Scottish Needs Assessment Report & Guide to Good Practice

Oral Health in Primary Care

From local health care co-operatives to community health partnerships

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1. INTRODUCTION

In 1997 it was stated that Dentistry should become fully involved in LHCCs along with other professions in Primary Care.

This document addresses the issues of involvement of dental professionals in a partnership approach to improving oral health and access to oral health care services within LHCCs. It looks at current practice since their introduction, reports on the problems that have arisen and why, and highlights important factors to be taken into account in the future. With the imminent formation of Community Health Partnerships, now is thought to be an opportune time to be reviewing past experience and, with this in mind, the report seeks to offer some guidance to the new Community Health Partnerships in involving the dental profession.

2. WHAT INFLUENCES ORAL HEALTH IN PRIMARY CARE?

The Scottish Executive "Action Plan for Dental Services" addresses the oral health improvement agenda. Dental caries in children and adults and other oral health priorities for adults, including oral cancer, can be more effectively tackled through a partnership approach to care and prevention, particularly as a number of chronic diseases, such as heart disease, cancer, strokes and accidents, share common risk factors.

Oral health improvement is also supported by policies directed at services in Primary Care outwith dentistry. These cover areas including healthy eating, joint futures, single children's services and strategies for health improvement and it is noted that all relevant documents promote collaborative working between key stakeholders. These stakeholders include Primary Care Workers, e.g. – Doctors, Dentists, Pharmacists, Health Visitors, School Nurses, Public Health Practitioners, and also Local Authority agencies, such as Social Workers and Education staff, as well as parents/carers and the wider public. Oral health improvement is dependent on a multi-disciplinary approach and the effective delivery of services. In terms of the development of LHCCs, General Medical Practitioners thus far have tended to assume a dominant role reflecting the common interest of Boards and GPs in developments at local and practice level aimed at integrating primary and community-based care and reducing the barriers between the community and acute hospitals. Relationships with other groups of independent contractors have usually not been close. This was due to three main reasons:-

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- The concern of independent contractors regarding loss of independence to LHCCs.

- Issues of remuneration for involvement with LHCCs.

- The imperative for LHCCs to focus on the huge task of drawing together GMPs, Local Authorities and the public as their main priority.

The strengthened role for LHCCs proposed in "Partnership for Care" around service planning and delivery will act as an incentive for a much greater focus on collaboration to improve services for the population. This improvement should also extend to closer integration of the component parts of the Primary Care Dental Services.

As LHCCs move to CHPs, there is the potential to increase their public health role and the capacity for health improvement. Relevant policy documents refer to strategic direction for public health improvement on the part of various Primary Care (non-Dental) professions and Local Authority partners. The public health role of Nursing, Allied Health Professions and Pharmacy is examined as well as how it contributes to the multi-disciplinary team approach necessary to produce improvements in oral health as part of general health.

Differences in terms of role and organisation between the various branches of the Primary Care Dental Service (PCDS) can sometimes hamper co-ordination of service delivery and add to the challenges faced by the LHCC when seeking greater integration of PCDS in their operation. The new CHP framework provides an opportunity for closer integration and partnership working and for redefining geographical boundaries of Dental Advisory Committees to increase effectiveness of service delivery. A degree of service redesign, where appropriate, could help tackle the problems of service access in some areas. Dental Practice Advisers, Clinical Directors and Consultants in Dental Public Health have an important role to play in securing integration of the PCDS and their working partnership with LHCCs/CHPs to improve oral health and reduce health inequalities. Well-developed IM&T systems are essential to support the effective involvement of the PCDS in the LHCC. There is currently available a range of dental information, including dental registration, school inspection and epidemiological data which can be used to build an LHCC profile and assist in planning for oral health improvement.

3. WHAT IS HAPPENING?

As an aid to compiling this Report, a Scotland-wide survey of stakeholders was carried out to establish baseline activity and identify the main issues for LHCCs in terms of involving Dental Services and improving oral health. Responses to open questions allowed examples of good practice to be quoted, as well as identification of barriers to progress to be made.

Involvement of PCDS, and in particular the General Dental Service, is difficult, partly due to problems with funding. Novel structures and posts are being trialled in order to overcome some of the difficulties highlighted.

A lot of work is being done in the area of oral/dental health needs assessment and many examples are quoted. However, no consistent methodology is being used. Good progress has been made in developing collaboration within LHCCs around the provision of oral health promotion and, again, examples are highlighted.

There is a clear understanding on the part of LHCCs of what they consider to be the main issues for Dental Services in their respective localities. These include inequity of access, out-of-hours services, unmet needs in vulnerable groups, lack of involvement of the General Dental Service and joint working between Dental Services, preventive programmes for pre-school children and training for all the LHCC team in oral health promotion.

4. WHAT NEEDS TO HAPPEN?

The report highlights the need to consider marketing, communication, organisational structures, support infrastructure and Dental Services as a means of successfully progressing the oral health improvement agenda within the LHCC/CHP context. It also highlights actions to be taken at local, area and national level.

Partnership working must be strengthened and all stakeholders should sign up to strategic goals for oral health. It is suggested that examples of good practice highlighted in the Report could form the basis of an Action Plan for local delivery.

Local action will also need to be underpinned by action at national level, particularly in terms of clarifying the strategic direction and organisation of PCDS. National support for development of IM&T within Dentistry is seen as essential to closer integration of PCDS within the LHCC/CHP.

5. KEY RECOMMENDATIONS

1. Consultation should take place with Primary Care Dental Service Practitioners to identify the mutual advantage of their involvement in LHCCs/CHPs.

2. Clear objectives should be set and joint planning take place amongst key stakeholders to effectively deliver the LHCCs/CHPs' oral health agenda.

3. There must be efficient and well developed IT systems for data capture and effective two-way communication between the PCDS and the LHCC. This must include access to the NHSnet.

4. Appropriate and effective representation of the PCDS should be established on the Core/Executive Group of each LHCC/CHP.

5. LHCCs/CHPs should secure the input of Clinical Directors of salaried PCDS, Consultants in Dental Public Health and Practice Advisers to provide support, information and management required for Dental Service provision and health improvement in their locality.

6. LHCCs/CHPs should facilitate the involvement of Dental and non-Dental partners in the joint delivery of oral health improvement.

7. There should be a clear national statement on strategic aims for the PCDS and how these services will fit into the CHP organisational context. Changes to the GDS contract and method of payment are urged as part of this process.

8. Evaluation of effectiveness and cost benefits of new approaches to involvement of PCDS in the LHCC should be carried out.

GLOSSARY

AHP   Allied Health Professions
                       (including Counsellors, Dieticians,
                       Occupational Therapists, Orthoptists,
                       Physiotherapists, Podiatrists,
                       Psychotherapists, and Speech &
                       Language Therapists)

CDPH   Consultant in Dental Public Health

CDS   Community Dental Service

CHD   Coronary Heart Disease

CHI   Community Health Index

CHP   Community Health Partnership

CSA   Common Services Agency

DPA   Dental Practice Adviser

ECCI   Electronic Clinical
                       Communications Implementation

GDP   General Dental Practitioner

GDS   General Dental Service

GMS   General Medical Service

GPASS   General Practice Administration
                       System for Scotland

IM&T	Information Management and Technology
LHCC	Local Health Care Co-operative
OHAT	Oral Health Action Team
PAF	Performance Assessment Framework
PCD	Professionals Complementary to Dentistry (including Dental Nurses, Hygienists, Therapists, Technicians)
PCDS	Primary Care Dental Service
PCT	Primary Care Trust
PHIS	Public Health Institute of Scotland
PHP	Public Health Practitioner
SCC	Scottish Consumer Council
SCI	Scottish Care Information
SGDS	Salaried General Dental Service
SHOW	Scottish Health on the Web
SPCDS	Salaried Primary Care Dental Service (Community Dental Service and Salaried General Dental Service)

1. INTRODUCTION

"Primary care depends on the contribution of a wide range of professionals working together..... Community pharmacists, dentists and opthalmic opticians provide essential services, and access to their skills and professional expertise can greatly enhance the effectiveness of the team."

This quotation from *Designed to Care*[1] in 1997 indicated government's intention that dentistry, in keeping with other primary care professions, should become a member of the LHCC, and join in a new form of working relationships at local level to improve the health of the local population.

Quite how this should come about was less obvious, but nevertheless examples of collaborative working began to emerge over time from LHCCs across Scotland. Several years on, and despite these enthusiastic endeavours, many people within Primary Care Dental Services (PCDS) and indeed colleagues within LHCCs and the wider Health Service began to question why more was not happening, and why there did not appear to be any consistency in approach or sharing of good practice. It was felt that these and other factors were inhibiting progress towards the ideals set out in *Designed to Care* including wider ownership of the health improvement agenda and, by extension, the achievement of real improvements in oral health.

It was therefore considered important to identify and explore the various issues which have influenced this situation as well as the barriers inhibiting future development.

A working group was set up to carry out this task and produce a report to assist LHCCs as they develop their agenda for improving the health of their local population, with specific emphasis on oral and dental health. Ways are suggested of overcoming the barriers identified, as are recommendations for effective involvement of the PCDS in the LHCC.

It is hoped the report will be seen and used as a guide to good practice, reflecting on progress which has been made to date across the country, and taking note of developments in service organisation and NHS structural changes currently proposed for the NHS in Scotland.

The recent White Paper, *Partnership for Care*[2] outlines proposals to move from LHCCs to the setting up of Community Health Partnerships by April 2004.   To some extent, therefore, the recommendations contained in this report will within a short timescale need to be applied in a different organisational context, although this may in fact help to secure more rapid implementation with the involvement of local authorities and secondary care providers.

2. WHAT INFLUENCES ORAL HEALTH IN PRIMARY CARE?

2.1 HEALTH IMPROVEMENT/DENTAL PUBLIC HEALTH ISSUES

The term "oral health" is used regularly throughout this report, and this is defined in the *Oral Health Strategy for Scotland*[3] as

> *"....a standard of health of the oral and related tissues without active disease. This state should enable the individual to eat, speak and socialise without discomfort or embarrassment, and contribute to a general well-being."*

The *Action Plan for Dental Services*[4] emphasises improving oral health in children and tackling the inequalities that impact on both dental health and access to oral health care. Interventions to improve oral health in children following the Action Plan have included free toothbrushes and fluoride toothpaste, with targeting of children living in deprived circumstances, programmes for tooth brushing, health promotion and healthy eating through schools, nurseries, health visitors, pharmacists and playgroups[5].

Challenges identified by the Scottish Executive in improving dental health in children include reducing children's consumption of dietary sugars, targeting appropriate preventive measures towards children living in deprived circumstances and water fluoridation. Systematic reviews on the effectiveness of oral health promotion interventions are limited in their conclusions and recommend further high quality studies to improve the evidence base. In contrast, some evidence suggests that chair-side one-to-one oral health promotion is the most effective intervention to reduce plaque in adults and that educating parents about plaque control and daily tooth brushing with fluoride toothpaste are effective for improving children's oral health[6]. Another review concluded that one-off health promotion initiatives fail to improve an individual's oral health, but approaches that use active participation and address social, cultural and personal norms and values are more likely to be effective[7].

There is also evidence from reviews of dental service interventions that school-linked sealant delivery programmes are effective in reducing decay in pits and fissures of children's teeth and that community water fluoridation is effective in reducing the cumulative experience of dental caries within communities[8].

Improving oral health in adults requires a different focus. Attitudes to dental and oral care in adults have changed dramatically over the last 30 years, with only 18% of Scottish adults suffering the loss of all their natural teeth in 1998, compared to 44% in 1972[9]. However, the 1998 figure for the UK was 13% and clearly there is no room for complacency in Scotland. Deprivation, systemic disease, poor nutritional status and drug associated changes impact on the ability of older people to maintain their oral health. As only 50% of the population are registered with an NHS dentist, many adults at risk of oral cancer are unlikely to access dental services, and therefore it is crucial that all those involved in the care of older dependant patients should be aware of oral health issues. The complexity of improving oral health requires engagement between NHS Boards, local authorities, the dental profession, medical professionals, health visitors, educational establishments, parents and carers[5]. Joint working between the dental profession and LHCCs has the potential to improve both oral and general health through a common risk factor approach[10]. A number of chronic diseases such as heart disease, cancer, strokes, accidents and oral diseases have risk factors in common. Risk factors are relevant to more than one chronic disease.

Diets high in saturated fat, sugar and low in polyunsaturates, fibre and vitamins, are associated with CHD, strokes, diabetes, cancers, obesity and tooth decay. A further malign influence is the food and advertising industries which continue to market unhealthy diets to successive generations of children and their parents.

Smoking is a cause of a large number of chronic diseases; cancer (including head & neck cancer), CHD, strokes and periodontal (gum) disease leading to tooth loss. High alcohol consumption is associated with hypertension, cirrhosis, CHD, cancers, malnutrition and many social problems such as domestic violence, crime, teenage pregnancies and injuries including fractures of the jaws and teeth. Figure 1 below provides a conceptual framework for a common risk factor approach. It is clear that structural change, such as banning tobacco, alcohol and child directed advertising and improving food labelling would reduce the chronic disease burden so prevalent in Scotland today.
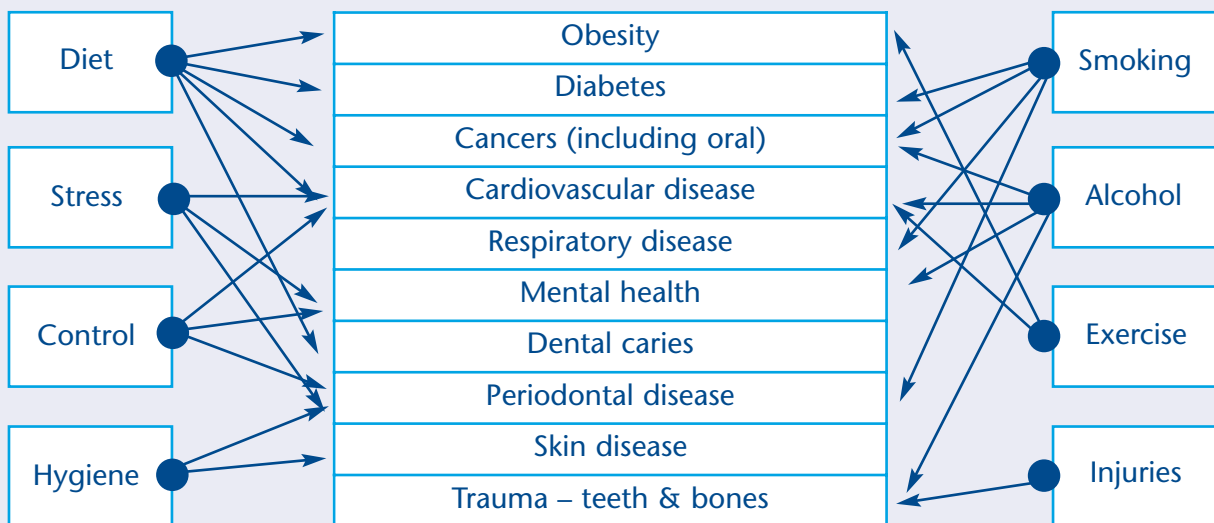

Figure 1   After: Sheiham & Watt (2000). The common risk factor approach.[10]

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In adopting the common risk factor approach opportunities will also exist to target general health promotion to individuals who attend a dentist. One example currently being investigated is the effectiveness of referral for smoking cessation introduced during routine dental attendance.

It is clear that agreement between the key LHCC stakeholders as identified by the Scottish Executive will be crucial in implementing the emerging evidence for effective interventions for improving both oral and general health. In this context, public involvement has become an important area for consideration in helping to develop health policy and re-design services. For example, the Scottish Consumer Council (SCC) utilised focus groups in 2003 to gather parents' views on how to tackle poor oral health in children in response to the Scottish Executive's consultation on *Towards Better Oral Health in Children*[11].

Their research focused on a small number of parents who might have experienced disadvantage and they identified that the prohibitive costs of "healthy" food, toothbrushes and toothpaste made it difficult for parents to ensure they adhered to guidelines for healthy diet and oral hygiene. Many parents did not attend the dentist regularly due to fear and the cost of treatment, and there was a widespread feeling that schools could do more to give children healthy meals.

2.2 WIDER POLICY CONTEXT FOR ORAL HEALTH IN PRIMARY CARE

There are a number of policies aimed at different parts of health and social services which, if implemented as intended, have the potential to support the improvement of the population's oral health. In 1996, *Eating for Health: A Diet Action Plan for Scotland*[12] produced a wide range of recommendations for improving the diet of Scottish people, including several which would have a direct impact on oral health by reducing sugar consumption and its frequency of intake. In particular, the Plan recommends a number of measures to give schools and nurseries a major role in improving the diet, and consequently the oral health, of children.

There are also new measures for improving health and social services for older people, underpinned by a standardised, but locally flexible single shared assessment of all elderly people who are in need. In 2001, the Scottish Executive made recommendations based on a report by the Joint Future Group[5] that social work, health and housing develop a single shared assessment procedure based on a minimum standards checklist with core data sets for assessed needs and care plans. Oral health is included in the Assessed Need Core Dataset and dental services are included in the Care Plan Core Dataset. Clearly the general health of older people is likely to benefit from oral health and dentistry being included in future core data sets. It is therefore unfortunate that oral health assessment is not necessarily being undertaken in some areas currently using these data sets, and LHCCs should take note of this in developing their Joint Futures activity.

For younger people, *For Scotland's Children*[13] (2002) identified ways in which local authorities, the NHS and the voluntary sector can work together to create a single children's services system to ensure that children can have the best possible start in life. This report produced a series of Action Points, including ensuring inclusive access to universal services, and recognises the contribution of informal collaborative initiatives to the health and well-being of children such as breakfast clubs in schools.

Partnership for Care[2] (2003) proposed that the Scottish Executive will "take forward in discussion with the dental profession proposals for changes to the system for rewarding primary care dentistry in order to promote prevention, improve access to services and improve recruitment and retention" (Chapter 6, para 28).

The White Paper also introduced a health improvement strategy which is detailed in *Improving Health in Scotland: The Challenge*[14]. This document notes the intention to deliver *special focus* programmes in the areas of physical activity, healthy eating, smoking, alcohol, mental health and well-being, health and homelessness and sexual health. Oral health is featured within two of these programmes: early years, and healthy eating. The early years priority includes an enhanced focus on improving childhood diet and oral health and the healthy eating programme aims to increase the demand for healthy food and to establish nutritional standards for school meals. This programme will also continue to implement the recommendations from the *Diet Action Plan*[12], with measurable results expected over the next 5-10 years.

2.3 DEVELOPMENT OF LHCCS

At the time of writing, it is more than five years since the concept of local health care co-operatives was born, first described in "Designed to Care", and four years since LHCCs were first established, under the new structure of Primary Care NHS Trusts. Described explicitly as "voluntary organisations of GPs which will strengthen and support practices in delivering care to their local communities", it was left to local systems to determine organisational structures. As they developed, the model of management and size of LHCCs varied widely across Scotland, depending on how agreement was reached on the voluntary association of GP practices and the size of the local population which ranged from 3,000 to over 170,000.

Over the succeeding 1-2 years, general medical practitioners came to dominate, reflecting the common interest of Boards and GPs in developments at LHCC and practice level aimed at integrating primary and community-based care, and reducing the barriers between the community and acute hospitals.

Relationships with other groups of independent contractors were usually not close and extremely variable in extent. While money could be targeted at specific short-term projects to promote, say closer working between LHCCs and community pharmacists, wider contact was patchy. Area professional committees of the independent contractors often nominated link people for LHCCs, but these nominations were, in most cases, sleeping partners. This was due to three main reasons:

- The suspicion of independent contractors regarding loss of independence to LHCCs.
- The concentration of LHCCs on the huge agenda facing them in drawing together local GPs, promoting closer working with the local authorities, and involving the public. This meant the main focus was not necessarily on dental issues in the first instance, if at all in some areas.
- Issues of remuneration for involvement with LHCCs.

In general, therefore, LHCCs did not secure the involvement of general dental practitioners (GDPs) in their activity, but they still managed to keep a focus on oral health issues,

particularly for children. In addition, the Community Dental Service (CDS) continued to provide and develop services for targeted groups not registered with GDPs, and in some areas, the CDS came to be directly managed within a Primary Care Trust and hosted by a single LHCC.

By the time the first major review of LHCCs was published in 2001, (*Connecting Communities with the NHS*[15]), a wider role for LHCCs was developing. In policy terms, the vision for LHCCs had been described thus:-

- to increase patient involvement and satisfaction with the health and social care they receive
- to increase the scale of partnership working with local authorities, the acute sector and voluntary agencies
- to tackle inequalities and improve access to primary care services

This appeared to be a better fit with the aspirations of a growing number of LHCCs who saw their role as "championing the health needs of their communities".

Against that background, the LHCC Best Practice Group in the Autumn/Winter of 2000 had found little evidence of dentists' involvement in LHCC direction, nor of oral health featuring significantly in their plans. Community Dental Services tended to continue to be managed outside of LHCCs, many General Dental Practitioners saw a loss of earnings and the lack of financial recompense as a barrier to becoming involved with LHCCs and frankly remained to be convinced of their relevance to general dental practice.

Around the same time, the publication of *An Action Plan for Dental Services in Scotland*[4] in 2004 brought a helpful focus to the issue. It is argued, however, that it missed an opportunity to highlight the developing role of LHCCs as potential allies in delivering the health and service improvement targets. The subsequent strengthening of LHCCs' health improvement role with the introduction of Public Health Practitioners in every LHCC in Scotland has however re-emphasised that opportunity, and issues relating to oral health and dentistry are more commonly featuring on LHCC agendae.

Although each LHCC will have local priorities for oral and dental health, these will in turn be influenced by national priorities and initiatives. The Action Plan for Dental Services contained specific and measurable targets for Oral Health, as follows:

By 2010…

- 60% of 5-year-old children to have no history of dental disease
- Less than 5% of adults aged 45-54 years with no teeth
  Specific actions for achieving children's oral health targets cover areas such as:
- Prevention and registration
- Service availability and access including Emergency Dental Services

- Quality and standards
- Responsive services
- Human resources and Teamworking
- Infrastructure
  (for more detail see Appendix 1)

As with all national targets for health, Boards, and by extension, LHCCs, are now asked to demonstrate via the Performance Assessment Framework (PAF) how they are making progress towards meeting oral health targets (Appendix 2). Oral health should also be seen in the wider context of general health and this introduces the concept of common risk factors and the potential benefits of involving a partnership of dental teams and other primary care professionals working together to achieve health improvement. Also, public involvement is key to the success of the LHCC and as around 50% of the adult population is registered with a dentist, there is great potential for the dental team to use patient contacts for promoting general as well as oral and dental health.

There is no doubt that the rather tentative and limited concept of the LHCC as an extension to general medical practice has been left behind. With the right kind of support and strategic influence, LHCCs have become significant players in community planning, in many cases taking the lead, and are helping to shape the emerging relationship between health and local government. With local councils now having a statutory role in health improvement, this will continue to grow and projects involving LHCC staff such as health visitors, school nurses and public health practitioners in secondary, primary and nursery schools will help to mainstream oral health and dentistry as core elements of the LHCCs' work.

The publication of Partnership for Care[2] in 2003 brought a recognition that LHCCs are the key building blocks for primary care services and that they are now the main focus for planning the development of community health services. From 2004 onwards they are expected to evolve into Community Health Partnerships to reflect a new and enhanced role in service planning and delivery. Their role will be to:

- ensure patients and a broad range of healthcare professionals are fully involved
- establish a substantive partnership with Local Authority services
- have greater responsibility and influence in the deployment of NHS resources by Boards
- play a central role in service redesign locally
- act as a local focus for integrating both primary and specialist health services
- play a pivotal role in delivering health improvement for their local communities

There will now be a requirement on NHS Boards to devolve appropriate resources and responsibility for decision making to frontline staff and ensure that Community Health Partnerships provide an effective basis for the delivery of local healthcare services. This will bring with it a greater incentive for all community and primary services (whether dental, medical, pharmaceutical or optical) to expect "a seat at the table" and to make effective use of the

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Partnership resources and relationships to help deliver modern dental and oral health services in Scotland.

2.4 DEVELOPING THE PUBLIC HEALTH ROLE OF PRIMARY CARE

"The public health will be best served if the specialist public health workforce is multidisciplinary and able to bring a wide range of experience and perspectives to the understanding and solution of public health problems"
Review of the Public Health Function in Scotland 1999[16]

Progress in developing the public health role of LHCCs has the potential to increase with the publication of *Partnership for Care*[2] which indicates that as LHCCs evolve into Community Health Partnerships, they will have greater responsibility for integrating health services, linking with local authorities and communities and playing a pivotal role in delivering health improvement for their local communities.

The report in 2002 of the Primary Care Modernisation Group, *Making the Connections: Developing Best Practice into Common Practice*[17] identified that there was a need to further build capacity for public health and health improvement in Primary Care. This has happened in the past two years with the introduction of LHCC Public Health Practitioners (PHPs) to provide a lead in the development of LHCC programmes for improving health and well-being in the local population. Many LHCCs are setting up public health teams to include PHPs, other primary care staff, health promotion specialists and public health consultants. Others have established local public health networks, bringing together primary care and public health staff from the NHS and from other organisations including local authority health improvement officers and staff from healthy living centres, new community schools and health demonstration projects.

The public health roles of nurses in LHCCs are also developing quickly in response to the recommendations in 2001 from *Nursing for Health*[18] which include:

• Working with individuals, families and communities at practice, leadership, strategy and policy levels
• Identifying and targeting needs effectively
• Working in partnership within and outside the NHS
• Appropriate training and support being made available.

A series of public health nursing conferences was organised in the summer of 2002 to support the development of health visitors and school nursing towards public health nursing. The discussion at the seminars identified that public health nurses regard themselves as being integral to public health, focusing on health improvement rather than disease management, and that they work best for health improvement in partnership with others in community-based, multi-agency teams. They are keen to explore different models of service delivery in relation to local needs and could be seen as potentially valuable links between Primary Care Dental Services and the LHCC.

Nursing for Health: Two Years On[19] documents progress made by nurses in developing their

contributions at all levels to the public's health by 2003. School nurses and midwives are increasingly becoming linked to, or part of the LHCC structures, and partnership working outwith NHS structures is becoming more established. Many LHCCs are developing multi-disciplinary health improvement teams, for example for youth health and oral health.

The Allied Health Professions (AHPs) have adopted similar principles for public health to their nursing colleagues, and in 2002 these were documented in *Building on Success: Future Directions for the Allied Health Professions in Scotland*[20]. They see their roles in health improvement to be working within a collective multi-professional team, shifting the focus of their work from reactive service provision to being proactive in improving health. AHPs are developing public involvement initiatives and community-based activity, such as the community food workers project developed by community dieticians and community health workers in Ayrshire and Arran.

Also in 2002, *Pharmacy for Health: The Way Forward for Pharmaceutical Public Health in Scotland*[21] identified the ways in which pharmacists can respond to the new environment for health improvement including taking a population perspective as well as supporting individual needs. It highlights, among other issues, that community pharmacists are ideally positioned to give oral health advice and play a role in the early referral of suspected oral cancers. Pharmacists are keen to work more closely with LHCCs, particularly through linking with PHPs and other multidisciplinary colleagues.

2.5 DENTAL PUBLIC HEALTH
Dental Public Health is a specialty of dentistry and is defined as, *"the science and the art of preventing oral disease, promoting oral health and improving the quality of life through the organised efforts of society."*

Consultants in Dental Public Health are based in NHS Boards and are primarily concerned with the development of a local strategic framework for Health Improvement and the delivery of dental services within national guidance and local priorities. Working across the public sector their role in improving oral health and reducing dental health inequalities makes them a key stakeholder for partnership working with LHCCs/CHPs.

The discipline includes such topics as oral epidemiology, dental health services research, preventive dentistry, especially in relation to communities, dental health education and promotion, clinical research with particular emphasis on the care of special groups, behavioural sciences related to dentistry, decision theory, and dental health economics.

2.6 ROLE AND ORGANISATION OF PRIMARY CARE DENTAL SERVICES
Primary Care Dentistry is provided by dentists and by Professionals Complementary to Dentistry (PCDs) in the General Dental Services (GDS), in the Community Dental Service (CDS) and Salaried General Dental Service (SGDS) These service branches are known collectively as the Primary Care Dental Service (PCDS).

2.6.1 GENERAL DENTAL SERVICES
As at March 2002, there were 1866 dentists (not whole-time equivalents) providing NHS dentistry in Scotland[22].

Key points about General Dental Practitioners (GDPs) are that they:

• are independent contractors
• employ their own staff
• do not receive financial support for staff costs, administration, management, premises costs, and practices are run almost entirely from fees generated from care and treatment provided to patients
• own their own premises

These last two points differ significantly from arrangements for General Medical Practitioners. Dentists, unlike doctors, receive no financial help with staff costs, premises (apart from reimbursement of business   rates), equipment or materials, all of which must be funded directly from earnings. Because of this, any time spent away from the chair-side effectively results in a loss of earnings, whilst practice overheads continue to accrue. Increasingly there are professional quality issues which make further demands on time and many GDPs now feel the NHS fee structure does not adequately support the requirements of modern dental practice.

These factors have an important bearing on whether GDPs can become involved in the working of LHCCs to any meaningful extent without direct reimbursement for time spent away from their practices. At the British Dental Guild reimbursement rate of £219.50 per session (August 2003) it is unlikely many LHCCs could afford to fund this involvement. A different approach to the problem may be required, and possible ways of doing so are looked at in section 3.

The GDPs have a contract with, and are accountable to, the Primary Care Trust (or Island NHS Board) to provide General Dental Services. However they are not obliged to accept any patient under GDS arrangements nor are they restricted in the location of their practice. It is increasingly common for GDPs to offer treatment under private contract as well as/instead of GDS.

2.6.2 SALARIED GDPs
There is a small number of dentists (96) accounting for 4.9% of practitioners who provide GDS care and treatment but receive a salary rather than fee per item of service. They have a contract of employment with the Primary Care Trust/Island NHS Board and are managed as part of the CDS, working in health centres/community clinics. In addition there are some Joint CDS/GDS posts where the postholder is a salaried NHS employee and undertakes both GDS and CDS duties.

2.6.3 COMMUNITY DENTAL SERVICE
The CDS is a salaried dental service employing 225 dentists. They also employ hygienists, therapists, nurses and Oral Health Promotion staff. Together with the salaried practitioners described in 2.5.2 they form what has come to be known as the Salaried Primary Care Dental Service (SPCDS). Community dental staff are employed by the Primary Care Trust and are responsible for the provision of dental care to priority groups including patients with special needs, and specialist services such as general anaesthesia and sedation to the wider population The service also discharges a Dental Public Health role in terms of dental inspections, epidemiological field work and oral health promotion.

It is clear that SPCDS practitioners, unlike independent contractors, could in theory devote time to the LHCC without suffering the penalty of "lost income". This must be seen however against a background of increasing waiting lists/times for treatment in the salaried services.

Another issue to consider is that as a managed service with a relatively "flat" structure, there are few individuals available to represent the service at executive level. Thus, in Boards which have several small LHCCs, it may not always be possible to have adequate representation of the SPCDS on the LHCC.

On the other hand, the CDS is fortunate to have developed well established networks of LHCC and CDS staff due to a history of a shared approach to the care of priority groups, and this has helped to establish a common awareness and understanding of relevant issues without the necessity of a formal presence on committees.

Nevertheless, the emergence of Community Health Partnerships (CHPs) which will be larger and fewer in number than existing LHCCs, should facilitate a more effective representation of SPCDS, and hopefully also GDS, due to the reduced number of dentists required for committee membership.

2.6.4 PROFESSIONALS COMPLEMENTARY TO DENTISTRY

PCDs are employed to support the work of dentists in all branches of primary care dentistry. They include dental hygienists and therapists who practise under the direction of the dentist and carry out a limited range of treatments. The roles of hygienists and therapists have recently been extended by the General Dental Council and it is possible they will be able to help alleviate access problems due to the current shortage of dentists by carrying out a greater range of duties. Given the emphasis on partnership working in the LHCC/CHP context, there is a need to consider skill-mix in dentistry in the same way as has happened in other health care professions. It would therefore be possible to increase "dental" input to partnerships in a cost-effective way by the creative use of PCDs in future.

2.6.5 DENTAL PRACTICE ADVISERS

The National Dental Advisory Committee carried out a review of Dental Practice Advisers (DPAs) in Scotland in 2001[22], and made recommendations on their role. However, with the proposal that CHPs should have a strengthened role in service planning and delivery as well as provide a forum for independent contractors to come together to support health improvement[23], it is clear that the DPA's proposed advisory and communication links need to be revisited to strengthen and make more relevant their input at this level. The group recognises that the role of the DPA could have a significant impact on further integration of the PCDS and raise the profile of the independent contractor service within the CHP.

There is growing evidence of problems in accessing GDS dentistry as fewer practices appear willing to accept new patients under GDS arrangements. In addition there is difficulty in recruiting dentists to many areas of Scotland. The Scottish Executive has introduced financial incentives to attract practitioners to rural and remote areas to complement earlier incentives eg "Return to Work" and "Scottish Dental Access Initiative".

2.6.6 CO-ORDINATION OF PCDS AND INVOLVEMENT WITH LHCCs

It can be seen that due to the fundamental differences in roles, funding and method of service delivery between the component branches of the PCDS, there are significant challenges to the provision of a seamless and co-ordinated service for patients. Existing professional committees serve to provide professional advice to NHS Boards and to advise on independent contractor service issues, and are therefore not suited to co-ordinating service delivery in response to need at a local level. As LHCCs develop towards CHPs, there is likely to be greater co-terminosity between CHP and local authority boundaries. This would present a good opportunity for Dental Committees to review their geographical area of responsibility and align themselves in a similar fashion instead of present arrangements which might cover two or more LHCCs and local authorities. This would establish a more appropriate grouping which could facilitate effective communication, organisation and delivery of services in response to local needs.

Another issue is that access to PCDS can be rather difficult in some LHCC areas due to geography, recruitment and retention, and/or lack of service availability. This has led to increased pressure experienced by GPs to provide pain relief or control of dental infection, often out-of hours. Although there are dental workforce issues which contribute to this situation, closer integration of PCDS and the LHCC would help to improve understanding of the problem, identify solutions, and improve the eventual journey for the patient. Where it is not possible to identify a dental practice to provide NHS dentistry, salaried practitioner or joint posts may be established in a locality following a business case for redesign being approved by the Scottish Executive. The LHCC can contribute to the business case in partnership with the Clinical Director of SPCDS and the Consultant in Dental Public Health.

2.6.7 CONCLUSION AND RECOMMENDATIONS FOR ACTION

Whilst this new CHP framework presents an exciting opportunity for achieving real progress in oral and dental health improvement there nevertheless continues to be a lack of awareness within the independent contractor sector of PCDS of how partnership working might benefit both themselves and the patients they care for.

This essentially requires a cultural shift given that the structure and organisation of the GDS has since its inception supported the existence of stand-alone independent practices, which to an extent are "competing" for patients. However, evidence is emerging in some localities where practitioners, through engagement with LHCCs have benefited by support for clinical governance, training and improved information flow to assist in the care of individual patients. Cultural change takes time, but a clearer articulation by LHCCs of the benefits to be gained through partnership working together with practical advice on how to implement change would undoubtedly speed up the process.

It is argued here that there also needs to be a feeling of ownership and the ability to influence the agenda at a local level on the part of GDPs, and here again there is the potential for a significant change to take place as we move towards CHPs.

Whereas the NHS Board or Primary Care Trust was previously seen as a relatively remote body concerned solely with administrative matters, there could be a much closer interaction with the CHP in ways which would directly influence support for practices and a collaborative approach to health improvement.

The component parts of PCDS, i.e. General Dental Service and the Salaried Primary Care Dental Service consisting of the Community Dental Service and Salaried General Dental Service, have developed an improved degree of partnership working between themselves in recent years but again this is by no means a universal situation and is hindered by the lack of a robust framework within which to operate. This framework can potentially be provided by the CHP, and, together with a redefinition and clarification of roles of the Salaried Primary Care dental services as a result of a Scottish Executive review currently underway, should go a long way to facilitate a fresh approach to patient care and health promotion.

The Working Group recognises the opportunities presented in the move from LHCCs to CHPs for a more meaningful collaboration with Primary Care Dental Services to address the wider aspects of improving oral health. Recommendations for action include the following:

• GDPs could be more involved with the developing CHPs than previously within LHCCs
• Joint Future developments for older people should include oral health assessments using new core data sets
• Dental committees could review their geographical boundaries in order to align themselves more closely with CHPs
• Dental Practice Advisers could potentially have a significant role in integrating dental services with CHPs.

2.7 INFORMATION MANAGEMENT AND TECHNOLOGY

2.7.1 IM&T IN THE LHCC
An essential part of the infrastructure underpinning the successful and effective involvement of the PCDS in the LHCC must be efficient and well-developed IT systems both for data capture and exchange and also for effective communication.

2.7.2 USE OF DENTAL INFORMATION WITHIN THE LHCC
To date, dental information has not been widely used by LHCCs although some areas have used data to help inform local health needs assessment, e.g.

• school dental inspection data
• epidemiological data for specific age groups (by LHCC)
• dental registration data

These data may also be used, together with information on staffing levels, to assist in the planning, monitoring and evaluation of local services as well as health promotion and preventive interventions.

Dental information may be used to complement other information on population demographics, economic, and general health and function indicators to help build a health profile of the LHCC and indeed districts within it. A good example of this can be seen in the exercise carried out by PHIS for Paisley LHCC[24] bringing together a wide range of data on health and its determinants to assist local planning.

Information currently collected within Primary Care Dental Services (PCDS) is contained in Appendix 3. One difficulty with PCDS information is that there is a lack of direct comparability in some aspects of data collected by the CDS and GDS, e.g. disease status, treatment details, registrations, and LHCCs should be aware of this when interpreting the data.

Sources of other information which may be useful to LHCCs in progressing the oral health agenda are also listed in Appendix 5.

2.7.3 USE OF INFORMATION MANAGEMENT AND TECHNOLOGY (IM&T) BY THE PCDS

Whilst LHCC IM&T developments have resulted in much improved and more rapid communication between GPs, Community Services and Primary Care administration, PCDS have, to date, experienced a lack of any co-ordinated IM&T development. In addition there appears to be a wide variation in progress both within the CDS across Trusts, and between independent practices across the country.

Within the GDS, IT is used for patient administration, practice administration and links with the Practitioner Services Division of the CSA in respect of fees for service. Software used is not currently compatible with GPASS (GP Administration System for Scotland – used by around 80% of GP practices) or other LHCC software systems.

Within the CDS development of IM&T has been patchy. The main issue is the lack of dedicated software for a CDS patient administration system, but this problem is now being addressed with support being given to the development of a national software programme for the SPCDS. When operational, this will also be able to interface with GPASS and be able to generate GP17 Reports to collect patient treatment data and facilitate payments by the Common Services Agency (CSA).

2.7.4 CONCLUSIONS AND RECOMMENDATIONS

The lack of standardisation in data collection and also the patchy use of IT act as a barrier to development of information systems within individual PCDS branches but also to any meaningful collaboration and partnership working by PCDS within the LHCC. Many of these issues have been recognised at national level, and a report published by a National Dental Information Working Group in 2001[25] recommended 32 specific areas for action to address them. The Working Group endorses these recommendations within the context of this report and in addition, would make the following recommendations to help create an effective IM&T system to underpin collaborative working:

• A minimum dental data-set should be collected containing reliable and valid data from CDS and GDS to be able to identify local oral health needs for LHCCs. This data would be shared within the LHCC in a format conducive to easy interpretation and include inter alia references to oral/dental health, dental registration, coverage of preventive programmes.

• Dental information to be accessed via SHOW LHCC website.

• A standardised approach by the different branches of PCDS to collection of specific data with which to populate the minimum data set.

- Use of the Community Health Index (CHI) number as a patient identifier, to bring PCDS into line with developments elsewhere in the NHS. This should happen at the earliest possible date.

- Compatibility between the software systems used by LHCC and PCDS.

- Linking of GDS practices to the NHSnet thereby facilitating e-mail communication between PCDS service branches and between PCDS and the wider LHCC. This would include access to Electronic Clinical Communications Implementation (ECCI) and Scottish Care Information (SCI) store.

- Use of Electronic Data Interchange for patient registration and payments to independent and Salaried GDPs.

3. WHAT IS HAPPENING?

3.1 LHCCS AND ORAL HEALTH

To establish a baseline of LHCC activity in the area of oral health, the project sent out a Questionnaire (See Appendix 3/4) to all LHCCs, Clinical Directors of Community Dental Services, Consultants in Dental Public Health and Dental Practice Advisors. The overall response rate for questionnaires was 55%. The Questionnaire looked at a range of issues under four main headings: Structures, Oral/Dental Health Needs Assessment, Public Health and Dental Services.

3.1.1 STRUCTURES

While all LHCCs have extensive GMP involvement with their formal structures, the link to GDPs is very limited indeed. Links with local salaried dentists appear to be stronger. Some LHCCs have a dental involvement with Clinical Governance committees, but GDP membership of LHCC Steering or Executive Groups is very limited; a contact person may have been nominated by the Local Dental Committee but will usually be unable to attend the meetings, and where there is an individual presence, wider communication with GDP colleagues can be problematic. This highlights the issue of remuneration for GDPs and the contractual differences between themselves and GMPs (see 2.6.1). Some LHCCs have tried to engage with GDPs, but have been unable to do so. There are some notable exceptions to this, but most LHCCs reporting contact with dentists, had achieved this through the CDS e.g. in establishing referral links for vulnerable groups, needs assessment, or joint health promotion initiatives.

A model of Oral Health Action Teams (OHATs) which has been established in Glasgow had some success in involving GDPs. OHATs seek to progress NHS Board oral health strategy and link LHCCs with community networks in order to co-ordinate local resources for promoting oral health. They adopt a multidisciplinary approach and are composed of the LHCC General Manager, Public Health Practitioner, dietician, health visitor, pharmacist, general dental practitioner (working on average 2 sessions a month), community dental officer, community representatives and oral health promoter. The GDP on the team seeks to facilitate the involvement of other GDPs in OHAT activity.

There was significant financial support for the development of this model and evaluation in due course will determine whether it is a viable and effective model suitable for wider application.

Another example of a way of linking the PCDS and LHCC can be seen in West Renfrewshire, where the LHCC has established a novel post of Dental Public Health Liaison Worker. The aim is to have a funded liaison post engaging with all the dental practices in the area covered by the LHCC linking full-time between the LHCC, the GDS, and also the Salaried Primary Care Dental Service. This post, by taking the LHCC to the practice, involves the GDPs without their sustaining a financial loss of surgery down-time to LHCC meetings (or the heavy reimbursement costs to the LHCC should it try to fund GDP sessional time). Issues progressed include staff training and joint projects linked to oral health. GDPs perceive tangible benefits to the practice through the link with the LHCC and as a consequence are more motivated to become involved. The LHCC in turn benefits from having a member of staff with an oral health remit facilitating collaborative work around oral health involving primary care and community networks. This approach will be evaluated at the end of the pilot stage in 2004.

3.1.2 ORAL/DENTAL HEALTH NEEDS ASSESSMENT
There is no consistent approach to needs assessment. In some areas it has been carried out on a NHS Board-wide basis. In others, smaller scale local assessment has been undertaken either around a single locality or by targeting children at particular ages e.g. 2 and 4 years, Primaries 1 and 7, or the pre-five group as a whole.

Prior to 2003, the CDS carried out dental screening to identify treatment need on some or all of these groups depending on resource availability. A new inspection system is now in place throughout Scotland which will identify the risk of children developing dental disease, and information resulting from this exercise could be made available on LHCC/CHP basis.

A more detailed inspection is also in place which will give calibrated epidemiological data on dental disease for primary 1 and primary 7 children as part of a rolling programme. The data are available on a NHS Board basis but could also be collected for the LHCC/CHP locality.

Apart from CDS staff, a wide range of staff are reported to be involved in needs assessment including: Health Visitors, School Nurses, CDS staff, Oral Health Promotion staff, Public Health Practitioners (PHPs), Consultant in Dental Public Health, LHCC Managers.

Health Visitors have been closely involved in caries risk assessment of pre-school children, e.g. in Dundee where research has produced a model of risk assessment which can be used in any primary care setting to facilitate the accurate targeting of health care resources[26].

Another model of risk assessment has been used in Inverclyde where Health Visitors complete a risk assessment card for all new babies at the first home visit. Follow up and appropriate interventions by Oral Health Educators takes place at GP Well Baby clinics or in CDS clinics.

3.1.3 PUBLIC HEALTH-ORAL HEALTH PROMOTION
LHCC activity in oral health promotion is extensive and collaborative working with staff from Health Promotion Departments is common although variable. The Community Dental Service has as part of its remit a public health role and has in recent years established good working links with health visitors and education staff. The advent of the Public Health Practitioner post has made a significant difference to levels of activity in this area at LHCC

level, and represents a key resource for further development. The type of work reported consists of the following:

- Tooth brushing initiatives
- Work within schools including School Nutrition Action Groups, healthy tuck shops, fresh drinking water
- Encouraging registration with GDPs including birthday card schemes for one-year olds
- National Smile Week
- Dental hygienist/oral health promotion staff input to well baby clinics
- Oral health awareness training
- Fissure sealants schemes
- Targeting school leavers
- Involvement with health promoting nurseries and schools
- Involvement of smoking cessation services
- Provision of drinking cups for under 5s
- Oral Cancer awareness training

Several LHCCs reported a very close link with Consultants in Dental Public Health (CDPHs) and listed specific examples of joint work. Some others felt they "could approach the CDPH if issues arise" and were aware of a named contact.

3.1.4 DENTAL SERVICES (MAIN ISSUES FOR LHCCs)
This section elicited an extensive response, and had several clear themes.

1. Services were inequitable due to a range of factors:

- Problems of recruitment and retention of dentists
- Difficulties in many areas in accessing NHS Dentists
- Remote and rural issues of transport and access
- Poor dental health records
- Waiting lists
- Lack of free dental checks for low income families
- Disabled access

2. Out of Hours Services were variable and difficult to access and LHCCs did not have a close linkage with these services.

3. Addressing the needs of older people and ethnic minorities

4. Lack of involvement of GDPs in LHCCs, and lack of joint working between GDPs and CDS

5. Need to do more outreach work aimed at nurseries and young parents

6. Developing educational events for all groups with an oral health interest including GDPs

3.2 FOLLOW-UP AND DISCUSSION

A follow-up to the questionnaire was made by contacting a small number of LHCCs to see if any further detail could be gained. In general, there was little to be added, apart from acknowledgement that much more needed to be done in the area of oral health.

There was nevertheless much evidence of activity around oral health being carried out by LHCC staff, Health Promotion Departments, CDS and Consultants in Dental Public Health (CDPH). The picture is far from bleak, and there are opportunities to share the many examples of good practice which were reported. Issues which generated particular comment were:

1. Needs Assessment

Oral and dental health needs assessment requires information on demographics and health status and may also look at service availability.

Many of the determinants of oral and dental ill-health, as with other types of morbidity, originate in lifestyle and social background. The dental profession collects a lot of data regarding actual disease status in individual clinical examinations or epidemiological surveys of groups of the population. Screening for risk of disease is only carried out in pre- and primary school aged children.

At LHCC level, however, much of the other data required for planning either community interventions or re-designing PCDS may not be available from dental sources.

On the other hand, the LHCC Primary Care Team has a considerable amount of demographic and social information available and it would make sense to carry out needs assessment on a collaborative basis.

Responses to the questionnaires indicate that health needs assessment information was, indeed, drawn from many sources as well as dental services, e.g. – Health Visitors can provide information on general health, social background and siblings' dental health, invaluable information when making an assessment of an infant's risk of dental disease.

What is perhaps missing is a consistent and structured method for carrying out oral and dental health needs assessment for different population groups. As a starting point, it is suggested that when an oral health needs assessment is required for whatever purpose, not only dental staff but the wider Primary Care Team is consulted[27].

2. Links between GDPs and LHCC

These are still very limited, and the following comment seems to sum up the view of many:

"The LHCC is very keen to engage with GDPs and would welcome advice from other LHCCs on how to gain (their) support. We have a few enthusiasts but the majority are still asking "What's in this for me?"

3. WHAT IS HAPPENING?

Clearly, the motivational aspect in any form of collaboration is very important and particularly so in the case of independent contractors who will, perhaps, have a different cultural perspective from a large multi-professional organisation such as an LHCC, and be financially disadvantaged by some aspects of involvement.

The benefits of partnership working therefore have to be clarified, both from a patient's as well as an individual GDP's perspective. As LHCCs move towards CHPs it is possible, for example, that they could hold delegated authority for budgets. This could, in turn, mean that GDPs would deal directly with the CHP on issues such as practice improvement grants, contracts for support services including Health & Safety, waste disposal, IT, etc.

Other benefits might include organising accredited training events for dentists and staff, either on a uni- or multi-professional basis. These initiatives would establish inter-personal relationships which are essential to creating a sense of ownership and this could be further developed by developing joint working in areas such as clinical audit, research and oral health-related projects.

Examples of projects could include:

• the early detection of oral cancers involving GDPs, GMPs and other staff
• oral health promotion and registration with GDPs aimed at children under 5

The increasing public health role for school nurses and health visitors, and the support of public health practitioners give LHCCs the opportunity to prioritise action around oral health, and support closer working with both the CDS and GDPs.

One of the most frequently mentioned barriers to GDPs attending meetings is the opportunity cost of lost income from patient treatment. There are several ways in which this might be overcome, e.g.:

• Flexibility of meeting times – possibly outwith surgery hours, although the opportunity costs of meetings held in "free time" should not be underestimated.
• Meetings agendae structured such that dentists can focus on (for them) relevant issues in the limited time available to them.
• Funding a link post i.e. a person who can liaise between the LHCC and all practices at a time suitable to them instead of one GDP attending meetings and having to try to contact colleagues thereafter.
• Increased use of skill-mix to progress in a cost-effective way partnership working. This could be achieved by the wider and more creative use of PCDs than happens at the present time and should apply to clinical as well as public health duties.

Another powerful incentive for securing the involvement of GDPs might be for the LHCC to work on the provision of new facilities and the sharing of premises with other Primary Care professionals. This would be of particular benefit where the requirements of new legislation, e.g. Disability Discrimination Act, could not be met by dentists in their existing accommodation. This would also help with recruitment to secure better access in rural areas.

In terms of service access, a more radical area for the CHP of the future might be to provide sessional funding on a contractual basis for specific types of service, e.g. children's dental care.

At the present time however this arrangement would not be possible without new primary legislation.

3. Out of Hours Services

These have been highlighted in responses as areas of major concern for LHCCs. Redesign of out-of-hours services is now underway in the NHS, driven by the roll-out of NHS24 and the implementation of the GMS Contract. This presents both the GDS and CDS with an important opportunity to become involved thereby ensuring that benefits to patients are maximised. Issues being considered by NHS Boards are:

- The relationship with NHS24 as it becomes the first point for all public telephone contact with services.
- The relationship between out-of-hours medical services in A&E and General Medical Practices.
- Transport issues for people requiring out-of-hours treatment and care.
- Specific challenges to access faced by people in remote and rural areas.

These redesign issues affect all parts of the NHS – Dentists and Community Pharmacists, as well as GPs and Hospital services. The opportunity to join up services across service boundaries and around the patient journey is an opportunity that should be carefully considered by Primary Care Dental Services.

Conclusion

This section reflects the information received from LHCCs across the country, and the many issues raised under each topic. It is encouraging it has produced so much evidence of work taking place within and across the LHCCs to improve oral health, although there appears to be a lack of consistency either in range or scope of action.

Equally, the various barriers to further progress are clearly highlighted and this serves to define the key challenges which need to be addressed for the future.

There is a general recognition of the need for improved collaboration, particularly with the independent contractor sector of the PCDS, whilst acknowledging the tensions caused by different cultural perspectives. There is also evidence of a willingness to make it work, even though solutions to a lack of progress may be difficult to identify.

The "added value" to oral health improvement of joint working by the wider primary care team is frequently observed as is the willingness on the part of respondents to engage in this process.

4. WHAT NEEDS TO HAPPEN?

4.1 PARTNERSHIP WORKING

Partnership Working is not a new concept but it is increasingly recognised as an effective means of enhancing service delivery.

Section 3 lists many examples of "good practice" indicating that possibilities for partnership working do exist and are being acted upon locally to develop collaboration between PCDS and the LHCC with a view to improving oral health. Equally, barriers to collaboration have been identified together with ways in which some of these can be overcome. Based on this feedback, many areas where action could take place have been identified, and a summary of these is presented in Table 1 (see page 35). Clearly the domains listed in the table are interdependent and action should be progressed in as many of these as possible to achieve synergy and maximised outcomes (the list of examples within domains is illustrative and by no means exhaustive and could be augmented/modified to suit local circumstances).

Where collective agreement has been reached amongst stakeholders on strategic goals, action could and should be introduced quite quickly. Examples such as community health promotion involving Oral Health Promoters/Educators, Public Health Practitioners, Health Visitors and Local Authority staff will hasten the necessary process of cultural change in a process of "learning by doing" which is crucial for future success.

It is recommended that:

- **LHCCs/CHPs and the PCDS could reflect on the examples listed in Table 1 and use these to develop an action plan to take forward the concept of partnership working.**

Where novel structures or posts are set up, it is further recommended that:

- **Evaluation of the effectiveness and the cost-benefits of these initiatives is carried out. This in turn will provide a growing evidence-base on which effective practice can be built for the future.**

4.2 A FRAMEWORK FOR CHANGE

Progress will of necessity take place in different stages and at different levels, and the table identifies what should happen at local, area (NHS Board) and national levels.

So, whilst immediate action can begin at LHCC/CHP and Board level, there are nevertheless limits as to what can be achieved and it should be recognised that action is also required at national level to provide the necessary service strategy, framework and workforce for success. Unless action does take place at national level the Working Group is of the view that progress will continue to be unco-ordinated and lacking focus, with a less effective output as a result.

For example, national guidance on LHCCs and, more recently, CHPs, is clear in its aspiration that PCDS should be seen as part of the LHCC/CHP, yet there is no indication as to how this can be achieved in the context of existing PCDS policy, structures and organisation. As a consequence, there is little strategic direction which might influence and motivate change and the organisation and delivery of the PCDS.

Recommendation:

- **There should be a clear national statement on strategic aims for the PCDS, and how these services will fit into the CHP organisational context. This should form the basis for a review of roles and service delivery as those currently in place have clearly been developed to suit an NHS Health Board organisational context which, with the exception of the Islands, no longer exists.**

4.3 INDEPENDENT DENTAL CONTRACTORS

There are also issues of remuneration linked to the GDP contract which would benefit from review at a national level, as funding and access to resources is a critical part of the motivational jigsaw where the independent contractor is concerned. Given that the present GDS system is largely based on item of service fees, the inhibiting effect this has on flexibility of service delivery presents one of the strongest barriers to closer partnership working.

Already in England and Wales, the Health and Social Care Bill allows for a variety of ways in which GDPs can be contracted by PCTs to provide services, and how they receive payment for these services. This contractual flexibility could, if applied by NHS Boards and CHPs in Scotland, help to redesign a PCDS which would be more appropriate and relevant to local needs.

Recommendation:

- **The system of remuneration in the GDS in Scotland should be revised to reflect and support the principles of partnership working, and the ability to deliver oral health improvement at a local level**

4. WHAT NEEDS TO HAPPEN?

4.4 WORKFORCE ISSUES

Workforce issues are also a significant factor in delivering better services. Access to dental services is often a problem due to difficulties in recruitment which is caused in part by insufficient numbers of graduates.

It is therefore recommended that:

- **consideration be given to creating an expansion of the dental workforce including and with particular reference to Professionals Complementary to Dentistry. As well as addressing access problems, PCDs could be used creatively within the CHP context to become involved in community-based collaborative work to improve oral and dental health.**

4.5 INFRASTRUCTURE AND COMMUNICATION

These high-level actions need to be backed up by national support for infrastructure and, in particular, IM&T as outlined in Section 2. The national commitment to these actions, if made, would form the basis for a cohesive and structured move towards integration of PCDS in the working of LHCCs and CHPs for the future.

Finally, it is recognised that communicating good practice across LHCCs and CHPs would be of considerable benefit in speeding up the pace of change. Apart from local communication networks, it is recommended that:

- **the SHOW website for LHCCs is utilised as a tool for promulgating information on a national basis, and could serve as an effective electronic forum to facilitate wider partnership development.**

TABLE 1
GUIDE TO GOOD PRACTICE

SUMMARY OF KEY THEMES AND RECOMMENDATIONS FOR ACTION IN TAKING A PARTNERSHIP APPROACH TO IMPROVING ORAL HEALTH

DOMAIN	THEMES	RECOMMENDED ACTIONS	LEVEL FOR ACTION		
		(these examples are illustrative - for further detail see sections 3&4)	LOCAL	AREA	NATIONAL
MARKETING	Address the "What's in it for us?" question	- Consultation to identify potential "collaborative advantage" e.g. support for clinical governance/staff training/facilities	X	X	X
	Secure motivation and shared vision	- Clarify objectives, potential benefits for staff and patients and plan jointly for delivery	X		
COMMUNICATION	clear lines, direct and indirect	- agree communication methods, standards and accountability	X		
	develop IT links within profession and LHCC	- all PCDS and LHCC staff to be linked to NHSnet - use SHOW website	X X	X	X X

DOMAIN	THEMES	RECOMMENDED ACTIONS	LEVEL FOR ACTION		
	representation of stakeholders on LHCC	Core/executive group membership by PCDS - Advocacy on core/executive group by PHP or other liaison post - Involvement in sub-groups e.g. clinical governance - Involvement of the public in consultation and decision making, with focus on identified target groups e.g. older people/ethnic minority	X X X X		
	disseminating and sharing good practice	- Website/local seminars and training/presentation at national conferences	X	X	X
ORGANISATION	professional committees "fit" with LHCC, e.g. function/co-terminosity	- Review boundaries of existing committees for fit, consult on proposed changes to achieve co-terminosity		X	
	LHCC committees appropriate for task e.g. multidisciplinary/multi-agency Oral Health Group	- Seek clarity of purpose of partnerships and design structures to deliver output – must be action-based; no "tokenism"	X		

DOMAIN	THEMES	RECOMMENDED ACTIONS	LEVEL FOR ACTION		
SUPPORT INFRASTRUCTURE FOR PCDS	Dental Practice Adviser	- Clear links , accountability to, and ring-fenced time (funded) for, each LHCC/CHP	X	X	X
	Primary Care administration	- Administration functions to be managed by LHCC/CHP	X	X	
		- Support services e.g. Health & safety provided by LHCC/CHP	X		
	Consultant in Dental Public Health	- Involvement in needs assessment, monitoring and health improvement strategy development	X	X	X
	Facilities provision/ development	- GDS practice development funding to be managed by LHCC/CHP	X	X	
		- Joint planning for facility developments including dental surgeries	X	X	
	Training	- Funding of joint training for PCDS and LHCC	X		
		- PCDS also involved in delivery of training			

DOMAIN	THEMES	RECOMMENDED ACTIONS	LEVEL FOR ACTION		
DENTAL SERVICES DEVELOPMENT	Recruitment/Retention	- LHCC to consider possible incentives e.g. facilities training and support (see above)	X		
		- Triage facilities and staff support for OOH	X		
	Improved effectiveness of care	- Use existing joint planning structures, e.g. – local care partnerships, Joint Futures, Health Improvement/ Public Health networks	X	X	
	Integration of PCDS within LHCCs	- LHCCs/CHPs should carry out collaborative needs assessment. This would encourage primary care staff to consider oral health within their field and it would acknowledge the effect that the wider determinants of health have on oral health	X	X	
		- In relation to oral health promotion, good practice should be shared across LHCCs/CHPs and consideration should be given to sustainability of funding for initiatives that have shown evidence of positive outcomes	X	X	

DOMAIN	THEMES	RECOMMENDED ACTIONS	LEVEL FOR ACTION		
	Liaison with Acute Services	- Establish managed clinical networks e.g. early detection of Oral cancer	X	X	
	Joint planning for property issues, e.g. Disability Discrimination legislation	- audit of all primary care premises, including dental to reflect fitness for purpose	X	X	
		- develop business case for property to ensure consistent standards and approach	X	X	
	GDS contracts	- Need to have national review linked to clear strategy for PCDS			X
		- LHCC/CHP actively involved in lobbying for review, and feedback on eventual consultation	X		

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APPENDIX 1

ACTION PLAN FOR DENTAL SERVICES IN SCOTLAND
TARGETS AND ACTIONS IDENTIFIED IN PAF 2002-2003

Each NHS Board should develop an updated Action Plan for Dental Services for their area, in line with the priorities listed below.

Oral and dental health services can make a vital contribution to health improvement and patient care, as part of the wider NHS system. It is also important that these services are developed in partnership with Local Health Care Co-operatives, local professional bodies, and patient organisations and others.

Priority Area 1: Oral health/prevention

National targets: By 2010
- 60% of 5-year-old children with no history of dental disease
- Less than 5% of adults aged 45-54 years with no teeth

ACTIONS

- NHS Boards to ensure continued maintenance and expansion of existing schemes to improve child oral health
- NHS Boards to review oral/public health strategies for local population
- NHS Boards to review existing oral health care provision and treatment for older adults in care home settings, and put in place strategies to address gaps in provision.

Priority Area 2: Access to NHS Dental Services

National targets: Proposed:
- 25% of children (0-16 years) involved with preventive dental treatment (enhanced capitation) programmes by 2006
- 90% of children (0-16 years) registered (under care) with a dental team by 2008

ACTIONS

- NHS Boards and Primary Care Trusts to review current access to NHS Primary Dental Care Services within their areas and develop Board-wide strategies to ensure the community's dental health needs are met
- NHS Boards and Primary Care Trusts to review existing emergency dental service provision and plan/put in place measures to ensure local population has access to treatment in the event of dental emergencies

Priority Area 3: Human Resources and team working

National targets: Proposed
- Workforce output targets - set and achieved for all dental teams by 2006
- Education, training and working practice targets set and achieved by 2010

ACTIONS

- NHS Boards and Primary Care Trusts, working in conjunction with SEHD and NHS Education for Scotland, to support training, development and integration of dental workforce
- NHS Boards and Primary Care Trusts to actively support and encourage Professionals complementary to Dentistry

Priority Area 4: Quality and Standards

National targets: Proposed
- All dental practices inspected under current scheme by 2003
- All dental practices with "quality accreditation" by 2007

ACTIONS

- NHS Boards and Primary Care Trusts to ensure that national clinical standards and quality assurance requirements are adhered to and complemented by local guidelines and appraisals

Priority Area 5: Infrastructure/Resources

National targets: Proposed
- Premises standards achieved by 2006
- Dentistry fully integrated within national and local IM&T systems by 2006

ACTIONS

- NHS Boards and Primary Care Trusts to ensure Primary Care Dental Service premises meet required standards
- NHS Boards and Primary Care Trusts to include PCDS in local IM&T strategies

APPENDIX 2

PERFORMANCE ASSESSMENT FRAMEWORK HDL (2002) 78
PAF Indicators which will be influenced by or directly involve dental services.

1. Health Improvement and Reducing Inequalities

Number	Indicator	Rationale
1.02.01	Coronary Heart Disease	Dietary advice to improve oral health leading to better diet overall
1.02.02	Cancer	Dietary advice to improve oral health leading to better overall diet
1.02.03	Stroke	Dietary advice to improve oral health leading to better diet
1.04.02	Breast Feeding	Pregnant & nursing mothers receive free dental care and are encouraged to breast feed by their family dentist
1.05.01	Dental Disease – Pre-school	Direct influence of preventive care provided by dentists in an LHCC / CHP area. Effects of oral health promotion throughout pre-school and nursery schools
1.08.01	Pregnant Women Smoking	Pregnant & nursing mothers receive free dental care and are encouraged to stop smoking while pregnant
1.08.02	Adult Smokers	Family dentists now include recording of tobacco habits in taking a medical history. Referral to smoking cessation or direct intervention by trained staff
1.13.01	Persons Eating Fruit & Vegetables	Dietary advice to improve oral health leading to better overall diet. Promotion of fruit and vegetables and tooth friendly
1.14.01	Inequalities, Pregnant Women Smoking	Pregnant & nursing mothers receive free dental care and are referred to smoking cessation services

1.14.02	Inequalities, Dental Disease – Children under 5 Years	Direct influence of preventive care provided by dentists in an LHCC / CHP area. Effects of oral health promotion throughout pre-school and nursery schools.
1.14.03	Inequalities, Adult Smokers	Family dentists now include tobacco habits in taking a medical history. Referral to smoking cessation or direct intervention by trained staff.

2. Fair Access to Healthcare Services

2.05.02	Dentist population ratios	Adequate dental services available in a LHCC / CHP area. Recruitment and retention issues.
2.07.01	Access to NHS Dentists Children 0-17	Adequate dental services available in a LHCC / CHP area. Recruitment and retention issues.
2.07.02	Access to NHS Dentists Adults	Adequate dental services available in a LHCC / CHP area. Recruitment and retention issues.
2.07.03	Dental Health Action Plan – assessment	Health Board function.

3. Clinical Governance Quality and Effectiveness of Healthcare

3.05.01	Appropriate Prescribing Antibiotics	Dentists prescribe a proportion of the total antibiotics in an area.

4. Patient Experience Including Service Quality

4.08.01	Outpatients Waiting Times	Referral guidelines and managed clinical networks influence waiting times. Also availability of specialist services in primary care.
4.08.02	Inpatients and Day Cases Waiting Times	Referral guidelines and managed clinical networks influence waiting times. Also availability of specialist services in primary care.

5. Involving Public and Communities

5.01.01	Our National Health Commitments	Extent of performance against the commitments in Section 5, 'Involving People' of 'Our National Health: a plan for action, a plan for change' and the 'Patient Focus and Public Involvement' framework.Opportunities to use dental patients to access opinions of the "general public."

6. Staff Governance

6.01.01	Workforce Planning	Compliance with agreed integrated approach to strategic and operational workforce planning to ensure that the numbers, skills and mix of people is right. This must include general dental practitioners as in PAF indicator 2.05.02
6.02.01	Effective Staff Information Systems	A two way regular, relevant information system that keeps staff informed will operate effectively. This must include general dental practitioners and their staff.
6.06.01	Towards a Safer Healthier Workplace	*'Towards a Safer, Healthier Workplace'* will be fully implemented and resources allocated to ensure the safety and well being of all staff. This includes general dental practitioners and their staff.

APPENDIX 3

ORAL HEALTH & THE LHCC – QUESTIONNAIRE

NAME:

TITLE:

ORGANISATION:

SECTION 1: SERVICE STRUCTURES

Please tick relevant box(es)

Q1. What Dental Services are directly represented within your LHCC?

Community Dental Services   (CDS)

General Dental Services   (GDS)

Hospital Dental Services   (HDS)

Please tick relevant box(es)

Q2. At what level does this representation take place?

	CDS	GDS	HDS
Executive/Management Group			
Sub Group (specify)			
Other (specify)			

Q3. **Are there formal structures in place to support multi-disciplinary/multi agency working to involve Dental Services within the LHCC?**

Yes [ ]   No [ ]

If YES, please describe briefly

SECTION 2: ORAL/DENTAL HEALTH NEEDS ASSESSMENT

i) **Does your LHCC carry out any specific Health Needs Assessment in relation to Oral/Dental Health?**

Yes [ ]   No [ ]

ii) **If YES, can you state briefly what types of assessment are carried out?**

iii) **Who/which staff group is responsible for conducting the Needs Assessment?**

iv) **What published information/data are you able to access in connection with Health Needs Assessment and from what source?**

SECTION 3: PUBLIC HEALTH

i) **Does the LHCC have any involvement in Oral Health Promotion initiatives and, if so, what are these?**

Yes [ ]   No [ ]

If YES, please describe

ii) **Is there a Public Health Practitioner in your LHCC at the present time?**

Yes [ ]   No [ ]

iii) **Is this post shared with another LHCC?**

Yes [ ]   No [ ]

iv) Is the Public Health Practitioner involved in any specific Oral Health Promotion activity?

Yes ☐   No ☐

v) Is there any input from a Health Promotion Department to your LHCC?

Yes ☐   No ☐

vi) If YES, is this input concerned with

a) General health promotion

b) Dental/oral health promotion

vii) Does the LHCC have any links with the NHS Board's Consultant in Dental Public Health?

Yes ☐   No ☐

viii) If YES, please describe

SECTION 4: SERVICES

i) What links/arrangements does your LHCC have for Out-of-Hours Dental Emergencies?

ii) What do you consider to be the main issues re Dental Services for your LHCC?

Are there any other issues not covered by the questions you wish to mention?

APPENDIX 4

ORAL HEALTH & THE LHCC – QUESTIONNAIRE RESULTS

Group	Number Sent Out	Number Returned
Local Health Care Co-operative	81	45
Consultant in Dental Public Health	7	6
Clinical Dental Director	15	11
Dental Practice Adviser	13	4
Chief Administrative Dental Officer	3	2
TOTAL	119	66 (55%)

LHCC RESPONSES

SECTION 1: SERVICE STRUCTURES
Q1. What Dental Services are directly represented within your LHCC?

CDS	GDS	HDS	CDS+GDS	CDS+HDS	CDS/GDS HDS	Nil	No Response
20%	8.9%	0%	33.3%	2.2%	11.1%	31.1%	2.2%

Q2. At what level does this representation take place?

COMMUNITY DENTAL SERVICE						
Executive Management Group	Steering Group	Other	EMG + SG	SG + Other	No Response	N/A
15%	22.5%	10%	7.5%	2.5%	7.5%	35%

GENERAL DENTAL SERVICE						
EMG	SG	Other	EMG + SG	EMG/SG + Other	No Response	N/A
21.6%	18.9%	5.4%	2.7%	2.7%	10.8%	37.8%

HOSPITAL DENTAL SERVICES					
EMG	SG	Other	EMG + SG	No Response	N/A
0%	9.1%	13.6%	0%	13.6%	63.6%

Q3. Are there formal structures in place to support multi-disciplinary/multi agency working to involve Dental Services within the LHCC?

YES	NO
51%	49%

SECTION 2: ORAL/DENTAL HEALTH NEEDS ASSESSMENT

1. Does your LHCC carry out any specific Health Needs Assessment in relation to Oral/Dental Health?

YES	NO	No Response
33.3%	62.2%	4.5%

SECTION 3: PUBLIC HEALTH

i. Does the LHCC have any involvement in Oral Health Promotion initiatives and, if so, what are these?

YES	NO	No Response
68.8%	28.8%	2.2%

ii. Is there a Public Health practitioner in your LHCC at the present time?

YES	NO	No Response
100%	0%	0%

iii. Is this post shared with another LHCC?

YES	NO	No Response
20%	77.8%	2.2%

iv. Is the Public Health Practitioner involved in any specific Oral Health Promotion activity?

YES	NO	No Response
26.6%	71.1%	2.2%

v. Is there any input from a Health Promotion Department to your LHCC?

YES	NO	No Response
75.5%	17.8%	6.7%

vi. If YES, is this input concerned with

GHP	OHP	GHP + OHP	N/A	No Response	Nil
42.2%	2.2%	26.7%	17.8%	6.6%	4.4%

vii. Does the LHCC have any links with the NHS Board's Consultant in Dental Public Health?

YES	NO	N/A	No Response
46.7%	44.4%	2.2%	6.7%

APPENDIX 4

FEEDBACK FROM OPEN QUESTIONS - SELECTED EXAMPLES

SECTION 1: SERVICE STRUCTURES
ARE THERE FORMAL STRUCTURES IN PLACE TO SUPPORT MULTI-DISCIPLINARY/MULTI-AGENCY WORKING TO INVOLVE DENTAL SERVICES WITHIN THE LHCC?

If YES, please describe briefly

- HVs working in close liaison/collaboration with CDS/GDS re national and local under-5's projects.

- Local Oral Health Group which is part of joint planning structure with local Council.

- LHCC supports multi-agency/disciplinary working via local and national oral health initiatives and organising educational/study events.

- Nominate member of CDS who sits on each LHCC Clinical Governance Committee.

- LHCC Oral Health Action Team – GDP, CDS, OHP, HV, Dietician, Pharmacist, PHP, local parents and child care worker.

- Dental representation on LHCC Executive, planning and professional committees. Also advises LHCC Public Health Improvement Committee.

SECTION 2: ORAL/DENTAL HEALTH NEEDS ASSESSMENT
DOES YOUR LHCC CARRY OUT ANY SPECIFIC HEALTH NEEDS ASSESSMENT IN RELATION TO ORAL/DENTAL HEALTH?

If YES, can you state briefly what types of assessment are carried out?

- General assessment of under 5s in DEPCAT 1-4 re dental health to identify "at risk" families. DEPCAT 5,6 and 7 covered under national and local initiative.

- New Community School screening.

- GA figures.

- Local information from nurseries, schools and brushing programmes.

- Consulting with local GDPs.

- Data collected on an LHCC basis – all P1 and P7 schoolchildren are examined under the National Dental Inspection Programme.

- Carried out as part of HIF Project – monitoring of inequalities, dental caries.

Who/which staff group is responsible for conducting the Needs Assessment?

• Health Visitors.

• School Nurses.

• CDS/Director of Dental Services/Community Dental Officers.

• Oral Health Promoters.

• Dental Health Promotion.

• Consultant in Dental Public Health/Department of Public Health.

• Public Health Practitioner/PHP with PCT and HB support.

• Health Board/ISD.

• LHCC Needs Assessment Task Group – GP, PHP, Integrated Care Manager, LHCC Manager and Support Person. Responsible for conducting Needs Assessment via questionnaire, focus groups, extended groups and locally sensitive statistical information.

• Primary Care Manager and LHCC General Manager.

What published information/data are you able to access in connection with Health Needs Assessment and from what source?

• Via PHIS (former Scottish Needs Assessment Programme).

• Locally – ie, Department of Public Health/CDPH; Health Promotion Unit; ISD Department; Health Board; Trust Audit Department; CDS.

• Local registers, eg – CHD, diabetes.

• Monthly figures in children registered with dental service, pre-5 caries.

• Scottish NHS Boards' Dental Epidemiological Programme Annual Reports.

• Range of Scottish Executive publications {NHS Net}.

SECTION 3: PUBLIC HEALTH
Does the LHCC have any involvement in Oral Health Promotion initiatives and, if so, what are these?

• Registration Scheme - encouraging school children to register with a GDP; in partnership with PCT Dental Directorate promoting dental registration of all one-year-olds (HVs and birthday card scheme).

- Introduction of OHAT.

- Liaison between local services and PHP for input to local event or particular work in schools.

- Piloting "Whole School" approach to oral health and nutrition in targeted New Community Schools.

- Health Promotion Dept tends to operate on its own and not part of LHCC/locality structures – LHCCs would welcome this as development to support local initiatives.

- One year pilot to introduce OHP/education sessions for all professions complementary to dentistry.

- Sharing of information and referral opportunities between GDPs, GPs, HVs and Smoking Cessation Service.

Is there any input from a Health Promotion Department to your LHCC?

- Limited – tends to be advice/information or policies.

Does the LHCC have any links with the NHS Board's Consultant in Dental Public Health? If YES, please describe

- Named contact.

- Regular contact with Consultant in Public Health.

- Member of local Dental Forum and Oral Health Group.

- Member of Partnership in Public Health Steering Group.

- CDPH on Steering Group for OHAT.

- CDPH involved in developing Oral Health Strategy and attends LHCC Oral & Dental Health Sub Group. Strong links developed through organisation of PGEA education/study events in the LHCC.

SECTION 4: SERVICES
What links/arrangements does your LHCC have for Out-of-Hours Dental Emergencies?

- Patients usually self-refer to GP O-O-H who have links with acute dental services.

- Joint scheme for – LHCC – discussion underway on extending (possibly lined to GP co-op).

- Links with pilot project based at local hospital.

- Hosted by one of the city's LHCCs on our behalf.

- Limited service – LHCC Core Group looking at clarification of dental emergency and dental pain and have begun to discuss with dentists and GPs the development of joint information to patients re simple pain relief.

- 3 out of 4 dental practices in the LHCC take part in a OOH arrangement with a practice from a neighbouring LHCC.

What do you consider to be the main issues re Dental Services for your LHCC?

- Lack of NHS Dentists – including recruitment and retention in both CDS and GDS a problem.

- Salaried Service – existing service overwhelmed; need for additional posts; retention of Salaried Dentists.

- Frozen Registration lists – difficult for public to access any dentist, private or NHS.

- Service provision – lack of services including pre-school, local orthodontic service; access to services for socially excluded groups.

- Initiatives to increase routine checks and children to attend regularly would delay the already long waiting list.

- More outreach work into nurseries and communities – eg, health promotion and education particularly aimed at school age children and young mothers/parents.

- Children's dental health.

- Addressing needs of elderly – input to residential nursing homes.

- Special Needs Groups – mental and physical impairment, facilities with disabled access.

- Lack of joined-up working between CDS/GDPs.

- Problem of links to other LHCCs.

- Premises Issues.

- Developing stronger links between Dental Services and Primary Care and acknowledging/ understanding links from their perspective.

- Oral Cancer.

- Working with Local Authority to ensure oral health promotion included in HIP.

Are there any other issues not covered by the questions you wish to mention?

- Dental Services involved in health events organised through LHCC.

- LHCC have a major difficulty with capacity issues.

- Would be interesting to repeat this exercise in 5 years time.

- Dental Services managed outwith LHCC structures.

- Fluoride Debate.

- LHCC has only one health centre where both CDS and GPs work together.

- LHCC area includes communities ranked amongst the most deprived. Individuals who live in more deprived areas are likely to be exposed to negative influences on their health, including dental health. They are also less likely to easily access the resources locally which could help them avoid these negative influences. This emphasises the need for improved partnership working, both with other agencies and the communities themselves to improve circumstances; to support healthier lifestyles and to tackle priority health topics.

- LHCC is very keen to engage with Dental Practitioners and would welcome advice from other LHCCs on how to gain support from GDPs we have a few enthusiasts but the majority are still asking "What's in this for me".

APPENDIX 5

DENTAL INFORMATION ROUTINELY COLLECTED WITHIN THE PRIMARY CARE DENTAL SERVICE

Service	Data collection form	Detail
General Dental Service/Salaried GDS	GP17 (Payment claim form)	Patient-based Data Registrations Patient Charting (disease/treatment status) Fees and Remissions
	GP17 O	As above, but for orthodontic treatment only
Community Dental Service	SMR13	Patient-based Data Referral Source Types of Treatment Patient Category
	SMR00 SMR01	Out-Patients Within dentistry, these forms relate to specialist functions e.g. - In-Patients/ General Anaesthetic Day Cases/ Services
	ISD(S)37	Health Education/Promotion Preventive Programmes
	NDIP Basic and Detailed reports	National Dental Inspection Programmes dental inspection of pre-5s and primary school children (NB – epidemiological and basic inspection data may be collected and used by the LHCC in collaboration with the CDS)

APPENDIX 6

SOME USEFUL SOURCES OF DENTAL INFORMATION FOR LHCCS/CHPS

1. Dental Health Services Research Unit   **www.dundee.ac.uk**

2. Office for National Statistics   **info@ons.gov.uk**

3. Information and Statistics Division   **www.isdscotland.org**

4. NHS Education for Scotland   **www.nes.scot.nhs.uk**

5. NHS e-library   **www.elib.scot.nhs.uk**

6. British Dental Association   **www.bda-dentistry.org.uk**

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