



Oral Health in Scotland

Gathering views on the Future of Oral Health in Scotland

June 2017



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Section 1: Executive Summary

- 1.1 The Scottish Government's Chief Dental Officer and Dentistry Division approached the Scottish Health Council to ask for assistance with its planned consultation exercise on the future of Oral Health services. The purpose of the consultation exercise was to build on the success of actions undertaken since the publication of the Dental Action Plan in 2005 and produce a new Oral Health Improvement Plan which would guide development of services for the next 10 to 15 years.
- 1.2 The Scottish Health Council organised small discussion groups in eight NHS Board areas in Scotland. In one of those Board areas two discussion groups were held and in another, in response to a request, views from members of two Chest Heart and Stroke groups were fed into the discussion. In a ninth Board area we visited three sites and conducted face-to-face interviews with parents, grandparents and carers of young children as this was felt to be a more suitable form of interaction for that group of stakeholders. The nine areas where we gathered views were Ayrshire & Arran, Dumfries & Galloway, Fife, Forth Valley, Greater Glasgow and Clyde, Highland, Lanarkshire, Lothian and Tayside.
- 1.3 The discussion groups were arranged by the Scottish Health Council's local offices in each of the above areas. Six of the groups were designated as general population groups with local office staff inviting a range of contacts from their database. In order to particularly explore the experience and views of communities which may experience barriers in accessing oral health services, two of the groups focused on obtaining views of members of the public from minority ethnic communities and were arranged with the assistance of Central Scotland Regional Equality Council and the Rainbow Muslim Women's Group (who are pictured on the front cover with the Chief Dental Officer and Scottish Health Council staff). Another of the discussion groups was focused on gathering views of older people since services for older people was one of the topics in the Oral Health consultation. The Chief Dental Officer and Dentistry Division also particularly wished to obtain the views of parents of young children and this was organised with the assistance of Early Years Scotland and Saheliya. Early Years Scotland facilitated access to two mother & toddler groups and Saheliya brought together parents from minority ethnic communities and in particular women who were either refugees, migrants or asylum seekers.
- 1.4 A total of 113 members of the public took part (55 attended the discussion groups and 58 gave views via one-to-one discussions). Discussions and questionnaires focused on predetermined questions designed to gather views on five main themes:
 - general views on dental care
 - links between oral health and general health
 - cost and value of dental care
 - the national Childsmile programme, and
 - services for older people.

1.5 General views on dental care

Participants identified a number of points which they saw as benefits of dental registration, in particular the development of a one-to-one relationship with a dentist and the provision of choice for patients as to where they elect to receive treatment.

Participants considered the suggestion that dental check-ups every six months be replaced with an annual one but overall it was clearly felt that early intervention was critical and so participants were of the opinion that a six-month period between check-ups was reasonable.

Across the discussion sessions, participants identified common barriers to dental treatment which were:

- Access, including physical access to dental premises, was difficult for patients with mobility issues.
- Communication such as language barriers, lack of interpreter services (including British Sign Language) and perceptions of staff discourtesy to patients.
- Cost of treatment was identified at most of the sessions as a barrier.
- Most participants identified fear and anxiety as being a major barrier to seeking dental care.

Participants also identified a number of suggestions for changes they would like to see in Scotland's dental services for example:

- A number of participants felt that dental treatment should be provided free at the point of delivery.
- Consideration should be given to extending practice opening hours including weekend appointments. Participants felt this would help accommodate working people to access dental treatment.
- More widespread use of the text message reminder system for appointments which was considered a good system.
- Better interaction between health professionals such as General Practitioners, dentists, hospital staff, when considering specialist treatments.

1.6 Links between oral health and general health

Across all discussion groups, it was felt that oral health risk assessments would be beneficial particularly in the context of early intervention and flagging up symptoms of health problems. There was discussion about the proposal to offer this at age 18 –

some participants felt it should be earlier at say 15-16 years whereas others felt it should not be a one-off exercise and should be a regular feature for all dental patients.

When discussing the issue of encouraging improvements for teenage oral health the general feeling was that there needed to be a continuous programme of information and education through the school system and supported via social media. There was a suggestion that the “positive power” of peer pressure should be harnessed to encourage young people to take better care of their own oral health.

1.7 Cost of dental care

This topic created mixed views with the majority of participants in four of the groups (three groups designated as 'general population' and one designed to gather the views of older people) feeling that the service was good value for money. In five other groups (which specifically involved people from minority ethnic communities, parents, grandparents and carers of young children groups) participants felt that the costs were too high. However there was a feeling from some participants that it was difficult for the lay person to know whether or not they were getting value for money.

Participants expressed the view that some dentists were felt to be “pushing” private treatment and almost suggesting to patients that the NHS option might not be good quality treatment. Others commented that some dentists did not appear to fully explain a proposed non-NHS treatment and whether it would truly solve the problem.

The absence of visible price lists in waiting areas was also commented on and participants said that often the first indication of the treatment plan price being available was when the patient returned to the reception area. Some participants felt that payment plan options should be more widely available and displayed.

1.8 The Childsmile programme

In the discussion groups designated as 'general public', most had not heard of the national Childsmile programme but among those who had, there was favourable comments on its effectiveness. In the discussion groups that specifically involved minority ethnic communities, although most were not aware of the name of the programme, a number were familiar with work that was ongoing to teach young children how to look after their teeth. Among the parents, grandparents and carers of young children groups, almost all were aware of the programme although some of the parents who identified as being asylum seekers, migrants or refugees were not aware, with the language barrier being cited as a common reason for this. Finally, within the older people's discussion group there was a somewhat even split between those who had heard of the programme and those who had not.

The most common grouping of suggestions as to how the oral health of children could be improved concerned health education activities in schools. Participants from a number of groups felt that such activities were very important. Dental staff

presence in schools was commonly felt to be an effective means to encourage children to recognise the importance of a good oral cleanliness regime.

Closely following in popularity among participants were suggestions concerning the role of parents. Participants from a number of groups felt that it is important that parents are given advice and information to ensure they reinforce learning and practices to promote oral health.

1.9 Services for Older people

While participants in two groups were of the view that the majority of dental practices in their area were physically accessible for older patients, the feeling in other discussion groups was that there was a perception that a significant number of practices were not accessible. The main reason for this was attributed to dental practices being in older buildings with stairs. In three of the groups, transport issues were raised as a barrier which caused difficulties for accessibility, with participants particularly mentioning parking problems and a lack of good public transport.

Across the groups the most common topic of discussion about non-physical barriers to accessing services concerned communication. Many participants felt that there were issues relating to accessing services for people with specific conditions that can impact on their capacity to communicate, such as dementia for example. In several groups there was reference to other conditions which can commonly be associated with an ageing population. The potential barriers to accessing services for people whose first language is not English was also mentioned and one group suggested that longer appointments should be offered to older patients or those with access support requirements.

When discussing possible actions to bring about improvements in the oral health of older people, in a number of groups it was felt that specific attention should be given to people who were in care homes. There were various suggestions about the monitoring of oral health by nursing staff and the Care Inspectorate as well as suggestions for making it mandatory for dentists to attend care homes to provide dental care. Participants also suggested that there was a need to provide clarity on who was responsible to look after the oral health of residents within care homes.

The discussions on care homes led to participants to consider the links between dentists and other professionals. In a number of groups it was felt that those links should be strengthened with some participants suggesting that the dentist should be included as part of a multi-disciplinary team in relation to overall care.

1.10 Next steps

The Scottish Government's Chief Dental Officer and Dentistry Division published an analysis of the consultation responses at the end of June 2017. This can be found on the Scottish Government's website at: www.gov.scot/scotalhealthplananalysis. The

Chief Dental Officer and Dentistry Division will utilise the findings of the consultation responses and the Scottish Health Council's engagement activities to help guide the development of a new national Oral Health Improvement Plan. It is intended that the Plan will be finalised and published before the end of 2017.

Section 2: Background

- 2.1 The Scottish Health Council was established in 2005 to promote Patient Focus and Public Involvement in the NHS in Scotland. The Scottish Health Council works to support the engagement of people and communities in the development of health and social care services. The Scottish Health Council is part of Healthcare Improvement Scotland, which seeks to drive improvements that support the highest possible quality of care for the people of Scotland.
- 2.2 The Scottish Government's Chief Dental Officer and Dentistry Division approached the Scottish Health Council to ask for assistance with its planned consultation exercise on the future of Oral Health Services. The purpose of the consultation exercise was to build on the success of actions undertaken since the publication of the national Dental Action Plan in 2005 and produce a new Oral Health Improvement Plan which would guide development of services for the next 10 to 15 years.
- 2.3 The Chief Dental Officer and Dentistry Division issued a consultation document with a questionnaire inviting dental professionals, other staff and patients/members of the public to submit their comments. The Division also organised a series of roadshow events around Scotland targeting dentists, dental care professionals and other NHS staff and distributed posters and leaflets to each dental practice in Scotland which encouraged patients to take part in the consultation.
- 2.4 The Scottish Health Council was asked to arrange a series of discussion groups across the country with members of the public to obtain views on issues raised in the consultation document such as disease prevention, the cost of dental treatment, and services for children and older people. The feedback received will be fed into the new Oral Health Improvement Plan for Scotland.
- 2.5 The consultation exercise was launched in September 2016 and the Scottish Health Council led engagement activities commenced in November 2016.

Section 3: Engagement Approach

- 3.1 A number of different organisations are currently developing the Our Voice framework, including the Scottish Government, NHSScotland, the Scottish Health Council, Healthcare Improvement Scotland, the Convention of Scottish Local Authorities (COSLA), the Health and Social Care Alliance Scotland (the ALLIANCE) and other third sector partners such as Chest Heart and Stroke Scotland.
- 3.2 Our Voice is based on a vision where people who use health and social care services, carers and members of the public are enabled to engage purposefully with health and social care providers to continuously improve and transform services. People will be provided with feedback on the impact of their engagement, or a demonstration of how their views have been considered.
- 3.3 The Scottish Health Council's Gathering Public Views methodology very much supports the Our Voice vision by feeding public views into the heart of the development of policy and services. Other examples of the application of this methodology are available on the Scottish Health Council's website.
- 3.4 The approach used by the Scottish Health Council was consistent with our normal Gathering Public Views practice in so much as it is not undertaken as formal research nor as a formal public consultation. Our engagement activity is to supplement the consultation activities of the commissioning agency, in this case the Scottish Government's Chief Dental Officer and Dentistry Division. Responsibility for conducting the overall consultation involving an appropriate range of stakeholders, also rested with the Dentistry Division.
- 3.5 The Scottish Health Council regards gathering views via discussion with small groups of members of the public as a particularly effective way of obtaining feedback. Our main consideration is always about the quality of that engagement rather than the quantity of people involved and experience demonstrates that feedback from participants tends to be consistent regardless of the numbers involved.
- 3.6 The Scottish Health Council organised small discussion groups in eight NHS Board areas in Scotland. In one of those Board areas two discussion groups were held and in another, in response to a request, views from members of two Chest Heart and Stroke groups were fed into the discussion. In a ninth Board area we visited three sites and conducted face-to-face interviews with parents, grandparents and carers of young children as this was felt to be a more suitable form of interaction for that group of stakeholders.

The nine areas where we gathered views were Ayrshire & Arran, Dumfries & Galloway, Fife, Forth Valley, Greater Glasgow and Clyde, Highland, Lanarkshire, Lothian and Tayside.

3.7 The discussion groups were arranged by the Scottish Health Council's local offices in each of the above areas. Six of the groups were designated as general population groups with local office staff inviting a range of contacts from their database. In order to particularly explore the experience and views of communities which may experience barriers in accessing oral health services, two of the groups focused on obtaining views of members of the public from minority ethnic communities and were arranged with the assistance of Central Scotland Regional Equality Council and the Rainbow Muslim Women's Group. Another of the discussion groups was focused on gathering views of older people since services for older people was one of the topics highlighted in the Oral Health consultation. The Chief Dental Officer and Dentistry Division also particularly wished to obtain the views of parents of young children and this was organised with the assistance of Early Years Scotland and Saheliya. Early Years Scotland facilitated access to two mother & toddler groups and Saheliya brought together parents from minority ethnic communities and in particular women who were either refugees, migrants or asylum seekers.

3.8 A total of 113 members of the public took part:

- 55 took part in small discussion groups
- 58 provided views through one-to-one discussions

The discussion groups were facilitated by the Scottish Health Council using a standard set of pre-determined questions (see Appendix i). The one-to-one discussions with members of parents, grandparents and carers of young children groups utilised the questionnaire as noted in Appendix ii of this report. Evaluation activities were conducted with participants in order that any learning can be taken into account for similar work in the future; details of the evaluation can be obtained upon request to the Greater Glasgow and Clyde office of the Scottish Health Council.

Section 4: Feedback Views

Please note that the quotes that appear in this section of the report are from members of the public who took part in the Scottish Health Council's engagement activities

4.1 In your view, what does it mean to be registered with a dentist?

In the general discussions, participants accepted that it was normal practice for people to register with a dentist.

Participants identified a number of points which they saw as benefits of dental registration such as:

- it allowed access to treatment and regular dental check-ups
- it encouraged the development of a one to one relationship with the dentist which then led to building trust and confidence, and
- it provided choice for patients as to where they could elect to receive treatment.

*'It's just part of life
– something you
just do.'*

The discussions in one group also highlighted some misconceptions that patients would be removed from a practice list if they had not attended for 18 months or more and that patients had to reside in a certain catchment area for registration with a dentist.

Several additional issues were identified by participants in discussion groups involving minority ethnic people particularly in relation to:

- Many felt unclear of the difference between an NHS dentist and a private dental practitioner and felt more information was required to clarify this.
- It is important for dental staff understanding that brushing techniques and equipment are different depending on where group members previously lived where tooth brushing was done with a stick brush and therefore cultural differences had to be taken into account.

*'As teeth are part of
your overall health
and looks this
makes it important
to be registered
with a dentist.'*

The overall view from participants was that dental registration was a good thing and should be promoted.

4.2 Most patients attend the dentists for a check-up every six months. How would you feel if you were told you only needed to go once a year?

Participant feedback indicated that they clearly thought that early intervention was critical and participants were of the opinion that a six-month period between check-ups was preferable.

Some of the other issues and reservations were around:

- whether a move to an annual check-up was a “money saving exercise” and even if not the advantages of the change were questioned by participants
- differing practices where a family had dental checks every six months but the dental hygienist offered appointments every three months
- a feeling that any move to annual check-ups should be as a result of discussions between the dentist and patient and should be dependent on personal circumstances or indeed long-term conditions such as diabetes or cancer
- concerns that annual check-ups could result in dentists advising on more treatment than was actually necessary.

During discussions within the groups specifically involving minority ethnic people some additional issues and comments were noted. These included:

- Extended check-up periods would not be a major problem for people with no problems with their teeth.
- In one particular group the majority of participants said that they currently did not attend for dental check-ups – the reason given was a lack of awareness of NHS dentists and concerns about the potential costs of any treatment. It was acknowledged that if they had a better understanding of the dental system they may be encouraged to attend.

‘The dentist might offer more than you really need but how would we know this? It could end up costing more than if you were visiting twice a year.’

Throughout the discussion sessions there was a feeling of support for the continuation of the current system of dental check-ups every six months as participants felt that “prevention is better than cure”.

4.3 Have you experienced any barriers in accessing dental care?

Across the discussion sessions, all participants identified some common barriers to dental treatment. These related to:

- Access – both in terms of physical access difficulties for patients with mobility issues and general accessibility for patients with learning disabilities.

- Communication – there were a number of issues identified in relation to communication such as language barriers and lack of interpreter services (including British Sign Language) for those with hearing impairments, perceptions of staff discourtesy leaving patients with a feeling of being undervalued and therefore less likely to return.
- Cost – this was identified at most of the sessions as a barrier and often related to that was the feeling that dental treatment needed to be considered alongside other financial commitments.
- Fear or anxiety – most participants identified fear and anxiety as being a major barrier to seeking dental care and treatment. This seemed to be based either on participants' personal experience or that of friends or relatives.

4.4 Are there any changes you would like to see in dental services?

This question generated good discussion across the range of groups and a number of suggestions were offered.

- A number of participants felt that dental treatment should be provided free at the point of delivery.
- Consideration should be given to extending practice opening hours including weekend appointments. Participants felt that this would enable people who were working to access dental treatment.
- Participants felt that the text message reminder system for appointments was a good process and should be extended across all dental practices.
- Some participants felt that there should be better interaction between health professionals such as general practitioners, dentists, hospitals including dental hospitals when considering or planning specialist treatments.
- Improvements to suitability of and access to premises was highlighted which then led on to group discussions around practice hygiene standards etc.
- Several participants commented on the importance of speaking with carers when dealing with patients who had cognitive conditions before any treatment commenced.
- Participants raised concerns about charging for missed appointments and compared it to not being the practice within the wider NHS.

'Dentists should allow flexibility of appointment times to allow working people to get to the dentist, say for example one late night per week.'

- Participants in one group felt there should be more information available to the public on how dental practices operated and what professional standards were in place to ensure they were fit to practice.

4.5 Would you welcome general health advice from your dentist? For example, alcohol intake or diet advice?

There was general acceptance across the discussion groups that it would be acceptable to receive health advice from the dentist. Indeed there were several examples provided which suggested this already happens in some practices.

Examples provided by participants tended to relate to soft tissue issues, mouth cancer detection and the effect that diet can have on oral health.

'I already get such advice as I am a smoker and I am continually asked if I want to be referred to smoking cessation.'

However, there were a number of comments and queries around whether dentists were qualified to provide health advice and if there was financial remuneration for the 'additional' service given by dentists then participants felt this could impact on appointment times.

While the general feeling was that health advice would be welcomed, participants nonetheless felt that there should be guidance as to what types of advice should be given.

In one of the groups involving minority ethnic people whilst there was strong support for dentists giving health advice – many believed that it would not necessarily cause a change in behaviour for example, "those who enjoy fizzy drinks would be unlikely to stop".

'Would that not involve dentists needing more training on general health issues?'

4.6 How important is your oral health in terms of your overall health?

There was little doubt from participants that oral health was considered important to overall general health. It was acknowledged that good oral health can impact on a number of issues depending on existing conditions or illnesses.

It was also stressed that it was important for young adults or people with learning disabilities, and who may require additional communication support, to have their oral health looked after.

One participant highlighted that the practice hygienist worked through a 'check list' so they were in effect already carrying out a health check.

'If you've got good health, you've got good teeth.'

Participants in one of the remote and rural groups suggested that a more combined service such as a nurse located at the practice to provide blood pressure checks or a drop-in service would be worthwhile.

4.7 Dental health is getting better though we need to improve this throughout life; therefore we are looking to prevent having oral health problems. Do you have any views on how we can prevent oral health problems?

Participants acknowledged many improvements in helping people to keep their own teeth for longer but it was felt important that knowledge of the impact that previous initiatives had in relation to improved oral health, for example, fluoride varnishing, should be made available to the public.

Some participants discussed the quality of materials used by dentists for NHS patients and held the perception that cheaper materials were used where possible.

Another identified issue was the disappearance of school dentist visits which previously ensured that all children were seen by a dentist. In two of the groups this was felt to be a big loss.

For the majority of participants the key issues related to a need for more education and information sharing. It was felt that people of all ages needed to understand how diet and lifestyle affected oral health; that people should know how to brush their teeth properly and understand why it was important to see a dentist regularly. In some of the groups there was a suggestion that education and information sharing should be specifically targeted at individuals and groups most at risk such as those who do not attend regularly for check-ups, communities in low income areas and particularly those people who either smoked or drank heavily.

'There should be readily accessible information and leaflets on teeth cleaning, good and health eating etc.'

4.8 Would a risk assessment be helpful in maintaining your oral health as an adult?

Across the discussion groups, it was felt that oral health risk assessments would be beneficial particularly in the context of early intervention and flagging up symptoms of health problems. There was discussion about a proposal to offer this at age 18 but some participants felt it should be earlier at 15-16 years. Others felt that it should not be a one off exercise with some also supporting the idea of a risk assessment for older people.

For some participants it was important that follow up care was necessary to reinforce the message given in any assessment. Participants queried how oral health risk assessments would fit in with other health programmes such as Well Man or Well

'It seems to be a good idea but perhaps should probably start at 15-16 years.'

Woman clinics. Participants were also of the view that dental professionals should also highlight the consequences of not following advice or completing treatments plans.

4.9 Dentists have told us that when patients reach their teenage years their level of personal oral health care begins to suffer. Do you have any suggestions on how we can improve the oral health for this age group?

Across all of the discussion groups the general feeling was that there needed to be a continuous programme of information and education through the school system and via social media. Participants spoke about the “positive power” of peer pressure which should be harnessed to encourage young people to take better care of their own oral health. It was also highlighted that teenagers seemed to be very self-conscious of their appearance and a lack of good oral health could result in self esteem problems.

As a general consideration it was felt that more could be done to limit access to soft drinks and snack machines particularly in schools, colleges and other public buildings such as hospitals etc.

‘Teenagers can be a tough group (to influence) as they tend to think they know everything and are invincible.’

Some participants felt that there was an air of what they described as “know it all” within the younger age group and therefore it was important that parents actively encouraged their children to keep good oral health.

Participants also felt that practices such as fluoride varnishing should be continued into secondary schools and that restrictions or controls should be placed on e-cigarettes.

4.10 In your opinion do you receive value for money for the service you are provided with?

This topic created mixed views with the majority of participants in four of the groups (three groups designated as 'general population' and one designed to gather the views of older people) feeling that the service was good value for money. In five other groups (which specifically involved people from minority ethnic communities, and parents, grandparents and carers of young children groups) participants felt that the costs were too high. However there was a feeling from some participants that it was difficult for the lay person to know whether or not they were getting value for money.

There were references to the perceived quality and cost of treatment provided on the NHS when compared to private treatment. Some participants felt that some dentists were “pushing private treatment” and suggesting to patients that an NHS option might not be good quality treatment. Others commented that some dentists did not

fully explain proposed private treatment and whether it would truly solve the problem. There was a feeling that, whilst it was important to have choice in treatment, the cost could prove prohibitive in many instances.

Participants mentioned that price lists were often not displayed in practice waiting areas which meant that the first indication they had of the cost of treatment was when they returned to the practice reception. Some participants felt that payment plan options should be more widely available.

Participants from the discussion groups involving minority ethnic people queried the difference between NHS dental services and private dentistry – they generally felt that costs of treatment were too high and as a result patients would suffer when they could not afford treatment.

'We get free check-ups which is a bonus.'

'For the medical side of things we don't pay a penny so why do we pay for eye and teeth treatment.'

'We are happy to pay costs because we are working.'

4.11 In Scotland there is a programme especially for children called the Childsmile programme which includes toothbrushing instruction for children. Are you aware of this programme?

In the general public discussion groups most had not heard of the Childsmile programme but those who had commented favourably on its usefulness in terms of improving oral health for children. In the discussion groups involving minority ethnic people, although most were not aware of the name of the programme a number were aware that work was ongoing to teach young children how to look after their teeth. Among the parents, grandparents and carers of young children groups almost all were aware of the programme although some of the parents who identified as being asylum seekers, migrants or refugees were not aware, with the language barrier being cited as a common reason for this. Within the older people's discussion group there was an evenly split awareness of those who had heard of the programme and those who had not.

4.12 Do you have any experience of the Childsmile programme?

In the discussion groups designated as 'general population' most participants did not have experience of the programme, however in the discussion groups specifically involving minority ethnic people and older people there were a number who had some experience of Childsmile.

Among the parents, grandparents and carers of young children engaged with almost all had experience of the programme derived from the nursery teams and Health Visitors. Positive comments were made concerning the impact of the programme with these participants agreeing that education for children and parents was a good way to embed healthy habits at an early age. However among the group involving people who identified as refugees, migrants and asylum seekers some did not have experience of Childsmile. There was comment that some children were not passing on information received at school and therefore it was suggested that parents should be contacted by post and provided with relevant information. There was general concern that a language barrier was a reason for parents not being informed of the programme and that a better partnership between schools and parents whose first language was not English would be beneficial.

‘Sometimes it can be confusing as to what can be healthy for children and what can affect their teeth.’

4.13 Do you have any suggestions on how we can improve the oral health of children?

The most common grouping of suggestions concerned health education activities in schools. Participants from a number of groups felt that such activities were very important and a “dental staff presence” in schools was commonly felt to be an effective means to encourage children to recognise the importance of a good oral cleanliness regime. For a number of participants this suggestion was made particularly with reference to teenagers where parents could have limited influence in ensuring good oral hygiene. It was also felt by some that this would potentially help those less likely to visit a dentist regularly such as those in deprived areas, commenting that if children became used to going to the dentist then they were more likely to continue in adulthood. One of the participants suggested that there should be a system of local dentists visiting schools and appointments being made there for children to visit the local practice.

Closely following in popularity amongst participants were suggestions concerning the role of parents. Participants from a number of groups felt that it was important that parents were given advice and information to ensure they reinforced learning and practices to promote oral health. Participants felt that parents needed to be encouraged to understand why it was important to ensure children had regular check-ups and listen to advice from professionals. Participants advocated for dental health information to be shared with parents and not just children themselves. In one group it was suggested that social media should be used to reach parents and pass on information and ideas and in another it was advocated that health visitors provide information on oral health whilst visiting parents.

The issue of oral health information featured heavily in the discussion. Participants felt that making people aware of the oral health issues to be taken into account when making food and drink decisions was important, for example; smoothies were often seen as healthy and a good way for parents or carers to get children to have fruit in

their diets but they could have an adverse impact on teeth. In one group there was discussion around the idea of ‘traffic light labelling’ on food packaging (red/yellow/green alerts) that could be utilised along with simplified clearer information to show what it means to be taking the amount of sugar, for example how many teaspoonfuls of sugar in a tin of beans? There was consensus around this and participants agreed that labeling was confusing.

In another group the format of information was raised as an issue and it was suggested that all information should also be available in the first language of parents (there were three languages being used within this group session).

‘You forget that some foods are harmful like fruit juices but I know they are good for giving the kids vitamins.’

In a number of groups the issue of restricting access to food items that posed dangers for oral health produced some suggestions. In two of the groups there was support for Government activity in terms of a ‘sugar tax’ and general regulation of the food and drinks industry. In another group, there was a suggestion that perhaps there should be a restriction of the availability of confectionary and drinks machines in schools, local authority and government premises and in yet another group there was support for general discouragement of fizzy drinks.

Fear of the dentist/dental treatment was a matter discussed in two of the groups and tackling this issue was suggested as a way to help improve oral health. Dentists who develop a positive relationship with a patient instil confidence in a patient and this was felt to be a key element in making sure people attended regularly. In addition, the dentist’s role in helping people to reduce anxieties and fears about getting treatment was highlighted as being key by most participants in one of the groups. Allied to this was the feeling that communication skills in dental practices were important.

Finally, there was some discussion and suggestions around technical matters. In two of the groups participants emphasised the importance of fluoride varnishing of teeth with one participant suggesting that the coating/varnishing programme should be applied to children at nursery age through to high school pupils as a prevention method. In one group some suggested that ‘fuzzy brushes’ (disposable toothbrushes) should be made available in high schools and in another group, thinking of younger children in schools, participants proposed that children be provided with prompts (such as sand timers to show them how long they should brush their teeth for).

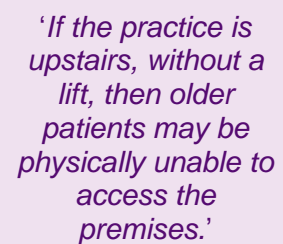
‘Appointment times should be longer for older patients or those with special needs this would allow for information sharing and discussions around needs.’

4.14 How accessible are dental practices within your area for older patients?

Although in two of the groups participants were of the view that the majority of dental practices in their area were physically accessible for older patients, in many of the

other discussion groups there was a perception that a significant number of practices were not. The chief reason among participants for this was the feeling that many practices were in older buildings with stairs and some were also close to the pavement making the building of an access ramp impractical. In two of the groups participants commented that some practices with stepped entrances did have alternative ramped access but such access was not well sign posted and/or patients had to notify reception in advance in order to gain access.

In three of the groups transport issues were raised as causing difficulties for accessibility with participants particularly mentioning parking problems and a lack of good public transport. Participants also discussed accessing dental services for those older people who would struggle to visit the dental practice. Participants in two of the groups cited examples of dentists who visited housebound patients and this was thought to be positive and should be encouraged as good practice. In one group there was discussion about the support for older people in remote and rural areas. Participants were concerned that the mobile dentist service could become obsolete. There were suggestions that there should be greater partnership between district nurses, doctors and dentists. As part of this it was felt that Scottish Government regulations need to be looked at to allow other professionals to give a dental assessment.



'If the practice is upstairs, without a lift, then older patients may be physically unable to access the premises.'

4.15 Can you think of any barriers older people might face in accessing dental care?

Across the groups the most common topic of discussion concerned communication. Specifically mentioned were the challenges facing people with dementia in accessing dental care and treatment. Some commented that if a patient had dementia they may not recognise they need treatment or be able to express their needs. In one group there was a suggestion that each area should have a dentist who understood and provides treatment to patients with dementia and related conditions. In several groups there was reference to other conditions which can be associated with an ageing population. In particular there was mention of barriers faced by individuals who may be hard of hearing or deaf, or with a visual impairment or registered blind. In another group the issue of English not being a first language was raised as a potential barrier to people accessing dental treatment. Related to these issues, in one group it was felt that appointment times should be longer for older patients or those with access support requirements adding that it may also be appropriate to enhance payments to dentists to allow for consultations with older people to be extended.

In a number of groups, participants felt that physical accessibility of premises (stairs) allied to mobility issues for many older people could create barriers. In two of the

groups there was specific mention of dental chairs as being a potential barrier. It was felt that older frail people could struggle to get in and out of chairs or to feel comfortable while sitting.

Dental care for residents in care homes was discussed in several groups – participants were not sure about the arrangements for providing dental care and treatment and they were concerned this could be a barrier. In addition in two of the groups the topic of cost was raised – participants felt that for older people on a limited income, cost could be a barrier to accessing treatment.

'The cost of treatment for older people on a limited income could be a barrier.'

4.16 What can the dental team do to help improve the oral health of older people?

In a number of groups it was felt that action should be taken with regard to dental services for older people in care homes. In one group it was suggested that monitoring of oral health should be part of the role of nursing staff within care homes and this should be recorded alongside other monitoring which takes place. To support this it was recommended that staff in care homes should have appropriate training around oral hygiene. It was highlighted that the Care Inspectorate has a role to monitor care homes and there was suggestion that oral health should be part of that (perhaps within the patient quality indicators or questions about oral hygiene in audits). In another group participants advocated that it be mandatory for dentists to visit care homes to provide routine dental care. Participants also called for the provision of more clarity on what was the responsibility of care homes in looking after the oral health of its residents. Participants were also supportive of more care home staff being offered “Caring for Smiles” Training (which is a similar model to Childsmile but geared towards older people).

The discussions around care homes led participants to consider the links between dentists and other health professionals. In a number of groups it was felt those links should be strengthened – some participants were unsure of exactly where dental staff currently fit into the system of integrated health and social care but nonetheless they felt it was important that the dentist was included as part of a multi disciplinary team in relation to overall care. Some participants suggested that information and medical records should be shared between, for example general practitioners and dentists – although not all participants shared this view.

Patient accessibility generated much discussion in a number of groups. This included reference to mobile services, for example, in one group there was a suggestion that there should be a mobile service which could provide basic check-ups (similar to breast screening mobile units). It was felt this would encourage people to access treatment closer to home. Participants felt there was a need to find a way to get information out to older people in the community and make them aware of the importance of oral health. In another group participants discussed the possibility of a “flying dentist” going to the more remote and rural island communities although

participants acknowledged that there would be a need to have dental equipment on each island to support such a service. In another group it was felt that improving oral health would require NHS dental practices that were physically accessible for all as well as NHS dental treatment that was free of cost to patients.

Section 5: Next Steps and Acknowledgements

- 5.1 The Scottish Government's Chief Dental Officer and Dentistry Division published an analysis of the consultation responses at the end of June 2017. This can be found on the Scottish Government's website at: www.gov.scot/scotoralhealthplananalysis. The Chief Dental Officer and Dentistry Division will utilise the findings of the consultation responses and the Scottish Health Council's engagement activities to help guide the development of a new national Oral Health Improvement Plan. It is intended that the Plan will be finalised and published before the end of 2017.
- 5.2 The Scottish Health Council would like to thank all the participants who shared their views about Oral Health in Scotland. Participants should note that in addition to preparing this report which summarises their feedback, the Scottish Health Council provided detailed individual session reports to the Chief Dental Officer and Dentistry Division. We would also like to thank the following organisations for assisting us with organising discussion sessions for participants in Glasgow: Early Years Scotland (Easterhouse Parish Mother & Toddlers Group and Hillington Mother & Toddlers Group) and Saheliya. In Forth Valley we express our thanks to the Central Scotland Regional Equality Council and the Rainbow Muslim Women's Group. Finally we would like to thank Chest Heart and Stroke Scotland for their assistance in facilitating the input from members of two of their Dumfries & Galloway groups.

Appendix i - Discussion Group Questions

1. In your view, what does it mean to be registered with a dentist?
2. Most patients attend the dentists for a check-up every six months. How would you feel if you were told you only needed to go once a year?
3. Have you experienced any barriers in accessing dental care?
4. Are there any changes you would like to see in dental services?
5. Would you welcome general health advice from your dentist? For example, alcohol intake or diet advice?
6. How important is your oral health in terms of your overall health?
7. Dental health is getting better though we need to improve this throughout life; therefore we are looking to prevent having oral health problems. Do you have any views on how we can prevent oral health problems?
8. Would a risk assessment be helpful in maintaining your oral health as an adult?
9. Dentists have told us that when patients reach their teenage years their level of personal oral health care begins to suffer. Do you have any suggestions on how we can improve the oral health for this age group?
10. In your opinion do you receive value for money for the service you are provided with?
11. In Scotland there is a programme especially for children called the Childsmile programme which includes toothbrushing instruction for children. Are you aware of this programme?
12. Do you have any experience of the Childsmile programme?
13. Do you have any questions on how we can improve the oral health of children?
14. How accessible are dental practices within your area for older patients?
15. Can you think of any barriers older people might face in accessing dental care?
16. What can the dental team do to help improve the oral health of older people?

Appendix ii - Parents, Grandparents and Carers Questionnaire

Section 1

1. Are you aware of the Childsmile programme that's in place throughout Scotland that gives instruction on tooth brushing for children?
2. Have you had experience of this programme?
3. Can you suggest how we can improve the oral health of children in general?

Section 2

1. In your view, what does it mean to be registered with a dentist?
2. Most patients have a six-month check-up at the dentist. How would you feel if advised to have an annual check-up instead?
3. Would you recommend any changes to dental services in Scotland?
4. Have you ever experienced a barrier in accessing dental care at any time?
5. In your opinion do you receive value for money for the service you are provided with? Do you think what you have to pay at the dentist is too high, too low or not enough?

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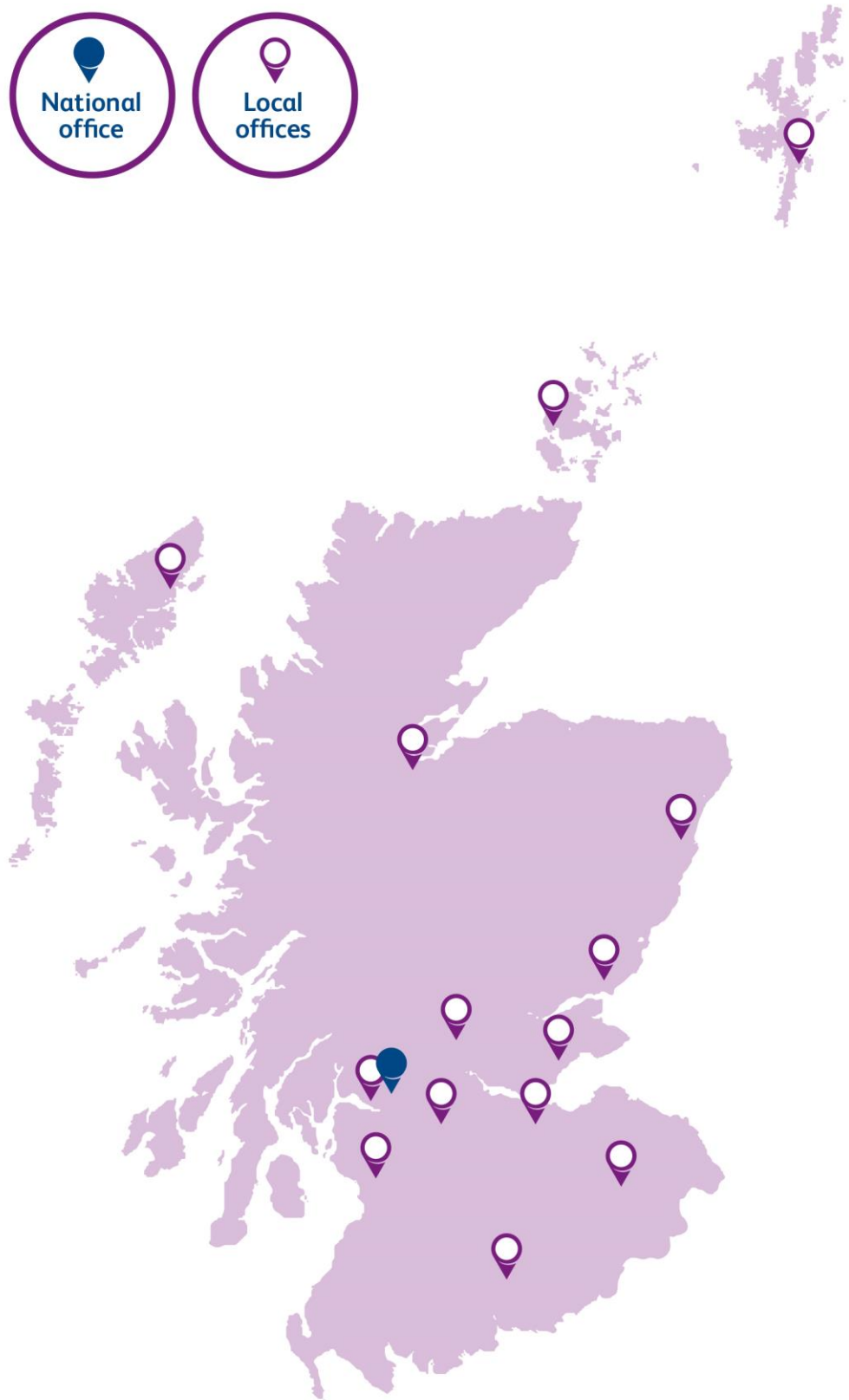
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