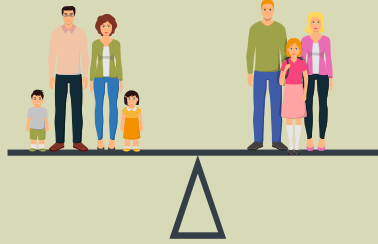


Oral Health Improvement Plan



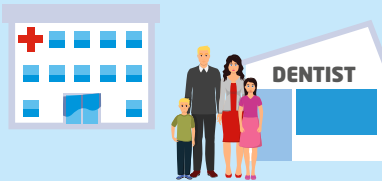
Focus on
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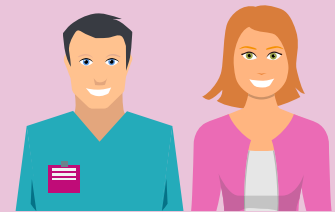
Reducing
Oral Health
Inequalities



Meeting the Needs
**of an Ageing
Population**



More Services
on the
High Street



Improving Information
For Patients



Quality Assurance
and Improvement



Workforce



Finance



**Healthier
Scotland**
Scottish
Government



Section Contents

Ministerial Foreword

1. Policy Statement

Oral Health and General Wellbeing
Guiding Principles

2. Focus on Prevention

Moving to a Preventive Based Approach
Water Fluoridation
Ensuring the Childsmile Programme in All Age Groups
New Preventive Care Programme for Adults
Basic Check-Ups
Periodontal Care (Gum Disease)
General Health Checks for Adults

3. Reducing Oral Health Inequalities

Community Development
Community Challenge Fund
Deprivation Payments to Dental Practices
Priority Groups

4. Meeting the Needs of an Ageing Population

New Domiciliary Care Provision
Care Homes
People in their Own Home
Health and Social Care Partnerships (HSCPs)

5. More Services on the High Street

Practitioners with Enhanced Skills
Oral Cancer Pathways
Specialist Orthodontic Practices

6. Improving Information for Patients

Simplifying Items of Service



7. Quality Assurance and Improvement

Professional Leadership and Strategic Oversight at Board Level
Applicants Listing to Deliver NHS General Dental Services
Safe Delivery of NHS Dental Services
Monitoring of Clinical Quality
Scottish Dental Practice Board (SDPB)
Assurance that Service Providers are Safe and Effective
Improvement Activity is Evidence-Based and Data-Driven
National Framework

8. Workforce

Skill Mix and Direct Access to Dental Care Professional (DCPs)
Remote and Rural Areas
EU Citizens (Brexit)
Out of Hours Care
General Dental Practitioner Fellowship Programme
Protected Learning Time
Occupational Health
Widening Access to University

9. Finance

Payments to General Dental Practitioners/Dental Practices
Payment Verification
Financial Management/Health and Social Care Partnerships
Patient Charges

10. Conclusion and Next Steps

Workstreams
Regular Updates from the Chief Dental Officer
Roadshows
Young Dentists, EU Dentists and Remote and Rural Dentists
Patient Forum
General Evening Events

Summary of Commitments

Glossary



Ministerial Foreword



Introduction

Let me introduce you to Scotland's Oral Health Improvement Plan (OHIP). The purpose of this document is to provide the strategic framework for improving the oral health of the next generation.

Regardless of age, the impact of a healthy mouth on general health is significant. In children it can mean the difference between regular attendance at school or not. For older people not only can there be an increase in oral cancer, poor oral health can affect their ability to eat, speak and socialise.

As you may be aware we have been on a journey for some time now that began with the publication of our initial consultation exercise in September 2016.

During this period, we have had the opportunity to engage with members of the public and a wide range of professionals. The consultation exercise has helped shape our thinking on what to include within the Plan and we would like to reiterate our thanks to everyone who took part in this process.

Preventive Care Pathway

As the oral health of the population improves there are new challenges in taking forward NHS dentistry. The system at present is mainly about restorative services provided to patients by General Dental Practitioners (GDPs), while our focus in the future must be to encourage a more prevention-based provision recognising the benefits of anticipatory care.

To do this we will introduce a preventive care pathway and an Oral Health Risk Assessment (OHRA). In time, all adult patients will receive an OHRA on a regular basis with intervening reviews between assessments. Each patient will receive a personalised care plan based on an assessment of the level of risk to their oral health.

Oral Health Inequalities

We also need to find innovative ways to tackle oral health inequalities in Scotland, recognising first and foremost that we need to enable people to have more health promoting behaviours. Despite the considerable success of the Childsmile programme in improving the oral health of young children through intervention by health visitors, education staff and dental teams, it remains particularly difficult to achieve good oral health in some of our most deprived communities in Scotland.

We want to supplement the Childsmile programme with community-led initiatives supported by a Challenge Fund, which will allow our partners in the third sector to bid for resources for projects aimed at supporting communities to improve their oral health. The Childsmile programme will continue to expand and we also intend to change the payment arrangements to GPs to ensure that older children and young people receive sufficient levels of preventive care.

Ageing Population

We also need to recognise that the population of Scotland is ageing, presenting new challenges that we have to meet. More older people have their own teeth than we have ever seen before. While many people continue to see their dentist on a regular basis, this changes when they become housebound and have to rely on domiciliary care services. We face particular challenges in ensuring that residents of care homes also continue to receive regular effective dental care.

As a first step, the new domiciliary care arrangements will enable an accredited practitioner to be assigned to a care home to provide routine preventive oral health care to care home residents. These practitioners will work in partnership with care home staff to ensure the maintenance of good oral health and hygiene. It is also important at this stage to acknowledge the complementary role provided by the Public Dental Service (PDS) in providing domiciliary care, and we envisage that this role will continue.

Conclusion

Continuing to improve the oral health of the population and providing high quality NHS dental services in the years to come will require the involvement of all parts of our society. We will depend on our dental workforce and Health and Social Care Partnerships (HSCPs) working together with local communities in order to achieve a joined up approach.

We need to be ambitious but at the same time realistic and we will need time to implement the changes required. We recognise that change can cause uncertainty for patients and service providers. We are therefore committed to a pace of change that balances the need to make progress but does not jeopardise the substantial achievements we have made to date nor the sustainability of practices.

I look forward to working together to realise our ambitions as set out within this plan.



Shona Robison

Cabinet Secretary for Health and Sport

Policy Statement



Introduction

This document follows the publication of the consultation exercise in September 2016 which set out the current landscape in NHS dentistry and included a number of proposals for the future direction of the policy.

As part of the consultation exercise there was a period of stakeholder engagement through a consultation questionnaire, roadshows for professionals and focus groups for the public. Each of these exercises proved invaluable in helping to identify the priorities for the future. The analysis of the consultation exercise was published in June 2017.

Both the consultation document and the analysis can be found at: <https://consult.scotland.gov.uk/dentistry-division/oral-health-plan/>

Oral Health and General Wellbeing

Our consultation exercise confirmed that patients were aware of the link between oral health and general wellbeing. During the patient focus groups it was acknowledged that “good oral health can impact on a number of issues depending on existing conditions or illnesses.”¹

It is important to consider how we can take NHS dentistry forward in a way that will not only improve oral health but will also contribute to improvements in the general health of the population. The first section of this document, ‘Focus on Prevention’, highlights the need for a shift from restorative to preventive dentistry, which was well supported during the consultation exercise.

The World Health Organisation recognises that “The interrelationship between oral and general health is proven by evidence.”² Improvements in oral health cannot be achieved solely by providing dental services. It is important we tackle the broader issues which impact on poor oral health such as diet, smoking and alcohol intake. These issues were all recognised by respondents of the consultation as being factors which significantly contribute to an individual’s oral health.

The Scottish Government has made progress in addressing the challenges associated with alcohol, smoking and diet. We recognise however, there is still work that can be done. The 2016 Scottish Health Survey noted that “As a modern, developed society, Scotland faces substantial challenges to public health as a result of lifestyle behaviours and social-cultural norms that counteract positive health choice making amongst the population.”³

- 1 The Scottish Health Council, Oral Health in Scotland. Gathering views on the Future of Oral Health in Scotland http://www.scottishhealthcouncil.org/publications/gathering_public_views/oral_health.aspx
- 2 World Health Organisation, Oral Health Policy Basis, http://www.who.int/oral_health/policy/en/
- 3 The Scottish Government, The Scottish Health Survey, <http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey>

The Scottish Government will be publishing strategies on alcohol, smoking and diet, and it will be important for oral health to feature.

Action 1: The Scottish Government will ensure oral health is featured in future strategies on alcohol, smoking and diet.

The First Minister's Programme for Government 2017 included a commitment to establish a national population health improvement body by 2019.⁴ We want this body to be mindful of the importance of good oral health and our intention is to work with them to help us achieve our goal of improving oral health.

Action 2: The Scottish Government will ensure the new population health improvement body to be established by 2019, recognises dentistry and improving oral health as a priority.

Guiding Principles

Our main aim is to achieve good oral health for the whole population. To achieve this outcome, we will be guided by the following principles:

Effective policy making relies on strong evidence. An evidence-based approach may be defined as “helping people make well informed decisions about policies, programmes and projects by putting the best available evidence... at the heart of policy development and implementation.”⁵

Since the publication of the consultation analysis we have engaged with a number of experts who have helped us identify the current evidence and consider how it should be applied to the future development of policy on NHS dentistry and improving oral health.

We believe that everyone deserves to have good oral health. The World Health Organisation recognises that “Oral health means more than good teeth; it is integral to general health and essential for wellbeing.”⁶ Poor oral health affects overall health, nutrition, quality of life, communication and appearance. Our ambition is that this plan will make a significant contribution towards improving people's oral health.

4 The Scottish Government, 'A Nation with Ambition: The Government's Programme for Scotland 2017 - 18', <http://www.gov.scot/Publications/2017/09/8468>

5 Davies, 'What is evidence based education?', British Journal of Educational Studies, 47,2, pp 108-121

6 World Health Organisation, Oral Health Policy Basis, http://www.who.int/oral_health/policy/en/



In reducing health inequalities we will take a proportionate universalism approach. Proportionate universalism is defined as “the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.”⁷

GDPs will continue to be the mainstay for the provision of NHS dental care. For 70 years, since the beginning of the NHS, GDPs have delivered the majority of NHS provision and contributed hugely to the improvement in the oral health of the nation. They will continued to be complemented by the Hospital Dental Service (HDS) and the PDS.

Scotland is a country of diverse geographies and socio-economic mix. The co-ordination and delivery of NHS dental services in remote and rural areas and deprived communities both have unique challenges. Addressing these challenges will require solutions which are appropriate to the needs of these areas and communities.

The solutions require everyone to be involved. We will be working with dental teams, third and independent sector organisations, schools, councils and HSCPs to ensure we take a holistic approach to the challenges we need to address.

⁷ Marmot, M, 'Fair society, healthy lives: the Marmot Review: strategic review of health inequalities' in England post - 2010, <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf>

2

Focus on Prevention



Moving to a Preventive Based Approach

Dental disease is almost entirely preventable so it makes absolute sense to focus our future policy direction on designing a system that encourages a more preventive approach to oral health care for patients of all ages. As the opportunity to focus on a preventive approach is recognised, the system providing NHS dentistry needs to change to accommodate it.

Water Fluoridation

Although we recognise that water fluoridation could make a positive contribution to improvements in oral health, the practicalities of implementing this means we have taken the view that alternative solutions are more achievable.

Ensuring the Childsmile Programme in All Age Groups

At present the Childsmile programme of toothbrushing and fluoride varnish application at nursery and primary school is a major factor contributing to its success. Dental practices can provide preventive care as part of the Childsmile programme for children up to 5 years of age. The programme will continue to be evaluated and amended as required.

For older children, aged 6 to 17 years of age, maintaining good oral health depends on good diet, regular toothbrushing and intervention from the dental practice. The good habits learned through the Childsmile programme need to be maintained in older children. We need to ensure preventive care is available to older children in dental practices. Many dental teams are doing an excellent job but we need to ensure consistency of provision across Scotland.

We intend to change payments to dentists to encourage better compliance with preventive care treatments such as toothbrushing instruction, fluoride varnish application and fissure sealants. The system of capitation payments will be supported by monitoring, meaning that the dentist needs to record the completion of these treatments for future payments to be authorised.

Action 3: The Scottish Government will change payments to dentists and introduce a system of monitoring to ensure that all dental practices provide preventive treatment for children.



New Preventive Care Programme for Adults

We intend to introduce a preventive system of care for adults by phasing in an OHRA. The assessment will include a comprehensive clinical examination and a discussion about lifestyle choices, for example diet, alcohol and smoking, and how these impact on the patient's oral health. The patient will receive a personalised care plan in relation to oral cancer, gum disease and decay according to their degree of risk. There will be on-going reviews between assessments.

Action 4: The Scottish Government will introduce an Oral Health Risk Assessment.

Basic Check-Ups

At present, patients can receive a basic check-up every six months. However, six-monthly appointments with the dentist for all patients regardless of their state of oral health are not supported by the clinical evidence.

This is reflected in the National Institute for Health and Care Excellence (NICE) guidelines 'Dental checks: intervals between oral health reviews' which states that "Recall intervals for patients who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease may be extended over time up to an interval of 24 months."⁸


Under the new system of preventive care, patients will be seen according to their OHRA. This may mean that many people will no longer have to attend every six months if they have good oral health and a healthy lifestyle. Patients in poorer oral health with higher risk factors are likely to be seen more frequently.

Periodontal Care (Advanced Gum Disease)

Gum disease is caused by the build-up of plaque on the teeth, which if not removed through regular brushing, can cause the gums to become red, swollen and bleed easily when brushing or eating hard foods. Eventually plaque hardens into a substance called calculus which can make brushing less effective, causing more inflammation.

The mainstay of NHS provision has been a simple scaling and polishing which was thought to prevent gum disease. However, the balance of evidence has now thrown significant doubt on the clinical effectiveness of this approach. The most effective option for routine care is adequate oral hygiene by the patient themselves.

⁸ National Institute for Health and Care Excellence (NICE) 'Dental checks: intervals between oral health reviews', 2004 <https://www.nice.org.uk/guidance/cg19/chapter/1-guidance>



The intention is to move to a new system of dental care and treatment that is more clinically appropriate and evidence-based than at present. For patients with periodontal disease or a high risk of developing it, they will receive a clinically proven programme of periodontal care.

As this will be a significant change for patients and dental practices, we envisage that a substantial period of transition will be required to ensure continuity of provision.

Action 5: The Scottish Government will introduce a clinically-proven programme of periodontal care for patients with periodontal disease and those with high risk of developing it.

General Health Checks for Adults

The dentist is the one health care provider in primary care whom adults consult on a regular basis throughout their lives. As at September 2016, 91% of the Scottish adult population were registered with a dentist and almost three quarters attended in the previous two years.⁹

It may be of benefit to our general practice medical and nursing colleagues if we could harness this patient cohort for routine general health checks to assist in the early detection of long-term chronic diseases, for example diabetes. It will also allow patients to receive advice and treatment on how to manage their health at the earliest opportunity.

Action 6: The Scottish Government will explore the potential for introducing general health checks for adult patients whilst attending for routine dental checks.

⁹ ISD Scotland Dental Statistics – Registrations and Participation, January 2017 <http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2017-01-24/2017-01-24-Dental-Summary.pdf>

Reducing Oral Health Inequalities



The oral health of the population has improved dramatically, though there is still significant adverse impact from poor oral health amongst those living in the most disadvantaged communities.

Community Development

The First Minister's Programme for Government 2017 acknowledged the importance of empowering communities to change behaviours in order to build a fairer society.¹⁰ It is vital that going forward we ensure community-level interventions form a significant part of the overall approach to addressing oral health inequality.

Whilst the role of the dentist and the wider dental team is vital in treating and preventing dental disease; dental treatment and clinical prevention alone will not eliminate oral health inequality. We believe that the key to improving oral health in our most disadvantaged communities lies within the communities themselves.

There is good evidence that community engagement can improve health and wellbeing and is a recognised means of engaging the 'hard-to-reach' groups. This was a view shared by members of the public during the focus groups where it was noted that:

"Education and information sharing should be specifically targeted at individuals and groups most at risk such as those who do not attend regularly for check-ups, communities in low income areas and particularly those people who either smoked or drank heavily."¹¹

We know that there is good work being carried out by third sector organisations across the country, supporting people with long term health conditions. Our approach to improving oral health will seek to learn from this work.

Community Challenge Fund

We intend to introduce a Community Challenge Fund to allow organisations to bid for funding to work in deprived communities and support people to change their oral health behaviours.

This fund will initially be a three-year test of change programme and represents our first step in a significant journey to reduce oral health inequality. We will invite a range of partners, including third sector organisations, to help formulate the approach and agree appropriate outcomes.

¹⁰ The Scottish Government, 'A Nation with Ambition: The Government's Programme for Scotland 2017-18, <http://www.gov.scot/Publications/2017/09/8468>

¹¹ The Scottish Health Council; Oral Health in Scotland: Gathering Views on the Future of Oral Health in Scotland. http://www.scottishhealthcouncil.org/publications/gathering_public_views/oral_health.aspx

Action 7: The Scottish Government will introduce a new three-year Community Challenge Fund for Oral Health Improvement. We will host an event with our partners to help develop the key components of the fund.

Deprivation Payments to Dental Practices

We need to ensure dentists and dental practices continue to provide care to patients in areas of greatest oral health need such as those areas with a high degree of deprivation.

Many payments and allowances at present do not reflect the socio-economic status of patients registered in the practice. To tackle oral health inequality the funding of NHS General Dental Services (GDS) needs to better reflect the different challenges in oral health outcomes between areas of social deprivation and relative affluence.

Action 8: The Scottish Government will ensure that payments for practice-based allowances reflect the social deprivation status of the patients in the practice.

Priority Groups

Since the publication of the previous Dental Action Plan¹² in 2005, significant progress has been made in terms of oral health improvement for those population groups which need additional support such as children and older people. Our 'Caring for Smiles', 'Mouth Matter's and 'Smile4life' programmes have been well received by a wide range of health, social care, local authority, justice and third sector partners.

There are many elements common to these programmes and the Childsmile programme. We must therefore ensure we maximise the effectiveness of all programmes and develop common educational opportunities and partnership working wherever possible.

Action 9: The Scottish Government will establish a single working group to provide a strategic oversight to all national oral health improvement programmes and ensure we maximise our oral health improvement effort.

¹² An Action Plan For Improving Oral Health And Modernising NHS Dental Services In Scotland, Scottish Government, 2005, <http://www.gov.scot/Publications/2005/03/20871/54815>



The mainstay of delivery of NHS dental services for priority group patients, such as people with a disability and those who are homeless, is the PDS. This service will continue to remain at the forefront in the delivery of future dental care to priority groups. The largest group of primary care dentists, however, work in General Dental Services (GDS) as independent contractors in a 'high-street' setting. Wherever possible, people in our priority groups should receive their dental care in practices close to where they live, for example within a 'shared care' arrangement with the PDS providing more complex treatments.

Action 10: The Scottish Government will ensure the PDS actively pursue shared care arrangements with local 'high-street' dental practices.

4

Meeting the Needs of an Ageing Population



Current projections suggest that the population of Scotland will rise to 5.7 million by 2039, with the proportion of people aged 65 and over increasing by 53% between 2014 and 2039.¹³ It is therefore vital we take this into account when planning NHS dental services for the future. We want to ensure that everyone, no matter what their age, can have access to dental care in order to maintain good oral health.

At present one in five of the population of Scotland aged 75 years or more are not registered with a NHS dentist.¹⁴ We have identified a substantial gap in domiciliary care provision, both in care homes and for patients who may be confined to their own homes.

The PDS is currently the main provider for delivering domiciliary dental care to those people resident in a care home or those unable to leave their own home. With the population who are likely to require domiciliary dentistry increasing, it is important that we support GDPs to provide domiciliary care.

New Domiciliary Care Provision

Care Homes

We intend to develop an accreditation scheme for GDPs with the necessary skills and equipment to see patients in care homes. These practitioners and their teams would work with care home staff to ensure adequate preventive care is in place for residents, complementing the PDS, which will continue to provide those procedures that cannot readily be done by a GDP. With the increasing numbers of people living in care homes it will be necessary to ensure the PDS are only used for patients requiring their advanced skills.

Action 11: The Scottish Government will introduce arrangements to enable accredited GDPs to provide care in care homes. These practitioners will also work with care home staff and the PDS to ensure the maintenance of good oral health and hygiene.

Having a clean, healthy mouth is fundamental to human dignity and when someone is unable to maintain their own oral health they should be given help to do so. Routine oral care should be happening as part of a duty of care, and we want to ensure this is given the appropriate level of priority.

¹³ National Records Scotland: Projected Population of Scotland (2014-based)

¹⁴ Dental Statistics – NHS Registration and Participation <https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2017-01-24/2017-01-24-Dental-Report.pdf>, statistics as at 30 September 2016



'Caring for Smiles' is the national oral health promotion, training and support programme for older people. The accompanying guide acts as a helpful training tool for care home managers and staff in conjunction with hands-on training from oral health teams. We recognise that there is often a competing number of demands on those who care for older people, however, we want to ensure that oral health care is recognised as a priority. Therefore we will work with organisations such as the Care Inspectorate on a campaign to raise awareness of 'Caring for Smiles'.

Action 12: We will work with organisations such as the Care Inspectorate to ascertain how we can continue to raise the profile of oral health care in care home settings.

People in their Own Home

We also need to find ways to ensure older people who are cared for in their own home continue to receive dental care. Our intention is that the patient's GDP would continue to provide routine monitoring, care and treatment, but where it might be necessary to carry out more complex treatment in the patient's home, there is likely to be a role for an accredited GDP or the PDS.

Action 13: Once we have sufficient numbers of accredited GDPs in place, the Scottish Government will introduce new domiciliary arrangements for people who are cared for in their own home.

Health and Social Care Partnerships

In setting out our plans for future improvement we need to be mindful of the valuable role HSCPs can play. The Health and Social Care Delivery Plan states that "For better integrated care to become a reality, the new Health and Social Care Partnerships must plan and deliver well-coordinated care that is timely and appropriate to people's needs."¹⁵

Action 14: The Scottish Government will work with Chief Officers within HSCPs to establish how we can work together to improve the oral health of people who are cared for in domiciliary settings.

¹⁵ The Scottish Government, Health and Social Care Delivery Plan, 2016, <http://www.gov.scot/Publications/2016/12/4275/downloads>

5

More Services on the High Street



We recognise the important role of Hospital Dental Services (HDS) in delivering NHS dental treatment. It is necessary to ensure that the balance of care between hospital and GPs is appropriate; this can be achieved by ensuring that we have a robust dataset for decision-making, clear referral criteria and an appropriate primary-secondary care pathway.

Action 15: The Scottish Government will work with NHS Boards to ensure that adequate secondary care data is available on which to establish primary-secondary care pathways.

The consultation highlighted that in signalling the shift of the balance of care it is important to ensure that those providing the treatments have the necessary training and experience as well as appropriate equipment and funding. This is similar to the new General Medical Services (2018) contract for Scotland which establishes the concept of the GP being an 'expert medical generalist'.¹⁶

Practitioners with Enhanced Skills

We need to make full use of the skill-set of GPs working in a primary care 'high street' environment. Some oral surgery and intravenous sedation procedures can be delivered safely and more cost effectively in a primary care setting. At present some patients requiring these treatments are inappropriately referred to HDS.

Our intention is to introduce a system of accreditation that recognises GPs with enhanced skills and allows these professionals to carry out certain procedures which can be safely done within a primary care setting. We envisage that the system of accreditation will include support, mentoring, governance, quality assurance and training. Building on our initial consultation, the following areas have been identified for future accreditation:

- Oral surgery/oral medicine;
- Treatment under intravenous sedation;
- Restorative services (complex treatment);

A key priority would be oral surgery/oral medicine; currently the interface amongst oral surgery, oral medicine and oral and maxillofacial surgery services is unclear. There needs to be clarification of roles in order to make best use of the skills of the clinicians.

¹⁶ The Scottish Government, The 2018 GMS Contract in Scotland, <http://www.gov.scot/Publications/2017/11/1343>



Action 16: The Scottish Government will introduce a system of accreditation that recognises GPs with enhanced skills enabling them to provide services that would otherwise have to be provided in HDS.

Oral Cancer Pathways

It is widely recognised and accepted that patient outcomes are improved if there is a clear clinical pathway.

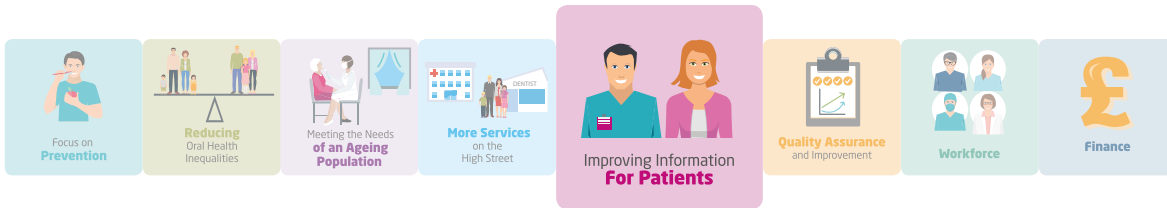
Action 17: The Scottish Government will ensure that the clinical pathway across Scotland is safe, consistent, clear, and effective.

Specialist Orthodontic Practices

The current arrangements for orthodontics will be maintained.

6

Improving Information for Patients



The Scottish Government's 'Making it Easy' strategy recognises that “modern health and social care can place daunting hurdles in our way – the language and processes of health and care services can be hard to understand.”¹⁷ The public deserves to have access to information to help them improve their oral health, including the dental treatment they may require.

During the focus groups with members of the public, the Scottish Health Council found that ‘the absence of visible price lists in waiting areas was also commented on and participants said that often the first indication of the treatment plan price being available was when the patient returned to the reception area.’¹⁸

There is of course, a difference in the knowledge base between those who are providing dental treatment and those receiving it. Whilst we know the vast majority of dentists will make it clear to patients what treatment is available, we want to ensure that patients are aware of what they are entitled to receive under the NHS and for this to be communicated clearly by the dentist. It is also important that patients are aware of the costs of NHS treatment compared to private treatment.

Action 18: The Scottish Government will develop the standard of NHS oral health information on self-care, treatments available, costs and services to be made available to the public by dental practices and dentists.

Simplifying Items of Service

GDPs provide over four million courses of treatment to adults every year. With over 400 separate items of service (treatments) available under the GDS at present in Scotland, it is understandable that patients and dentists find the whole system confusing and unwieldy. There needs to be a substantial simplification of this regime to ensure that patients have a well-informed understanding of what they are paying for, and it is less administratively complex for dentists.

¹⁷ The Scottish Government, 'Making it Easy' <http://www.gov.scot/resource/0045/00451263.pdf>

¹⁸ The Scottish Health Council, Oral Health in Scotland – Gathering views on the Future of Oral Health in Scotland http://www.scottishhealthcouncil.org/publications/gathering_public_views/oral_health.aspx



Some initial scoping work has allowed us to identify eight categories of dentistry which are provided under the GDS. These are:

- Oral Health Risk Assessment (including prevention)
- Periodontics
- Minor oral surgery (e.g. wisdom teeth removal)
- Fillings
- Dentures
- Orthodontics
- Endodontics (e.g. root canal treatment)
- Crowns and bridges

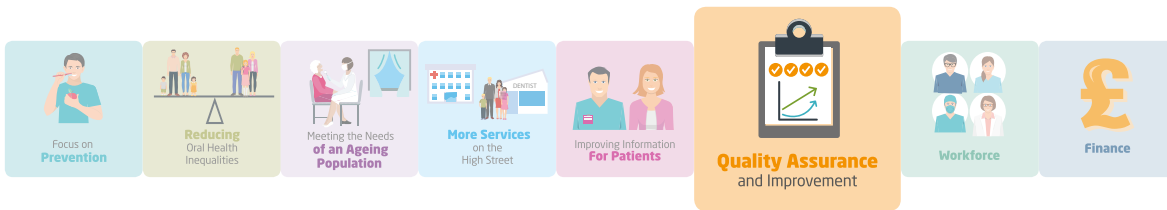
Typically most dentists use around 100 items of service.

Action 19: The Scottish Government will streamline items of service payments to GPs.

The intention would be to introduce this change progressively to ensure that practices are not destabilised by the rate of change.

7

Quality Assurance and Improvement



The consultation provided an opportunity to look at how we assure that patients receive the best quality care under the NHS. Currently service delivery, scrutiny and quality assurance for NHS dentistry can be disjointed. This chapter looks at each of these functions and how they may be enhanced.

Professional Leadership and Strategic Oversight at Board Level

NHS Boards have an important function in providing assurance to the public that the care they receive as a NHS patient is safe, person-centred and effective. These functions include:

- considering applications to join the dental list to provide or assist with the provision of GDS;
- undertaking dental practice inspections to ensure a high quality service;
- ensuring dentists and bodies corporate comply with their NHS terms of service;
- working with PSD on payment verification to ensure treatment claims and payments are appropriate; and,
- referring dentists and DBCs for NHS Discipline or Tribunal procedures where appropriate.

We believe that NHS Boards would benefit from a single professional source of advice and accountability. This would be in the same vein as the directors of medicine, nursing and pharmacy. There are a range of models of professional dental leadership across Boards with Consultants in Dental Public Health (CDPH), Chief Administrative Dental Officers (CADO), clinical leads for the PDS and Dental Practice Advisers (DPA) each having an overview of particular elements of oral health activity.

It is our view that a professional Director of Dentistry within each NHS board would ensure a more co-ordinated approach to local assurance and a strategic approach to primary and secondary care service planning and oral health improvement across each of the Board functions. The NHS Board would be expected to designate an existing senior dental member of staff to be the Director of Dentistry.

This person would provide a point of contact for national policy delivery in association with other organisations such as NHS National Services Scotland (NSS), Healthcare Improvement Scotland (HIS) and NHS Education for Scotland (NES) to ensure that national policy is being delivered at a local level.

Action 20: The Scottish Government will work with NHS Boards to introduce a Director of Dentistry in each Board area.



Applicants Listing to Deliver NHS General Dental Services

In general the listing arrangement is a suitable mechanism for ensuring that GDPs meet certain standards to provide GDS. However the consultation exercise has identified a number of weaknesses with the current process.

NHS Boards have concerns that their role is sometimes too passive, and that they do not have sufficient powers to refuse applications, only to defer in certain circumstances. While it is important that these processes are designed to ensure the NHS Board is able to establish the competency of the applicant and for the applicant to be confident the process is fair and reasonable, we feel that the balance of the process currently favours the applicant.

In future we will bring forward amendment regulations to provide NHS Boards with the powers to refuse applications where they are not satisfied that the applicant would be able to provide a safe and competent service. We will work with the service on the precise grounds for refusal of an application.

We also looked at ways that information on listing could be shared between NHS Boards to avoid duplication of effort. In the first instance, as part of the initial consultation exercise we considered moving to a national listing arrangement but concluded it was important that local arrangements continued particularly as NHS Boards are best suited to react to difficulties in access to dental services for the public.

While the national approach was viewed as impractical and could jeopardise local assurance, there was support for a single database that could be shared between NHS Boards. This would reduce the administrative workload of listing and make it easier for GDPs to list in new areas.

We also take the view that NHS Boards do not have sufficient intelligence on who is providing GDS in their areas. This is mainly to do with bodies corporate, in particular those bodies corporate that are not listed. In many circumstances it is important for the NHS Board to be able to contact the owner of the practice. The present listing arrangements for bodies corporate do not allow this to happen.

Action 21: The Scottish Government will:

- introduce regulations to provide NHS Boards with more powers to refuse potential applicants;
- introduce arrangements for a single database of information for NHS Boards; and,
- explore options in order to gather relevant information on bodies corporate.

Safe Delivery of NHS General Dental Services

NHS Boards have obligations to ensure safe provision of GDS in their areas. In 2015 NHS Boards were provided with additional powers to make an unannounced inspection of a practice where there were concerns about patient safety. However, there remain certain critical circumstances where the NHS Board requires additional powers to ensure the practice is unable to provide GDS until the NHS Board is satisfied the circumstances that led to the cessation have been put right. For example, at present a Board cannot stop the provision of GDS in a practice with insufficient decontamination provision.

Action 22: The Scottish Government will explore the possibilities for providing NHS Boards with more powers to prevent GDS being provided from practices where there is danger to patients.

Monitoring of Clinical Quality

The Dental Adviser (DA) function provides pre-treatment reviews and approval for complex or high cost treatment plans, including orthodontics. The Dental Reference Officer (DRO) service monitors the quality of NHS dental treatment by inspecting a random sample of patients. At present the service is not well attended by patients. During the consultation exercise GPs had many views about how the service could be improved, including whether patients could be seen in the practice rather than elsewhere. With over four million courses of treatment being provided annually and the move to a more preventive based approach there is a requirement for a more effective clinical quality monitoring service.

Currently, both the DA and DRO service are hosted within Practitioner Services Division (PSD). However it would seem appropriate to separate the payments function from clinical quality monitoring. The DA service with its payment verification function should remain within PSD and the DRO service with its clinical quality monitoring remit should transfer to be under the direction of the Director of Dentistry within NHS NSS.

Action 23: The Scottish Government will work with NHS NSS to reconfigure the DRO and DA service to ensure a more effective and responsive service in the future.



Scottish Dental Practice Board (SDPB)

The consultation highlighted a significant degree of misunderstanding amongst respondents of the role of PSD and the SDPB. PSD makes payments to GDPs on behalf of NHS Boards but also make certain payments or estimated payments on behalf of the SDPB. We believe that the governance of this process should be entirely under the remit of NSS.

Action 24 : The Scottish Government will consider how the functions of the SDPB can be subsumed within NHS NSS.

Assurance that Service Providers are Safe and Effective

The consultation highlighted the concerns that some GDPs have with the disciplinary process, in particular that some NHS Boards are using the General Dental Council (GDC) as the only recourse for disciplinary issues. In many cases this is unnecessary, it is not satisfactory from the point of view of the GDC and can cause unnecessary distress for the GDP.

Against this backdrop the Chief Dental Officer (CDO) has chaired a working group on ensuring that satisfactory arrangements are in place that are proportionate to the problem under consideration. As well as publishing a pathway for supporting practitioners for NHS Boards to work to, the intention of the Scottish Government is to ensure that NHS Discipline and Tribunal procedures are in place so that NHS Boards have a satisfactory recourse without unnecessary referral to the GDC.

Action 25: The Scottish Government will:

- publish a pathway to support dental practitioners locally; and,
- when necessary, ensure that NHS Boards use local disciplinary procedures and NHS Tribunals where appropriate.

Improvement Activity is Evidence-Based and Data-Driven

The consultation reported on a Scottish Government pilot, launched on 1 April 2015, to gather information on a range of quality indicators, both at practice and GDP level. The intention is to roll this out nationally by 1 January 2020.

The quality indicators would include anti-microbial prescribing patterns; Childsmile interventions; practice inspection; out of hours arrangements; DRO scores; practice complaints procedure and involvement in quality improvement.

Action 26: The Scottish Government will work towards a single database of quality improvement information for NHS Boards with appropriate access for dental teams and the public.

National Framework

In June 2014, the then Cabinet Secretary for Health, Wellbeing and Sport announced that HIS would lead on developing and delivering more comprehensive assessments of the quality of care across health and social care services. The final report; 'Building a comprehensive approach to reviewing the quality of care: Supporting the delivery of sustainable high quality services' was published in March 2016.¹⁹

Based on the HIS report the intention is to develop a new framework in dentistry that will drive improvement at practice, NHS Board and national level. The framework should provide guidance on what 'good' quality care might look like, what form of evidence might be available to provide assurance of this and what support dental teams may need to deliver any improvement in quality.

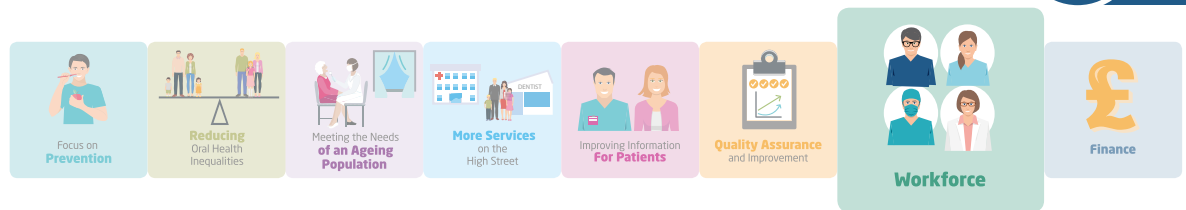
The framework will assist the public to be suitably informed on what they can expect of their NHS dental service and what is expected of providers. We also intend HIS and NES to support the framework by providing the dental team with education and study development in quality improvement.

Action 27: The Scottish Government will:

- commission the development of a National Framework for Quality Assurance and Improvement across NHS dental services, using the HIS report as a starting point; and,
- work with HIS and NES on ensuring an overarching approach to quality improvement education and activity for NHS dental teams.

¹⁹ Healthcare Improvement Scotland, 'Building a comprehensive approach to reviewing the quality of care: Supporting the delivery of sustainable high quality services', 2016, http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews/design_panel_final_report.aspx?theme=mobile

Workforce



There has been a substantial increase in the NHS dental workforce in Scotland since the publication of the previous Dental Action Plan,²⁰ with a 46% increase in the number of dentists in the workforce, from 2,474 in March 2007, to 3,613 in March 2017.²¹

This is an excellent platform. We want our dental workforce however, to adapt and respond to the challenges of the future. This Plan is helping us shape how NHS dentistry and oral health improvement is taken forward, including an increasing emphasis on prevention for all life stages and in particular for older people in care settings.

Skill Mix and Direct Access to Dental Care Professionals (DCPs)

We want to ensure that dental teams make best use of dentist and DCP skills to deliver the key actions included within this plan. The CDO is currently taking forward a body of work to explore the practicalities and benefit to the patient of introducing direct access to DCPs, particularly for older people cared for at home.

Action 28: The Scottish Government will establish a Dental Workforce Planning Forum chaired by the CDO to provide regular workforce planning across the dental team.

The Forum will make suitable recommendations to the CDO on workforce requirements, composition of the workforce, morale of the workforce and the issues that affect dentists and members of the dental team working in remote and rural areas. The Forum will also be able to commission intelligence reports.

Remote and Rural Areas

Despite the increase of the dental workforce, some remote and rural areas still experience difficulty in recruiting and retaining practitioners in their areas. We need to maximise recruitment in remote and rural areas by encouraging practitioners already in the area to become trainers for new graduates, including allowing them to recruit ahead of other areas in Scotland. We have recently reviewed the recruitment and retention allowance and will continue to keep it under review to ensure there are adequate incentives to work in remote and rural areas.

Action 29: The Scottish Government will develop programmes for promoting working in remote and rural areas.

²⁰ The Scottish Government, 'An Action Plan For Improving Oral Health and Modernising NHS Dental Services in Scotland', 2005, <http://www.gov.scot/Publications/2005/03/20871/54815>

²¹ ISD Scotland NHS Dental Workforce Statistics, March 2016 <https://www.isdscotland.org/Health-Topics/Workforce/Publications/2016-06-07/2016-06-07-Workforce-Report.pdf>

EU Citizens (Brexit)

The First Minister continues to send a strong message about the impact Brexit will have on public services,²² a message shared by the Chief Executive of NHS Scotland in a letter of 7 June 2017 to NHS Chief Executives emphasising the valuable skills and experience EU citizens bring to the health service.²³ Future workforce planning in NHS dentistry will take cognisance of the positive contribution made by EU citizens in providing NHS dentistry in Scotland.

Action 30: The Scottish Government will establish an EU dentist's network which will provide the opportunity for dentists from the EU to engage with the CDO on issues which are a consequence of Brexit.

Out of Hours Care

Over the past ten years local NHS Boards have established a range of out of hours (OoH) NHS dental services. Whilst there is consistency for the public across Scotland in terms of accessing OoH services, namely through NHS 24 and the 111 telephone number, the models of OoH care at the point of service delivery differ from area to area.

Some NHS Boards operate a rota system that includes all GPs in their areas, while others pay sessional fees to a group of dentists. We are aware that there are strengths and weaknesses in both models of care. The rota system recognises that all GPs have a terms of service requirement to provide OoH care to their registered patients, while a sessional system of care acknowledges the efficiencies of relying on a smaller number of dedicated professionals.

At present the area where the patient's dental practice is situated determines where the patient will be directed by NHS 24 to access an OoH service. This can cause significant problems when a patient is currently residing in another NHS Board area from where they are registered with a dentist. Registration is often linked to where the patient may work or a previous home address.

Action 31: The Scottish Government will commission a short-life working group to look at models of OoH NHS dental care and the patient's OoH care journey. This group will report to the CDO with recommendations on how OoH care should be taken forward in the future.

²² Scottish Government, 'Scotland's Place in Europe: People, Jobs and Investment' <http://www.gov.scot/Publications/2018/01/6407>

²³ Scottish Government Health and Social Care Directorates: <http://www.sehd.scot.nhs.uk/publications/DC20170707EU.pdf>



General Dental Practitioner Fellowship Programme

It is important that dental teams feel competent to deliver care. In the future continuing professional development should be available across Scotland for all members of the team.

Additionally we see all GDPs taking on a clearer leadership role within the team to ensure that the dental team can deliver a wider, more complex range of NHS dental care for their patients. It is important that GDPs are able to undertake more strategic leadership roles for the profession with NHS Boards and will require on-going training and skills to allow this to happen. We see this programme as underpinning our proposals around providing more services in the high street.

Action 32: The Scottish Government will commission NES to develop a General Dental Practitioner Fellowship Programme to enhance clinical skills, develop quality improvement skills and support remote and rural working.

Protected Learning Time

We also want to ensure that our skilled workforce continues to be trained to the highest standard, with opportunities available for the dental team to take time out from clinical practice to allow practice staff to address their own learning and professional development needs. The principle of protected learning time is widely accepted in general medical practice.

The consultation asked respondents whether protected learning time should be rolled out for GDPs and practice staff. This question received overwhelming support with 77% of respondents agreeing with the proposal.

We will therefore work with NHS Boards to support the introduction of protected learning time for practice-based dental teams. In taking this forward we will consider the issues raised by the dental team during the consultation exercise that protected learning time should be adequately funded and remunerated. We will provide further details of how this will work in practice following our work with NHS Boards.

Action 33: The Scottish Government will work in partnership with NHS Boards and NES to ensure protected learning time for practice staff.

Occupational Health

At present there are no consistent occupational health advice and guidance services for GDPs and the dental team, including support staff. Going forward we want to ensure that all members of the dental team have access to an occupational health service to help support them to keep well, both physically and mentally.

Action 34: The Scottish Government will introduce an occupational health service for GDPs, members of the dental team and other practice staff.

Widening Access to University

The report 'Social inequalities in oral health: from evidence to action' highlights the widening socio-economic gap and the impact this will have on oral health inequalities.²⁴ We believe that having a dental workforce which reflects the rich diversity of the Scottish population will help us to deliver substantial improvements in the oral health of the population.

The First Minister's programme for Government 2017 committed to "drive forward the recommendations of the Commission on Widening Access's Report 'Blueprint for Fairness', so that every child, no matter their background or circumstances, has an equal chance of going to university by 2030."²⁵

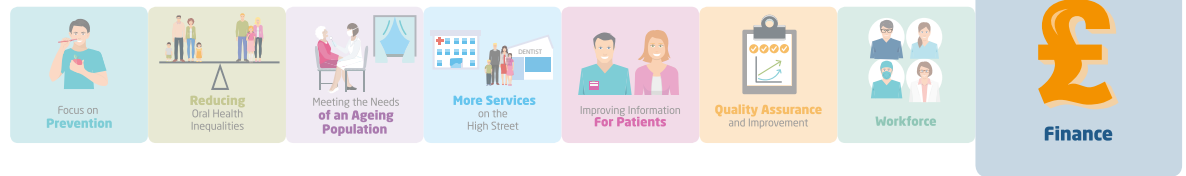
We want to ensure that the opportunity to apply to study dentistry is open equally to everyone who has the ability to become a dentist.

Action 35: The Scottish Government will work with the Scottish Funding Council and the universities to widen and improve access to dental education in Scotland.

²⁴ Social inequalities in oral health: from evidence to action. 2016 , Edited by Richard G Watt, Stefan Listl, Marco Peres and Anja Heilman, http://media.news.health.ufl.edu/misc/cod-oralhealth/docs/posts_frontpage/SocialInequalities.pdf

²⁵ The Scottish Government, 'A Nation with Ambition: The Government's Programme for Scotland 2017-18, <http://www.gov.scot/Publications/2017/09/8468>

Finance



We acknowledge that this ambitious programme of work will require both new investment and the realignment of certain existing funding streams. Our intention is to proceed in a progressive manner in order for practices that provide GDS to have the opportunity to plan accordingly whilst maintaining their financial stability.

Payments to General Dental Practitioners/Dental Practices

The strength of the existing payments regime for GDS is that there is a mixed economy of item of service, capitation and continuing care payments, and individual and practice allowances. We will continue to retain a mix of payments going forward, but the balance of payments will change accordingly.

In summary there will be:

- a new system of capitation payments to support preventive care and treatment in children and young adults, supported by monitoring;
- a new system of enhanced continuing care payments to support the introduction of Oral Health Risk Assessments for adult patients;
- a simplified set of item of service payments for restorative care and treatment;
- changes to the General Dental Practice Allowance to incentivise general dental practices with patients from more deprived communities;
- changes to the reimbursement of rental costs to ensure that payments are based on an appropriate size of practice and taking into consideration its location;
- a new NHS commitment criteria; and
- a single quality-based practice allowance which reflects the unique circumstances faced in both remote and rural areas and deprived communities.

Payment Verification (PV)

Practitioner Services make all payments under the Statement of Dental Remuneration (SDR), on behalf of all NHS Boards. We need to encourage a stronger partnership model between NHS Boards and NSS to ensure that payment verification is carried out thoroughly.

Action 36: The Scottish Government will work with NHS Boards and NSS to ensure that any PV issues are dealt with.

Enhanced Services/The Health and Social Care Partnerships (HSCPs)

As we develop our plans for enhanced service provision we need to take into account the role of HSCPs in planning and delivering services. Legislation to implement health and social care integration came into force on 1 April 2016, bringing together NHS and local council care services under one partnership arrangement for each area.

We are mindful that the consultation process highlighted concern over the security of the devolved funding and whether HSCPs have a level of experience and understanding of managing the GDS budget. Going forward we need to consider how we can build effective working relationships with each of these partnerships.

Action 37: The Scottish Government will actively consider how we can increase the engagement and participation of the dental profession in HSCPs through our programme of stakeholder engagement.

We appreciate this may take time as we undertake this journey and our stakeholder engagement activities prior to implementation of the plan will be a key component in achieving this. Further information on our stakeholder engagement plans can be found in the 'Next Steps' section of this document.

Patient Charges

As we take forward actions to simplify the number of treatments dentists can provide under GDS this will result in the charges for patients becoming more straightforward.

At present, adult patients, unless exempt from NHS dental charges, contribute towards their NHS dental treatment. Arrangements are in place to ensure that vulnerable groups and those on low incomes are protected. These arrangements will remain in place as we move forward. Further information on patient charges and exemptions can be found at: <http://www.gov.scot/Resource/0052/00525866.pdf>.

Conclusion and Next Steps



This Oral Health Improvement Plan is an ambitious programme of work which we hope will make a significant contribution to improving the oral health of the population.

A summary of the key commitments and actions which will form the basis of our programme of work is provided at the end of this document.

The consultation exercise provided an essential and valuable opportunity to ask the profession, the public and a range of stakeholders for their views on how to reach our goal of improving oral health and how we shape NHS dentistry going forward. The consultation tested a number of proposals which helped inform decision-making essential to taking this plan forward.

We are fully committed to realising the ambitions set out within this plan. We recognise however, that what we have set out is a combination of short-medium- and long-term goals. We want to ensure that as plans are put in place to take forward these actions patient care is maintained and businesses remain viable.

We recognise that the actions within this plan will have an impact on dentists, the dental team and patients. In order to implement this plan we have identified the following next steps.

Workstreams

To facilitate implementation our immediate priority is to create a number of short-life working groups to advise the CDO on design and implementation of the priorities for this plan.

The CDO is already involved in a number of groups to set policy direction, including domiciliary care and oral surgery. Therefore our next step is to establish working groups to develop the OHRA, preventive care pathway and simplification of the SDR. A key role for the workstreams will be to produce timeframes for implementation.

Action 38: The Scottish Government will establish a number of short-life working groups to take forward the actions set out within this plan.

Regular Updates from the Chief Dental Officer

With any substantial change in policy direction it is important to keep the public and key stakeholders informed about the progress towards implementation.

Action 39: The CDO will produce a bi-annual newsletter to provide an update on progress toward implementation.

Roadshows

During the consultation process we held a series of roadshow events with the profession which was an important part of the consultation process. Feedback from these events was largely positive with a number of attendees stating in their evaluation forms that the process was a valuable one that they would welcome in the future.

We will therefore commit to delivering a second series of roadshow events for the profession which will provide attendees with the opportunity to discuss the content of the OHIP with the CDO and feed into our plans for implementation. These events will take place once the working groups have started their initial work.

Action 40: The Scottish Government will run a number of roadshow events to discuss the implementation arrangements for the OHIP.

If you would like to register an interest in taking part, and be notified once registration opens, please send your details to: oralhealthplan@gov.scot

Young Dentists, EU Dentists and Remote and Rural Dentists

Following on from the roadshow events with the profession it became clear that we have found it difficult at times to engage effectively with particular groups. We subsequently included webinar events with groups of young dentists and dentists from remote and rural areas.

Since the publication of the consultation analysis we have hosted evening events with young dentists and dentists from the EU.

We intend to continue with these events to help support the work of this plan. If you are interested in finding out more please email: oralhealthplan@gov.scot

Patient Forum

Our work with the Scottish Health Council on focus groups with patients proved to be a valuable resource in helping us shape this plan. We believe that as we move towards implementation, further engagement with patients is important. Therefore, we will work with the Scottish Health Council to develop a Patient Forum which will allow patients the opportunity to feed in to the implementation process at regular intervals.



Action 41: The Scottish Government will work with the Scottish Health Council to develop a Patient Forum.

General Evening Events

The CDO has a long standing commitment where she hosts small evening events across Scotland with dentists who work in NHS general dental practice.

As with the events for the specific groups described above, the intention is for this programme of work to continue going forward. If you are interested in finding out more please email: oralhealthplan@gov.scot

Delivery of Commitments

Action



Policy Statement

Chapter 1. Policy Statement

- | | |
|---|---|
| 1 | The Scottish Government will ensure dentistry is featured in future strategies on alcohol, smoking and diet. |
| 2 | The Scottish Government will ensure the new population health improvement body to be established by 2019, recognises dentistry and improving oral health as a priority. |



Focus on
Prevention

Chapter 2. Focus on Prevention

- | | |
|---|--|
| 3 | The Scottish Government will change payments to dentists and introduce a system of monitoring to ensure that all dental practices provide preventive treatment for children. |
| 4 | The Scottish Government will introduce an Oral Health Risk Assessment. |
| 5 | The Scottish Government will introduce a clinically-proven programme of periodontal care for patients with periodontal disease and those with high risk of developing it. |
| 6 | The Scottish Government will explore the potential for introducing general health checks for adult patients whilst attending for routine dental checks. |



Chapter 3. Reducing Oral Health Inequalities

7	The Scottish Government will introduce a new three-year Community Challenge Fund for Oral Health Improvement. We will host an event with our partners to help develop the key components of the fund.
8	The Scottish Government will ensure that payments for practice-based allowances reflect the social deprivation status of the patients in the practice.
9	The Scottish Government will establish a single working group to provide strategic oversight to all national oral health improvement programmes and ensure we maximise our oral health improvement effort.
10	The Scottish Government will ensure the PDS actively pursue shared care arrangements with local 'high-street' dental practices.



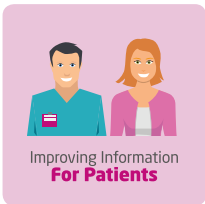
Chapter 4. Meeting the Needs of an Ageing Population

11	The Scottish Government will introduce arrangements to enable accredited GDPs to provide routine preventive care in care homes. These practitioners will also work with care home staff and the PDS to ensure the maintenance of good oral health and hygiene.
12	We will work with organisations such as the Care Inspectorate to ascertain how we can continue to raise the profile of oral health care in care home settings.
13	Once we have sufficient numbers of accredited GDPs in place, the Scottish Government will introduce new domiciliary arrangements for people who are cared for in their own home.
14	The Scottish Government will work with Chief Officers within HSCPs to establish how we can work together to improve the oral health of people who are cared for in domiciliary settings.



Chapter 5. More Services in the High Street

- 15** The Scottish Government will work with NHS Boards to ensure that adequate secondary care data is available on which to establish primary-secondary care pathways.
- 16** The Scottish Government will introduce a system of accreditation that recognises GDPs with enhanced skills enabling them to provide services that would otherwise have to be provided in HDS.
- 17** The Scottish Government will ensure that the clinical pathway across Scotland is safe, consistent, clear and effective.



Chapter 6. Improving Information for Patients

- 18** The Scottish Government will develop the standard of NHS oral health information on self-care, treatments available, costs and services to be made available to the public by dental practices and dentists.
- 19** The Scottish Government will streamline items of service payments to GDPs.



Chapter 7. Quality Assurance and Improvement

20	The Scottish Government will work with NHS Boards to introduce a Director of Dentistry in each Board area.
21	<p>The Scottish Government will:</p> <ul style="list-style-type: none"> • introduce regulations to provide NHS Boards with more powers to refuse potential applicants; • introduce arrangements for a single database of listing information for NHS Boards; and • explore options in order to gather relevant information on bodies corporate.
22	The Scottish Government will work with the dental profession to provide NHS Boards with more powers to prevent GDS being provided from practices where there is clear danger to patient care.
23	The Scottish Government will work with NHS NSS to reconfigure the DRO and DA service to ensure a more effective and responsive service in the future.
24	The Scottish Government will consider how the functions of the SDPB can be subsumed within NHS NSS.
25	<p>The Scottish Government will:</p> <ul style="list-style-type: none"> • publish a pathway to support dental practitioners locally; and • when necessary, ensure that NHS Boards use disciplinary procedures and NHS Tribunal where appropriate.
26	The Scottish Government will work towards a single database of quality improvement information for NHS Boards with appropriate access for dental teams and the public.
27	<p>The Scottish Government will:</p> <ul style="list-style-type: none"> • commission the development of a National Framework for Quality Assurance and Improvement across NHS dental services, using the HIS report as a starting point; and, • work with HIS and NES on ensuring an overarching quality approach to NHS dentistry



Chapter 8. Workforce

28	The Scottish Government will establish a Dental Workforce Planning Forum chaired by the CDO to provide regular workforce planning across the dental team.
29	The Scottish Government will develop programmes for promoting working in remote and rural areas.
30	The Scottish Government will establish an EU dentist's network which will provide the opportunity for dentists from the EU to engage with the CDO on issues which are a consequence of Brexit.
31	The Scottish Government will commission a short-life working group to look at models of OoH NHS dental care and the patient's OoH care journey. This group will report to the CDO with recommendations on how OoH care should be taken forward in the future.
32	The Scottish Government will commission NES to develop a General Dental Practitioner Fellowship Programme to enhance clinical skills, develop quality improvement skills and support remote and rural working.
33	The Scottish Government will work in partnership with NHS Boards and NES to ensure protected learning time for practice staff.
34	The Scottish Government will introduce an occupational health service for GDPs, members of the dental team and other practice staff.
35	The Scottish Government will work with the Scottish Funding Council and the universities to widen and improve access to dental education in Scotland.



Chapter 9. Finance

36	The Scottish Government will work with NHS Boards and NSS to ensure that any PV issues are dealt with.
37	The Scottish Government will actively consider how we can increase the engagement and participation of the dental profession in HSCPs through our programme of stakeholder engagement.



Chapter 10. Conclusion and Next Steps

38	The Scottish Government will establish a number of short-life working groups to take forward the actions set out within this plan.
39	The CDO will produce a bi-annual newsletter to provide an update on progress toward implementation.
40	The Scottish Government will run a number of roadshow events to discuss the implementation arrangements for the OHIP.
41	The Scottish Government will work with the Scottish Health Council to develop a Patient Forum.

Glossary

Allowances

A range of payments made to eligible General Dental Practitioners and dental practices, These include maternity, paternity and adoptive leave payments to General Dental Practitioners and reimbursement of non-domestic rates and rent to practices.

Capitation Payments

A monthly payment made to dentists for each registered child (0-17 years), to cover dental examination and a set range of treatments.

Childsmile

A national programme which combines targeted and universal approaches to tackling children's oral health improvement in Scotland through the programme's four components (Core, Nursery, School and Practice).

Clinical Quality Monitoring

Collective term for systems which ensure patients receive appropriate high quality NHS dental care in Scotland.

Consultant in Dental Public Health (CDPH)

Take an epidemiological approach to improving health, planning services and advising Boards on strategy.

Dental Advisor

A dentally qualified member of the Practitioner Services Division of NHS National Services Scotland who will decide, after examination of a patient, that a course of treatment which will be of high cost to the NHS is in the best interest of the patient. This is known as 'prior approval', the current prior approval limit is £390.

Dental Care Professionals (DCP)

A collective term for dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.

Dental Examination

A routine inspection of the teeth and surrounding soft tissues of the oral cavity.

Dental Reference Officer (DRO)

A dentally qualified member of the Scottish Dental Reference Service who monitors the standard and quality of NHS dental treatment by inspecting a patient's mouth, either before extensive work is carried out or after it.

Dentist

A collective term for General Dental Service and Public Dental Service dentists. Depending on the context, this can also include Hospital Dental Service dentists.

Domiciliary Care

NHS dental care that is provided in the person's home or a care home setting.

Enhanced skills

Advanced clinical skills in relation to patient assessment, examination, diagnosis and treatment provision in a primary care setting.

**General Dental Council (GDC)**

Regulatory body for dental professionals in the UK.

General Dental Services (GDS)

Legal terminology for NHS dental services in Scotland provided by General Dental Practitioners, Dental Bodies Corporate and Public Dental Service dentists on behalf of NHS Boards.

Health and Social Care Partnerships (HSCPs)

Constituted under the Public Bodies (Joint Working) (Scotland) Act 2014, primary function relates to the strategic planning and commissioning of health and social care services provided by Local Authorities and NHS Boards.

'High Street' environment

Most general dental services are provided in a primary care setting, that is, through general dental practices which are found throughout Scotland often in areas where there are many people passing; hence the 'High Street'.

Hospital Dental Service (HDS)

Secondary care NHS dental services for treatment of patients on referral from medical and dental practitioners.

Intravenous sedation

When a drug is administered into the blood system during dental treatment to induce a state of deep relaxation. The patient will remain conscious and will also be able to understand and respond to requests from the dentist.

Listing arrangements

If a dentist or a Dental Body Corporate wishes to provide general dental services on behalf of a Health Board they must first apply to join the Health Board's Dental List. Listing arrangements are the processes in place to allow this to happen.

Minor oral surgery

Smaller surgical operations which include removing wisdom teeth, impacted teeth, and severely broken-down teeth, as well as apicectomies, certain biopsies and other procedures. These can be undertaken in a primary care setting and do not require general anaesthesia.

NHS Commitment Criteria

A practice that meets certain commitment criteria in terms of numbers of patients and General Dental Services activity is entitled to certain allowances. For example, for a non-specialised practice to be "NHS committed", General Dental Services must be provided to all categories of patient, with an average of at least 500 registered patients per dentist (100 of whom should be fee-paying adults), and average gross earnings per dentist of £50,000 or more in a given period of 12 months.

National Health Service (General Dental Services) (Scotland) Regulations 2010

Regulations that govern the arrangements for the provision of General Dental Services in Scotland.

Oral Health Inequalities

Oral health inequalities are avoidable differences in oral health status between groups of people within a population. These are often due to inequalities in social and economic conditions and their effects on people's lives which determines their risk of oral disease, the actions they are able to take to prevent disease or their access to treatment when it occurs.

Oral Health Risk Assessment (OHRA)

A comprehensive assessment of the oral health of the patient with a particular emphasis on a preventive, long-term approach that is risk-based and meets the specific needs of individual patients. The Oral Health Risk Assessment also aims to encourage the involvement of patients in managing their own oral health.

Patient Charges

Unless entitled to free NHS dental treatment or help towards the cost, an adult patient is required to pay a percentage of their NHS dental treatment cost up to a set maximum per course of treatment. The Scottish Government meets the remaining costs. Children under 18 years of age receive free NHS dental treatment.

Periodontal care

Periodontal care is the treatment required by patients to treat periodontal disease; which is itself the result of untreated gingivitis. If left untreated, periodontal disease can lead to receding gums, loose teeth and eventual tooth loss.

Public Dental Service (PDS)

Dentists who are directly employed by the NHS Board, their primary function is the provision of NHS dental treatment to people with special care needs.

Restorative Care

Restorative care involves the dentist replacing missing teeth or repairing damaged tooth structure due to decay, deterioration of a previously placed restoration, or fracture of a tooth. Examples of restorations include; fillings, crowns, bridges and dentures.

Scottish Dental Practice Board (SDPB)

Statutory Body responsible for the authorisation of item of service fees to General Dental Practitioners and practices providing General Dental Services in Scotland.

Statement of Dental Remuneration (SDR)

Statement that includes all items of treatment that can be provided under General Dental Services, and allowances payable to General Dental Practitioners and dental practices providing General Dental Services in Scotland.

Third Sector Organisations

A term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.



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