greater Glasgow there are substantial inequalities in terms of :

- levels of oral health, where geographically there is a direct relationship with poverty and deprivation (with the most affluent areas enjoying levels of oral health up to 3-4 times better than the poorest communities), with age, and within ethnic minority and special need groups. The PAF reveals that inequalities in oral health amongst 5 year olds have increased between 1993 and 2003 (largely as a consequence of oral health improving faster in DEPCAT 1)
- access to dental services, with many marginal groups, for example older people in care, homeless people and children with special needs, receiving limited support in terms of treatment, care and prevention, again directly related to disadvantage

##### Cultural Impediment

## **EMBARGOED UNTIL DATE OF MEETING.**

Arguably Greater Glasgow's oral health is so poor because currently too few people consider it to be very important. Oral health mirrors the pattern of Greater Glasgow's general ill health, with Glaswegians having a poor attitude towards their own health in general. Although there are some signs of improvement on key issues like diet and oral hygiene, unsurprisingly Greater Glasgow continues to perform less well in both of these issues than elsewhere in Scotland. There is a reluctance to change attitudes to oral health and the profile and priority of good oral health remains low.

### **Resource Conundrum**

Compared with the rest of Scotland, Greater Glasgow has amongst the highest numbers of NHS dentists per population and highest rates of registration with a dentist, and yet our oral health record is amongst the poorest. Of expenditure on oral health in Greater Glasgow, 88% is spent on general dental services yet, because of the limitations of the present contract, this spending conspires with other factors to leave major gaps in our provision. Unlike general medical services the alternative public service option is limited in oral health, with the community dental service, for example, being proportionately smaller than in other areas in Scotland.

## **3 Context**

Oral health is currently the subject of much national attention. Responses from the Scottish Executive is expected in the autumn to two major consultations on "Improving the oral health of children and "Modernising NHS Dental Services". The Board has previously commented on both of these consultation documents. The responses of the Scottish Executive will shape the future national framework for the delivery of dental services and determine the prospects for better oral health. The proposed Oral Health Strategy for Greater Glasgow has attempted to anticipate the outcomes.

## **4 The Strategy**

Our vision for oral health in Greater Glasgow is that "Healthy mouths matter in Greater Glasgow Good oral health will be valued as part of healthy living. Everyone will have healthy mouths and be able to maintain them."

To deliver the vision, our strategy is built on the following core principles

- Reducing inequalities
- Integrated working and pathways
- Evidence-based practice
- Making oral health everybody's business
- Making oral health integral to holistic health

The strategy rotates around two main aims

- To improve oral health  
and
- To enhance dental services

The strategy argues that, to improve oral health, we must change expectations and attitudes, by raising the profile and priority of oral health, strengthening our public health leadership, and targeting health improvement efforts, particularly towards children, with greater emphasis on community-based approaches and integration.

The enhancement of dental services will be achieved by improving access, closing the main service gaps, placing greater stress on prevention, modernising dentistry by improving quality, developing a mixed economy of provision, advancing specialist services and engaging with patients and the public.

## **5 Critical Success Factors**

The success of the strategy will depend on the implementation of certain critical factors. These include:

### **Partnership working**

Improvements in Oral health will depend on not just dentists. The delivery of the strategy will rely on the close working, co-ordination and leadership of a wide range of primary care professionals, including dental nurses, therapists, hygienists and health promoters, as well as dentists. Better integration is necessary also with secondary care, notably with the Dental Hospital and School. Progress on oral health crucially relies on engaging effectively with other health professionals, such as GPs and health visitors, as well as with non-NHS stakeholders, in particular local authorities in their public health role, in terms of education and social work.. Oral health has to impress its case on wider service delivery and planning, especially Child and Community Care arenas. Community Health Partnerships could be very apt for the purpose.

### **Service Change**

A number of important dental services can be expected to change significantly over the lifetime of the strategy. These include the potential for resiting of the Dental Hospital and School, meeting waiting time targets for dental specialities, delivering on national plans for dental training, relocating and streamlining the child dental GA service, redesigning the oral and maxillo-facial service (including dental surgery) and responding to a new national contract for General Dental Practitioners. It is vital that all of these changes are consistent with the aims and objectives of the strategy.

### **Leadership**

The strategy contains many different types of actions, from those which we can initiate ourselves and involving a change in use of existing resources or processes, to those which will require some action by others including the Scottish Executive. Crucial to the latter category is the issue of water fluoridation. The strategy identifies this as the single most effective measure that can be taken to counter dental decay. The strategy also acknowledges that it is a highly contentious issue which is likely to take at least five years to implement, even within a favourable or permissive national policy environment. Consequently, the strategy advocates a battery of other measures, some exclusive are exclusive to oral health, others shared with other strategies. If fully supported, these measures could provide Greater Glasgow with an effective alternative or interim response.

### **Resources**

The strategy requires that existing resources will be used to better effect in the future and it also requires further investment if Greater Glasgow's oral health is to be improved. Specific measures are identified.

## **6 Conclusion**

This is a five year strategy which, if put fully in place, will go a long way to enabling Greater Glasgow to meet the national targets. The performance of the strategy will be reviewed annually and possibly rolled out as part of the PAF within the Accountability Review process. The consultation process is being structured to reflect the underlying philosophy of the strategy i.e. that oral health is everyone's business.

**GREATER GLASGOW NHS**

**ORAL HEALTH STRATEGY  
2004-2009**

**CONSULTATION DRAFT**

**JULY 2004**

# **GREATER GLASGOW**

## **ORAL HEALTH STRATEGY**

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# SECTION ONE

## INTRODUCTION

Oral health in Greater Glasgow lags stubbornly behind that of the rest of Scotland and even more so the rest of Europe. Within the national Performance Assessment Framework oral health, or rather the lack of it, is a persistent red light indicator. Poor oral health has serious consequences stretching beyond bad teeth. Conversely, good oral health is life enhancing and arguably a reliable barometer of our general outlook and level of general health. The purpose of this strategy is to set out the basis of achieving a stepped change in improving the oral health of the population of Greater Glasgow.

*“Oral Health is a state which should enable the individual to eat, speak and socialise, without discomfort or embarrassment, and contribute to general well being”. (OHSS, 1995.)*

While previous strategies have made notable strides, and indeed this strategy builds on their progress, all of the indications are that on the basis of current trends we will fall significantly short of the national target set by the Scottish Executive that 60% of 5-year olds should be free of dental disease experience by 2010. Though the focus of the national target is rightly on young children there are oral health issues across the entire population in Greater Glasgow usually affecting our most vulnerable people. More requires to be done if we are to break the cycle of poor oral health and low expectations and not to condemn future generations to a prospect of pain, fillings, infection and extractions as well as wider social consequences such as embarrassment in speech or appearance, swallowing difficulties, work absence, high repair costs, stigma and psychological problems.

The strategy takes its lead from the three overarching objectives of the Local Health Plan to improve health, reduce inequalities and improve health services. While prevention is key, provision of high quality accessible dental services is fundamental. The tackling of oral health is complex and inextricably bound up with issues of culture, lifestyle and deprivation. Oral health in Greater Glasgow represents a significant public health challenge. Similarly, whilst dental professionals in Greater Glasgow have a principal contribution to delivering the strategy, others also have critical roles. These include other health professionals, local authorities, voluntary and community organisations as well as the Scottish Executive, which retains responsibility for policy direction, resource allocation and critically, setting the new GDP contract. This strategy depends on their collective and co-ordinated contribution.

We believe that Greater Glasgow’s oral health can be markedly improved and that for too long it has been a neglected area. In addressing this strategy we have consciously scanned for evidence of good practice and successful approaches from elsewhere in the UK and across Europe. While we are of the view that, supported by strong evidence, water fluoridation represents the single most effective measure of improving oral health we are also realistic in understanding that its introduction lies outwith our gift. Correspondingly this strategy comprises a battery of actions which when applied in combination would, we believe, deliver a stepped change. We recognise that this will mean changes in the way in which we prioritise and target our present spending as well as the need for additional investment.

The starting point for the strategy is that our pattern of poor oral health, while long established, is unacceptable and does not need to be this way. While it may take time it can with sustained commitment be changed if we want to do it.

# SECTION TWO

## ORAL HEALTH NEEDS IN GREATER GLASGOW

### Introduction

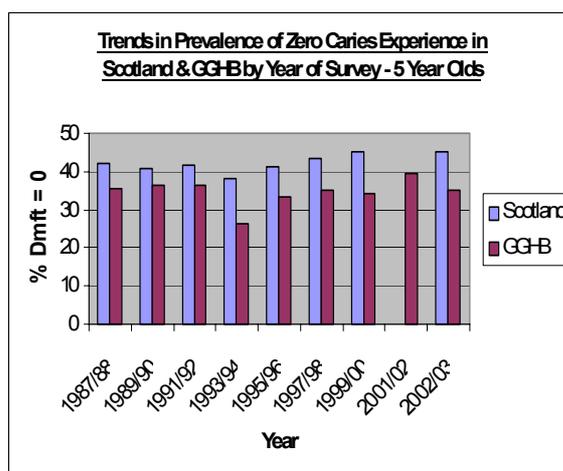
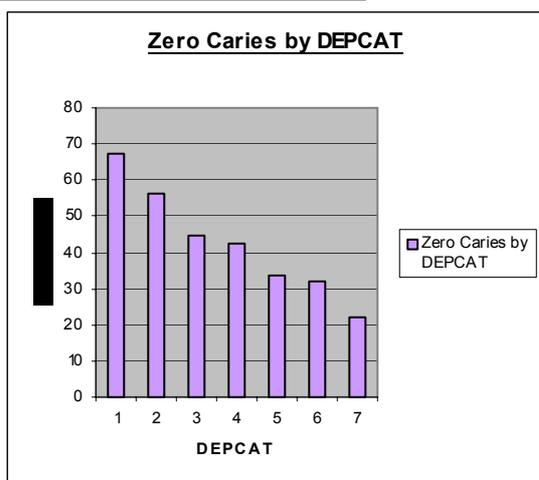
This section presents a ‘snap shot’ of the current picture of oral health in Greater Glasgow. The assessment relies on information from a wide variety of sources including national epidemiology programmes and local surveys. The information quality is variable but provides valuable insight into the state of oral health. However, in some areas there are information gaps where further work and analysis is required.

### General Population

In general, oral health within Greater Glasgow is the worst in Scotland at all ages. Not only do we have the highest levels of decay within the population, but the association of dental decay with deprivation creates a pattern whereby the majority of Glaswegians are affected by high levels of the disease, with those living in the most deprived areas having the most serious decay. Those living in the most affluent areas have the lowest levels of decay which are still higher than in other similar areas in the rest of the UK, suggesting our best could still be better.

### Pre-Fives

#### *Five Year Olds- Caries Free*

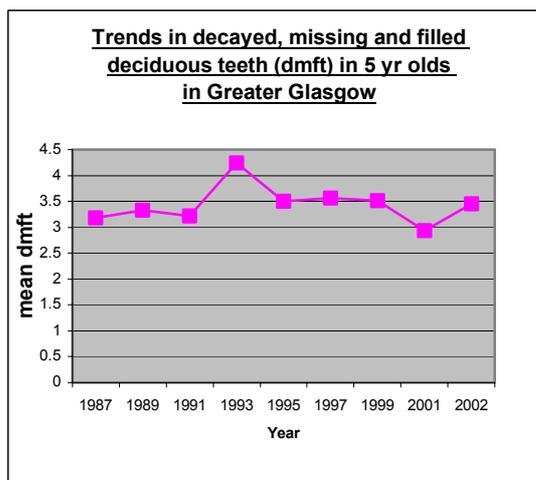
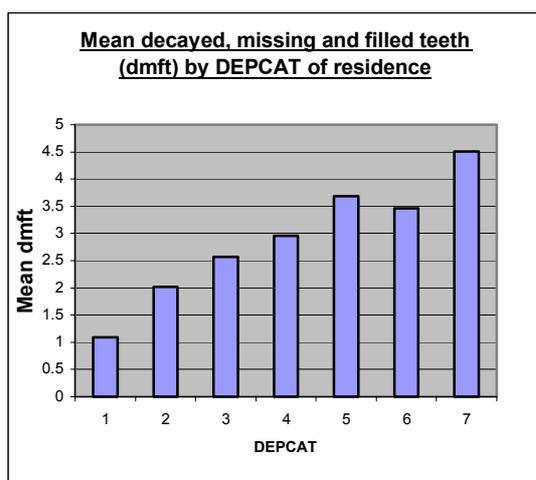


The target set by the Scottish Executive is that 60% of 5-year-olds should be free of dental caries experience by 2010. In 2002/03 in Scotland, 45% of 5 year olds had no decay experience whilst in Greater Glasgow only 35% had no decay experience. In Greater Glasgow, 2 in every 3 young children have had dental decay by the age of 5yr. Only

DEPCAT 1 areas have reached the target level although DEPCAT 2 areas are close to it. All other more deprived communities fall far short of the target, with only 34% of 5 yr old children in DEPCAT 6 and 22% in DEPCAT 7 showing no experience of dental disease. As over 50% of the child population in Greater Glasgow lives in DEPCAT 6 and 7 areas, the dental health of children from the least affluent areas has a large impact on the overall figure for Greater Glasgow.

Only Argyll and Clyde amongst Scottish health boards was worse than Greater Glasgow in 2002/2003. Comparable data for other countries show that for 5 yr olds, 60% in England, 70% in Holland and 71% in Denmark have no experience of dental decay.

### Dental Decay In 5 Year Olds



The graphs do not illustrate the wide range of dmft scores for individual children which range from 0-20 in Greater Glasgow.

Trends in the experience of decay (dmft) over the last 15 years illustrate that what improvement there has been in terms of filled and decayed teeth has mostly occurred amongst affluent children.

### Child Dental General Anaesthesia (GA)

Child dental GAs in Greater Glasgow have dropped by 80% since 1997/98 but still remain amongst the highest in Scotland. In 2003-04, 2174 young children aged 3-5 had teeth extracted under GA. A further 300 under 3s experienced dental GA treatment at Yorkhill. 40% of cases come from outwith Greater Glasgow, predominantly from Lanarkshire and Argyll and Clyde.

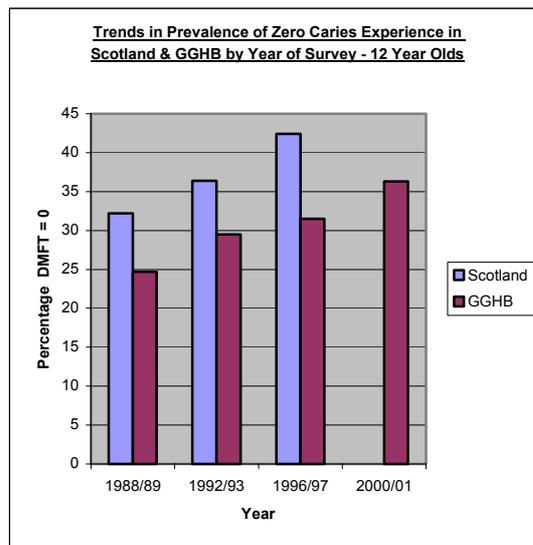
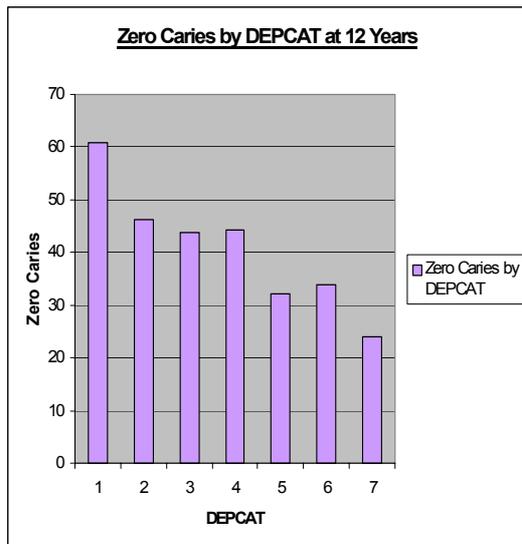
**Attendances for dental treatment under general anaesthetic in Greater Glasgow by service and year.**

Year	GDS	CDS	GDH	Total
1997/98	9,460	1,826	4,550	15,836
1998/99	7,757	1,616	4,195	13,568
1999/00	3,903	1,394	3,323	8,620
2000/01	3,566	1,135	3,840	8,541
2001/02	433	1,225	3,925	5,583
2002/03	nil	852	2,867	3,719
2003/04	nil	700 est	2,200	2,900 est

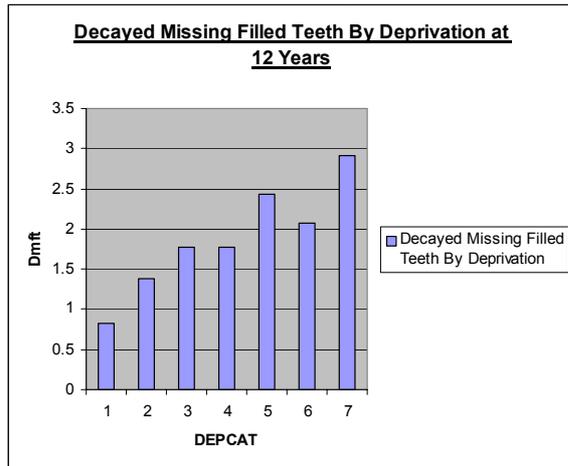
**Older Children**

Between the ages of 6 years and 14 years the majority of a child's adult teeth erupt into the mouth. It is therefore of particular importance that high standards of oral health are maintained from the age of 6 years to maximise the longevity of adult teeth.

Caries Free At 12 Years



### Prevalence of Dental Decay At 12 Years



In 2000/2001, 64% of children aged 12yr in Greater Glasgow had dental decay experience. While this has improved markedly since the late 1980s Greater Glasgow has been consistently out performed by Scotland as a whole. If anything the gap has increased over time.

A similar pattern to pre-fives is evident in later years with more almost three times as many children in DEPCAT 1 having no caries experience as compared to children living in the most deprived DEPCAT 7 areas.

### General Anaesthetics

Approximately 1500 dental general anaesthetics were given to older children in Greater Glasgow in 2003/2004. Dental caries is the single biggest reason for GA admission to hospital in the under 14s. Tooth extractions main the largest single reason for children receiving general anaesthesia in hospital.

### **Adults**

Oral Health is perceived to deteriorate with age but this is not an unavoidable consequence of ageing *per se*. The perception is the consequence of the cumulative effect of the lengthening time of exposure to risk factors throughout life.

The greatest oral health improvement in the last twenty years has occurred amongst adults. In 1998, 82% of all adults in Scotland have some or all of their own teeth, an improvement on the position in 1972 when only 56% of adults had any natural teeth. Adults are more likely to have no natural teeth (edentate) with increasing age and if they live in deprived areas.

In Scotland, there has been a significant improvement in the number of adults who have there own teeth over the years, the proportion of 45-54 year olds without their own teeth has fallen from 54% in 1972 to 13% in 1998. However, more recent data from the latest Greater Glasgow Health and Well Being Survey (HWBS) suggests that this may now have fallen to 8.6% but still short of the Scottish Executive target of under 5% of 45-54 year olds without their own teeth by 2010.

### Edentate Adults

#### PERCENTAGE OF ADULTS (AGED 18 YEARS AND OVER) IN SCOTLAND WITH NO NATURAL TEETH

	16-24 yrs	25-34 yrs	35-44 yrs	45-54 yrs	55-64 yrs	65 + yrs	All
1998	1	0	4	13	33	56	18
1988	1	2	7	33	48	72	26
1978	2	10	27	54	64	85	39
1972	2	13	35	54	78	87	44

Source: Adult Dental Survey (1998)

Researchers from the University of Newcastle have found that adults who smoke are more likely to suffer from gum disease. Levels of smoking though falling across most groups in Greater Glasgow, still remain relatively high especially in more deprived areas.

### Oral Cancer

In Greater Glasgow approximately 100 new cases of oral cancer are diagnosed each year. The 5 year survival rate is approximately 50%.

Incidence rates in males are double those of females. Between 1990-99, incidence rate increased by 34% in both males and females. Around 85% of new cases occur in those aged 50+ years, however, incidence rates are increasing among younger adults. The incidence of oral cancer is comparable with some other cancers many of which have higher public profiles. In 1996 the number of new cases of oral cancer, cancer of the uterine cervix and malignant melanoma of the skin were 487, 366 and 664 respectively.

Smoking prevalence remains high in deprived areas, despite general improvements, with 49% of people in deprived areas still smoking, as compared to 27% in non SIP areas (HWBS).

Excessive alcohol consumption in conjunction with smoking increases the risk of oral cancer. 13% of the adult population report exceeding weekly alcohol recommended limits with 5% reporting drinking alcohol 6-7 days per week.

### Impact Of Dental Disease

The Adult Dental Health Survey of Oral Health in the United Kingdom (1998) of people's self-perceived impact of dental disease reported that over 50% of the adults experienced an oral problem in the previous year with most (40%) having experienced pain, and 27% reporting psychological problems such as self-consciousness. Other impacts included trouble pronouncing words or difficulty with eating, as well as an inability to cope. It is clear that poor oral health can affect people's lives in various, sometimes serious, ways.

## **Older Adults**

In 1998, the latest year that figures are available, 56% of people aged 65+ were edentate (had no natural teeth). This represents a dramatic improvement compared to 20 years earlier when almost 9 in every 10 older people did not have their own teeth. Based on evidence of improving oral health in the younger adult population it is anticipated that this trend will continue. When combined with projections of rising numbers of older people this will place increased pressures on dental services in the future.

## **Population Groups With Additional Needs**

Defined as groups having specific needs or requiring different levels of services and /or intervention in order to promote and maintain oral health status.

### Individuals Who Are Medically Compromised

A range of conditions impact on the oral health status of individuals. Each condition requires consideration and appropriate level of needs assessment to define this impact and the subsequent dental needs of each patient group. Specific conditions include:

- Chemotherapy/Radiotherapy patients
- Stroke patients
- Immuno-compromised patients

### Ethnic Minorities

- *Adults*  
A recent study of people in Glasgow of Asian, Chinese and Caucasian descent found that
  - All groups were concerned to keep their natural teeth
  - Chinese (27%) and Whites (30%) were far more likely to say that working commitments would discourage them from attending the dentist, compared to the South Asian group (15%).
  - In terms of oral health practices, people of Chinese descent were more likely to use fluoride toothpaste and mouth-rinse and far less likely to clean their teeth with fingers and water than those of Asian descent

A two year qualitative research project funded by the Chief Scientist's Office is currently being undertaken to investigate the oral health perceptions, practices and service access amongst different ethnic minority groups in Greater Glasgow.

- *Children*

A recent caries epidemiology study of 5-year-olds in all primary schools in Glasgow with a minority ethnic population of greater than 25% shows that children from some ethnic minority groups had a significantly higher levels of dental decay compared to white children. This difference was seen even within the same socio-economic groups.

<b>Ethnic background</b>	<b>N</b>	<b>Mean dmft</b>
White	335	2.28
Indian	24	1.83
Pakistani	215	4.07
Chinese	7	4.43
Other Asian	2	3.00
African	5	3.60
Arab	7	6.57
Mixed origin	28	2.53
Unknown	26	2.19
Total population	649	2.95

#### Asylum Seekers

Dental services are being provided to asylum seekers arriving in the city but no information on their oral health needs is yet available.

#### Special Needs Children

Caries epidemiological examinations of children attending special educational needs schools in Greater Glasgow carried out in 2003 found

- 1 in 5 Primary 7 special needs children had already had permanent teeth extracted
- little evidence that young special needs children were receiving preventive clinical or home dental care
- more extractions with greater reliance on GA and less restoration
- only two schools were served by a mobile dental unit.
- dental disease was a more traumatic issue for these children

#### Young People Who Are Looked After And Accommodated

Recent research through the Big Step found notable improvements in the oral health attitudes of young people aged 14-20 living in foster care in Glasgow with 66% having visited a dentist in the last 6 months (compared with 51% in 2001), with a further 22% visiting between 6-12 months. 92% said they brushed their teeth daily.

#### Adults with learning needs

#### Homeless People

A Needs Assessment was carried out by the Board in 2003 and reported on the dental needs of a group of homeless people. It showed that as a population group the homeless have high caries levels, much of it untreated, and poor oral hygiene leading to a high incidence of periodontal disease.

Patients in methadone programmes have a particularly high incidence of dental caries. The homeless population generally have a high proportion of the risk factors for oral cancer and thus the need for appropriate screening.

### Other Groups

There are some people in the population such as those who are homeless, or have learning disabilities or mental illnesses for whom there is little or no specific information on their oral health needs.

## **Causal Factors**

The reasons for Greater Glasgow's poor oral health record are well established and apply across the population. They are

**Poor Diet**– Greater Glasgow, in line with the rest of Scotland displays high levels of sugar intake through consumption of fizzy drinks, sweets, chocolate and processed foods. Over frequent sugar consumption causes rapid and serious dental decay. This is a particular concern amongst children. For example it is estimated that the average child from a deprived area in Scotland consumes the equivalent of 60 teaspoons of sugar a day, 4 in 10 children consume chocolate or biscuits more than once a day and over 50% have a sugary drink. In Scotland mothers have historically introduced non-milk drinks at an earlier age (13 weeks) than their southern counterparts with baby syrups (since withdrawn) and fruit squash being the most common. Older children are avoiding routine mealtimes and replacing them with increased consumption of snacks with low nutritional value and of both sweets and sugary fizzy drinks with boys consuming more fizzy drinks than girls. Amongst secondary school children peer pressure rather than parental influence determine food choices. The problems of diet extend to the older age groups with frail elderly people often compensating for their reduced food intake (a consequence of deteriorating physical or mental condition) by consuming more “additional calorie food” such as jam or honey.

Despite evidence of improvement Greater Glasgow still ranks lowest in Scotland for the consumption of fruit and vegetables with only 38% of men consuming fresh fruit daily or 31% consuming green vegetables more than once a week. (SHS 1998), suggesting Greater Glasgow is far from achieving the national target of 5 items per day. Although general public awareness of types of food that are required for a healthy diet are high, people find it difficult to translate this into quantities and relative proportions. Shopping, cooking and preparation skills are also required in order to apply the principles of a healthy diet. This is particular relevance at the weaning stage in any child life, when good or bad eating habit are often established.

**Smoking and alcohol consumption** – Smoking levels within Greater Glasgow are currently at 33% (HWBS 2002), in line with the national average of 33% (SHS 1998). However smoking rates in areas of deprivation at 49% far exceed the national average (HWBS 2002). It is estimated that this may be higher and as much as 50-70% of the population smoke in some communities. The HWBS indicated that smoking cessation rates were greater in more affluent areas.

Alcohol consumption impacts on oral health particularly in relation to oral cancer, when patients smoke and drink the risks are not merely additive but multiplicative. The most recent figures suggest that 36 % of men and 12% of women in Greater Glasgow are drinking more than the weekly sensible drinking limits while 9% of men are drinking over 50 units per week. In addition to this, 49% of men and 28% of women in Greater Glasgow drank more than twice the recommended daily benchmark quantity on their heaviest drinking day.

**Lack of Oral Hygiene** More women than men report that they brush their teeth more than once a day. Overall 66% brush twice daily with more in affluent areas (73%) than in deprived areas (51%). Within deprived areas 12% report brushing less than once a day, seldom or never (HWBS). From 1990-1998 there was a significant improvement nationally of boys brushing their teeth more than once a day but still less than girls. There is a definite social gradient with children from deprived backgrounds less likely to brush their teeth even once a day.

**Exposure to Fluoride** The most common means available is via toothpaste. Approximately 93% of respondents to the Scottish Health Survey 1998 indicated using a fluoride toothpaste. In an attempt to increase exposure to fluoride toothpaste 45% of pre five establishments in Greater Glasgow are taking part in the national nursery tooth brushing programme.

Another dimension of this issue is the absence of a fluoridated water supply. Those areas with either natural (eg. Moray) or artificial fluoridation (eg. Newcastle, Birmingham) report markedly better oral health amongst their populations. Until now there has been a reluctance to address this issue and public reaction has been mixed but may be changing. The HWBS found 35 % in favour of fluoridation and 28% against, with a further 32% undecided. The main areas of concern center on safety and long term side effects.

**Negative Attitudes** Fear and anxiety can be a barrier especially amongst children with a previous 'bad' dental experience with toothache making them less inclined to visit the dentist regularly. A study, conducted in the late 1990s among carers of pre-5-year-olds from areas of deprivation within the West of Scotland identified barriers to the early registration of infants including public's demonisation of dental services, the perceived attitudes of general dental practitioners to infant attendance, behavioural management skills of practitioners, the physical accessibility of dental practices and the attitude of parents, especially if they had a fear of dentistry themselves.

**Deprivation and Life Circumstances** - There is a clear relationship between postcode related measures of social deprivation and caries at all ages. The prevalence of dental caries, irrespective of the method of measurement is strongly associated with increasing levels of deprivation. The ability to access a healthy diet depends on the availability of shopping facilities, transport and having enough money to make choices in relation to the type of food that is purchased and where it is purchased. Research by the National Consumer Council has shown that in many deprived or socially excluded communities where low income households are concentrated there is often inadequate shopping provision with only a limited range of food available

## **SECTION THREE**

### **POLICY CONTEXT**

Oral health has been the subject of much recent attention at national level by the Scottish Executive in their efforts to address some of the present shortcomings. Much of this work is still underway but it is vital that the local strategy reflects the current debate and **must necessarily take account of important changes taking place or planned not only for oral health but across the NHS in general, both at local and national levels.**

However, oral health is not the preserve of only dental professionals but is also influenced by other policies, both in the NHS and beyond and consequently has a very wide range of relevant stakeholders. This section reviews the main policies affecting oral health at both local and national level, (generic and specific) and highlights the main messages that need to be absorbed by ‘(reflected in) the local strategy’.

#### **National-Generic**

At a national level the principal mainstream NHS policies which are important to oral health are

**Partnership in Care** advocates that advancement can only be secured within a single NHS system which places more emphasis on health improvement to reduce inequalities, closer integration of services across primary and secondary care, with local authorities through community health partnerships and managed clinical/care networks, service redesign to secure greater effectiveness and efficiency, more commitment to patient focus and public engagement in service planning and delivery, giving a higher profile to regional planning for shared specialist services, defining standards and measuring performance based on outcomes and engaging health professionals in decision making on service planning and resources.

#### **National-Dental**

At a national level a series of policy proposals specific to oral health have been issued or are under development. These relate to:

**Towards Better Oral Health in Children** which sought views (Consultation document) to transform the oral health of children across Scotland arguing the need for “radical steps” including a multi-stranded approach to oral health improvement including locating preventive action within wider health programmes alongside other professionals, focusing on the behaviour of mothers during pregnancy, greater prevention from dental services and parenthood and taking stronger measures towards food retailers, manufacturers and advertisers to reduce sugar content of processed food including baby food. It also addressed the case for fluoridation.

**The Action Plan for Dental Services** endorses a partnership approach to oral health care and prevention and requires each Health Board to develop an updated local action plan to address the main PAF targets relating to oral health - oral health prevention, access to NHS dental services, human resources and team working, quality and standards and infrastructure and resources.

**Modernising Dental Services** proposes the design of a new GDP contract rewarding oral health improvement and prevention, and designing an oral health system which promotes quality, equitable access and provision, integrated team working and improved recruitment and retention of the dental workforce to the benefit of both patients and professionals. Included is consideration of changing the basis of patient charges but only in ways that do not undermine the stability of the present system. Health Boards are encouraged to lead the development of dental services and to support the creation of a mixed economy of dental service providers.

**Oral Health in Primary Care**, based on a survey of LHCCs across Scotland, reviews the experience of involving dental services in primary care and assesses how dental professionals can engage more effectively in future with other health professionals to improve oral health and service access. With the prospect of CHPs it recommends facilitated engagement of dental professionals, more joint planning for oral health with other stakeholders, integration of all dental interests, development of support infrastructure especially IMT and a consolidated and coherent national strategic framework.

**The Review of Salaried Dental Services** is looking at the potential to combine community dental services and salaried dental services within a common career structure.

## **Local-Generic**

The present **Local Health Plan 2004-07** has three overriding objectives to improve health, reduce inequalities and to enhance services. It seeks to maintain the previously agreed strategic directions but reprofiles commitments and plans to conform to current financial availability. Oral health does not feature prominently but is a small beneficiary of additional Unmet Needs monies from the Scottish Executive.

Progress is underway to establish **Community Health Partnerships (CHPs)** across Greater Glasgow in partnership with local authorities. These are aimed also at securing better integrated working across primary and secondary care and are scheduled to be operational from 1 April 2005.

## **Local-Dental**

The Community Dental Review of 1999 which led to the setting up of Oral Health Action Teams and the creation of the post of Director of Dental Primary Care Services.

## SECTION FOUR

### CURRENT PROVISION

#### Current Investment

##### Revenue

Spend on the prevention, treatment and care of oral health is incurred within many different areas of NHS Greater Glasgow (NHSGG). This includes Health Promotion, Adult and Children's hospital sites, the Dental Hospital and School and, to the greatest extent, within the Primary Care setting.

In the financial year 2004-05 over £51 million will be spent on oral health on Greater Glasgow residents, 90% on GDS services.

The estimate does not include other areas, such as oral & maxillofacial surgery services as spend within such areas is heavily intertwined with a number of other aspects of care and oral costs cannot be readily identified at this time.

**TABLE 1: ESTIMATED SPEND ON ORAL HEALTH – NHSGG RESIDENTS**

	2002/03	2003/04	2004/05	
Location	£'000	£'000	£'000	Comments
General Dental Services (note1)	40,686	43,100	45,600	This represents cost of providing treatment within the primary care setting
Glasgow Dental Hospital and School	2,848	2,960	3,078	The Dental Hospital also receives income from the other West of Scotland Boards (£M) and for providing teaching to students (£XM)
Community Dental Services	1,853	1,920	2,000	
Services to Homeless	30	31	32	
Yorkhill Hospital	170	177	184	Includes GA and medically compromised children
Stobhill Hospital	54	56	58	Includes treatment for special needs and oral maxillofacial surgery
Health Promotion	56	58	60	
Oral Health Action Teams	427	531	552	
Total Spend	46,124	48,833	51,564	

Notes:

1) Source Accounts Note SFR11 – 2002/03

2) Increases from 02/03 based on estimated inflation increases.

For a number of years there have been additional non-recurring funding allocations to support improvements in Primary Care Dental Services, £590k and £606k in 2002/03 and 2003/04 respectively.

## Capital

Capital expenditure is funded through the normal Greater Glasgow NHS capital planning process. During the past year only minor items were purchased for the Dental Hospital and School and within local health centres. The proposal for a new Dental Hospital and school will require substantial but as yet unspecified capital funding.

## **General Dental Service (GDS)**

In primary care, 413 independent general dental practitioners in 200 practices provide General Dental Services. Unlike some other parts of the country the vast majority (around 80%) of the dental practices in Greater Glasgow remain within the NHS. Currently Greater Glasgow has 0.46 dentists per 1000 population compared to 0.39 per 1000 for the rest of Scotland and 0.42 for England and Wales. Similarly Greater Glasgow has been less affected by practice closures. Of 68 closures in Scotland between 1999-2002 only 2 occurred in Greater Glasgow.

The GDS also employs Professions Complementary to Dentistry (PCDs) including dental hygienists, dental therapists and dental nurses. 90% of dental services are provided by the GDS. Although part of primary care, GDPs have tended to be less involved with LHCCs because of their status and lack of remuneration.

## **Community Dental Service (CDS)**

Greater Glasgow Primary Care NHS Trust is also responsible for the directly managed Community Dental Service which delivers a range of services including the treatment of children under general anaesthetic, patients with special needs, the homeless, school dental inspections and epidemiology. The CDS also provides the “safety net” function for patients who cannot, or will not, access the general dental services.

The current staffing level of the CDS is approximately 18 whole time equivalent (wte) dental practitioners including sessions from the Clinical Director and Senior Dental Officer. In addition, there are 1.6 CDO trainees and 2.6 wte hygienists/therapists. About 3.5 WTE CDOs are committed to the National Dental Inspection Programme and are not available to undertake clinical care. The geographical distribution of the CDS varies across Greater Glasgow. By comparison with elsewhere in Scotland the CDS in Greater Glasgow is seriously under-resourced and to be equitable it should employ around 60 dentists and ancillary staff.

	<b>* Total No of CDO's WTE</b>	<b>No of Salaried GDP's WTE</b>	<b>Sp Needs Dentists WTE</b>	<b>Sp Needs Dental Hygienists WTE</b>
<b>Lothians</b>	25.5	17	16	8
<b>Greater Glasgow</b>	15	0	3	1

## **Salaried General Dental Services (Non Cash Limited)**

Salaried dental services provide a means of plugging gaps in the local dental services. There are currently no salaried dental services in Greater Glasgow which is the only Health Board in Scotland without salaried GDPs. This in large measure is a function of the relative levels of

GDPs in Greater Glasgow which are also supported from this funding pool. Arguably, this basis of allocation takes insufficient account of the scale of deprivation in Greater Glasgow and in particular the high proportion of children in DEPCATS 6 and 7. Notwithstanding, bids from Greater Glasgow for salaried dental services to provide a treatment centre at the Dental Hospital and for paediatric and homeless services are presently under consideration by the Scottish Executive.

The Out of Hours service which operates in Glasgow Dental Hospital premises is staffed by GDPs on weekday evenings and Saturday and Sunday sessions.

A “Accident and Emergency” dental service runs in GDH each weekday

## **Health Promotion**

The Health Promotion Team provide strategic direction and operational support to oral health initiatives within a variety of population groups and in key settings such as new community schools, workplaces, local authorities and communities in line with national, regional & local community planning partners. Key initiatives delivered by the team include: Strategic support for Oral Health Action Teams, Training Programmes to build capacity for Oral Health, co-ordination of National Toothbrush Demonstration Projects, School Breakfast Club programmes, development of oral health resources and campaigns, Oral Health Policy development and Development and piloting of programmes with marginalized group e.g. Looked after & Accommodated Children and Older people.

### Oral Health Action Teams (OHATs)

OHATs are multidisciplinary teams tasked with improving oral health among pre fives by identifying oral health needs, promoting oral health gain through community based initiatives and creating oral health networks and partnerships. The first OHAT was established in 2001 based on earlier evaluation of a 4 year pilot project in Possilpark which demonstrated significant improvement in the oral health of young children in a severely deprived area. During 2004 the roll out of OHATs across all 16 LHCCs is due to be complete. A recent review of the initiative urges stronger focus on pre threes, increased resourcing and follow through at primary schools.

### Toothpaste/Toothbrushing

The National Demonstration Project supports the distribution of free toothbrushes and toothpaste to all children at 8 months and at regular intervals to children in areas of deprivation until the age of 4 years. This is delivered to over 4000 children in about 150 nurseries in low-income areas across our 6 local authority areas.

### Dental Health Educators

The current remit of dental health educators is the delivery of oral health programmes to special needs groups and individuals within educational and health settings. Health Fayres and training for nursing staff are supported by dental health educators throughout the year.

Over the last year there has been an increase in the requests from teaching staff and recently appointed health development officers for support and resources to assist in raising oral health issues within the Health Promoting School.

### Starting Well

Starting Well is a Scottish Executive sponsored demonstration project piloted in two deprived communities in Greater Glasgow. Its aim is to deliver more intensive child health home support to almost 1300 mothers and young children to determine through evidence based practice how this can improve gains via healthy eating, infant feeding, advice on oral health dental hygiene and registration with GPs. In addition, a local Development Fund also been supportive providing opportunities for local groups and nurseries to access funding for activities including oral health and healthy eating.

### West of Scotland Cancer Awareness Project

The WoSCAP is a NOF funded project with the remit to develop a high profile public awareness campaign to promote earlier presentation in relation to risk of oral and bowel cancer. The project has now completed the oral cancer stage and has worked with local dental services to establish communication networks, patient pathways, multi-professional and community (lay worker) training programmes and support materials. The project is underpinned by market research and evaluation to measure changes in public awareness and impact on services.

## **Dental Hospital and School**

### Specialist Services

The Dental Hospital provides a range of specialist dental services including conservative dentistry, periodontics, prosthodontics, orthodontics, oral surgery and oral radiology. In 2002-03 162,000 outpatients from across the West of Scotland used services at the Dental Hospital making it one of the busiest NHS facilities in the country. It receives referrals from GPs, GPs and hospital consultants but there are also significant “walk ins” or self referrals.

The facility is part funded for its service by West of Scotland health boards and for its education by NES. A service level agreement with West of Scotland boards is presently up for renewal.

Forthcoming changes will see the consolidation of child dental GA services at the Dental Hospital from Townhead Health Centre. The future service will treat up to 3,500 children a year aged 3-14 (under 3s are treated at Yorkhill Hospital), from Greater Glasgow, Lanarkshire and Argyll and Clyde, a fall of 40% on levels five years ago. Ultimately the entire GA service will be centred on Yorkhill. A further imminent change will see the A&E service transfer to primary care.

### Training

Glasgow is one of only two dental schools in Scotland. As part of the national workforce plan, the Glasgow School aims to produce 79 qualified dentists and 10 Dental Hygienists. From 2005, dental therapist rather than dental hygienists will be produced. Relative to previous years, these numbers are increased reflecting of the increased need for dental

professionals. Of national concern is that a large proportion of newly qualified dentists are not entering NHS practices after their Vocational Training.

### **Oral Maxillofacial Surgery Services**

This service provides diagnosis and treatment of conditions affecting the face, mouth, jaws and associated structures and serves not only patients from Greater Glasgow but also from other West of Scotland health boards. The services includes oral surgery, trauma, pain management and treatment of head and neck cancer and skeletal deformities. The inpatient service, which deals with 1000-1200 admissions per year (almost 50% are emergency cases) is based at a 12 bed unit at the Southern General. Outpatient services are provided at clinics at the Southern, Victoria, Stobhill and Dental Hospitals and comprise mainly of high volume low cost oral surgical procedures such as removal of wisdom teeth.

Due to pressures of junior doctors hours, clinical governance and teaching, a business plan is presently under consideration proposing further centralization of inpatient services for the West of Scotland.

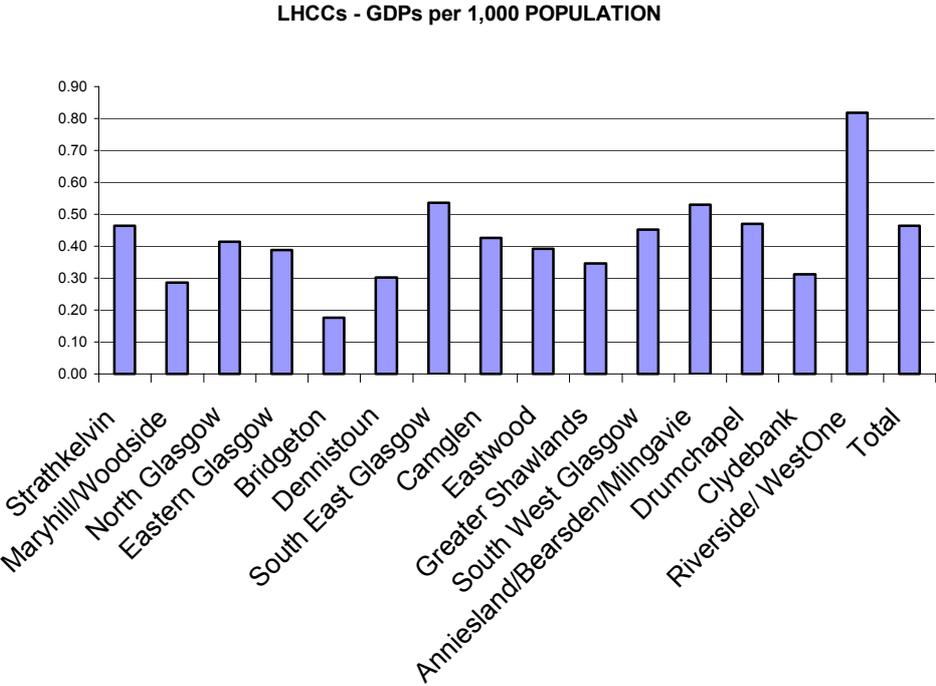
# SECTION FIVE

## ACCESS TO DENTAL SERVICES

Access by people in Greater Glasgow to dental services is an issue. Across the Board area there are serious inequalities in access.

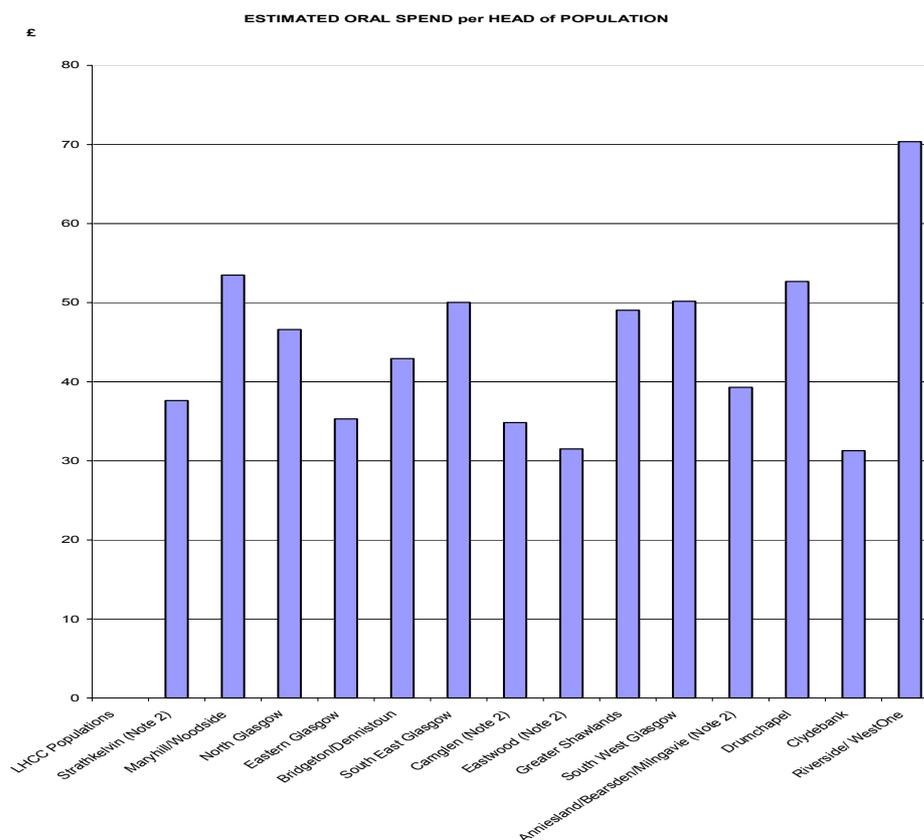
### Access To General Dental Services

Although there remain relatively high levels of NHS dentistry in the city and registrations are favourable in national terms, the distribution of dental practitioners and practices varies across Greater Glasgow from 0.18 dentists per 1000 population in Bridgeton to 0.82 in Riverside/Westone



The distribution of dentists shapes the distribution of service investment of the £36 million spent in the General Dental Service. While the Greater Glasgow NHS Board has a statutory obligation to ensure adequacy of general dental services across the area, it has no power to “manage” the independent contractor sector. Consequently, practitioners determine for themselves where they invest in capital and premises, and this in turn can lead to inequalities of access.

**Figure XX. Estimated spend on oral health per head of population by locality**



Differential local access has other consequences. Activity data provided by Glasgow Dental Hospital and School for 2001/02 shows that 22.5% of children who attended Glasgow Dental Hospital and School for dental extractions under general anaesthetic came from Easterhouse compared to 1.5% from Anniesland/Bearsden/Milngavie. (See also A&E below). This is a consequence of dental health not access.

In primary care, both the General Dental Service (GDS) and the Community Dental Service (CDS) are experiencing unacceptably high rates of failed appointments (Do Not Attends - DNAs). Recent data from the CDS (June 2003) show DNA rates of 31% for routine appointments and 18% for Special Needs appointments.

Registration

Registration with a dentist is higher in Greater Glasgow compared to elsewhere in Scotland, a reflection of the relatively higher levels of dentists. This pattern is consistent across all age groups in the population. There is no direct relationship between oral health and dental registration.

**NHS DENTAL REGISTRATION RATES (%) AT 31 MARCH 2003**

	0-2	3-5	6-12	13-17	18-24	25-34	65-74	75+
<b>Scotland</b>	34.4	67.7	75.6	68.1	51.8	52.0	39.1	27.4
<b>Greater Glasgow</b>	38.6	71.5	81.3	70.9	50.2	58.4	39.3	30.0

Source Scottish Dental Practice Board Annual Report 2002/2003

Amongst young children dental registrations in Greater Glasgow rise with age (from 15% for those aged less than 1 year to 82% for those aged 5 years). However child dental registration is commonly misreported by parents. In Greater Glasgow the pattern of child dental registrations is strongly associated with parental behaviour and the need to address the symptoms of dental disease.

In general child registration with a family dentist has increased over the last ten years. Although it outstrips the national rate registration is not synonymous with attendance, treatment or good dental care.

According to the Health and Well Being Survey 74% of adults in Greater Glasgow claim to be registered with a dentist. Scottish Dental Practice Board data record that 52.7% of adults in Greater Glasgow are registered with a GDP. People living in deprived areas are less likely to be registered with a dentist than those living in affluent areas (65% as against 76%). Since 1999 there has been a fall of 7% in the level of reported registration.

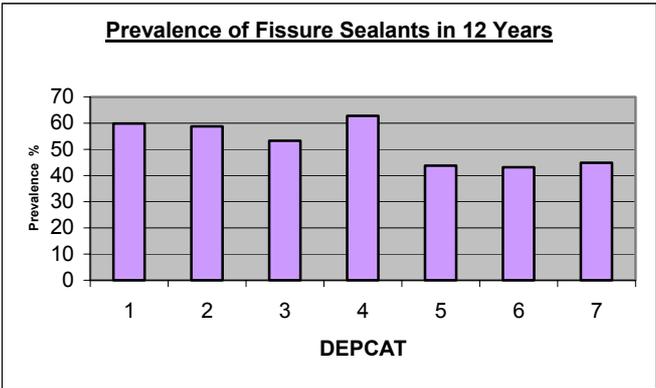
Registration with a dentist appears to significantly decrease with age with barely a quarter of older people being registered.

The issue of access is intensified for those 5800 older people who stay in 140 care homes in Greater Glasgow. The Community Dental Service currently provides a service to care homes, but data relating to the level of service is currently unavailable. However, indications are that the level of care proposed within National Care Home Standards 2000 is currently not being met. In addition an estimated 1300 hospital in-patients are thought to require dental care each year.

**Access To Preventive Measures**

Repeated surveys of children’s dental health have illustrated that there is insufficient and frequently inappropriate provision of caries prevention and treatment services for children in Scotland. It is apparent that, in Greater Glasgow restoration of decayed primary teeth is infrequently carried out - a decayed tooth is four times more likely to be extracted than it is to be restored.

New GDS regulations indicate that 6 and 7 yr olds considered to be at risk should receive fissure sealants. Fissure sealants are well documented as a highly effective means of protecting children’s new adult teeth.



In Greater Glasgow 51% of children had one or more fissure sealed teeth in 2000/01 and although the distinction between rich and poor is not as sharp as in other aspects of oral health, children from poorer areas are less likely to receive fissure sealants.

## **Access To Accident and Emergency Services**

Analysis of attendances at the Accident and Emergency Department of Glasgow Dental Hospital and School (2001/02) showed differences in the attendance rates, ranging from 22.2 attendances per 1000 population in G34 (Easterhouse) to only 9.0 per 1000 in G64 (Strathkelvin). This would suggest that the needs of people from Easterhouse are not being met in their own community. However, no investigation has been undertaken to explore underlying reasons for this. It may mean that access to primary dental care in that locality is limited or not appropriate to their needs, or it may simply mean that patients prefer to attend the Dental Hospital and access the service on a “casual” basis rather than commit themselves to regular attendance at a local general practitioner.

## **Access To Specialist Services**

The table below illustrates that there are currently local people can experience prolonged waits for some specialist dental treatments at the Dental Hospital. These are being addressed as part of the national waiting target initiative which sets a maximum for outpatient services of 26 weeks by December 2005.

**SPECIALIST SERVICES WAITING TIMES AND NUMBERS**

<b>Department</b>	<b>Waiting Time (weeks) for first appointment</b>	<b>Numbers waiting</b>
Anxiety/Hypnosis	<b>29</b>	<b>54</b>
Child Dental Health	<b>8</b>	<b>136</b>
Conservation	<b>47</b>	<b>1210</b>
Oral Medicine	<b>58</b>	<b>1292</b>
Oral Surgery	<b>16</b>	<b>679</b>
Orthodontics	<b>32</b>	<b>1022</b>
Periodontology	<b>58</b>	<b>1533</b>
Prosthodontics	<b>55</b>	<b>519</b>
Sedation (Oral Surgery)	<b>11</b>	<b>11</b>
Conservation	<b>8</b>	<b>6</b>

## **Main Determinants**

### Poverty

Poverty is a hugely significant factor in Greater Glasgow in terms of oral health and access to dental services. Whereas in the rest of Scotland 18% of children are in DEPCATs 6 and 7 this proportion in Greater Glasgow is almost three times that level (53%). Furthermore, 70% of the most deprived communities in Scotland are to be found in Glasgow City.

According to Gray *et al* (1970) and Bulman (1968) cited in the Black Report (1980), “working class people” make less use of dental services and receive inferior dental care. Whilst these studies are rather old, recent epidemiological evidence (National Dental Inspection Programme 2003) suggests that the relationship between socio-economic status and dental disease, access and uptake of services persists in Greater Glasgow.

Landes and Bradnock (1996) observed that parents from deprived social backgrounds tended not to take their children to see a dentist until they had pain. Young children from such backgrounds were more likely than the rest of the population of receiving a general anaesthetic for dental extractions due to decay.

The effect of social and personal factors on the utilisation of dental services in Glasgow was studied by Pavi, Kay and Stephen (1995). Their results showed a highly significant association between social deprivation and reported dental attendance. Barriers to dental attendance experienced by deprived populations were not easily changed.

In response to the Health and Well Being Survey (2003) 6.4 % said they had great/ some difficulty getting an appointment to see the dentist. Interestingly, this access issue was less (2.7%) in SIP areas than it was in non SIP areas (7.7%)

#### Ethnicity

Amongst people from black and ethnic minorities local surveys have found that there is a barrier to attendance because of language difficulties and that this may be particularly high amongst the Chinese community (38%). High proportions across all black and ethnic minority groups indicated that they would have preferred to have an interpreter.

#### Age

Evidence of the population’s uptake of primary care dental services can be obtained from Practitioner Services’ data on registration with general dental practitioners. Current registration data show poor uptake in the over 65 population with approximately one third of this age group being registered

#### Special Needs

Some care groups receive an inadequate service. A survey of children attending special needs schools in Greater Glasgow reveals that they receive much lower levels of dental care than the rest of the population. Similar patterns are observed for other special needs groups.

#### Gender

With regard to oral cancer, Todd and Lader (1988) confirmed a commonly held view amongst dental practitioners that those least likely to attend for regular examination were men in unskilled occupations who were also those most at risk of developing the disease. This tendency makes it difficult for such individuals to benefit from opportunistic screening and oral health promotion.

## **SECTION SIX**

### **THE ORAL HEALTH CHALLENGE**

There have been improvements in oral health in Greater Glasgow in terms of reduced levels of decay amongst children, more adults retaining their own teeth, relatively high levels of dental registration and the introduction of new oral services and health promotion initiatives. Whilst these advances are to be welcomed the issue for the NHS Board is that they are neither happening far enough or fast enough. Our progress continues to be outstripped in most cases by the rest of Scotland, Britain and Europe and where improvement has happened it has often been the more affluent sections of our community that have most benefited. Poverty and deprivation remain critical factors in explaining patterns of oral health. On top of that we cannot afford to be complacent even about our existing progress as there are mounting threats for example in maintaining current levels of service and of countering increased availability and consumption of foods damaging to teeth.

Taking into account the current levels of dental disease in Greater Glasgow and the performance of oral health promotion and dental services, the strategy has to face up to four key challenges. These are:

- Improving dental health;
- Ensuring that the main determinants of oral health are in place;
- Improving access to services for all population groups;
- Planning for emerging risks and maximising new opportunities.

#### **Improving Oral Health**

Evidence suggests that there is a need to improve oral health right across the entire population. More worryingly present trends and behaviours are being repeated or not arrested between generations. Compounding our problems the Scottish Executive has set targets for child oral health which will be very exacting for Greater Glasgow.

The magnitude of the challenge facing us can be well illustrated by reference to our performance in relation to the Scottish Executive's target for 2010 that 60% of 5 year olds will be caries free. By comparison Greater Glasgow is currently barely half that and while forecast to rise by 2005-06 will still be well short of the target. A DEPCAT analysis of our performance is even more sobering revealing the deep lying inequalities in oral health.

The task for the strategy will be to engineer an approach or approaches which can deliver improved oral health across the whole pre 5 population but with a stepped change in the lower DEPCATS where dental decay is greatest. Candidly this will be difficult as time is running short, a huge advance is needed and the very youngest children are difficult to access.

The challenge continues for older children to ensure that they safeguard their irreplaceable adult teeth. At the heart of the matter in oral health is our population's attitude and culture

towards health in general and oral hygiene in particular. This has been compounded in Greater Glasgow where oral health has not always assumed a high NHS priority.

## **Main Determinants of Oral Health**

If oral health is to be significantly improved in Greater Glasgow effective action is needed on the main casual factors of poor oral health such as diet, tobacco, fluoride and oral hygiene. Yet on most if not all of these Greater Glasgow is in a weak position. Central to the strategy is that, NHS Greater Glasgow in partnership with other agencies, will address the key determinants of oral health and accessible to the whole population. These are:

- The scale and intensity of poverty and multiple deprivation particularly within Glasgow City which has 70% of the most deprived communities in Scotland totalling 186,000 people;
- Access, availability and affordability of a healthy diet to include fresh fruit and vegetables;
- Exposure to Fluoride, whether by means of dietary supplements, toothbrushing or water fluoridation as a public health measure;
- The knowledge and understanding of self-care, i.e., maintaining good oral hygiene by toothbrushing and regular dental attendance;
- Providing dental services which focus on the needs of the patients particularly in relation to clinical prevention of dental disease e.g., fissure sealants and topical fluoride for children and long-term treatment planning for the older population.

## **Improving Services**

There are a number of challenges concerning dental services including access, orientation, quality and isolation.

In terms of access there are serious issues of under provision regarding geographical access particularly in more deprived communities together with critical gaps in service to vulnerable groups such as older people in care, people with learning disabilities, children with special needs and homeless people as well as in the range of service options on offer eg sedation. These have been longstanding and undermine the notion of a universal service. It is unlikely that the new GDP contract will address these shortcomings.

Our dental services and the majority of our oral health resources are being channelled into treating dental disease and decay. If we are going see a stepped change in Greater Glasgow's oral health record we need greater emphasis on preventing decay occurring in this first place. This is widely acknowledged but is not straightforward. A new GDP contract may increase prevention activity in the future but the strategy cannot place complete faith in the contract and needs to address itself also to a wider set of contingency actions. Similarly, a desire for more prevention cannot be met by a simple switch of resources. As more people retain their

teeth for longer there will have to be a degree of double running to meet increasing demand for restorative care.

The need for continuous improvement in quality and standards throughout dental practice in Greater Glasgow will be at the forefront of the Strategy. This will include meeting the new NHS Quality In Scotland standards for primary dental care and the Healthcare Governance standards. There is an additional need to look at service redesign in some areas to maintain and improve services.

Oral health relies on inputs from many different sources not only dental services. Yet, dental services appear to be relatively isolated from other NHS services and appear to have a less well formed working relationship with other influential services. A change is required at operational and strategic levels to enable dental services to become more involved in wider initiatives and for others to incorporate oral health into their own planning.

## **Emerging Risks**

While there is still a relatively high level of access to NHS dental services this can't be taken for granted in the longer term with reports of restrictions being applied by some practices. There are already signs of disillusionment amongst the dental workforce with a possible issue around retention and recruitment. To deliver the clinical prevention and treatment services envisaged, it will be necessary to attract and retain new dental graduates within the NHS in Greater Glasgow. The imminent changes to the general dental practice contracts in England remain a threat to our already diminishing dental workforce, while in Scotland there remains uncertainty about the form of the new contract.

New opportunities to improve the skill-mix in primary dental care will also arise within the next two years when the newly qualified Dental Hygienists/Therapists are due to seek employment. Further changes in the skill mix need to move in tandem with programmes of dental education and training. In both cases these factors will require to be reflected in future workforce planning.

## **Outcomes**

These include

- achieving national targets on oral health especially for children
- increasing the proportion of adults with their own teeth
- increasing in the proportion of older people who are registered with a GDP
- obtaining more robust data on other vulnerable population groups such as ethnic minorities and young people who are looked after.
- reducing the number of children requiring a general anaesthetic for dental treatment
- improving access to conscious sedation for all patients who require this form of anxiety management in primary care

# SECTION SEVEN

## OUR VISION

Our vision for oral health in Greater Glasgow is that

***'Healthy mouths matter in Greater Glasgow:  
Good oral health will be valued as part of healthy living.  
Everyone will have healthy mouths and be able to maintain them.'***

The earlier sections have shown how poor Greater Glasgow's oral health is, as well as the shortcomings in our current dental services. Our vision is that good oral health will be valued by everyone in Greater Glasgow and be seen as a normal part of daily living. To turn around this situation more concerted action will be needed in Greater Glasgow to improve the oral health of the population and to enhance dental services. To deliver the vision our strategy is built on the following core principles

- Reducing inequalities
- Integrated working and pathways
- Evidence based practice
- Making oral health everybody's business
- Making oral health integral to holistic health

The strategy rotates around two main aims

*To improve oral health*  
and  
*To enhance dental services*

Improvements in oral health will require stronger leadership on public health issues to tackle the main determinants of oral health head-on. This includes exposure to fluoride. Our poor oral health is not a recent phenomenon and there are many deep-seated obstacles that require changes in expectations and attitudes about oral health

We believe that if we are going to make a long term impact on the poor oral health of Greater Glasgow we must focus on the next generation. More effort, attention and resources need to be devoted to oral health if we are avoid repeating existing patterns among pre-fives. Lifestyle, behaviour patterns and valuing of good teeth require to be developed in childhood and be continued into adulthood.

Within Greater Glasgow there are clear inequalities in oral health. In contrast with affluent areas people in the poorest areas have the highest levels of dental decay and poorest services.

The strategy addresses the future of our dental services. We are aware of the commitment of individual dental practitioners to improving their practice but there has been no overall strategy for Greater Glasgow. We are committed to modernising our primary and secondary care dental services and ensuring that all the people of Greater Glasgow have access to high quality dental services fit for the 21<sup>st</sup> century.

This strategy concerns not only dental services but locates oral health within an holistic view of an individual's as well as a community's well being. In doing so it recognizes that many other services and professions have a stake and contribution to make to the improvement of oral health at operational and strategic levels. Harnessing their input and involvement will be crucial to the success in implementing this strategy.

In short, what the strategy sets out to do is to enable oral health to punch its weight and argue for fair recognition alongside many other competing and merited health priorities.

## **STRATEGIC AIMS, OBJECTIVES AND PRIORITIES**

### **Strategic Aim: To Improve Oral Health**

**Strategic Objective A:** To change expectations and attitudes regarding the importance of oral health.

*Strategic Priority A1:* To raise the profile and priority of oral health in communities, professional groups and organizations.

*Strategic Priority A2:* To build public policy and practice which are supportive of oral health.

**Strategic Objective B:** To target health improvement action with a special focus on children

*Strategic Priority B1:* To develop community based approaches to tackle oral health needs (with a special emphasis on pre-fives)

*Strategic Priority B2:* To ensure that oral health is integrated within the wider child health agenda

### **Strategic Aim: To Enhance Dental Services**

*Strategic Priority C:* To tackle inequalities in access to services

*Strategic Priority D:* To emphasise prevention in dental services

*Strategic Priority E:* To improve quality of dental services

*Strategic Priority F:* To develop a mixed economy in dental services

*Strategic Priority G:* To develop specialist services

*Strategic Priority H:* To engage with public and patients



# SECTION EIGHT

## IMPROVING ORAL HEALTH

### Strategic Approach to Health Improvement

It is generally accepted that dental decay is preventable. We are conscious that the poorest people living in the most disadvantaged circumstances than those living in less deprived areas suffer substantially more avoidable illness and disability and premature mortality (PHIS 2002). This includes oral health which in turn is a barometer for wider health inequalities. Therefore, improvement of oral health relies on the implementation of specific measures in the context of wider policies and programmes to reduce avoidable and systematic inequalities in general health.

Health promotion literature supports an holistic approach . The Ottawa Charter (WHO 1986) clearly outlines the main issues for improved oral health :

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health service

To date, developments and policy within the oral health field have largely concentrated on dental treatment and dental services, with some consideration given to dental education where prevention messages have been based largely on influencing aspects of behaviour and lifestyle eg. sugar avoidance and toothbrushing. This strategy advocates a change of emphasis based on

- the premise that current levels of oral ill health are unacceptable and preventable across the population and particularly amongst children
- taking an integrated approach to oral health incorporating public health, dental services and health promotion alongside other non dental professionals and services
- strengthening our community development approach to oral health within mainstream health service redesign
- intervening appropriately throughout the life cycle
- complementing a targeted individual approach with a population approach to achieve the greatest health gain
- fostering multiple approaches rather than relying on unconnected singleton actions

From the assessment of oral health needs in Greater Glasgow and of our progress so far in tackling these, our objectives for improving oral health are

- Strengthening public health leadership in tackling the main determinants of poor oral health
- Changing the attitudes and culture surrounding oral health
- Targetting oral health improvement particularly towards children

## **Strengthening Public Health Leadership**

In terms of public health there are three main areas where effective action is crucial to our prospects of improving oral health. These are

- Diet
- Tobacco
- Fluoride.

These represent principal determinants of poor oral health.

### Diet and Tobacco

The NHS Board is already prominently engaged often alongside other partners to develop policy and implement measures to support healthy lifestyles and to address related social and environmental issues. Whilst delivery of these policies and measures have wider health benefits their success can also yield oral health gains. Oral health is often addressed indirectly within these policies and emerges as a beneficiary. However these gains are not automatically assured. The recent review of Breakfasting Clubs in Glasgow City revealed that oral health was not a priority amongst the vast majority of clubs even though this represented an ideal opportunity to improve children's oral health. Improved oral health must be more explicitly and aggressively pursued within public health.

This strategy does not question the direction and effectiveness of existing policies but seeks to raise the profile of oral health in their delivery. It is evident that

- Until or unless significant in-roads are made on the consumption of confectionary and fizzy drinks and of healthier balanced diets the route to improved oral health will be steep if not impossible.
- Similarly with tobacco use, the rising levels of oral cancer will not be arrested without significant falls in the levels of smoking.

Diet and dietary behaviour are perhaps the single most important factors in the aetiology of dental decay. The frequency of sugar consumption has been known to be associated with the prevalence of tooth decay for many, many years, yet children's frequency of consumption of sugar has increased over the past thirty years. Whilst we commend the Scottish Executive's support for the numerous diet improvement initiatives, such as Fruit in Schools and Healthy Choices Awards etc, currently under way in Scotland, we would encourage the NHS Board with local authorities and the Scottish Executive to adopt a more aggressive stance against the sale of foods and drinks containing sugar by way of:

- Implementation of Hungry for Success in primary and secondary schools by the year 2006 with cessation of commercial sponsorship of school meals services by manufacturers and retailers of inappropriate food and drinks, the phasing out of sales of products containing high levels of fat and sugar via school meals, tuck shops and vending machines in schools and the introduction of a range of alternative more healthy products (sub paras)
- continual monitoring of Hungry for Success within the context of school inspections and the extension of the policy to include pre 5 establishments

- the sustainable development of food initiatives and local retail schemes promoting the availability, affordability and accessibility for healthy foods in low income communities
- exclusion of advertisements on television and satellite channels for confectionary, soft drinks and alcohol during peak children's viewing times
- obligation for manufacturers of prepared foods to adopt clear labelling of contents policy

## Fluoride

It is widely acknowledged that the biggest single impact to improve oral health could be achieved through increased and sustained exposure to fluoride.

Presently the most readily available and effective method of fluoride delivery is within toothpaste. Toothpaste, with an optimum fluoride content of 1000ppm, is widely accepted for use by people of all ages. A national pilot programme for the distribution of free toothpaste for children under 4 years living in low-income areas is in place. However local research and epidemiology suggests a pattern of usage within Greater Glasgow that indicates those who need it most are not accessing fluoride toothpaste with sufficient regularity to benefit their oral health. We would urge the Scottish Executive and the NHS Board to maintain funding at levels which allow regular distribution to those with an increased risk of dental decay.

In addition topically applied fluoride in the form of varnish and gel may be determined by GPs to be of further benefit individuals. Further investigation is also required here to establish current levels of use and to promote more consistent practice.

Recent scientific reviews [University Of York, Department of Health (Republic of Ireland) and Medical Research Council] of the world literature have confirmed the dental benefits of water fluoridation. Research in Moray where there is a natural optimally fluoridated public water supply has confirmed that the children at the age of 5/6 years had 96% less dental caries after lifetime exposure to this water supply relative to children living in neighbouring non-fluoridated communities. Similar results where fluoride has been deliberately added to the public water supply are evident in Newcastle and Birmingham.

Greater Glasgow's residents are disadvantaged by the low level of naturally occurring fluoride in the public water supply. There is strong evidence that water fluoridation is safe and effective. Given the widespread occurrence of dental disease in all age groups of Glasgow's residents across all socio-economic strata, water fluoridation would have the greatest potential of any single measure to improve dental health. The improvement would be most evident in children in the earliest years but would, year on year, be displayed to ever increasing extents across all age groups. Without water fluoridation, Greater Glasgow is compromised in its ability to reach the target set for 2010 of at least 60% of its 5 year olds having no cavities, fillings or extractions.

We acknowledge that there is some opposition to water fluoridation but we believe that much of this opposition is based upon spurious claims relating to unsubstantiated effects of fluoride upon health. Whilst we do not disagree that further research should be undertaken, we believe that the withholding of optimally fluoridated public water unnecessarily disadvantages Glasgow's population. We encourage the Scottish Executive to facilitate the introduction of water fluoridation at the earliest possible time. The NHS Board should seek clarification of

the Scottish Executive's support for water fluoridation and raise the issue with local authorities.

Until such time that water fluoridation can be introduced, alternative delivery systems should be promoted and assessed in Scotland. Greater Glasgow is enthusiastic to become involved in any multi-centre trials of slow release fluoride devices. We would urge the Scottish Executive to invest heavily in dental research in children to assess the effectiveness of various systems. There is an ideal opportunity to compare the effectiveness of water fluoridation against alternative methods of fluoride delivery.

We are aware that water fluoridation by itself will not eliminate dental caries. Experience, however, shows that it has the potential to reduce the harmful effects of frequent sugar consumption and inadequate oral hygiene both of which behaviours are known to the public to be causes of dental decay, yet they remain common behaviours.

## **Changing Attitudes and Culture**

The ability to change the oral health experience of Greater Glasgow is one that requires awareness raising, knowledge of how to prevent decay as well as the ability to change the factors contributing to decay on every level.

The current position within Greater Glasgow is that the actions required to prevent decay are often not undertaken by individuals, communities and organizations. The importance placed on oral health relates to a number of factors such as the life circumstances and health beliefs held by these groups. We need to address this. On an organizational level we can take actions to create supportive policy, environments and services to make the healthy choice the easier choice.

A number of factors will impact on the ability to create this generation of children with good oral health, not least the ability to empower parents to tackle lifestyle risk factors as part of their parenting role. Actions taken in relation to the development of skills, community action and services provided to support the general health of children within Greater Glasgow will essentially impact on and potentially deliver good oral health. Similarly the accessibility, availability and affordability of a healthy diet is fundamental to the maintenance of oral health. Actions to improve the diet of the population of Greater Glasgow will determine the oral health experience.

We can work with communities and individuals through the provision of information and skills to encourage the valuing of good oral health and foster the ability to address lifestyle issues creating poor oral health. In order to change expectations and attitudes regarding the importance of oral health two strategic goals have been identified.

- To raise the profile and priority of oral health in communities, professional groups and organisations
- To build public policy and practice supportive of oral health

### Oral Health for Life

People should have their teeth for all of their life. To achieve this a pattern of care requires to be established from birth. Appropriate health improvement emphasis is required at various life stages. The health improvement goals to be considered at each life stage are set out in Table 2 below. Appendix IV gives further details of the key interventions and settings proposed within the strategy.

To achieve the goals set out within this paper it is necessary to facilitate the engagement of partners, both internal within the NHS and external statutory agencies and the voluntary sector to promote health improvement and acknowledge a shared responsibility to address oral health.

The infrastructure to support health promotion activity across these partnerships requires to be integrated with area-wide strategic planning fora, such as children’s service planning, older people’s planning groups and joint health improvement planning with local authorities. Local health promotion activity and capacity building with professionals and communities should be supported by Community Health Partnerships and Oral Health Action Teams.

#### **PARTNERSHIP WORK FOR ORAL HEALTH**

<b>Life stage and main objective</b>	<b>Partners</b>
Early Years <5 Years  Prevention Of Dental Decay	<ul style="list-style-type: none"> <li>▪ Pre-five establishments</li> <li>▪ Parent &amp; Toddler (Groups)</li> <li>▪ Family Learning Centres</li> <li>▪ Primary Care Services</li> <li>▪ Community Venues</li> <li>▪ Social Work Services</li> <li>▪ Carers / childminders</li> </ul>
Children And Young People (Teenage Transitions)  Prevention Of Dental Decay Protection Of Oral Health	<ul style="list-style-type: none"> <li>▪ Schools – New Community Schools</li> <li>▪ Youth setting in formal</li> <li>▪ Further education</li> <li>▪ Housing</li> <li>▪ Leisure</li> </ul>
Adults Of Working Age  Maintaining Care	<ul style="list-style-type: none"> <li>▪ Workplaces</li> <li>▪ Inter-mediate Labour Market</li> <li>▪ Unemployed support services</li> <li>▪ Community venues</li> <li>▪ Primary Care services</li> <li>▪ Community Groups</li> <li>▪ Retailers</li> </ul>
Older Adults  Maintaining Care	<ul style="list-style-type: none"> <li>▪ Voluntary sector</li> <li>● Care and Support services</li> <li>● Community Venues</li> <li>▪ Primary Care</li> <li>▪ Residential homes</li> <li>● Nursing homes</li> </ul>

## **Targeting Parents and Children**

Good oral health needs to be established and maintained from the earliest age. Evidence suggests that many behaviour patterns developed in childhood are continued into adulthood making parents and carers of pre-five children a key group to target in order to create a population with little experience of dental decay. Working with parents to improve confidence and skills is essential in changing the behaviour of very young children. Recent evidence suggests that working with mothers ante-natally is also important

Achievement of the Scottish Executive's target of 60% of 5 year olds caries free by 2010 represents a huge challenge for Greater Glasgow. It is clear that it cannot be reached by dental services alone. A broader public health approach as advocated in this strategy is essential.

The pattern of dental decay is such that there is a need to improve the oral health of all children within GG but if we are also to reduce the inequalities associated with dental disease we specifically need to reduce the burden of disease experienced by those children with the most decay.

To achieve the target of 60% children to be caries free by age of five requires a focusing of activity from birth to 3 years old to ensure teeth are protected from the earliest age and are maintained as caries free. This age group is difficult to access due to limited engagement with statutory services before nursery.

Much remains to be done to improve the dental health of pre-school children in all communities. Evidence suggests that inequalities in oral health are likely to widen with health education programmes targeting the whole population. Local programmes targeting most vulnerable groups should be developed to address this. The strategy of explicitly targeting the most deprived communities continues to be justified and requires to be central to this strategy. The need to improve the dental health of children in the more affluent communities however continues to exist.

Our future aim on Greater Glasgow should be to reach the target by raising the caries free level across all social groups but in particular the lower DEPCATS. Therefore scenario C from the earlier table most closely approximates the desired outcome for the strategy achieving improvements across all DEPCATs but with significant advances among the more deprived populations.

In order to target children two strategic goals have been identified:

- to develop community based approaches to oral health
- to ensure integration of oral health with wider child health agenda

Specific actions proposed are:-

### ***1. Developing OHATs***

OHATs have now been rolled out across all of Greater Glasgow with a remit to develop oral health promotion activity targeting pre 5 children. Currently investment varies only by LHCC size and is not related to need. The potential of OHATs to impact on the oral health of the most at risk population is limited by the current distribution of effort, local commitment and

the level of resourcing in response to the size of the population at risk (53% of children in Greater Glasgow live in DEPCAT 6 and 7 areas. To achieve our aim of improving oral health in the future amongst young children further resources should be targeted to those areas currently with the worst oral health. The original oral health gain pilot project in Possilpark and Blackhill/Ruchazie achieved the sort of stepped change necessary to attain the target and it is proposed that those OHATs in priority areas (see table??) should be further enhanced to a comparable level.

The effectiveness of OHATs should be further supported by implementation of the main recommendations of the recent review including to increased targeting of pre 3s, creating local networks and capacity and developing improved partnership working with LHCCs, health promotion and GDP. The initiative should however continue to be evaluated to ensure that resources are adequately deployed and to assess impact on key factors of oral health.

The approach within the OHAT initiative supports long-term cultural, organizational and behavioural change within local communities and as such the OHAT initiative is key to the implementation of this strategy. The OHAT initiative can only contribute partially to achieving the pre-five target and health visiting commitment to oral health is required if the target is to be achieved. The NHS Board should ensure oral health is a priority area of action when implementing Hall 4 Guidance.

## ***2) fluoride toothpaste initiative***

Without water fluoridation, the most acceptable and effective method of providing fluoride within the population is through fluoride toothpaste. The cost of toothpaste has previously been identified as a barrier within low income communities. There is further evidence, to suggest that ‘cultural’ aspects also affect the use of toothpaste. The National Demonstration Project providing free toothpaste (and toothbrushes) to establish good oral hygiene habits at a young age addresses both of these barriers.

In comparison with other Health Board areas, many of which have progressed to implementing toothbrushing programmes in primary schools Greater Glasgow faces a significantly greater challenge due to the number of programmes required at pre-school. The limitations of local infrastructure (staffing in nurseries/competing priorities for Health Visitors/OHAT capacity/distribution mechanisms), the size of the challenge and the level of funding allocated to Greater Glasgow have reduced the potential impact of these initiatives. To achieve a comprehensive toothbrushing programmes the NHS Board should seek commitment to oral health from local authority partners specifically in relation to toothbrush/toothpaste distribution, toothbrushing programmes and Health Promoting School initiatives.

Further action to improve the affordability and accessibility of toothbrushes and toothpaste for low income families would be beneficial in sustaining toothbrushing behaviour throughout life, this should include exploring the potential to remove VAT.

### *3) integrated with children's services*

The betterment of children's oral health is reliant on wider actions beyond either dental services or even the NHS. In future it will be critical to ensure that a central plank to oral health improvement is locating child oral health within the NHS Board's wider child health policies and its children's services planning with local authorities recognizing their role. This should apply not only to planning but also to the delivery of children's services.

- initiatives such as Starting Well, Sure start and Health Visiting corporate caseload approaches seek through new and more intensive inputs to improve the health of vulnerable parents and their children
- oral health can be promoted in a variety of settings, such as nurseries, schools, Family Learning Centres and child development centres, aimed at parents and children to instill good habits in diet and oral hygiene
- other non-dental professionals have vital roles to play in this area such as health visitors and public health nurses alongside others such as teachers who should all be enabled to promote good oral health as an integral part of their responsibilities
- New Learning Communities offer fresh opportunities to sustain the good start achieved at pre-5 years into older age groups as children gain their adult teeth through initiatives supporting the availability of fluoride toothpaste, and toothbrushing programmes, breakfast clubs, healthier food choices and the Health Promoting School Awards
- The School Health Service could develop to provide links with dental services particularly in relation to accessibility of fissure sealants prioritizing low income areas. The school health team comprising school nurses, school nurse assistants and health development officers are well placed to ensure that oral health is part of their wider health promotion agenda eg linking with diet and physical activity

The NHS Board should seek commitment from Local Authority partners to develop oral health within Learning Communities and the School Health Service. New children's services plans for 2005-08 present such an opportunity and require to be prepared by 2005.

The strategy proposes the implementation of the SIGN guidelines for preventing caries in pre 5 children (to be published) and for 5-14 year olds including the employment of PCDs to provide intensive prevention services for example, application of fluoride varnish, fissure sealants and xylitol gum specifically targeting high risk children.

# SECTION NINE

## ENHANCING DENTAL SERVICES

### Tackling Inequalities in Access to Services

The Strategy will ensure that dental services are available and accessible in all areas of Greater Glasgow.

#### *New developments*

The Primary Care Division has secured funding to take forward new developments that will improve access in the following areas:

#### *Primary Care Treatment Centre – Floor 1, Glasgow Dental Hospital and School*

A team of five Salaried General Dental Practitioners and their support staff will provide an emergency treatment service for unregistered patients who require urgent dental treatment. Once the immediate problem has been treated, patients will be given information on how to obtain routine dental care and treatment in their own locality. This new service that will replace the former Accident and Emergency service is due to commence on 1 September 2004.

#### *Improving Dental Surgery Facilities*

Funding has been made available by the Scottish Executive to enable general dental practitioners to apply for improvement grants which will allow them to upgrade dental equipment and to help them to comply with the provisions of Disability Discrimination legislation. This programme of improvements is now in its fourth year of operation and is expected to continue, with all practices in Greater Glasgow having benefited.

In the financial years 2004/05 and 2005/06, Scottish Executive funding will enable the Primary Care Division to invest in a new development at Pollok Health Centre and a refurbishment project at Springburn Health Centre. The main benefits will be improved access for patients who require to be treated in their wheelchairs, and for special needs patients, adults and children who require sedation.

#### *Providing Incentives in Deprived Areas*

There is a concern to retain as well as to enhance GDP services in deprived communities. The recent Scottish Executive proposal to consider the introduction of incentives whether in the form of enhanced practice allowances or infrastructure support is welcomed. This could extend to greater sharing of risks in operating a GDP practice in return for contributions to NHS services.

The strategy will ensure comprehensive service provision is addressed. For example, the centralisation of the children's dental general anaesthetic service at Yorkhill and the increasing availability of sedation services as part of the children's dental care pathway will

greatly improve the service as well as minimising risk to patients. A greater availability of for example sedation services should enable a greater proportion of older children 7-12 to avoid the need for GA as they may tolerate restorative care under sedation at an earlier age compared to current practice.

The strategy will ensure that all vulnerable people have fair and proper access to dental prevention and treatment.

NHS Greater Glasgow plans to make it easier for all population groups to access dental services. This will include patients with special needs, frail and vulnerable elderly people, black and ethnic minority populations, asylum seekers and refugees. The dental and oral health promotion needs of these care groups will be the subject of further analysis and plans will be prepared in response to this work in the short to medium term.

Dental services for patients with special needs are provided by the General Dental Service, the Community Dental Service and the Hospital Dental Services. The Community Dental Service is the major care provider. In Greater Glasgow, however, the Community Dental Service is very small relative to the dental needs of the population and additional investment is urgently required. NHS Greater Glasgow also believes that as for the population as a whole, there should be more emphasis on oral health promotion and the clinical prevention of dental disease.

#### *Older People in Care Homes*

As the number of elderly people with their own teeth is increasing, there is an increasing need for long-term treatment planning and continuing restorative care. The Primary Care Division's Dental Directorate held a successful stakeholder event in November 2003 on the oral health of the elderly.

A new dental health screening system on the oral health needs of care home residents is being developed nationally and a recent review in Greater Glasgow indicated that additional dentists, dental hygienists and dental health educators will be required to provide screening and treatment for all care home residents.

#### *Children with Special Needs*

In the child with special needs, the impact of poor oral health is often more severe than in the rest of the population and they often have one or more serious medical problem. A recent review of dental services for these children recommended that a care pathway should be developed taking into account the needs of the children from the pre-school age through to young adulthood.

Oral health promotion and dental health services for this care group require additional investment to ensure that they are adequately resourced and developed. A stakeholder event will be held in the near future to involve parents and representatives from education, social services and NHS Greater Glasgow in planning new services which will meet the children's needs.

#### *Adults with Learning Difficulties, or Acquired Physical and Mental Impairment or Medically Compromised*

This represents a group of patients with very diverse and complex needs and a detailed needs assessment will be conducted to assess the care required to provide comprehensive oral health

promotion and dental services for them. (Medically compromised children receive dental services via Yorkhill Hospital).

### *Homeless People*

A needs assessment on the dental needs of homeless people has also been conducted and NHS Greater Glasgow has applied to the Scottish Executive for approval to appoint 1.5 whole time equivalent salaried general dental practitioners and support staff to meet these needs. At the time of writing, the outcome of this application is awaited.

## **Emphasising Prevention in Dental Services**

The majority of individuals are affected by dental decay and most adults suffer from gum disease. Both are chronic diseases and to a large extent preventable. Appropriate oral health care will not in itself reduce the prevalence of dental disease, but it is an important strand of a prevention strategy.

### Increasing Preventive Activity within the General Dental Services

The ideal model of dental care should focus more on the medical “health maintenance” philosophy rather than the surgical intervention approach. This includes diagnosis and monitoring disease progression, controlling causal agents, pharmacological treatment and minimal intervention.

Currently in Greater Glasgow 87% of our oral health expenditure goes on payment to General Dental Practitioners largely for restorative care, yet the system of financial incentives for NHS dentistry works perversely against the interests of preventative oral health. It rewards dentists for quantity rather than quality of treatments through an item of service payment system. The British Dental Association has raised concerns that the current system potentially rewards poorer practice stating that “positive encouragement to produce more and more items of treatment in order to generate greater cash turnover has led to a danger of over treatment.” (Audit Commission report).

An Enhanced Capitation Scheme for children’s dental care introduced nationally in 1998 provides enhanced monthly registration payments for GDCPs to undertake increased preventative activity. For 0-2 year olds, a sliding scale recognises the greater challenge faced by dentists in more deprived areas, and 3-5 year olds registered with practices in DEPCAT 6 and 7 areas attract the enhanced payment. For children aged 6 and 7 years, the enhanced capitation rate also varies according to DEPCAT, but is conditional upon the practitioner conducting an assessment of the child’s caries risk status and the application of fissure sealants (plastic coating to prevent dental decay) of the first adult molar teeth as soon as they erupt into the mouth. While registration levels have increased appreciably, many children do not benefit from exposure to this increased level of preventive activity as the model depends on compliance and regular attendance.

At a national level, the Action Plan for Dental Services in Scotland proposes reviewing this scheme to ensure that it continues to meet its objectives. At a local level, a new children’s pathway will ensure that children in the most deprived areas who are at high risk of dental caries can benefit from comprehensive clinical prevention which will be delivered by general dental practitioners, and therapists/hygienists.

## Developing Pathways and Protocols

### *Children*

Children's dental services should provide a child centred service that offers comprehensive prevention and restorative care at the most appropriate stage in a child's dental development commencing from the time that teeth erupt. Evidence confirms that this approach with regular patient attendance can produce a marked reduction in dental caries.

Based on this approach a new Clinical Care Pathway for Children's Dental Services has been developed. This innovative approach will involve:

- employment of Salaried General Dental Practitioners, and Dental Hygienists/therapists;
- intensive clinical prevention for children identified as being at high risk;
- referral protocols to secondary care i.e. the Child Dental Health department at Glasgow Dental Hospital and School;
- routine care, treatment and oral health promotion advice by general dental practitioners;
- assessment of patients requiring treatment under general anaesthetic or sedation by dentists within the Paediatric Network;
- ultimately, the centralised dental general anaesthetic service at Yorkhill Hospital

### *Adults*

In England and Wales "NHS Dentistry: Options for Change" has made proposals for testing local commissioning of dental services and alternative methods of paying dentists. A central recommendation is that the patient gateway to NHS dentistry should be through an oral health assessment. This assessment should focus on prevention of disease, lifestyle advice, the discussion of any necessary treatment and date of the next assessment.

## **Developing a "Mixed Economy" in Dental Services**

Given the long history of poor oral health in Scotland, and in Greater Glasgow particularly, there is widespread recognition that the status quo is not an option which is likely to improve the position. The Consultation Document identifies that any major reforms must be effected in such a way as to maintain stability within the system and it is likely therefore that changes will be evolutionary while "building on a culture of quality". Whatever payment system is introduced must include a preventive focus as we are dealing with a preventable disease.

If changes to the national system are to evolve slowly, local initiatives are required that will enhance the infrastructure of the dental system in the interim. In the short to medium term, therefore, innovative funding sources should be explored to ensure that Greater Glasgow NHS Board invests in a transitional service which will improve the oral health of the population.

Primary dental care services in the future should comprise both a salaried and a contracted service rather than the current General Dental Service and Community Dental Service to form a unified salaried service delivering:

- prevention and oral health promotion for children;
- comprehensive screening and treatment for the elderly;

- tailored dental services for special needs groups;
- care for medically compromised patients.

In a “mixed economy”, a committed dental workforce supported by a range of health professionals would be available to provide comprehensive programmes of preventive dental care.

Such measures required might include additional local development funding to employ dental professionals directly on preventive treatment programmes or alternatively, to seek approval from the Scottish Executive for the appointment of salaried general dental practitioners pending the successful design of a new General Dental Service contract. A different perspective on the GDP non cash limited funding is required which recognizes the scale of deprivation in Greater Glasgow, the degree of poor oral health, the complexity of the issue of access and the high demand for restorative care.

One option which NHS Greater Glasgow is keen to pursue relates to paying dentists a sessional fee for providing specific dental services which would be distinct from their existing contractual arrangements. This would allow dentists to provide clinical prevention for children by giving a fixed time commitment to the programme and not being restricted to claiming individual Item of Service fees or being subject to the stringent criteria which apply to the current Enhanced Capitation Scheme.

One option so far not available in Scotland is Personal Dental Services (PDS). Though present in England and while a parallel exists for medical services (including within primary care in Greater Glasgow), no PDS pilots have been established in Scotland. The advantages of PDS are that it is based on practices or groups of practices, takes a needs not demand based approach to treatment, promotes access for populations with poor dental hygiene, enables activity and outcome targets to be specified based on local needs not a treatment fee model and facilitates an appropriate skill mix involving PCDs for a preventive service. Consideration should be given by the Scottish Executive to the introduction of such a model for dental services in Scotland.

### Changing the Skill Mix

There is evidence to support the introduction of a different skill mix in general dental practice. To meet the challenges of the existing dental manpower crisis and the changing skill-mix, workforce planning is required at national and local level. Particular pressure points are

- Retention of trainee dentists amid worrying signs that recent graduate have not taken up local posts
- The changing gender mix of the profession towards women
- Increasing demand for PCDs including newly dual-qualified dental hygienists/therapists. We believe that further provision should be made in education and training for growth and demand beyond present planned growth in PCD training.
- While it is possible to collate data on directly employed professionals, support staff and contractor professions, it is less easy to do so in relation to contractors’ support staff.

A local workforce planning exercise is about to start in collaboration with the profession and this should inform the planning process as to what further action is required to achieve our aims. This exercise will be taken forward therefore in collaboration with the profession.

## **Improving Quality of Dental Services**

Any major reforms arising from Modernising Dental Services must be effected in such a way as to maintain stability within the system and it is likely therefore that changes will be evolutionary while “building on a culture of quality”. The strategy is concerned to improve the quality of current dental services.

### Supporting Training for the Dental Team

Initial Primary Care Division initiatives to provide professional education and training opportunities for the whole dental team, including dental nurses, receptionists and practice managers will be developed. Ideally, training should be delivered in practice teams to emphasise the importance of communications and team-working. Elsewhere in primary health care, protected learning time is provided. However, to date, no funding has been available to provide similar support for dental practice and in future other funding streams to promote this model will be explored.

The Board enjoys good working relationships with NHS Education for Scotland (NES) and will continue to work closely with them to develop new educational programmes. This will include modular training for dental nurses (SVQ) and in collaboration with the local dental practice managers’ network, a management course which can be adapted for dental practice management.

### Ensure Quality Assurance

All parts of the dental service are engaged in quality assurance.

- The quality agenda for GDS has traditionally been managed by the Scottish Executive for example through quality assurance mechanisms such as the Dental Reference Service organised by Practitioner Services.
- The CDS is a locally managed service and quality development is already part of the Primary Care Division quality agenda e.g. guideline implementation and audit.
- The secondary care dental services are mainly based in acute hospitals with a major focus on Glasgow Dental Hospital and School as a service provider and educational centre.

In future further effort will be given to evolving a single system approach to quality assurance throughout dental services. This should include extending initiatives to improve quality e.g. Investors in People (IIP) and the Quality Practice Initiative (QPI).

## Drivers of quality in dental services

General Dental Service	Community Dental Service	Hospital Dental Service
<ul style="list-style-type: none"> <li>• Practice Inspection Programme</li> <li>• Colleagues through peer review and audit</li> <li>• Practice Managers through efficient administration systems, including complaints</li> <li>• Professions Complementary to Dentistry, through team delivery of care with potential to whistle blowing</li> <li>• Dental Reference Officers (DRO) reports on routine patient examinations</li> <li>• Continuing Professional Development (CPD)</li> <li>• Quality Practice Initiative pilot</li> </ul>	<ul style="list-style-type: none"> <li>• PCD quality initiatives (audit, guideline implementation)</li> <li>• Performance Management Systems( including waiting list information and activity data)</li> <li>• Infection Control, Health and Safety and Radiological Protection (organised Division wide)</li> <li>• Personal development Planning (PDP) and appraisal Continuing Professional Development (CPD)</li> <li>• Development of a Managed Clinical Network for children's dentistry</li> </ul>	<ul style="list-style-type: none"> <li>• Staff appraisal (including the new Consultant Appraisal System)</li> <li>• External validation e.g. General Dental Council (GDC), SAC and junior staff intercollegiate assessments</li> <li>• Continuing Professional Development (CPD) for all clinical staff</li> </ul>

### Quality Practice Initiative

The Quality Practice Initiative is a joint project being piloted by NHS Greater Glasgow Primary Care Division, NHS Education for Scotland and NHS Quality In Scotland (QIS). The Primary Care Division appointed two Clinical Governance Advisers to give support to dental practices to improve and maintain quality, and more specifically, to prepare them to meet the new standards for primary dental care being introduced by QIS. The Initiative comprises three levels of quality and practices progress by completing a series of modules at each level. The overall aim of this pilot is to identify and quantify the support practices require to achieve the new standards. At the end of the pilot phase, the Scottish Executive and NHS Boards will decide on any further developments such as implementation throughout Scotland and the establishment of the Clinical Governance Adviser role.

In the meantime, patients and dental professionals in Greater Glasgow are benefiting from this new investment in quality improvement and the Board would wish the Initiative to be established permanently, subject to evaluation of the project by the Dental Health Services Research Unit.

### Clinical Governance

Clinical Governance was defined in the Consultation Document "A First Class Service" (Department of Health, 1998) as:

*"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."*

The Health Board has a duty to develop and maintain arrangements for the purpose of monitoring and improving the quality of health care provided to individuals. This sits

alongside the role of the General Dental Council (GDC) for professional registration, regulation, continuous professional development and re-certification of dentists and PCDs as well as patient protection. A GDC Performance Review Scheme to deal with poor clinical performance being developed in collaboration with the Dental Practice Advisers will require funding support from the Scottish Executive.

In its policy document “A Commitment to Quality, a Quest for Excellence” (2001) the Department of Health stated that people had the right to expect services which:

- Were responsive to their needs
- Were delivered to a consistently high standard
- Treated them with respect
- Provided them with good information

The strategy for NHS Greater Glasgow dental services strives to meet these expectations by providing a mechanism for listening to feedback from patients, carers and other stakeholders and learning from adverse events and “near misses”.

### Providing Support Infrastructure

#### *Premises*

NHS Greater Glasgow is committed to providing infrastructure and resources for ensuring the delivery of patient-focused service dental services with the highest possible standards of care. This will include premises developments such as the replacement of Glasgow Dental Hospital and School, dental surgery facilities within the Ambulatory Care and Diagnostic Centres at Stobhill Hospital and the Victoria Infirmary site, as well as health centre and clinic developments throughout Greater Glasgow.

All new premises developments will be compliant with the provisions of the Disability Discrimination Act and in each locality there will be a facility whereby wheelchair patients can be treated in their own chairs.

#### *Dental Appointments*

Steps will be taken to establish the underlying causes of the high failure rate in keeping dental appointments. Current booking systems will be assessed to determine whether they are “user friendly”, if appointment times are suitable for the population served and indeed whether surgeries are located in the most appropriate places.

#### *IM&T*

The national IM&T strategy aims to link all general dental practitioners to the NHS Net by 2006. This will bring major benefits to patients and practitioners as they will be able to use e.mail and Internet access to make electronic referrals to specialists as well as accessing patient education material, research findings and other evidence-based information for clinical and patient administration purposes.

There is also the possibility of dentists in Greater Glasgow taking part in a teledentistry project in conjunction with Glasgow Dental Hospital and School which is expected to rationalise the referral process and improve waiting times for access to secondary care.

## **Developing Specialist Services**

### Oral Maxillofacial Surgical Services

To address mounting pressures on both in-patient and out-patient OMS services a review will be commissioned to assess the future resourcing, design and organization of the service. This will be led by Greater Glasgow NHS in consultation with other West of Scotland health boards.

### Glasgow Dental Hospital

Services at the GDH will change in the short term as a consequence to address waiting times (see below) and to consolidate child dental GA services on the site under a revised protocol. Before the end of this decade it will be necessary to provide a new dental hospital and school. Planning is already underway to locate a suitable site and to design the new facility. Inclusive processes with key stakeholders such as NES and other West of Scotland health boards are already well established.

Reducing the current waiting times at the Dental Hospital (see Section 4) to meet the 26 week target by December 2005 represents a testing challenge for most specialities. Clinicians and managers from primary and secondary care have embarked on an exercise to investigate the waiting lists and to review and rationalise referral protocols for each of the dental specialties. The group are collaborating with the dental profession throughout the West of Scotland. The review will lead to revised referral documentation being produced to reflect the clinical and non-clinical information which the secondary care clinician requires in order to accept referrals. By minimising inappropriate referrals, specialists' expertise can be maximised to the benefit of patients.

### Yorkhill

In addition to the present specialist dental services provided for under 3s it is planned to relocate all child dental GA services to Yorkhill by 2008.

### Ambulatory Care And Diagnosis (ACAD) Hospitals

Dentistry will be engaged as part of the acute services review implementation process in cross disciplinary discussions on the layout and design of the new ACAD hospitals at Stobhill and the Victoria. Likely dental requirements will include provision for oral surgery, out of hours services, emergency treatment (after closure of GDH and if still required) plus a possible centre for "well" elderly. It is vital that a unified dental approach is developed.

## **Engaging with Patients**

Public involvement is a main theme within Partnership for Care (2003)<sup>v</sup> with a call to involve the public at earlier stages, to extend beyond traditional means of consultation and to ensure decision making is open and transparent.

The document “MCN: A Guide to Implementation” (2002)<sup>vi</sup> identifies five methods of public involvement in healthcare services:

1. Involvement of an individual patient in decisions about their own care
2. Involvement of patients in monitoring and improving the quality of care in an existing service
3. Involvement of patients and the public at an organisational level e.g. committee level
4. Involvement of patients and the public in the planning of change in service provision
5. Involvement of the public in the wider public health agenda - through community action

The involvement of patients in decisions about their care is becoming increasingly common. The quality of this involvement, however, can often be token or ineffective. Healthcare systems traditionally characterise the clinician as ‘the patient’s advocate’. To enable patients and members of the public to contribute effectively:

- Public Involvement has to be meaningful and be able to influence outcomes and actions.
- Public Involvement has to be supported to ensure the individuals or groups are skilled and comfortable and therefore able to contribute fully.
- There is a need for some degree of training for staff and public involved in the process
- Public Involvement means ensuring people are informed enough to be able to contribute.
- Public Involvement should reflect the core principles of community development - *participation, empowerment, citizenship, partnership, collective action and preventative action*<sup>vii</sup>
- New approaches and methods for involving patients in review and monitoring of services are required. Traditional use of questionnaire surveys and focus groups have been valuable in investigating problems but are less useful in the initial identification of problems.
- Feedback should be provided following specific public involvement activities. Demonstrating to people that they can make a difference is probably the best way to ensure that feedback continues.

# SECTION TEN

## IMPLEMENTATION

### **Integrated Working**

Within Greater Glasgow overarching responsibility for developing and implementing the strategy rests with the Oral Health Planning and Implementation Group (OHPIG). Membership includes representation from primary and secondary care, the Area Dental Committee and its GP sub-committee, child health, finance, and health promotion.

The success of implementation will depend on how this responsibility is discharged. The key for oral health is to be more outward looking and not insular. The delivery of the strategy is reliant on many different players including local authorities. If significant change is to occur then others must be successfully engaged in the implementation of the strategy. It will be the role of the PIG to represent the strategy across this network and to secure the appropriate understanding and commitment. The nature of this communication and these relationships will be critical to the strategy's prospects.

### **Community Health Partnerships (CHPs)**

The emergence of CHPs provides a further opportunity to project the oral health agenda. CHPs are intended to have devolved control of services and resources and to integrate planning, resource allocation and delivery across the NHS and with local authorities. These will include oral health services and a phased implementation is planned to include OHATs, oral health promoters, community dental services, salaried dentists and GPs. This should improve the potential for oral health to be fully incorporated into key strategies and plans at local level, to engage with local communities, and to develop local oral health planning, preventative initiatives, and service redesign to reflect local needs.

Against this background, there is little doubt that the dental profession should be involved in CHPs. Working closely with the new CHPs will provide dental health professionals with the most appropriate infrastructure, resource deployment and community involvement to make the improvements in oral health and reduce the inequalities in oral health status which are so necessary in our population.

The recent report published by NHS Health Scotland "Oral Health in Primary Care" recommended *inter alia* that local health care co-operatives and the emerging CHPs should facilitate the involvement of dental and non-dental partners in the joint delivery of oral health improvement. The consultation document on modernising NHS dental services specifically refers to "Partnership for Care" and identifies the need for developing better community level support for prevention of dental disease and better contact with other health and community care professionals. The "Joint Future" and "Children Services" agendas are good examples of the value from involving the dental professionals in local planning.

Locally, the design and setting up of CHPs is being taken forward through the Board's CHP Steering Group on which the Primary Care Division's Dental Director and the Chair of the Oral Health Planning and Implementation Group are both represented.

## **Regional Planning**

GGNHS Board chairs the West of Scotland regional dental consortium which has membership from Ayrshire and Arran, Argyll and Clyde, Lanarkshire, Forth Valley and Dumfries and Galloway NHS Boards. This provides an important forum through which to discuss and agree changes to key regional issues such as access to specialist services at the Dental Hospital, future training of dentists and PCDs, siting of a new Dental Hospital and School, and redesign of child dental GA and oral maxillofacial services.

## **Performance Management**

In "Our National Health" the Scottish Executive gave a commitment that the NHS would place greater emphasis on performance management and accountability. This includes oral health. A core element of the implementation arrangements will be monitoring performance of the strategy to ensure progress and improvement and where necessary to make adjustments. This will have both national and local dimensions

Nationally the performance assessment framework (PAF) is designed to form the mandatory core framework for assessing the performance of the NHS in Scotland. At present the key PAF indicator for dental health in line with the national target is the:

- proportion of 5 year olds with no experience of dental disease
- ratio of 5 year olds with dental cavities in DEPCAT 5 to DEPCAT1

In addition there are indicators for access to dental services and care

- number of dentists WTEs per 100 Arbuthnot weighted population
- percentage of the population aged 0-17 registered with an NHS dentist
- percentage of the adult population registered with an NHS dentist

As part of the PAF each NHS Board is also asked to report on progress in relation to the implementation of the Dental Action Plan. This covers the areas of

- oral health/prevention
- access to NHS dental services
- human resources and teamworking
- quality and standards
- infrastructure and resources

Alongside the national targets the OHPIG will give consideration to developing an overall framework to assess performance in oral health on at least an annual basis possibly in tandem with the Accountability Review process for NHS Greater Glasgow.

## **Financial Planning**

It is important that oral health receives fair consideration with other specialties when additional funding becomes available either locally or nationally.

In order to deliver on the strategy it is likely that additional financial resources will be required. In light of the current difficult financial climate within NHSGG and the necessity of delivering the Acute Services Plan it is likely that there will be limited funding available to support further developments in the next few years. Nonetheless the OHPIG continues to have important responsibilities. In the face of limited new funding it will be important that

- priority proposals arising from the strategy are prepared with justification and anticipated benefits and presented timeously to the appropriate planning fora
- use of all resources is reviewed to obtain maximum benefit
- co-ordinate submissions to the capital and revenue processes

As well as pursuing funding at local level it is vital that Greater Glasgow secures its fair share through the Scottish Executive of national resources for NHS dental services. Present comparisons of oral health needs and resources do not appear to suggest that present comparisons are in any way equitable and this requires to be urgently addressed.

# SECTION ELEVEN

## ACTION PLANS

### Criteria For Prioritising Actions:

All actions in the action plan reflect the following criteria:

1. Must be likely to deliver/impact positively on strategic goal  
- demonstrated in **Outcome** column
2. Must be able to demonstrate measure of success for evaluation purposes  
– listed in **Performance measure** column
3. Must be
  - i. undertaken with in existing resources or
  - ii. OH PIG committed to obtaining new funding  
- Indicated in **Funding implication** column

**STRATEGIC AIM:** TO IMPROVE ORAL HEALTH

**STRATEGIC OBJECTIVE A:** To change expectations and attitudes regarding the importance of oral health

**STRATEGIC PRIORITY A1:** To raise the profile and priority of oral health in communities, professional groups and organisations.

Ref	Actions	Outcomes	Performance measure	Funding implication
A1.1	To develop and implement a training and development programme for key professionals	Multi-disciplinary oral health 'workforce' with the appropriate skills and practice to promote oral health and support individuals and communities to take action on oral health	Number of <ul style="list-style-type: none"> <li>Individuals trained</li> <li>Primary Care Professional updates on oral health</li> <li>Community based local campaigns</li> </ul>	Continued HIF allocation
A1.2	Use consultation and implementation arrangements to encourage active participation in the development of oral health strategy	Awareness of oral health issues should be strengthened across a range of disciplines and organisations	Number of <ul style="list-style-type: none"> <li>area-wide and local partnerships progressing strategy</li> <li>partnership actions undertaken</li> </ul> Feedback report from consultation	
A1.3	Develop information and communication strategy underpinned by local needs assessment	Promotion of accurate oral health messages and healthier lifestyle options through a range of formats to meet the needs of different population and professional groups.	Needs Assessment Strategy Document Dissemination Development of Media strategy Public Health education/ information materials Increased Awareness of oral health initiatives and Knowledge/reported behaviour through surveys	Dedicated budget for media reqd.
A1.4	Development of health promotion programmes supported by evidence based practice	Develop opportunities for oral health promoting behaviours and Fluoride availability through a range of formats to meet the needs of different population groups and life circumstances. Specifically: <ul style="list-style-type: none"> <li>Toothbrush &amp; paste distribution (Get Brushing)</li> <li>Oral Cancer Awareness campaign</li> <li>Sugar free medicines</li> <li>New Community School programmes / support teenage transitions</li> <li>Workplace &amp; community programmes</li> <li>Programmes targeting older people</li> </ul>	Monitoring Distribution of Fluoride toothpaste Evaluation of Fluoride toothpaste scheme -no of children etc. Number of oral health initiatives developed  Pharmacy audit programme  Increased Awareness of oral health initiatives and Knowledge/reported behaviour through surveys	Get Brushing requires funding to support distribution 2005/2006 onwards (SE funding non recurrent)
A1.5	Develop GGNHSB's role in lobbying for Oral Health	Communication with SE regarding specific oral health issues;	Board communications	

		<ul style="list-style-type: none"><li>• Food advertising directed at children</li><li>• Food labeling</li><li>• Water Fluoridation</li><li>• VAT on Oral Health Products</li><li>• Research opportunities within Glasgow</li></ul>		
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**STRATEGIC AIM:** TO IMPROVE ORAL HEALTH

**STRATEGIC OBJECTIVE A:** To change expectations and attitudes regarding the importance of oral health

**STRATEGIC PRIORITY A2:** To build public policy and practice which is supportive of oral health

Ref	Actions	Outcomes	Performance measure	Funding implication
A2.1	Develop key policies to support oral health action	Increased opportunities for healthier lifestyle choices through the development of initiatives and services to address accessibility, affordability, availability and environmental issues to achieve good oral health.	Evidence of Oral Health in key strategies and implementation plans: <b>NHS</b> -Local Health Plan -Elderly strategy -Food & Health Guidelines for Elderly -Infant Feeding policy - Cancer Plan -Special Needs strategy -CHP Health Improvement plans <b>Local Authorities</b> - Children's services plan - Education/ Schools health policy - Looked after & accommodated -Food & health Frameworks -Care Home standards	
A2.2	Champion oral health through Community Planning and Children's Services Planning	Create supportive environments through re-orientation of school health services, health promoting schools and nurseries establishing a clear understanding of the role local authorities can play in oral health.	Uptake of positive oral health promoting initiatives <ul style="list-style-type: none"> <li>• Hungry For Success</li> <li>• Pre 5 nutrition specifications</li> <li>• Fruit in schools</li> <li>• Water in schools</li> <li>• Smile Nursery</li> <li>• Breakfast Clubs</li> <li>• Brushing in Nurseries &amp; Schools</li> <li>• Fluoride Toothpaste distribution</li> </ul>	continued & new funding through Com. Planning with LAs
A2.3	Fund dental input to LHCCs/CHPs	Oral health integrated within planning process Enhanced contribution of dental teams in health improvement	No of <ul style="list-style-type: none"> <li>• CHP plans with explicit dental or oral health priorities</li> <li>• CHP Patient Referral Pathways</li> </ul>	Requires additional funds 2004/2005 onwards

A2.4	Development of supportive food environments out-with the home	Increase availability of healthy food choices – particularly in organizations catering for areas of deprivation	<ul style="list-style-type: none"> <li>• Hungry for Success implementation in Schools</li> <li>• Food provision policies within key agencies – Local Authorities</li> <li>• SHAW food policies</li> <li>• Scotland's Healthy Choices awards</li> </ul>	SHCA requires continued HIF allocation
A2.5	Continued development of OHATs to deliver local oral health promotion practice	<p>Locally developed action to support oral health strategy responsive to local needs including;</p> <ul style="list-style-type: none"> <li>• Local implementation of strategy</li> <li>• Engagement and involvement of communities in Oral Health Planning</li> <li>• Local training for key professionals</li> <li>• Local targeting to the most socially excluded inc. New parents</li> <li>• Local capacity building e.g. volunteering, lay workers</li> <li>• Local projects to facilitate access to healthy diet and fluoride</li> <li>• Local initiatives to develop lifeskills to support healthy diet and oral health</li> <li>• Redesign of local dental services to reflect local need</li> </ul>	<p>OHAT action plans  OHAT monitoring &amp; evaluation framework  Oral Health Epidemiology targets</p>	OHATs require continued HIF allocation

**STRATEGIC AIM:** TO IMPROVE ORAL HEALTH

**STRATEGIC OBJECTIVE B:** To target health improvement action with a special focus on children

**STRATEGIC PRIORITY B1:** To develop community-based approaches to tackle oral health needs (with a special emphasis on pre-fives)

Ref	Actions	Outcomes	Performance measure	Funding implication
B1.1	Continued development of OHAT community based approach to oral health particularly targeted to the most socially excluded	Local communities should be empowered to undertake action to support healthier lifestyles through skills development and capacity building and promotion of services	Evidence of <ul style="list-style-type: none"> <li>initiatives to target most vulnerable groups</li> <li>initiatives targeting deprived areas</li> <li>capacity building –number of volunteers/sessional staff/ training participants</li> <li>localized initiatives with strong community development process</li> </ul>	Continued funding to support OHATs
B1.2	Development of local partnerships and infrastructure for oral health improvement	Interventions which promote the development of lifeskills and facilitate the opportunity for healthier choices are required in the context of local needs Specifically: The promotion of healthy eating opportunities through Food & Health Frameworks. <ul style="list-style-type: none"> <li>Weaning Initiatives</li> <li>Milk Token Initiative development</li> <li>Fruit &amp; Vegetable Initiatives</li> </ul> Facilitate awareness, accessibility, affordability and availability of a healthy diet. <ul style="list-style-type: none"> <li>Get Shopping</li> <li>Get Cooking</li> </ul>	Evidence of initiatives to <ul style="list-style-type: none"> <li>Facilitate access to healthy diet</li> <li>Develop lifeskills to support healthy diet and oral health</li> <li>Access to affordable toothpaste and brushes</li> </ul>	Community food initiatives require continued HIF allocation
B1.3	Support and empower NHS staff to promote public involvement within existing dental services	Communities should be empowered to access dental services, which meet their needs in relation to availability, acceptability and affordability for all population groups.	<ul style="list-style-type: none"> <li>Community Involvement programme within dental services</li> <li>Evidence of redesign of local dental services to reflect local need</li> <li>Access to services monitoring through market research</li> </ul>	

**STRATEGIC AIM:** TO IMPROVE ORAL HEALTH

**STRATEGIC OBJECTIVE B:** To target health improvement action with a special focus on children

**STRATEGIC PRIORITY B2:** To ensure that oral health is integrated within the wider child health agenda

Ref	Actions	Outcomes	Performance measure	Funding implications
B2.1	Ensure that the Health Visitor role [in light of Hall 4 (2002)] and the emerging Public Health Nurse role are encouraged and supported to undertake oral health promotion	Develop public health role of child health professionals to include oral health	Service specifications & job/role descriptions include oral health CHP health improvement plan	
B2.2	Include oral health activity within specific initiatives to support vulnerable	Vulnerable children and young people able to access oral health promotion activity and services	Evidence of oral health initiatives for vulnerable groups <ul style="list-style-type: none"> <li>• homeless</li> <li>• accommodated young people</li> <li>• teenage mothers</li> </ul>	
B2.3	Ensure Oral Health continues to be an integrated development within Starting Well roll out	Develop Oral Health within new models of working	Evidence of Oral Health initiatives undertaken within SW monitoring & evaluation processes.	
B2.4	Establish toothbrushing programmes as core practice within education setting.	Established toothbrushing programmes, in every nursery, Breakfast club and the primary school in deprived area	Number of <ul style="list-style-type: none"> <li>• Brushing programmes</li> <li>• Children participating</li> </ul>	Brushing progs. require funding to support distribution 2005/2006 onwards (SE funding non recurrent)

**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY C:** To tackle inequalities in access to services

Ref.	Actions	Outcomes	Performance measure	Funding implication
C1.1	Establish primary care dental treatment centre at Glasgow Dental Hospital	Access to emergency dental care for unregistered patients	No. of patients treated	Revenue funded from GDS non-cash limited allocation. Additional capital of £500,000 required for refurbishment
C1.2	Modernise dental facilities in Pollok and Springburn to comply with provisions of disability discrimination legislation and link with wider premises strategy	Provide dental surgeries within modern primary health care facilities	No of additional patients treated No. of additional appointments available	
C1.3	Review provision of dental services for patients with special needs including: <ul style="list-style-type: none"> <li>• Patients with learning difficulties</li> <li>• Patients with acquired physical/mental impairment</li> <li>• Medically compromised adult patients</li> </ul>	Access to appropriate screening and treatment	No. of patients screened and treated No. of patients excluded/unable to access service	May require capital for mobile dental units as well as additional staffing
C1.4	Develop a strategy and action plan for improving the oral health of older people: <ul style="list-style-type: none"> <li>• Establish oral health assessment and treatment in care homes</li> <li>• Provide training on oral hygiene for care providers</li> <li>• Ensure access to dental services</li> <li>• Maximising opportunities for oral health promotion</li> </ul>	Oral health assessment and longer term treatment planning for individual patients  Early detection and treatment of dental and oral soft tissue disease Improved quality of life for older people	No. of patients accessing service	Requires additional funds
C1.5	Establish a salaried service for homeless people by appointing salaried general dental practitioners	Service designed to meet needs of different client groups e.g., homeless individuals and families	No. of target population treated	
C1.6	Review provision of dental services for asylum seekers and refugees, and develop action plan	Detailed needs assessment data obtained about population group	No. of asylum seekers accessing services	
C1.7	Conduct detailed needs assessment for dental anxiety management in adults	Availability of data to improve service planning to meet gaps in service		

**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY D:** To emphasise prevention in dental services

Ref	Actions	Outcomes	Performance measure	Funding implication
D1.1	<p>Introduce clinical pathway of care for children:</p> <ul style="list-style-type: none"> <li>Establish an intensive prevention service for children involving the deployment of dental therapists/hygienists targeting areas of highest need</li> <li>Provide sedation as an alternative to GA and a programme of sedation training for practitioners and post-qualification training for dental nurses</li> <li>Centralise service at Yorkhill Hospital for children requiring a general anaesthetic for extraction of carious teeth</li> </ul> <p>Introduce post-GA follow up prevention for high risk children</p>	<p>Integrated clinical pathway of care</p> <p>Minimised risk to patients</p> <p>Minimised risk to patients</p>	<p>No. of general anaesthetics</p> <p>No. of adverse incidents associated with dental general anaesthesia</p> <p>No. of repeat general anaesthetics</p>	<p>Salaried general dental practitioners funded form GDS non-cash limited allocation</p> <p>Capital for new theatre suite</p> <p>Revenue for project management</p> <p>Additional staffing</p>
D1.2	Lobby Scottish Executive for revised GDS contract to achieve oral health gain	Dental practices to be rewarded for health needs assessment and adherence to clinical protocols	Local health gain targets Audits of health needs assessments an clinical protocols	
D1.3	To develop oral health improvement training programme for dental workforce	Trained and effective workforce acting within clear evidence based guidelines	<p>Numbers of</p> <ul style="list-style-type: none"> <li>dental hygienists</li> <li>dental nurses</li> <li>dentists</li> </ul> <p>trained in local protocols and guidelines</p>	Training costs – protected time
D1.4	Provide educational programme for primary health care professionals on oral implications of diabetes, giving priority to ethnic minority populations	Oral health implications of diabetes recognized in management of the disease	No. of medical practices who include oral health within chronic disease management	Funding to support practice-based educational

				programme
D1.5	Introduce health promotion within Young persons clinics, diabetes clinics and care of the elderly programmes	Oral health integrated with general health improvements	No of LHCCs/CHPs with oral health promotion objectives incorporated in local plans	
D1.6	To agree oral health clinical pathways for adults and develop service for older adults not accessing General Dental Services	Evidence based pathways and protocols for assessment and intervention Safety net preventative service	Pathway documentation Evidence base No of older people excluded/not accessing prevention services	Requires additional funds

**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY E:** To improve quality of dental services

Ref.	Actions	Outcomes	Performance measure	Funding implications
E1.1	<b>Training for the dental team</b> <ul style="list-style-type: none"> <li>To conduct role clarification and role definition exercises within dental teams</li> <li>To provide patients with clear information about NHS dental services and charges</li> </ul>	Enhanced contribution of all members of dental teams Clarity for patients on the nature and cost of NHS dental services	No. of enquiries processed	
E1.2	To introduce programmes of team training with protected learning time	Improved team working to facilitate implementation of guidelines and protocols	No. of training interventions organized Proportion of practice staff participating	
E1.3	Investigate barriers to dental attendance	Availability of locally sensitive qualitative data- e.g., on failed appointments which will improve service planning	Proportion of population accessing services/ registering with GDS "Failed to Attend" rates	
E1.4	To continue support for appraisal of performance and to continue to promote the technique in general dental practice	Feedback on performance	No of practices with appraisal systems in place	
E1.5	To ensure that personnel in all care sectors have Personal Development Plans	Systematic and prioritized approach to training	Evidence of plans	
E1.6	To create a coherent and costed training plan for the dental services in NHS Greater Glasgow	Systematic and prioritized approach to training to ensure organizational objectives are met	Evidence of plan	
E1.7	To review organisational structures and skill mix on a continuing basis	A career structure which will facilitate recruitment and retention of dental professionals and support staff		

**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY E:** To improve quality of dental services

Ref.	Actions	Outcomes	Performance measure	Funding implications
E2.1	<b>Quality assurance</b> Developing and applying evidence-based practice: To develop effective mechanisms for the dissemination and implementation of clinical guidelines and protocols	Sharing of good practice and raising standards of care	Proportion of practices/clinics implementing guidelines	
E2.2	To support and facilitate the introduction of systems for quality assurance and accreditation processes	Improved quality of patient care	Proportion of practices and clinics achieving respective awards	
E3.1	<b>Clinical governance</b> To promote and support clinical effectiveness through structured programmes of clinical audit and peer review	Sharing of good practice and raising standards of care	No of audits conducted	
E3.2	To develop safer services	Minimising risk to patients and health care practitioners /staff	No of adverse incidents and near misses No of complaints and litigation cases	
E3.3	To promote the research agenda involving all care sectors and the University Dental School	Enhanced knowledge and skills of dental teams	Number of dental professionals involved in research projects No. of research projects in primary and secondary care	
E4.1	<b>Performance Review:</b> Establish a local performance review system to support dental professionals whose performance is sub-optimal	Pro-active and preventative approach to poor performance Reducing risk to patients and managing risk to NHS	No of dental professions accessing system No of professionals undertaking retraining	Funding for initial training of panel members
E5.1	<b>Providing support infrastructure IM&amp;T</b> <ul style="list-style-type: none"> <li>lead project planning and implementation groups in connection with the national IM&amp;T policy as it relates to general dental practice</li> <li>maximize the use of IT to allow dissemination of information e.g., learning outcomes from critical incident reviews and other intelligence</li> </ul>	Practitioners linked to the NHS net, electronic booking and referral systems  Learning form adverse events Sharing best practice	No of IT developments in progress	£££
E6.1	<b>Focusing on patients and communities through Community Health Partnerships</b> <ul style="list-style-type: none"> <li>develop and maintain effective links with key planning partners (CHPs), staff and patient/public partnerships</li> </ul>	Collaborative and integrated planning of services which reflect and respond to local	Evidence of feedback mechanism Dental representation on CHPs	

	<ul style="list-style-type: none"> <li>examines scope for redesign of services through Managed clinical networks</li> <li>collaborate with partners on a Patient Charter for dental services</li> <li>obtain information from professionals and the public about patient experience and use to develop and plan patient focused services</li> </ul>	<p>needs Clarity on patients' rights and obligations</p> <p>Feedback on the patient experience</p>	<p>No of stakeholder events organised</p>	
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**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY F:** To develop a mixed economy for dental services

Ref.	Actions	Outcomes	Performance measure	Funding implications
F1.1	To create a unified salaried service			
F1.2	To raise with the Scottish Executive the issue of the equitable basis of allocation of GDS non cash limited funds			
F1.3	To introduce a system to pay dentists sessional payments for provision of specific services			
F1.4	To press the Scottish Executive to introduce a Personal Dental Service model in Scotland			
F1.5	To participate in workforce planning exercise and increase number of Professionals Complementary to Dentistry in primary care dental service	More appropriate and cost effective clinical skill mix to achieve health gain	Numbers of <ul style="list-style-type: none"> <li>• dental hygienists</li> <li>• dental nurses</li> </ul> per 1000 population	

**STRATEGIC AIM:** TO ENHANCE DENTAL SERVICES

**STRATEGIC PRIORITY G:** To develop specialist services

Ref	Actions	Outcomes	Performance measure	Funding implications
	Oral and Maxillo-facial Surgery services			
	Waiting Times			
	Referral protocols			
	Yorkhill?			
	Replacement of GDH			
	Ambulatory Care and Diagnostic Centres			

**STRATEGIC AIM:** TO ENAHNCE DENTAL SERVICES

**STRATEGIC PRIORITY H** To engage with public and patients

Strategic Priorities	Focus of Public Involvement	Current /available information	Public involvement process	Approach
Vision for Oral Health in Greater Glasgow	Ownership and identification with vision		What are current perceptions relating to oral health? Current value base for Oral Health in Greater Glasgow	E.g. Market research
Changing Attitudes and Culture	Community development	OHAT needs assessments Social research literature review	Current attitudes and expectations in relation to oral health Current 'local needs' in relation to oral health Priority of oral health with partners Validation of research with local info Define communication processes	<ul style="list-style-type: none"> <li>▪ Community indicators</li> <li>▪ Focus groups</li> <li>▪ Sustainability model</li> <li>▪ Participatory A. /Priority search</li> </ul>
Targeting the Young	Community development	OHAT needs assessments Partnership consultations	Mapping opportunities for targeting young and integrating oral health with partners	<ul style="list-style-type: none"> <li>▪ Community indicators</li> <li>▪ Focus groups</li> <li>▪ Sustainability model</li> <li>▪ Participatory A. /Priority search</li> </ul>
Tackling inequalities	Service Development	Geographical. Mapping of services Activity data Current usage patterns Registration mapping Policy /research exclusion issues Barriers research literature review	Definition of other Needs Assessments Identification of needs of 'excluded' groups and non attenders  Mapping of range and ability of services to meet needs Validation of research with local info Acceptability of dental services for these groups Priorities for service	<ul style="list-style-type: none"> <li>▪ Focus groups</li> <li>▪ Market research</li> </ul>
Emphasising prevention	Policy and service development	Current treatment patterns Current financial spend across system	Public perception of focus on prevention rather than treatment Public support for items of prevention / treatment	Needs to link with Community Development approach <ul style="list-style-type: none"> <li>▪ Action planning</li> </ul>
Improving quality	Improving quality of Patient Experience	Quality guidance Complaint & feedback info Performance Indicators as Quality Indicator	Public perception of 'quality' criteria for dental services Patient experience of disease and services Consultation /involvement in development Analysis of users within different parts of the service Feedback/monitoring processes	<ul style="list-style-type: none"> <li>▪ Comments cards</li> <li>▪ Market research</li> <li>▪ Patient participation groups</li> </ul>

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## ANNEX

### References

- <sup>v</sup> Scottish Executive Health Department. Partnership for Care: Scotland's Health White Paper. SEHD. Edinburgh February 2003
- <sup>vi</sup> Managed Clinical Networks: A guide to implementation NHS Scotland. Hayward Medical Communications, October 2002
- <sup>vii</sup> Barr & Hashigan. Achieving Better Community Development. Community Development Foundation, 2000
- <sup>viii</sup> Scottish Executive Health Department. Partnership for Care: Scotland's Health White Paper. SEHD. Edinburgh February 2003
- <sup>ix</sup> Managed Clinical Network's: A guide to implementation NHS Scotland. Hayward Medical Communications, October 2002
- <sup>x</sup> Barr & Hashigan. Achieving Better Community Development. Community Development Foundation, 2000
- <sup>xi</sup> Scottish Executive Health Department. Partnership for Care: Scotland's Health White Paper. SEHD. Edinburgh February 2003
- <sup>xii</sup> Managed Clinical Network's: A guide to implementation NHS Scotland. Hayward Medical Communications, October 2002
- <sup>xiii</sup> Dumfries and Galloway MCN for CHD Quality Assurance Programme ([www.scot.nhs.uk/mcn/pdf/qual\\_assure.pdf](http://www.scot.nhs.uk/mcn/pdf/qual_assure.pdf)) October 2002
- <sup>xiv</sup> Barr & Hashigan. Achieving Better Community Development. Community Development Foundation, 2000

## ANNEX

The table illustrates a series of hypothetical targets and the prevalence of children with zero caries in the respective DEPCAT communities and the level of change that would be needed to be achieved if, in Greater Glasgow, to boost the level of zero caries experience including the target of 60%, at any future time.

**TABLE 5: HYPOTHETICAL TARGETS AND DEGREE OF IMPROVEMENT REQUIRED TO MEET THESE TARGETS IN RESPECTIVE DEPCAT COMMUNITIES IN GREATER GLASGOW**

DEPCAT	Proportion of GGHB population	Prevalence % dmft =0 (2002/03 p)	Hypothetical targets for % of children with zero caries experience (% change) in respective DEPCAT communities and resultant GGHB outcomes with .						
			A	B	C	D	E	F	G
1	10.7	67.5	75 (↑ 11.1%)	85 (↑26.4%)	83 (↑23%)	70 (↑ 3.7%)	65 (↓3.7)	60 (↓ 11.1%)	67.5 (- -)
2	7.6	56.5	71 (↑ 25.7%)	80 (↑41.6%)	80 (↑41.6%)	70 (↑ 23.9%)	65 (↑15%)	60 (↑ 6.2%)	67.5 (↑19.5%)
3	8.2	44.7	64 (↑ 43.2%)	70 (↑56.6)	75 (↑67.8%)	65 (↑ 45.4%)	65 (↑45.4%)	60 (↑ 34.2%)	67.5 (↑51%)
4	13.2	42.3	43 (↑ 1.7%)	47 (↑11.1%)	60 (↑41.8%)	65 (↑ 53.7%)	65 (↑53.7%)	60 (↑ 41.8%)	67.5 (↑59.6%)
5	8.5	33.5	37 (↑ 10.4%)	45 (↑34.3%)	55 (↑64.2%)	60 (↑ 79.1%)	60 (↑79.1%)	60 (↑ 79.1%)	67.5 (↑101.5%)
6	23.4	32.8	37 (↑ 12.8%)	42 (↑ 28%)	53 (↑61.6)	55 (↑ 67.9%)	57 (↑73.8%)	60 (↑ 82.9)	67.5 (↑105.8%)
7	27.8	22.2	29 (↑ 30.6%)	40 (↑80.1%)	53 (↑138.7%)	55 (↑ 147.7%)	57 (↑156.8%)	60 (↑ 170.3%)	67.5 (↑204.5%)
<b>GGHB</b>	<b>~100</b>	<b>35.2</b>	<b>47</b> (↑ 33.5%)	<b>50</b> (↑ 42%)	<b>60</b> (↑ 70.5%)	<b>60</b> (↑ 70.5%)	<b>60</b> (↑ 70.5%)	<b>60</b> (↑ 70.5%)	<b>67.5</b> (↑91.8%)

p= provisional

( )=percentage and direction of change relative to 2002/03 preliminary values.

All calculations displayed in Table 3 assume that the relative distribution of 5 year olds across DEPCAT categories remains unchanged.

Scenario A has already been proposed as an interim target for Greater Glasgow in 2005/2006.

Scenario B illustrates the possible milestones that would be required if 50% of Greater Glasgow's 5 year olds were to have zero caries experience.

Scenarios C, D, E and F illustrate four of the various arithmetical scenarios which would allow the 2010 target to be reached assuming differential rates of change in respective DEPCAT communities. Scenario F assumes elimination of all inequalities in dental caries prevalence in 5 year olds and a lowering of the DEPCAT 1 value.

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Scenario G assumes that no further reduction in the prevalence of dental caries is achieved in DEPCAT1 communities and that all other communities can be improved to the level that DEPCAT 1 achieved in 2002/03.