NHS Borders

Oral Health and Dental Services

Oral Health Needs Assessment 2020

Authors and Acknowledgements

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Executive Summary

Oral health is an important aspect of general health and wellbeing. While oral diseases are mostly preventable, they remain common and share risk factors with a number of general health problems. Promoting good oral health is closely linked to wider public health priorities and can help reduce the need for treatment and demands on dental services.

Changing demographics in the Borders and developments in dental service delivery and approaches to oral health promotion over a number of years have brought new pressures on services.

This needs assessment report describes the oral health status of the population of the Borders and the availability and use of dental services in the area.

Findings from a review of available data sources and engagement with dental teams and members of the public has led to identification of a number of priorities and the development of recommended actions to take these forward. These are summarised in the section which follows.

Priorities for Action

These priorities are not presented in order of importance. It is recognised that it will not be possible to take forward all actions immediately and that several of them will require gradual change over a number of years.

These recommendations will be used to inform a strategic plan for oral health and dental services in the Borders. Development of the strategic plan will allow for prioritisation and will inform timelines for implementing the changes suggested in this report.

PRIORITY: Raising the Profile of Oral Health

1. In line with the Health in All Policies approach already adopted across Borders HSCP, oral health should be included during development of any strategies/policies which could have an impact on health or oral health
2. Routes for oral health issues and information to be fed up to Board level and through the Integrated Joint Board should be explored

PRIORITY: Maintaining and Improving Oral Health

3. Oral health improvement should incorporate action to address wider determinants of health and take a common risk factor approach, working alongside general health improvement teams
4. Continue to focus on maximising child oral health as the foundation for good oral health throughout life
5. Action should be taken to improve oral health for the whole population with a particular focus on groups recognised to be at greatest risk of poor oral health
6. Awareness of the role of the oral health improvement team and ability to make referrals to them should be raised among dental professionals and wider health and social care partners

PRIORITY: Maintaining Access to Primary Care Dental Services

7. Continue to monitor and highlight issues relating to access to dental care.
8. Maintain emergency dental services at level required to meet needs for urgent dental care

PRIORITY: Encouraging Recruitment and Retention of Dental Professionals

9. Promote the Borders as an attractive place to work as a dental professional
10. Continue to develop high quality dental services with opportunities for career progression and job satisfaction to retain dental professionals in the area

PRIORITY: Meeting the Needs of Ageing Patients

11. Deliver support through expansion of the national Caring for Smiles oral health improvement programme for dependent older people for those in residential care and receiving care at home services
12. Oral health should be actively considered and included in individuals' care plans across all health and social care services
13. Continue to implement and support further roll out of the eGDP model for domiciliary dental care

PRIORITY: Meeting the Needs of Dental Priority Groups

14. Expand engagement with priority groups (adults with additional care needs, those with physical and cognitive disabilities, poor mental health, addictions and the homeless)
15. Consider a more flexible approach to delivery of dental services for those who may have difficulty accessing traditional models of care
16. Increase support offered to those who have difficulty attending dental appointments and raise awareness of the availability of translation services, including British Sign Language interpreters

PRIORITY: Developing the Role of the Public Dental Service

17. It remains necessary to retain the access function of the PDS to ensure sufficient provision of dental services for the general population. The main focus should however be on providing support to patients who have special care requirements
18. PDS referral criteria should be updated and self-referrals for routine dental care only accepted from patients who are unable to access a general dental practice
19. Awareness of the function of PDS should be raised to facilitate referrals from health and social care partners and others working with priority groups
20. Options for input from Specialists in Paediatric Dentistry and Special Care Dentistry should be explored including the possibility of establishing networks with neighbouring Boards

PRIORITY: Developing the PDS Workforce to Provide a More Specialised Service

21. Continue to support and maximise opportunities for training and development of PDS staff

PRIORITY: Developing Patient Pathways to Dental Services

22. Interprofessional links should be promoted across GDS, PDS and HDS through shared professional development and quality improvement activities
23. Consideration should be given to wider use of eGDP models to support delivery of more complex dental treatments in primary care and reduce pressure on secondary care dental services
24. Demand management work which has been undertaken with oral surgery services should be supported

25. All dental services delivered in BGH, including specialist services, should be reviewed to identify those which could be safely transferred out with a hospital environment to primary care settings

PRIORITY: Promoting Networking and Engagement of Dental Teams and Wider Partners

26. Dental teams from across the Borders should be brought together through existing professional groups and organisations and CPD events
27. The format of the Area Dental Committee and its lines of communication with the Board and the wider dental profession should be reviewed to encourage engagement with the Committee
28. Use of the internet and social media should be promoted to enhance communication with the dental profession locally
29. Links between dental services, other health and social care services and wider partners should be developed and strengthened

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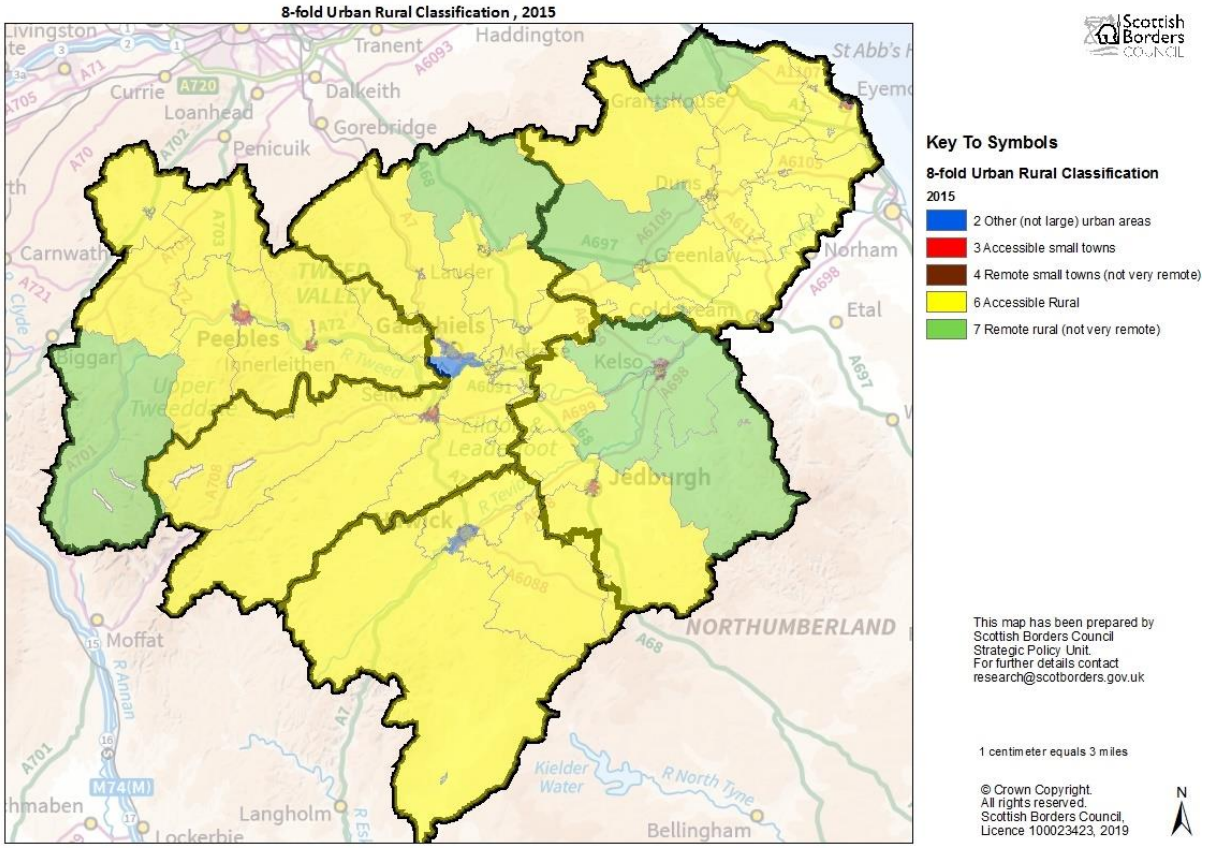
1. Background

The Borders

The Borders is a rural area in the South East of Scotland with a population of around 115 000. The Borders is the 4th most sparsely populated mainland area in Scotland, with a population density of 24 per km^2, and 30% of residents living in settlements of less than 500 people.

The Scottish Government's Urban Rural Classification[1] differentiates between urban areas, small towns, rural and remote areas based on settlement size and drive time to major settlements. Figure 1 shows the breakdown of Urban Rural Classification within the Borders. The majority of the Borders is classified as "Accessible Rural" – settlements with a population of less than 3 000 and within 30 minutes drive time of a settlement of 10 000 or more, or "Remote Rural (not very remote)" – settlements of less than 3 000 within 30-60 minutes drive of a settlement of 10 000 or more. Two areas are "Other (not large) Urban Areas" – settlements with a population of 10 000 – 124999, these include the towns of Galashiels (population 12 600) and Hawick (population 13 300). The Borders has a number of "Accessible small towns" – settlements with a population of 3 000-9 999 within 30 minutes drive of a settlement of 10 000 or more.

Figure 1 – Map of Scottish Borders 8 Fold Urban Rural Classification



The Borders is served by a single Health Board (NHS Borders) and Local Authority (Scottish Borders Council). Borders Health and Social Care Partnership (HSPC) brings together NHS primary and community services, and social care functions provided by the

Council and the Independent and Voluntary Sector. Primary care dental services are hosted by the HSPC and are provided by General Dental Practitioners (GDPs) and the Public Dental Service (PDS).Secondary care dental services are provided in the Borders General Hospital covering the specialties of oral surgery and orthodontics.

Oral Health

Oral health is defined as:

> *A standard of health in the oral and related tissues without active disease. That state should enable the individual to eat, speak and socialise without discomfort or embarrassment, and contribute to general wellbeing.*
>
> Department of Health, 2004

The impact of poor oral health on general health is well established and it could be argued that there is “no health without oral health”.

In general oral health in Scotland is improving, however dental caries (tooth decay) and periodontal disease (gum disease) remain common. A third condition, oral cancer, though rare, remains a concern due to the significant impact it has on individuals affected.

Determinants of Oral Health

Most oral health problems are preventable and many of the risk factors are common to other health conditions, including a diet high in sugar and low in fruit and vegetables, tobacco use and drinking alcohol over the recommended weekly limits.

Oral health has a strong association with the social determinants of health, with individuals from more deprived backgrounds experiencing poorer oral health than the more affluent. Some population groups are also known to be at risk of poorer oral health, including those with additional care needs, certain medical conditions and the socially excluded.

Policy Context

In January 2018, the Scottish Government’s Oral Health Improvement Plan (OHIP)[2] was published. The plan includes 41 actions outlining their vision for oral health and dental services in Scotland. It encourages a focus on prevention and has a strong emphasis on meeting the needs of an ageing population.

The OHIP follows on from the 2005 Action Plan for Improving Oral Health and Modernising Dental Services in Scotland[3]. The 2005 plan had a significant impact on improving access to NHS dental services and in establishing national Oral Health Improvement Programmes. These initially focused on children (Childsmile) and, following publication of the National Oral Health Improvement Strategy for Priority Groups in 2012[4], Caring for Smiles for dependent older people, Smile 4 Life for people experiencing homelessness,

Mouth Matters for prisoners and, most recently, Open Wide for adults with additional care needs.

More generally, new Public Health Priorities for Scotland[5] were published in June 2018, setting out ambitions to achieve:

1. **A Scotland where we live in vibrant, healthy and safe places and communities**
2. **A Scotland where we flourish in our early years**
3. **A Scotland where we have good mental wellbeing**
4. **A Scotland where we reduce the use of and harm from alcohol, tobacco and drugs**
5. **A Scotland where we have a sustainable inclusive economy with equality of outcomes for all**
6. **A Scotland where we eat well, have a healthy weight and are physically active**

These priorities have been accepted by NHS Borders and Scottish Borders Council as the Scottish Borders Public Health Priorities. Actions to improve oral health link closely with these priorities (Table 1).

Table 1 - Public Health Priorities and links to oral health

Public Health Priority	Oral Health
PRIORITY 1 **A Scotland where we live in vibrant, healthy and safe places and communities**	Access to dental services and oral health improvement programmes for all
PRIORITY 2 **A Scotland where we flourish in our early years**	Childsmile Oral Health Improvement Programme
PRIORITY 3 **A Scotland where we have good mental wellbeing**	Reciprocal relationship between poor oral health and poor mental health
PRIORITY 4 **A Scotland where we reduce the use of and harm from alcohol, tobacco and drugs**	Reducing use of alcohol, tobacco and drugs improves oral health
PRIORITY 5 **A Scotland where we have a sustainable inclusive economy with equality of outcomes for all**	Inequalities closely linked to oral health. Oral health improvement programmes focus on priority groups
PRIORITY 6 **A Scotland where we eat well, have a healthy weight and are physically active**	Diet (particularly sugar reduction) is key to oral health

Locally an Oral Health Improvement Strategy for Borders 2007-2012 was developed following publication of the 2005 Scottish Government Dental Action Plan. While much of its content has remained relevant beyond 2012, there have been changes in oral health and dental services in the Borders during this time.

In the current financial climate it can be challenging to continue to deliver high quality care and meet increasing demands and expectations on services. A statement of intent for financial turnaround is being developed by NHS Borders to guide how services should be delivered to maximise efficiency and effectiveness with an overall aim of achieving financial balance. It is recognised that any recommendations from this needs assessment should align with actions in the statement.

This oral health needs assessment provides an opportunity to review the current oral health status and needs of the population of the Borders. It also addresses how well current services are able to meet these needs and will inform a new strategic plan for oral health in the Borders.

2. Scope of Needs Assessment

This needs assessment will review oral health needs of the population in NHS Borders and services available to meet the needs identified and improve oral health**.**

The needs assessment includes:

- General Dental Services
- Public Dental Service
- Specialist/Hospital Dental Services
- Oral Health Improvement Activity
- Dental Workforce
- Access to dental services
- Cross Border dental attendance

The needs assessment will not include:

- In depth analysis of Special Care Dentistry provision
- e-Dental and e-Health

SECTION 1:
DEMOGRAPHICS, HEALTH AND ORAL HEALTH

3. Population Profile

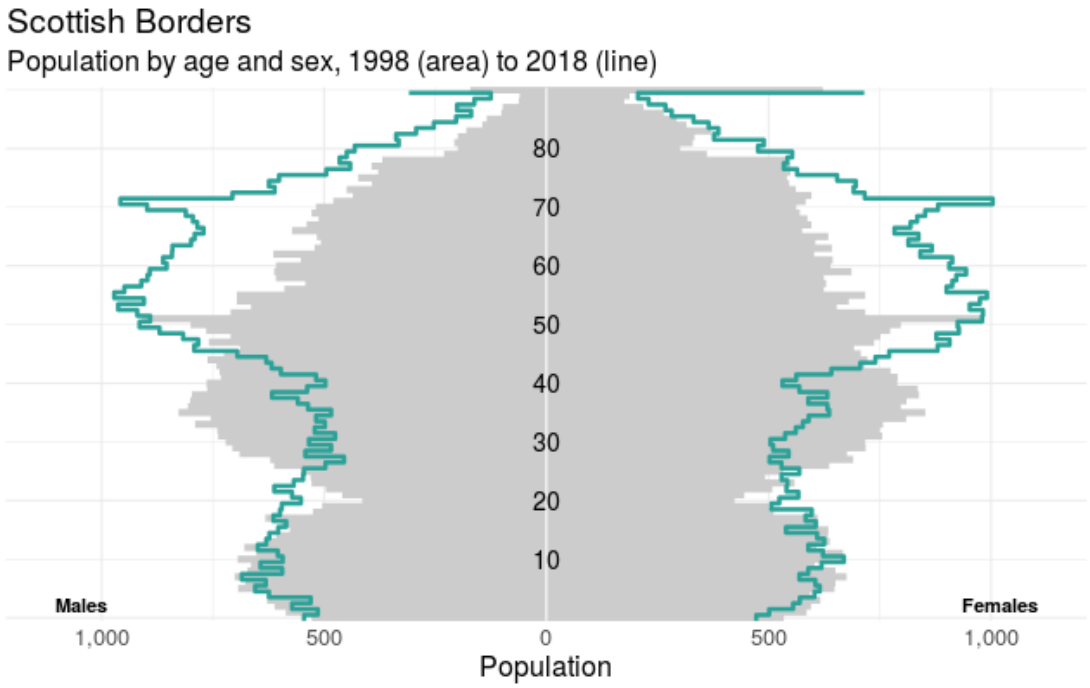
Profile

The population of the Borders was estimated to be 115 270 in mid 2018. This has been gradually increasing in recent years, and is projected to continue to grow. The main driver of population change is migration with more people moving in to the area than leaving. A higher number of deaths than births in the area means that natural change (number of births minus number of deaths) currently results in a net reduction in population size. The majority of in migrants to the Borders are from other areas of Scotland (57%) or the rest of the UK (37%), with only 6% coming from overseas. The largest net migration in to the Borders is seen in age groups between 30-39 years old, with a second peak for age groups between 55 and 69 years old. Out migration from the Borders follows a similar pattern in terms of destination with the majority of those who leave moving to other areas of Scotland. The most common age to leave the area is between 15 and 19 years old.[6]

The proportion of the population who are aged 65 or older (24%) is higher in the Borders than in Scotland as a whole (19%), with a smaller working age population (59%), than Scotland (64%). The proportion of children aged 0-16 years is similar to that of the Scottish population at 17%.[6]

Increased life expectancy and a growing ageing population has resulted in a changing pattern of age distribution in recent years. Figure 2 shows the change in age structure of the population in the Borders between 1998 and 2018.

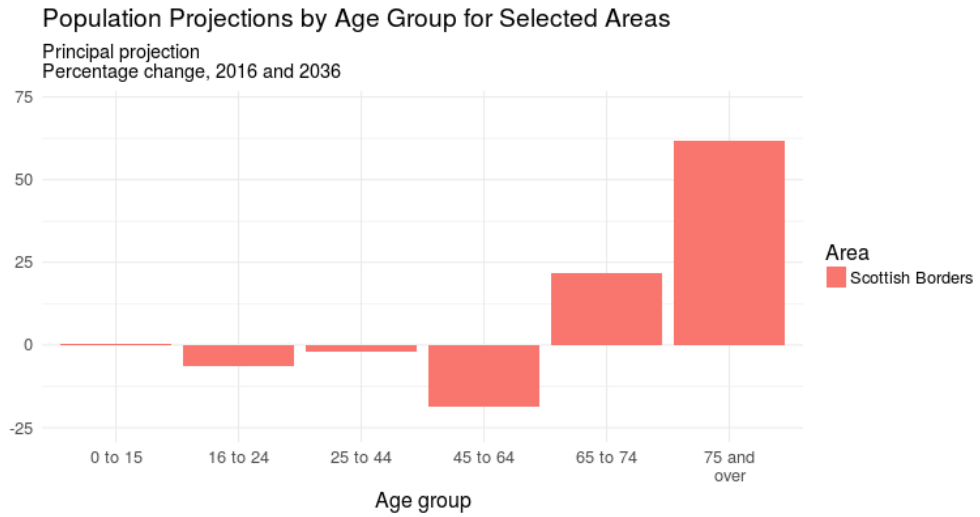
Figure 2 - Change in Age Structure of Population in the Borders 1998 (shaded) and 2018 (line)



https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

Projections suggest that demographic changes will further reduce the proportion of working age adults in the area and increase the proportion of older adults, particularly those aged 75 or older. The projected percentage change by age group in the Borders between 2016 and 2036 is shown in Figure 3.

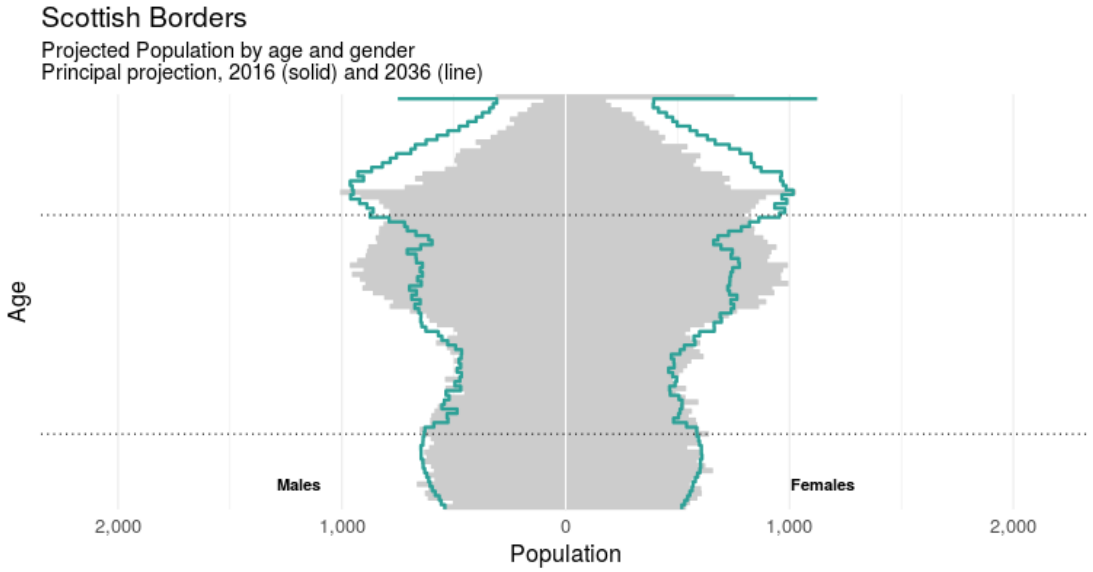
Figure 3 - Projected population change (%) by age group 2016-36 in the Borders



https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

Between 2016 and 2036 this is likely to have a further effect on population structure as illustrated in Figure 4.

Figure 4 - Scottish Borders population by age and gender, 2016 (shaded) and projection for 2036 (line)

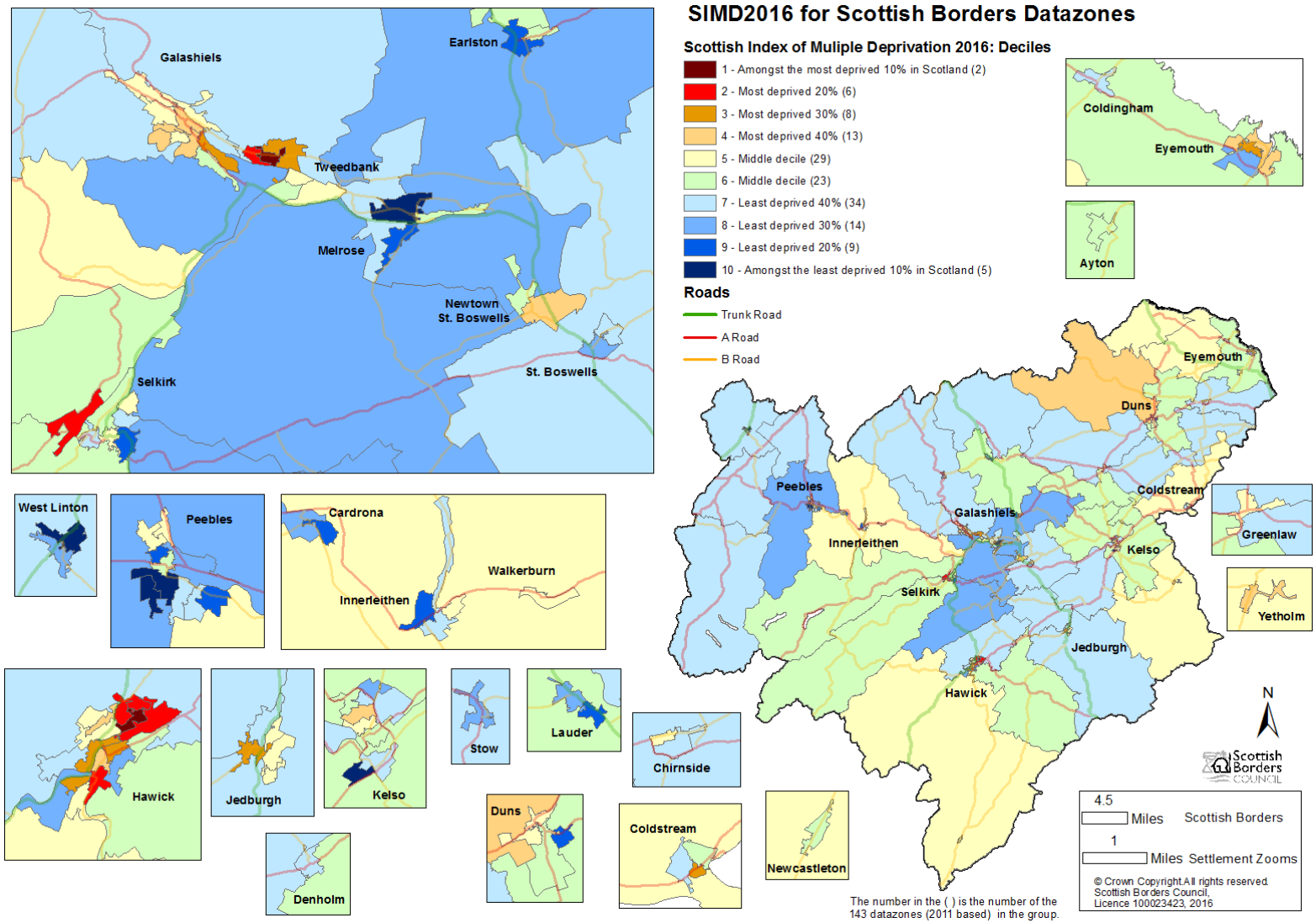


https://scotland.shinyapps.io/nrs-population-projection-variants-scotland-uk/

The Borders has higher levels of employment than the Scottish average, although wages tend to be lower. The Borders comprises 143 SIMD* datazones, of which two (Burnfoot in Hawick and Langlee in Galashiels) are in the most deprived 10% in Scotland (SIMD 1) and five are in the least deprived (SIMD 10). Figure 5 show the relative levels of deprivation for datazones within the Borders.

*The Scottish Index of Multiple Deprivation (SIMD) is an area based tool which ranks datazones of between 500-1000 people by indicators of multiple deprivation.

Figure 5 - SIMD (2016) Levels of Deprivation of Datazones in the Borders



While area SIMD can be useful for making comparisons between communities by level of deprivation, the lower population density in the Borders means that area level measures may mask pockets of deprivation within communities. It is therefore difficult to quantify the extent of oral health inequalities affecting Borders residents and factors other than area of residence require to be considered when examining socio-economic influences.

The rural nature of the Borders, with a significant proportion of the population living out with the main towns, often with limited public transport available, can make accessing services, including dental care, challenging. This geographic isolation may impact on oral health, though quantifying its effects is complex.

Priority Groups

Three specific groups who are recognised to be at increased risk of poor oral health were mentioned in the 2012 National Oral Health Improvement Strategy for Priority Groups[4]:

- Dependent older people
- People with additional care needs
- People experiencing homelessness

Dependent Older People

As already identified, the Borders has a higher proportion of older people than other areas of Scotland and the number of older people is projected to increase. As an individual ages, their level of dependency often increases. Within the Borders 20.9% of adults provided unpaid care to family, friends or neighbours during 2017, compared to 17.4% across Scotland as a whole[7]. Reasons for providing unpaid care can include physical or mental ill health or disabilities in addition to old age, however the increased level of unpaid care provision in the Borders may reflect the higher proportion of older people in the area.

There are currently 21 care homes in the Borders which provide accommodation for older people who require support. It is recognised that a significant number of older people out with the care home sector also require support with day to day life. In the Borders 1190 people were in receipt of Home Care provided by the local authority during 2017 with an average of 6.8 hours of support per day provided to each client and 200 people over the age of 65 years receiving 10 or more hours of support.[8]

Additional Care Needs

Additional care needs is a broad category, encompassing a variety of challenges arising in a range of circumstances including physical, cognitive or sensory disabilities and a number of health conditions including poor mental health.

Within the Borders 647 individuals were known to the Local Authority during 2017-18 to have a diagnosis of learning disability, equating to 6.7 per 1 000 population, slightly higher than the Scottish rate of 5.2 per 1 000. One hundred individuals, 15.5% of the population in the Borders, are known to have a diagnosis of Autism Spectrum Disorder, compared to 18.7% of the population of Scotland.[9]

Data are not available to quantify the prevalence or severity of physical or sensory disabilities in the Borders or of people living with specific disabling conditions.

People Experiencing Homelessness

There were 735 homeless applications in the Borders during 2018-19.Thirty applicants had slept rough at least once in the previous three months and 15 the previous night. While rough sleeping is not common in the Borders, on 31st March 2019 81 households were living in temporary accommodation in the Borders.[10]

Other Priority Groups

In addition to those mentioned in the Priority Groups Strategy[4], a number of other population groups are recognised to be at increased risk of poor oral health, including care experienced children, those in the criminal justice system, and those with addictions.

In 2017-18 2% of children in Scotland were looked after or on the Child Protection Register[11]. Local data describing the number of care experienced children and young people in the Borders are not available.

There are no prison services in the Borders, however support is available through the local Criminal Justice Service including supervision of probation orders, supervision of community payback or community service, through-care services, supervised release orders and supervision on parole. During 2017-18, 384 Criminal Justice Social Work Reports were submitted in the Borders, of whom 223 were subject to Community Payback Orders, 10 to Drug Treatment and Testing Orders and 6 were Diversion from Prosecution cases[12].

The most recent national drug prevalence study for years 2015-1613 estimated problem drug use in the Borders to be the lowest of any mainland Local Authority area in Scotland at 0.73%. During 2018-19 approximately 120 individuals accessed drug and alcohol addiction services each quarter, around 2/3 of whom sought help for addiction to alcohol and the remainder for drug addiction.[14]

The availability of data is limited for many of the priority groups and most of the categories highlighted comprise small number of individuals, however it is important that these groups are not overlooked as their specific needs require to be identified and addressed.

4. Health Status

General Health

General health is closely related to oral health, with many common health conditions impacting on oral health, either as a direct consequence of the condition, a side effect of medication or by influencing an individual's ability to maintain their oral hygiene. In general, health in the Borders appears to be slightly better than the national average.

Pooled data from the 2014-17 Scottish Health Surveys[15] indicate that 77% of adults in the Borders rated their general health as good or very good and 6% rated their health as bad or very bad, compared to the national averages of 74% and 8% respectively. Over the same time period 52% of people in the Borders and 54% in Scotland as a whole reported having no long term illnesses. Twenty percent of Borders residents reported having a long term illness which limited their day to day life, and 20% reported having a long term illness which was not limiting, compared to a Scottish average of 32% and 14%.

Many systemic diseases have been linked to oral health. Diabetes is associated with an increased risk of periodontal (gum) disease and is known to affect susceptibility to infection and impact on healing following surgery. Improved diabetic control has been demonstrated following treatment of periodontal disease. In the Borders around 6% of the population have been diagnosed with diabetes, slightly higher than the national average of 5.6%[16]. Links between cardiovascular disease and oral health have also been suggested.

Approximately 16% of the population of the Borders have a cardiovascular condition, compared to the national average of 15%.[15] The slightly higher prevalence of each of these conditions is likely to reflect the age structure of the population as the conditions are more common in older age groups which make up a larger proportion of the local population.

Obesity is becoming increasingly common and is recognised to be a growing public health concern in Scotland and the UK as a whole. Obesity and dental caries share the common risk factor of a diet high in sugar. Medical issues associated with obesity can affect safe provision of dental care and the fact that standard dental chairs accommodate patients up to a maximum weight limit of around 21 stones have important implications for dental services. The proportion of adults in the Borders who are classed as overweight or obese (BMI≥25) is slightly higher than the national average at 66% (compared to 65%), though the proportion who are obese (BMI≥30) is 25%, slightly below the national average of 29%.[15]

Mental Health

Mental health has a reciprocal relationship with oral health. Poor oral health has the potential to negatively impact on mental wellbeing and mental ill health often makes it more difficult for an individual to maintain good oral health. Many medications used in the

treatment of mental health conditions can lead to dry mouth, with loss of the protective effects of saliva putting the oral tissues at risk.

Two measures of mental health are included in the Scottish Health Survey, the Warwick Edinburgh Mental Wellbeing Scale (WEMBS) which measures mental wellbeing and the 12 point General Health Questionnaire (GHQ-12) which measures risk of developing mental ill health.

In the Borders the average WEMBS score was 50.2, slightly higher than the Scottish average of 49.9. The proportion of people scoring 4 or above in the GHQ-12, an indicator of probable mental ill-health, was however slightly higher in the Borders (18%) than in Scotland as a whole (16%). A slightly higher proportion of Borders residents (62%) recorded a GHQ-12 score of zero than across Scotland as a whole (61%).[15] Residents of the Borders therefore appear to be more likely to experience good mental health, though those who do have a mental health condition seem to be more severely affected.

5. Oral Health

Children

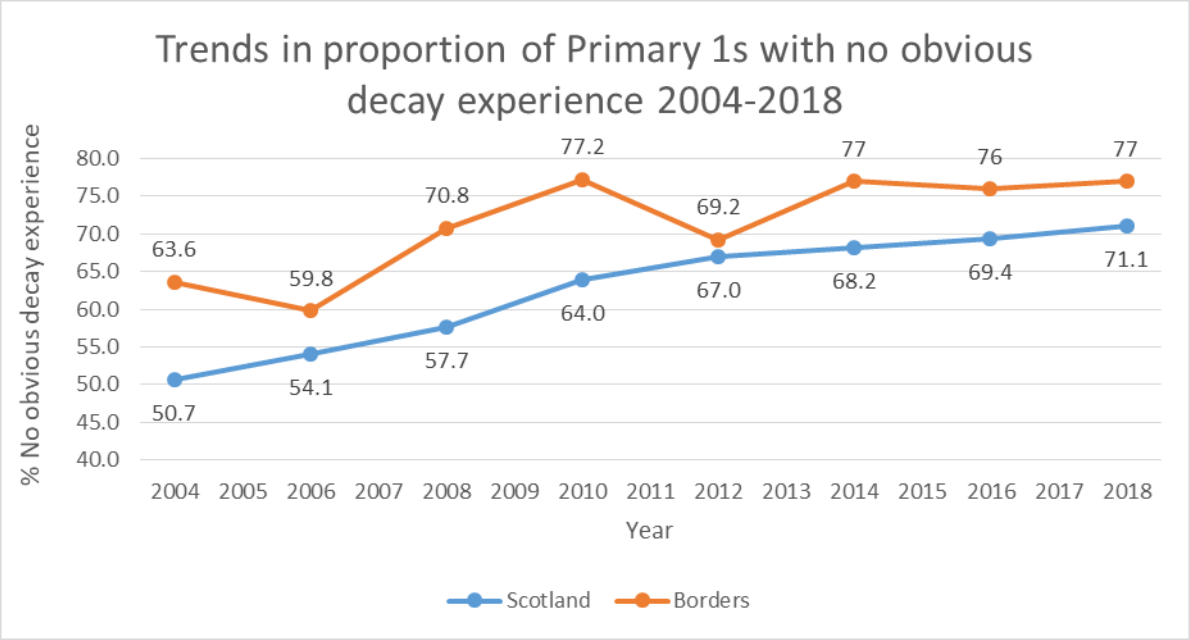
Robust data on children's oral health is gathered through the National Dental Inspection Programme (NDIP). On an annual basis, all children in Primary 1 and Primary 7 attending Local Authority schools are offered a Basic Inspection to provide monitoring data and inform parents/carers of their child's oral health status. In addition, in alternating years, a sample of children in P1 or P7 undergo a Detailed Inspection by trained and calibrated examiners which provides reliable information on prevalence of dental caries (decay) for use by Scottish Government, NHS Boards and other organisations concerned with children's health.

In general, children in the Borders enjoy good oral health. The most recent Detailed Inspection of Primary 1 children, during the academic year 2017-18 shows that 79% of those inspected in the Borders had no obvious decayed, missing or filled primary teeth[17]. The Detailed Inspection of Primary 7 children during 2018-19 reported that 78.6% of those inspected had no obvious decayed, missing or filled permanent teeth[18].

Nationally the proportion of children with no obvious decay experience has increased significantly since NDIP was introduced in 2004 and improvements have also been evident in the oral health of children in the Borders, as shown in Figures 6 and 7. The most recent data suggest that the rate of improvement in child oral health is slowing at both the local and national levels.

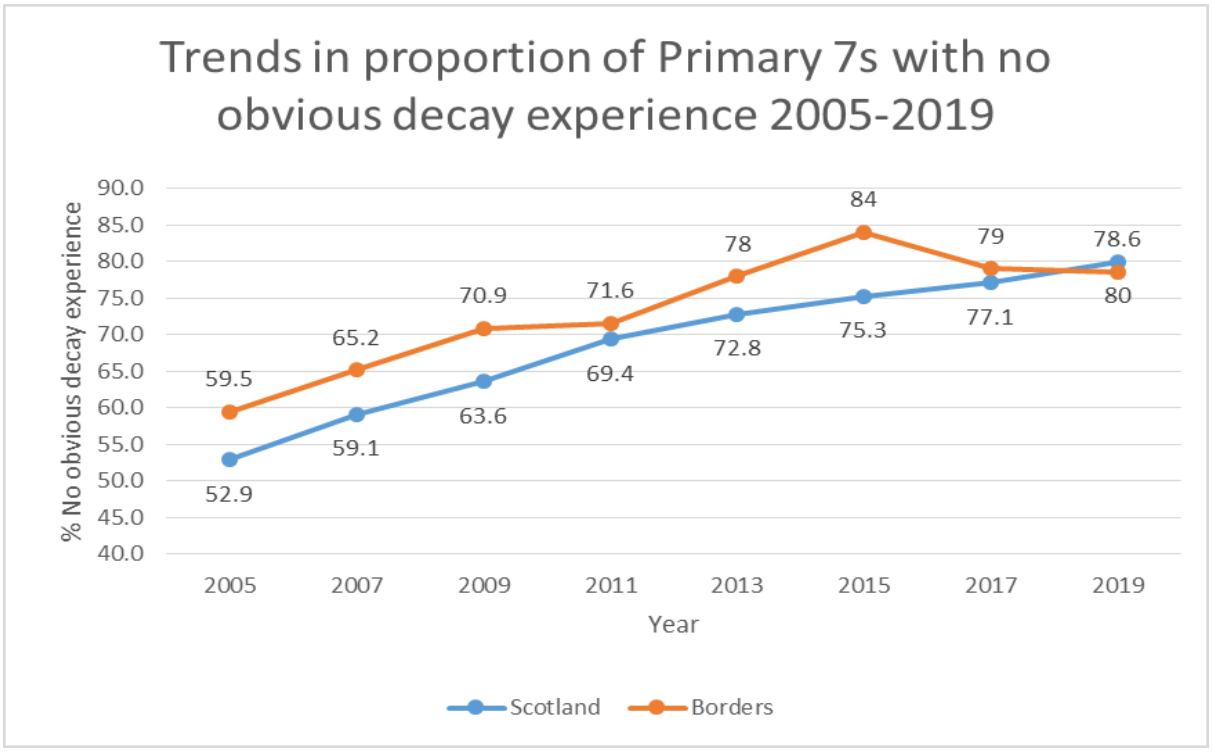
Caution is required in interpreting trends in obvious caries experience over time within the Borders due to the relatively small sample size. Sampling for the Detailed NDIP inspection is at class level, aiming to include a minimum of 250 children or 8% of the population of the year group (P1 or P7 depending on year). In the Borders during 2018-19 317 children (27.3% of the P7 population) received a detailed inspection and in 2017-18 338 pupils (27.9% of the P1 population) were inspected. As a result, small variations in obvious caries experience of children inspected may over-estimate any increase or decrease in the overall proportions of children with no obvious decay experience.

Figure 6 - Trends in proportion of Primary 1s with no obvious decay experience in Scotland and Borders



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2018-10-23/2018-10-23-NDIP-Report.pdf

Figure 7- Trends in proportion of Primary 7s with no obvious decay experience in Scotland and Borders



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-10-22/2019-10-22-NDIP-Report.pdf

The Scottish Government has set national targets for 75% of P1s and 80% of P7s to be free of obvious decay experience by 2022. The target has been achieved in the Borders for P1s since 2014.The target was exceeded for P7s in 2015, though has dropped slightly below 80% in the two subsequent inspection years. Further local targets have been set for each Health Board to deliver an improvement of 10% in the proportion of children with no

obvious decay experience which was recorded in 2014 for P1s and 2015 for P7s. For NHS Borders this has resulted in ambitious targets of 84.5% of P1s and 92% of P7s to be free from obvious decay by 2022 which will be challenging to achieve.

Nationally it is evident that inequalities in oral health have persisted despite the overall improvements, with children from more deprived areas continuing to experience more dental decay. Caries data are not reported by deprivation category at Board level and as previously discussed it is likely that area level measures of deprivation may not be sensitive enough to capture the extent of inequalities in the Borders where pockets of deprivation are often masked within smaller communities.

Adults

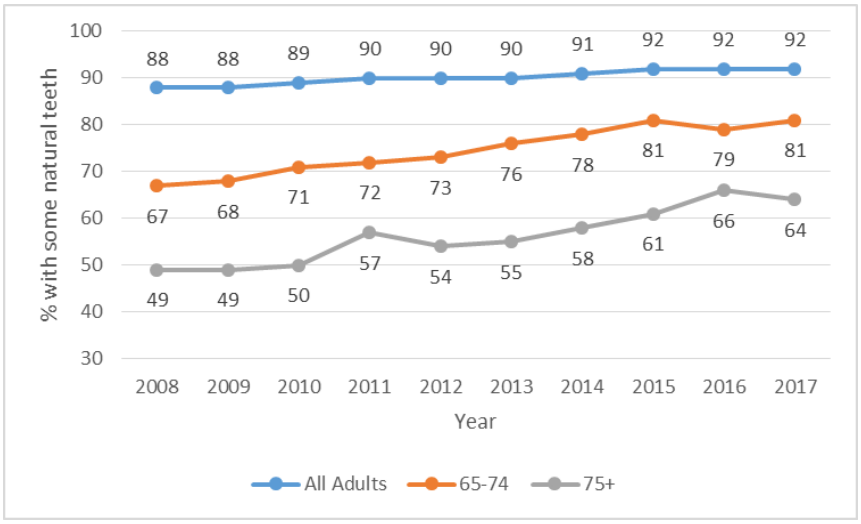
Less data are available to describe the oral health of adults, with most only reported at national level. As childhood oral health is known to predict future oral health it would be hoped that the good oral health observed in children in the Borders would also translate to older age groups.

The annual Scottish Health Survey[19] includes self-reported presence of natural teeth as a measure of oral health for a representative sample of adults aged 16 years and older reported at national level. In 2017 92% of respondents reported having some natural teeth with 76% reporting that they had 20 or more natural teeth*. Some measures within this survey are aggregated for the previous four years to enable reporting at Health Board level. Unfortunately measures of oral health have not been included in aggregated reports to date.

*The presence of 20 or more natural teeth, known as the functional dentition, is regarded as the minimum number of teeth required for an individual to eat what they like without requiring a partial denture

The proportion of individuals in Scotland with one or more natural teeth has been increasing over time, particularly amongst older age groups as shown in Figure 8.

Figure 8 - Trends in proportion of Scottish adults with at least 1 natural tooth 2008-2017 for all adults (age 16+ years), 65-74 years and 75+ years



https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-main-report/

The greater proportions of older adults retaining some natural teeth is expected to continue as those with improved oral health increase in age. This is likely to result in greater demand for dental services.

During 2015-16, a pilot Scottish Adult Oral Health Survey[20] (SAOHS) was undertaken to test the feasibility of collecting adult oral health data during routine dental examinations, with a further "boost sample" added in 2018. In future it is hoped that a SAOHS programme can be introduced to record adults' oral health in Scotland.

The 2019 report[21] pools data for 3114 dental patients aged 45 years and above examined during the course of the two data collection periods, 201 of whom (6.5%) were from the Borders. Due to the nature of the pilot it was not possible to report results at Health Board level. Nationally it was found that 96% of those examined had at least one natural tooth.

The survey demonstrated inequalities in adult oral health, with those from more deprived areas being less likely to have any natural teeth or, where teeth were present, less likely to have a functional dentition and more likely to have untreated decay. Oral health was also noted to vary with age, with older adults more likely to have fewer teeth, less likely to have teeth which were sound (not decayed or filled) and more likely to wear dentures. Those over 75 years old tended to have poorer oral hygiene. Untreated decay reduced with age, being lowest amongst those aged 64-75 years, before increasing again in those over the age of 75.

Although known to be the most common oral diseases, no data are available to describe the prevalence of dental caries or periodontal (gum) disease amongst adults in the Borders. The third major oral disease, oral cancer, is much rarer, but is important as it has a significant impact on those affected. In the Borders in 2016, the most recent year for which data are available, 8 new cases of oral cavity cancer (ICD 10, C01-06) were diagnosed and one individual from the Borders died as a result of the condition during 2016[22].

Determinants of Oral Health

There are a number of factors known to influence oral health. Diet, particularly the frequency and amount of sugar consumed, increases the risk of dental decay. No data are available to quantify sugar consumption in the population of the Borders, however measures of fruit and vegetable consumption reported in the Scottish Health Survey provide some indication of dietary practices. Aggregated data from 2014-17 show that 70% of adults in the Borders eat fewer than the recommended 5 portions of fruit and vegetables per day, with 8% reporting that they do not eat fruit or vegetables on a daily basis. These figures compare favourably with the Scottish average of 79% eating less than 5 portions of fruit and vegetables per day and 11% not eating fruit and vegetables on a daily basis[15].

Smoking is associated with poorer periodontal (gum) health and is known to increase the risk of developing oral cancer. Smoking rates have been declining in recent years and currently around 18% of the population of the Borders report that they are regular smokers, which is slightly lower than the national average of 21%[15]. Alcohol is also associated with oral cancer, with a synergistic effect observed where there is exposure to

both alcohol and tobacco. Alcohol may also increase the risks of oro-facial trauma and excessive toothwear. In the Borders around 21% of adults are described as having harmful/hazardous drinking habits (drinking above the recommended limit of 14 units per week), in comparison to 25% across Scotland as a whole[15].

Fluoride is known to protect against dental caries. Fluoride can be delivered in a number of formats, including toothpastes, professionally applied gels and varnishes and fluoridation of domestic water supplies. People living in fluoridated areas tend to experience less dental decay than those in non-fluoridated areas and there is evidence that water fluoridation can narrow oral health inequalities[23]. In the Borders, as with the rest of Scotland, supplemental fluoride is not added the water supply. The Scottish Government have made it clear that water fluoridation is not being considered at the present time, stating in the Oral Health Improvement Plan that: “Although we recognise that water fluoridation could make a positive contribution to improvements in oral health, the practicalities of implementing this means we have taken the view that alternative solutions are more achievable”. Currently, the national direction is to focus on delivery of topical fluoride through twice daily brushing with fluoride toothpaste, supplemented by professional application of fluoride varnish to those at greatest risk of decay.

As noted earlier, both adults and children from deprived areas are at greater risk of poor oral health though it is difficult to quantify the extent to which this is the case in the Borders. It has been suggested that in the Borders, geographic isolation may also impact on the oral health of those affected. Lack of data also limits our ability to describe the oral health of particular population groups in the Borders who are likely to be at increased risk of poorer oral health, including people experiencing homelessness, care experienced children, those with additional care needs and those with poor mental health.

Main Findings Section 1: Demographics, Health and Oral Health

- **There is a large and growing proportion of older people in the Borders**
- **Inequalities in the Borders are often masked by area measures of deprivation**
- **General health in the Borders is relatively good. Increased prevalence of some conditions may reflect the age structure of the population**
- **Oral health of children is good, though the rate of improvement appears to be slowing**
- **There is a lack of data to describe the oral health status of adults or "priority groups"**
- **Health behaviours including fruit and vegetable intake, smoking and hazardous drinking are more favourable in the Borders than the rest of Scotland though there is still room for improvement**

Key Discussion Points

Ageing Population

The large, and growing, proportion of older adults in the Borders has important implications for dental services in the area. In combination with increased numbers of people reaching older age, the fact that more people are retaining natural teeth will place increasing demands on dental services. In the Borders where the proportion of older people is higher than the national average this is likely to present particular pressures to dental services in the future.

While improvements in oral health have led to more teeth being retained, past dental disease means that many of these teeth will have been subject to dental treatment, often with large restorations or crown and bridge work which can be complex to maintain and which will require replacement over time.

In addition to increased requirements for treatment, there are challenges associated with providing dental care for an ageing population. Increasing prevalence of health conditions and co-morbidities with advancing age, cognitive decline and increasing frailty introduce complexities into treatment provision. Many of the medications required for these conditions can also impact on oral health and dental care, for example through side effects of dry mouth, effects of immuno-suppression or anticoagulants.

Advancing age may also make it more difficult for patients to access dental care as mobility declines and presents barriers to attending dental appointments. The ability of individuals to maintain high standards of daily oral care may also reduce, either due to physical limitations or with cognitive decline. Dependence on care providers to support oral

hygiene and mouth care is an important aspect to be considered in any packages of personal care. Daily oral care is essential to reduce the risk of dental problems and requirement for dental interventions which would be complex to provide.

Migration

While the increasing proportion of older people in the Borders is likely to have the greatest impact on dental services in the future, the main driver of population growth is net migration into the area. A small proportion, around 6%, of those arriving in the Borders are from overseas, however it is recognised that there are specific considerations for dental services, including the requirement for translation services to support provision of dental care. During financial year 2017-18 114 requests for translators were made by the Public Dental Service, incurring a cost of £13 626. This was an increase on the previous year when 84 requests were made and the cost was £6 798. The increases over this time were most likely due to new arrivals in the area, including a number of Syrian families with refugee status, which is supported by the fact that the most commonly requested language was Arabic. Greater consideration of the reasons for requesting interpreters and an increased use of telephone interpretation reduced costs of providing translation services to £3 626 in 2018-19.

No data were available for costs of translators supporting patients attending General Dental Practices and it is unclear whether this is because the services are not used or their use is under recorded. Patients who have English as a second language should not automatically be directed or referred to PDS, though groups with particular needs such as refugees may be identified as requiring the additional input which can be offered by the PDS.

Aside from challenges and costs associated with providing dental care to individuals whose first language is not English, oral health needs of those arriving from other countries can be expected to differ from the local population. The relatively good oral health in the Borders makes it likely that oral health of new arrivals will be poorer and this is particularly the case for people arriving from areas of high caries prevalence such as Eastern Europe or refugees who often have high health needs. The specific needs which may differ from the general population of the Borders require to be taken into account when planning and delivering oral health services, including preventive interventions.

Priority Groups and Health Conditions

While data to describe individuals likely to be at increased risk of poor oral health, including priority groups and those with additional care needs or specific health conditions, are limited it is known that many such individuals are resident in the Borders. It is important to ensure that the oral health of these groups is not over looked and the specific oral health needs (which are likely to be greater than those of the general population) must be identified and taken into consideration to ensure they are met.

Child Oral Health

The oral health of children in the Borders is good and for a number of years has been consistently better than the national average. The small population in the Borders requires a degree of caution in interpreting local trends in results of school dental inspections. Locally the rate of improvement which has been observed in child oral health has been slowing. This has also been observed in other areas of Scotland and is felt to reflect that

fact that while oral health improvement programmes have been successful for the majority of children further action is required to reach children who have not fully benefited from the interventions to date. To continue to reduce levels of dental disease it will be necessary to place greater emphasis on those children who continue to be at risk of experiencing dental decay. This will require an increased emphasis on community based approaches to reach out to families of children who need increased support to maximise their oral health.

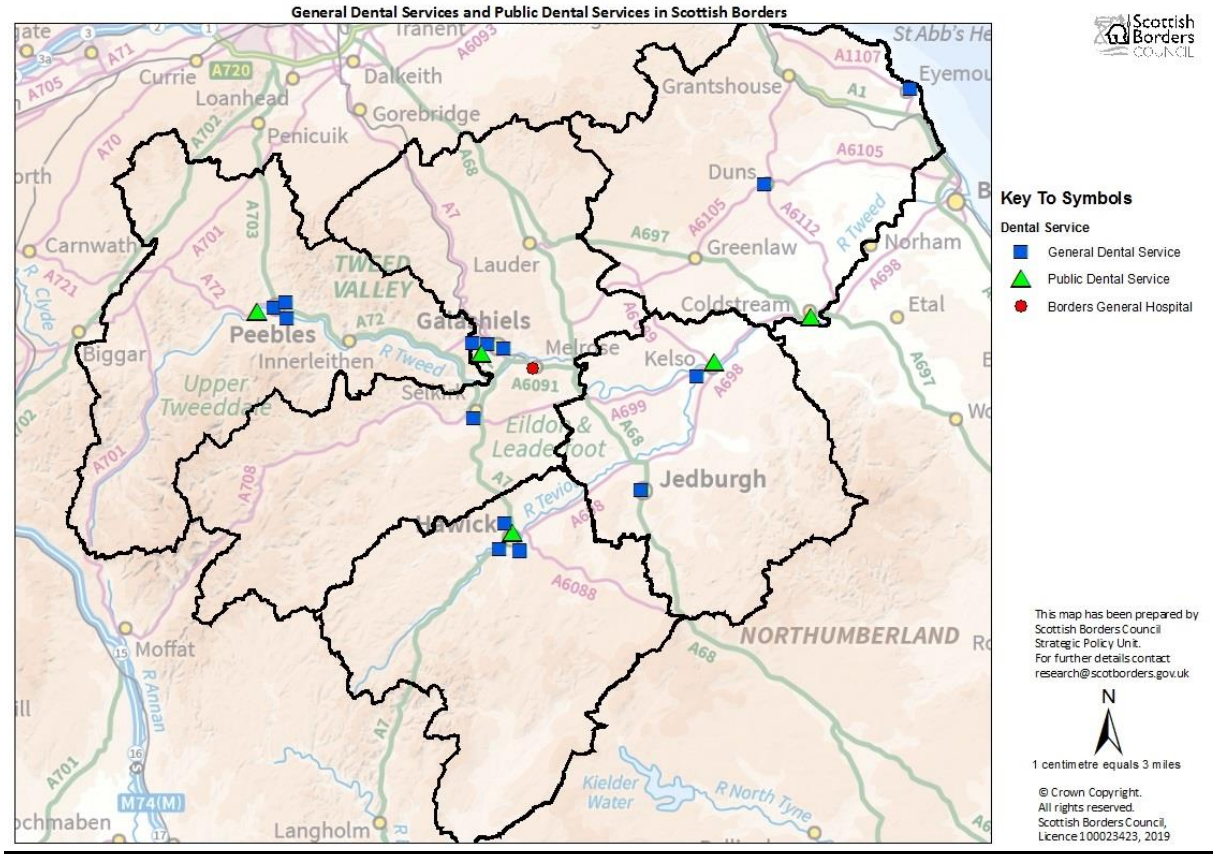
SECTION 2:
DENTAL SERVICES IN THE BORDERS

6. Provision of Dental Services

Primary Care Dental Services

Primary Care dental services are available in a number of locations across the Borders, provided for the NHS by either the General Dental Service (GDS) or Public Dental Service (PDS). Figure 9 shows the distribution of GDS and PDS clinics in the Borders. Clinics are generally available in the areas of greatest population density, though it is evident that residents in some areas may have to travel significant distances to access a dental clinic in the Borders.

Figure 9 – Map showing distribution of GDS and PDS Dental Services in the Borders



Funding of Primary Care Dental Services

Primary care dental services are funded by Scottish Government. GDPs receive payments via Practitioner Services Division as item of service payments, (minus patient contribution), continuing care / capitation payments for registered patients plus allowances. The GDS budget is non cash limited. The PDS is hosted by the HSCP and is funded via an allocation from Scottish Government with some additional funding from the Health Board. In addition NHS Borders receives funding through the “Superbundle” for delivery of the national oral health improvement programmes e.g. Childsmile, the emergency dental service and clinical waste for all primary care dental services.

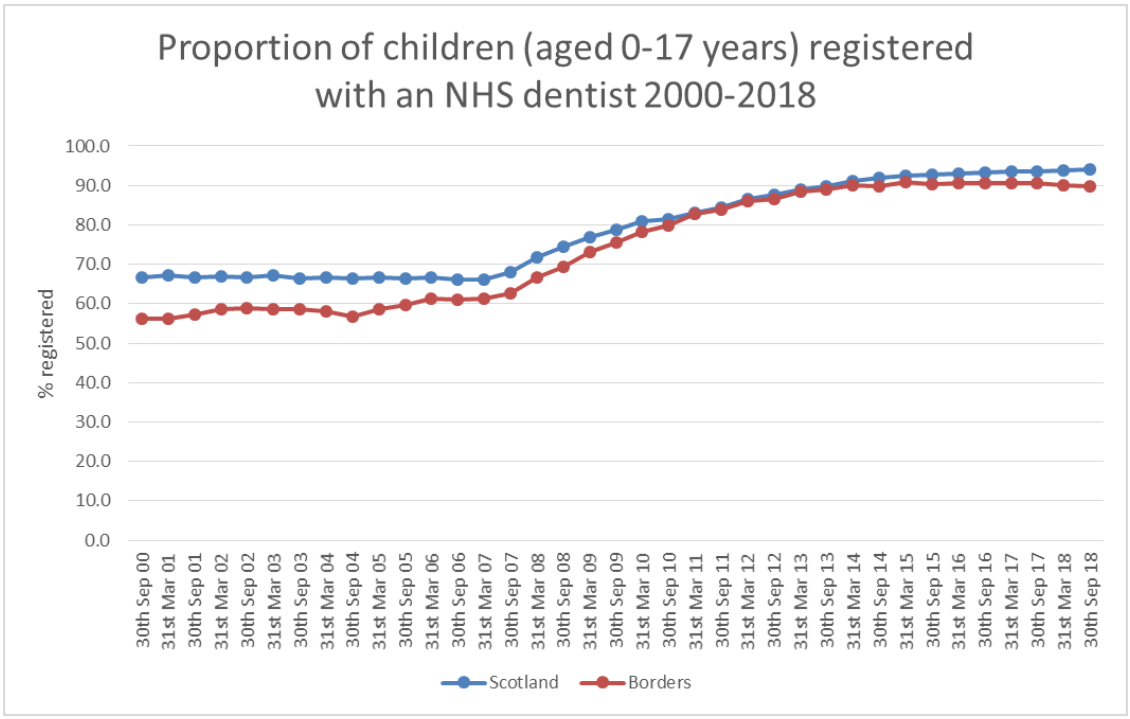
Dental Registration

The proportion of the Borders population registered with an NHS dentist has increased significantly in recent years. On 30th September 2018, 81.6% of adults and 89.7% of children were registered with an NHS dentist in the Borders, in contrast to 2003/4 when less than 40% of adults in the Borders were registered. NHS dental registration in the Borders is slightly below the national average of 94.3% of adults and 94.1% of children.[24] It is worth highlighting that some individuals attend for dental care on a private basis and are therefore not included in this figure, though they do access dental services. Information is not available to describe the number of individuals currently accessing private dental care, though it is known that this is offered by a number of local practices. The proportion of the population who are currently not accessing dental care is therefore difficult to quantify but likely to be well below 20%.

Until 2006 registration with an NHS dentist was time limited and would lapse if the patient had not attended within the previous 15 months. From 2006 the registration period was extended to 36 months, then 48 months in 2009. Following further changes to the Regulations, lifelong registration was introduced in 2010. Anyone who has been registered with an NHS dentist since this time remains registered unless the dentist actively chooses to de-register a patient or the patient opts to attend a different NHS dentist at which point their registration will transfer to the new dentist.

Figures 10 and 11 show trends in dental registration for children and adults with NHS dentists since 2000 for Scotland and the Borders.

Figure 10 - Trends in dental registration for children in Scotland and the Borders 2000-2018

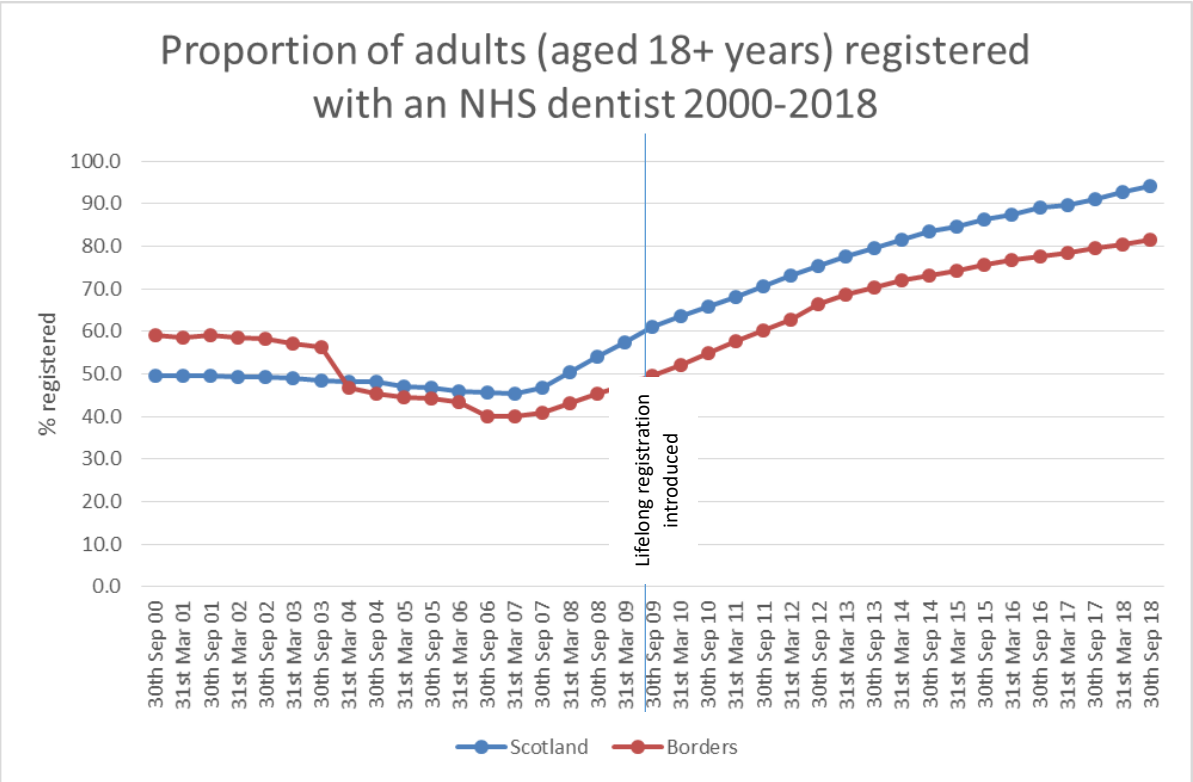


https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

The pattern of registration rates has been similar for children in the Borders as in other parts of the country, though in 2000 there were fewer children registered with an NHS dentists in the Borders than in Scotland as a whole. As registration rates increased, this

occurred more rapidly for children in the Borders, though it appears that the registration rate for children is levelling off at around 90%.

Figure 11 - Trends in dental registration for adults in Scotland and the Borders 2000-2018



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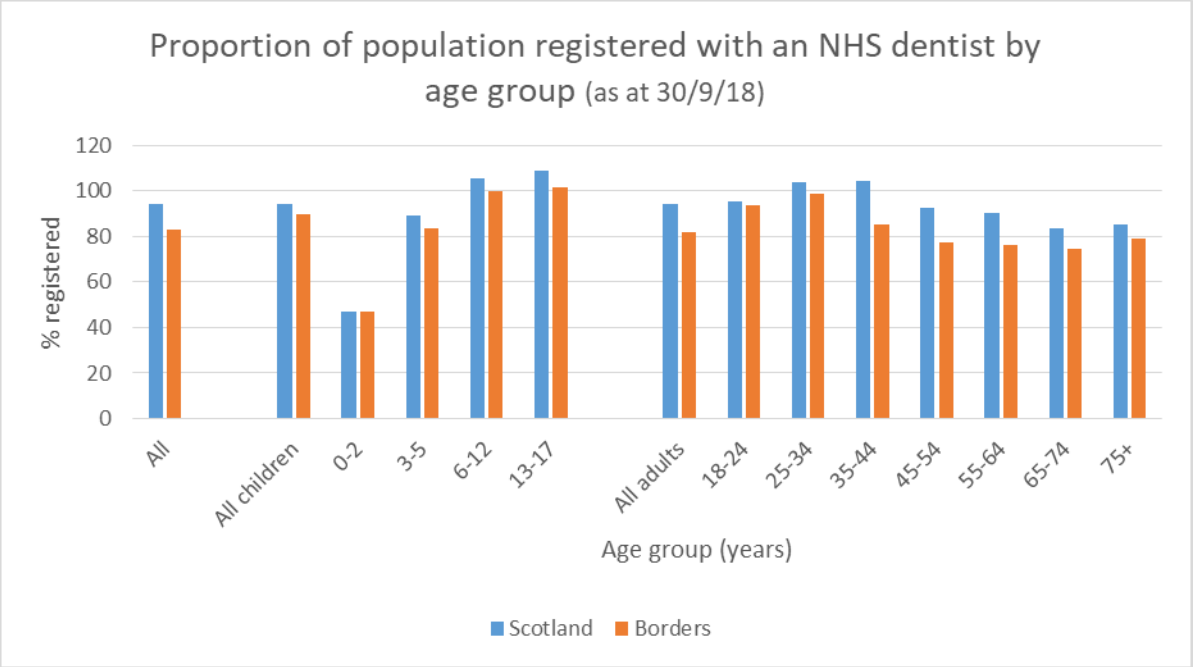
Trends in dental registration for adults in the Borders have varied slightly from the national picture. In 2000 a greater proportion of adults in the Borders were registered with an NHS dentist than in Scotland as a whole. Registration rates declined sharply around 2003-4, when a number of local dentists reduced their NHS commitment and the balance shifted towards increased provision of private dental care. As registration rates have increased, this has happened more slowly in the Borders than in other parts of Scotland and while the current level of 89.6% of adults being registered is a significant improvement on 49% in 2003, it remains below the national level.

Registration rates tend to vary with age, with highest registration amongst children and the 25-34 age group. Levels of registration by age group in the Borders and Scotland are presented in Figure 12. In general registration by age follows a similar pattern in the Borders as the rest of Scotland, with lowest registration amongst the youngest age group where only 46.7% of those aged 0-2 years are registered with a dentist. The Borders is slightly unusual in having a higher proportion of the 75+ age group (79.1%) registered with a dentist than any other group from 45 and above.

Figure 12 – Proportion of Population in the Borders and Scotland Registered with an NHS Dentist by Age Group



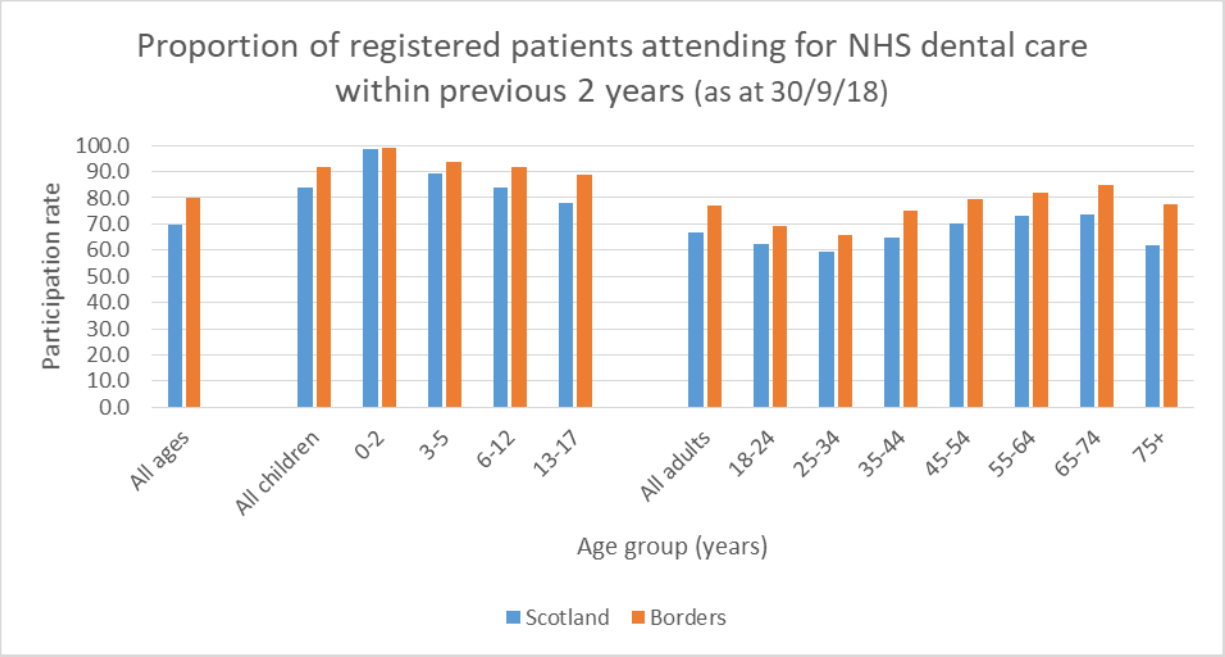
https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Participation with Dental Services

Since the introduction of lifelong registration in 2010, being registered with a dentist no longer represents continuing active engagement with dental services and a new measure of participation has been introduced as a measure of those who regularly attend dental services. Participation is defined as having attended an NHS dentist for examination or treatment within the previous two years. In the Borders in September 2018 77.1% of adults and 91.7% of children registered with an NHS dentist had participated with NHS dental services during this time period. This is higher than the national average of 66.6% of registered adults and 84.1% of registered children across Scotland.[23] Borders patients who are registered with an NHS dentist are more likely to attend the dentist regularly than in other parts of Scotland.

Like registration participation rates vary with age, being highest amongst children and lowest among young adults and the oldest age groups. Participation rates by age group for NHS Borders and Scotland are shown in Figure 13. In the Borders the proportion of older adults participating with dental services is higher than in other parts of the country.

Figure13 - NHS Dental participation rates by age group in Scotland and the Borders



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Cross-Boundary Dental Attendance

Unlike General Medical Services which have strict geographical boundaries for registration, patients can choose to register with a General Dental Practitioner in any location, including in other Health Board areas. Data from NHS National Services Scotland Information Services Division (ISD) show that during financial year 2018-19 274 patients from the Borders received NHS dental care in Dumfries & Galloway and 6186 Borders residents attended NHS dentists in Lothian. It is possible that some people accessing dental care out with the Borders do so because they are unable to register with a dentist locally, though this is unlikely to be the only explanation. Reasons for accessing dental services out with the Borders could be varied, including patients who have moved from another area opting to remain registered with the dentist they have previously seen, a dental practice in a neighbouring area being closer to a patient's home or having more direct transport links than the nearest service within the Borders, or for an individual who works in the neighbouring Board area it may be more convenient to attend a dentist close to their place of employment. Registration and participation figures are based on the patient's home postcode and as such, the figures above include residents of the Borders regardless of where in Scotland they are accessing dental care.

The proximity of the Border with England means that some residents of the Borders may choose to access dental services in England for reasons similar to those outlined above. Due to the different model of delivery of primary care dental services in England, there are no equivalent figures for registration and participation with an NHS dentist. A request was made to the English NHS Business Services Authority (NHSBSA) for information regarding the number of Scottish patients known to be accessing dental care in England.

Between August 2017 and July 2019 (a standard 2 year period which NHSBSA works to) around 6 000 patients seen in England were identified as having a Scottish home postcode. Of these, 2 810 were residents of the Borders, making up 46.7% of all Scottish people who received dental care in England over this time. Perhaps unsurprisingly, the

next most frequent area from which Scottish patients were accessing care in England was Dumfries & Galloway, however this accounted for only 13.4% of Scottish residents seen in England over this time.

Reasons for Scottish patients accessing dental care in England may include requiring emergency dental care for an acute problem while on holiday. Analysis of the number of claims for urgent treatments for Scottish patients showed that while the majority (37.2%) of these were submitted in the North of England, claims for urgent dental treatments were made across most areas of England and were noted to be higher in areas recognised to be holiday destinations such as Blackpool and Cornwall.

Band 1 FP17 claims (claims for basic items of treatment including a dental examination) could be considered a proxy for patients receiving regular dental care. A significant proportion (81.2%) of all Band 1 FP17 claims for Scottish residents were submitted in the North of England (Cumbria, Northumberland and Tyne & Wear). Contract analysis also revealed that the area where most claims for Scottish residents were submitted per contract was Berwick upon Tweed (3 299 claims), with the majority of these patients being resident in the Borders. It should be noted that this does not equate to the number of individual patients seen, as it would be expected that patients receiving regular dental care would have received more than one course of dental treatment (hence generating more than one claim) during the 2 year reporting period.

While some patients from the Borders opt to access dental care in England, it is known that some English residents travel to attend dental practices in the Borders. During financial year 2018-19, information from ISD shows that 777 patients from England were treated by NHS dentists in the Borders, with a total of 1146 courses of treatment provided over this time period.

General Dental Services

The majority of dental care in the Borders is provided in Primary Care by independent contractor General Dental Practitioners (GDPs). GDPs providing NHS dental services are required to meet criteria for listing by the NHS Board and are registered to work in a practice which is subject to a 3 yearly rolling programme of practice inspections. GDPs listed to provide NHS services are obliged to offer the full range of NHS dental treatments as set out in the Statement of Dental Remuneration[24] to patients registered with them for NHS care.

Treatment provided in NHS dental practices is funded mainly on a fee-per-item basis with patients paying 80% of the cost of treatment unless they fall into an exemption category (under 18, aged 18 and in full time education, pregnant or have had a baby in the previous 12 months or in receipt of certain benefits). NHS dental examination is free of charge for all patients. Treatment fee income is supplemented by additional payments and allowances, for example continuing care payments for registered patients, payment for participating in continuing professional development and reimbursement of some business expenses. A Remote Areas Allowance is payable to dentists working in an area with less than 0.5 people per hectare, or those who have retained a list number in a practice 90 minutes or more from the closest Postgraduate Dental Education Centre, which made them eligible for the Remote Areas Allowance prior to 2006. During 2018-19 a total of £188 100 was paid by Scottish Government in Remote Areas Allowances to dentists in the Borders[26].

A Recruitment and Retention Allowance is available to encourage dentists to take up posts providing NHS dental care in Designated and non-Designated Areas of Scotland where it is recognised that there is a shortage of dentists. This allowance is payable to dentists on completion of training or in applying to join a dental list in the area, having not been listed there in the previous 5 years. To qualify for the allowance they must undertake to provide at least four sessions of NHS dentistry per week in the three subsequent weeks, with NHS earnings accounting for not less than 80% of their total income over this time. One area in the Borders is classed as a non-Designated area, which is Coldstream. As the only dental practice in Coldstream is a PDS clinic, this allowance may help to encourage recruitment to a PDS post were it to become available but would be unlikely to bring new GDPs to the Borders.

GDPs may also offer additional private treatments to their NHS patients, for example where a treatment is not available in the SDR. Many also opt to provide private care to patients who are not registered as NHS patients. The level of commitment to the NHS varies between individual practitioners and between dental practices.

There are 15 dental practices in the Borders who provide NHS dental care, most of which also offer private treatment to a greater or lesser extent. Details of NHS dental practices and dentists in the Borders are presented in Table 2. Forty six dentists are listed to provide NHS dental services in the Borders (as at December 2019). The majority are self-employed independent contractors to the Health Board. Two dentists are employed by dental practices as assistants. An assistant is a qualified dentist who is employed by the dental practice usually on a salaried basis and works alongside a principal dentist. During their first year in General Dental Practice, recently qualified dentists will take up a post as a Vocational Dental Practitioner (VDP). A VDP is a fully qualified, registered dentist who works alongside an experienced GDP who can provide support during this first year. There is currently one VDP in the Borders.

Table 2 – Dental Practices in the Borders

Town	Dental Practice	Number of dentists listed	NHS/ Private*
Duns	Duns Dental Practice	2	Predominantly Private
Eyemouth	The Eyemouth Dental Practice	5	NHS & Private
Galashiels	Roxburgh Dental Practice	5	NHS & Private
	Bank Street Dental Practice	7	NHS & Private
	Albert Place	3	NHS & Private
Hawick	GK Dental	2	NHS & Private
	North Bridge Dental Practice	3	Adults Private, Children NHS
	Teviot Dental Practice	2	Predominantly Private
Jedburgh	EM&B Dental Practice	1	NHS
	Jedburgh Family Dental Practice	7	NHS & Private
Kelso	The Gentle Touch	4	Predominantly Private
Peebles	Peebles Dental Practice	3	NHS & Private
	Rosalind Kerr Dental Practice	3	NHS & Private
	Kingsmeadows Dental Practice	1	Adults Private, Children NHS
Selkirk	Selkirk Dental Practice	4	NHS

*Based on practices status as "NHS committed" and whether accepting new patients as at December 2019. This does not directly reflect the number of NHS patients registered with each practice.

Traditionally General Dental Practices were owned by a principal dentist, or partnership of dentists within the practice who took on responsibility for running the practice in addition to providing clinical care. Self-employed associate dentists work in dental practices and pay a proportion of their income to the practice owner(s) to cover practice overheads. While this remains the most common model of delivery of General Dental Practices in Scotland, in recent years there has been an increase in the number of practices owned by Dental Bodies Corporate (DBC), commercial companies who own a number of dental practices staffed by associate or assistant dentists. Three of the fifteen NHS dental practices in the Borders are currently owned by DBCs. In addition there is one specialist NHS dental practice providing orthodontic treatment. A referral pathway has been established for orthodontic services in the Borders to support GDPs to refer patients to either the specialist orthodontic practice or Borders General Hospital as appropriate (Appendix 1). In line with the Scottish Government's Health and Social Care Delivery Plan[27], this ensures that patients who can be managed in a Primary Care setting are treated in the community, and only those with more complex orthodontic needs are directed to the hospital based consultant orthodontist. Staff in the orthodontic practice comprise a specialist orthodontist, a dentist who is employed by the practice to provide orthodontic treatment and an orthodontic therapist.

There are two dental practices in the Borders which only offer private dental care. Private practices which do not have any dentists listed to provide NHS dental care are not subject to Health Board dental practice inspections. Non-NHS dental practices are regulated by Healthcare Improvement Scotland (HIS). Requirements of the NHS practice inspection checklist are included in the HIS inspection process, though these inspections do not follow the same three yearly rolling programme. Reports of HIS inspections of independent hospitals and clinics, including private dental practices, are published on the HIS website.

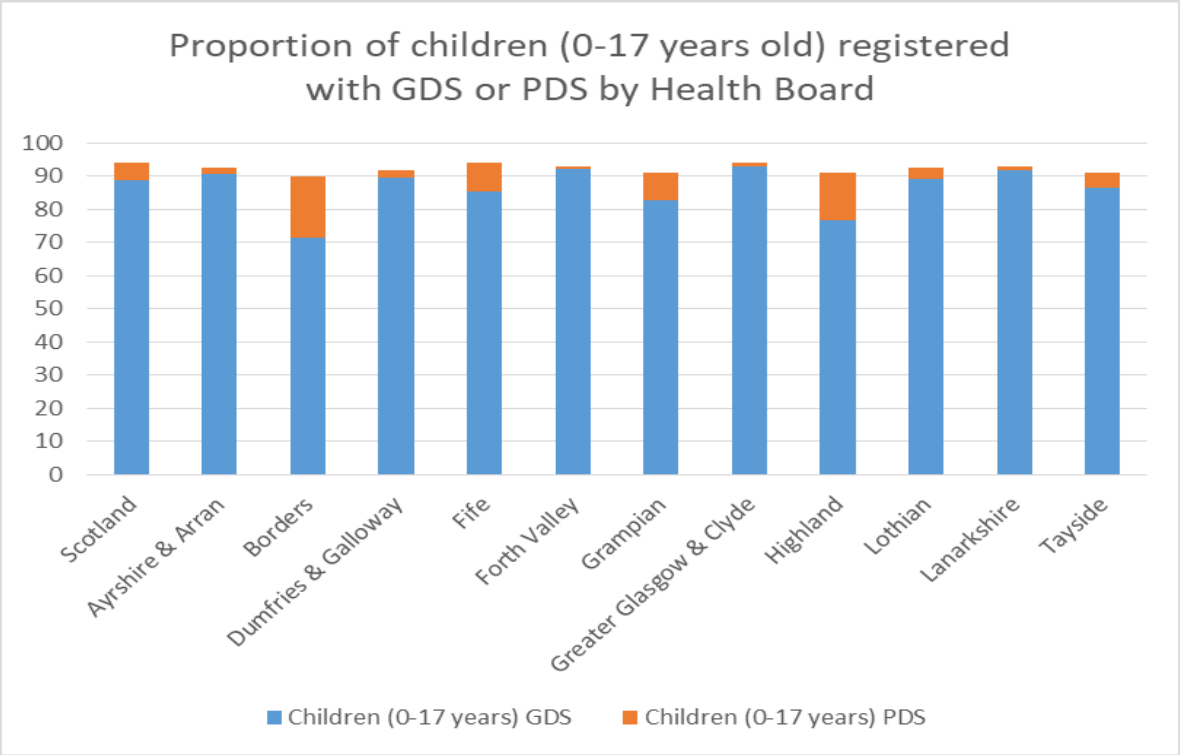
Public Dental Service

The Public Dental Service (PDS) offers a complementary Primary Care dental service for patients who are unable to access care from a GDP. The primary purpose of the Public Dental Service is to provide care to patients with additional needs which make providing dental care more complex, for example those with disabilities, medically compromised patients, pre-cooperative children, socially excluded groups and those with severe dental anxiety or phobia. In addition PDS teams provide care to inpatients in acute and community hospitals requiring dental treatment. The PDS also has a role in providing routine dental care to the general population in areas where they are unable to register with a dentist due to lack of service availability. The PDS provides dental care under the same GDS terms and conditions as GDPs, with patients who are not exempt from NHS charges paying the same fees as they would for care by a General Dental Practitioner. As Health Board employees, PDS dentists are not permitted to offer additional private treatments.

The 2005 Dental Action Plan sought to improve access to NHS dental services, with substantial investment in Salaried Dental Services in areas where there were fewer NHS GDPs. Due to the acute shortage of NHS dentists in the area at this time, the Borders benefited from this through the creation of new dental centres in Hawick and Coldstream, and recruitment of additional staff members to the PDS.

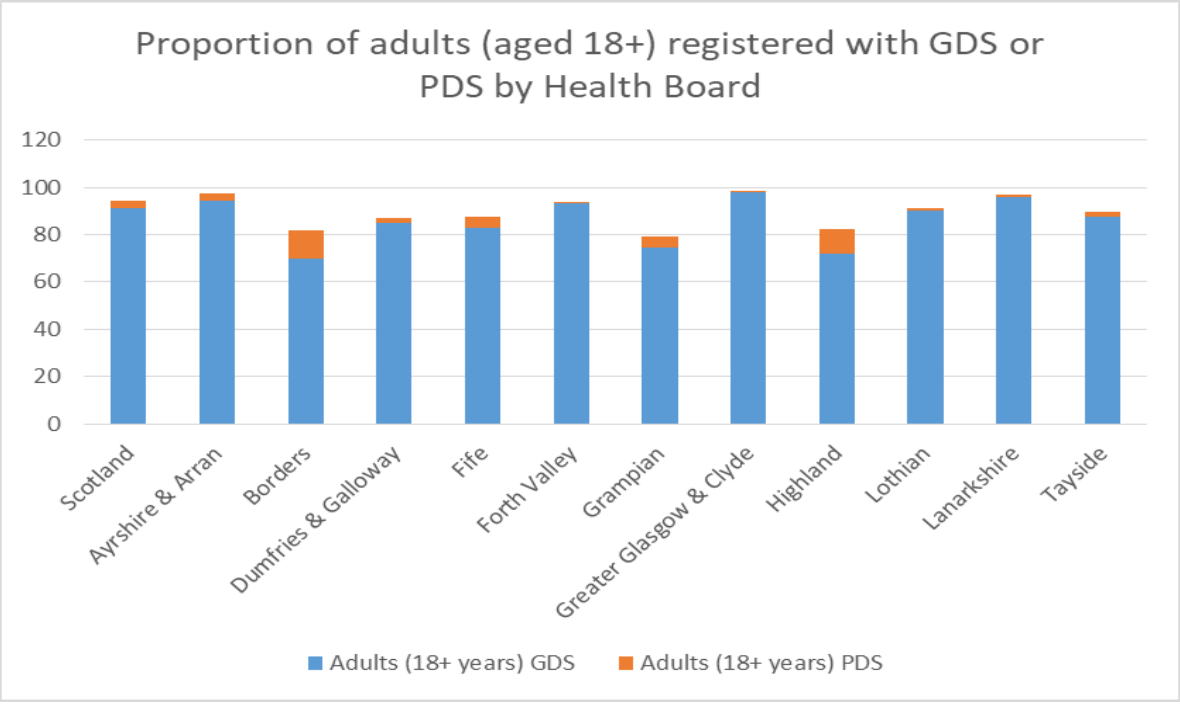
Nationally access is no longer considered to be a political priority and there is increasing emphasis on encouraging patients to attend a GDP where possible. PDS main focus will then be on the care of more complex patients for whom treatment in a GDS setting would not be possible. In the Borders the access function, providing regular dental care for routine patients, remains a significant proportion of the PDS workload when compared to other parts of the country as shown in Figures 14 and 15 for children and adults respectively.

Figure 14 – Proportion of Children Registered with GDS or PDS by Health Board



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

Figure 15 – Proportion of Adults Registered with GDS or PDS by Health Board



https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

There are currently six PDS clinics in the Borders. All but one clinic (Peebles) operate five days per week. Most clinics provide care for a mixture of routine (GDS) patients and those requiring special care dentistry. The clinic within Borders General Hospital only accepts patients who have been referred for treatment. Table 3 outlines the number of dental chairs and staffing level in each clinic. Table 4 outlines the number of staff employed in each role within the PDS.

Table 3 – PDS Clinic size, staffing levels and categories of patients seen (December 2019)

Clinic	Chairs	Staff*	Days	Patient types
BGH	1 PDS chair in dept with 3 surgeries	2 dentists 3 dental nurses	4 days	Referral only Special Care General Anaesthetic IV sedation Inhalation Sedation Anxiety management
Peebles	1	1 dentist 1 dental nurse	1 day/ fortnight	Doms Special Care only
Galashiels	3	2 dentists 1 hygienist-therapist 3 dental nurses	5 days	Routine Special Care
Kelso	2	3 dentists 1 hygienist-therapist 5 dental nurses	5 days	Routine (GDS) Special care
Coldstream	5	3 dentists 2 hygienist-therapists 7 dental nurses	5 days	Special care Routine (GDS)
Hawick	8	5 dentists 2 hygienist-therapists 10 dental nurses	5 days	Routine Special care

*Staff may work across a number of sites on different days. Staffing levels correct as at December 2019, but will vary depending on service requirements.

Table 4 - Staff in NHS Borders Public Dental Service as at December 2019

	Headcount	WTE
Clinical Director	1	0.85
Specialist Dentist	0	0
Senior Dentists	3	2.87
Dentists	9	7.27
Hygienist-Therapists	4	3.85
Hygienists	0	0
Dental Nurses	31	26.64
Reception/Admin	10	9.92
Local Decontamination Unit	6	5.6

The Bateman Casemix tool[27] is used by PDS to quantify the complexity of patient treatment by scoring six categories:

- Ability to communicate
- Ability to co-operate
- Medical status
- Oral risk factors
- Access to care
- Legal and ethical barriers to care

The breakdown of patient complexity as assessed by the Casemix model recorded for PDS patients attending clinics in the Borders during 2019 is shown in Table 5.

Table 5 - Level of complexity of patients seen in NHS Borders PDS (2019) Classified according to Bateman Casemix Tool

Level of complexity	Proportion of patients
1: No complexity	49.6%
2: Mild complexity	34.6%
3: Moderate complexity	11.6%
4: Severe complexity	2.8%
5. Extreme complexity	1.4%

The high proportion of patients recorded as having no or mild complexity may reflect the fact that many patients attend the service for its dental access function, however as a Casemix score was not recorded for every patient, it may not accurately reflect the proportions of patients within each category. In addition, the Casemix tool is scored in relation to the specific course of treatment, therefore a patient who may score high complexity for active clinical interventions would receive a lower score if the assessment has been based on a simple treatment plan such as a routine recall appointment with no other more invasive treatment required.

While a number of patients are registered with the PDS in the Borders for routine general dental care, treatments are provided to PDS patients which are less frequently provided by GDPs, for example as at August 2018 approximately 492 residents in care homes in the Borders were registered with PDS dentists for domiciliary dental care, equating to provision of dental care for around 70% of the total number of residential spaces available in care homes for older people in the region. It is anticipated that the balance of domiciliary dental care provision will shift from PDS to GDS in the future as the new enhanced skills GDP (eGDP) model becomes established, though this will depend on sufficient uptake of the role by GDPs.

Patients who attend PDS may be unable to tolerate routine treatment due to dental anxiety or other additional needs. During 2019 a total of 86 children had dental extractions under general anaesthetic. Providing dental treatment under general anaesthetic is considered to be a last resort for patients who cannot receive their treatment in any other way.

For some individuals sedation can help them to cope with treatment without the requirement for a general anaesthetic. During 2019, 73 patients were treated under inhalation sedation with nitrous oxide and 49 with intra-venous sedation (25 midazolam (dentist led), 24 propofol (anaesthetist led)).

Patients can access PDS services via self-referral, or on referral from a GDP or another professional involved in their care. The majority of new patients seen in PDS have self-referred, with GDPs being the most frequent source of professional referrals. Referrals to PDS are triaged centrally at Borders General Hospital and allocated to PDS, oral surgery or orthodontics based on the request of the referring dentist. The most common type of referral received by PDS is for children requiring sedation or general anaesthetic to enable them to accept dental treatment. Other referrals are for adults requiring sedation, those with special care needs and inpatients in acute and community hospitals.

Table 6 - Number of referrals to PDS by age group and category (January 2018 – December 2018)

Reason for referral	Age at referral					Total Number of Referrals
	0-18	19-44	45-64	64-75	75+	
Sedation	13	68	43	7	3	134
Special Care Dentistry	2	9	14	8	7	40
Paediatric Dentistry	231					231

Patients who self-refer are directed to their nearest GDP practice in the first instance. Priority group patients will be offered an appointment at the clinic closest to their home. Other patients requesting treatment with PDS are placed on a waiting list but encouraged to register with a GDP practice. A recent review of the waiting list for an appointment to register with the PDS at Coldstream Dental Centre identified that of the 324 on the list, around half had some access to dental care, though this was often not NHS care. Patients who are formally referred are prioritised and fitted in to appointment books where spaces are available.

Emergency Dental Care and Dental Enquiry Line

Emergency Dental Care is provided through the Borders Emergency Dental Service (BEDS). During practice opening times GDPs are responsible for providing emergency cover for their registered patients. Unregistered patients can access emergency care during weekdays by calling the Dental Enquiry Line. On a rota basis, all local dental practices and PDS clinics take a turn to hold predetermined emergency slots each day for treatment of unregistered patients who have contacted the enquiry line with an urgent dental problem.

Out of hours triage of dental emergencies for both registered and unregistered patients is provided by NHS 24, with emergency dental sessions available at weekends from the clinic at BGH between 1-4pm on Saturdays, Sundays and bank holidays. All GDPs providing NHS care and PDS dentists participate in the out of hours rota and are required to work approximately two out of hours sessions each year. During 2018 776 patients attended the out of hours dental service. The number of attendances at out of hours has remained relatively static since 2016 with 765 patients attending in 2016 and 753 patients in 2017.

In addition to being the contact number for unregistered patients who have dental problems or pain, the Dental Enquiry Line provides general advice about dental services, can provide up to date details of practices currently accepting new NHS patients and helps support unregistered patients who wish to find a dentist. During 2018 the enquiry line received over 2700 calls, a slight increase on 2017 when 2203 calls were received.

Secondary Care Dental Services

Specialist NHS dental care is provided for two dental specialities (oral surgery and orthodontics) from hospital dental clinics based in the acute sector in Borders General Hospital (BGH).

Orthodontics

One consultant orthodontist is based in BGH six sessions per week, with one additional session in Edinburgh Dental Institute (EDI), where it is possible to provide joint clinics with the Restorative and Paediatric Dentistry Departments, for Borders patients requiring more complex or multi-disciplinary care. Specialty trainees in orthodontics usually based in EDI also provide clinical input to the service in the BGH on a regular basis.

The orthodontic referral pathway which has been established in the Borders enables the consultant to focus on treating the more complex cases, while those suitable for treatment in primary care are managed in specialist practice out with the hospital setting.

During 2018 there were a total of 1792 attendances for orthodontic treatment in BGH, 151 of which were new patients and 1641 reviews and ongoing treatment. Waiting times for orthodontic assessment are within the 12 week referral to treatment target.

Oral Surgery

A total of 12 sessions of oral surgery are provided by two consultant oral surgeons, who are joined by a specialty trainee in oral surgery from EDI 1 day per week.

The oral surgeons accept referrals for a full range of oral surgery treatments from simple extractions on patients with complex medical histories, including those on anticoagulant medications, to surgical extractions and removal of impacted teeth. The oral surgeons also accept referrals relating to the specialty of oral medicine. Treatments are provided under local anaesthetic, intravenous sedation or general anaesthetic depending on the nature of the surgery and patient's ability to tolerate treatment.

During 2018 there were approximately 840 out-patient attendances at the oral surgery department (SMR00 data) and 141 patients were treated as day cases (SMR01 data). The oral surgery service has been under pressure with waiting times reaching 20 weeks. Waiting list initiative clinics have been provided to help reduce the backlog and reduce waiting times to around 12 weeks. Once assessed, patients requiring treatment under local anaesthetic can be treated fairly soon, however those requiring general anaesthetic may wait several months.

Other Dental Specialties

Patients requiring other aspects of specialist dental care may be referred on to Edinburgh Dental Institute. Treatment of Borders patients in EDI is managed via a Service Level Agreement (SLA). Prior to referring any patient to the Dental Institute, approval is required from NHS Borders and any referrals received in EDI without this approval in place will be

rejected. There are no arrangements in place between NHS Lothian and NHS England for cross-charging treatment costs and as a result EDI are unable to accept patients who live in England. Referrals for patients resident in England, even if referred by a GDP based in Scotland, are returned to the referrer who is advised to refer the patient to Newcastle.

There is an expectation that patients requiring orthodontic or oral surgery treatments will be referred to local services in the Borders in the first instance, however there are no restrictions on patients from the Borders being referred to the paediatric dentistry, restorative dentistry or oral medicine departments. Formal referral and acceptance criteria apply universally to all referrals received by EDI, whether from local dentists within NHS Lothian or neighbouring Boards served by the Dental Institute (Borders, Forth Valley and Fife). Decisions on acceptance of patients by EDI are based on the following considerations:

- Specialist review of the clinical information contained in the referral
- Core referral/acceptance criteria
- Recognition of the skill set within and across GDPs
- Recognition of available training capacity requirements (referrals falling out with the acceptance criteria may be accepted on occasion as training cases based on individual requirements)

Patients requiring treatment for oral cancer or head and neck trauma are transferred to the regional Oral and Maxillo-Facial Surgery (OMFS) unit in St Johns Hospital, Livingston.

Oral Health Improvement

There is an active oral health improvement team based within NHS Borders PDS whose main workload is delivery of the national oral health improvement programmes for children (Childsmile) and dependent older people (Caring for Smiles).

The Childsmile programme is well established in Borders nurseries and schools. Childsmile toothbrushing programmes are in place in all nurseries and the majority of Primary Schools and fluoride varnish application is offered in 40% of Primary Schools in the Borders, with Childsmile offered in most of these schools up to and including Primary 7, which exceeds the requirements of the programme. Childsmile is also delivered in additional support units in mainstream schools and Leadervalley School for children with complex additional needs.

The Childsmile practice arm includes oral health support workers (OHSW) who provide advice to families to promote good oral health and support them to access dental care for their child. During financial year 2018-19 545 families were contacted by an OSHW including 444 who were referred to an OHSW with a requirement for additional input to maintain their oral health and support dental attendance[29]. These referrals include children who have been referred to PDS for dental treatment under general anaesthetic all of whom are offered additional support by the Childsmile team.

Since 2011 Childsmile has been incorporated into the Statement of Dental Remuneration so that a fee can be claimed by dental practices for providing Childsmile interventions: diet advice and toothbrushing instruction for children aged 0-2 and 3-5 years and fluoride

varnish application for children between 2 and 5 years old. This enables monitoring of delivery of "Childsmile Practice". Table 7 shows the proportion of children registered with NHS dental services who received Childsmile interventions during 2018-19 compared to the national average. The oral health improvement team offer support to GDPs to encourage delivery of Childsmile interventions.

Table 7 - Proportions of children registered with GDS receiving Childsmile Interventions

Childsmile intervention	Proportion of children registered with a GDP receiving intervention (%)	
	Borders	Scotland
0-2 years diet advice	79.9	74.4
0-2 years toothbrushing instruction	79.8	76.7
3-5 years diet advice	58.1	46.3
3-5 years toothbrushing instruction	57.5	46.2
2-5 years fluoride varnish application (1 or more)	55.7	41.4
2-5 years fluoride varnish application (2 or more)	30.9	20.1

http://www.healthscotland.com/uploads/documents/36660-Childsmile%20National%20Headline%20Data%20-%20Nov2019.pdf

In PDS and some GDS practices dedicated Childsmile clinics are delivered by extended duties dental nurses (EDDNs) who offer preventive interventions including oral hygiene advice, diet advice and fluoride varnish application. One full time EDDN is directly based within the oral health improvement team in NHS Borders, with a further six dental nurses currently working in PDS available to provide sessions for Childsmile when required.

The Caring for Smiles programme aims to improve oral health of dependent older people by training staff in care homes to provide and document daily oral care, including toothbrushing and denture care. Within the Borders 71% of care homes currently have a staff member trained as an oral health champion, with plans to increase the number of care home staff who have received training.

There is one dental health support worker based in the Caring for Smiles team who works closely with clinical services in the PDS, providing a link between the care home and clinicians to support the delivery of domiciliary dental care when it is required.

The Caring for Smiles team have expanded beyond the care home setting and also offer training in oral health to home care teams in the private sector and from Scottish Borders Council.

The oral health improvement team recognise the value of joint working with colleagues in wider health improvement and have links with drug and alcohol services, smoking cessation services, the family nurse partnership, pre-diabetes groups and learning disability teams. They work in partnership with wider teams to promote good nutrition and oral health in schools.

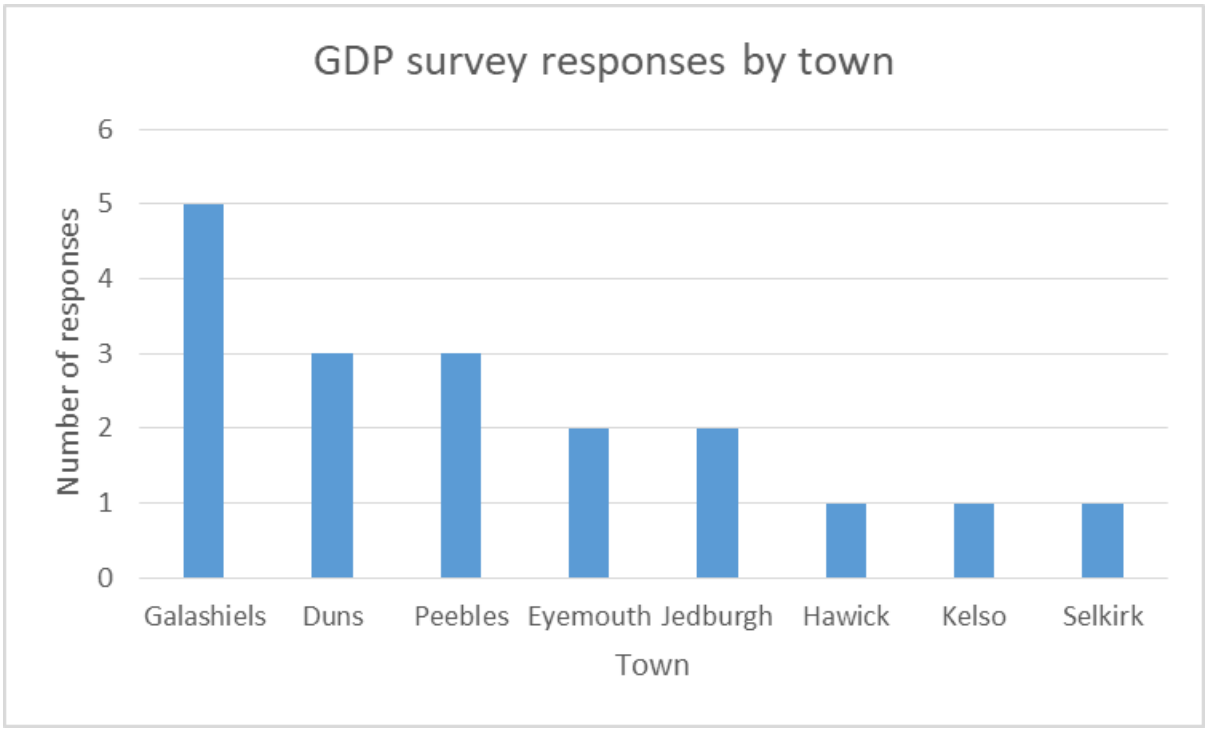
7. Reported Current Primary Care Dental Provision and Future Possibilities

General Dental Services

Between July and September 2019 an online survey was undertaken, with individual GDPs in the Borders invited to provide details of current service provision, staffing levels, utilisation of referral services and anticipated changes.

A weblink to the survey was sent by email by the local Dental Practice Adviser using the distribution list for GDPs who participate in the Borders Emergency Dental Service. Seventeen responses were received (37% response rate). The majority of respondents were practice principals (8), or associates (6). Two respondents were non-clinical practice owners who were not asked questions relating to clinical care, being directed to those regarding staffing. One respondent to the clinical section was a practice manager. The practice manager's responses relating to individual demographics were excluded from analysis, however to ensure that details of service provision for the practice were captured, responses relating to this were included on the assumption that responses reflected the practice as a whole. Responses were received from owners or principal dentists of nine practices (75% of practices in the Borders). All towns with General Dental Practices were represented (Figure16)

Figure 16 - Responses to GDP survey by town where practice located



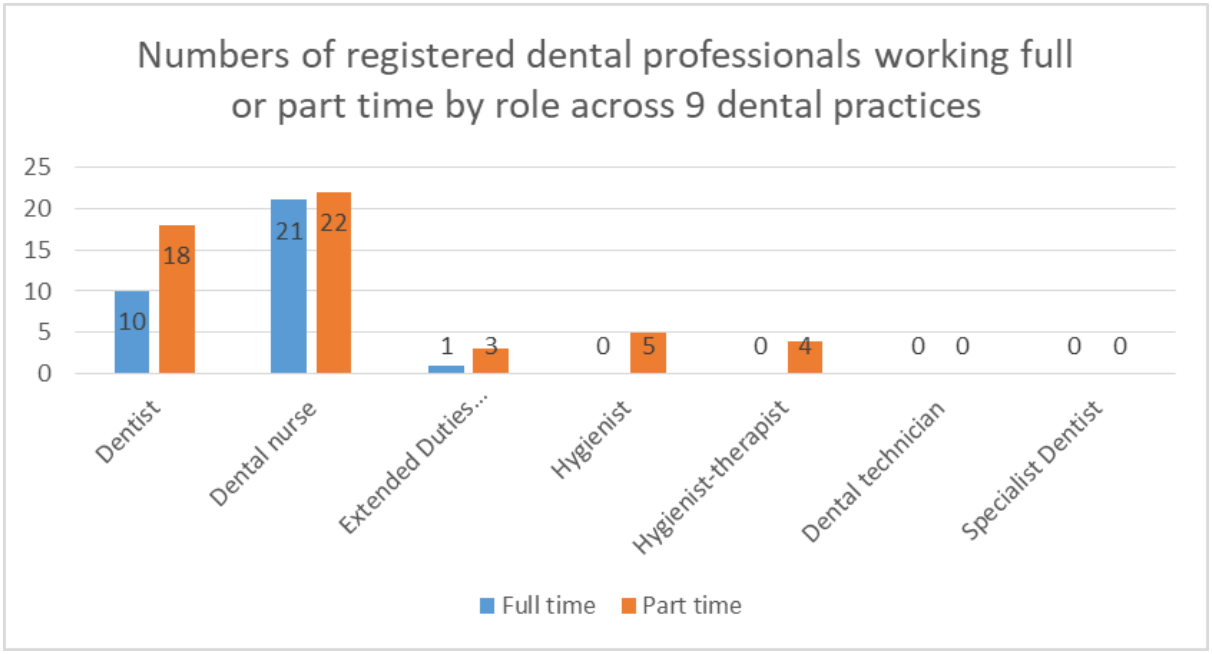
Survey Respondents

Given the response rate of 17 of the 46 GDPs invited to participate in the survey, it is unlikely that respondents are representative of the overall GDP workforce in the Borders. Of those who responded there were an equal proportion of males and females and 60% fell into the 41-50 years age bracket. Seventy nine percent of respondents were British and the remaining 21% EU nationals. The vast majority (86.7%) reported that they commuted less than ten miles to work and none commuted more than 40 miles.

Dental Practice Staff

Practice owners/principals of nine (from the total of fifteen) practices provided details of the numbers dental professionals working either full or part time in their practices. As would be expected the largest professional group was dental nurses, followed by dentists. Similar numbers of dental nurses worked full and part time (21 and 22). The majority of dentists worked part time (18), compared with ten working full time. None of the practices employed dental technicians or dental specialists on either a full time or part time basis. None of the practices for whom responses were provided employed full time dental hygienists or hygienist-therapists, though a number did employ either a part time hygienist or hygienist-therapist.

Figure 17 - Numbers of registered dental practitioners across the nine practices for which survey responses were received

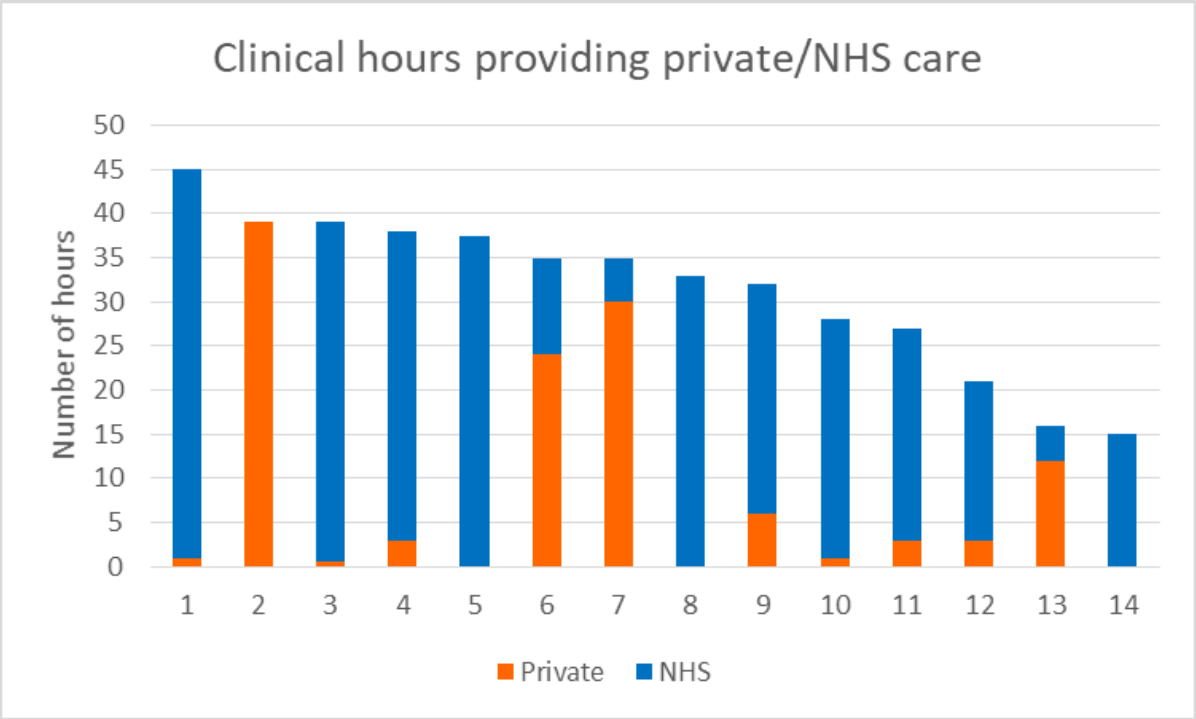


Two practices (22%) reported that they currently had at least one vacant post within their practice. Both of the vacancies were for associate dentists. One practice had no current vacancies but reported that they had advertised for an associate dentist the previous year and were unable to fill the post. They reported that they had plans to re-advertise but were concerned that they may again be unable to recruit to the post. Further pressures included nurse shortages due to illness and maternity leave. Seven of the nine practices reported that they had encountered difficulties with recruitment and retention of staff over the past five years.

Dental Care Provision

The total number of clinical hours worked by each respondent ranged from 15 to 45 hours per week. The split between private and NHS dental care is illustrated in Figure 18. While four respondents provided predominantly private dental care, the majority of those who responded to the survey spent most of their clinical time providing NHS care.

Figure 18 - Hours providing private or NHS dental care per dentist



All respondents provided NHS dental care for child patients, though one reported that children were only accepted for NHS care if their parents were registered with the practice as private patients. All but one respondent reported that they provide NHS dental care for adults. Five respondents (33%) were currently accepting new adults as NHS patients and eight (53%) were accepting new child patients. No distinction was made between adults who were exempt from NHS charges in terms of which adult patients were currently seen, or would be accepted as new patients.

20% of respondents do not currently register child patients from birth. One respondent reported that this was due to their list being closed to new patients. Another reported that this was partly due to the requirement to see a patient for them to become registered with the practice, when in the past it had been possible to submit a form to register a new patient prior to their attendance for examination. It was also felt that parents were not aware they could bring a child to the dentist before teeth are present, with most children not being brought to the practice until they are around a year old.

Capacity to See Patients

To gain an idea of the level of demand on NHS dental services, respondents were asked to give an indication of how soon existing registered patients and new patients wishing to register could be offered an appointment. Most respondents (69%), could offer existing patients an appointment within one month, with the remainder all able to offer an appointment within three months. New patients wishing to register with a practice were

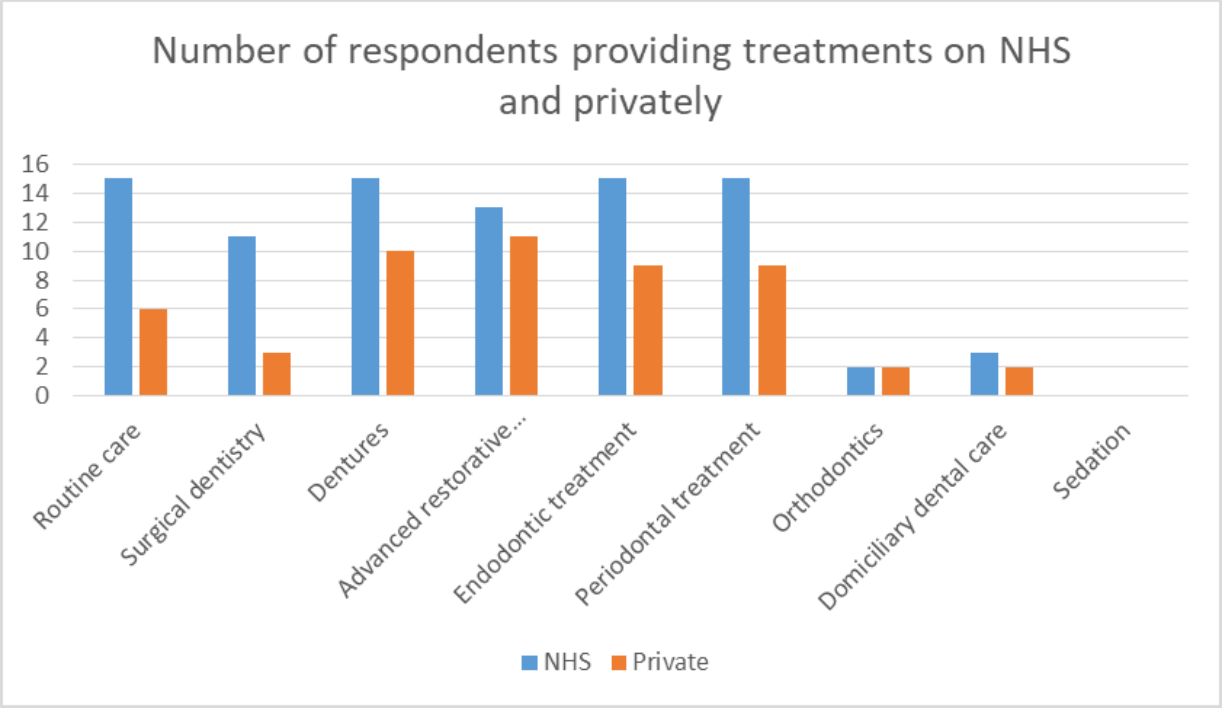
likely to wait longer for an appointment, with only one respondent able to offer an appointment within a month, and the majority (44%) reporting that a new patient would be seen within 6 months to a year.

Treatments Provided

Respondents were asked to indicate which types of treatment they provided on the NHS and privately. Treatments provided on the NHS and privately are presented in Figure 19.

All fifteen respondents offered routine dental care (including examinations, simple restorative treatments and routine extractions), dentures, endodontic treatment and periodontal treatment on the NHS. The most common treatments provided privately were restorative treatments, including advanced restorations (crowns and bridges) (11 respondents), dentures (10 respondents) and endodontic and periodontal treatment (9 respondents for each). None of the dentists who responded to the survey offer dental treatment under sedation either privately or on the NHS, though it is known that one local practice does offer intravenous sedation.

Figure 19 - NHS and private treatments provided by survey respondents



Dentists were asked how many domiciliary visits they had provided within the past year. The vast majority (9 respondents) had not provided any domiciliary dental care, 2 had provided one visit each, 2 had provided two visits and 1 had provided four. The remaining dentist had provided six domiciliary visits.

Referral Services

The survey asked respondents to indicate how frequently they referred patients to a range of specialist dental services. All of the dentists who responded indicated that they referred to oral surgery, orthodontic practice and private dental practice. Frequency of referral to different specialist services is presented in Table 8.The most frequently referred to service appeared to be the orthodontic practice.

Table 8 – Frequency of referral to specialist dental services by GDPs

Referral service	Never	Rarely (up to 1-2 referrals per year)	Occasionally (up to 1 referral per month)	Regularly (approx. 2 referrals per month)	Often (more than 3 referrals per month)	Not answered
BGH Oral Surgery	0	5	5	4	1	-
BGH Orthodontics	2	8	2	1	0	2
Orthodontic practice	0	0	6	4	5	-
Edinburgh Dental Institute	1	12	1	1	0	-
Private practice	0	4	6	3	1	1
Other/out of Board referral	8	5	0	0	0	2

Respondents were asked to specify which private practices and "other" services they referred to. Within the Borders referrals were made to a private endodontist and a recently opened private specialist referral practice. Patients were referred out with the Borders to an orthodontic practice in East Lothian and two private dental practices in Edinburgh. One respondent reported referring patients to St Johns Hospital for Oral Medicine, while another stated that they referred patients to Newcastle Dental Hospital though did not specify to which specialties.

Future Service Provision

The survey asked dentists whether they expected to continue to be providing dental care within the same town in the future. The majority (79.6%) of respondents anticipated that they would still work in their current town in 5 years time, and 60% expected to still be there in 10 years time. Of those who did not expect to still be providing care in the same town the most common reason given was retirement.

Dentists were also asked whether they expected to continue to accept the same categories of NHS patients as they do currently. Around two thirds of respondents stated that they were likely to continue to accept NHS patients on the same basis as they do currently. Four respondents (27%) reported that they were likely to either stop accepting NHS patients or reduce which categories of patients they would take on in future. Reasons given for reducing the number of NHS patients taken on included the fact that their lists were reaching capacity. Two respondents reported a desire to expand their practices or move to larger premises to enable them to continue to accept patients, however they were concerned that it may not be possible to recruit an additional dentist if their practice was to expand. None of the respondents felt it was likely that they would increase which categories of patient they would accept for NHS treatment in the future.

At the time the survey was conducted, a new model of delivery for domiciliary dental care was in the process of being introduced. The new model is based on "enhanced skills GDPs" (eGDP) providing dental care to care home residents. At the time of the survey one local dentist was undergoing training and mentoring towards accreditation as an eGDP. Respondents were asked whether they were likely to consider becoming an enhanced skills GDP for domiciliary dental care in the future. Only one respondent said this was something they would consider, with all others saying they would not.

Although currently limited to domiciliary dental care, the Scottish Government's Oral Health Improvement Plan also includes a proposal to increase access to dental services "on the high street" through enhanced skills GDPs offering other more specialised dental treatments within practice. Six respondents stated that they would consider becoming an enhanced skills GDP in the future. Four of the respondents who expressed an interest in providing this service stated that they would wish to provide oral surgery under this model. One respondent would be interested in becoming an enhanced skills GDP providing orthodontics.

Public Dental Services

To gauge the current skill mix of staff working within the PDS, all PDS staff were invited to provide a list of recognised courses and qualifications they had undertaken in addition to their primary dental qualification. There was also an opportunity to undertake a "skills and preferences exercise". Separate questionnaires were devised for each of the professional groups – dentists, dental hygienist-therapists and dental nurses, based on their scope of practice and responsibilities. Members of PDS staff were asked to rate their level of skill or confidence to treat specific patient groups, work in particular settings, provide a range of different treatments and to undertake additional non-clinical duties which may be expected within their role. Level of skill or confidence was rated on a five point scale:

I am confident and can perform independently	I am fairly confident but may need occasional support	I am familiar but would need support	I understand the theory but have no experience	I have little or no knowledge

In addition to rating their confidence or skill level, for each item on the list staff were also asked to rate their preferences, or how they would feel about undertaking them. Preferences were rated on a four point scale:

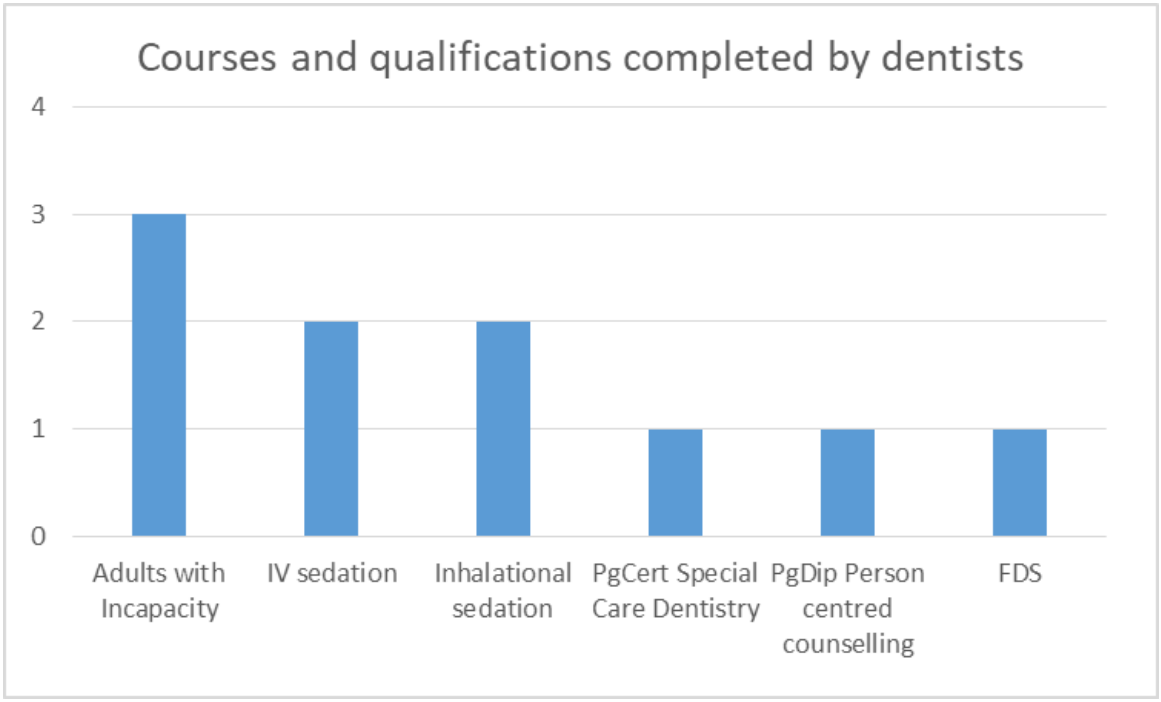
I am happy and get satisfaction	I don't mind	I have little or no experience but willing to learn	I would prefer not to do this

Dentists

Eleven dentists responded to the questionnaire (response rate 100%).

Additional courses and qualifications which dentists had completed are outlined in Figure 20.

Figure 20 - Dentists' additional qualifications



*It has been highlighted that there may have been some misinterpretation of the survey relating to dentists completing training in Adults with Incapacity as the majority of dentists within PDS have completed this training but only three responses indicated that this was the case.

Two further dentists were undertaking the Certificate in Special Care Dentistry at the time the survey was completed and were due to complete their qualification in September 2019.

Dentists' skills

The patient group which dentists were most comfortable to treat was children, with all but one rating themselves as confident to treat them independently. The majority of dentists were also comfortable treating older people, adults and children who are anxious and those with mild or moderate learning disabilities. Fewer dentists felt they would be confident to treat adults or children with more severe learning disabilities or physical disabilities. Only two dentists would feel confident to manage patients experiencing homelessness or those with addiction problems, while five dentists reported that they would require support to treat these patient groups.

In terms of settings, around half of the dentists would be comfortable to provide treatment on a domiciliary basis or in a hospital. Levels of confidence to manage patients within a mental health unit were lower which is likely to reflect that this type of service is currently only provided by the PDS team working within the BGH.

The majority of dentists were confident providing items considered routine dental care, including restorations, extractions, dentures and unscheduled (or emergency) dental care. Most were also comfortable to provide crown and bridge work, endodontic treatment and periodontal treatment. Dentists were less confident providing more complex or specialised items of treatment including minor oral surgery, preformed metal crowns for children and taking a neutral zone impression.

Only some dentists had experience of providing treatment under sedation or under general anaesthetic, which was reflected in the fact that dentists tended to either feel confident or said they had little or no experience, with no middle ground. There was an even spread among dentists relating to their skills in behaviour management of adults and children.

Most dentists were comfortable to liaise with colleagues in other areas of health and social care or with health improvement teams. While the majority of dentists felt able to mentor new or less experienced members of staff, they were less confident with their ability to deliver a presentation or in public speaking.

One dentist commented that it can take time to develop confidence, knowledge and independence due to different systems, documentation and protocols in place. Others highlighted that levels of confidence vary depending on opportunities to undertake different aspects of care, for example as more special care patients are seen a dentist may upskill in some areas relating to specific treatments being provided, but will at the same time de-skill in other areas for example more advanced restorative procedures which are less likely to be undertaken. It was acknowledged that to maintain confidence in more complex treatment items, such as minor oral surgery, these procedures need to be undertaken regularly. This can be hard to achieve in primary care where there are time pressures and there is an ability to refer on to the consultant led oral surgery service. Another dentist stated that although they had completed training in intravenous sedation, there had subsequently been an insufficient number of cases requiring sedation to maintain skills or confidence in the procedure.

Dentists' preferences

In general the dentists' preferences were in line with the skills ratings – where they were most confident they were more likely to report being happy and getting satisfaction. Generally for the more complex patient groups – severe learning disabilities, physically disabled and medically complex, more dentists reported that they would prefer not to work with them. The exception was with people experiencing homelessness and those with addictions, where none of the dentists opted for "prefer not to" and almost half stated that they had little experience but would be willing to learn.

Preferences for working in different settings were divided. There was a fairly even spread of ratings for domiciliary dental care, with some being happy, others who didn't mind or were keen to learn and a few who would prefer not to provide domiciliary care. Working in a hospital environment was more polarised with dentists tending to either be happy to work there or preferring not to. There was a relatively even split between dentists who were happy to provide care in a mental health unit, would be happy to learn about providing care in this setting or would prefer not to, with no one reporting that they "didn't mind".

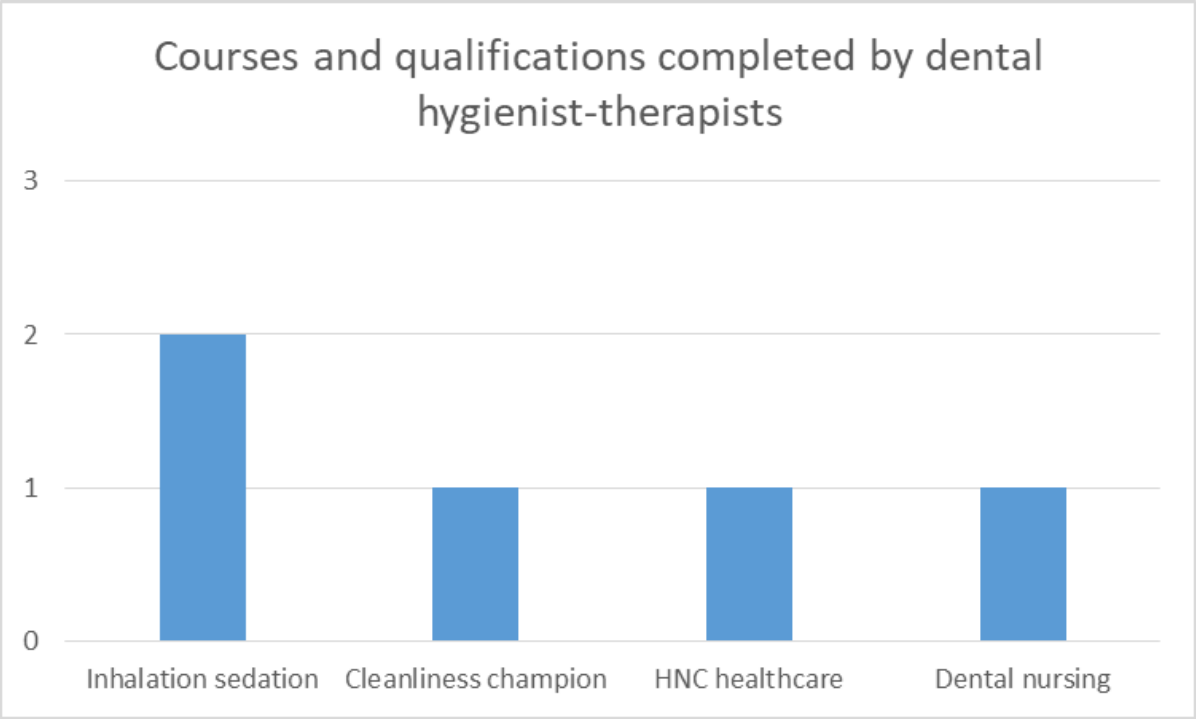
Dentists were either happy or didn't mind providing most types of treatment. The only procedure which the majority would prefer not to do was minor oral surgery. Dentists were either happy to provide treatment under general anaesthetic or sedation or not. No one "didn't mind", they were either happy, willing to learn or would prefer not to provide sedation or treatment under general anaesthetic. Preferences regarding additional non-clinical duties were also broadly in line with the dentists' confidence levels regarding teaching, public speaking and liaising with other professionals.

Hygienist-Therapists

All three hygienist-therapists responded to the questionnaire.

Additional courses and qualifications which hygienist-therapists had completed are outlined in Figure 21.

Figure 21 - Hygienist-therapists' additional qualifications



One hygienist-therapist was in the process of completing supervised inhalation sedation sessions.

Hygienist-therapists' skills

In general the hygienist-therapists were confident in their ability to provide care for most patient groups, though it was indicated that more support may be required by them when treating patients experiencing homelessness and addictions and children with severe learning disabilities. The aspect where hygienist-therapists appeared to be least confident was providing care in different settings, with a range of confidence from independent to requiring support for domiciliary dental care, and greater levels of support required or lower knowledge and experience working within a hospital setting or in a mental health unit.

The hygienist-therapists were confident to provide the majority of treatments, with the majority of items of treatment being rated as "confident to provide independently" and none scoring less than "familiar but would need support".

One of the hygienist-therapists had not undertaken training in inhalation sedation and, as would be expected, rated this as being an area of limited knowledge. One hygienist was experienced and confident to undertake school dental inspections, with another planning to become involved in the inspections in the coming school year. Since the survey was

undertaken the third hygienist-therapist has also completed training and calibration required to participate in school dental inspections.

Hygienist-therapists' preferences

Like dentists, ratings for preferences were broadly in line with self-rated skills or confidence. The hygienist-therapists were either happy or didn't mind treating the majority of patient groups listed and were willing to learn more about treating those experiencing homelessness or addictions and children with severe learning disabilities.

The hygienist-therapists were either happy or didn't mind providing all of the items of treatment listed. While only two hygienist-therapists had undertaken training in inhalation sedation, the third indicated a willingness to learn.

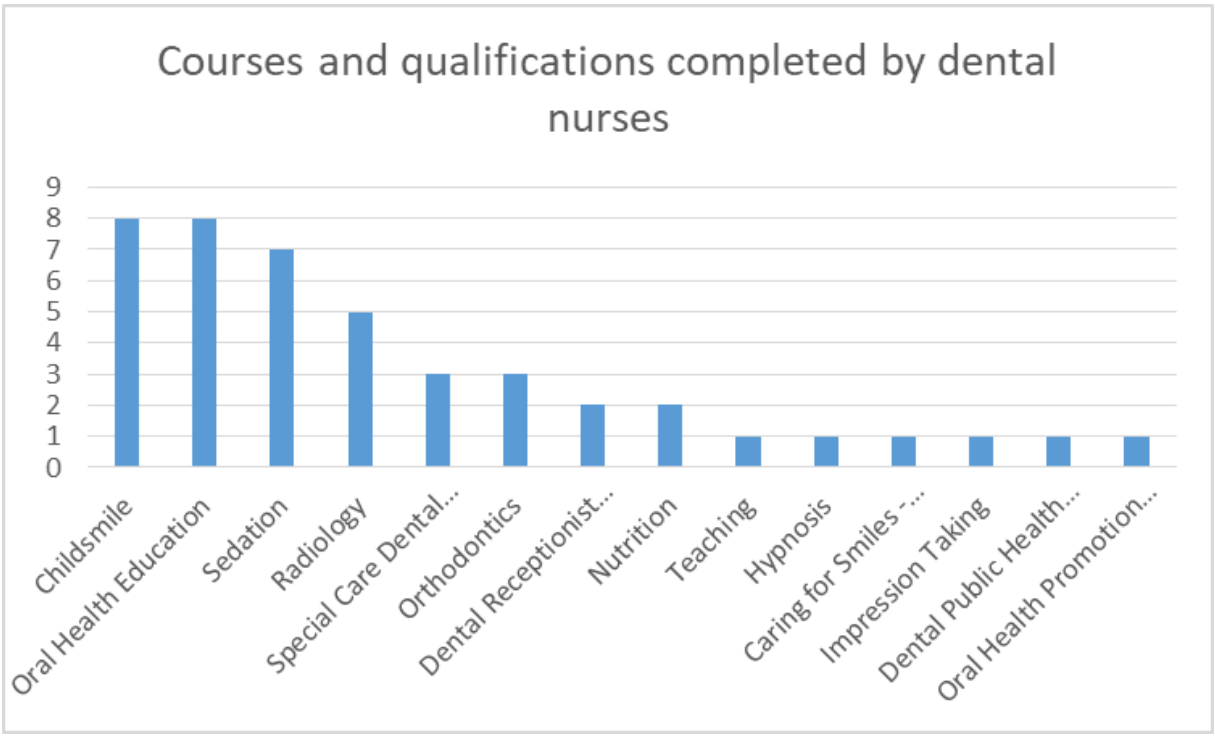
One of the hygienist-therapists indicated through additional comments a preference for treating anxious children and enjoyment of undertaking acclimatisation with adults with learning disabilities. Another felt that they would enjoy working in the hospital environment with complex adults and children and general anaesthetic cases.

Dental Nurses

Thirty dental nurses responded to the questionnaire.

Additional courses and qualifications which dental nurses had completed are outlined in Figure 22.

Figure 22 - Dental nurses' additional qualifications



PDS Staff Skills and Preferences

Overall, for all staff groups, levels of confidence and experience reflected the staff member's role and workload. While a greater number of staff members were confident with some patients, settings or treatments than others, there were no areas where no one felt comfortable to provide care. It is recognised that as a role becomes more specialised, the individual in that role is likely to provide more of some types of treatment and less of others and that their confidence and skill level will grow to reflect this. It may be beneficial to encourage some staff members to develop specific skills, particularly in providing treatments which are less common to maximise their exposure to these procedures and further develop their experience providing these treatments to build their skills and confidence.

The preference rating "I would prefer not to do this" was not commonly used and often related to more specific areas which it would be reasonably expected that some people would be happier to provide than others. Very small numbers of people said they would prefer not to do any single item and across the service it is evident that there are sufficient numbers of people in all roles willing to undertake each item to deliver the full range of services.

Main Findings Section 2 - Dental Services

- **There are 15 General Dental Practices and 6 Public Dental Service Clinics in the Borders**
- **81.6% of adults and 89.7% of children in the Borders are registered with an NHS dentist (slightly lower than the national average)**
- **77.1% of adults and 91.7% of children in the Borders who are registered with an NHS dentist have attended in the past 2 years (slightly higher than the national average)**
- **NHS Specialist dental services in the Borders are provided for Oral Surgery and Orthodontics by Consultants in Borders General Hospital and a Specialist Practice in Orthodontics**
- **The PDS in the Borders provides a greater proportion of the routine general dental care in the area than PDS services in other Scottish Health Boards**
- **Many General Dental Practices are at or near full capacity in terms of patient numbers**
- **Seven out of nine practices reported having experienced difficulties in recruitment and retention of staff in the past 5 years**

Key Discussion Points

Access to Primary Care Dental Services

The proportion of the population registered with an NHS dentist is slightly lower in the Borders than in other parts of Scotland, however the figures do not include patients who access private dental care, or those who attend an NHS dentist in England. The vast majority of residents in the Borders do therefore have access to dental care. As the population continues to increase, an anticipated growth in demand for dental services makes it important to retain capacity within primary care dental services to meet future oral health care needs.

Currently most General Dental Practices in the area suggest they are operating at or near capacity in terms of the number of patients seen. Twenty seven percent of GDPs who responded to the survey reported that they were likely to stop accepting new NHS patients or reduce the categories of NHS patients they would take on in future. To continue to meet demand and ensure services are available to those not currently accessing dental care in the area, it will be necessary for dental services to take on additional patients which is likely to require additional GDPs.

Unfortunately difficulties with recruitment and retention of staff, particularly associate dentists are common. Seven of the nine practices who responded to the survey reporting that they have experienced difficulties with recruitment and retention of staff over the past five years. Concerns about the ability to attract new dentists to the area have been

identified as barriers to expansion of existing dental practices. This has the potential to have a negative impact on access for those looking to register with a dentist.

Role of PDS

Currently the PDS in the Borders sees a higher proportion of the overall number of patients registered with an NHS dentist than their counterpart PDS services in other mainland Health Boards. While providing dental access services is no longer a core activity of the PDS, it is evident that at the present time there is no spare capacity within GDS. Withdrawing provision of routine dental care by the PDS would have a significant negative impact on dental access in the region and would therefore not be advisable.

Supporting access to routine dental care should however not come at the expense of providing care to priority group patients who are unable or would face challenges to accessing care in a General Dental Practice. These patients should continue to be offered preferential access to PDS care. Over the longer term the main emphasis within PDS should be to expand the provision of special care dentistry services and focus on the delivery of dental care to the more vulnerable patients who require additional support to access and receive dental care.

This shift in emphasis should be a gradual process to reduce the impact on General Dental Services and to allow staff working in PDS, many of whom have provided predominantly an access function in the past, to develop their knowledge and skills as they continue to adapt to treating more complex patient groups.

PDS Staff Development

The PDS skills and preferences exercise indicated that across all staff groups, there was a willingness to learn a number of new skills and develop their roles into new areas. This should be encouraged and capitalised on through the existing appraisal and PDP systems and dentists' job planning.

There has been a strong history of staff development within the PDS, including the employment of trainee dental nurses, support for dental nurses within the service to take on additional post-registration qualifications and facilitating dental nurses to train to become hygiene-therapists. Hygiene-therapists are also encouraged to maximise their potential, having been provided with opportunities to complete training in provision of inhalation sedation and to become calibrated examiners for school dental inspections. The service has also been involved in VDP training in the past, with one current member of staff having been a previous VDP. Over the past two years there has been an increase in training to support provision of care to more complex special care patients with a number of dentists embarking on postgraduate qualifications in special care dentistry and one of the senior dentists attending study days with the NHS Lothian special care dentistry team. Another dentist has recently enrolled on a Masters degree in Oral Surgery which will develop skills of benefit to the service as a whole.

One issue identified was the challenge of retaining skills and confidence in providing treatments which are not required in large volumes such as intravenous sedation or the management of patients with rare conditions. While training a single clinician to provide such types of treatment would maximise that individual's exposure to the treatment and enable them to build their personal expertise, it is important to ensure that there is

sufficient cover for those providing more specialised aspects of care should that individual be unavailable or on leave. Building resilience within the service will be important to succession planning to protect future provision in the event of an experienced staff member or one with a specific skill set or area of expertise moving on. As greater emphasis is placed on building the special care patient base it is likely that more opportunities will present for staff to be exposed to a wider range of patient groups and to build their skills and confidence in providing care and treatment for these individuals.

Referral Pathways

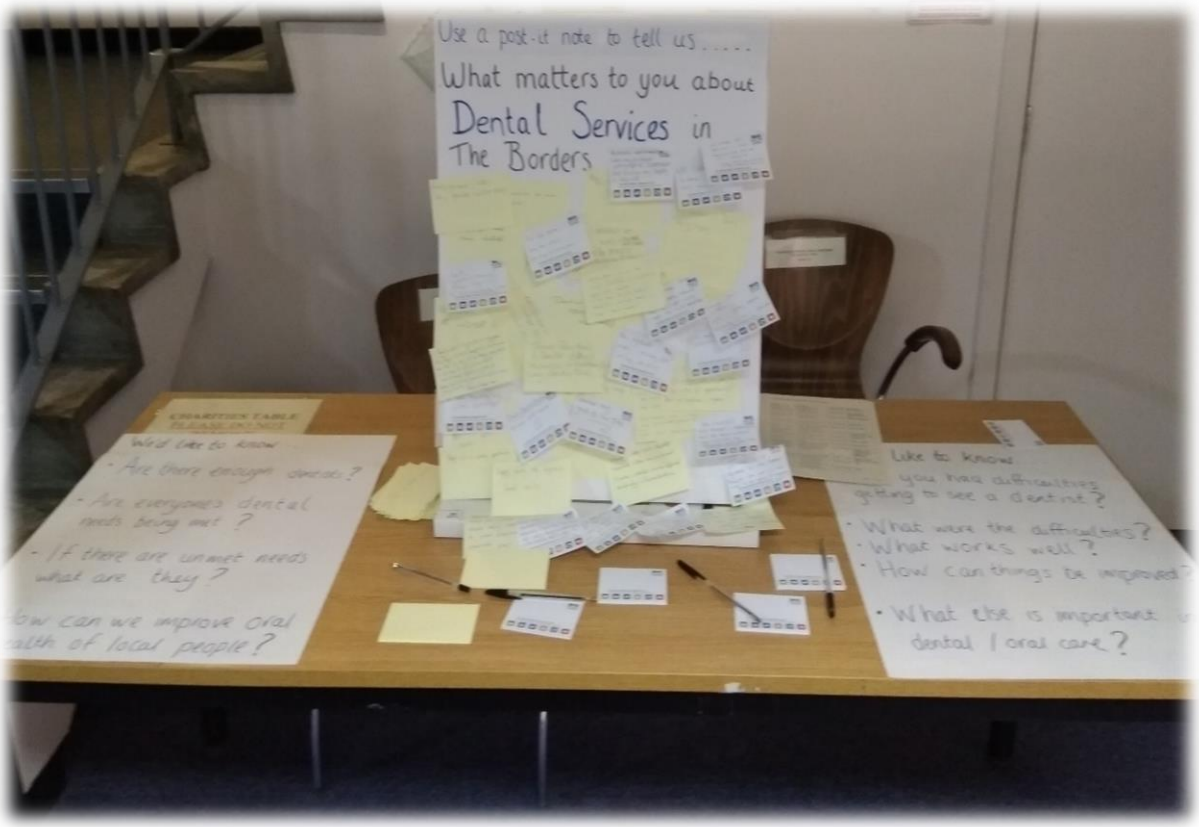
Referrals into the PDS and dental specialties based in BGH are received through SCI-Gateway and processed through the TRAK care system. Interpreting data extracted from TRAK in the context of this needs assessment presented some challenges as it was not immediately clear which specialty patients were referred to and in the case of PDS patients it was not possible to identify the reasons for referral or to break down which types of PDS services were requested – whether for example patients were referred for anxiety management, domicilliary care, additional needs or medical complexities. Patients referred to PDS are triaged by a senior dentist based on PDS acceptance criteria. PDS referral criteria are being updated at present and consultation is underway with representatives and local dentists to agree the final version.

Clear referral criteria have been agreed for orthodontic care which have been made available to referring dentists and appear to facilitate the patient journey to the most appropriate care provider. There are no specific criteria for Oral Surgery and no intermediate tier between primary care dentists and consultant oral surgeons. This may contribute to the large volume of patients being seen as all referred patients are currently accepted and offered treatment.

The new referral criteria for PDS will be made available to local dentists to increase their awareness of the role of PDS and range of services available on referral. In future the offer of shared care should be explored, with PDS providing support for specific items of treatment on referral while the patient remains registered with the GDP who provides ongoing routine examinations and maintenance which can be provided in general dental practice. As many of the patients in greatest need of PDS care may find it difficult to access GDPs, referral criteria should also be publicised among services working with priority group and vulnerable patients to raise awareness of the additional support which is available to facilitate dental attendance and to encourage referral of those who currently may not be accessing dental care.

SECTION 3

ENGAGEMENT WITH DENTAL TEAMS AND THE PUBLIC



8. Dental Staff Perceptions

General Dental Services

As the majority of dental care in the Borders is provided by GDPs, it is essential that this needs assessment takes account of their views. Engagement with this independent contractor group was anticipated to be challenging as there tends not to be a single forum where they will all come together. GDP engagement began with the local Area Dental Committee (ADC), with more in depth follow up with individual dental practitioners through an online questionnaire.

Area Dental Committee

On 20th March 2019, an overview of the needs assessment process and reasons for conducting it was presented to those in attendance at the ADC meeting. Attendees were then asked what they felt the priorities and challenges facing GDPs in the Borders were at that time. Topics of discussion included:

1. Recruitment of staff,
2. Patient access to dental care,
3. Dental referral services,
4. Aspects of the Scottish Government's Oral Health Improvement Plan,
5. Health tourism.

The committee also provided valuable input into the format and content of the questionnaire being developed to gather information on services provided by GDPs and the views of NHS GDPs across the Health Board area.

Recruitment of practice staff

Recruitment of staff was a concern shared by all present with comparisons drawn between the relative ease of recruitment in cities such as Glasgow and difficulties in a rural area like the Borders. Despite financial incentives and higher rates of remuneration being offered in the Borders than in other areas, practices locally struggle to recruit dentists to the area. It was highlighted that even in Galashiels where there is direct access to Edinburgh by train, two practices have recently struggled to attract new staff members. It was also noted that practices who do successfully recruit, often take on a dentist from another practice within the Borders, resulting in the vacancy being passed to another practice, as opposed to bringing a new practitioner to the area. In addition to difficulties recruiting dentists, some of those present had also found it difficult to recruit dental nurses, with access to dental nurse training courses described as challenging.

There were concerns that recent changes to regulations, requiring dentists coming to work in Scotland for the first time to attend a mandatory training course could increase difficulties with recruitment and introduce delays in new recruits taking up posts. Practice owners were also anxious about the potential impact of Brexit on dentist numbers. Currently there are a number of EU nationals working as GDPs in the area, with the risk that they may opt to leave the UK. It was also felt that in future it is less likely that EU

nationals would take up posts in the UK, potentially further reducing the availability of dentists in the area.

Patient access to dental care

GDPs reported that there still seems to be a large demand from patients wishing to register for NHS dental care, and that this does not seem to be reflected in the high proportion of the population reported to be registered with an NHS dentist in national figures. It was queried whether many of the patients seeking to join a new practice perhaps don't realise that if they have been registered since 2010, they have lifelong registration with that practice, assuming that their registration will have lapsed as was previously the case. It was also suggested that some patients may be keen to move practice as it is known that it is common for patients to travel to different towns for dental care based on where they were originally able to register at the time when dental services were less readily available.

The GDPs were aware of disparities in access to services and the challenge some patients face in travelling to appointments. It was highlighted that there is limited public transport serving some communities and for those reliant on bus services it may require a full day for them to travel to a single dental appointment. Travel difficulties were acknowledged to be a particular challenge for older people. It was also recognised that as there are more older people living in their own homes, many of them may become unable to attend a dental appointment as their level of dependence increases. The group also discussed the fact that a GDP is unlikely to know if a patient is struggling to attend and that there is a need for follow up of patients whose attendance pattern drops off. They also felt that there would be benefits in strengthening links between the GDS and PDS, perhaps using oral health support workers to engage with older people at home who may be struggling to attend appointments.

GDPs valued input from Childsmile, both in school and supporting attendance at dental practices. They described dental health support workers as very proactive and valued their input in following up children who had missed appointments in practices.

Dental referral services

Locally GDPs are able to refer to oral surgery and orthodontic services in the BGH as well as to the Public Dental Service. They felt there was a need for more support with complex periodontal cases, particularly with an increasingly dentate older population. Referrals for restorative dental care to Edinburgh Dental Institute were described as often being "bounced back". GDPs reported that when a patient is referred to the Dental Institute they will often be provided with a treatment plan and returned to the referring dentist to provide treatment, which can be challenging to deliver. The general feeling was that for restorative care, including endodontics, referrals tended to be made to private dental services due to lack of availability of specialist support on the NHS.

Oral surgery services were described as being "good when the patient gets there", with long waiting times for treatment not being ideal. There was a feeling that there has been some improvement recently with waiting times now beginning to reduce.

Waiting times for paediatric dental general anaesthetic were noted to have increased and practitioners described a changing demographic of child patients, with more children from

other countries presenting with extensive caries which often requires referral for general anaesthetic.

Oral Health Improvement Plan

In general there was support for the Oral Health Improvement Plan, though it was stressed that Scottish Government need to be mindful of the business needs of practices and patients already being seen. Comment was made that roadshows during the consultation phase prior to publication of the plan were not well attended and there was no roadshow event held in the Borders.

GDPs were in agreement with the proposed increased focus on prevention and suggested that there may be opportunities presented with the new Galashiels Academy to promote healthy food choices. There was a strong feeling that it would be beneficial to take a joined up, common risk factor approach to improving diet, by linking with the diabetes and obesity agendas. There was some disappointment with the Government stance regarding water fluoridation, with some dentists feeling that there should be a focus on promoting the benefits of fluoridated water.

The proposal to introduce an oral health risk assessment and dental recall intervals based on oral health status was discussed and generally supported. There was a suggestion that certain points in the life course could be identified as times when the oral health risk status may change, for example as teenagers gain increased independence.

The committee also recognised the value of focussing on the ageing population and there was discussion of the new model for delivering domiciliary dentistry. There was a suggestion that it may be cheaper to make arrangements for patients to be transported to dental surgeries to receive care, than to remunerate GDPs for providing domiciliary care. The group was also keen to highlight the benefits of providing treatment in a surgery environment where the full range of treatment is available and a higher standard of care is possible. The PDS was described as having tight criteria for domiciliary referrals. There was a feeling that as patients gained more understanding that a wider range of treatment is possible in the surgery environment, there seem to be more patients willing to attend clinics.

Health tourism

One concern raised by GDPs, which had not previously been considered, was the impact of health tourism, with patients travelling abroad for dental care. Dental implants and dentures had been reported to be cheaper in Poland than the UK, and patients were also described as having received treatment in Turkey amongst other countries. In some instances patients have presented for their regular check-up appointment having undergone extensive cosmetic restorative treatments, which the GDPs do not always feel are beneficial to the general oral health of the patient. GDPs expressed anxiety regarding their ongoing duty of care to a patient who has undergone treatment out with their practice and which they would often have advised against. These patients leave the GDP in a position where there is a distinct possibility of having to manage complications of treatment or failure of complex restorations.

GDP Questionnaire

In addition to gathering information on general dental services, the questionnaire referred to in Chapter 7 provided an opportunity to gather GDPs' thoughts on what is good about being a GDP in the Borders, what they feel the main challenges facing oral health and dental services in the Borders are and what changes they would like to make to improve oral health and dental services in the area. The questionnaire also captured their opinions on other aspects of providing general dental services, including reasons for decisions around taking on NHS patients, considerations relating to working as an enhanced skills GDP, referral services and issues surrounding recruitment and retention of dental practice staff.

What is good about being a GDP in the Borders?

Almost all GDPs were positive about the Borders as a location, which they felt was a good place to live and to bring up a family. They referred to the Borders as a beautiful area and enjoyed the lifestyle on offer, including a good work-life balance and short commute to work. They were also very positive about their patient base, with a number of GDPs describing their patients as "lovely people". They enjoyed having a mixed patient base from all walks of life and the fact that patient lists were relatively stable, enabling them to provide continuing care and get to know their patients over time.

GDPs in the Borders also appreciate their working relationships, including "good support staff in the practice", well organised systems and opportunities for networking with colleagues. The Dental Practice Adviser was described as being knowledgeable and approachable.

Factors influencing decisions to take on NHS patients

For many dentists taking on NHS patients was just something they do, either because they or their practice has always had a high commitment to providing NHS dental care, or because they have been recruited by the practice to provide NHS dentistry. Other dentists reported providing NHS care as patients in the area were unable to afford private dental care.

Their ability to take on new NHS patients depended on capacity within the practice, with several reporting their lists were already either at, or near, full capacity. Judgements depended on the waiting times for existing patients to be seen and, in some cases, staffing levels within the practice. Practices with current vacancies for clinicians stated they would only be able to take on new patients once these posts were filled.

In practices where capacity to accept new patients was limited, priority was given to family members of existing patients, with one practice only accepting patients under the age of 21 years and only if their parents were registered with the practice as private patients.

Three respondents reported that their decision on whether to take on NHS patients depended on factors relating to remuneration and support available from the NHS, including a consideration of whether they felt able to provide "adequately funded, quality care in a well-equipped, well-run environment". One dentist was concerned about patient expectations and limitations on what can be provided as NHS dental care, while the other described "Bureaucratic and often outmoded treatment choices".

Enhanced skills GDP (domiciliary care) considerations

Only one dentist who responded to the survey stated that they would consider becoming an enhanced skills GDP for domiciliary dental care. Those who were not interested in taking on such a role provided a number of reasons for this, ranging from not being interested in providing this type of care and being concerned about spending time away from an already busy list in the surgery to concerns about the administrative burden and potential inadequate remuneration.

One dentist reported that they had provided domiciliary dental care in the past but had been put off by new requirements to undertake risk assessments and carry emergency equipment. Dentists highlighted the increased time taken to travel to a patient's home, set up and treat a patient in a domiciliary setting compared to providing care in the clinic. They noted additional challenges faced in the provision of domiciliary care, including locating the address, communicating with carers and arranging for payment to be made. A number of dentists felt that there would be insufficient patients to make providing domiciliary care worthwhile and that remuneration was inadequate to make it financially viable. It was not clear whether the remuneration referred to related to current regulations for non-enhanced skills practitioners, or whether this also applied to the new arrangements published in July 2019 which apply to designated enhanced skills practitioners.

One GDP felt that the new arrangements included "too many hoops to jump through" in relation to the requirement to complete training which includes a portfolio and period of mentoring as well as ensuring the practice is able to provide cover for registered domiciliary patients who have a dental emergency.

Referral services

Around 33% (5 respondents) reported that they felt the referral services currently available met their needs, 2 respondents reported that they did not meet their needs, and 53% (8 respondents) felt that their needs were partially met.

Oral surgery services at BGH were regarded as providing good quality care, though several GDPs mentioned long waiting times for patients to be seen. There was also a feeling that patients referred to oral surgery requiring urgent treatment (due to pain) should be able to be seen more quickly than they currently are.

A number of dentists highlighted that there is no access to NHS specialists in periodontics or endodontics in the area, with one dentist reporting a feeling that restorative support from EDI was "not fit for purpose". Another described many referrals being rejected and a further dentist stated that "my patients are hardly seen at EDI". One GDP reported that they tend to refer patients privately as they have had "limited success getting patients seen or treated at EDI".

Long waiting times were also reported to be an issue for adults and children with additional needs and that parents were unhappy with the "lack of care" available.

GDPs were also asked which services they would like to be able to refer to which are not currently available to them. The majority (8 respondents) would like to be able to refer patients for periodontal care, followed by restorative care (3) and endodontic care (3). Others mentioned an oral surgery emergency service, prosthodontic service, oral medicine

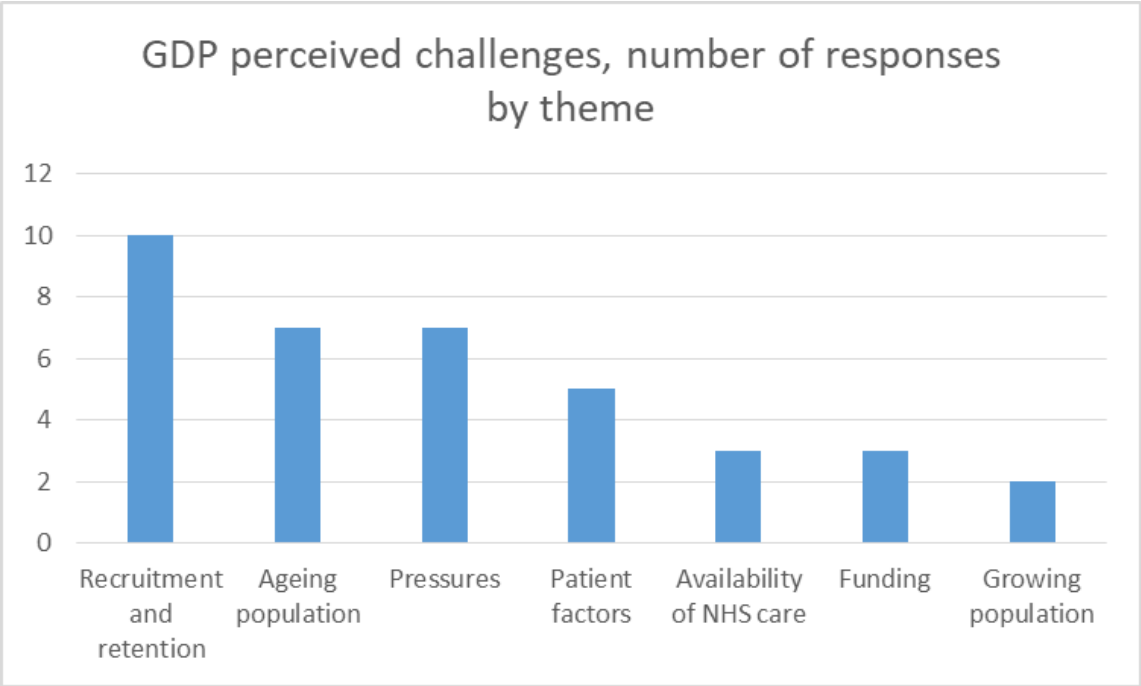
and a paediatric trauma clinic. One dentist would like to see services available to provide complex treatments such as post removal, endodontics and oral and maxillo-facial surgery, while another would like a local service providing “everything that EDI offers”

One of the respondents stated that they would rather see investment in improving the currently available services than spreading the resource more thinly in an attempt to offer additional services.

What are the challenges for GDPs in the Borders?

GDPs identified a number of challenges which fell into seven main themes as outlined in Figure 23.

Figure 23 - GDP Perceived Challenges, Number of Responses by Theme



Recruitment and retention

The most common challenges mentioned related to recruitment and retention, being raised by around two thirds of respondents. One respondent indicated that they would like to expand their practice to meet demand from patients wishing to register, however they felt unable to commit to this as they were not confident it would be possible to find an associate dentist who would want to work in the area.

Ageing population

Around half of the respondents highlighted their ageing patient base and the fact that many more older people have retained their natural teeth. They noted that older patients can face challenges accessing the dental clinic and mentioned the additional complexity of providing care for older patients.

Pressures

A range of pressures facing dental practices were highlighted. In addition to insufficient numbers of clinicians, these included ensuring the availability of accessible care, waiting

times for patients referred to hospital clinics and delays in processing of Prior Approvals*. Pressure was also felt to arise from a number of obligations on dental practitioners including requirements to follow standards, have policies and protocols in place and comply with continuing professional development requirements and mandatory audit and quality improvement activity. Other non-clinical pressures relating to employment of staff were also mentioned, including managing pensions, sick leave and requirement to use agency staff to cover absences.

*NHS dentists are required to apply to Practitioner Services Division of NHS National Services Scotland for Prior Approval before providing treatment for patients where the total cost of the course of treatment will exceed £410, and for a small number of specific items of treatment. A new electronic system for processing Prior Approval was introduced with all dentists required to use the electronic system from 1st October 2018.

Patient factors

There was a feeling that there are "too many patients" with a large demand for care resulting in high numbers of patients registered with each dentist, and that patient expectations are increasing. It was felt that some patients "lack accountability and self-ownership" of their oral health and that there was a requirement for better education for patients and transparency around costs of treatment to the NHS.

Patient demographics and oral health risk factors were also noted to present challenges. Specific aspects of patient care which can present challenges were also mentioned, including poor periodontal health and management of anxious dental patients.

Availability of NHS care

It was felt that it was a challenge to maintain sufficient NHS dental services to meet demand for them. There was felt to be a lack of availability of dental centres accepting new NHS patients and a lack of availability of NHS dental appointments. There was also a concern that unregistered patients are unable to gain access to regular dental care.

Funding

In the past grants were available to support GDPs to set up a practice, with funding available for items such as dental chairs or dental handpieces. Respondents were disappointed that "those days are gone" with reduced availability of financial support. Remuneration for NHS dental treatment was also mentioned, with a specific comment that fees are insufficient to cover costs of treatment requiring lab work (dentures, crowns and bridges). Lab work was described by some as being "expensive or poor quality".

Growing population

It was also felt that as the population in the Borders is increasing in size this places additional pressure on existing dental services which are already seeing large numbers of patients.

Difficulties with recruitment and retention

As recruitment and retention had been highlighted as being of significant concern by members of the Area Dental Committee, the survey included specific questions for practice principals and owners relating to their experiences of staff recruitment.

All practice principals and owners who responded to the questionnaire had recruited staff within the past five years, amounting to: six dentists, two hygienists, four hygienist-therapists and nine dental nurses across the nine practices.

Of the staff who had been recruited over this time, around two thirds of practices reported that new members of staff who had joined the practice had already left their posts. One practice had recruited a dentist, hygienist-therapist, nurse and receptionist, all of whom had left. Others had lost dentists who had stayed for between one or two years. Reasons for dentists having left their posts (where given) were varied. Several described dental nurses leaving, some after being in post for as little as one month.

Four of the practices reported that vacancies had been advertised but remained unfilled. Not all respondents provided detail of which roles had been unfilled, however all who did reported that these were for associate dentists. One respondent noted that they had had a vacancy for an associate for six months, while another reported that they currently had a post which had been unfilled for one month “so far”. There was also a comment that when there has been a gap between a dentist leaving and being able to recruit to the post this places additional stress on the whole practice team in managing a larger quota of patients and dealing with more emergency appointments. Another commented that as a result of difficulties with recruitment there have been times when they have had to close a surgery within the practice or use agency staff, bringing additional financial pressures and reducing the number of appointments available to patients.

Three of the practices reported having to change the nature of posts due to an inability to recruit. Measures had included offering part-time working or altered working hours. One practice had recruited a dedicated dental receptionist as a result of being unable to recruit a dental nurse. It was noted that having a dedicated receptionist had reduced flexibility within the practice as previously all nurses had worked both in surgery and on reception and had been able to provide cross cover for each other. Another practice reported that they offered a retention package to their associates and had increased wages for dental nurses, however this has had a financial impact on the practice.

Seven of the nine responses (78%) indicated that they had experienced difficulties with recruitment and retention. One dentist reported that very few, if any, dentists respond to advertisements for posts and that dentists do not seem keen to move to take up an NHS post. Another noted that they had had to increase wages of all staff to aid recruitment and retention. In general it was reported to be easier to recruit dental care professionals (DCPs) than dentists, though it was noted that there can be a high turnover of dental nurses.

Many of the respondents felt that recruitment difficulties were due to the rural nature of the area, reporting that dentists, and particularly younger dentists were not interested in working outside cities. There was also a suggestion that for those who live in cities, commuting to many Borders towns can be difficult by public transport if they do not own a car.

There was a feeling that Brexit has had a compounding effect on recruitment issues. It was noted that while in the past Borders practices have been successful in recruiting dentists from the EU, more recently there have been no European applicants for posts. This was

highlighted as a significant concern as “UK graduates nearly all want to work in or close to a city and there is rarely any interest from UK graduates [for posts in the Borders]”.

The requirement for dentists who have not worked in Scotland within the previous five years to undertake Mandatory Training before being eligible to work as an NHS GDP was also felt to be an additional hurdle. While the benefits of the training were acknowledged, it was suggested that the cost of the course and requirement to complete it may have an impact on the number of applicants for posts.

Suggested changes

Dentists were asked what changes they would like to see made. Many of the comments related to the challenges which had been highlighted around recruitment and retention and access to specialist referral services. It was suggested that there should be more support with recruitment and retention and efforts made to promote the Borders as a good area to work, with a view to attracting more dentists to the area.

It was suggested that there should be more specialist clinics, with shorter waiting lists and support available for more complex aspects of treatment including periodontics and endodontics and an increase in the availability of sedation services. There was also a feeling that services should be more accessible geographically, making it easier for patients living further from BGH to access services.

GDPs were keen that access should be improved for unregistered patients and that they should be offered more than just emergency care. Dentists also suggested changes which would help to promote good oral health, including training for carers to promote dental care and targeting school leavers to encourage them to maintain regular dental attendance. There was also a request for more local delivery of CPD sessions.

Although not possible to change at the local level, there were several GDPs who would like to change the current system for remuneration of NHS dental care. It was suggested that the number of NHS dentists in the area could be increased by offering “realistic remuneration”, while another dentist felt than increasing payments would enable dentists to spend more time with their patients leading to increased job satisfaction. Others focussed on the payment system as a whole, suggesting that it should be more fluid to allow treatment to be tailored to patients’ individual needs. It was also suggested that there was a need to alter fee scales to reflect changes in dentistry such as availability of new dental materials. The Oral Health Improvement Plan includes a commitment to simplify the Statement of Dental Remuneration and a number of working groups led by Scottish Government are currently working to develop a “new model of care” which is expected to result in changes to the payment structure for NHS dental practitioners.

Further thoughts

The questionnaire closed with a final question asking dentists to provide any further information which they felt the oral health needs assessment should capture. One respondent reported that they felt oral health needs are high in the area. Another described oral health in the area as declining and stated that “without proper remuneration and an increased number of NHS dentists the cliff edge is rapidly approaching”.

Many of the dentists mentioned concerns about the increasing proportion of older patients, highlighting difficulties they can have accessing dental care. There was a feeling that older people are less able to travel to dental clinics, especially if treatment in BGH is required and concerns were raised around managing the complex medical needs of many older patients. One GDP felt that it would be good for older people to be able to be seen in a setting which was appropriate for them “like a health centre”.

Transport to dental appointments was also highlighted as a challenge, particularly for patients who rely on public transport. Access to the BGH for patients requiring specialist treatment was noted to be challenging from some parts of the Borders and this had become more of an issue since the referral criteria have been tightened.

It was also noted that children may be looked after by a range of family members. This could mean that messages regarding positive oral health behaviours are not always passed on to everyone involved in a child’s care, making it difficult to maintain consistent messages.

GDP Study Day

In September 2019 an NHS Education for Scotland study day for dental teams was hosted in the Borders. This provided an opportunity for further engagement with GDPs. On the day, of a total of 57 delegates, 15 GDPs were in attendance, with the majority of attendees being dental nurses and a number of PDS staff in attendance. The event was used to promote the GDP questionnaire which was active at the time, encouraging those present to respond to it and to encourage colleagues in their practices to do so too. GDPs were also give an opportunity to share further thoughts on what matters to them about dental services in the Borders.

Opinions shared at the study day were similar to those which had been discussed at the Area Dental Committee and findings from the questionnaire responses, including the need for additional specialist services, particularly for restorative dentistry and financial pressures facing dental practices. There were also requests for more training to be delivered locally, with a suggestion that increasing the availability of training in the area may bring dentists in to the area.

Public Dental Services

Staff Meetings

Staff working in PDS meet on a regular basis within their main hub area. Time was allocated during these meetings in Coldstream (24 staff members based in Coldstream and Kelso) and Hawick (27 staff members from Hawick, Galashiels and Borders General Hospital) in December 2018 to give PDS staff the opportunity to feed their views in to the needs assessment. Staff were asked four questions:

1. What are the main challenges for oral health and dental services in the Borders?
2. What works well?
3. What doesn’t work so well?

4. What changes would you like to see to improve oral health and dental services in the Borders?

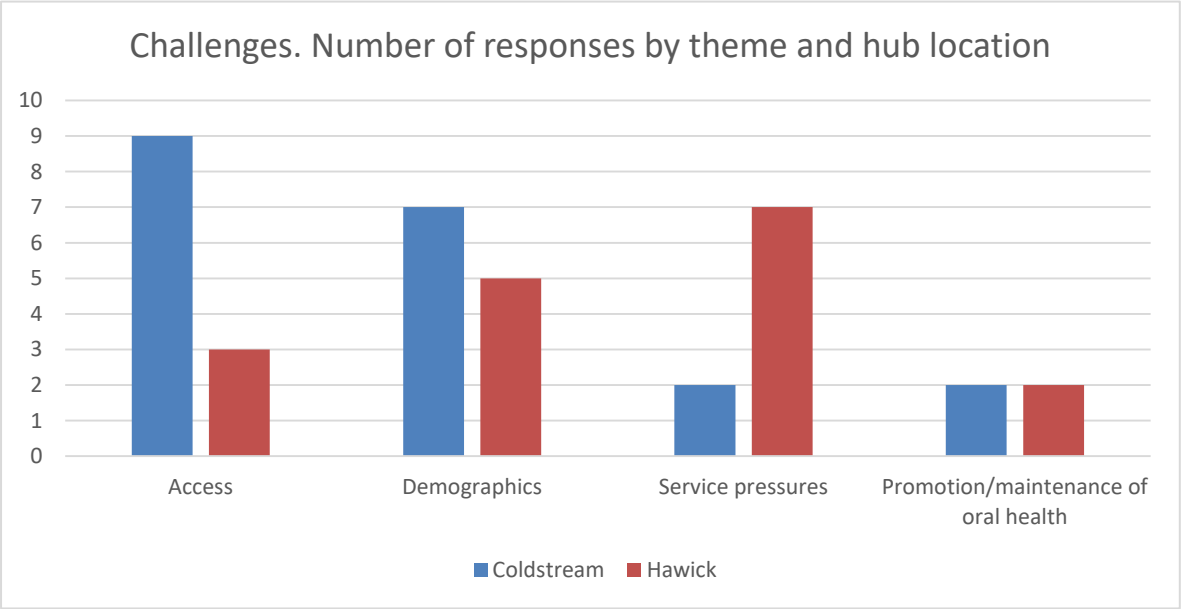
Participants discussed their answers to each question in small groups before feeding back to the wider meeting. Responses from each small group were collated and common themes identified.

For all questions, similar themes were identified in both hub locations, though emphasis differed slightly and there were some points which were only raised in one of the sites.

Challenges

As an introduction to the meeting, staff were asked for their thoughts on the biggest challenges they faced in providing dental care and promoting good oral health. The main themes identified at each location are presented in Figure 24.

Figure 24 – PDS Perceived Challenges, Number of Responses by Theme and Hub Location



Access

The most commonly reported challenge overall was access to dental care, which received particularly strong emphasis in Coldstream. The main difficulty was felt to be in relation to the distribution of services and difficulties faced by those in more remote areas where there is a requirement to travel and public transport can be limited. Teams in Coldstream highlighted that although General Dental Services may be available, not all offer NHS care, particularly for new patients. In Hawick it was noted that patients with special care needs may find it particularly difficult to access services.

Demographics

Demographic issues were also mentioned in both areas, including the challenges faced in providing care for an ageing population, with complexities associated with multi-morbidities and frail older people. In addition to recognising the challenges of providing dental

treatment for older people, maintaining daily oral care was also highlighted and ensuring oral hygiene is maintained in care homes was recognised as a challenge.

There was recognition that inequalities and deprivation have a significant impact on oral health and may be linked to unemployment, poor housing, mental health status and motivation to take on board oral health advice. While teams described some patients as lacking “motivation”, there may be a number of factors which contribute to the ability of an individual to act on advice given which will also be important to consider.

Promoting/Maintaining Oral Health

Lifestyle factors, including diet, sugary drinks, tobacco and alcohol were mentioned in both areas as being difficult to address. It was suggested that this may be due to lack of education or knowledge of the negative effects on oral health, but it was also acknowledged that when advice is provided it can be difficult for individuals to make the changes being recommended.

Service Issues

Lack of staffing was the biggest concern affecting services in both areas. There was a feeling that staffing levels were insufficient for the geographic area being covered. Difficulties recruiting staff (particularly dentists) to the area was strongly highlighted.

In common with many other services, it was recognised that the current financial climate may have an impact on what can be delivered and how care is provided.

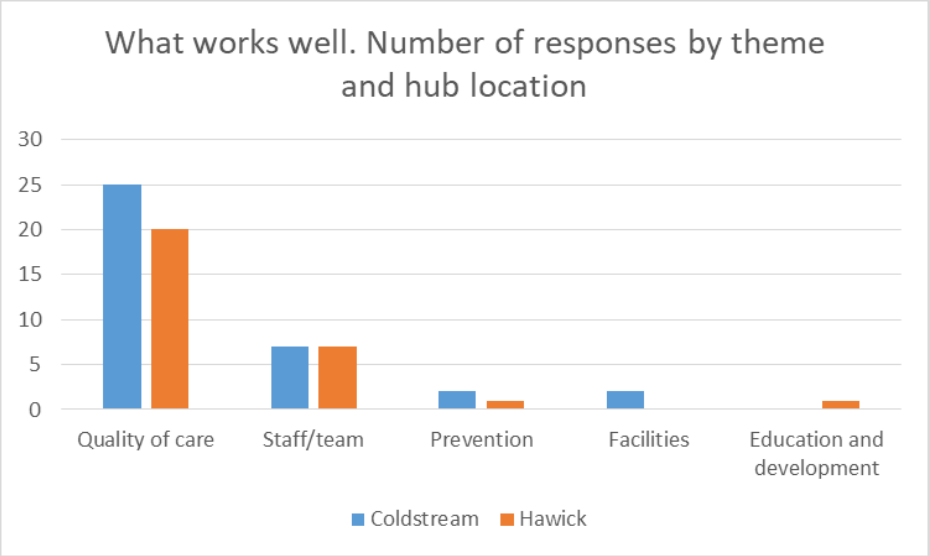
In the Hawick hub, it was suggested that there was a lack of capacity for dental access patients. It was also noted that there had been an increase in the number of children requiring dental treatment under general anaesthetic, and that there seemed to have been an increase in the complexity of the children referred to this service which placed additional pressure on the service. This is likely to have been more apparent at this hub as the team providing the general anaesthetic service, being based at BGH were in attendance at this meeting.

In both sites, patients missing appointments were mentioned, and the challenge of following up patients who had failed to attend. In Coldstream this was particularly in relation to child patients who were not brought to their appointments. Since these meetings took place a new Child Not Brought policy has been introduced and an adult Did Not Attend policy has been developed and will be implemented in the near future.

What Works Well?

Teams were asked for their views on the positive aspects of service provision by the PDS. Their responses are presented in Figure 25.

Figure 25 - PDS Perceptions of What Works Well, Number of Responses by Theme and Hub Location



Quality of Care

Teams felt that the care provided to patients of the service is of a high standard in terms of treatment provided and interpersonal relationships. The teams were pleased to offer prompt access to emergency dental care when required and the dental emergency line for unregistered patients was also recognised as a service which works well.

Staff were particularly positive about the care provided to children and spoke highly of the support provided by Childsmile teams in terms of delivery of toothbrushing in schools and within PDS clinics. Support from the Childsmile and oral health improvement team in following up vulnerable children and those who had not attended appointments was highlighted as a very valuable part of their care. Staff recognised that the good oral health observed in children in the area is down to the combined efforts of Childsmile, oral health support workers and extended duties dental nurses working with clinical teams providing dental care and treatment.

The PDS was felt to provide a good service to vulnerable patients, including those with learning disabilities, older people, those with special and complex needs and patients whose first language is not English (though a language barrier would not in itself be a reason for a patient to attend PDS). One of the main benefits of the service provided by PDS for these patients was felt to be the ability to take time to provide the additional support which these patients require. Input to improve oral care for older people from the Caring for Smiles team and the introduction of oral care training for care workers was valued by clinical teams.

The ability to provide domiciliary dental care to patients who are housebound was also recognised and the fact that urgent visits can be arranged to prioritise patients who have an acute dental problem but are unable to attend a clinic. Care for anxious patients and those with dental phobias was also highlighted to be a strength by teams in Coldstream.

The availability of secondary care services for oral surgery and orthodontics were also described as being valuable.

Staffing/Teamwork

Staff in both areas were very positive about their colleagues and teamwork within clinics. Although recruitment of staff had been highlighted as challenging, retention of staff was noted to be high. Input from support staff, including admin teams was recognised as a positive and it was felt that teams had demonstrated their ability to work positively through challenging times.

The contribution made by dental care professionals was recognised, with trainee dental nurses being mentioned specifically. The role of hygienist-therapists was also highly valued in providing care to patients across both locations.

Prevention

As well as recognising the contribution of oral health improvement teams, in particular Childsmile and Caring for Smiles, prevention was felt to be an aspect which worked well. Staff were confident with the oral health messages being provided around sugar, tobacco, alcohol and oral cancer and valued the availability of resources to promote oral health.

Facilities

Clinic facilities were felt to be of a good standard and staff highlighted that there were no physical barriers, with all clinics being accessible to patients with disabilities. The service provided by the Local Decontamination Units in each area were also valued and felt to work well.

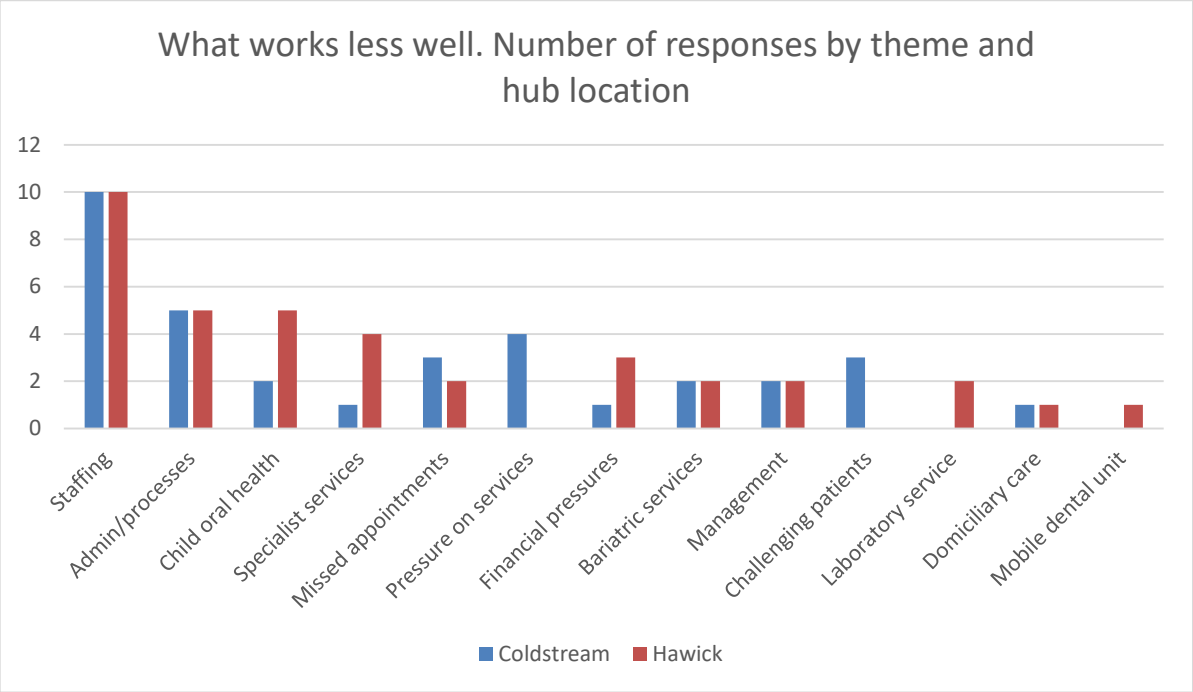
Education and Development

Staff in Hawick valued study days for dental teams and being able to participate in continuing professional development.

What Works Less Well?

Teams were then asked about aspects which they felt did not work so well. Aspects which were felt to work less well are presented in Figure 26.

Figure 26 – PDS Perceptions of What Works Less Well, Number of Responses by Theme and Hub Location



Staffing

Although team working and positive staff relationships were recognised as a significant strength within PDS, there was a strong message that staff numbers were too low. Lack of dentists was the major concern, though issues with nurse cover were also raised. Staff absence due to sickness was mentioned frequently and appears to be the main reason for staff shortages, in combination with difficulties in recruiting new members of staff. It was suggested that there may be an over reliance on hygienist-therapists to cover the shortfall in dentists and there was a feeling that greater flexibility around working patterns for dentists and streamlined working hours could be helpful in providing cover for those on sick leave.

While the overriding staff issue was pressure due to low numbers, there was also a suggestion of some dissatisfaction from some members of staff, with mention of a lack of opportunities for career progression and a need for staff to feel more valued.

Management

Management structures for dental services had changed over the previous year, with loss of the dental service manager post in 2018 and practice manager post in 2019. These posts have not been backfilled due to financial constraints by the Board and it was felt that it has been challenging to provide the level of support the staff have been used to. Staff in both hubs reported feeling that lack of managerial support was having a negative impact on communication and motivation.

Pressure on Services

In Coldstream in particular, the service seemed to be under particular pressure. It was highlighted that there are only two GDP practices within Berwickshire, one of which provides predominantly private dental care. Demands on the clinic in Coldstream seem to

be particularly high and it was felt that an insufficient number of appointments are available for the number of patients which can impact on the timing of care provision.

There was also a feeling that an increasing number of referrals are being received from GDPs in the area, and it was questioned whether dentists may be less confident to provide certain aspects of care.

Missed Appointments

An additional frustration, adding to the pressure on services, is high numbers of patients failing to attend appointments. This was an issue highlighted in both hubs, with concerns about the time required to follow up patients who have missed appointments and a worry that some children who have missed appointments may miss out on treatment they require if follow up is not successful. The nature of PDS patients means that more broken appointments are to be expected and the focus requires to be on supporting patients to maximise attendance as far as possible. Since the meetings a new Child Not Brought policy has been developed (Appendix 2) which aims to address this and a policy for adults is in development.

Challenging Patients

A particular concern in Coldstream related to challenging patients, with a feeling that reception staff were faced with managing disgruntled patients on a daily basis. Patients attending the clinic in Coldstream were described as having high expectations on both the clinical care being provided and having a service available “on the doorstep”. There was a feeling that many of the patients expressing dissatisfaction were not necessarily the core group of patients for whom PDS services were primarily made available. One member of staff described the clinic as having “opened ourselves to a patient group who *can* access GDP services”. Others described patients who opt to attend the PDS clinic for routine check-ups, but when they require treatment choose to visit a private dentist to access more complex or aesthetic treatments which are not available on the NHS. There was a feeling from staff that this did not represent best use of the service and that their primary purpose as a PDS service should be to focus on more vulnerable patients who require additional input or support and would find it challenging to access general dental care.

Specialist Services

While the treatment provided by the consultant led oral surgery service in BGH was valued, staff reported that patients who were referred faced long waits to receive treatment. It was also highlighted that there was a lack of secondary care facilities for other dental specialties, including periodontal treatment and endodontics.

Domiciliary Dental Care

Despite highlighting domiciliary dental care as one of the areas which works well, it was felt that provision from Coldstream may be insufficient to meet the levels of demand in the area. Dentists were also keen to highlight that although they aim to provide the highest standard of care possible, it is not feasible to provide all treatments in a domiciliary setting in comparison to the level of care which could be provided within a clinic.

Bariatric Dental Services

Staff highlighted that there are currently no dental facilities within the Borders which can accommodate bariatric patients. With increasing prevalence of obesity, staff had concerns that more patients will present who are unable to access care in a standard dental clinic as their weight exceeds the safe working limit of the dental chair. Currently these patients require to attend BGH to be treated in the operating theatre on a hospital trolley, though there are a small number of dental chairs in the PDS which can accommodate patients weighing up to 28 stones.

Children (GA, Prevention)

Members of staff were concerned that some vulnerable children who require dental care may be being missed, and that there may be a misconception by some parents that Childsmile input in schools is equivalent to them having a "school dentist". While Childsmile is seen as very valuable, it was suggested that delivery of Childsmile interventions in General Dental Practices may not happen consistently in all practices. There was also a worry that school input from Childsmile does not continue beyond primary school and once a child reaches secondary school, there is no further follow up to ensure oral health is being maintained.

Admin/Processes

Staff were frustrated with the volume of administrative tasks impacting on clinicians' time, this was particularly related to the recent introduction of electronic submission of prior approval (for treatment involving particular individual items requiring approval, or where the cost of treatment exceeds £410). Staff also felt that there could be better use of information technology, pointing out that it would be beneficial for systems to link with those of other health services.

There was also a feeling that the requirement to follow processes and pathways could be challenging and there were restrictions on what treatments they are able to offer, particularly in relation to regulations set out in the Statement of Dental Remuneration, with restrictions on the timing of when some items can be provided.

Finances

There was a feeling that financial pressures had led to a restriction in the availability of some dental materials within PDS, however there was also a feeling that money was being lost through wastage of materials.

Removal of Mobile Dental Unit

Staff in Hawick were unhappy that the mobile dental unit which had been in use until 2016/17 had been withdrawn. There was a feeling that there was still a demand for this service.

Changes

Suggestions for changes which staff felt would improve the services delivered included introducing measures to deal with staff absences and make cover available, which was mentioned in both hubs. Other suggestions took a different focus in each area.

In Coldstream it was felt that there was a need to focus the service on patients most in need of PDS care, with less time being spent on patients who could access GDS services. They were keen to improve communication with the public to highlight the shift in emphasis from Salaried General Dental Services to a Public Dental Service and to increase awareness of what treatments are available to NHS patients. There was a feeling that a simplified Statement of Dental Remuneration would be helpful, though it was acknowledged that this would require substantial change at a national level.

In Hawick there was a stronger focus on children's oral health, with a desire for input in the early years to follow up patients through maternal health groups, and expansion of oral health improvement activities into secondary schools.

Specialist Dental Services

Orthodontics

Orthodontic services

Discussions were held with both the hospital based consultant in orthodontics and specialist practitioner. Both were positive about the interface between each of their services and felt that the level of orthodontic provision in the area seems to be about right. The specialist practice has no waiting list for new patients and the waiting list for orthodontic assessment within the hospital is consistently within the 12 week target. In addition to orthodontic services provided through the NHS, there was an awareness that a recently opened private dental practice provides orthodontic treatment and approximately 8-10 local dentists also offer orthodontic treatment, mainly to adult patients on a private basis. The orthodontic specialist practice provides predominantly NHS treatment for child patients, though does receive some referrals for adult patients who may have declined private treatment. Adult patients are triaged by the practice, with the specialist practitioner only accepting patients where treatment will be of benefit to them. Overall it was felt by both orthodontists that the balance between supply and demand for orthodontic treatment is well met and there was no requirement to increase the level of service currently being provided.

The interface between the hospital and primary care orthodontic services was felt by both to work well, with clear referral criteria (Appendix 1) available to support dentists to direct patients to the most appropriate clinic. It was reported that some dentists may be unclear of the criteria or have a preference to refer to a particular service, but where referrals are repeatedly directed inappropriately, a copy of the referral criteria will be sent out to that practitioner as a reminder. The hospital consultant reported that a few referrals had to be "bounced back", usually to request additional information. Both orthodontists reported that it was more likely that patients would be seen in the specialist practice and require to be transferred to the hospital clinic than the other way round, which was felt to be as it should be.

Orthodontic referrals

The specialist practitioner felt that most, around 60% of, referrals were appropriate and were made at the right time. Both services reported receiving some late referrals, most commonly for impacted canine teeth, where problems could have been identified at an earlier stage. They also described receiving some referrals at too early a stage. It was acknowledged that you "can't expect referrers to be orthodontists", however there was a

concern that there may be a lack of knowledge of normal dental development among some dental practitioners. The orthodontic consultant described some referrals which state the problem to be crowding (a relatively common and straight forward problem), then on assessment patients are found to have complex orthodontic problems which will require orthognathic surgery (a joint orthodontic and surgical approach to realign the jaws).

Oral health/hygiene

The orthodontists acknowledged that oral health of children in the Borders is generally very good, describing seeing very few patients with untreated dental decay and reported that there appear to be only a few small “hot-spots” where caries rates appear to be higher. The specialist practitioner did describe often seeing patients with poor oral hygiene, though reported that once they have been given oral hygiene instruction, the vast majority of patients take this on board and manage to make improvements. It was unclear whether these patients have not received advice on improving their oral hygiene from the referring dentists, or whether patients don’t adhere to advice from their usual dentist but will pay more attention to that from the orthodontist.

Interfaces with other specialties

Some orthodontic treatment plans will require input from other dental specialties, most commonly oral surgery or restorative dentistry. Generally those requiring multi-disciplinary care have more complex orthodontic needs and will be treated by the hospital based orthodontic consultant. Patients who require joint restorative-orthodontic care, for example for hypodontia (missing teeth as a result of failure of some teeth to develop) are referred to Edinburgh Dental Institute (EDI) where they are seen by the orthodontist from the Borders, jointly with the other specialists required for their care. This system is felt to work reasonably well and in general, patients from the Borders accept the requirement to travel to receive this level of specialist care. Patients seen in the specialist practice who require the input of a restorative dentist will be referred on to the hospital orthodontist who will make arrangements for them to be referred on to EDI.

The hospital orthodontic consultant holds a joint orthodontic-oral surgery clinic every two months in the BGH for patients who require surgical dentistry as part of their orthodontic treatment. Surgical interventions required will then be provided by the oral surgeons within the BGH. While most patients requiring multi-disciplinary input receive their orthodontic care within the hospital, the specialist practitioner does provide treatment for some patients who require surgical interventions, for example for exposure of impacted canine teeth. Patients from the specialist orthodontic practice are referred to an NHS oral surgery specialist practice in Edinburgh, where they can be seen more promptly than if they were referred to the oral surgery department at the BGH. Patients requiring more complex orthognathic surgery will be referred via the hospital orthodontist to her clinic in EDI, for input from oral and maxillo-facial surgeons.

In the past PDS clinics for paediatric patients were scheduled to coincide with orthodontic clinics in the BGH, though the orthodontist described this as joint time, with patients being passed between each other rather than a true joint clinic where both clinicians would see the patient together. The hospital orthodontist felt that having input from a specialist in paediatric dentistry would bring significant benefits, enabling her to provide a better service to her patients, through for example joint planning regarding long term prognosis for first permanent molar teeth (it was noted that although an orthodontist can advise on long term planning following extraction of teeth, they are not the most appropriate person to judge

the quality of teeth to advise on whether they should be extracted) and the ability to offer more advanced restorative care to young patients.

Local need for additional dental specialists

It was felt that local input from a specialist in paediatric dentistry would bring benefits not only through opportunities to link with orthodontic care, but that specialist input to the Public Dental Service would provide support to staff, bringing opportunities for them to develop their skills and enhance the service currently being provided, reducing the need for paediatric patients to travel to EDI for specialist care for example in the event of dental trauma.

In addition to input from a paediatric dentist, it was also suggested that specialist special care dentistry input could bring similar benefits in terms of supporting and upskilling PDS staff to provide care for more complex patients, helping to develop the service from providing access for routine patients to focussing on more vulnerable patient groups.

The orthodontists highlighted that the only dental specialties available at specialist level in the area are oral surgery and orthodontics, with patients requiring restorative care, including prosthodontics or periodontics to either opt for private dental care or be referred to EDI. Periodontal care was also highlighted as being particularly needed, with many of the adult patients referred for an orthodontic opinion requiring periodontal treatment.

Networks/interaction with colleagues

The hospital orthodontist highlighted the additional benefits of also working within EDI where there is the opportunity to link in with colleagues and gain exposure to different ideas and ways of working. This helps to avoid isolation which they feel could be a risk for people working exclusively in the Borders where there are limited opportunities to interact with others.

Oral Surgery

Oral surgery services

Discussions were held with each of the part time oral surgery consultants. The overriding concern raised by both was the workload and pressures on the service. The consultants described long waiting times for initial assessment and to receive treatment, particularly where general anaesthetic or sedation was required. They reported that recent additional sessions and locum provision of treatment out of hours and at weekends had helped to reduce waiting times, though there was a concern that when these additional measures cease, waiting times will grow again.

Sessions delivered

The oral surgeons were keen to increase the number of sessions the visiting oral surgery specialty trainees could provide within the department. In addition to addressing waiting times this would also allow further access to training opportunities. It had not been possible to take this forward due to lack of available surgery space. They suggested that it would be beneficial to review clinic utilisation within the department with a view to transferring some treatments and services currently provided in the department into a primary care setting, thus freeing up space in the hospital for additional oral surgery clinics.

Demand / nature of referrals

One of the reasons for the long waiting lists was the high volume of referrals into the service. The oral surgeons felt that this most likely reflects a lack of experience or confidence in managing oral surgery and oral medicine amongst primary care dentists. There was also perceived to be an element of "risk aversion" with dentists preferring to refer extractions rather than being comfortable to provide the treatment themselves. They stressed that they did not wish to put pressure on primary care dentists to work out with their comfort zone or level of skill, and indicated that they would be willing to provide support and training to primary care colleagues who wished to develop their knowledge and skills.

Treatments provided

The consultants highlighted that a number of the referrals they received were for treatment which they considered to be routine and which does not require the expertise of a consultant. At present there is no threshold for the level of complexity of treatment to be provided. The consultants feel that for a patient who has been referred for an oral surgery procedure, regardless of the complexity, the most appropriate person to provide their care is an oral surgeon. They acknowledged that surgical procedures can go from easy to difficult very quickly, and that it can be challenging for a primary care dentist to predict which treatments are within their level of competency. It was also highlighted that complexity was not solely related to the nature of the procedure but also patient factors, including medical conditions which require to be taken into consideration in provision of care.

Need for additional dental specialists

The consultants felt that input of a specialist in special care dentistry based in PDS would be valuable as treatment could be provided by a specialist in special care dentistry (or experienced dentists working within a specialist led service) for patients who require their care to be provided in a hospital setting as a result of medical complexity rather than the need for an advanced surgical dentistry procedure. This is also true for patients requiring routine oral surgery under sedation. Currently a Senior PDS dentist provides dental treatment under sedation for patients with dental anxiety. It is possible that more of the patients referred to oral surgery for sedation could be directed to PDS where sedation is required due to patient factors rather than an advanced surgical procedure.

It was also suggested that having a specialist in special care dentistry on the team would bring further benefits through an ability to provide support to other members of staff, encouraging development of more specialised skills amongst their PDS colleagues. It was however recognised that it can be difficult to recruit specialist expertise to a rural area and there was a suggestion that building links to special care dental services in Lothian could help strengthen the service within the Borders.

Oral surgery/EDI interface

Current links with the oral surgery department at EDI were viewed as a valuable asset, enabling the oral surgery team to join monthly clinical governance meetings, including continuing professional development, audit and incident reporting. In the past oral surgeons from BGH would deliver clinical sessions in EDI and those from EDI would come down to provide treatment in BGH. The oral surgeons felt that this previously well-

established clinical link, was valuable and should be re-visited for peer review and support purposes.

In contrast there was reported to be no direct link to oral and maxillo-facial surgery (OMFS) services, other than when oral cancer cases are referred on for management. Patients presenting with a facial swelling may also require to be transferred to OMFS due to lack of out of hours cover for these patients within BGH. The oral surgeons felt they work well with medical colleagues within BGH and while they would welcome OMFS input if it were offered were comfortable with the current arrangements.

Networks / interaction with colleagues

It was highlighted that as the two oral surgeons work part time and are present in the department on different days, there are limited opportunities for them to meet with each other or undertake peer review, which can be isolating. Issues can also arise if one person is unavailable or on leave as they are unable to provide cross-cover for each other. This is another instance where a more formal network with EDI clinics could be beneficial.

Being the only oral surgeon present can also provide challenges fitting in emergency patients should they arise, with one person managing a clinical session, patients on the ward and having to fit in any additional patients. Having the specialty trainee around was noted to help ease these challenges by facilitating a team approach to managing the multiple demands.

Oral surgery in primary care

The oral surgeons were asked for their views on the proposal in the Scottish Government's Oral Health Improvement Plan[2] for more dentists on the high street, to include oral surgery services in a primary care setting. The oral surgeons felt that a suitably trained primary care practitioner could form part of a managed clinical network to provide some oral surgery in primary care. If this was a non-specialist, they believe it would need to be made very clear to patients that they were not seeing a specialist oral surgeon. It was felt that increasing training opportunities for oral surgery specialty trainees within the hospital would hopefully help to deliver more suitably trained specialists to work in primary care.

There was also a feeling that an NHS specialist practice model could be helpful, but that this would require careful management, clear agreed referral criteria, appropriate regulation and would have to be adequately funded.

If the enhanced practitioner model were to be introduced for oral surgery, it was felt that there was not currently anyone working in the Borders who would be in a position to provide oral surgery in primary care. It was acknowledged that there may be a practitioner who is unknown to the department as they manage their own oral surgery cases and have not required to make many referrals to the department.

Oral Health Improvement

A general discussion was held with members of the Oral Health Improvement Team, giving them the opportunity to describe their roles and work being undertaken particularly in relation to the Childsmile and Caring for Smiles programmes. Conversations were

structured around what worked well, what they felt they main challenges were and what changes they would like to make to maximise opportunities to improve oral health.

Childsmile

Staff working with the Childsmile team were happy that the programme works well, highlighting the fact that they now see fewer children with caries than they did in previous years. They also described seeing fewer children who were not registered with a dentist – mentioning that while working in nurseries and schools earlier that day they had seen two unregistered children, where a few years ago it would have been usual to see around 20-25.

In the past Oral Health Support Workers had been allocated to a specific area and provided support to both practices and educational establishments in that area. More recently their roles have focussed on either working with Childsmile practice (encouraging dental registration and attendance) or Childsmile nursery and school (supporting the toothbrusing and fluoride varnish programmes). The teams felt that these new arrangements were more effective.

Teams described positive and longstanding relationships with Health Visitors, though they do find that some tend to refer more children to them than others. The decision on whether a child requires referral to Childsmile depends on the Health Visitor's individual judgement and once referred the Health Visitor and Oral Health Support Worker will tailor the level of support provided to the needs of the individual child.

The team described their process for following up children who have been referred to a dental practice by Childsmile, by making contact four months after the referral to ensure the child has attended and all is well. They felt this was beneficial and provided an opportunity to identify children who had not engaged with dental services and who required further support to do so. Participation with dental services among children was felt to be good and the teams believed that this was due to the support offered by the Oral Health Support Worker.

Childsmile clinics within the PDS were seen as a valuable means of delivering preventive care and advice and were described as working best when the Extended Duties Dental Nurse takes ownership for delivering them. They were felt to work particularly well in some clinics, however there were inconsistencies in others where clinics were either irregular or seldom delivered.

The teams described positive relationships between Childsmile and clinical teams within the PDS and reported that over time they felt Childsmile oral health improvement teams and the clinical teams had developed to a stage where they work well together.

Childsmile is generally well accepted by schools and nurseries in the area and positive relationships have been built, with the majority of staff in these establishments welcoming Childsmile teams. In the past schools had been prioritised for Childsmile input based on SIMD quintiles, however more recently there has been recognition that in the Borders SIMD may not be sensitive enough to identify the schools or children where caries risk is highest. As the number of schools receiving Childsmile interventions have increased,

factors such as free school meals, attainment money and obesity level have also been used to guide which schools receive most input.

The team described the strong relationships that Oral Health Support Workers have developed with nurseries and schools and the benefits of both parents and staff knowing the Childsmile teams. They also noted the benefits of working in a small Board area where people know each other, which facilitates communication between education and health services, allowing for information to be shared appropriately without the barriers faced by some of their colleagues in other Health Board areas.

Childsmile input to Leadervalley School for children with complex additional support needs was described as “fantastic”. One Extended Duties Dental Nurse is allocated to the school and to the additional support units in other schools across the region and was very positive about her role there, feeling that it was good to have the opportunity to concentrate on children with additional needs. She reported that there was a requirement to “tweak” the way Childsmile is delivered to children with additional support needs in comparison to mainstream schools, dependent on the unit or class and needs of individual children. For some children specific toothbrushes may be required, and consideration needs to be given to timing of toothbrushing and visits from the team. She reported that not all children are able to accept fluoride varnish application, though around half of the children she sees do manage to have varnish applied. The EDDN reported that she is recognised by the children and has also developed good relationships with parents through attending parents nights and has received “nice feedback” about the input of the Childsmile team.

Challenges described by the Childsmile team included a feeling that, despite the success to date, it will be very difficult to achieve the government target for 2022 of 84.5% of Primary 1s and 92% of Primary 7s having no obvious decay experience.

The teams also identified the lower rates of dental registration among very young children (aged 0-2 years). In an attempt to address this a pilot was being undertaken in one area where registration was known to be an issue in which Health Visitors had agreed to refer all children to the Childsmile team at their 6-8 week visit through the Universal Health Visiting Pathway. It was hoped that through all families having contact with an Oral Health Support Worker at this early stage that more parents would be encouraged to register their baby with a dentist. The teams were keen to see the outcomes of this pilot, but also explore what impact the increased number of referrals would have on their workload.

Relationships with GDP practices were described as variable and going through “peaks and troughs”, varying over time and being more positive with some practices than others. Teams felt that twice yearly fluoride varnish applications in dental practices, as recommended by the Childsmile programme, were not always being delivered and that promoting this among GDPs was another challenge they faced.

The teams felt that it could be difficult to balance the roles of Extended Duties Dental Nurses who spend part of their working week delivering Childsmile and part working in clinics. At times this dual role could make it difficult to deliver what they had planned as clinical sessions were given higher priority and Childsmile clinics may be cancelled if the nurse was required to work with a clinician. They felt that Childsmile clinics should be viewed as a higher priority than they perhaps appeared to be at the time.

Broken appointments within PDS clinics were also discussed, with a feeling that children who have not been brought to appointments are not always followed up. The teams felt that there was a need for greater understanding of factors which may have contributed to a missed appointment. They felt that clinicians may not always see beyond the wasted clinical time and that there should be a greater focus on the more vulnerable patients and appreciation that PDS has an important role in ensuring patients who may have complex life circumstances are given the support necessary to receive dental care. The team felt that there was a need for dentists to "adjust to see what else was going on" rather than "write off" a patient as a poor attender. The introduction of a "Child Not Brought" policy since this discussion was held aims to help to address this issue.

A further challenge had come about through the discontinuation of the Mobile Dental Unit which had previously offered a local dental service in areas where there was no dental clinic. The team reported doing a lot of work to engage with families who had previously used this service to encourage them to come in to clinics. This work was ongoing despite it being over a year since the mobile service had ceased.

At times the teams face challenges following up consents for children to participate in Childsmile fluoride varnish application, reporting that it is necessary to follow up with parents who have not returned forms and that despite their efforts parents do not always respond. Within nurseries and schools, although relationships were good with most establishments, others remained more difficult to engage with. The teams felt that as Childsmile has become well established over the years, positive relationships have developed, though there is still a need to "keep selling" the programme. They valued the "PR work" done by Oral Health Support Workers to continue promoting the programme and suggested that it may be beneficial to have a "Childsmile relaunch" where the benefits and positive impacts of the programme could be highlighted.

Caring for Smiles

The Caring for Smiles programme was described as evolving all the time. To date no care homes in the area have declined the offer of Caring for Smiles training, though promoting uptake by care home staff was described as a challenge. Positive relationships are being developed between the Oral Health Improvement team and care homes and it was felt to be beneficial that the Caring for Smiles coordinator attended monthly care home managers' meetings, though this has ceased since the discussion took place as meetings were not always well attended and frequently cancelled at short notice.

One Oral Health Support Worker is allocated to the Caring for Smiles team and this role was viewed as valuable in bringing together the Oral Health Improvement and clinical PDS teams. In addition to supporting the delivery of the Caring for Smiles, the delivery of domiciliary dental visits by PDS staff is supported, through liaison with the care homes to ensure that necessary arrangements and paperwork are in place prior to the dentist's visit.

While Caring for Smiles and PDS staff work well together, there was a feeling that there was still room to strengthen links with GDPs, PDS and Caring for Smiles to enable them to work more effectively together.

Adults with Learning Disabilities

At the time of the conversation with the Oral Health Improvement team the Open Wide, national oral health improvement programme for adults with additional care needs had not been launched, however work was already underway to build links to support adults with learning disabilities in the Borders. The Caring for Smiles Oral Health Support Worker was already working with Social Workers who would notify him of anyone requiring support to register with a dentist. The Oral Health Support Worker felt that this was a positive piece of work, though it could be challenging and there was a need to persevere to successfully facilitate access to dental care. It was also acknowledged that working with adults with learning disabilities is “not for everyone”.

9. Public Perceptions

To gain an insight into the oral health needs perceived by residents of the Borders and their priorities in relation to oral health, groups representing the population were consulted. In addition a number of direct public facing engagement events were arranged to gather views of Borders people first-hand.

Patient Representative Group

Patient representatives were consulted via the NHS Borders Patient Representative Group (PRG) meeting in February 2019. The PRG is chaired by the NHS Borders Public Involvement Officer and consists of volunteer members of the public, including a representative for people who use mental health services and a representative of people who are deaf and hard of hearing. The meeting on 18th February also included a local secondary school pupil with a view to encouraging representation of younger people. Points raised by the group related to:

1. Access to dental services
2. Requirement to travel
3. Treatment costs
4. Prevention
5. Relationships with other health services

Access to Dental Services

It was reported that people moving in to the area can find it difficult to register with a dentist. One member stated that it could take between 12-18 months to find a dentist in the area. Another member referred to a wait of around one year to register with the [PDS] dental clinic in Coldstream.

Requirement to Travel

It was recognised that access to dental care can be more problematic in some areas than others, with limited availability of public transport adding to the issue. The burden of travelling to access care was felt to be particularly challenging for older people. Travelling was noted to be a common difficulty shared with other medical services including, for example, opticians. It was also highlighted that the out of hours dental service is based in the Borders General Hospital, which may not be easily accessible for some people.

Treatment Costs

Costs of dental treatment were also discussed. Members were positive about the clear breakdown of charges on the NHS, and highlighted that private costs were often significantly more. The group also discussed “mixing and matching of NHS and private treatment” and the fact that dentists will at times advise of private options to provide particular types of treatment.

Prevention

Members of the group commended the good standard of oral health of children in the area and the positive impact of the Childsmile programme in nurseries and schools. They did however question why Childsmile input does not continue beyond primary school and felt pupils would benefit from the continuation of the toothbrushing programme through secondary school.

Relationships with Other Health Services

There was a feeling among the group that they would like to see a better “tie up” between doctors and dentists, suggesting that there should be greater communication and more ability for referral between the services.

Public Engagement Events

Between February and September 2019, a variety of opportunities were provided for members of the public to help inform the needs assessment by asking them

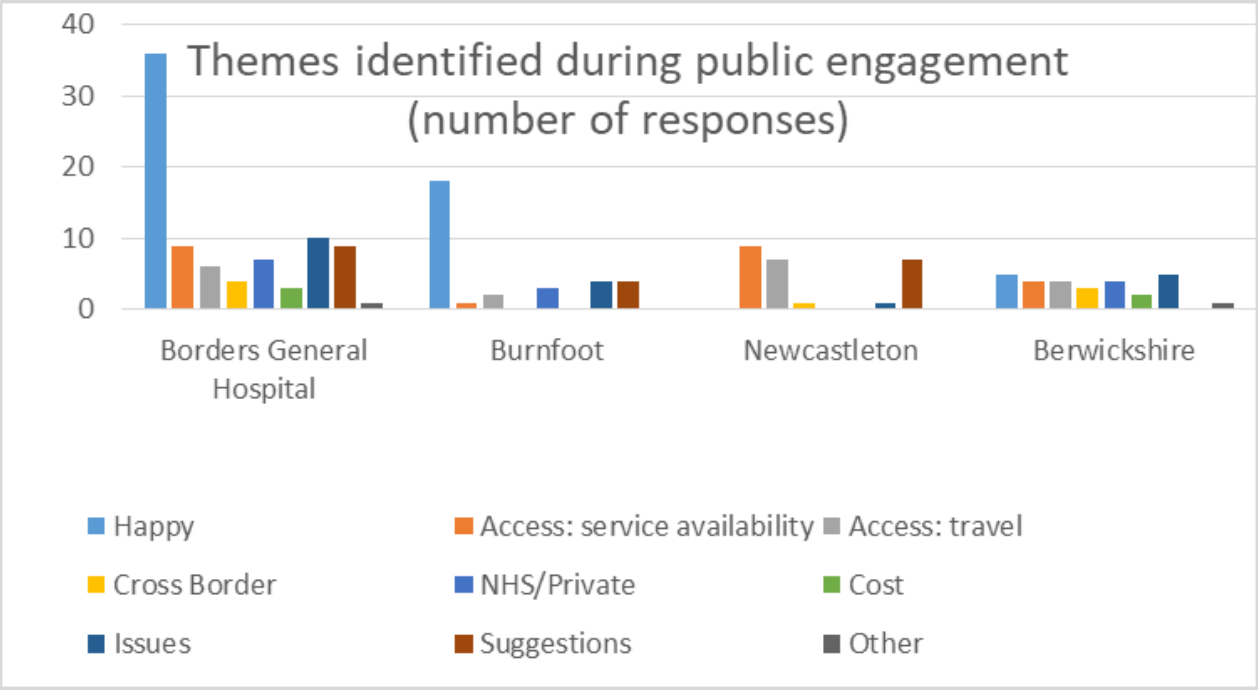
What matters to you about oral health and dental services in the Borders?

The first and largest event was held in Borders General Hospital, however in recognition of the fact that this was a central location with good access to dental services nearby, follow up events were arranged in three health centres in more remote areas of the Borders: Eyemouth, Chirnside and Newcastleton. Two further events were also held in Burnfoot Community Hub, an area of high deprivation in Hawick and with employees of Farne Salmon, a fish processing plant in Duns. Stands were set up in each location, with passers-by asked to provide feedback on post-it notes, which were collated and analysed for common themes.

In the Borders General Hospital around 80 responses were received from patients, visitors and members of hospital staff. Twenty nine responses were received in Burnfoot, 23 in Newcastleton and 25 from the three events in Berwickshire (10 in Chirnside, 4 in Eyemouth and 11 in Duns). Due to the smaller number of responses in each of the Berwickshire events, these have been collated to provide a summary of feedback from Berwickshire as a whole.

Figure 27 provides a summary of responses by theme for each location.

Figure 27 – Themes Identified During Public Engagement



Happy

Around half of the responses in the BGH and Burnfoot were very positive about dental care.

- *"Having an NHS dentist in the Borders has been great. Out of hours was also fantastic when I needed it." (BGH)*
- *"Attend NHS dentist. Happy with service. Children love their dentist and attend regularly as a family" (BGH)*
- *"I hope they continue to benefit the community, doing a great job" (Burnfoot)*
- *"Think the service is excellent – great in schools, excellent Childsmile, great service" (Burnfoot)*
- *"Access and quality of service is much better than down South – we are very lucky" (Chirnside)*
- *"Efficient out of hours care over weekend" (Chirnside)*

It is noteable that Newcastleton was the only location where none of the responses expressed satisfaction with dental services, with the majority of feedback there highlighting difficulties accessing dental services.

Access - Availability of Dental Care

The most common issue raised across all of the locations was around access to dental care, and lack of availability of dentists. This was a particularly strong feeling in Newcastleton and mirrors staff concerns.

- *"All Borders towns lacking NHS dentists" (BGH)*
- *"Too few dentists take NHS patients. Not enough NHS dentists/places" (BGH)*
- *"Dental services in the village would be so much more accessible" (Newcastleton)*
- *"Why is there a doctor in Newcastleton and not a dentist? Dental health is very important" (Newcastleton)*

Most comments about availability of services in Berwickshire tended to focus specifically on low availability of NHS dentists in the area.

- *"Not enough and very few and far between dentists on the NHS" (Duns)*

One person at the BGH event felt there was good availability of dentists, though this view did not appear to be widely shared.

- *"Gala practice was advertising for patients recently. Not sure why people complain they can't get a dentist" (BGH)*

Access: Travel

A number of respondents reported that they travelled several miles to access dental care.

- *"I live in Jedburgh but have to travel to Gala for dentist" (BGH)*
- *"Not enough dentists in local area. My dentist is in Edinburgh" (BGH)*
- *"I previously had to travel to Glasgow" (BGH)*

The distance to the nearest dental practice, and issues with transport were raised frequently in Newcastleton.

- *"At present it is difficult to access dental services. 30 minute drive to nearest which only has one dentist at any one time. Local service would be a huge help" (Newcastleton)*

Within Berwickshire, the need to travel to receive dental care seemed to be most of an issue for people in Chirnside. Difficulties for people who rely on public transport to get to appointments were also highlighted.

- *"Need to travel quite a distance for NHS treatment" (Chirnside)*
- *"Travel distances and costs. Lack of public transport at good times" (Chirnside)*

Whilst travelling to dental appointments was noted as an inconvenience by some, it was highlighted that for some individuals the requirement to travel posed more of a barrier.

- *"Difficult for people with learning disabilities – difficult to travel" (BGH)*
- *"As an elderly person, transport is very limited and bus stop too far to walk from to dental centre" (Newcastleton)*

Cross-Border Care

Some respondents, particularly those living in the East of Berwickshire, reported accessing dental care in England, despite living North of the Border.

- *"Lack of access to NHS dentist in local town" (Peebles).*
- *Still attending dentist in Newcastle where I moved from" (BGH)*
- *"Travel to Northumberland for dental care as I used to live there" (BGH)*
- *"So… my dentist is in Berwick because originally I could not register with a dentist in Duns. I think that would no longer be the case. I do wonder would the service be different if I was in the 'Scottish System'" (BGH)*
- *"Registered in Berwick – had to for NHS dentist" (Eyemouth)*
- *"Had to register in England as couldn't get in anywhere here" (Eyemouth)*

There was little mention of people travelling to England for dental care from more western parts of the Borders, though one respondent in Newcastleton did describe travelling to Newcastle for dental care.

NHS vs. Private Dental Care

A number of patients reported having "had to" change from NHS to private dental care, particularly when a previously NHS dentist has switched to providing private care.

- *"Need to keep NHS dentist availability. Too many going private. Otherwise very good" (BGH)*
- *"My dentist went private. I didn't have an option" (BGH)*
- *"Family dentist is private and very good but we changed to NHS in same practice. Have now been told that they may not be taking NHS patients so will need to look for new dentist. We all cannot afford to go private. Borders dentists are good but a lot are going private." (BGH)*
- *"In Duns I need to go private to get a dentist" (Duns)*

Some respondents in Burnfoot did mention receiving private care, all of whom expressed a preference to receive NHS care if it was available.

- *"Currently registered with a private dentist but would rather be with an NHS dentist" (Burnfoot)*

Private dental care was not mentioned in any responses in Newcastleton.

While some patients would prefer to continue to receive NHS dental care, others reported being happy with private care.

- *"Now registered privately (previously NHS) but happy with dentist" (BGH)*
- *"Happy to pay for private if get good service" (BGH)*
- *"Registered privately but easy to get an appointment when needed (expensive though)" (Eyemouth)*

Costs

In BGH, some patients mentioned finding dental treatment expensive, though it was not always clear whether this referred to private or NHS charges. The cost of dental care was not mentioned in either Newcastleton or Burnfoot and in Berwickshire the only mention of cost was to highlight that private dental treatment is more expensive than NHS.

Problems and Queries

Some patients provided feedback on specific problems they had faced, including lack of continuity of dentists through frequent changes of personnel and appointments being cancelled or rearranged at short notice.

- *"Four different dentists in 1 year. No continuity – each had differing opinions" (BGH)*
- *"Always changing your dentist without telling you" (Berwickshire)*

In one area, a number of patients expressed dissatisfaction with the service they received from their dental practice. Many of the comments related to the same practice, though it should be noted that there were also positive comments recorded relating to the same practice.

Others mentioned having to wait long periods of time to get an appointment, or being removed from a dentist's list for missing an appointment and unable to pay fees charged for the missed appointment.

One respondent raised the issue of lack of disabled access to the local dental practice. Under the Equality Act (2010) service providers are required to make "reasonable adjustments" to ensure people with disabilities are not disadvantaged. Arrangements are in place for any dental practice where it is not feasible to provide disabled access to refer patients on for dental care in PDS, where all clinics support wheelchair access.

Questions were raised about referral pathways and there was a feeling that these are not always clear, which can result in delay for patients if they are not referred to the correct place in the first instance. Another asked about thresholds for making referrals as there was a feeling that some dentists seem to make more referrals than others.

A member of hospital staff asked about cover for inpatients who may have a dental problem and was unaware that this is available through the PDS.

Suggestions

Some respondents provided suggestions to improve oral health and services. These included increasing the focus on preventing poor oral health with more publicity for oral care and encouragement for workplaces to support good oral health.

Respondents felt it would be beneficial if dental services were easier to contact, for example for advice between appointments, and they would like dental practices to make more contact with them. There was also a request for practices to offer later appointment times to accommodate work and commuting. It was suggested that patients should be reregistered with the dentist closest to their home to address the fact that many patients travel to an alternative town to attend the dentist.

All of the suggestions made in both Newcastleton and Burnfoot related to improving access to dental services. The vast majority of these related to reinstating the mobile dental service which had previously visited both locations.

- "Mobile dental should be reinstated" (Newcastleton)
- "Mobile dental service very good at the time. Needs to come back" (Burnfoot)
- "Bring back the mobile dental service to Burnfoot. It was well used and an asset to our community" (Burnfoot)

Others suggested introducing a part time dental service in Newcastleton, or reinstating the dental clinic within the school.

- "Need dentist in village, even once a week" (Newcastleton)

The strength of feeling about providing a local dental service was evident among the community in Newcastleton, with an offer to contribute financially towards making a service available.

- "I would be happy to pay £5 per week to improve services" (Newcastleton)

Specific Population Groups

It is recognised that some members of the population can experience particular difficulties accessing dental care, including those with physical or cognitive disabilities, mental health problems, people experiencing homelessness and those with addiction problems. Representatives for the deaf and hard of hearing and people with mental health conditions on the PRG were able to provide feedback relating to these specific groups.

The main concern raised relating to patients who are deaf was around availability of British Sign Language interpreters to support communication between patients and dental teams and it was identified that there was a need to make dentists aware that they have the facility to book a sign language interpreter through translation services. It was also suggested that it would be helpful to let patients who may require an interpreter know that this is something which can be arranged and that they should feel able to request.

A number of challenges were described relating to dental attendance for patients with poor mental health and it was reported that many patients with mental health problems do not go to the dentist. Problems accessing care include high levels of anxiety among this patient group, and that when having a “bad day” patients may find themselves unable to bring themselves to attend a dental appointment which had been arranged previously. Memory problems were also highlighted as these may result in non-attendance for appointments. The representative felt there was a need for a flexible approach to providing dental care for these individuals and for mental health support workers to play a role in supporting patients to attend dental appointments. A need for dental input to East Brig Rehabilitation Unit was also highlighted

It was recognised that information relating to wider priority group populations had not been captured through the PRG meeting or the wider public engagement events. A number of local organisations and groups working with people who may be at increased risk of poor oral health, or who may find it more difficult to access care were contacted to explore whether they were aware of problems with oral health and access to dental care amongst their clients.

Responses were received from two organisations, both of which provide addiction services. Representatives from both services reported that their clients did struggle to access dental care. They described difficulties registering with a dentist due to limited availability of NHS dental services in the area. It was highlighted that their clients often rely on emergency dental services, however they may be offered an emergency appointment anywhere in the Borders and transport can present a challenge to attending. For patients who have managed to register with a dentist, it is recognised that attendance patterns may be erratic, either due to memory problems which are common amongst this group, or the fact that support is required when clients are at their most chaotic and attending appointments tends not to be prioritised when patients are at this point. It is common for GDPs to charge a fee for appointments which have been missed which must be paid prior to a new appointment being arranged and this was reported to be a barrier to attending for dental care.

Staff working in addiction services indicated a desire to improve the situation through preventive actions to improve oral health and facilitating access to dental services and attendance at appointments. Addiction services already work closely with other health

services, for example the sexual health service and suggested that it would also be beneficial to build links with oral health and dental services. It was also suggested that an open access or drop in dental service may be helpful to this client group and it was highlighted that if positive experiences and early interaction with dental care can be encouraged this would help to better meet the oral health needs of this client group.

No information was received from organisations working with other groups likely to be at increased risk of oral disease or facing challenges to access dental care. Further engagement with relevant organisations and patient groups will be necessary to ensure the needs of these individuals are not overlooked.

Main Findings Section 3 – Engagement and Dental Teams and the Public

- **Access to dental care was the main concern for dental staff in both PDS and GDS and for members of the public**
- **The vast majority of dental patients were happy with the care they receive**
- **GDS and PDS staff both described feeling under pressure**
- **Low staffing levels and issues with recruitment and retention were major concerns in both GDS and PDS**
- **53% of GDPs described their needs as being "partially met" by currently available specialist dental services**
- **Dental teams and the public were positive about preventive services, particularly Childsmile, but all felt that input should continue into the secondary school stage**

Key Discussion Points

Access to Dental Care

Feedback from both patients and members of primary care dental teams indicates that access to dental services is a much greater concern than registration and participation figures would suggest.

Several reasons were suggested for the level of demand for dental services being experienced at present despite high registration levels, including the possibility that a number of those seeking to register as new patients may already be registered with an NHS dentist, either looking to move to a different practice, or through lack of awareness of lifelong registration.

The main sources of new NHS dental registrations in the area are likely to be from patients moving in to the area, patients currently accessing private dental care looking to switch to NHS and patients who have accessed care in England looking to register in Scotland for the first time. Through the engagement events it was apparent that long term residents of the Borders who had been registered with a dentist for a number of years were happy with the care they received and that the main difficulties were faced by new residents moving into the area and seeking to register for the first time as a new NHS patient, or patients who had been attending an NHS dentist which had switched to offering only private dental care.

While some members of the public reported that they were happy to opt for private dentistry, it was clear that others currently receiving care on a private basis would prefer to receive NHS care. There were also a number of reports of dentists "going private" with patients facing a choice of continuing to attend their current dentist or seeking a new NHS dentist. The possibility of a shift in care provision with more dentists making a decision to

focus on providing private dental care cannot be ruled out and could be expected to result in a significant increase in demand for those continuing to provide NHS dental services.

The PDS experience a high demand from individuals seeking to register as NHS patients. It was suggested by staff that some of the patients seeking PDS care would be able to register with a GDP and that some may in fact already be registered. There is felt to be a lack of awareness among the general public of the difference between GDS and PDS and the purpose of PDS as a "safety net" service for those unable to receive care in GDS. They identified a need to raise awareness that being registered with the PDS clinic closest to a patient's home was not equivalent to being registered with their local medical practice. One suggestion made during patient engagement was that patients should be reregistered with the dental practice closest to their home to reduce numbers travelling between towns for dental care. Under current arrangements this is not something which could be implemented as patients are free to choose which dental practice they wish to register with regardless of its location.

Alongside the reported lack of availability of NHS dental care, it was also highlighted that those living in the more remote parts of the Borders may face difficulties travelling to dental clinics, particularly if they rely on public transport. This issue was particularly strongly expressed in the Newcastleton area by patients who were previously able to access care via a mobile dental unit (MDU) which had visited the town until 2017. Despite requests for this service to be reinstated, providing care from a mobile unit is no longer considered viable as the unit would not have met requirements to pass a dental practice inspection. In addition the vehicle used was unlikely to pass an MOT test and the necessary parts to maintain the roadworthiness were not available. At the present time there is no additional financial resource available to replace the mobile unit, however new domiciliary dental equipment has been purchased to enable treatment to be provided at home for patients who are unable to travel to a clinic.

The Oral Health Improvement Team have also provided, and continue to provide support to residents previously served by the MDU to help them register with a dentist and encourage them to continue to access regular dental care. While it is recognised that there are areas in the Borders which would benefit from a dental practice being set up locally, areas with a small population are unlikely to be viewed as a viable business opportunity by GDPs and the Health Board has no authority to request that a dentist opens a new practice in a particular location. In the past grants have been available to encourage practices to open in areas of high need, however such funding is no longer available and would not address concerns regarding longer term financial viability.

Staffing Levels

Issues with access to dental services are likely to be compounded if staffing levels within dental services cannot be maintained. Significant concerns were also raised around the recruitment and retention of staff in both general dental practice and the PDS. Despite a number of benefits described by GDPs working in the Borders including higher remuneration, well established dental lists, lower costs of living and pleasant surroundings, dentists seem reluctant to consider a post in a more rural area.

One of the measures to increase the availability of dentists following publication of the 2005 Dental Action Plan[3] was a recruitment drive to encourage dentists from other EU countries to relocate to Scotland. This proved successful at the time and GDPs reported

that while there are often no applicants from within Scotland for associate posts, in the past there have usually been dentists from other parts of the EU who have shown an interest in applying. A marked reduction in applications for posts from EU dentists has been observed since 2016, with significant uncertainties relating to the UK's departure from the EU and its future implications. The ability to recruit dental professionals and measures which can be taken to attract new practitioners to the area will require careful consideration to maintain and build the dental workforce.

Staffing levels can also be challenging where there are high rates of absence or sickness within a team. In GDS this can have a significant financial impact as practices require to take on agency staff to enable them to continue to provide a service. Within PDS, the small size of the team means that absence of one staff member can have a significant impact on the workloads of other members of the team. Robust processes for maintaining resilience and managing absences are necessary to enable services to continue to meet the needs of their patients.

Engagement with GDPs

As independent contractors who are not employed by the Health Board, there was no single forum through which to engage with GDPs to ensure their views were considered as part of the needs assessment. The online questionnaire was felt to be the best option to gather feedback from as wide a range of GDPs as possible, however not all GDPs invited to participate responded and the profile of dentists who did respond does not appear to be representative of the entire GDP workforce in the area.

To ensure that decisions which affect GDPs are acceptable to them it is important to maximise engagement with this group who are the main providers of dental services in the Borders. Opportunities for GDPs to have their voices heard should be made available and they should be encouraged to participate in local networks and to link in with wider groups. Attendance at meetings such as the Area Dental Committee has been noted to have declined in recent years and there is a need to reinvigorate these groups and encourage GDPs to become more involved in shaping decisions which affect their practices.

It was highlighted that during the consultation phase prior to publication of the Scottish Government's Oral Health Improvement Plan[2] that none of the roadshows took place within the Borders. With increasing use of technology, it may be worth considering the possibility of arranging for dental teams in the Borders to link in to such national events via video-conference to ensure that those working in more remote areas are able to feed in their perspective, which may differ from that of a dentist working in a city centre practice, thus ensuring that a full range of views is considered.

Specialist Services

Dental teams were positive about the specialist services available to them in the Borders, though it is clear that the waiting times for oral surgery are an issue. One of the challenges faced by the oral surgeons appears to be the volume and range of referrals being accepted in the department. Clear referral criteria and the possibility of a primary care based oral surgery service, similar to the model for orthodontic care currently in place in the Borders could be considered to help address some of these difficulties. In parallel with this needs assessment a demand management process has been conducted to review the

workload of the oral surgery department and it is hoped that the findings of this needs assessment can help to inform decisions on the future direction for oral surgery services.

Dentists in both PDS and GDS highlighted the lack of NHS specialist restorative dentistry services in the Borders. Although it is possible to refer patients to Edinburgh Dental Institute for restorative care, there was a feeling that referrals are often “bounced back” or that patients are provided with a treatment plan to be delivered by the referring dentist which they do not always feel confident to deliver. There may be a perception that referrals are less likely to be accepted from dentists in the Borders than those working more locally to EDI in NHS Lothian, which is however not the case. The same referral and acceptance criteria apply to all patients whether they are referred from within NHS Lothian or a neighbouring Health Board.

The restorative department in EDI has 3 whole time equivalent consultants serving a population of close to 1.5 million and as a result there are significant demands on the service. Consultants therefore focus on their core responsibilities which include restorative management of trauma, head and neck cancer, cleft lip and palate and patients requiring restorative treatment as part of orthognathic provision. They have a secondary focus on things which can only be provided on the NHS in a secondary care hospital setting such as implant supported prostheses in line with guidelines from the Royal College of Surgeons. Capacity to provide assistance with more general restorative cases is limited, requiring strict referral criteria for the department and while the most complex periodontal, prosthodontic and endodontic cases will be accepted where possible, treatment cannot be offered to all patients referred to the department. There is recognition that GDPs do not always feel confident to deliver treatment plans which have been provided following referral and consultation.

NHS provision of restorative dentistry is under similar pressure across Scotland and to some extent there may be a need to manage expectations of primary care dentists in relation to what treatments can be offered by these services. It is clear however that dentists in the Borders do feel a need for more support and alternative options to support provision of more complex restorative care in the Borders should be explored. The possibility of a local service or network for restorative dentistry could be considered including a potential eGDP model in the future. Lessons can be learned from other areas where local services have been introduced and a key factor will be ensuring that there is clarity around what treatments will and will not be provided with formal referral criteria to manage patient flows.

Surgery Utilisation in BGH

The dental department in BGH consists of three dental surgeries, which are used by oral surgery, orthodontics and the PDS. Space within the department is at a premium with a desire by some services to increase their clinical sessions limited by lack of surgery space. It was identified that some items of treatment currently provided by dental teams in BGH could be safely and effectively delivered in a primary care setting. One solution could be a facilities utilisation review, with appropriate staff engagement, to look at innovative approaches to take some services into a primary care setting, thus reducing pressure within the department.

This is in line with the NHS Borders Clinical Strategy[30] which aims to ensure care is provided out with hospital and in settings closer to patients’ homes. It is also recognised

that delivery of services in a primary care setting can reduce costs and, in the case of dental care, patients receiving treatment will, unless exempt, make a contribution to treatment costs promoting greater equity between patients who have been referred for treatment and those who are offered equivalent treatments by their usual GDP.

Care will be required not to withdraw PDS services completely from BGH as a presence will still be necessary to provide care which cannot be delivered in primary care and to provide adequate cover for inpatients who may develop a dental problem. The ageing population and fact that more people are living longer with chronic conditions should also be taken into consideration as the number of patients who may in future require treatment within a secondary care setting is likely to continue to increase.

Specialist Input to PDS

The consultant orthodontist and both oral surgeons highlighted benefits which a specialist in special care dentistry and in paediatric dentistry could bring to the PDS in terms of expertise in managing more complex patients and items of treatment and in sharing their experience with the wider team to support upskilling across the service. These benefits are also recognised by the PDS leads, however previous attempts to recruit a specialist to PDS in the Borders have been unsuccessful in attracting applicants. Alternative opportunities to link PDS with specialist input may be possible through enhancing existing links with the special care and paediatric dentistry teams in PDS in NHS Lothian.

Prevention

Members of dental teams and members of the public recognise the benefits of promoting good oral health and were positive about current oral health improvement activity, particularly the Childsmile programme. All did however suggest that it would be beneficial for this input to continue beyond primary school age. The oral health improvement team do currently have some input in to health promotion activities in the secondary school setting, usually around the time of P7 transition, however it would be worth exploring opportunities for additional input, while being mindful of the finite resource available to deliver additional oral health improvement activities.

While discussion with clinical teams tended to focus on individual chairside prevention and oral health education, it is recognised that the ability to take action and make the changes which have been recommended depends on the patient's wider circumstances. Oral health promotion has an important role in developing environments which support individuals to take positive steps to improve their oral health. Clinical teams should also be encouraged to recognise challenges which may limit an individual's capacity to take on board preventive advice and aim to offer realistic goals which can be agreed with the patient.

10. Conclusion

Ongoing work is required to ensure all members of the population in the Borders benefit from the best possible standard of oral health.

The high and growing proportion of older adults is expected to introduce new challenges for oral health, both through meeting daily oral care needs and managing additional complexities of providing dental treatment.

Registration and participation with dental services is high, though there remains a significant demand from those wishing to register for NHS dental care. Access to NHS dentistry, particularly in the more remote areas is a concern both to members of the public and to dental professionals. Challenges in recruiting dentists and DCPs has the potential to further impact on availability of dental services and will require careful monitoring.

New models for providing specialist dental care are being developed and have the potential to reduce pressure on current services and increase availability of the range of specialist care offered.

A strategic plan for oral health services in the Borders will be developed to take forward recommendations from this needs assessment to continue to promote and improve oral health and to develop dental services to meet the needs of the local population.

References

1. Scottish Government (2020) Scottish Government Urban Rural Classification https://www2.gov.scot/Topics/Statistics/About/Methodology/UrbanRuralClassification

2. Scottish Government (2018) Oral Health Improvement Plan https://www.gov.scot/publications/oral-health-improvement-plan/

3. Scottish Government (2005) An Action Plan for improving oral health and modernising NHS dental services in Scotland https://www2.gov.scot/Publications/2005/03/20871/54817

4. Scottish Government (2012) Oral Health Improvement Strategy for Priority Groups https://www.gov.scot/publications/national-oral-health-improvment-strategy-priority-groups-frail-older-people-people-special-care-needs-those-homeless/pages/13/

5. Scottish Government (2018) Public Health Priorities for Scotland https://www.gov.scot/publications/scotlands-public-health-priorities/

6. National Records of Scotland (2019) Mid-2018 Population Estimates Scotland https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2018

7. Scottish Government (2019) Scottish Surveys Core Questions 2017 https://www2.gov.scot/Topics/Statistics/About/Surveys/SSCQ/SSCQ2017

8. Scottish Government (2017) Social Care Services, Scotland, 2017 https://www2.gov.scot/Topics/Statistics/Browse/Health/Data/HomeCare

9. Scottish Commission for Learning Disabilities (2018) Learning Disability Statistics 2018 https://www.scld.org.uk/2018-report/

10. Scottish Government (2019) Homelessness in Scotland 2018 to 2019 https://www.gov.scot/publications/homelessness-scotland-2018-2019/

11. Scottish Government (2019) Children's Social Work Statistics 2017-18 https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/

12. Scottish Government (2019) Criminal Justice Social Work Statistics: 2017-2018 https://www.gov.scot/publications/criminal-justice-social-work-statistics-scotland-2017-18/pages/3/

13. ISD Scotland (2019) Prevalence of Problem Drug Use in Scotland 2015-16 https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2019-03-05/2019-03-05-Drug-Prevalence-2015-16-Report.pdf

14. ISD Scotland (2019) National Drug and Alcohol Treatment Waiting Times 1 July – 30 September 2019 https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2019-12-17/2019-12-17-DATWT-Report.pdf

15. Scottish Government (2018) Scottish Health Survey: Results for local areas 2014-2017 https://www.gov.scot/publications/scottish-health-survey-results-local-areas-2014-2015-2016-2017/pages/2/

16. Scottish Diabetes Group (2019) Scottish Diabetes Survey 2018 http://www.diabetesinscotland.org.uk/Publications/Scottish%20Diabetes%20Survey%202018.pdf

17. ISD Scotland (2018) National Dental Inspection Programme (NDIP) 2018 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2018-10-23/2018-10-23-NDIP-Report.pdf

18. ISD Scotland (2019) National Dental Inspection Programme (NDIP) 2019 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-10-22/2019-10-22-NDIP-Report.pdf

19. Scottish Government (2018) The Scottish Health Survey 2017 Edition Volume 1 Main Report https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-main-report/

20. ISD Scotland (2017) Scottish Adult Oral Health Survey: Pilot Study 2016 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2017-02-21/2017-02-21-SAOHS-Report.pdf?87963503600

21. ISD Scotland (2019) Scottish Adult Oral Health Survey 2016-2018 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-04-30/2019-04-30-SAOHS-Report.pdf

22. Information Services Division Cancer Statistics Head and Neck Cancer https://www.isdscotland.org/Health-Topics/Cancer/Cancer-Statistics/Head-and-Neck/#oral

23. Public Health England (2018) Water Fluoridation Health Monitoring Report for England 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692754/Water_Fluoridation_Health_monitoring_report_for_England_2018_final.pdf

24. ISD Scotland (2019) Dental Statistics – NHS Registration and Participation. Statistics up to 30 September 2018 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-01-22/2019-01-22-Dental-Report.pdf

25. Scottish Government (2019) Statement of Dental Remuneration http://www.scottishdental.org/professionals/statement-of-dental-remuneration/

26. ISD Scotland (2019) Primary Care in Dentistry Annual Report 2018/19 https://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2019-11-26/2019-11-26-SDPB-Report.pdf

27. Bateman P., Arnold C., Brown R., Foster L.V., Greening S., Monaghan N., Zoitopoulos L. (2010) BDA Special care casemix model. British Dental Journal 208(7) pp.291-6

28. Scottish Government (2016) Health and Social Care Delivery Plan https://www.gov.scot/publications/health-social-care-delivery-plan/

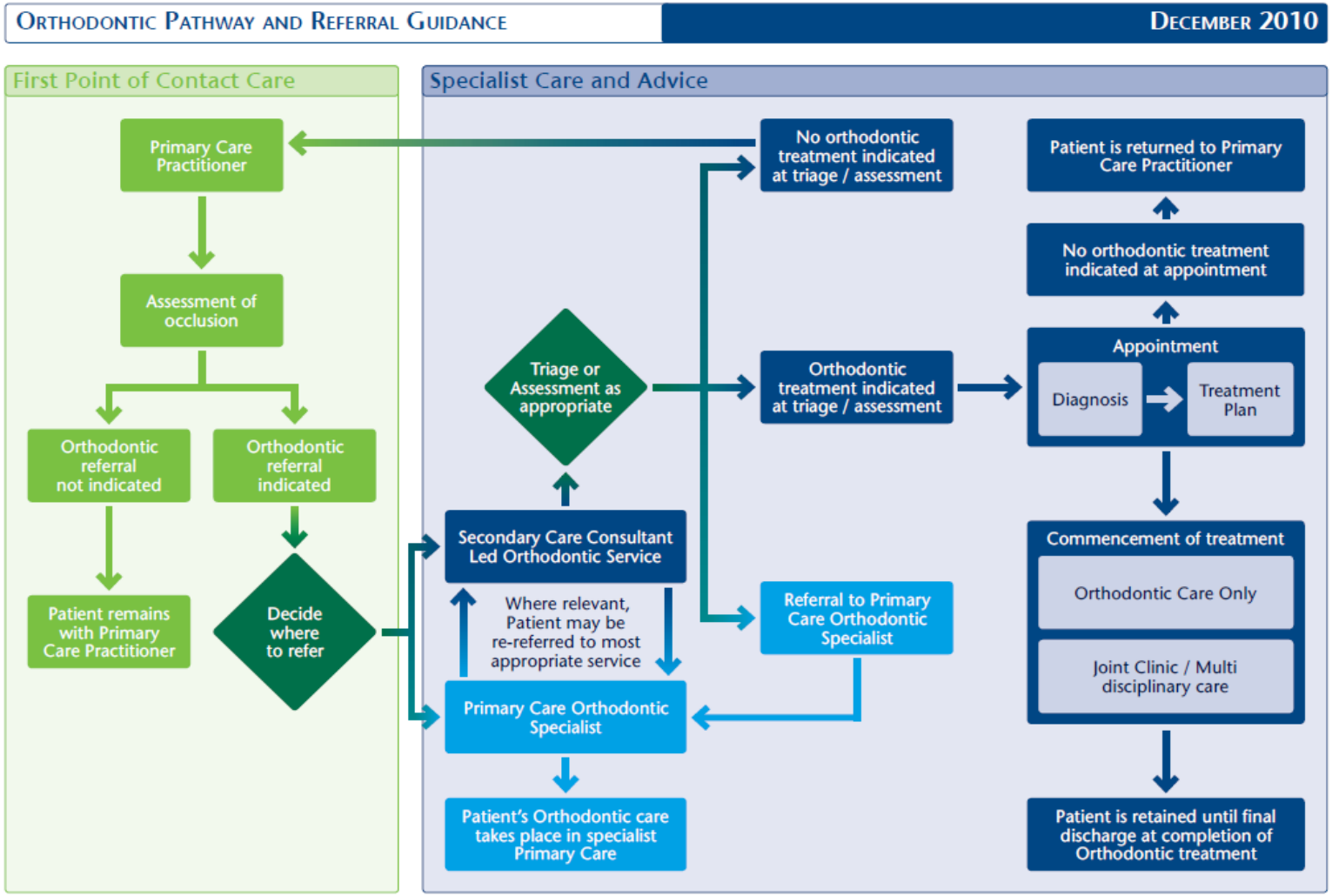
29. NHS Health Scotland (2019) Childsmile Headline Data http://www.healthscotland.com/uploads/documents/36660-Childsmile%20National%20Headline%20Data%20-%20Nov2019.pdf

30. NHS Borders (2017) NHS Borders Clinical Strategy http://www.nhsborders.scot.nhs.uk/media/502734/nhsbordersclinicalstrategy_final_aug17.pdf

Glossary

ADC	Area Dental Committee
BEDS	Borders Emergency Dental Service
BGH	Borders General Hospital
Caring for Smiles	National oral health improvement programme for dependent older people
Childsmile	National oral health improvement programme for children
CPD	Continuing Professional Development
DBC	Dental Body Corporate
DCP	Dental Care Professional, includes dental nurses, dental hygienists, hygienist therapists and dental technicians
DEL	Dental Enquiry Line
Dental caries	Tooth decay
Dental registration rate	Proportion of the population registered with an NHS dentist
Domiciliary dental care	Dental care provided in a patient's place of residence including a private dwelling or care home setting
EDDN	Extended Duties Dental Nurse
eGDP	Enhanced Skills General Dental Practitioner
EDI	Edinburgh Dental Institute
Endodontic	Involving root canals within teeth
GDP	General Dental Practitioner
GDS	General Dental Service
GHQ-12	General Health Questionnaire – A 12 question tool to screen for potential mental health conditions
HIS	Healthcare Improvement Scotland
HSCP	Health and Social Care Partnership
Hygienist-therapist	Dental Care Professional who provides items of clinical care including periodontal treatments, fillings and extraction of deciduous teeth
ISD	Information Services Division
NDIP	National Dental Inspection Programme
NHSBSA	NHS England Business Services Agency
OHIP	Oral Health Improvement Plan
OHSW	Oral Health Support Worker (also known as Dental Health Support Workers)
OMFS	Oral and Maxillo-Facial Surgery
Open Wide	National oral health improvement programme for adults with additional care needs
PDS	Public Dental Service
Participation	Proportion of patients registered with an NHS dentist who have attended within the previous 2 years
Periodontal	Relating to gums and supporting tissues around the tooth
PRG	Patient Representative Group
Prosthodontic	Relating to replacement of teeth by dentures or dental implants
Restorative Dentistry	Dental Specialty concerned with restoring teeth to function, includes periodontal, prosthodontic and endodontic treatment
SIMD	Scottish Index of Multiple Deprivation
WEMBS	Warwick Edinburgh Mental Wellbeing Scale
VDP	Vocational Dental Practitioner

Appendix 1 – Orthodontic Referral Pathway



ORTHODONTIC REFERRAL MANAGEMENT TABLE

This referral management table can be used as a basis for discussions for agreement at local level.

Presenting Condition	Main presenting problem	Referral not indicated	Refer to Specialist Practice	Refer to Hospital
Canines	Not palpable buccally 10+ years		*	
	Palatally placed on radiographs		*	*
	Cs retained, not mobile 11+ years		*	*
Cleft lip and palate and syndromes				*
Crowding	Crowding in mixed dentition	*		
Crowding in permanent dentition	Mild crowding, little significant aesthetic detriment	*		
	Mild crowding, significant aesthetic detriment		*	
	Moderate or severe crowding		*	
Hypodontia (ignore 8's)	One buccal tooth missing per quadrant		*	
	More than one tooth missing per quadrant			*
Incisor Crossbite	1 or 2 permanent incisor teeth in crossbite		*	
	3 or 4 permanent incisor teeth in crossbite		*	*
	Posterior crossbites		*	
Increased Overjet	Overjet under 6mm at any age	*		
	Overjet 6-9mm 10+ years		*	
	Overjet over 9mm 10+ years		*	*
Medical history or management issues complicating treatment		*		*
Overbite	Overbite traumatic to tissues, or open bite >3mm		*	
Problems likely to need specialist surgical or restorative care				*

This table is based on work originally developed by NHS Grampian (2009) (Modified NHS Borders, 2013)

Appendix 2 – Child Was Not Brought Policy

Title	**CNB - Child Not brought**
Document Type	**Policy**
Issue no	***DEN002/001***
Issue date	**30.05.13 (DNA policy) 20.12.16 (revised)**
Updated	**14.07.19**
Review date	**14.07.21**
Distribution	**Dental Staff Team**
Prepared by	**Children's Dental Needs Steering Group**
Developed by	**Children's Dental Needs Steering Group**
Equality & Diversity Impact Assessed	**Completed 21 April 2015** **Reviewed and updated 14 March 2016**

Children and Young People aged 0-18 years
CNB (Child Not Brought) Policy for NHS Borders Public Dental Service

The GIRFEC values and principles must be at the forefront of all interactions regarding the wellbeing of a child. While this CNB policy is designed as guidance for administration staff, it must be remembered that it is the whole dental team's responsibility to work together in the best interests of each child.

The R4 Marker system must be used for all children and young people registered within PDS in addition to text messaging, which indicates who needs a phone call reminder on the day or day before the appointment. All communication must be documented in Comms (Communications tab in R4).

Marker 2+1: All children and young people with a history of vulnerability and or poor dental attendance who should receive a call on day before or day of appointment. Any barriers to access should be noted and a referral made to Childsmile Practice if additional support needed to ensure future attendance.

Marker 2: All other children and young people.

0-5 year olds and primary school age children

If Child is not brought for 1st exam appointment a member of the admin team will attempt to make contact with parent/guardian by phone during the working day. If no contact is made with this first call, a first CNB letter will be sent out, if no response to first CNB letter, a second CNB letter will be sent 2 weeks later and the child put on a 6 month recall.

On the day of the first missed appointment for treatment a member of the admin team will attempt to make contact with parent/guardian by phone during the working day. If no contact is made with this first call, a first CNB letter will be sent out, if no response to first CNB letter, a second CNB letter will be sent 2 weeks later indicating that all future appointments will be cancelled and a referral made to Childsmile via the generic e-mail box.

If a child does not attend for 2 appointments, whether consecutive or not, or if there is a pattern of non attendance, a Childsmile referral should be completed by admin and sent to the Childsmile generic e-mail inbox, cc to the clinician responsible.

A Childsmile OHSW will respond to any referral within approx 1 month by noting all contact made in R4 Patient Comms and HIC, OHSW will also record on EMIS. If no contact has been possible an email will be sent from the OHSW to the clinician (cc admin notifying them this has been done). This ensures that any concerns regarding the patient's treatment needs will be reported to the Children and Families Social Work duty team by the clinician if deemed necessary.

Any Child referred to PDS from Childsmile who is not brought to appointments should be referred back to Childsmile.

Secondary school children and young people up to age of 18

Where possible, all correspondence for secondary school aged children or young people should be directly with the young person i.e. letter addressed directly to young person, phoning or texting a personal mobile phone number, If no contact details are available for the young person directly, then use their parent/guardian's contact details.

If a young person is not brought/fails to attend for 1st exam appointment a member of the admin team will attempt to make contact by phone with the young person or parent/guardian. If no contact is made with this first call, a first CNB letter will be sent out. If no response to first CNB letter a second CNB letter will be sent 2 weeks later and the young person will be put on a 6 month recall.

On the day of the first missed appointment for treatment a member of the admin team will attempt to make contact with the young person or parent/guardian by phone. If no contact is made with this first call, a first CNB letter will be sent out 2 weeks later indicating that a referral will be made to the staff member responsible for secondary schools and all future appointments will be cancelled.

If a young person does not attend for 2 appointments, whether consecutive or not, or if there is a pattern of non attendance, a referral should be completed and sent to the staff member responsible for secondary schools (cc to the clinician responsible).

The staff member responsible for secondary schools will respond to any referral within approx 1 month by noting all contact made in R4 Patient Comms. If no contact has been possible an email will be sent to the clinician (cc to admin notifying them this has been done). This ensures that any concerns regarding the patient's treatment needs will be reported to the Children and Families Social Work duty team by the clinician if deemed necessary.

All children and young people aged 0-18 years

If the clinic is unable to make contact by phone, details will be entered on the CNB spreadsheet, which will be reviewed monthly by admin team to ensure all appropriate action has been taken regarding the child's attendance and that all documentary evidence is in the R4 notes, this will support and evidence all contact made by the PDS ensuring the child/young person does not fall through the safety net.

After 6 months and 12 months a letter will be sent inviting the young person or their parent/guardian to contact the clinic to make an appointment. If the young person or parent/guardian does not make contact, no further letter will be sent or contact made, though the child/young person will remain registered and able to access dental care until they are 18.

When the child/young person reaches the age of 18, a letter will be sent to them asking if they still wish to be registered with our service, and if so, to contact the dental clinic. If they do not contact us, they will be de-registered, and removed from the child not

brought spreadsheet.

Practitioner Services will inform the Public Dental Service (through the dentist's monthly schedule) if a child or young person becomes registered elsewhere, when picked up this must be noted on R4.

All dental team members must log every attempt to contact patients on R4 Comms - this supports chronologies outlining support given, should there be a need for a child/young person concern meeting.

If any child referred into the Public Dental service from a General Dental Practitioner does not attend their appointment they should be referred back to the referrer by a member of the admin team, any appeal on this action would be given consideration on a basis of individual need.