

**Greater Glasgow NHS Board****Board Meeting**Tuesday 22<sup>nd</sup> March 2005

Board Paper No. 2005/23

Director of Planning and Community Care

**Oral Health Strategy 2005-2010: Outcome of Consultation****Recommendations:**

Members are asked to:

- (a) **note the main comments from consultation and proposed response at section 3;**
- (b) **approve the final strategy appended at Annex 2.**

**1. Introduction**

- 1.1 In August 2004 the Board agreed to consult on a draft oral health strategy. This paper reports on the outcome of the consultation process and on the proposed changes to the Oral Health Strategy.
- 1.2 In addition the paper identifies those events that have occurred in the intervening period and discusses their implications for the strategy.

**2. Consultation Process**

- 2.1 The consultation process was deliberately targeted at key constituencies who would be critical to delivery and achievement of the oral health strategy. These included dental professionals in primary and secondary care, LHCCs, OHAT stakeholders, GGNHS clinical committees, planning and implementation groups, local authorities, neighbouring NHS boards, the Scottish Executive and expert opinion (see Annex 1). As well as the wide distribution of the full strategy and executive summary a structured response form was provided and specific sessions were offered to each of the constituencies led by a member of the oral health planning and implementation group.
- 2.2 In total 79 responses were received. Full copies of the responses are available to members of the Board at the meeting or on request, and are being lodged on the Board's website. The following section focuses on the principal comments received together with the proposed response. In addition a series of minor points have also been incorporated into the strategy.

**3. Results of Consultation**

- 3.1 Overall there is widespread support for the strategy. There is no disagreement that oral health is an issue that requires to be addressed. The overwhelming majority of respondents endorsed its analysis of the problem, setting out of the challenge, its vision, its strategic aims and objectives and for many of its individual proposed actions. The strategy is welcomed as comprehensive with a wide-ranging analysis and as proposing holistic solutions. It is described as ambitious and many responses confirm that it needs to be to achieve the desired improvements.
- 3.2 Oral health is not seen as an exclusive NHS issue. Many respondents concurred with the importance placed by the strategy on partnership working of dental personnel with not only other health professionals but also with local authorities particularly in terms of their responsibilities in relation to education, community planning and health improvement. Indeed, it is worth noting that local authorities were enthusiastic in their support for the strategy. In addition, the parallel responsibilities of individuals and parents in oral health protection, disease prevention and care were also endorsed. As a consequence of the common view that oral health was crucially a shared responsibility the vision of the strategy in Section 7 has been modified to include the phrase “oral health is everyone’s business”.
- 3.3 However, there were also many critical but constructive comments. In most cases they concern matters of degree and balance and do not involve any fundamental change to the strategy. These revolved around the following issues.

3.4 Resources

Although respondents supported the wide-ranging nature and ambition of the strategy there were concerns that oral health and the strategy would be under-resourced.

Firstly, in respect of the number of dental professionals operating in Greater Glasgow, the view was consistently expressed that there were insufficient dentists and PCDs to provide an adequate service relative to the population’s needs. This position is partially borne out by the results of the recent national report on accessing dental services. This extended not only to the GDS but in particular to the CDS where the feeling was that an already small service would not be capable of fulfilling all of the roles defined in the strategy.

Secondly, respondents recognised and supported that much remains to be done in the field of oral health but expressed concerns that the strategy contained no financial commitments and consequently little assurance was felt by some respondents that it would ever be fully implemented because it was not a high enough Board priority.

In response, the strategy is to be achieved over five years and we would look for investment to be increased over that period. Sections 10 and 11 refer to the different ways in which resources might be secured for the strategy. However, even in the period since the Board approved the consultation draft, new revenue and capital resources have been identified for oral health for example in providing salaried dental services and for a new dental decontamination unit in Glasgow Dental Hospital and School. Many of the following responses to issues raised by the strategy will have resource implications.

3.5 Targeting

Many respondents argued that whilst they had no dispute with the attention to be given to parents and children recognising that this was essential to break the cycle with new generations, they felt that the strategy implied that other priority groups highlighted as having poor oral health and/or poor access to services would be ignored. These included frail older people, homeless people, older children, children and adults with special needs and people from black and ethnic minorities.

In response, the strategy has been modified in Section 9 to make clearer the commitment to addressing the needs of excluded groups. In many cases, however, basic planning information on their needs and appropriate service model is not available and will require to be formulated in the first instance. This in turn will define the need for additional investment.

3.6 Focus on Primary Schools

A number of responses questioned why the strategy proposed to concentrate only on the needs of under-fives and was not more forceful in proposing measures which would protect the emerging permanent teeth of older children. It was suggested that additional focusing of dental provision on primary schools would provide a more effective means of securing child inclusion within the dental care system.

In response, Section 8 of the strategy has been strengthened with reference to the place of oral health within integrated children's planning with local authorities. Increased delivery of dental services to primary school children extends the role of OHATs and school health teams in the context of New Learning Communities, Integrated Community Schools and emerging CHPs. This action will rely not only on the response of the NHS but also on further co-operation with local authorities and in particular their education services. In addition Section 10 has been amended to emphasise that OHATs require to be developed to assume a pivotal role on oral health planning within CHPs.

3.7 Deprived Areas

Doubt was expressed in some quarters as to whether the strategy accounted adequately for the further actions required to address the dental service shortfalls in the communities of greatest need, invariably the DEPCAT 6 and 7 communities.

An amendment has been made to Section 9 acknowledging that in areas where there is little GDS provision for children, a dedicated children's dental service is required linking OHATs, school health services and the CDS. A start on this has been made with the successful bid for salaried dental services for children which will be focused on Easterhouse and Pollok health centres. A specific reference has been made to consider oral health in the risk assessment of vulnerable families using Hall 4.

3.8 Public Health Leadership

Queries were raised about the public health leadership role. While almost all were in support of it and regarded it as vital to change attitudes and behaviours, to challenge commercial forces and institutional inertia on oral health some felt that it should be more clearly articulated.

The strategy now emphasises that this is not only a GGNHS role but is a shared role to be exercised with other partners including non-dental health professionals and others, in particular, local authorities. A specific sub-section has been added on the need to take action in relation to smoking and oral cancer and the need to make necessary linkages with the tobacco strategy.

3.9 Workforce Development

Following on from concerns expressed about the lack of dental resources in Greater Glasgow some respondents queried the robustness of the strategy in relation to training, recruitment and retention.

Within Section 9 of the strategy, 'creating a mixed economy, has been modified to address these issues more comprehensively. The Board in turn will need to relate these actions to the proposed measures in the current Smoking, Health and Social Care Bill to enable it to take more direct action. In particular, the strategy highlights the role of the Board along with NES in regularly scrutinising the performance of the Glasgow Dental School and in conducting a local workforce planning exercise.

3.10 Water Fluoridation

When the strategy was approved by the Board for consultation, this issue alone received all of the media attention. Water fluoridation featured in many of the consultation replies. Indeed, some people responded only on this one issue. There is a definite split in the responses between those of individuals who were strongly against fluoridation of the public water supply, and the responses of health bodies and the health establishment who were unanimously in favour. Local authorities, when they commented, tended to be particularly conscious of the importance of securing local popular support for such a measure.

As the consultation document only reported the state of the issue in a balanced way and did not commit the Board to further action in the absence of any national decision, the strategy remains unchanged.

**4. Other Factors**

4.1 Since August 2004 there have been a number of developments that are germane to the strategy. At national level these are:

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### 4.2 The Smoking, Health and Social Care (Scotland) Bill

This Bill anticipates the introduction of free dental examinations before 2007 and also signals intentions to reform the GDS structure of dentist's fees and patient charges, to merge CDS with salaried GDS and to enhance the role of health boards in planning, funding and delivering dental services.

The focus of the Bill on smoking has meant that any public health action on fluoridation, the subject of much comment when the strategy was launched for consultation, has been put back indefinitely.

The strategy has anticipated these developments but will be informed by the Scottish Executive's response to consultations - "Better Oral Health for Children" and "Modernising NHS Dental Services in Scotland".

The response of the Scottish Executive to these consultations is now expected in March 2005. The indications are that it will confirm significant new investment to improve the oral health of children via health promotion interventions. A commitment to double the GDS practice allowance from £6000 to £12,000 has already been announced.

### 4.3 Access to NHS Dental Services

The Scottish Executive Health Committee commissioned a report investigating the support of dentists for the NHS and access relative to need and demand. Relevant account of the report's analysis and findings has been taken in Section 5 of the amended strategy.

4.4 Locally, there have been four significant developments which have a bearing on the strategy.

### 4.5 New Services for Children and Homeless People

Successful bids were made to the Scottish Executive for salaried dentists to provide services to these vulnerable groups. These address key priority areas identified in the strategy and are presently being implemented.

### 4.6 Infant Pilot

In anticipation of a Scottish Executive children's oral health programme aimed at improving the oral health of children throughout life commencing at birth proposals are being developed for implementation in the north and east of the city. This programme aims to develop a closer link between health visitors and dental teams using intermediary lay health support workers. This is likely to be a principal beneficiary of the Ministerial announcement in March 2004.

### 4.7 Unmet Needs

A Scottish Executive decision is pending to provide support from its Unmet Needs programme for a GGNHS submission which included oral health. If successful, this will consolidate funding for OHATs and provide investment to develop services were crucial

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gaps have been identified in the strategy in relation to special needs children, children in primary schools and children aged under 3 years.

### 4.8 Partnership for Care: The Next Steps

The Board's plans for single system working offer the opportunity to re-organise dental services into a more coherent and unified structure which will serve to strengthen the profile and leadership for oral health improvement and to enhance implementation within the future health system. Mention of this is made in Section 10.

## 5. Launch of the Strategy

- 5.1 The strategy is to be launched by the Chairman and Chief Executive on 6<sup>th</sup> May 2005. A multi-disciplinary and multi-agency audience will be invited to attend.

**Publication:** The content of this paper may be published following the meeting

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**GREATER GLASGOW NHS**

**ORAL HEALTH STRATEGY  
2005 - 2010**

**MARCH 2005**

**GREATER GLASGOW**  
**ORAL HEALTH STRATEGY**

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# SECTION ONE

## INTRODUCTION

- 1.1 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 (meaning that it requires urgent attention). 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 level of 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.)*

- 1.2 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.
- 1.3 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-coordinated contribution.
- 1.4 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 proposes a series of measures 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.

- 1.5 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

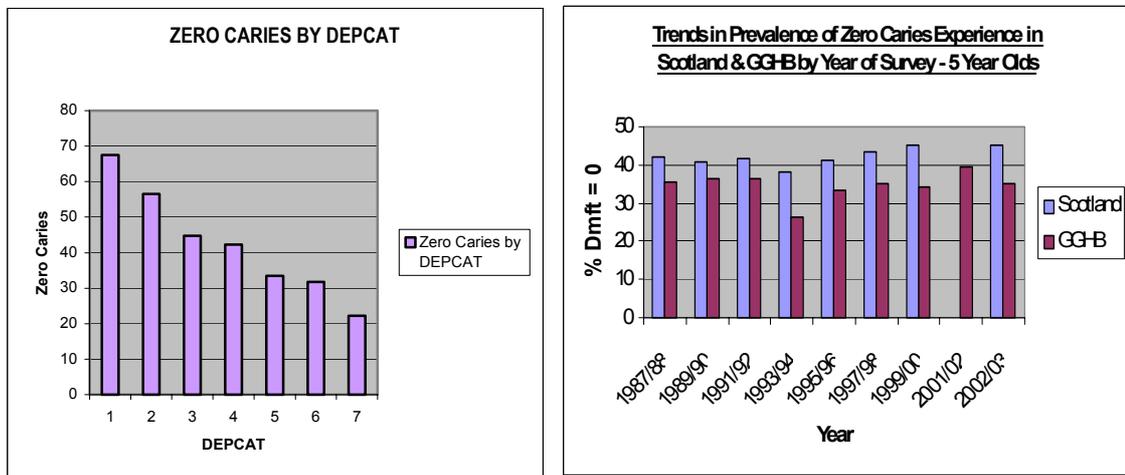
### Introduction

2.1 This section presents a 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. While information quality is variable it provides valuable insight into the current state of oral health. However, in some areas there are information gaps where further work and analysis is required.

### General Population

2.2 In general, oral health within Greater Glasgow is the worst or near 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.

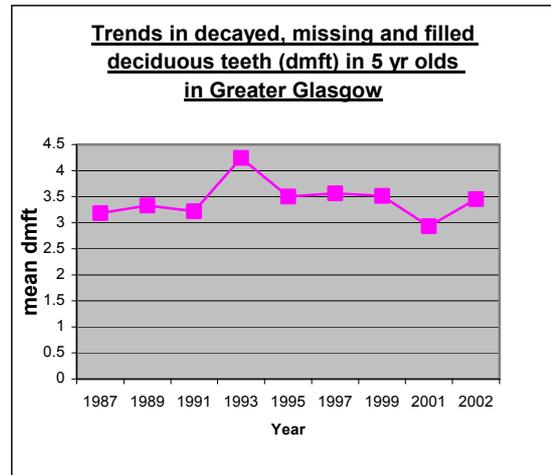
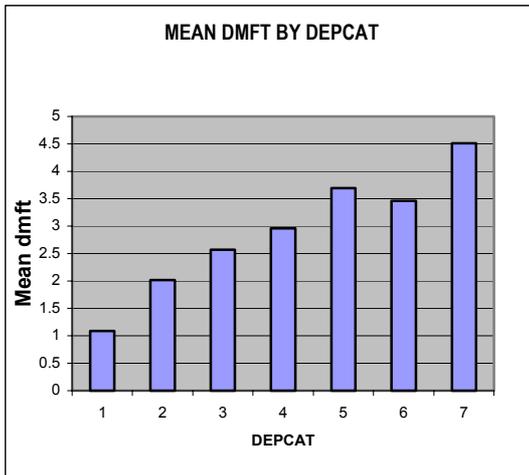
### Pre-Fives



2.3 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.

- 2.4 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.



- 2.5 The graphs do not illustrate the wide range of scores for individual children which range from 0-20 dmft (decayed, missing and filled teeth) in Greater Glasgow.
- 2.6 Trends in the experience of decay (dmft) over the last 15 years illustrate that what improvement there has been has mostly occurred amongst affluent children.
- 2.7 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, approximately 1500 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. The following table shows the trend of dental GAs for all children.

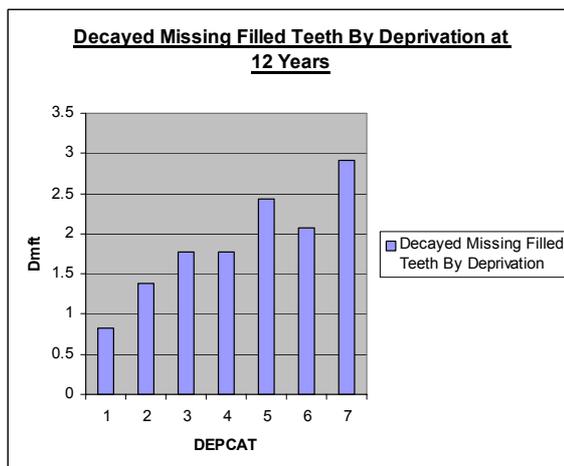
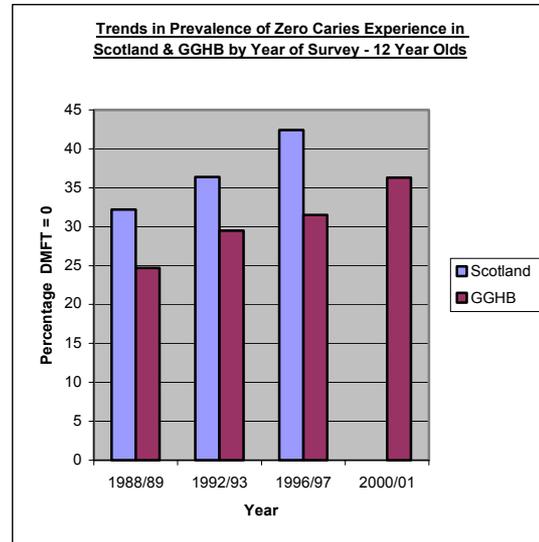
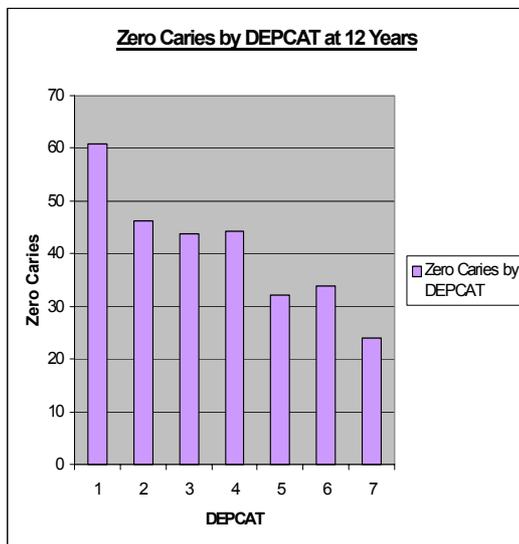
**TABLE 5.5 ATTENDANCES FOR DENTAL TREATMENT UNDER GENERAL ANAESTHETIC IN GREATER GLASGOW BY SERVICE AND YEAR**

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*	2,200	2,900*

\*estimate

## Older Children

- 2.8 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.



- 2.9 In 2000/2001, 64% of children aged 12 years in Greater Glasgow had dental decay experience. While this has improved markedly since the late 1980s Greater Glasgow has been consistently outperformed by Scotland as a whole. If anything the gap has increased over time.
- 2.10 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.

The care index (% of decayed teeth that have been restored) for 12 year olds in Greater Glasgow in 2000-01 was only 46%. While it is thought to have improved since then no more recent or comparable information is available.

## 2.11 Child Dental General Anaesthesia (GAs)

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

## **Adults**

2.12 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 longer exposure to risk factors throughout life.

2.13 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.

2.14 In Scotland, there has been a significant improvement in the number of adults who have their 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.

**TABLE 2.9 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
<b>1998</b>	1	0	4	13	33	56	18
<b>1988</b>	1	2	7	33	48	72	26
<b>1978</b>	2	10	27	54	64	85	39
<b>1972</b>	2	13	35	54	78	87	44

2.15 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.

## 2.16 Oral Cancer

In Greater Glasgow approximately 135 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, 382 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 (Social Inclusion Partnership) areas.

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.

## 2.17 Impact Of Dental Disease

The national Adult Dental Health Survey 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. For example there are reports of operations having been cancelled because of untreated dental decay and overt infection.

## **Older People**

2.18 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, an aging dentate population will place increased pressures on dental services in the future arising from oral cancer, dental caries and periodontal disease.

## **Causal Factors**

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

### 2.20 Poor Diet

The association between sugar consumption and dental caries, with respect to both the amount and frequency of sugar consumption has been widely demonstrated in literature. Greater Glasgow, in keeping with the rest of Scotland, displays high levels of sugar intake through consumption of fizzy drinks, sweets, chocolate and processed foods. 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 sweet snacks between meals of little nutritional value.

The levels of sugar consumption are further compounded by other dietary factors, particularly low levels of healthier alternatives to sweet snacks such as fruit. 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, 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 is 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 of particular relevance at the weaning stage in any child life, when good or bad eating habit are often established.

### 2.30 Smoking and Alcohol Consumption

Smoking and alcohol consumption impacts on oral health particularly in relation to oral cancer. According to the local Health and Well Being Survey smoking levels within Greater Glasgow are currently at 33% in line with the national average. However smoking rates in areas of deprivation at 49% far exceed the national average. It is estimated that this may be higher and as much as 50-70% of the population smoke in some communities. Smoking cessation rates are greater in more affluent areas.

When an individual smokes and drinks 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.

### 2.31 Lack of Oral Hygiene

Toothbrushing is the most common form of oral hygiene with the additional benefit of applying fluoride toothpaste. 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. 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.

### 2.32 Exposure to Fluoride

The most common means available is via toothpaste. Approximately 93% of respondents to the 1998 Scottish Health Survey 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 (e.g. Moray) or artificial fluoridation (e.g. 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 Board's local Health and Well Being Survey found 35 % in favour of fluoridation and 28% against, with a further 32% undecided. The main areas of concern centre on safety and long term side effects.

### **Main Determinants of Poor Oral Health**

A number of wider socio-economic and cultural factors impact on the oral health experience of specific population groups. These groups and individuals have additional needs and require different levels of services and /or interventions in order to promote and maintain oral health status. Currently a lack of oral health information is available for many of these groups.

### 2.33 Negative Attitudes to Dental Services

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 general public 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. Efforts are required to establish a positive dental experience with a young child at the earliest opportunity.

### 2.34 Deprivation and Life Circumstances

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.

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.

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.

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 from the 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 to receive a general anaesthetic for dental extractions due to decay.

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

Many of the groups most vulnerable to the effects of poverty will often have other additional health needs and complicated lifestyles that will further compound their oral health needs including those individuals and families with addictions, homelessness, mental health conditions and learning difficulties. The planning and development of oral health programmes for these groups requires the consideration of these complex issues. Little information is available regarding the oral health needs of people with mental health conditions.

*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.

*Homeless People* - A needs assessment carried out by the Board in 2003 showed that as a population group homeless people have high caries levels, much of it untreated, and poor oral hygiene leading to a high incidence of periodontal disease.

*People with Addictions* - 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.

### Age

Many behavioural patterns such as tooth brushing and dietary patterns are laid down in early childhood. The importance of establishing a 'good start' for new generations is critical if we are to establish good oral health as the norm within Greater Glasgow.

The risk of oral health problems unsurprisingly increases with age due to increased exposure to causal factors. The maintenance of good oral health is primarily supported by continued tooth brushing with fluoride toothpaste, healthy eating and regular dental visits. Compromises to these behaviours brought about by illness, loss of physical ability, financial constraints or loss of independence will result in a decline in oral health. The impact of poor oral health on the nutritional status and emotional well-being of an individual requires to be recognised.

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.

### Gender

The value placed on good oral health may be affected by gender issues (in similar ways to patterns reflecting health in general). Women frequently report higher levels of tooth brushing and regular dental visits likely to maintain oral health. Longitudinal surveys however indicate that more women than men are likely to have no natural teeth relying on dentures.

Men are less likely to access dental services unless experiencing pain and discomfort. 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 dental decay. This tendency makes it difficult for such individuals to benefit from opportunistic screening and oral health promotion.

### Ethnicity

The oral health needs of people from Black and Minority Ethnic groups are likely to vary within groups and from the indigenous population for cultural, behavioural and educational reasons as well as communication barriers.

Focus groups exploring the oral health needs of different groups reported dietary habits particularly relating to drinks that promote dental decay and proposed the need for a greater awareness of oral health issues within these communities. Collectively the groups did not identify access to regular dental care as a priority, generally attending only when treatment was necessary. When attending dental services the use

and availability of interpreters was widely recognised but a desire for professionals from different communities was expressed.

Local surveys have found that language difficulties are a barrier to attendance. 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.

*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.

**TABLE 2.10 MEAN DMFT BY ETHNIC BACKGROUND**

<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

Many individuals will have additional needs that contribute to their oral health experience and specific consideration should be given to individuals with: special

educational needs, physical disabilities and medical conditions that compromise oral health.

*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

*Adults with Learning Difficulties, Physical Disabilities, Acquired Brain Injury and Sensory Impairment* - Limited information available but disabled access, lack of self-referral and communication barriers are likely obstacles to dental care. Whilst the needs of these groups reflect many of the issues shared by the population at large, specific challenges include social and emotional as well as physical abilities plus the compromising effects of medication. Wider physical access and communication issues also need to be addressed in line with DDA.

*Children Special Educational Needs* - Caries epidemiological examinations in 2003 of children attending special educational needs schools in Greater Glasgow 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

A survey of children attending special needs schools in Greater Glasgow revealed that they receive much lower levels of dental care than the rest of the population.

## SECTION THREE

### POLICY CONTEXT

- 3.1 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.
- 3.2 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 reflected in a local strategy.

#### National-Generic

- 3.3 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

- 3.4 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** consulted on proposals to transform the oral health of children across Scotland arguing the need for “radical steps” including a multi-stranded approach to oral health improvement locating preventive action within wider health programmes alongside other professionals, focusing on the behaviour of mothers during pregnancy, with greater prevention through 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. A response to consultation from the Scottish Executive is awaited.

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

**Modernising Dental Services** consulted on the design of a new GDP contract rewarding oral health improvement and prevention, 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. Also under consideration is 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. A response to consultation from the Scottish Executive is awaited.

**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**

- 3.5 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.
- 3.6 Progress is underway to establish **Community Health Partnerships (CHPs)** across Greater Glasgow in partnership with local authorities. CHPs will have significant devolved responsibilities for health improvement and service planning and delivery. They are intended also to secure better integrated working across primary and secondary care and are scheduled to become operational during 2005.

## **Local-Dental**

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

advocated partnership working between professions, health promotion and lifestyle change.

## SECTION FOUR

### CURRENT PROVISION

#### Current Investment

##### 4.1 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, primary care.

In the financial year 2004-05 over £51 million will be spent on oral health on Greater Glasgow residents, 88% 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 4.1 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 (£1.3M) from providing teaching to students (£6.6M) and from other sources (£1.5M)
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.

## 4.2 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. In 2005-06 it has been agreed to spend £1.2M to create a new dental decontamination unit for the sterilisation of dental equipment.

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

- 4.3 In primary care, 431 independent general dental practitioners (GDPs) 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. Greater Glasgow has been less affected by practice closures. Of 68 closures in Scotland between 1999-2002 only 2 occurred in Greater Glasgow.
- 4.4 90% of dental services are provided by the GDS. Amongst practices 29% are single handed and 34% of GDPs are women. The GDS also employs Professions Complementary to Dentistry (PCDs) including 20 dental hygienists and 500 dental nurses. 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)**

- 4.5 The directly managed Community Dental Service currently 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.
- 4.6 The current staffing level of the CDS is approximately 18 whole time equivalent (wte) dental practitioners plus a Clinical Director and Senior Dental Officer. In addition, there are 31 dental nurses, 4 dental health educators and 2 hygienists/therapists. About 3.5 CDOs (wte) 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. On the basis of a limited comparison with Lothian the CDS in Greater Glasgow appears to be significantly under-resourced.

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

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

- 4.7 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.
- 4.8 The out of hours Glasgow Emergency Dental Service (GEDS) operates in Glasgow Dental Hospital premises on weekday evenings with Saturday and Sunday sessions. In 2002-2003 it treated 3221 patients, double the previous year.
- 4.9 A primary care dental treatment centre providing a weekday accident and emergency service at the Glasgow Dental Hospital and staffed by salaried dentists has now commenced.

### **Health Promotion**

- 4.10 The Health Promotion Team provides 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, shaping oral health policy and piloting of programmes with marginalized group e.g. looked after & accommodated children and older people.

#### **4.11 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. The roll out of OHATs across all 16 LHCCs was completed during 2004. A recent review of the initiative urges stronger focus on pre-threes, increased resourcing and follow through at primary schools.

#### 4.12 Toothpaste/Tooth brushing

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 the 6 local authority areas in Greater Glasgow.

#### 4.13 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 Fayers 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.

#### 4.14 Starting Well

Starting Well is a Scottish Executive sponsored national demonstration project being 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 has been supportive providing opportunities for local groups and nurseries to access funding for activities including oral health and healthy eating.

#### 4.15 West of Scotland Cancer Awareness Project (WoSCAP)

The WoSCAP is a national lottery (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**

#### 4.16 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 GDPs, 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 may 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 from Greater Glasgow, Lanarkshire and Argyll and Clyde, a fall of 40% on levels five years ago. Ultimately the entire child dental GA service will be centred on Yorkhill.

A further change has seen the A&E service replaced with a primary care treatment centre.

#### 4.17 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, emphasis will shift from training dental hygienists to dental therapists. 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.

### **Yorkhill Hospital**

4.18 Medically compromised children receive dental services via Yorkhill Hospital. Each year around 300 children aged under 3 receive a dental GA at the hospital.

### **Oral Maxillofacial Surgery Services**

4.19 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 service 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% as 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 surgical dental procedures such as removal of wisdom teeth.

Due to pressures arising from the European Working Time Directive, clinical governance and teaching, a business plan is presently under consideration proposing further centralization of inpatient services for the West of Scotland while maintaining and improving out patient services.

# SECTION FIVE

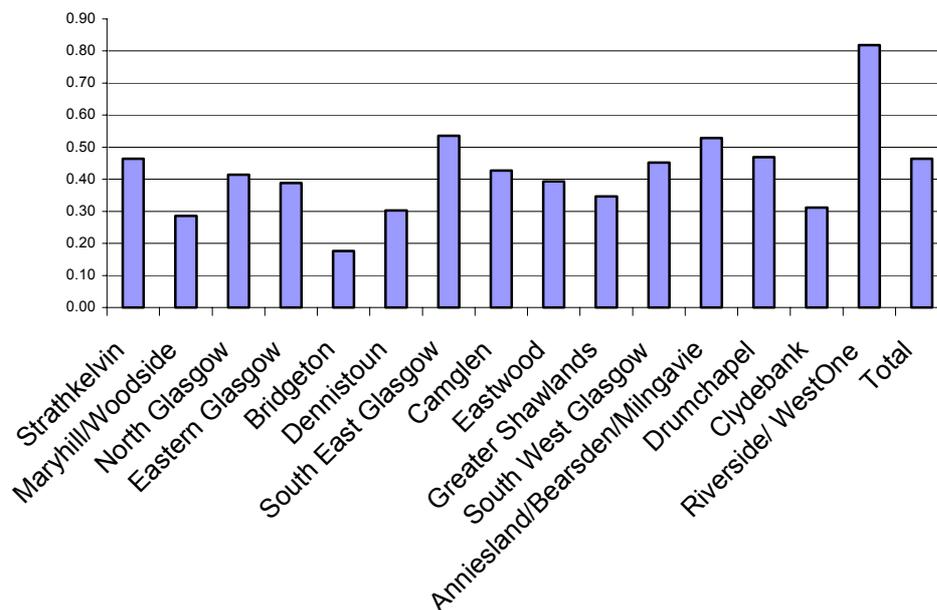
## ACCESS TO DENTAL SERVICES

5.1 Access by people in Greater Glasgow to dental services is an issue. Across the Board area there are serious inequalities in access. A report prepared for the Scottish Executive Health Committee defines access as “the ability of clients to utilise and benefit from oral health care and the *degree of fit* between client and health care system” but which is guided by equity in relation to need.

### Access To General Dental Services

5.2 Greater Glasgow has the highest levels of NHS dentistry in the country (3.69 per 10,000 population). A recent national survey has estimated that dentists in the city spend 85.2% of their time on providing NHS dentistry.

TABLE 5.1 LHCCs - GDPs per 1,000 POPULATION



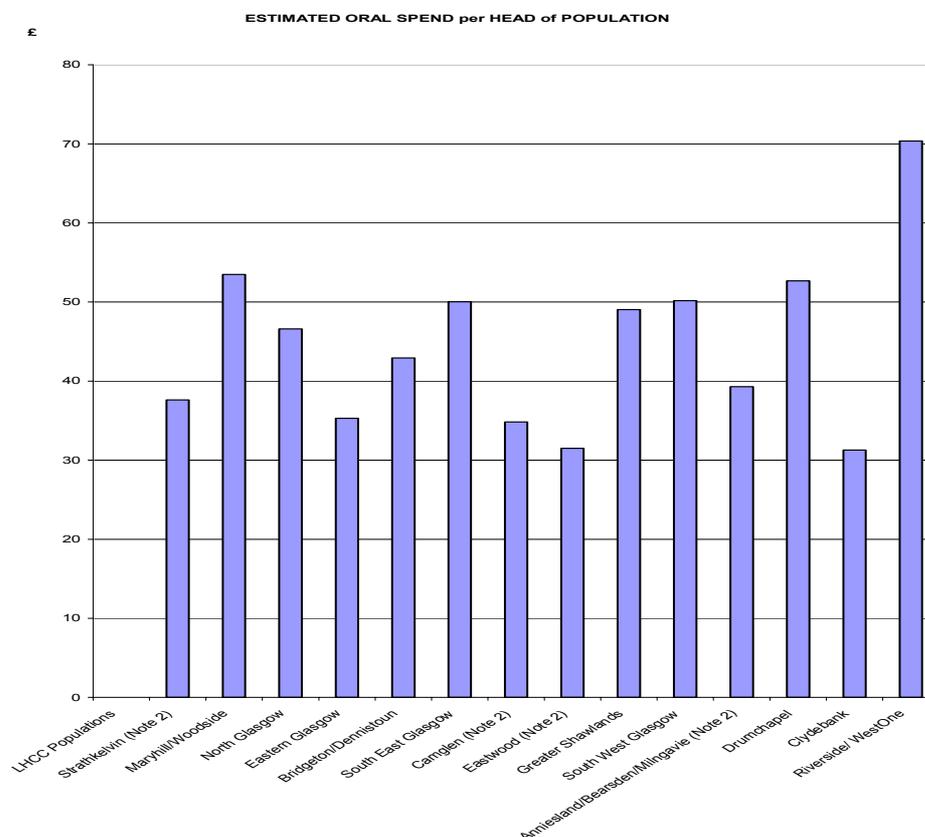
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However when deprivation is taken into account the city has the second lowest provision relative to other Health Board areas (1.79 per 10,000 population).

5.3 Within the city the distribution of dental practitioners and practices varies across Greater Glasgow from 1.8 dentists per 10,000 population in Bridgeton to 8.2 in Riverside/Westone. The distribution of dentists shapes the distribution of service investment 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.

**TABLE 5.2. ESTIMATED SPEND ON ORAL HEALTH PER CAPITA BY LOCALITY**



5.4 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 5.11).

5.5 While dentists in Greater Glasgow offer the shortest waiting time for services anywhere in Scotland (3 weeks on average), both the General Dental Service (GDS) and the Community Dental Service (CDS) are experiencing high rates of failed appointments (Do Not Attends - DNAs). Recent data from the CDS (December 2004) show DNA rates of 27% for routine appointments and 16% for special needs appointments.

5.6 In terms of other measures of access 41% of dentists in the city offer evening or weekend appointments and only 50% work in wheelchair accessible premises.

5.7 Registration

Unlike general medical services where registration with a GP is for life, registration with a dentist, due to national regulations, must be renewed every 15 months.

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.

**TABLE 5.3 NHS DENTAL REGISTRATION RATES (%) AT 31 MARCH 2004**

	<b>0-2</b>	<b>3-5</b>	<b>6-12</b>	<b>13-17</b>	<b>18-24</b>	<b>25-34</b>	<b>65-74</b>	<b>75+</b>
<b>Scotland</b>	34.4	67.7	75.6	68.1	51.8	52.0	39.1	27.4
<b>Greater Glasgow</b>	39.8	70.7	81.7	70.9	48.5	57.4	40.8	31.5

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.

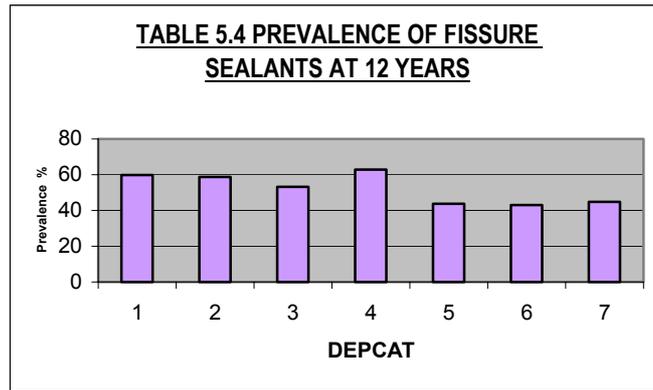
According to the Health and Well Being Survey, 74% of adults in Greater Glasgow claim to be registered with a dentist. Scottish Dental Practice Board data record that 52.7% of adults in Greater Glasgow are registered with a GDP. People living in deprived areas are less likely to be registered with a 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.

- 5.8 In terms of new registrations national survey information indicates that 74% of dentists in the city are continuing to accept new children registrations and 69% new adult registrations higher than most other parts of Scotland.

## **Access To Preventive Measures**

- 5.9 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. In Greater Glasgow it appears that 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.
- 5.10 GDS regulations require that 6 and 7 yr olds considered to be at risk should receive fissure sealants (a plastic coating to prevent dental decay). Fissure sealants are well documented as a highly effective means of protecting children’s new adult teeth.



5.11 In Greater Glasgow 51% of children at age 12 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**

5.12 Analysis of attendances at the Accident and Emergency Department of Glasgow Dental Hospital and School for 2001/02 showed differences in the attendance rates, ranging from 22.2 attendances per 1000 population in Easterhouse to only 9.0 per 1000 in 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**

5.13 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.

**TABLE 5.5 SPECIALIST SERVICES WAITING TIMES AND NUMBERS (JANUARY 2004)**

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

## **Issues affecting Access to Services**

The main determinants for oral health extend to issues of service access and the needs of groups most affected by these determinants are covered in section 2. However a number of key issues pertaining to access should be reflected on to ensure provision can be met by the Greater Glasgow dental system as a whole. These include:

- Physical accessibility of dental surgeries
- Flexibility of services to meet multi-cultural needs of different communities
- Availability of specialist care required by some patient groups including adequate time provision, skills and expertise as well as treatment protocols e.g. oral screening.
- Availability of NHS care generally and specifically to address pain
- Appropriateness and availability of services to meet the needs of individuals with complex lifestyles
- Provision of out- reach services where appropriate

## **SECTION SIX**

### **THE ORAL HEALTH CHALLENGE**

- 6.1 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.
- 6.2 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**

- 6.3 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.
- 6.4 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 the level in 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.
- 6.5 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.

6.6 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 priority.

### **Addressing Causal Factors**

6.7 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. Recent years have been marked by increasing inter-agency collaboration through pan Glasgow strategies to address tobacco and diet. However further action is required to extend this activity within Glasgow and to other local authority areas. Collaborative effort to address fluoride availability and self care skills are now widely recognised and partnerships will address:

- Access, availability and affordability of a healthy diet to include fresh fruit and vegetables;
- Exposure to fluoride, whether by means of dietary supplements, tooth brushing or water fluoridation as a public health measure;
- The knowledge and understanding of self-care, i.e., maintaining good oral hygiene by tooth brushing 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.

Integral to this approach is the recognition of the main determinants of health such as poverty and age and the needs of groups most affected by these.

### **Improving Services**

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

6.8 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 e.g. sedation. These have been longstanding and undermine the notion of a universal service. It is uncertain if the new GDP contract will address these shortcomings.

6.9 Our dental services and the majority of our oral health resources are being channelled into treating dental disease and decay. If we are going to see a stepped change in Greater Glasgow's oral health record we need greater emphasis on preventing decay occurring in the 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 structure and timing of any new 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 meeting increasing demand for restorative care and raising the priority on prevention.

- 6.10 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.
- 6.11 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**

- 6.12 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 already being applied by some practices. There are also signs of disillusionment amongst the dental workforce with possible issues around recruitment and retention. 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.
- 6.13 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 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**

- 6.14 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
  - reducing oral health inequalities
  - obtaining more robust needs assessment data on other vulnerable population groups
  - reducing the number of children requiring a general anaesthetic for dental treatment

# SECTION SEVEN

## OUR VISION

7.1 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.  
Improving oral health is everyone’s business’***

Central to this vision is the desire of NHS Greater Glasgow and its partners to fundamentally change the oral health experience of individuals both through oral health promotion and treatment of unmet dental need in the short to medium term and therefore ultimately changing the profile of level of dental services in the long-term.

7.2 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

7.3 The strategy rotates around two main aims

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

7.4 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.

7.5 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 to 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.

- 7.6 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.
- 7.7 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.
- 7.8 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.
- 7.9 In short, what the strategy sets out to do is to enable oral health to punch its weight and argues for fair recognition alongside other competing and merited health priorities.
- 7.10 In summary our strategy aims and objectives are

<b>Strategic Aim:</b> To Improve Oral Health
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***Strategic Objectives***

To strengthen public health leadership

To change attitudes and culture

To target priority groups.

<b>Strategic Aim:</b> To Enhance Dental Services
--

***Strategic Objectives***

To tackle inequalities in access

To emphasise prevention

To create a mixed economy of service provision

To improve quality

To develop specialist services

## **SECTION EIGHT**

### **IMPROVING ORAL HEALTH**

- 8.1 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. 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.
- 8.2 Health promotion literature supports a holistic approach. The WHO Ottawa Charter of 1986 clearly outlines the main issues for improved oral health:
- Build healthy public policy
  - Create supportive environments
  - Strengthen community action
  - Develop personal skills
  - Re-orient health services
- 8.3 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 e.g. sugar avoidance and tooth brushing. 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
- 8.4 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
- Targeting oral health improvement particularly towards children

### **Strengthening Public Health Leadership**

- 8.5 The strategy recognises the public health role of a wide range of agencies and groups and the need to harness collective and collaborative action on oral health is central to the approach outlined. The strategy requires to facilitate the development of local policy and to establish supportive environments and services to promote oral health. The role of the NHS will be to act as a catalyst for oral health activity in partnership with local authorities, employers, service providers, other community planning partners, communities and the Scottish Executive.
- 8.6 The public health approach required needs to reflect changes in specific health behaviours and lifestyles coupled with a wider common risk factor approach and action to address wider determinants such as life circumstances that impact on oral health. The need to recognise oral health within mainstream health and care policies is vital. However there are three main areas where effective action is crucial to our prospects of improving oral health. These are:
- Diet
  - Tobacco
  - Fluoride.
- 8.7 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 there 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.
- 8.8 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.
- 8.9 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
- 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

#### 8.10 Tobacco

Smoking is the biggest single preventable cause of premature death in Scotland and within Greater Glasgow the prevalence of smoking is higher than other areas of Scotland. People with low incomes have the highest rate of smoking and the lowest rates of cessation. Smoking is the major cause of health inequalities – two thirds of the social class gradient of premature mortality is attributable to smoking.

Tobacco use is the key risk factor for oral cancer which when coupled with regular alcohol consumption causes a dose – related increase in oral cancer. The effect of alcohol is independent of smoking, however it can be assumed that all levels of smoking will increase the risk of alcohol related cancers such as squamous carcinomas of the upper aerodigestive tract and cancers of the oral cavity, pharynx, larynx and oesophagus.

Continued commitment from the NHS Board to reducing tobacco use across Greater Glasgow is required through;

- ♦ the implementation of Glasgow Tobacco Strategy (including passive smoking, tobacco control and smoking prevention measures)
- ♦ the development of tobacco strategies with other local authorities
- ♦ ongoing support and development of comprehensive smoking cessation services particularly targeting key groups (young people and pregnant women)
- ♦ the development and implementation of the forthcoming NHS Tobacco Policy.

## 8.11 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 to individuals. Further investigation is also required here to establish current levels of use and to promote more consistent practice.

Recent scientific reviews of the world literature [e.g. University Of York, Department of Health (Republic of Ireland) and Medical Research Council] 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 national 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 feel that the evidence in support of water fluoridation as an effective preventive measure against dental decay is strong. We would ask the Scottish Executive to provide a lead as to the way forward.

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 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 strategy recognises the need to challenge current value systems relating to oral health within organisations, communities and individuals. The strategy proposes an approach based on information, development of personal skills, empowerment and strengthened community action.

- 8.12 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.
- 8.13 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.
- 8.14 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.
- 8.15 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 it will be necessary to raise the profile and priority of oral health in communities, professional groups and organisations and to build public policy and practice supportive of oral health.
- 8.16 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 the table below.

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. The role of local partnerships is essential in promoting the development of life skills and facilitating the opportunity for healthier choices through the roll out of health promotion interventions and services. Local health promotion activity and capacity building with professionals and communities should be supported by Community Health Partnerships and Oral Health Action Teams.

**TABLE 8.1 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 Priority Groups**

8.17 The strategy recognises the need to combine a population approach with the specific targeting of effort to ensure maximum oral health gain and equitable opportunity for oral health within the population. The strategy prioritises parents and children however the needs of groups with additional needs are also considered. The impact of the various determinants of oral health on population groups and their subsequent oral

health needs has been described in section 2. Within the context of health improvement a number of key areas require to be addressed however these are interwoven with service delivery issues and as such are fully discussed in section 9.

#### 8.18 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 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' antenatally 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 the actions of 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 Greater Glasgow 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 the desired outcome for the strategy is to achieve improvements across all DEPCATS but with significant advances among the more deprived populations.

In order to target parents and children the following specific actions are proposed. In general they will serve to further develop community-based approaches to oral health and to ensure integration of oral health with wider child health agenda, however for older children a re-orientation of dental services to provide preventative treatments is required.

## 8.19 Developing Oral Health Action Teams

Oral Health Action Teams (OHATs) support long-term cultural, organizational and behavioural change within local communities and as such the OHAT initiative is key to the implementation of this strategy. OHATs have now been rolled out across all of Greater Glasgow with a remit to develop oral health promotion activity targeting pre 5 children. Whilst current investment limits the potential impact of the OHAT approach within this age group the potential for significant development of the OHAT role beyond this age group and incorporating local dental service planning is recognised within the strategy.

The agenda for development of OHATs requires to be two-fold;

- ♦ The level of existing resources within the OHAT initiative 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 pre-five children further resources should be targeted to those areas currently with the worst oral health i.e. explicit targeting of the most deprived areas. 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 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 antenatal mothers and parents and carers of pre 3s.
- ♦ The strategy recognises potential of OHATs to co-ordinate and deliver local oral health promotion initiatives extending beyond pre-fives to address the needs of older children. Within the context of Community Health Partnerships, Learning Communities and Integrated Community Schools it is essential that oral health becomes central to the health education curriculum, Health Promoting School Award schemes and the work of Health Development Officers. The current level of local authority support, notably from Education Departments requires recognition but further development through formalised joint working and the development of models of good practice. 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 the wider health promotion agenda for example linking with diet and physical activity. The potential role of the School Health Service (SHS) in promoting oral health has also been identified and the association between schools, the SHS and local GPs should be supported by OHATs.

In areas of deprivation and where there is little GDS provision for children a dedicated children's dental service requires to be developed ensuring accessibility to preventative treatments such as fissure sealants and to restorative care. The role of the School Health Service and OHATs in forming a connection between school children, the CDS led dental inspection programmes and access to restorative treatment requires to be closely linked.

Commitment to oral health for older children by local authorities should be sort through Children's Services Committees.

The OHAT initiative will continue to be evaluated to ensure that resources are adequately deployed and to assess impact on key factors for oral health and the impact on the oral health of the most at risk populations.

The OHAT approach 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.

#### 8.20 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 tooth brushing 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 e.g. staffing in nurseries, competing priorities for health visitors, OHAT capacity and 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 tooth brushing programmes the Board seeks commitment to oral health from local authority partners specifically in relation to toothbrush/toothpaste distribution, tooth brushing programmes and Health Promoting School initiatives. Local authorities are asked to formally commit to this initiative through planning committees for children's services.

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

#### 8.21 Integration 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 Board's wider child health policies and its children's services planning with local authorities recognizing their role. This should apply not only to the planning role as identified above but also to the delivery of children's services:

- the OHAT initiative can only contribute partially to achieving the pre-five target and support is required from initiatives such as Starting Well, Sure Start and health visiting corporate caseload approaches that seek through new and more intensive inputs to improve the health of vulnerable parents and their children. Continued health visiting commitment to oral health is required if the target is to be achieved. Other measures will be necessary such as ensuring that oral health is a priority area

for action when implementing Hall 4 guidance and the risk assessment of vulnerable families considers oral health risk factors.

- 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 instil 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 tooth brushing programmes, breakfast clubs, Hungry for Success (healthier food choices) and the Health Promoting School Awards.
- 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 should be implemented.

A key building block required for this strategy is the development of an integrated oral health workforce, inclusive of dental and non-dental personnel. The building of capacity and employment opportunities through training and development across a wide range of personnel from public, private and voluntary sectors requires to be actioned.

Commitment should be sought 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.

# SECTION NINE

## ENHANCING DENTAL SERVICES

### Tackling Inequalities in Access

#### 9.1 Access for Communities

Dental services should be available and accessible to communities in all areas of Greater Glasgow. A series of actions are proposed or underway:

- To establish a Primary Care Treatment Centre at Glasgow Dental Hospital and School with a team of five Salaried General Dental Practitioners and their support staff providing 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 in late 2004.
- Enabling GDPs using funding from the Scottish Executive to improve dental surgery facilities to comply with the provisions of Disability Discrimination Act (DDA) and to upgrade dental equipment. 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.
- 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.
- In the financial years 2004/05 and 2005/06, Scottish Executive funding will enable the investment in dental facilities at Pollok and Springburn Health Centres to improve access for patients who require to be treated in their wheelchairs, and for special needs patients, adults and children who require sedation. This will augment the accessible CDS surgeries provided for GDPs in Easterhouse, Castlemilk and Maryhill Health Centres.
- There is a concern to retain as well as to enhance GDP services in deprived communities. A 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.
- Supporting the provision of infrastructure and resources will help ensure 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.

## 9.2 Access to Comprehensive Services

Issues concerning comprehensive service provision remain to be addressed. For example:

- The centralisation of the children's dental general anaesthesia 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 for anxious children should enable a greater proportion to avoid the need for dental GA as they may tolerate restorative care under sedation at an earlier age compared to current practice.
- For the population as a whole, there should be more emphasis on oral health promotion and the clinical prevention of dental disease.

## 9.3 Access for Vulnerable Groups

All vulnerable people require fair and proper access to dental prevention and treatment. 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.

All vulnerable people require fair and proper access to dental prevention and treatment. The dental and oral health promotion needs of specific groups will be the subject of further analysis and plans will be prepared in response to this work in the short to medium term.

### ♦ *People with Addictions*

The oral health needs of this group requires further exploration and links with local to Community Addiction Teams should be established in the first instance. Needs assessment is required to establish specific issues and needs as well as good practice and current evidence base. (including specific needs of methadone users)

### ♦ *Homeless People*

A needs assessment on the dental needs of homeless people has been conducted and an application has been made to the Scottish Executive for approval to appoint 1.5 whole time equivalent salaried general dental practitioners and support staff to meet these needs. The action plan for homeless services is required to consider accessibility issues and flexibility in service location.

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

A recent health needs assessment carried out by Looked After and Accommodated Children's (LAAC) Service identified that many children have untreated, complex oral health needs due to their social circumstances and have difficulties in attending general dental services. A number of oral health actions were identified. In addition the training and support needs of the LAAC team to provide oral health promotion as part of the care package were identified. Oral health needs appear to be greatest in children within residential units and those residing with emergency foster carers. The

LAAC team and Community Dental Service are undertaking a pilot project to establish care pathways for this group in the east of Glasgow.

♦ *Groups affected by Negative Attitudes and Anxiety*

Efforts to establish a positive dental experience from the earliest age should be encouraged through oral health promotion initiatives promoting early registration with GDPs. Parent and child centred initiatives that support early access to services such as Child Friendly Dentist schemes, group dental visits and local links to GDPs should be developed by OHATs. Additional efforts to ensure adequate preventive advice and treatment is provided within the practice from the time of registration is required.

A significant number of children, adolescents and adults experience anxiety when contemplating and later undergoing dental treatment. The degree of this anxiety ranges from mild to severe. In its severest form (dental phobia), all dental treatment is avoided until such time that discomfort, pain and infection become intolerable. Frequently some or total tooth loss is the only suitable treatment. The root of this anxiety is often reported to be previous unpleasant experience of dental treatment eg dental extractions under general anaesthetic.

Sedation techniques are now an integral component of the undergraduate dental curriculum. Research and development in dental sedation is ongoing. The factors have jointly the potential to make sedation techniques more widely available in dental practice and in specialist settings.

Whilst dental sedation is already available within the NHS General Dental Service it is not practised as widely as this NHS Board would wish. The NHS will support the development and practice of sedation services for appropriate dental patients to ensure that there is greater equity of access, particularly in areas where dental health is poor and dental attendances are avoided.

♦ *Children with Special Physical and Educational Needs*

For children 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. The level of specialist skill, time and accessibility of services requires consideration in developing an action plan. In addition an integrated model of practice to support children with special needs through the child health development centres should be explored.

Oral health promotion and dental health services for this care group require additional investment to ensure that they are adequately resourced and developed. Future planning should involve parents and representatives from education, and social services as well as the NHS.

♦ *Adults with Special Educational and Physical needs (inc. acquired brain injury and sensory impairment)*

This group of patients have 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.

Dental services for patients with special needs are generally 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.

The consultation process has further highlighted the oral health challenge and needs of these groups indicating a strategic assessment of needs is required similar to that undertaken for children. Specifically the needs of inpatients within general medical care (hospitals) and care homes should be identified.

The flexible approach required to treat these groups suggests that the model of dental care requires to be developed with links into community treatment centers, rehabilitation units and community physical disability teams. A number of basic communication issues require to be considered particularly for sensory impairment groups.

♦ *BME groups*

A brief focus group exercise was undertaken with four population groups as part of the consultation process. These sessions form to provide only an initial insight into the actions within the strategy that specifically relate to the needs of these groups. The importance of oral health was universally recognized, however there was limited understanding of preventative factors particularly relating to diet. The actions within the strategy, relating to prevention were supportive of developing good oral health in BME groups, however there was an indication that additional emphasis should be placed on supporting parents and linking action in nurseries etc to the home. Specific emphasis on the health improvement needs of BME groups should be built into core programmes within the action plan.

Access to dental services was mixed with accessibility to an NHS dentist and appointment booking issues being raised. A strong emphasis was placed on the use of services at the time of need (pain) and the preventative and maintenance role of the dentist was not recognized. Cost for adults was a frequently mentioned barrier and related to the perceived need for restorative treatment. Language was not recognized as a barrier for most groups with a wide knowledge of accessible interpreting services if required. The availability and focus of dental services at the point of presentation requires consideration during the planning of services through the strategy.

♦ *Asylum seekers*

Little specific information regarding the oral health needs of this group are known however additional barriers to treatment provision have been identified in relation to GDS payment. The provision of specialist services to this group should be considered as part of the mixed economy approach and linked to other aspects of health and social care provided for these groups.

♦ *Older people*

As the number of older people with their own teeth is increasing, there is an increasing need for long-term treatment planning and continuing restorative care.

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.

The strategy recognises that access to dental services for older people may be difficult and current levels of registration are lower in the over 65s age group. Specific attention is required to develop a comprehensive approach for older people. It is proposed that a needs assessment exercise and action plan be drawn up in partnership with the Older People's Planning and Implementation Group to address the following aspects identified within the consultation process;

- Older people living in care homes /nursing and carer roles in oral health /consistent and flexible dental services
- Older people living at home & housebound / home helps and carer roles in oral health
- Frail elderly / nutritional aspects
- Community care centres
- Oral cancer screening services
- Accessibility issues /transport/ cost barriers

## **Emphasising Prevention**

9.4 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.

### 9.5 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 88% 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."

An Enhanced Capitation Scheme for children's dental care introduced nationally in 1998 provides enhanced monthly registration payments for GPs 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 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 consultation paper on Modernising Dental Services in Scotland proposes possible changes to the GDS. A greater emphasis on prevention would contribute to achieving improved oral health across all ages.

## 9.6 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.

The oral health of children from birth through adolescence to the age of 18 years will be improved by providing oral health promotion in various settings including ante natal, early years, nurseries and primary schools, and by encouraging the development of services for children especially in those areas where services are not readily available. The GDP practice should continue to be promoted as the principal provider of preventive care but it will be necessary to provide complementary services where these are unavailable in some cases by way of a school based service.

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 anaesthesia service at Yorkhill Hospital
- programme for oral health improvement for dental workforce and primary care teams.

- *Adults*

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.

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.

## **Creating a Mixed Economy of Service Provision**

- 9.7 Given the long history of poor oral health in Scotland, and in Greater Glasgow particularly, maintaining the status quo is not an option which is likely to significantly improve the present position. In view of its poverty Greater Glasgow is relatively under resourced for dentists. To give some idea of the possible scale of the shortfall if Greater Glasgow was to have the level of provision akin to the Scottish average it may need in the region of 60 extra dentists. To rectify this situation it is proposed a mixed economy approach is adopted involving multiple development of all potential sectors of dentistry. This must include attention to GDS, CDS, salaried service, sessional payments, PDS and PCDs.
- 9.8 Within a developed mixed economy, the goal should be to create a committed dental workforce supported by a range of health and other professionals to provide comprehensive programmes of preventive and restorative dental care for all sections of the city’s population.
- 9.9 The aim of this should be not only to increase the overall dental resource for the general population but to address the many gaps in oral health provision across the city.. These will include
- prevention and oral health promotion for children;
  - comprehensive screening and treatment for the older people;
  - tailored dental services for special needs groups;
  - care for medically compromised patients and/or people in residential care.
- 9.10 General Dental Services (GDS)  
In view of its scale a critical factor affecting the outcome of the strategy or at least the speed of its achievement is the GDS contract. There is wide acceptance that the present contract is inadequate, offers insufficient incentives to GDPs particularly on prevention and needs to be reformed. It is not clear at this stage what the Scottish Executive’s proposals for changes to the contract will be. Previously it has signalled that any major reforms must maintain stability within the system suggesting that in all probability changes will be evolutionary while “building on a culture of quality”. Therefore while we should engage constructively with the GDS on the implementation of the strategy it is possible that over its lifetime the contract will continue to be a limiting factor. In that event it will be important for the Board to consider what local incentives it can offer to GDPs in the interim in support of the implementation of the strategy and local initiatives to enhance the infrastructure of the dental system.

9.11 Community Dental Services (CDS)

Delivery of the strategy will crucially depend on the formation of a unified salaried service. The CDS will form a vital part of this providing specialist services to vulnerable groups. The CDS in Greater Glasgow appears on the evidence available to be relatively under sized compared to other similar areas in Scotland. If the strategy aims are to be achieved this will require to be addressed.

9.12 Salaried Dentists

This could be advanced either by securing additional local development funding to employ dental professionals directly on preventive treatment programmes or alternatively, to seeking 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.

9.13 Sessional Payments

Dentists could be paid 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.

9.14 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.

9.15 Workforce Planning

*Training*

A recent workforce review has concluded that there is national shortage of dentists. In future, GGNHS is likely to face increasing competition for dental graduates from other health board areas as a result of the extension of outreach training.

The Board has a major strategic interest in safeguarding and developing dental education, training and research in GDHS. GGNHS is a main recipient of dental graduates and Professionals Complementary to Dentistry (PCDs) who have been trained in GDHS. In addition, as host of the GDHS and as a major stakeholder alongside NES and the University of Glasgow, GGNHS has a shared obligation to ensure that the value and standard of dental education, training and research provided

in GDHS is maintained at a high level. This should involve the further development of local research opportunities involving all care sectors and GDHS.

A further important dimension concerns the training of other health professionals. Nurses, midwives and health visitors in particular can have a major impact on the oral health of parents, children and carers in terms of advice and support on lifestyle and dental hygiene. Oral health should form part of the future training syllabus of other health professionals.

#### *Recruitment, Retention and 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 graduates 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 and 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 should be undertaken in collaboration with the profession inform the planning process as to what further action is required to achieve our aims in terms of the recruitment and retention of the required numbers and skill mix of dental professionals.

## **Improving Quality**

9.16 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.

### 9.17 Continuous Development of the Dental Team

Primary care 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.

### 9.18 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).

TABLE 9.1 DRIVERS OF QUALITY

<b>General Dental Service</b>	<b>Community Dental Service</b>	<b>Hospital Dental Service</b>
<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>

### 9.19 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). Two Clinical Governance Advisers have been appointed 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 Initiative should be established permanently, subject to evaluation of the project by the Dental Health Services Research Unit.

## 9.20 Clinical Governance

The Department of Health define clinical governance 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 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

This strategy 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”.

## 9.21 Engaging with Public and Patients

Partnership for Care requires the NHS, including dental services, to involve public and patients an early stage, to extend beyond traditional means of consultation and to ensure decision making is open and transparent. The document “Managed Clinical Network: A Guide to Implementation” identifies five methods of public involvement in healthcare services:

- Involvement of an individual patient in decisions about their own care
- Involvement of patients in monitoring and improving the quality of care in an existing service
- Involvement of patients and the public at an organisational level e.g. committee level
- Involvement of patients and the public in the planning of change in service provision
- 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 dental services need to ensure that:

- 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
- New approaches and methods for involving patients in review and monitoring of services are required.
- 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.

## 9.22 Providing Support Infrastructure

- *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**

### 9.23 Oral Maxillofacial Surgical (OMS) 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.

#### 9.24 Glasgow Dental Hospital

In the lifetime of the strategy it will be necessary to plan for a new dental hospital and school. A possible suitable new site has been identified but it is unlikely that any transfer will take place before 2011. Some preliminary planning has previously been undertaken to design the new facility with key stakeholders and in close consultation with others such as NES and other West of Scotland health boards. This process will be reactivated as project planning timescales become clearer. In the meantime a capital plan will be developed for the existing premises to ensure that it is fit for purpose and discussions will continue with the Scottish Executive to identify the necessary capital resources for refurbishment.

Reducing the current waiting times at the Dental Hospital (see Section 5) to comply with the 26 week target by December 2005 represents a testing challenge for most specialties. 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 is collaborating with dental clinicians and managers 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.

In terms of child dental GA pre-anaesthetic assessment has already been centred at the GDH under a revised protocol and subject to ongoing feasibility review of options services may be consolidated at the GDH in the short term.

#### 9.25 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 or at the earliest opportunity.

#### 9.26 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.

# SECTION TEN

## IMPLEMENTATION

### Integrated Working

- 10.1 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, planning and health promotion.
- 10.2 The success of implementation will depend on how this responsibility is discharged. The key for oral health is to become more outward looking. The delivery of the strategy is reliant on many different players both engaged in oral health, as well as elsewhere in the NHS and beyond in particular local authorities. If significant change is to occur then others must be successfully engaged in the implementation of the strategy. These will include the oral health community, other professionals across primary and secondary care, relevant GGNHS planning groups and professional advisory groups, west of Scotland health boards, local authorities and communities and the Scottish Executive. 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.
- 10.3 The prospects for integrated working will be shaped by GGNHS plans for a single system. This offers opportunities for a more unified and coherent approach to oral health in the future and to strengthen its profile and leadership. A critical component of the single system will be the CHPs.

### Community Health Partnerships (CHPs)

- 10.4 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. This will include oral health services and a phased implementation is planned to include OHATs, oral health promoters, community dental services, salaried dentists and GDPs. This should improve the potential for oral health to be fully incorporated into key strategies and plans at local level. The local planning responsibility of CHPs creates the potential for OHATs to develop into oral/dental planning fora to develop local oral health planning, preventative initiatives, and service redesign to reflect local needs.
- 10.5 Against this background, there is little doubt that the dental profession should be involved in CHPs and capitalising on the networks and capacity developed by OHATs augmented to reflect this new focus. The formalised involvement of GDPs

within CHPs is pivotal to this role extending beyond current OHAT capabilities and resources.

- 10.6 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.
- 10.7 NHS Health Scotland's report "Oral Health in Primary Care" recommends that emerging CHPs should facilitate the involvement of dental and non-dental partners in the joint delivery of oral health improvement. The consultation paper on modernising NHS dental services identifies the need for developing better community level support for prevention of dental disease and better contact with other health and community care professionals. Within CHPs dental professionals require to be more prominently involved in local planning and to champion the oral health agenda in particular in the joint arenas of community care, children's services and health improvement
- 10.8 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 PHPIG are both present.

## **Regional Planning**

- 10.9 The Board chairs the West of Scotland regional dental planning 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 key regional oral health issues such as access to specialist services at the Dental Hospital, future training of dentists and PCDs, plans for the Dental Hospital and School, and redesign of child dental GA and oral maxillofacial services.

## **Performance Management**

- 10.10 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.
- 10.11 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 indicators for dental health are:
- proportion of 5 year olds with no experience of dental disease
  - ratio of 5 year olds with dental caries experience in the most deprived quartile compared with those in the least deprived quartile

- 10.12 In addition there are indicators for access to dental services and care
- number of dentists WTEs per 1000 Arbutnott weighted population
  - percentage of the population aged 0-17 registered with an NHS dentist
  - percentage of the adult population registered with an NHS dentist
  - outpatient waiting times for specialist dental services
- 10.13 There are other indicators within the PAF which are also of interest to oral health, for example cancer, smoking and diet.
- 10.14 As part of the PAF the Board is also asked to report on progress in relation to the implementation of the Dental Action Plan. This covers and sets national targets for
- oral health/prevention
  - access to NHS dental services
  - human resources and team working
  - quality and standards
  - infrastructure and resources
- 10.15 Alongside the national targets, specified in the Dental Action Plan, the OHPIG will give consideration to developing an overall framework to assess performance in oral health including the setting of local improvement targets.

## **Financial Planning**

- 10.16 In order to deliver on the strategy additional financial resources will be required. It is important that oral health receives fair consideration with other priorities when additional funding becomes available either locally or nationally over the lifetime of the strategy.
- 10.17 In light of the current difficult financial prospects facing NHSGG and the necessity of delivering the Acute Services Plan it is likely that there will be limited new funding available to support further developments in the immediate future. There remains the issue of funding for oral health within established programmes including joint programmes where appropriate, for example for child health, older people and disabilities.
- 10.18 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 disparity of oral health needs and resources is of concern and requires to be urgently addressed. As a result of national consultations in oral health there have been indications that the Scottish Executive may allocate additional resources for this purpose.
- 10.19 The OHPIG will have important responsibilities to ensure that:
- priority proposals arising from the strategy are prepared with justification and anticipated benefits and are presented timeously in the appropriate planning processes
  - deployment of all resources is reviewed to obtain maximum benefit on oral health
  - submissions to capital and revenue processes are co-coordinated
  - opportunities to access external funding are exploited

# **SECTION ELEVEN**

## **ACTION PLAN**

The following action plan will form the basis of strategy implementation. The actions have been structured by the strategy's aims and objectives and follow a standard layout.

**Action** – linked to the appropriate sector of the community

**Outcomes** - reflects the positive impact expected

**Key Elements** - identifies the principal contributory factors or related components of the action

**Performance Measures** – indicates how success will be demonstrated for monitoring and evaluation process

**Funding Implications** – a four level classification is used

**STRATEGIC AIM: TO IMPROVE ORAL HEALTH**

**STRATEGIC OBJECTIVE A: To strengthen public health leadership**

Ref	Action Area	Expected Outcomes	Key Elements	Performance measure	Funding implication
A 1	Mainstream oral health within wider policy frameworks with particular reference to diet, tobacco and fluoride availability.	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.	<u>NHS</u> -Local Health Plan -Elderly strategy -Food & Health Guidelines for Elderly -Infant Feeding policy - Cancer Plan -Special Needs strategy -CHP Health Improvement plans <u>Local Authorities</u> - Children's services plan - -Food & health Frameworks -Tobacco Strategies -Care Home standards	<ul style="list-style-type: none"> <li>♦ Evidence of oral health in key strategies and implementation plans</li> <li>♦ Development of food and health strategic frameworks in all 6 local Authority areas</li> <li>♦ Tobacco polices across all 6 Local authority areas</li> <li>♦ No of children covered by toothbrushing programmes in each LA.</li> </ul>	B
A2	<b><i>Development of food and health policies to create supportive food environments out-with the home</i></b>	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>• Nutritional guidelines for pre-five establishments</li> <li>• Food provision policies within key agencies – Local Authorities</li> <li>• SHAW food policies</li> <li>• Scotland's Healthy Choices Awards</li> </ul>	<ul style="list-style-type: none"> <li>• No of agencies with SHAW, HCAs etc</li> <li>• No of local Authorities compliant with Hungry for Success</li> <li>• No of schools compliant with Hungry for Success</li> <li>• No of pre-five establishments compliant with new nutritional guidelines</li> </ul>	A
A 3	Develop GGNHSB's role in lobbying partner agencies to undertake action for oral health improvement	Change in local and national policy and local attitudes and culture towards better oral health	National <ul style="list-style-type: none"> <li>♦ Food advertising directed at children</li> <li>♦ Food labelling</li> <li>♦ Fluoride availability</li> <li>♦ VAT on oral health products</li> </ul> Local <ul style="list-style-type: none"> <li>♦ Local commitment to oral health initiatives such as Fluoride availability</li> <li>♦ Research opportunities within Glasgow</li> </ul>	<ul style="list-style-type: none"> <li>♦ Communication with SE regarding specific oral health issues</li> <li>♦ Agreed partnership actions with Local Authorities in Joint Health Improvement Plans (JHIP) an Integrated Childrens Service Plans (ICSP)</li> </ul>	A

**STRATEGIC AIM:** TO IMPROVE ORAL HEALTH

**STRATEGIC OBJECTIVE B:** To change attitudes and culture

Ref	Action Areas	Outcomes	Key elements	Performance measure	Funding implication
B 1	Establish local partnerships to support Oral Health activity across different life-stages in local venues and services.	Development of oral health action in wider range of settings and services to support oral health at different ages	<ul style="list-style-type: none"> <li>• Extension of OHAT partnerships for pre-fives and pre-threes</li> <li>• Development of partnerships for older children</li> <li>• Development of partnerships adults of working age</li> <li>• Development of partnerships for older people</li> </ul>	Evidence of local structures and partnership working	B
B 2	Develop local programmes to promote the development of lifeskills and facilitate the opportunity for healthier choices	Development and roll-out of evidenced based health promotion interventions and services in the context of local needs to support lifeskills and health behaviours and facilitate awareness, accessibility, affordability and availability of a healthy diet.	<ul style="list-style-type: none"> <li>• weaning initiatives “<i>First Foods</i>”</li> <li>• toothbrush distribution “<i>Get Brushing</i>”</li> <li>• milk token initiative development “</li> <li>• Community fruit &amp; vegetable initiatives</li> <li>• “<i>Get Shopping</i>”</li> <li>• “<i>Get Cooking</i>”</li> <li>• Smoking cessation</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> <li>• Support smoking cessation</li> </ul>	C
B3	Develop an information and communication strategy underpinned by local needs assessment to raise awareness of oral health in communities	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.	<ul style="list-style-type: none"> <li>• Local community based campaigns</li> <li>• Targeted activity</li> <li>• Links to national campaigns ( if possible)</li> </ul>	Evidence of: <ul style="list-style-type: none"> <li>• Needs assessment</li> <li>• Local communication strategies</li> <li>• Public health education/ information materials</li> <li>• Increased awareness of oral health initiatives and Knowledge/reported behaviour through surveys</li> </ul>	C

B 4	Programme of workforce development to build capacity for oral health	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	<ul style="list-style-type: none"> <li>♦ Implement multi-disciplinary training programme for key professionals (dental and non dental) on oral health promotion and health promotion</li> <li>♦ Implement a training programme for local people to support community capacity building and promote employment opportunities</li> </ul>	Number of <ul style="list-style-type: none"> <li>• No. of lay people trained</li> <li>• No of dental Professionals trained</li> <li>• No of non dental professionals trained</li> <li>• Primary care updates on oral health</li> <li>• Range of training delivered</li> </ul>	D
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STRATEGIC AIM: TO IMPROVE ORAL HEALTH

STRATEGIC OBJECTIVE C: To target priority groups - parents and children

Ref	Action areas	Outcomes	Key elements	Performance measure	Funding implication
C 1	Champion oral health through Children's Services Planning to gain formal commitment to oral health	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.	<ul style="list-style-type: none"> <li>• Development of links to General Dental service through OHATs and School Health Service</li> <li>• Inclusion of oral health risk factors when implementing Hall 4.</li> <li>• Development of oral health models of practice within Integrated community Schools and learning communities</li> <li>• Development of a dedicated children's dental service in areas of deprivation and service gaps</li> <li>• Ensure oral health continues to be an integrated development within Starting Well roll out</li> <li>•</li> </ul>	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>• <b>Fluoride toothpaste distribution</b></li> </ul>	C
C 2	Continued development of OHAT community based approach to oral health and implementation of the oral Health strategy on a local basis.	Local communities should be empowered to undertake action to support healthier lifestyles through skills development and capacity building	<ul style="list-style-type: none"> <li>• Explicit targeting of most socially excluded in deprived communities inc. New parents</li> <li>• Increased targeting of work with antenatal mothers</li> <li>• Increased targeting of work with parents and carers of pre-threes</li> <li>• Local capacity building through training 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>	OHAT action plans OHAT monitoring & evaluation framework Oral Health Epidemiology Evidence of <ul style="list-style-type: none"> <li>• initiatives to target most vulnerable groups, pre3, antenatal mothers</li> <li>• initiatives targeting deprived areas, fluoride, diet</li> <li>• capacity building –number of volunteers/ sessional staff/ training participants</li> <li>• localized initiatives with strong community development process</li> </ul>	C
C 3	Continued development of OHATs	Locally developed action to support oral	<ul style="list-style-type: none"> <li>• Development of oral health</li> </ul>	Evidence of:	C/D

	to address the needs of older children	health strategy and met needs of older children.	models of practice within Integrated community Schools and learning communities	<ul style="list-style-type: none"> <li>Evaluated models to target older children through OHATs</li> </ul>	
C 4	Enhanced links between OHATS and School Health Service and Dental services.	Access to preventative dental treatment and care for children.	<ul style="list-style-type: none"> <li>Development of a dedicated children's dental service in areas of deprivation and service gaps to improve accessibility to preventative treatment and restorative care</li> </ul>	Evidence of: <ul style="list-style-type: none"> <li>Structured links between OHATS and SHS</li> <li>Treatment plans targeting school children</li> <li>Links between NDIP and care plans</li> </ul>	C/D
C 5	Ensure oral health is a priority when implementing Hall 4 guidance and the risk assessment of vulnerable families.	Develop public health role of child health professionals to include oral health	<ul style="list-style-type: none"> <li>Inclusion of oral health risk factors when implementing Hall 4.</li> <li>Integration of oral health within Starting Well roll-out</li> </ul>	Service specifications & job/role descriptions include oral health CHP health improvement plan	A
C6	Establish tooth brushing programmes as core practice within education setting.	Established tooth brushing programmes, in every nursery, breakfast club and the primary school in deprived area	<ul style="list-style-type: none"> <li>Local Authority commitment</li> <li>Brushing programmes</li> <li>Distribution programmes</li> </ul>	Number of <ul style="list-style-type: none"> <li>Brushing programmes</li> <li>Children participating</li> </ul>	B

**STRATEGIC AIM: TO ENHANCE DENTAL SERVICES**

**STRATEGIC OBJECTIVE D: To tackle inequalities in access / Target Vulnerable Groups**

Ref	Action areas	Outcomes	Key elements	Performance measure	Funding implication
D1	Establish primary care dental treatment centre at Glasgow Dental Hospital	Access to emergency dental care for unregistered patients	<ul style="list-style-type: none"> <li>♦ Emergency Dental treatment</li> <li>♦ Salaried GDP service</li> </ul>	<ul style="list-style-type: none"> <li>♦ No. of patients treated</li> </ul>	<b>A (D)</b>
D2	Develop a premises strategy to ensure availability and accessibility of services including compliance with disability discrimination legislation	Provide dental surgeries within modern primary health care facilities	<ul style="list-style-type: none"> <li>♦ Modernise dental facilities in Pollok and Springburn</li> <li>♦ Dental Practice Improvements</li> <li>♦ Local enhancements to support services</li> <li>♦ Address accessibility issues</li> </ul>	<ul style="list-style-type: none"> <li>♦ No of additional patients treated</li> <li>♦ No. of additional appointments available</li> <li>♦ % of dental premises compliant with DDA</li> </ul>	<b>C/D</b>
D3	Identify the oral health needs and action for people with addictions	Improved oral health and dental services	<ul style="list-style-type: none"> <li>♦ Needs Assessment</li> </ul>	<ul style="list-style-type: none"> <li>♦ Recommendations from needs assessment</li> </ul>	<b>A</b>
D4	The development of an action plan for oral health and dental services for Homeless people	Improved oral health and dental services designed to meet needs of different client groups e.g., homeless individuals and families	<ul style="list-style-type: none"> <li>♦ Action plan in conjunction with Homeless PIG</li> <li>♦ Establish a salaried service for homeless people by appointing salaried general dental practitioners</li> </ul>	<ul style="list-style-type: none"> <li>♦ Action plan developed</li> <li>♦ No. of target population treated</li> </ul>	<b>A (D)</b>
D5	Implement oral health actions in response to the Looked After and Accommodated Children (LAAC) health needs assessment .	Improved oral health and dental services through development of care pathways for LAA Children	<ul style="list-style-type: none"> <li>♦ Pilot project to develop care pathway</li> <li>♦ Development of a training and support programme for LAAC team</li> </ul>	<ul style="list-style-type: none"> <li>♦ No of care homes in pathway</li> <li>♦ No of staff Trained</li> </ul>	<b>B</b>
D6	Development of services to reduce anxiety within patients and carers of children	Improved oral health and dental services	<ul style="list-style-type: none"> <li>♦ Child friendly / early registration schemes</li> <li>♦ Sedation services</li> </ul>	<ul style="list-style-type: none"> <li>♦ No of child friendly GDP services</li> </ul>	<b>C</b>
D7	Development of care pathways for children with special physical and educational needs	Improved oral health and dental services	<ul style="list-style-type: none"> <li>♦ Treatment and oral hygiene services</li> <li>♦ Integrated model with Child Development Centres</li> </ul>	<ul style="list-style-type: none"> <li>♦ Care pathway established</li> </ul>	<b>C</b>

D8	Identify the oral health needs and review provision of dental services for adults with special physical and educational needs inc. sensory impairment 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>	Improved oral health and dental services through access to appropriate screening and treatment	<ul style="list-style-type: none"> <li>• Needs assessment</li> <li>• Medical care settings</li> <li>• Residential Homes</li> <li>• Rehab. Units</li> <li>• Wider DDA approach</li> <li>• Service access</li> <li>• Communication needs</li> <li>• Collaboration with other planning groups</li> </ul>	<ul style="list-style-type: none"> <li>• Recommendations from needs assessment</li> <li>• No. of patients screened and treated</li> <li>• No. of patients excluded/unable to access service</li> </ul>	<b>A</b>
D9	Review provision of dental services for asylum seekers and refugees, and develop action plan	Detailed needs assessment data obtained about population group	<ul style="list-style-type: none"> <li>• Service availability and appropriateness</li> </ul>	<ul style="list-style-type: none"> <li>• No. of asylum seekers accessing services</li> </ul>	<b>C/D</b>
D10	Address the needs of BME groups within core health improvement and service delivery developments	Integrated approach to meet needs of BME groups	<ul style="list-style-type: none"> <li>• Mainstreamed approach to oral health of BME groups</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of:</li> <li>• BME inclusive activity and approaches</li> <li>• Tailored resources</li> </ul>	<b>B</b>
D11	Develop and implement a comprehensive action plan for improving the oral health of older people.	Development of a comprehensive action plan for older peoples oral health services maximising opportunities for oral health promotion to promote improved quality of life for older people	<ul style="list-style-type: none"> <li>• Needs assessment and audit of services for older people <ul style="list-style-type: none"> <li><i>House bound</i></li> <li>Care homes</li> <li>Frail elderly</li> <li>Community care centres/ services</li> <li>Mouth cancer screening</li> </ul> </li> <li>• Oral health assessment and longer term treatment planning for individual patients</li> <li>• Establish oral health assessment and treatment in care homes</li> <li>• Development of action plan in conjunction with older people's PIG</li> <li>• Provide training on oral hygiene for care providers</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Recommendations from needs assessment</b></li> <li>• Action plan developed</li> <li>• No. of patients accessing services</li> </ul>	<b>C/D</b>

STRATEGIC AIM: TO ENHANCE DENTAL SERVICES

STRATEGIC PRIORITY E: To emphasise prevention

Ref	Action areas	Outcomes	Key elements	Performance measure	Funding implication
E 1	Introduce clinical pathway of care for children with comprehensive clinical prevention and care	Integrated clinical pathway of care with minimised risk to patients	<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> <li>♦ Post-GA follow up prevention for high risk children</li> <li>♦ Revised referral protocols to secondary care</li> </ul>	<ul style="list-style-type: none"> <li>♦ No. of child dental general anaesthetics</li> <li>♦ No. of adverse incidents associated with dental general anaesthesia</li> <li>♦ No. of repeat general anaesthetics</li> <li>♦ Reduced DMFT/dmft in P1 and P7 children</li> <li>♦ Increased % caries free children</li> </ul>	C/D
E 2	Promote greater emphasis on prevention in the GDS through a revised GDS contract to achieve oral health gain	Dental practices to be rewarded for additional focus on prevention	<ul style="list-style-type: none"> <li>♦ health needs assessment</li> <li>♦ adherence to clinical protocols</li> </ul>	<ul style="list-style-type: none"> <li>♦ Local health gain targets</li> <li>♦ Audits of health needs assessments an clinical protocols</li> <li>♦ Revision of GDS contract</li> </ul>	A
E 3	Undertake oral health improvement training programme	Trained and effective workforce acting within clear evidence based guidelines	<ul style="list-style-type: none"> <li>♦ Oral health improvement training programme for dental workforce</li> <li>♦ Training programme for primary health care professionals</li> </ul>	Numbers of <ul style="list-style-type: none"> <li>• Dental hygienists</li> <li>• Dental nurses</li> <li>• Dentists</li> <li>• Primary care staff</li> <li>• Secondary care staff</li> <li>• Residential care staff</li> </ul> trained in local protocols and guidelines <b><i>No. of medical practices who include oral health within chronic disease management</i></b> No of secondary care/residential services with dental referral protocols	

**STRATEGIC AIM: TO ENHANCE DENTAL SERVICES**

**STRATEGIC PRIORITY F: To develop a mixed economy for service provision**

Ref	Action areas	Outcomes	Key elements	Performance measure	Funding implication
F1	Adoption of a mixed economy approach to service provision.	Creation of a committed dental workforce to provide a comprehensive programme of preventative and restorative care for our community including a range of dental and other professionals.	<ul style="list-style-type: none"> <li>♦ Practice linked prevention and oral health promotion for children</li> <li>♦ Screening and treatment for older people</li> <li>♦ Tailored services for vulnerable groups</li> <li>♦ Care for medically compromised patients (primary and secondary care)</li> </ul>	<p><b>Number of:</b></p> <ul style="list-style-type: none"> <li>♦ Additional services</li> <li>♦ Medical practices who include oral health within chronic disease management</li> </ul>	<b>C/D</b>
F2	Development of an unified salaried service	Increased dental service capacity within Greater Glasgow to support the implementation of the strategy. Modification of national NHS funding for dentistry more towards deprivation and unmet needs	<ul style="list-style-type: none"> <li>♦ Local incentive scheme for dentists to support the implementation of the strategy</li> <li>♦ Development off specialist services for vulnerable groups</li> <li>♦ Increased employment of salaried dental staff</li> <li>♦ Equitable allocation of GDS non cash limited funds by Scottish Executive</li> </ul>	<p>Number of:</p> <ul style="list-style-type: none"> <li>♦ sessional payments</li> <li>♦ Service developments with Salaried GDPs, dental therapists and hygienists</li> <li>♦ specialist services established</li> </ul> <p>Increase in expenditure on dental services in Greater Glasgow</p>	<b>C/D</b>
F3	Promote the introduction of a Personal Dental Service model in Scotland	Adoption of PDS model as national policy	<ul style="list-style-type: none"> <li>♦ Services to meet local needs</li> </ul>	Setting up of a PDS in Greater Glasgow	<b>A</b>
F4	Complete a local workforce planning exercise to recruit and retain adequate numbers and skill mix of dental professionals.	A modern workforce that meets future needs with appropriate knowledge and skills and cost effective clinical skill mix to achieve health gain	<ul style="list-style-type: none"> <li>♦ Continued development of education and training in GDHS.</li> <li>♦ Employment strategy to retain local trainees inc. PCDs</li> <li>♦ Influence training of non dental professionals</li> <li>♦ Development of local research opportunities involving all care sectors and the University Dental School</li> </ul>	<p><b>Numbers/ vacancies/trainees (per 1000 Population) of</b></p> <ul style="list-style-type: none"> <li>♦ dentists</li> <li>♦ dental therapists</li> <li>♦ dental hygienists</li> <li>♦ dental nurses</li> <li>♦ Local trainees employed locally</li> <li>♦ Number of dental professionals involved in research projects</li> <li>♦ No. of research projects in primary and secondary care</li> </ul>	<b>B</b>

STRATEGIC AIM:

TO ENHANCE DENTAL SERVICES

STRATEGIC PRIORITY G:

To improve quality of dental services

Ref.	Actions	Outcomes	Key Elements	Performance measure	Funding implications
G 1	Continuous development of the dental team	Enhanced contribution of all members of dental teams Improved team working to facilitate implementation of guidelines and protocols in line with strategy	<ul style="list-style-type: none"> <li>♦ programmes of team training with protected learning time</li> <li>♦ <b>role clarification and role definition within dental teams</b></li> <li>♦ continue support use of performance appraisal in general dental practice</li> <li>♦ personnel in all care sectors have Personal Development Plans</li> <li>♦ Training programme for dental services in NHS Greater Glasgow</li> </ul>	<ul style="list-style-type: none"> <li>♦ No. of training interventions organized</li> <li>♦ Proportion of practice staff participating</li> <li>♦ No of practices with appraisal systems in place</li> <li>♦ Evidence of PDPs</li> </ul>	C
G2	Develop effective quality assurance mechanisms and assure safer services	Sharing of good practice and raising standards of care to promote improved quality of patient care and minimise risk to patients and health care practitioners /staff	<ul style="list-style-type: none"> <li>♦ dissemination and implementation of clinical guidelines and protocols which emphasise evidence-based practice</li> <li>♦ introduction of quality assurance systems and accreditation processes</li> </ul>	<ul style="list-style-type: none"> <li>♦ Proportion of practices/clinics implementing guidelines</li> <li>♦ Proportion of practices and clinics achieving respective awards (IIP or QPI)</li> <li>♦ No of adverse incidents and near misses</li> <li>♦ No of complaints and litigation cases</li> </ul>	B/C
G3	Promotion and support of clinical governance through structured programmes	Sharing of good practice and raising standards of care pro-active and preventative approach to poor performance. Reduced risk to patients and managed risk to NHS	<ul style="list-style-type: none"> <li>♦ clinical effectiveness programmes</li> <li>♦ clinical audit</li> <li>♦ peer review</li> <li>♦ Establish a local performance review system to support dental professionals whose performance is sub-optimal</li> </ul>	<ul style="list-style-type: none"> <li>♦ No of audits conducted</li> <li>♦ No of dental professions accessing support system</li> <li>♦ No of professionals undertaking retraining</li> </ul>	B/C
G4	To maximize the use of IT in relation to general dental practice by leading project planning and implementation groups in line with national IM&T policy	Increased effectiveness of dental services	<ul style="list-style-type: none"> <li>♦ Improved communication</li> <li>♦ Implementation of learning from critical incident reviews and other intelligence</li> <li>♦ Access to research &amp; sharing of best practice</li> <li>♦ Access to education materials</li> </ul>	<p>Number of practitioners linked to the NHS net, electronic booking and referral systems</p> <p>No of IT developments in progress</p>	D

			♦ Patient admin and referral processes		
G6	Design more locally sensitive booking systems	Less failed appointments	♦ investigate barriers to dental attendance	Do not attend (DNA) rates	C/D
G7	Engage meaningfully with patients and communities in the planning, delivery and scrutiny of health services	Active participation in the development of oral health strategy through consultation and implementation. Collaborative and integrated planning of services which reflect and respond to local needs Clarity on patients' rights and obligations	<ul style="list-style-type: none"> <li>• Support and empower NHS staff to promote public involvement within existing dental services</li> <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>	<p>Evidence of use of feedback on the patient/community experience in planning, design and delivery of dental services</p> <p>Dental representation on CHPs</p> <p>No of stakeholder events organised</p> <p>Number of</p> <ul style="list-style-type: none"> <li>• area-wide and local partnerships progressing strategy</li> <li>• partnership actions undertaken</li> <li>• Feedback report from consultation</li> </ul>	C

STRATEGIC AIM: TO ENHANCE DENTAL SERVICES

STRATEGIC PRIORITY H: To develop specialist services

Ref	Action areas	Outcomes	Key elements	Performance measure	Funding implication
H 1	Review oral and maxillofacial surgery services	A sustainable and accessible inpatient and out patient service	<ul style="list-style-type: none"> <li>♦ Regional planning</li> </ul>	<ul style="list-style-type: none"> <li>♦ Implementation of review recommendations</li> </ul>	<b>A</b>
H 2	Design a new Dental Hospital and School	To open a modern GDHS after 2011 offering research, teaching and treatment	<ul style="list-style-type: none"> <li>♦ Identification of site</li> <li>♦ Consultation with stakeholders</li> <li>♦ Capital plan</li> </ul>	<ul style="list-style-type: none"> <li>♦ Implementation plan outcomes</li> </ul>	<b>D</b>
H3	Ensure that waiting times for specialist dental services meet national targets	No patient waiting longer than 6 months at December 2005 for any dental specialty	<ul style="list-style-type: none"> <li>♦ Review waiting lists and referral protocols</li> </ul>	<ul style="list-style-type: none"> <li>♦ Number of patients waiting and length of wait by specialty</li> </ul>	<b>D</b>
H 4	Relocate all child dental GA services to Yorkhill		<ul style="list-style-type: none"> <li>♦ implementation of relocation plan by 2008 or earlier</li> </ul>	<ul style="list-style-type: none"> <li>♦ Implementation plan outcomes</li> </ul>	<b>A/C</b>
H 5	Incorporate dental services into new Ambulatory Care and Diagnostic (ACAD) hospitals	ACAD facilities become part of comprehensive dental service	<p><b><i>Inclusion of :</i></b></p> <ul style="list-style-type: none"> <li>♦ facilities for oral surgery</li> <li>♦ services for out of hours</li> <li>♦ emergency treatment</li> <li>♦ older peoples service in plans for new ACADs</li> </ul>	<ul style="list-style-type: none"> <li>♦ Implementation plan outcomes</li> </ul>	<b>C</b>

**IMPLEMENTATION: Action implications**

<b>Ref</b>	<b>Action areas</b>	<b>Outcomes</b>	<b>Key elements</b>	<b>Performance measure</b>	<b>Funding implication</b>
I 1	Dental input to LHCCs/CHPs	Oral health integrated within planning process Enhanced contribution of dental teams in health improvement	♦ <b>GDS planning role</b>	No of • CHP plans with explicit dental or oral health priorities CHP Patient Referral Pathways	<b>C</b>
I 2	Management of a comprehensive performance assessment framework for oral health	Performance management across the strategy	♦ <b>National frameworks</b> ♦ <b>Quality indicators</b> ♦ <b>National targets</b>	♦ <b>National PAF indicators</b> ♦ <b>Service indicators</b> ♦ <b>Related health indicators</b> ♦	<b>A</b>
I 3	Financial planning to support strategy implementation	Rigorous financial framework to underpin developments	♦ <b>Appropriate resource deployment</b> ♦ <b>Capital and revenue submissions</b> ♦ <b>External funding sources</b>	<b>Changes within investment profile for oral health</b>	<b>A</b>

## **SECTION TWELVE**

### **FURTHER INFORMATION**

If you would like to receive a further paper or an electronic copy of the **full strategy or have any queries regarding its implementation or any other oral health issue**, please contact:

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## Annex 1

### Oral Health Strategy:

#### List of Responders

1	Kay Allan	Retired
2	Ken Stephen	Professor of Dental Public Health, University of Glasgow
3	Bobby Jones	West Dunbartonshire Council
4		Various Health Promotion staff
5		Camglen LHCC OHAT
6		Capital Monitoring Group
7		SW LHCC
8		OHAT Westone/Riverside LHCC
9	Maclean Currie	General Manager, North Glasgow & Maryhill/Woodside LHCC
10		North Glasgow and Maryhill/Woodside LHCC
11		GCC Joint Childrens Service Planning Group
12	Anon	
13	Alice Docherty	Glasgow Homeless Partnership
14		Nurseries (SW LHCC)
15		Clydebank, ABM and Strathkelvin LHCC
16	Brenda Doyle	Child and Family Services/Childrens Service Planning
17	Dr F Angell	Greater Glasgow Area Dental Committee
18	Sheila LM Gibson	MD, BSc, MF Hom
19	Tony Coia	GP Sub Committee of ADC
20	Chloe Stewart	Library and Learning Centre Manager, Stobhill Hospital
21	Lyndsay Ovenstone	BDS MPH
22	Anon	
23	Maureen Moodie	Dental Therapist
24	Nina Hutchison	Users Committee of Focal Point Day Centre
25	T Huntingford	West Dunbartonshire Health Improvement and Social Justice Committee
26		South Lanarkshire Council
27	John Womersley	Consultant in Public Health, Greater Glasgow NHS Board
28	Kirsty Scott	Eastbank Health Promotion, Smoking Cessation
29	Lynn Jackson	Black and Ethnic Minority Groups
30	Dr RR Welbury/Dr MT Hosey	Paediatric Dentistry, University of Glasgow Dental School
31	Bobby Jones	West Dunbartonshire Partnership
32	Andrene Belgrove	NHS Forth Valley
33	Kay Allan	
34	Rosemary Broad	General Dental Practitioner
35	Martha Wardrop	Martha Wardrop
36	Ann McClumpha	Allied Health Professions Committee
37	Anne Lee	Integration Co-ordinator, East Dunbartonshire Council
38	Isabel Diamond	Eastern LHCC Exec
39	Susan Toal	South East Glasgow LHCC

40	Katrina MacFarlane	Greater Shawland and Eastwood LHCC
41	Kerry McKenzie	East Renfrewshire Council
42	Sandra Billington	
43	Susan Toal	Local community event
44		Greater Pollok SIP
45	Olivia Cornacchia	Greater Glasgow Area Partnership Forum
46	Ian B Watson	Dental Staff Association of Glasgow Dental Hospital and School
47		Deaf Connections
48	Ray McAndrew	
49	Jennifer Rodgers	NHS Argyll and Clyde Public Health
50		Senior DSA, Community Dental Services, Pollok Health Centre
51	Lucy Reynolds	Consultant paediatrician, Glanfarg CDC, Possilpark Health Centre
52	Dr Lorna Macpherson	Senior Lecturer/Hon. Consultant in Dental Public Health, Glasgow Dental Hospital and School
53		Maryhill/Woodside LHCC Oral Health Action Team
54	Diana Morgan	Community Dental Staff
55	Anon	
56	Les W Callaghan	Dumfries & Galloway NHS Board
57	Dr Kath Leyland	Consultant Paediatrician, Community Child Health
58	Irene McKie	Strategic Planning, NHS Lanarkshire
59	Jan Cresswell	Senior Health Promotion Officer, NHS Greater Glasgow
60	Dr Jean Hannah	Nursing Homes Care Team
61	Dr Alison Rennie	Consultant Paediatrician, Southbank Child Centre
62		Pollok/Cardonald Public Health sub group
63	Dr Martin Bartos	Glasgow Branch of the Scottish Green Party
64	Sheona Brown	Supervisors of Midwives within GGNHSB Local Supervising Authority
65	Anne Muir	Bridgeton/Dennistoun & Eastern LHCC
66	Dr Ian B Watson	Consultant, Department of Prosthodontics, Glasgow Dental Hospital and School
67	Carrie Green	Strathkelvin OHAT
68		Westone/Riverside LHCC OHAT
69		Westone/Riverside LHCC OHAT
70	Pamela Ralphs	Physical and ABI Planning and Implementation Groups
71	Mr. A Main	Mr. A Main
72	May Bonnar	May Bonnar
73	Marie McHenry	Glasgow City Council, Policy and Resources (Community Safety and Health) Sub Committee
74	Robert Broadfoot	Glasgow Asylum Seeker and Refugee support group
75	Jackie Hale	Flora Muir - Multicultural Team
76	Carole Hunter	Glasgow Addiction Service
77	Jan Whyte	Glasgow City Older Peoples PIG
78	Jan Whyte	Adult Mental Health Services
79	Susan Fotheringham	Public Health Nurse - Schools SE Glasgow