Scotland's Oral Health Plan

A Scottish Government Consultation Exercise on the Future of Oral Health.

ANALYSIS OF RESPONSES

Healthier Scotland
Scottish Government

ACKNOWLEDGEMENTS

We would like to take this opportunity to thank the facilitators who gave their time and expertise to ensure the success of the roadshow events.

We would also like to thank the Scottish Health Council for undertaking a series of targeted patient engagement events across Scotland on behalf of Scottish Government.

We would like to thank everyone who contributed to this consultation process.

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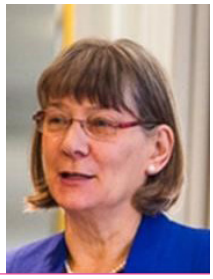
Chief Dental Officer Foreword



The landscape in NHS dentistry and oral health has improved significantly.

Our Childsmile programme has made excellent progress in improving the oral health of young children. The latest National Dental Inspection Programme (2016) showed that 69 per cent of primary 1 children in Scotland had 'no obvious decay experience', compared with 54 per cent in 2006. We have also seen similar progress amongst primary 7 children.

Access to NHS dental services is at its highest ever level, and there has been a 30 per cent increase in dentists providing NHS dental services since 2007.

However, it is important we recognise that significant challenges still remain. There are complex challenges around addressing oral health inequalities; meeting the needs of an ageing population; and moving from restorative dentistry to a more preventive-focused approach.

The consultation, 'Scotland's Oral Health Plan', was the first step in addressing these challenges. It was an opportunity for engagement and enabled us to listen to the views of the public, the dental team, and other health professionals, as well as the wider NHS, on how we should take NHS dental services forward to meet these challenges.

To reach as many people as possible we published an online consultation; held a series of roadshow events for dental professionals; and a series of public focus groups. We received, 427 responses to the consultation; 564 attendees across a series of roadshow events; and 113 members of the public participating in focus group events.

This document summarises the analysis of responses from the consultation and the roadshow events. The findings of the patient focus groups, conducted by the Scottish Health Council on behalf of the Scottish Government, has been published as a separate document.

The next step in addressing these challenges will be to produce an Oral Health Improvement Plan which will provide NHS dentistry with a new overarching approach. Prevention must be at the forefront of these plans, recognising that stakeholders – individuals, carers, parents, teachers at all levels, health and social care staff and the dental team – all need to contribute to good oral health outcomes. The Oral Health Improvement Plan will be about addressing new challenges so that patients and service providers have confidence there is strategic leadership and direction from the Scottish Government for the future of NHS dental provision. The intention is to publish the Oral Health Improvement Plan by the end of the year.

Margie Taylor
Chief Dental Officer

1 Analysis of Responses

Methodology

The consultation asked respondents a variety of questions relating to the proposals outlined in Scotland's Oral Health Plan. The majority of the questions were closed, inviting respondents to either agree, disagree, or neither agree nor disagree with the proposal outlined. Other formats utilised included: questions asking respondents to select their preferred option from a predetermined list; ranking items in order of importance; and a free text question allowing respondents to address any other concerns. For each question, regardless of format, respondents were able to provide free text comments to discuss their response and views on the proposals. The inclusion of free text comments for each question resulted in the need for a qualitative analysis of the responses to complement the statistics provided by the closed questions.

The statistics were automatically compiled by the consultation platform reflecting the options respondents selected. A framework was developed to carry out the qualitative analysis of the comments to ensure that all the responses were treated consistently. The comments discussed in the following sections are based on the most common themes that respondents choose to discuss in response to each question. However, a number of respondents did not use the questionnaire, instead submitting written papers based around the themes in the consultation document. As a result these returns were analysed as part of the final free text response.

Please note that the qualitative analysis is based solely on the comments provided, the number of which varied widely per question, and therefore the views expressed are not necessarily representative of the wider population.

Overview of Responses

The consultation platform received a total of 427 responses. Of these 347 were from individual respondents and 80 from organisations. Individual respondents were asked to select whether they were responding as a member of the public or one of a variety of dental professionals. The breakdown of respondents by category is as follows:

Responding as	Number of Respondents
Organisation	**80 (19%)**
Individual	**347 (81%)**
Member of the public	45 (11%)
Dentist	34 (8%)
Dentist – Practice Owner	95 (22%)
Dentist – Associate	67 (16%)
Dentist – Assistant	4 (1%)
Dentist – Hospital Dental Service	9 (2%)
Dentist – Public Dental Service	36 (8%)
Dental Care Professional	32 (7%)
Other	24 (6%)
Declined to specify	1 (0.2%)

Note: Percentages may not total 100 due to rounding.

Part A: Improving Oral Health

Question 1: Which of the following would you regard as the most important? (Please rank 1-3, in order of importance)

Of the 427 consultation responses, 403 respondents answered this question (94% response rate) and of those, 148 provided comments.

Option	1st choice	2nd choice	3rd choice	Total
Access to NHS dental services	147 (34%)	62 (15%)	59 (14%)	268 (63%)
Cost of NHS dental services	27 (6%)	49 (11%)	64 (15%)	140 (33%)
Services closer to your home address	2 (1%)	17 (4%)	18 (4%)	37 (9%)
Child dental services	32 (7%)	52 (12%)	43 (10%)	127 (30%)
Ageing population/domiciliary dental care	17 (4%)	47 (11%)	56 (13%)	120 (28%)
Oral health inequalities	53 (12%)	64 (15%)	73 (17%)	190 (45%)
Quality of NHS dental care	110 (26%)	101 (24%)	66 (15%)	277 (65%)
Other	15 (4%)	7 (2%)	16 (4%)	38 (9%)
Not answered	24 (6%)	24 (6%)	24 (6%)	24 (6%)

Note: Percentages do not total 100 as more than one option could be selected.

Summary of Responses

Of the respondents who selected 'other', a variety of issues were raised as the most important, including: remuneration and general funding for dental services; a focus on preventive dentistry; ensuring access to appropriate services for patients with additional support needs; and providing a range of treatments and services for all patients.

Of the comments provided, a substantial number of respondents expressed the view that all the options listed were equally important, with a small number also noting that they are all inter-linked, making them very difficult to rank. A few respondents noted that ranking them may not be appropriate. For these reasons some respondents chose only to rank one or two options, or not to rank any of them.

A large number of respondents commented that NHS dentistry needs to focus on prevention going forward, suggesting that this will help to address oral health inequalities, particularly in relation to children in order to build good dental habits early. Public health measures, such as sugar tax, water fluoridation, and education campaigns, were also suggested by a number of respondents as being beneficial for improving oral health.

A number of respondents also commented on the current level of remuneration, suggesting that fees are too low to be able to provide a high quality service to patients and maintain practice viability.

A Preventive-Based Approach to Oral Health Care

At present the balance of dental provision rests with restorative procedures. However, we have observed in recent years improvements in the oral health of the population, particularly children whose oral health has benefited as a consequence of the interventions of the Childsmile programme.

The consultation document introduced a number of models of how NHS dental services might be delivered in the future, including a preventive care pathway, initially for children and younger people with good, stable oral health, that would grow up with the patient. The emphasis would be on the maintenance of oral health preventing disease before it occurs in the mouth. The consultation document also offered the prospect of an Oral Health Risk Assessment (OHRA), initially at 18 years of age, but eventually at regular intervals. This would ensure that patients receive oral health advice based on their lifestyles.

Question 2(a): NHS dental services should increasingly focus on prevention. Agree or Disagree?

Of the 427 consultation responses, 406 respondents answered this question (95% response rate) and of those, 193 provided comments.

Option	Number of respondents
Agree	353 (83%)
Disagree	14 (3%)
Neither agree nor disagree	39 (9%)
Not answered	21 (5%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

As well as indicating support, a substantial number of respondents who agreed, chose to highlight important issues such as the link between oral and general health. Some respondents discussed wider public health measures such as water fluoridation and sugar tax.

A large number of respondents who agreed, also used this opportunity to acknowledge the success of the Childsmile programme, and how this might be extended to other age groups. Other respondents emphasised the increasing need for more periodontal treatment.

While there was consensus amongst respondents that there should be an increasing emphasis on prevention, some comments from those who agreed highlighted the importance of adequately resourcing any substantial policy shift.

There was a feeling across respondents that dentists should be adequately remunerated for carrying out preventive work. A small number of those who neither agreed nor disagreed were of the view that preventive approaches were already happening.

Question 2(b): The Scottish Government should introduce a preventive care pathway. Agree or Disagree?

Of the 427 consultation responses, 408 respondents answered this question (96% response rate) and of those, 190 provided comments.

Option	Number of respondents
Agree	280 (66%)
Disagree	45 (11%)
Neither agree nor disagree	83 (19%)
Not answered	19 (4%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Whilst there was a high level of support for this proposal, a number of those who agreed queried whether it would be possible to run two systems concurrently, and the precise mechanism for a patient moving between the two systems. A number of those who agreed also expressed concerns regarding how a preventive pathway would be funded, and how dentists would be remunerated.

Amongst those respondents who disagreed with the proposal, there was concern that too much emphasis was being placed on the dentist or dental treatment, and there needs to be more recognition that the patient has a significant responsibility for their own oral health. A small number of those who disagreed also raised questions about how a dentist would be rewarded for maintaining and improving oral health, particularly in deprived areas.

Question 2(c): Which group(s) of patients should a preventive care pathway be applied to in the first instance? (Please indicate a preferred option)

Of the 427 consultation responses, 403 respondents answered this question (94% response rate) and of those, 160 provided comments.

Option	Number of respondents
Only for children	35 (8%)
Start with children and extend to adults gradually	129 (30%)
Children and some adults	61 (14%)
From all dental patients from the start	151 (35%)
Other	27 (6%)
Not answered	24 (6%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

For those respondents who favoured the introduction of a preventive care pathway for all patients, there was concern that adults may be excluded from a preventive approach if the focus remained primarily on children. Those who favoured the children-first approach were concerned that more radical change could destabilise existing systems of care and that any change needs to be carefully managed through an evolutionary approach.

Although these two groups of respondents disagreed on how quickly a preventive care pathway could be introduced for adults, there does appear to be a consensus that the pathway should be introduced for children.

Question 3(a): In the future it would be beneficial to introduce an Oral Health Risk Assessment. Agree or Disagree?

Of the 427 consultation responses, 407 respondents answered this question (95% response rate) and of those, 205 provided comments.

Option	Number of respondents
Agree	297 (67%)
Disagree	44 (10%)
Neither agree nor disagree	66 (15%)
Not answered	20 (5%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

A number of respondents from across the spectrum commented that OHRAs are already being carried out as part of NHS dental care. There was some uncertainty amongst respondents about the exact meaning of an OHRA and the challenge will be for the Scottish Government to articulate its proposals as part of the forthcoming Oral Health Improvement Plan.

A large number of respondents who agreed expressed concerns around the time it might take to carry out this assessment, what it should include, how it might be implemented, and how it can evolve in the future taking cognisance of the latest evidence in dental care and treatment. Respondents who agreed were also of the view that dentists should be adequately remunerated for carrying out an OHRA. Some of those who agreed also provided suggestions about what should be included within the OHRA. This included an emphasis on smoking, diet and alcohol intake.

Question 3(b): If the Scottish Government introduced OHRAs, at what age should patients first receive an OHRA? (Please indicate a preferred option)

Of the 427 consultation responses, 382 respondents answered this question (89% response rate) and of those, 215 provided comments.

Option	Number of respondents
18 years of age	166 (39%)
21 years of age	16 (4%)
25 years of age	13 (3%)
Other	187 (44%)
Not answered	45 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst the respondents who selected 'other' and from '18 years of age' a large number of the comments suggested that the Scottish Government should consider introducing OHRAs at an earlier age. There was a sense that an OHRA would be more cost effective for younger patients, and if the decision of the Scottish Government is to introduce these assessments, then it should consider introducing them at an earlier point than 18 years of age.

Question 3(c): How often do you think OHRAs should be repeated? (Please indicate a preferred option)

Of the 427 consultation responses, 383 respondents answered this question (90% response rate) and of those, 236 provided comments.

Option	Number of respondents
Every 5 years	146 (34%)
Every 10 years	12 (3%)
Other	225 (53%)
Not answered	44 (10%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst those who chose 'other', a large number of respondents were of the view that the interval between assessments should be determined by the oral health of the patient rather than a set time. A number of respondents who selected 'other' also suggested it should be more frequent than five years.

Enhanced Services

The consultation document introduced the concept of enhanced services in the following areas:

- domiciliary care (complex cases);
- oral surgery (complex extractions);
- restorative services (complex treatment);
- treatment under intravenous sedation; and,
- orthodontics.

At present many of these services are largely provided by the Hospital and Public Dental Services. These proposals envisage that in the future some of these services could be provided by dentists with enhanced skills operating out of a general dental practice setting.

Question 4(a): Complex treatments should be delivered more frequently by a local dental practice. Agree or Disagree?

Of the 427 consultation responses, 403 respondents answered this question (94% response rate) and of those, 259 provided comments.

Option	Number of respondents
Agree	222 (52%)
Disagree	73 (17%)
Neither agree nor disagree	108 (25%)
Not answered	24 (5%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Respondents who agreed with this proposal also chose this opportunity to express a number of reservations, including the need for appropriate training, equipment, adequate funding, and the potential role of Health and Social Care Partnerships (HSCPs) in strategic planning and commissioning of these services. A number of respondents who agreed were of the view that a move to complex treatments being provided in local practices would improve patient access to NHS dental care.

For respondents who disagreed there was concern expressed regarding funding arrangements and the training and experience required to carry out certain complex treatments. Some respondents who disagreed were also of the view that certain complex treatments should be carried out within secondary care due to the resources and equipment available within hospital settings.

Those who selected 'neither agree nor disagree' were also concerned about funding arrangements, and training and experience. These respondents also requested more detailed information about the proposal.

Question 4(b): Which treatments should be delivered in this way? (Please tick all that apply)

Of the 427 consultation responses, 387 respondents answered this question (91% response rate) and of those, 146 provided comments.

Option	Number of respondents
Domiciliary care (care in your own home, or care home)	210 (49%)
Certain oral surgery procedures, such as complex tooth extractions	259 (61%)
More advanced dental restorations such as complex root canal treatment	234 (55%)
Treatment under sedation	229 (52%)
Orthodontic treatment	222 (52%)
Other	62 (15%)
Not answered	69 (16%)

Note: Percentages do not total 100 as more than one option could be selected.

Summary of Responses

Respondents were able to select more than one option for their response, which many of them chose to do.

The issues raised within the comments included the training requirements for carrying out certain complex treatments, views that the current fees are not appropriate for the complexity of these treatments, and concerns about the wider financial implications of carrying out these treatments in a general dental practice setting.

Some respondents chose to discuss the role of specialists, particularly in relation to orthodontics. These respondents stated that orthodontic treatment should only be provided by specialists. Other respondents noted that there will always be a need for some treatments to be carried out in a hospital setting by specialists.

Although the difference between the most and least favoured option is around 10 percentage points, domiciliary care came out bottom of the list of choices presented to respondents. This is possibly explained in the comments that a number of dentists made about the particular challenges of domiciliary care, including the time and equipment required to carry out a domiciliary visit.

Some respondents discussed the role of the Public Dental Service (PDS) in providing complex treatments, with many commenting on the experience and expertise within the PDS, particularly in relation to treating complex patients. Respondents also commented that should local practices provide more complex treatments this would reduce the strain on the PDS.

Patient Charges

At present children and young people under 18 years of age are entitled to free NHS dental treatment, while all adults receive free NHS examinations. An adult patient is required to pay 80 per cent of the cost of their NHS dental treatment up to a maximum of £384 per course of treatment unless they are in one of the groups entitled to free NHS dental treatment or qualify for help towards the cost under the NHS Low Income Scheme.

The consultation document acknowledged that NHS dental charges can be complicated for the patient, and because they are linked to the amount of care and treatment received, vary substantially. In view of these difficulties, the consultation exercise offered the prospect of a simpler system of charges, particularly for adult patients who may in the future qualify for a preventive care pathway.

Question 5: The existing system of NHS dental charges needs to be simplified. Agree or Disagree?

Of the 427 consultation responses, 406 respondents answered this question (95% response rate) and of those, 230 provided comments.

Option	Number of respondents
Agree	244 (57%)
Disagree	91 (21%)
Neither agree nor disagree	71 (17%)
Not answered	21 (5%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst those wishing to see a simpler system of charges, a substantial number of respondents recognised that the Statement of Dental Remuneration (SDR) would benefit from a degree of simplification, both in terms of the number of items, and the complex provisos related to each item.

A large number of respondents who agreed, and those who disagreed, felt that the current remuneration level is too low and that it should reflect the cost of materials, equipment and laboratory costs. There was a sense that the system of payment restricts the clinical freedom of the dentist, and more opportunity should be available in the future for dentists to provide patients with treatments that are appropriate for them. Additionally, a few PDS dentists commented that the current set of items of treatment do not adequately reflect the complexity of the work they routinely carry out.

For those who disagreed with the need to simplify charges a number believe that the current system works, with a few arguing that the complexity reflects the natural complexity of dental treatment. It was suggested that simplification can lead to a whole range of unintended consequences, including inequitable outcomes for patients.

A large number of respondents who disagreed and those who neither agreed nor disagreed were concerned this might mean a move to a system similar to that adopted in England, where dentists receive payments for 'units of dental activity'. There was concern that change, particularly something that duplicated the arrangements in England, could lead to a deterioration in the oral health of patients.

Of those who neither agreed nor disagreed a number of respondents acknowledged the complexity of the current system with some suggesting that it needs to reflect the complexity of modern dental treatment. A small number of respondents felt that it is not the charges that need simplified but the SDR itself, with unused codes being removed and items updated.

Part B: Arrangements for General Dental Services

The consultation document afforded the opportunity for discussion around the future administrative arrangements governing General Dental Services (GDS). At present NHS Boards are responsible for a range of administrative functions including holding the dental lists of contractors and assistants, practice inspections, NHS Discipline and Tribunal cases and General Dental Council (GDC) referrals.

The particular proposal in the consultation was that some or all of these functions could be carried out by a national body.

Question 6: A range of 'shared services', currently provided by NHS Boards, should be provided by a national body. Agree or Disagree?

Of the 427 consultation responses, 379 respondents answered this question (89% response rate) and of those, 152 provided comments.

Option	Number of respondents
Agree	127 (30%)
Disagree	92 (22%)
Neither agree nor disagree	160 (37%)
Not answered	48 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst a number of those respondents who agreed, and those who neither agreed nor disagreed, there was a sense that a national body could allow for greater consistency in the application of rules, and more standardisation in the services provided across NHS Board areas than happens at present. A variety of potential services were suggested by a number of respondents who agreed and neither agreed nor disagreed, including: listing; vaccination checking; pre-employment checks, such as Protecting Vulnerable Groups (PVG); and NHS Discipline and Tribunals.

A few of the respondents who disagreed believed that there would be no advantage to the proposal. Whilst others suggested that dentistry could learn from the administration of medical services, both in terms of the methods used to share information and in having a more standardised approach to listing.

The importance of local knowledge and concerns about its loss were emphasised across all respondents. A number of those who agreed with the proposal highlighted that a national body would need to take cognisance of local knowledge whereas amongst those who disagreed, a large number of respondents felt that NHS Boards know their areas and are in a better position to meet local needs.

Question 7: Which duties could be taken on by this national body? (Please tick all that apply)

Of the 427 consultation responses, 298 respondents answered this question (70% response rate).

Option	Number of respondents
Hosting dental lists	68 (16%)
Practice inspections	56 (13%)
NHS Discipline and Tribunals	43 (10%)
GDC referrals	37 (9%)
Other	94 (22%)
Not answered	129 (30%)

Note: Percentages may not total 100 due to rounding.

Of the 298 responses to this question 105 respondents provided comments. Most of the respondents who commented were selecting additional duties, as due to technical difficulties with the consultation platform only one option could be selected. To take these comments into consideration a manual recalculation of the support for each option, based on original choice selected and additional choices reflected in comments, has been carried out. The breakdown of this recalculation is as follows:

Option	Number of respondents
Hosting dental lists	111 (26%)
Practice inspections	95 (22%)
NHS Discipline and Tribunals	81 (19%)
GDC referrals	83 (19%)
Other	56 (13%)
Not answered	129 (30%)

Note: Percentages do not total 100 as more than one option could be selected.

Summary of Responses

A substantial number of respondents stated that they wanted to select all of the duties listed. Of the respondents who selected 'other', a large number suggested that there should not be a national body, whilst a small number commented that they needed more information about the proposal before options could be chosen. A small number of respondents were unsure or felt they did not know enough about the duties to make a decision. A variety of other services which could be provided by a national body were suggested by a few respondents, including: listing; NHS Discipline and Tribunals; and GDC referrals.

Contractual Arrangements for Practice Owners

The consultation document identified a number of specific areas for consideration, including whether there should be a formal written contract between the NHS Board and practice owners. At present rather than a written contract, NHS Boards make 'arrangements' with dentists or Dental Bodies Corporate (DBsC) to provide a service. A contract was thought to offer transparency of obligations and requirements on both sets of contractual parties.

Question 8: A formal contract should be introduced between NHS Boards and the practice owner(s). Agree or Disagree?

Of the 427 consultation responses, 379 respondents answered this question (89% response rate) and of those, 169 provided comments.

Option	Number of respondents
Agree	172 (40%)
Disagree	91 (21%)
Neither agree nor disagree	116 (27%)
Not answered	48 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

The need for more information was a dominant theme across all respondents but particularly amongst those who neither agreed nor disagreed with the proposal.

A number of those respondents who agreed with the proposal tended to see a contract as an opportunity to clarify the role of the NHS Board and practice owner; help to clarify liability and accountability; and identify who owns a practice and has responsibility for its day-to-day running. A few respondents felt that individual clinicians should still retain a degree of responsibility. Some general concerns about DBsC and how a contract would work in relation to DBsC were raised by a small number of respondents.

The potential for the proposal to lead to 'control of entry' was viewed positively by a small number of respondents who agreed and those who neither agreed nor disagreed. This would allow NHS Boards to better manage supply of practices and service delivery.

Amongst a number of those who disagreed with the prospect of a contract, there was a sense that this might become something similar to the arrangements in England with tendering for NHS dental services. A small number of those who disagreed expressed concern about the precise balance of professional responsibility between the individual dentist and practice owner, fearing the implications this could have on the employment status of associates. A small number of respondents felt that the arrangements at present effectively amount to a contract between the NHS Board and provider and this system should be continued.

Patient Registration

Patients currently register with an individual dentist. However, there are some circumstances where registration with a dentist may be problematic, for example, in the event that the dentist leaves the practice. Registration with the practice affords a number of advantages. This would ensure that in the event a dentist leaves the practice, patients would continue to be registered with the practice. At present a patient may have to register with another dentist in the practice or with another practice in these circumstances.

Question 9: Patients should be registered with the dental practice. Agree or Disagree?

Of the 427 consultation responses, 380 respondents answered this question (89% response rate) and of those, 164 provided comments.

Option	Number of respondents
Agree	254 (59%)
Disagree	78 (18%)
Neither agree nor disagree	48 (11%)
Not answered	47 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst a number of respondents who supported this proposal, there was a sense that this might enhance continuity of care, particularly when a dentist leaves the practice. Whilst a small number felt that the arrangement already exists, or for all intents and purposes, this is what happens in their experience. Concerns were raised about the impact of lifetime registration, with a small number suggesting that patients should have to attend regularly over a specified period of time to remain registered.

A large number of respondents who disagreed felt that patients should continue to be registered with an individual dentist, as they are the person responsible for the care of the patient. Concerns about what effect this change would have on the patient-dentist relationship and the impact of these proposals on the precise balance of payments that went to the practice and the individual practitioners working in the practice were raised by a number of respondents.

Concern about remuneration and the balance of payments and the view that this arrangement already exists was reiterated by a small number of those respondents who neither agreed nor disagreed with the proposal. Questions were raised over responsibility, with a few respondents believing that practices are already obligated to provide continuing care in the case of a dentist leaving and others suggesting the proposal could ensure accountability and be reassuring for patients.

Question 10: Patients should have a responsible dentist. Agree or disagree?

Of the 427 consultation responses, 383 respondents answered this question (90% response rate) and of those, 134 provided comments.

Option	Number of respondents
Agree	302 (71%)
Disagree	33 (8%)
Neither agree nor disagree	48 (11%)
Not answered	44 (10%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

A substantial number of comments, from respondents across all three groups, reflected the link between responsibility and registration, with a large number suggesting that the person with whom the patient is registered is their 'responsible dentist'. The view that having a 'responsible dentist' is something that already happens within the current system was also highlighted by a large cross section of respondents.

Amongst those who supported the proposal a substantial number of respondents emphasised its importance for continuity of care, and building a strong dentist-patient relationship, with many patients preferring to see the same dentist at every visit.

Of those who disagreed a few respondents noted that having a 'responsible dentist' is not necessary as this is not an arrangement that exists with GPs where patients are registered with the practice. The need for more information was highlighted by a few respondents who neither agreed nor disagreed with the proposal.

Earnings and Expenses Information

This section links to recent exercises by the Scottish Government to obtain earnings and expenses information of dentists in Scotland. Under the auspices of the Doctors' and Dentists' Review Body (DDRB) the Scottish Government conducted two separate earnings and expenses exercises for the 2016 and 2017 DDRB reports. In view of the difficulties of obtaining this information, the consultation document was a useful vehicle to explore the possibility of making the supply of earnings and expenses a terms of service requirement.

Question 11: The provision of earnings and expenses information should be a terms of service requirement. Agree or Disagree?

Of the 427 consultation responses, 370 respondents answered this question (87% response rate) and of those, 136 provided comments.

Option	Number of respondents
Agree	118 (28%)
Disagree	143 (33%)
Neither agree nor disagree	109 (26%)
Not answered	57 (13%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst respondents who agreed, a small number stressed that it was important to have transparency around earnings paid through public money to avoid suspicion and demonstrate the position clearly to DDRB. A small number of respondents noted that care would be needed when interpreting financial data, as practices operate using a variety of different business models and arrangements, with a few also noting that there would need to be appropriate measures in place to ensure confidentiality.

A substantial number of respondents who disagreed with the proposal felt strongly that they should not be required to share commercially sensitive earnings and expenses information as, in their view, dental practices are private, independent companies. A small number also noted that the proposal feels unnecessarily invasive. A number of respondents took the view that this information is already available from a variety of sources, including HMRC and the payments schedules held by Practitioner Services Division (PSD).

Amongst those who neither agreed nor disagreed a small number of respondents reiterated the view that this information is already available from a variety of sources. In discussing the need for transparency, a few respondents noted that it would be fair to have greater transparency around NHS earnings and expenses whilst others highlighted the view that the system used to gather the information needs to be transparent. A number of respondents also highlighted the need for more information, with some raising concerns about the purpose of the proposal and others noting that they did not understand the question.

Future Provision

The consultation document includes a number of proposals around responsibility for patients, including the prospect that DBsC would be required to list, and that GDC-registered practice owner(s) or director(s) would be required to provide a minimum number of hours of NHS clinical care per week in each practice. The intention behind these proposals is to ensure greater clarity of responsibility for patient care, and a stronger connection between practice ownership and the actual provision of clinical care to the local community being served by the practice.

Question 12: GDC-registered practice owners or GDC-registered directors of a dental practice should be required to provide a minimum number of hours of NHS clinical care per week in each practice location. Agree or Disagree?

Of the 427 consultation responses, 379 respondents answered this question (89% response rate) and of those, 181 provided comments.

Option	Number of respondents
Agree	170 (40%)
Disagree	150 (35%)
Neither agree nor disagree	59 (14%)
Not answered	48 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst those that agreed with this proposal, a small number felt that it would help address concerns relating to DBsC, be beneficial in improving patient care, and ensure that the owner was more in touch with the actual day-to-day running of the practice.

A large number of those that disagreed were concerned that the proposal was impractical and was unfair on practice owners, particularly those with multiple practices. A number of respondents were concerned that such a proposal was designed to address problems with DBsC but if enacted many would be unable to meet the requirement.

A number of respondents who neither agreed nor disagreed reiterated the view that the proposal was impractical, with a small number acknowledging that whilst there are issues with DBsC this proposal may not be the best way to deal with them. In discussing the impact on patient care a small number of respondents debated whether the proposal would be beneficial, ensuring owners were involved, or detrimental, as dentists would have limited time at each location.

Question 13: Bodies corporate must list with the NHS Board for the provision of GDS. Agree or Disagree?

Of the 427 consultation responses, 378 respondents answered this question (89% response rate) and of those, 78 provided comments.

Option	Number of respondents
Agree	280 (66%)
Disagree	15 (4%)
Neither agree nor disagree	83 (19%)
Not answered	49 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Of those who supported this proposal a number of comments reflected concerns with governance under the DBsC model and the lack of transparency in many cases with ownership. A small number of respondents viewed this proposal as an opportunity to standardise the listing, management and governance of DBsC and ensure accountability alongside other practices who subscribe to an independent contractor model.

Of those who neither agreed nor disagreed with the proposal a small number of respondents felt that they did not fully understand the question, highlighting the need for more information about the purpose of the proposal. A few respondents noted that some of the other proposals in the document would provide clarity over practice ownership, whilst others felt that rules should be applied equally to DBsC and individual owners. Concerns regarding the DBsC model were also reiterated by a few respondents.

Allowances

The General Dental Practice Allowance (GDPA) is paid for practice expenses (i.e. to help address increasing requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision). All practices which provide GDS are entitled to receive 6 per cent of accumulative gross earnings paid through GDPA, while practices that are deemed NHS committed are entitled to an additional 6 per cent (12 per cent in total)[1]. A practice that is NHS committed is also entitled to reimbursement of rent, abated by the proportion of NHS to total earnings.

For a non-specialist practice to be NHS committed, it must ensure that:

- all dentists provide GDS to all categories of patients;
- there is an average of at least 500 patients per dentist accepted for care and treatment, of which at least 100 per dentist must be fee paying adults; and,
- the dentists in the practice have average gross earnings of £50,000 or above per dentist during the last 12 month period.

A range of individual allowances are payable to dentists including commitment and seniority payments, payments for vocational trainers, maternity, paternity and adoptive leave, remote areas, recruitment and retention, and Continuing Professional Development (CPD) and clinical audit.

It is the Scottish Government's view that we need to work towards a reduced number of allowances, including a new practice allowance and a new allowance payable to dentists, that reward the level of NHS commitment and quality of service provided.

1 A practice is entitled to an additional allowance of 3 per cent (9 per cent in total) if the practice satisfies the requirement of an average of at least 500 registered patients per dentist.

Question 14: There should be a reduced set of allowances, including a new practice allowance and GDP allowance, that reward the level of NHS commitment and quality of service provided. Agree or Disagree?

Of the 427 consultation responses, 374 respondents answered this question (88% response rate) and of those, 186 provided comments.

Option	Number of respondents
Agree	157 (37%)
Disagree	93 (22%)
Neither agree nor disagree	124 (29%)
Not answered	53 (12%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

The need for more information was highlighted by a substantial number of respondents, particularly those who neither agreed nor disagreed with the proposal. A large number of those respondents who agreed with the proposal reflected on what elements allowances should reward, with some support for linking any future allowance to NHS commitment and quality. Other suggestions included: length of service, learning through CPD, postgraduate qualifications, and Dental Reference Officer (DRO) scores. A number of respondents were concerned that these proposals might result in a reduction in the amount of money that in future would be provided through allowances, emphasising that the system should be simplified rather than a reduction in funding to ensure the stability of practices.

For those respondents who disagreed with the basic proposal, a large number strongly highlighted the fact that many practices rely on allowances to maintain their financial viability. A number of respondents queried what measures or criteria would be used to determine quality and how this would be defined. There was some discussion by a small number of respondents of the view that item of service fees are too low.

Concerns were reiterated by a number of respondents who neither agreed nor disagreed that many practices rely on allowances to maintain their financial viability and that the proposal signalled a reduction in the overall value of funding, which it was stressed would have a negative impact on practices. A number of respondents also discussed what elements allowances should reward, favouring commitment and quality, potentially in combination.

Question 15: There should be a new qualification criteria to determine which practices are NHS committed. Agree or Disagree?

Of the 427 consultation responses, 371 respondents answered this question (87% response rate) and of those, 151 provided comments.

Option	Number of respondents
Agree	193 (45%)
Disagree	63 (15%)
Neither agree nor disagree	115 (27%)
Not answered	56 (13%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Amongst those who agreed with the proposal, a number of respondents speculated about potential suitable criteria for the determination of NHS commitment. A number of suggestions were made, including the number of patient registrations; the level or range of monitored treatment activity; and a minimum level of patients per surgery. There was a feeling practices that only offered NHS treatment to children or exempt adults should not qualify as NHS committed.

A small number of those who agreed also expressed the view that the current criteria of NHS commitment is unfair, the qualification threshold is set too low, and is easily manipulated by practices with business models that include a small amount of NHS exposure. It was also suggested by a small number of respondents that commitment criteria should be reviewed as part of a wider review of the whole remuneration system.

Of those respondents who disagreed with the proposal a small number expressed the view that the current system works well enough. Whilst others highlighted the view that it penalises practices for even a small amount of private treatment when they are otherwise NHS committed. Suggestions for alternative qualification criteria were made by a few respondents and included basing commitment on offering a full range of treatment; the percentage of patients registered; or having additional commitment payments for those in deprived areas.

Of those who neither agreed nor disagreed with the proposal, concerns that patients opting for private treatments could adversely affect commitment levels for practices which are largely NHS was highlighted by a few respondents. It was also noted by a few respondents that comparing NHS earnings to private is not always representative of commitment to the NHS and that practices need appropriate levels of funding to be able to provide high quality care. There was also a concern that changing the criteria would be used to make financial savings.

Finance

This particular proposal is linked to the earlier proposal to introduce a range of enhanced services within a national framework. At present the budget for GDS is held centrally by the Scottish Government and the consultation document proposed that there may be opportunities in the future to devolve some funding streams to NHS Boards and HSCPs, particularly any future funding stream connected with enhanced service delivery.

Question 16: The control of funding for NHS dental services should be gradually devolved to HSCPs. Agree or Disagree?

Of the 427 consultation responses, 375 respondents answered this question (88% response rate) and of those, 146 provided comments.

Option	Number of respondents
Agree	42 (10%)
Disagree	178 (42%)
Neither agree nor disagree	155 (36%)
Not answered	52 (12%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Of those respondents who disagreed and neither agreed nor disagreed with the proposal, a large number expressed concern over the security of the devolved funding and whether in the future NHS Boards or HSCPs would use this funding for priorities outside dentistry. A large number of respondents were also concerned about the level of understanding and experience that HSCPs have of managing a dental service and noted there is a lack of dental representation and as such are perhaps not equipped at present to take on this responsibility. Concerns were also raised by a number of respondents about the effect this proposal could have on the availability of, and access to, NHS dental services.

Professional Leadership, Quality Improvement and Scrutiny

The consultation document offered the opportunity for respondents to comment on a range of proposals related to professional leadership, and quality improvement and scrutiny, including:

- the introduction of a Director of Dentistry in each NHS Board, with strategic oversight of all aspects of NHS dental services and oral health improvement in their area;
- the future remit of the Scottish Dental Practice Board (SDPB);
- enhanced clinical monitoring;
- a national database of key indicators of quality; and,
- protected learning time for dentists and practice staff.

Question 17: There should be a Director of Dentistry with oversight of all aspects of dental services and oral health improvement at Board level. Agree or Disagree?

Of the 427 consultation responses, 377 respondents answered this question (88% response rate) and of those, 154 provided comments.

Option	Number of respondents
Agree	214 (50%)
Disagree	68 (16%)
Neither agree nor disagree	95 (22%)
Not answered	50 (12%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

A substantial number of respondents who agreed with the proposal highlighted that anyone appointed to this role would need to have appropriate experience. However, there was less agreement on what type of experience would qualify someone for this role, but the most common suggestion was the person should be a dentist. A small number of respondents also highlighted this role would require funding. It was noted by a few respondents that input from dental public health specialists, such as the Consultants in Dental Public Health, was essential for the planning and commissioning of dental services.

A number of respondents who disagreed with the proposal expressed the view that this role is unnecessary, adding additional bureaucracy and managerial positions. The financial implications of introducing this role were a concern for a number of respondents, and a few were also concerned that anyone appointed to this role would lack relevant experience.

Of those who neither agreed nor disagreed a number of respondents highlighted the need for relevant experience to undertake this role and the most common suggestion was that a dentist should be appointed. The source of the funding for this role was queried by a small number of respondents. The view that this role is already fulfilled by other positions was highlighted by a small number of respondents but the need for clear leadership within dentistry was also recognised.

Question 18: The Scottish Government proposes to review the remit of the Scottish Dental Practice Board. In your view should the SDBP be:

Of the 427 consultation responses, 342 respondents answered this question (80% response rate) and of those, 108 provided comments.

Option	Number of respondents
Tasked with a revised remit	55 (36%)
Placed with a different host organisation	8 (2%)
Abolish and its functions subsumed elsewhere	56 (13%)
Retain the existing remit	83 (19%)
Other	40 (9%)
Not answered	85 (20%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

Many of the respondents from across the spectrum chose to highlight their views of the Scottish Dental Practice Board as an organisation. A number of respondents were critical of the SDPB; however, there were also a number of comments expressing support for the organisation. A number of respondents also expressed views that they were unsure of the role of the SDPB.

From those respondents who selected 'tasked with a revised remit' there were a number who suggested the SDPB could take on the quality agenda including DRO scrutiny and practice inspections.

Enhanced Clinical Monitoring

The basis for the current system of clinical monitoring is two-fold; prior approval of NHS dental treatment plans where the cost of the treatment exceeds the prior approval limit (currently £390) or where a specific treatment requires prior approval, and the monitoring of pre- and post-treatment through the Dental Reference Service (DRS).

Question 19: In view of the proposal to introduce a new preventive care pathway, a new 'enhanced' Clinical Monitoring Service for patients would be required. Agree or Disagree?

Of the 427 consultation responses, 376 respondents answered this question (88% response rate) and of those, 146 provided comments.

Option	Number of respondents
Agree	220 (52%)
Disagree	74 (17%)
Neither agree nor disagree	82 (19%)
Not answered	51 (12%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

A number of respondents who agreed discussed issues around the practicalities involved in effective monitoring, including how a preventive system would be monitored, and the need for a monitoring system that was clear and concise for practitioners and patients.

Some respondents who agreed also discussed the role of the DRS and the level of monitoring it may be able to provide. Suggestions were made that DROs carry out their monitoring role in the practice, and that the current DRS should be reviewed with a view to expanding to include a focus on prevention.

A number of respondents who agreed also questioned how a new clinical monitoring service would be funded.

For those who disagreed, there was a concern about how a new system would be funded, with a few respondents of the view that the funding required would be better used elsewhere. Some respondents were also of the view that the current system was effective.

The most common response from those who neither agreed nor disagreed was the need for more information about the preventive pathway and what the enhanced monitoring would involve.

Quality Improvement Activities and Protected Learning Time

The consultation document also reported on a Scottish Government pilot, launched on 1 April 2015, to gather information on a range of quality indicators, both at practice and dentist level. The purpose of the pilot was to determine whether it would be possible to establish indicators that might help NHS Boards identify dentists and practices that are experiencing difficulties. The emphasis was on establishing an early warning system to allow NHS Boards the opportunity to provide support before the issue would escalate to the next level.

Question 20: The Scottish Government proposes developing, and rolling out across Scotland, a national database of key indicators of quality. Agree or Disagree?

Of the 427 consultation responses, 380 respondents answered this question (89% response rate) and of those, 145 provided comments.

Option	Number of respondents
Agree	229 (54%)
Disagree	63 (15%)
Neither agree nor disagree	88 (21%)
Not answered	47 (11%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

A number of respondents who agreed suggested that any new database of quality indicators should be linked to the Scottish Patient Safety Programme. Amongst those respondents who agreed, caution was expressed that the indicators should be robust, appropriate and relevant. Others commented on the need to ensure that this wasn't used as part of the disciplinary approach.

Some respondents who disagreed also shared the view that the system could be punitive towards dentists. For some of the respondents who disagreed there was a request for more information which was also requested by a number of those who neither agreed nor disagreed.

Question 21: The Scottish Government proposes the development of a process that will make protected learning time available for dentists and practice staff. Agree or Disagree?

Of the 427 consultation responses, 384 respondents answered this question (90% response rate) and of those, 158 provided comments.

Option	Number of respondents
Agree	328 (77%)
Disagree	24 (6%)
Neither agree nor disagree	32 (7%)
Not answered	43 (10%)

Note: Percentages may not total 100 due to rounding.

Summary of Responses

This proposal was well received by respondents, however, there were a number of points raised by those who agreed. This included how any protected learning time would be funded and how practitioners would be compensated for loss of earnings. A number of respondents who agreed also chose to discuss the potential benefits of protected learning time for the wider dental team and the opportunity it would provide to develop whole practice teams.

For those who disagreed there was some concern that it was difficult to find the time to carry out learning and development activities. The issue of funding for protected learning time was also raised by those who disagreed and neither agreed nor disagreed.

Part C: General Comments

The final question of the consultation offered respondents the opportunity to provide any additional comments. Of the 427 consultation responses, 327 respondents chose to use this option (77% response rate). A range of comments were provided, many of which relate to the issues covered within the previous questions. The summary below provides details of the issues which were raised that were not covered within the consultation questionnaire.

Respondents discussed the consultation process with some taking the view that the outcome of the consultation has already been decided and further consultation should take place. Others were more supportive and welcomed the process.

Some respondents took the view that the consultation document did not accurately represent the role of the PDS. Some comments were made regarding the limited discussion on the role of the Hospital Dental Service (HDS) and the Scottish Emergency Dental Service. A suggestion was also made regarding the importance of involving third sector organisations.

Piloting and gradual change was also suggested along with looking at regimes in other parts of the world.

Comments were made regarding patient charges, such as that treatment should be free at the point of need and that patients should be charged for failure to attend appointments.

Some respondents pointed out that each NHS Board can be different in terms of the population, geography and remote and rural issues, with recruitment and access to NHS dentistry being particularly difficult in remote areas.

Opportunities for career progression were discussed by some respondents. In addition to this, there were comments about what graduates are taught at dental school with suggestions being made that the curriculum should be more aligned with NHS dentistry.

A number of respondents chose to discuss lifelong registration with suggestions made that this does not show an increase in patient attendance.

Health inequalities were also addressed, with some respondents urging caution in relation to identification for services based on the Scottish Index of Multiple Deprivation (SIMD). The importance of considering groups such as those with special care needs, people who are homeless and older people was also noted.

The dental workforce was also raised, particularly the role of Dental Care Professionals (DCPs), with suggestions made that DCPs can often be under-utilised. A suggestion was made that more hygiene-therapists (HTs) should be trained. Concern was also expressed about what Brexit might mean for dentists from EU countries.

For a small number of respondents there was concern expressed regarding dentistry as a business. This included concern regarding the costs for staffing, materials and laboratory costs. Some respondents expressed concern regarding the lack of occupational health provision available. A number of respondents were of the view that the morale in NHS dentistry was low with suggestions that this was because of regulation and paperwork.

2 ROADSHOW EVENTS WITH STAKEHOLDERS

Approach

As part of the consultation exercise, the Scottish Government hosted 12 roadshow events across Scotland, from the beginning of October to the middle of November 2016. The purpose of these events was to give dental health care professionals the opportunity to engage directly with the consultation exercise.

A total of 564 people attended the events, including dentists, DCPs, and staff from NHS Boards. The format of the events were identical and allowed attendees the opportunity to listen to a presentation from the Chief Dental Officer (CDO), and a short video message from the Cabinet Secretary for Health and Sport, Shona Robison MSP. Attendees were then able to participate in a number of break-out sessions, under the following headings:

- Prevention and Risk
- Payments and Charges
- Organisation and Management
- Quality Improvement and Scrutiny.

These sessions were facilitated by a range of people, including Dental Practice Advisers (DPAs), Consultants in Dental Public Health and officers from PSD. For each session note-takers were present to record the discussions. Each event concluded with a round-up plenary session and an opportunity to address questions to the CDO.

The following is a summary of the discussions at the break-out sessions under the themed headings. However, it must be remembered that these views are not necessarily representative of the wider population.

Theme 1 – Prevention and Risk

For this particular session, participants were asked to discuss a range of proposals under the broad headings of a new preventive care pathway and oral health risk assessment.

Participants were asked to discuss and comment on several statements, including:

"It is our aspiration to introduce a preventive care pathway with more emphasis on maintaining or improving the level of oral health"

"Initially this new preventive care pathway will be introduced for children in good, stable oral health"

"As children with stable oral health transfer into the adult service (i.e. from the age of 18) they will remain on the preventive care pathway"

"Over time it is expected that adult patients with stable oral health would move from item of treatment to a preventive treatment pathway"

There was general enthusiasm for a preventive regime but concern that this might be limited to certain groups whereas prevention is important for all. It was recognised that this was a particular challenge for people from deprived areas but can be a general issue too.

There was support for the Childsmile programme, a feeling that it could be extended to older children and the model replicated for the older population. There was some concern that a preventive scheme might be difficult to monitor but that over treatment may be encouraged if the current system remained in place as dental health improved. There was support for maintaining a capitation approach to payment for prevention, although its limitations were recognised, specifically monitoring. Some thought that at a teenage stage contact can be lost with the patient.

Participants frequently mentioned payments both to dentists and the challenge of how to charge patients. The issue of the appropriateness of the SDR in relation to the treatment of periodontal disease was highlighted.

The importance of remembering general health messages e.g. on diet and smoking was noted as was training dentists to have the skills to impart the information. It was thought that DCPs might be better equipped to do this rather than dentists. It was also mentioned that some of these activities may be more appropriate for a DCP.

The preventive pathway should be available to all, although targeting high risk groups was important and should generally include fluoride varnish, fissure-sealants, oral health advice, and dietary advice. There was some support for the system growing up with the patient as an evolutionary approach but there was some concern that working with two systems might be difficult. If two systems were in place some thought that the opportunity for a patient to move between them would be beneficial. There was a feeling that complex treatments should only be provided if the patient's oral hygiene justified it.

There was discussion of partnership working in communities, sugar tax, greater control of advertising and water fluoridation.

Oral Health Risk Assessment

The second part of these sessions looked at the Scottish Government's proposals to introduce an OHRA. These proposals were described as follows:

"Our intention would be to introduce an Oral Health Risk Assessment (OHRA) for all patients at 18 years of age as part of oral health care planning"

"An OHRA involves a full dental examination and includes a discussion between the dentist and patient about the associated risk factors such as smoking, alcohol intake and medication"

There was considerable support for an OHRA but suggestions as to the age at which it should be introduced varied from twelve to sixteen years of age, although some agreed that eighteen years of age was appropriate. It was suggested that a written report of the OHRA should be given to the patient in plain English, perhaps using a scoring system.

There was also the suggestion that there needs to be an assessment for people at the other end of the age spectrum and at other important stages in life when there are significant changes. There was a variety of opinions as to the frequency for carrying out the OHRA, from every two years to targeting certain age groups although some thought an annual OHRA would be appropriate. It was suggested that DCPs could be involved in the OHRA.

It was thought that the frequency of attendance could be assessed as part of this process and there was a recognition that there was not a universal need for six monthly check-ups except in children or where a specific need is identified. However, there was concern that leaving a patient for two years without a check-up might be too long.

Theme 2 – Payments and Charges

For this particular session, participants were asked to discuss a range of proposals under the broad headings of a simpler system of payments and charges, and the proposals in the consultation document around enhanced services.

Participants were asked to discuss and comment on the following statement:

"The current system of remuneration for independent GDPs is complex, difficult to administer and manage, while equally difficult for patients and GDPs to understand"

On balance, most participants agreed with the general sentiments that the current system of remuneration, as defined by Determination I of the SDR, was complex and difficult to administer. Many participants observed that as practising dentists they typically used only around 25 per cent of the available codes and that simplification would help to reduce the administration of treatment.

There was some concern of the extent to which the range of treatments available on the NHS could constrain or reduce the discretion available to the dentist. It was generally recognised that a system that allowed absolute discretion may be subject to misuse, but that a sensible balance had to be found between discretion and financial governance. There was some questioning of particular restrictions, for example, why NHS and private treatment could not be provided on the same tooth.

Another theme that emerged from these sessions was the extent to which the SDR hadn't kept pace with new technological treatments in dentistry and the latest oral health care evidence. Some of the discussions pointed to the need to have a process where the SDR is updated on a timely basis, to reflect the latest clinical guidelines such as those produced by the Scottish Dental Clinical Effectiveness Programme (SDCEP).

In an increasingly challenging financial environment discussions focused on what should (and should not) be included in any future changes to the SDR. For example, some participants questioned whether in future the NHS should concentrate on periodontal treatment, and less so on largely cosmetic procedures such as veneers. Similarly the nature of the payments system, with items of treatment, doesn't encourage the dentist to provide the necessary level of preventive advice.

That aside there was some support for the existing system, that while it clearly has a number of deficiencies, changes need to be evolutionary, progressive and proportionate. There was a general recognition that the current system of item of service payment needed to be reformed, but not replaced with a completely new system of payment that could potentially destabilise NHS dental practices and compromise the needs of the patient.

Focus on Prevention

The following statement was discussed amongst participants:

"Our vision for a new preventive dental culture requires a system of payments to dentists which reflects its positive nature and aligns payments to the needs of the patient"

Most participants recognised the need to align any future payments system to a more preventive focus and that the current system of remuneration was unsustainable in light of improvements in oral health. There was a general acknowledgement that fewer restorations are being placed, and there was a growing requirement for a preventive-based system of payment.

That aside, there were a number of challenges that would need to be addressed. There was a general concern that patients may not be responsive to preventive advice and treatment, and any payments system that is too closely aligned to the health of the patient could unfairly penalise the dentist. Any future payments system would need to carefully balance incentivising prevention with mitigation for dentists that might be unfairly penalised for the poor oral health behaviour of their patients.

The view was that the current SDR does not favour preventive treatment, and certainly not for adult patients. It is also important to recognise preventive treatment takes time, and any future fee structure needs to adequately reflect the amount of time that is taken with the patient. The general view was that there needed to be much more emphasis on periodontal treatment in any future payments system for NHS dentistry.

There was also some concern expressed about the perception and behaviour of patients. As described above dentists were generally concerned about the extent to which they may be financially penalised for the poor oral health outcomes of their patients, when this could be the consequence of patient behaviour, and not failed preventive treatment on the part of the dentist. There were also some misgivings amongst dentists about the low value patients place on preventive care, and that at present we have a system that has reinforced the perception that patients attend a dentist to have a problem remedied. In summary, any future system of preventive care needs to ensure that patients are properly educated on the true value of a preventive approach to their future oral health.

Patient Charges

Participants were asked to consider the current system of NHS dental charges and the impact on patients:

"At present the charging system (for patients) is extremely complex…We propose that adults in good oral health should pay a simplified system of charges"

Participants had varied views on the level of dental charges, and to some extent these views reflected their particular patient base. A number of dentists were concerned that NHS dental charges were too low, and typically patients were generally surprised at how little they had to pay. Amongst this group of dentists there was a feeling that the patient contribution, for patients who are not exempt from NHS dental charges, was too low and undervalued NHS dental care.

However, some dentists whose patient base consisted mainly of patients from deprived and less well-off areas took the opposite view and were sensitive to the financial constraints of their patients. Their concern was that an increase in NHS dental charges could affect the attendance of patients and could potentially be detrimental to oral health.

For some dentists there was a concern that the system of charges was compounding inequalities, with comparatively well-off patients paying too little, while for patients on lower incomes, the cost of NHS dental care was still a concern. Some participants were keen for the Scottish Government to explore a system of sliding-scale NHS dental charges that were linked to a patient's ability to pay.

Check-Ups

There was more consensus amongst participants about the value of free NHS check-ups. This was seen as critical in ensuring that patients attend the dentist on a regular basis, particularly patients who may be put off at the prospect of how much they may have to pay.

Allowances (Paid to NHS Dental Practices and Dentists)

Participants were asked to express their views on the following proposal:

"It is the Scottish Government's view that we need to work towards a reduced number of allowances, including a new practice allowance and a new allowance payable to GDPs, that reward the level of NHS commitment and quality of service provided"

In general dentists were concerned about the precise detail contained in these proposals, and were keen to emphasise the importance of allowances in ensuring the continued financial viability of NHS dentistry. Some participants were concerned that a consolidation of existing allowances could financially destabilise practices and that it was difficult to ensure against adverse outcomes given the diversity of circumstances between practices and dentists.

Whilst consolidation to some degree might be sensible, some participants thought consolidating from the current set to only two allowances might be overly ambitious. For example, it was felt that there would always be a role for specific allowances such as the remote and rural allowance, vocational training, and maternity allowance. There was also strong support for the General Dental Practice Allowance (GDPA) and rent reimbursement scheme, as these provided dental practices with a regular reliable and substantial source of income.

The mix of principal-owners and associates meant that the discussions sometimes focused on how radical change in the balance of practice and dentist allowances could impact on the relationship between principal and associate.

There was some scepticism about any new allowance that was linked to quality. A number of participants thought that quality should be something that is automatically provided and not something that is directly linked to any future allowance. There was also some concern about the appropriate measures of quality and how these could be included in future allowance payments.

Enhanced Services

The second part of these sessions looked at the Scottish Government's proposals around expanding the role of dentists in providing domiciliary care to patients and other more complex clinical procedures. These proposals were described as follows:

"Introduce an enhanced service model for the provision of domiciliary care in a care home setting, and for highly dependent people in their own homes"

"Undertake in partnership with NHS Boards and Health and Social Care Partnerships (HSCPs) the development work to pilot enhanced services within GDS in oral surgery, restorative services, intravenous sedation and orthodontic care"

Generally dentists gave a qualified welcome to these proposals. A key issue was the need for adequate remuneration; if these enhanced services were to successfully shift the balance of care from hospital or the Public Dental Service to independent dentists, then it is important that the funding properly incentivises dentists. There was some concern that the existing fee structure would not be an adequate incentive with a number of participants indicating oral surgery as a case in point.

With regard to domiciliary care, many participants thought that this might not be the best fit for an enhanced service model. Dentists tended to see domiciliary care as a mainstream service and it was important to ensure that as many dentists, and members of the dental team, continued to see their patients as possible. It was important for the patient to maintain continuity of care and in many circumstances that meant retaining their own dentist.

A number of other considerations were raised, including whether there was the prospect that enhanced services would be available in some NHS Board areas, but not necessarily across all of Scotland. There was a danger, depending on the priorities between NHS Boards, that patient choice could be affected. There was a real concern about the role of HSCPs in any future determination on enhanced services provision.

Other issues identified were the level of training required in order to provide these services, whether they were genuinely cost effective compared with a specialist in a hospital setting, and the possibility that it may create a two-tiered system of care with some practices offering these services and others not.

There was also some reservations that these proposals amounted to the English-based system of commissioning services, and that any replication of this system would not be well received with dentists in Scotland. There were concerns that dental practices may invest in providing an enhanced service only to lose the contract at a later date. There was a concern that if the system of enhanced service provision wasn't designed properly, then this could financially destabilise practices.

In summary, most dentists were content to work within an enhanced services framework, and that it made sense to explore ways to shift the balance of provision in certain areas where more complex procedures could be safely delivered in a general dental practice setting.

Theme 3 – Organisation and Management

For this particular session, participants were asked to discuss a range of proposals under the broad headings of contractual arrangements and locality planning.

Participants were asked to discuss and comment on the following statement:

"The Scottish Government believes that the present arrangements (for the governance of GDS) need to be modernised to more fully reflect a contract between NHS Board and the practice, while retaining arrangements with each individual GDP"

Generally speaking there was an element of scepticism amongst attendees at these events with the prospect of a formal contract between the NHS Board and the dental practice. Ostensibly to ensure that the NHS Board has sufficient oversight of the delivery of dental services in their area, there was a general concern amongst dentists that the level of control would be disproportionate. Most of the discussions demonstrated that dentists value their independent status and regarded these proposals as a potential long term threat to this status.

Participants expressed a number of particular misgivings about this proposal, including how responsibility for patient care would be discharged. For example, would the practice owner have ultimate responsibility for patient care, and how could they discharge that responsibility when the care and treatment is provided by another dentist within the practice. There was some concern that the status of associates could be adversely affected by this proposal, and whether in the future it could change the model of service delivery, in favour of salaried dentists.

On balance, there was recognition that there may be a problem with governance and visibility of practice ownership, particularly with the growth of bodies corporate, but that it was important that any solution was proportionate. There was a general feeling amongst participants that all dentists should not necessarily have to bear significant changes if the problem was confined to a minority of providers.

Closely linked to this proposal was the following statement:

"At present patients are registered with individual dentists or Dental Bodies Corporate. The Scottish Government would like to explore further the benefits of a patient being registered with a practice, while having a responsible GDP within the practice"

Similar to the first proposal in this particular set of discussions, the response to this proposal was broadly negative. Dentists were concerned there would be no identifiable individual to ensure responsibility for and continuity of patient care.

Dentists felt that the existing system of capitation and continuing care payments was working reasonably well and any move towards a system where patients registered with the practice could jeopardise the present arrangements.

There was a general view that the existing system allows the dentist to build a relationship with the patient. However, where the patient is registered with the practice this may adversely affect the dentist-patient relationship. Participants were concerned about the adverse consequences of these proposals, and while the present system is not perfect, it is important that in any future changes, the value from the existing arrangements is not lost.

Concerns were also expressed about the financial consequences of these arrangements for associates. As referred to above, because each dentist, principal-owner and associate has their own list of patients, they receive capitation and continuing care payments. Associates who participated in these sessions were concerned that registration with the practice would mean the loss of these direct payments and would place more emphasis on the principal-associate agreement.

The final proposal in this section was as follows:

"There needs to be a much stronger link between practice ownership and the delivery of day to day patient care... The Scottish Government believes this is the correct opportunity to consult on a requirement for GDC-registered practice owners or directors to provide a minimum number of hours of NHS clinical care per week in each practice"

The perception amongst participants was that this proposal was a reaction to particular problems attached to the body corporate model, where the practice owner becomes quite detached from the actual clinical care provided to the local community. While this proposal had some support amongst principals who owned a single practice, those who owned multiple practices spoke out strongly against it. Their concern was that they were being unfairly penalised for a situation that had arisen with the body corporate model, and that if these proposals were to be introduced, they could be seriously detrimental to the viability of their business.

Practice owners also expressed the view that clinical care could deteriorate as a consequence of this proposal. They envisaged a situation where they have to spend one day per week in each of their practices, and felt this could jeopardise the safety and effectiveness of the care they provide. For some participants who were directors, the feeling was the proposal would make it impossible for them to continue with their present business model.

Finally, practice owners were concerned about the potential impact on those who chose to reduce their commitment during the later period of their career. It is possible that this proposal could jeopardise any attempt by practice owners to retain ownership but reduce their level of clinical commitment.

In summary the general feeling amongst participants was that this proposal had the potential to be wide ranging in impact, with the potential for adverse consequences throughout the whole dental community. If the Scottish Government and NHS Boards were concerned about the body corporate model, then it was important to identify solutions that addressed this rather than impacting on the independent contractor model.

Locality Planning

The second part of these sessions looked at the Scottish Government's proposals around locality planning, with a greater role for Health and Social Care Partnerships, and having a Director of Dentistry in each NHS Board area:

"In the medium to longer term we envisage an increasing role for HSCPs in locality planning for NHS dental services in their respective areas"

There was a general recognition that market forces were perhaps not the best mechanism for dealing with local service planning. Depending on the location of these roadshow events, dentists sometimes spoke out strongly about concerns of over-supply, particularly in the central belt areas of Scotland. At present NHS Boards have no powers to restrict where practices set up and in many cases this is leading to the displacement of patients as practices set up close to one another. At the same time some degree of strategic planning might encourage more practices to set up in deprived areas.

Some participants reflected on their experience of the Scottish Dental Access Initiative (SDAI) Scheme. While this scheme had improved access significantly in many areas of Scotland, it was increasingly challenging for existing SDAI practices to meet their grant conditions of additional patient registrations when other practices decide to locate within their catchment area.

A number of participants, while accepting that over supply in certain areas was a very real danger, thought that greater strategic control would ultimately impact on their independent contractor status. As independent contractors they have to accept the risk of the potential for over supply and that is the price of independent contractor status. There were also misgivings expressed about the role of HSCPs, that dentistry is not a priority for these relatively new organisations, whether it will just add another layer of bureaucracy to the planning process, and is there sufficient knowledge and intelligence to plan dental services in their locality.

Director of Dentistry

Participants were asked to consider the following proposal:

"We envisage a Director of Dentistry in each NHS Board who will have strategic oversight of all aspects of NHS dental services and oral health improvement in their area"

In general this was seen as a reasonable way forward by participants. For example, some participants commented that having a Director of Dentistry might help to ensure some degree of joint stewardship of both GDS and PDS. Others commented that while the role was excellent in theory, it might be difficult to recruit suitably qualified people with experience of the independent contractor model, PDS, and other NHS Board dental services. There was also a feeling that the role should not displace other roles within the NHS Board such as the Clinical Director.

Theme 4 – Quality and Scrutiny

For this particular session, participants were asked to discuss a range of proposals under the broad headings of monitoring a future preventive pathway; use of quality indicators; and the proposals in the consultation document around direct access to dental care professionals.

Participants were asked to discuss and comment on the following statement:

"The Scottish Government envisages a new Clinical Monitoring Service that will monitor the new preventive care pathway for those patients with good oral health"

Given that the consultation document did not contain a detailed preventive care pathway and views were being sought on the principles, the discussion was quite wide ranging. There was a clear understanding that a preventive pathway would require monitoring, although it would not be straightforward and was very patient dependent.

Participants agreed that prevention was important, however, there was only so much the dental team could achieve, as changing patient oral health behaviours was equally as important. It was recognised that the dental team would benefit from education on strategies to help patients make the requisite behavioural changes.

The DRS of PSD currently delivers scrutiny of clinical care and could be a vehicle to monitor any preventive pathway. However, it was variously described as critical, adversarial and destructive. Therefore, the DRS should be restructured and redefined. Overwhelmingly, participants commented that the DROs should visit dental practices to undertake clinical scrutiny. This should be a supportive visit and the role should be one of clinical improvement and not criticism. Several commented that the DRO visit could coincide with the practice inspection visit.

Some participants speculated that routine monitoring of prevention could be through a review of record cards and claims submitted. The challenge of monitoring preventive care is the lack of tangible measures to observe, unlike current items of service treatments. Although over the longer term there would be improved outcomes.

Use of Quality Indicators

Participants were asked to consider the use of quality indicators:

"A pilot commenced on 1 April 2015 gathering information on a range of quality indicators, both at practice and GDP level. The purpose of the pilot is to determine whether we can identify at an early stage those practices or GDPs that are experiencing difficulties, enabling the NHS Board to offer support"

Discussions were typically broader than describing potential indicators, although periodontal status and caries rates were generally regarded as important indicators. Most participants recognised the need to demonstrate that dentists deliver quality services and had an improvement focus both at individual and practice level.

It was suggested that peer review, continuing professional development, clinical audit, significant event analysis, practice inspection, DRO scrutiny and patient complaint review were good processes but not linked in any structured way to bring about real benefit. It was felt that systematic patient surveys were required, perhaps similar to travel review websites. There was some concern expressed that quality indicators may inadvertently lead to 'league tables' of dental practices which was thought to be unhelpful. Equally, multisource feedback should be introduced perhaps as part of dentist appraisal and should be based on similar processes that already exist for GPs.

Quality Improvement Activities

A number of participants suggested that all quality and improvement processes could be subsumed within a Practice Development Plan (PrDP). The PrDP would be developed using information from:

- the DRO (who would have visited the practice);
- the DPA with information on actions arising from the practice inspection and quality indicator performance;
- a CPD Tutor from NHS Education for Scotland who would have helped the dental team develop Personal Learning Plans; and,
- a dentist appraisal process.

Participants took the view that it was important to develop appropriate support networks in such a challenging environment, and therefore the DRO, DPA, CPD Tutor and Dentist Appraiser should be at the centre of any support network.

Protected Learning Time (PLT)

"We believe that PLT could be of benefit to dental practices and teams, to assists them in undertaking quality improvement initiatives"

Generally this was welcomed as a proposal with most participants viewing this as a positive and progressive development, providing it was supported with adequate funding, was team focused and managed by NHS Boards. The feeling was the introduction of PLT could facilitate collective learning between practices.

The Scottish Dental Practice Board

Finally these discussions allowed the opportunity for participants to consider the future role of the SDPB. For most participants there was no clear delineation between the Board and the role of PSD; in fact a number of participants confused the two bodies, and the specific remit of the SDPB was not well understood. It was therefore difficult for participants to comment on any future role when the existing role was so poorly understood.

Direct Access to Dental Care Professionals

The second part of these sessions considered the specific workforce proposal around DCPs:

"We are currently exploring options for listing DCPs to allow patients to directly access treatment under General Dental Services from them, without the requirement to first be seen by a dentist"

Participants had very mixed views on the introduction of direct access to DCPs and the impact this would have on practices. There was no settled view with some participants seeing this as a threat and others that this proposal might present opportunities. DCPs currently work to a significant degree with children and this should continue. Many felt that there was merit in increasing the role of DCPs in providing on-going dental care and oral health prevention to older people, particularly those who are housebound or living in residential care settings.

That said, it was important if direct access was to be introduced that DCPs take full responsibility for any care they delivered and it should not fall to the dentist as team leader. Some felt direct access was primarily a cost cutting exercise by the Scottish Government.

Wider Workforce Issues

In terms of wider workforce roles, generally participants felt that there was a danger of over supply of dentists and with DCPs also increasing in number, and able to take on more of the routine dental care of patients. There needed to be a primary care dental workforce review focusing on changing roles and their long term impact and skill mix requirements for the future.

There was also felt to be a need for a more team based delivery focus with clarity over roles. For example, the first OHRA could be undertaken by a dentist, but then the patient could be seen:

- by a DCP for up to two years on a care pathway before returning to the dentist for review; and,
- by the dentist due to the complexity of the care required.

WEBINARS

The purpose of the roadshow events was to engage with a range of dental professionals across the country. Following our initial analysis of these events it became clear that we had not managed to reach many dentists in remote and rural areas and dentists who have been qualified for under ten years.

Engagement with both of these groups is particularly important. We recognise that the challenges faced in remote and rural areas are often different to what we see in other parts of Scotland. The involvement of young professionals is also crucial, given our intention that the Oral Health Improvement Plan will shape NHS dentistry for the next decade.

The CDO hosted three webinar sessions, which followed a similar format to the roadshow events; one with dentists in remote and rural areas and two with dentists who have qualified within the last ten years. However, it must be remembered that these views are not necessarily representative of the wider population.

The table below illustrates the number of attendees at each webinar.

Remote and Rural	24 January 2016	29
Young Dentists	18 April 2017	3
Young Dentists	19 April 2017	5

Summary of Key Findings – Remote and Rural

Theme 1 – Prevention and Risk

Participants were asked for their views on a preventive care pathway and were largely supportive of this proposal, however, they would like more detail on what a preventive care pathway would look like.

The proposal to introduce an OHRA was also discussed. Participants were in favour of this, however suggestions were made that this should be introduced at age twelve.

Theme 2 – Payments and Charges

Participants were asked to discuss the proposal of a simpler system of payments and charges. There was general agreement that the range and volume of items of service treatments is what makes it complex.

Participants were asked to discuss the proposals to expand the role of dentists in providing domiciliary care. It was noted that domiciliary visits in remote and rural areas can be problematic for GDS dentists, particularly when travel to other islands is required.

The proposal to develop an enhanced service model was also discussed. Participants stated that for an enhanced service model to meet the needs of remote and rural areas, consideration would need to be given to the existing service range of the PDS.

Theme 3 – Organisation and Management

For this section, participants were asked to discuss a range of proposals under the broad headings of contractual arrangements and locality planning.

Views were expressed regarding the variations between HSCPs, with strong agreement that local planning is important in remote and rural areas.

Participants expressed mixed views regarding the proposal of patients registering with a practice.

Participants also expressed mixed views regarding practice owners providing a minimum number of hours of clinical care. Whilst participants could see the potential benefits of this, for practice owners who have multiple practices this may not be practical.

The proposal to introduce a Director of Dentistry would be helpful to promote oral health priorities within the NHS Board area.

Theme 4 – Quality, Improvement and Scrutiny

Participants were asked to discuss a range of proposals under the broad headings of monitoring a future preventive pathway; use of quality indicators and direct access to DCPs.

Participants felt there was a need for clarity on quality indicators and any link to SDCEP guidance.

Participants discussed training for dentists who are coming to work in remote and rural areas to prepare for both professional and geographical isolation.

Participants were of the view that recruitment in remote and rural areas can be challenging.

Summary of Key Findings – Young Dentists

Theme 1 – Prevention and Risk

Participants were asked for their views on a preventive care pathway and were largely in agreement that the focus should be on prevention.

The proposal to introduce an OHRA was also discussed. Participants suggested that age eighteen was perhaps too late to introduce an OHRA.

The frequency of check-ups was discussed. There was broad consensus that six to twelve months was sensible for most patients, however, for patients who were at a higher risk this may be more frequent.

Theme 2 – Payments and Charges

Participants were asked to discuss the proposal of a simpler system of payments and charges. Suggestions were made that the SDR should be simplified and encourage prevention.

The proposal to introduce an enhanced service model was also discussed. Views were expressed that training for domiciliary visits could be done at undergraduate level by linking universities to care homes.

The proposal for dentists to offer more complex treatments was also discussed. Participants were concerned that referring patients to another practice runs the risk of losing the patient.

Theme 3 – Organisation and Management

For this section, participants were asked to discuss a range of proposals under the broad headings of contractual arrangements and locality planning.

Participants expressed concern regarding the involvement of HSCPs.

Mixed views were expressed regarding the proposal for patients to register with a practice, particularly around the issue of patient care.

Participants agreed that the proposal to introduce a Director of Dentistry would be useful.

Participants discussed the proposal for practice owners to be required to deliver a minimum number of hours of clinical care. It was suggested that this would be helpful in relation to DBsC.

Theme 4 – Quality, Improvement and Scrutiny

Participants were asked to discuss a range of proposals under the broad headings of monitoring a future preventive pathway; use of quality indicators; and direct access to DCPs.

Participants were supportive of the proposal to introduce PLT.

Participants discussed the prospect of DCPs carrying out certain procedures and were of the view that this should be done under the dentist's prescription.

Participants discussed the DRS and highlighted the poor attendance rate from patients. Feelings were also expressed that many find the system punitive.

PUBLIC ENGAGEMENT

4

Whilst we recognise that the consultation document was largely relevant to dental professionals, and indeed the majority of the responses to the questionnaire were received from dental professionals, it is vital that views of the public are also considered and taken into account when developing the Oral Health Improvement Plan.

Scottish Health Council

With this in mind, the Scottish Health Council was commissioned to deliver a series of patient focus groups across the country. A total of 113 members of the public took part in focus groups, face to face interviews and by completing questionnaires.

Discussions and questionnaires focused on the key proposals which are relevant to the wider public, including oral health inequalities, a preventive care pathway and patient charges.

The findings from this exercise are available on the Scottish Health Council's website at: http://www.scottishhealthcouncil.org/publications/gathering_public_views/oral_health.aspx

Our Voice Citizens Panel

Through our engagement with the Scottish Health Council we were also provided with the opportunity to include the first question from the questionnaire in the first 'Our Voice Citizens Panel' questionnaire.

The panel provides a source of public opinion on health and social care issues. The questionnaire was sent to the 1291 members of the panel with 617 responses received.

The findings are available at: Our Voice Citizen's Panel Report.

5 CONCLUSIONS AND NEXT STEP

It is clear to see from the preceding chapters that the level of support for the proposals was varied and in many cases the need for more detailed information was highlighted. However, there were a range of proposals which received clear support. A move towards a more preventive system for NHS dental services received substantial support across the range of stakeholders. Support was also received for the introduction of oral health risk assessments and the simplification of NHS dental charges. Whilst the introduction of enhanced services for the delivery of a variety of services was supported, the need to consider training requirements, equipment and the funding arrangement for this type of service was highlighted.

There was some support for a range of the proposals related to the arrangements for General Dental Services, including patients being registered with the dental practice and having a responsible dentist, although many considered this to be happening already. There was also support for the listing of DBsC; the introduction of a Director of Dentistry; an enhanced clinical monitoring service; and the introduction of a national database of key quality indicators. Substantial support was received for PLT for dentists and practice staff.

However, a number of those proposals received more mixed support, including the introduction of a national body and formal contracts between NHS Boards and practice owners. Whilst the potential benefits of the requirement for owners to provide a minimum number of hours NHS clinical care were recognised, concerns were raised about the practicalities and the potential impact on patient care.

The proposals around allowances also received mixed support, with concerns that the changes would affect the overall value of funding available for NHS dentistry. Whilst it was recognised that there needs to be transparency around earnings from public money, the proposal to make the provision of earnings and expenses information a requirement also raised concerns about how this information would be used. Concerns were raised about the proposal to devolve funding to HSCPs, recognising that whilst more local control of funding could have benefits, these bodies are relatively new and may not yet have the expertise to manage NHS dental services.

Oral Health Improvement Plan

The consultation exercise marked the first step in addressing the challenges facing NHS dentistry in Scotland. The level of engagement received through the consultation platform, at roadshow events, and at patient focus groups has been impressive, and the time and effort invested in providing thoughtful and considered responses to the proposals has been greatly appreciated. However, it must be remembered that while the views expressed are valuable in giving a flavour of opinion, they are not necessarily representative of the whole profession or the wider population, and the conclusions in this document must be considered in this light.

It is our intention to publish an Oral Health Improvement Plan by the end of the year, which will shape the future of NHS dentistry for the next decade.

Annex A

Summary Report

Scotland's Oral Health Plan – A Scottish Government Consultation Exercise on the Future of Oral Health Services – respondents by category.

Question 1: Which of the following would you regard as the most important? (Please rank your top three, 1-3, in order of importance)

Responding as	Access	Cost	Closer to home	Child dental services	Ageing population	Inequalities	Quality	Other
Organisation	**38 (9%)**	**10 (2%)**	**6 (1%)**	**15 (4%)**	**24 (6%)**	**35 (8%)**	**39 (9%)**	**6 (1%)**
Individual	**230 (54%)**	**130 (30%)**	**31 (7%)**	**112 (26%)**	**96 (22%)**	**155 (36%)**	**238 (56%)**	**32 (7%)**
Member of the public	39 (9%)	24 (6%)	8 (2%)	13 (3%)	6 (1%)	16 (4%)	25 (6%)	4 (0.9%)
Dentist	19 (4%)	15 (4%)	3 (0.7%)	8 (2%)	7 (2%)	15 (4%)	23 (5%)	4 (0.9%)
Dentist – Practice Owner	51 (12%)	39 (9%)	5 (1%)	35 (8%)	26 (6%)	38 (9%)	75 (18%)	15 (4%)
Dentist – Associate	48 (11%)	23 (5%)	6 (1%)	19 (4%)	12 (3%)	28 (7%)	57 (13%)	3 (0.7%)
Dentist – Assistant	3 (0.7%)	2 (0.5%)	0	1 (0.2%)	2 (0.5%)	2 (0.5%)	2 (0.5%)	0
Dentist – Hospital Dental Service	6 (1%)	3 (0.7%)	0	1 (0.2%)	2 (0.5%)	6 (1%)	7 (2%)	1 (0.2%)
Dentist – Public Dental Service	20 (5%)	6 (1%)	2 (0.5%)	12 (3%)	22 (5%)	24 (6%)	20 (5%)	1 (0.2%)
Dental Care Professional	27 (6%)	14 (3%)	3 (0.7%)	13 (3%)	9 (2%)	11 (3%)	17 (4%)	1 (0.2%)
Other	16 (4%)	3 (0.7%)	4 (0.9%)	10 (2%)	10 (2%)	14 (3%)	12 (3%)	3 (0.7%)
Declined to specify	1 (0.2%)	1 (0.2%)	0	0	0	1 (0.2%)	0	0

Note: Percentages do not total 100 as more than one option could be selected.

Question 2a: NHS dental services should increasingly focus on prevention. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**60 (14%)**	**0**	**3 (0.7%)**	**17 (4%)**
Individual	**293 (69%)**	**14 (3%)**	**36 (8%)**	**4 (0.9%)**
Member of the public	39 (9%)	1 (0.2%)	5 (1%)	0
Dentist	28 (7%)	2 (0.5%)	2 (0.5%)	2 (0.5%)
Dentist – Practice Owner	76 (18%)	3 (0.7%)	16 (4%)	0
Dentist – Associate	57 (13%)	4 (0.9%)	5 (1%)	1 (0.2%)
Dentist – Assistant	4 (0.9%)	0	0	0
Dentist – Hospital Dental Service	8 (2%)	0	1 (0.2%)	0
Dentist – Public Dental Service	31 (7%)	1 (0.2%)	4 (1%)	0
Dental Care Professional	26 (6%)	2 (0.5%)	3 (0.7%)	1 (0.2%)
Other	23 (5%)	1 (0.2%)	0	0
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 2b: The Scottish Government should introduce a preventive care pathway. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**56 (13%)**	**2 (0.5%)**	**7 (2%)**	**15 (4%)**
Individual	**224 (52%)**	**43 (10%)**	**76 (18%)**	**4 (0.9%)**
Member of the public	36 (8%)	4 (0.9%)	5 (1%)	0
Dentist	24 (6%)	3 (0.7%)	5 (1%)	2 (0.5%)
Dentist – Practice Owner	51 (12%)	19 (4%)	25 (6%)	0
Dentist – Associate	37 (9%)	8 (2%)	21 (5%)	1 (0.2%)
Dentist – Assistant	4 (0.9%)	0	0	0
Dentist – Hospital Dental Service	9 (2%)	0	0	0
Dentist – Public Dental Service	23 (5%)	5 (1%)	8 (2%)	0
Dental Care Professional	22 (5%)	2 (0.5%)	7 (2%)	1 (0.2%)
Other	17 (4%)	2 (0.5%)	5 (1%)	0
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 2c: Which group(s) of patients should a preventive care pathway be applied to in the first instance? (Please indicate a preferred option)

Responding as	Only children	Start with children	Children and some adults	All dental patients	Other	Not answered
Organisation	**0**	**13 (3%)**	**12 (3%)**	**32 (7%)**	**6 (1%)**	**17 (4%)**
Individual	**35 (8%)**	**116 (27%)**	**49 (11%)**	**119 (28%)**	**21 (5%)**	**7 (2%)**
Member of the public	1 (0.2%)	19 (4%)	6 (1%)	17 (4%)	2 (0.5%)	0
Dentist	1 (0.2%)	15 (4%)	4 (0.9%)	9 (2%)	3 (0.7%)	2 (0.5%)
Dentist – Practice Owner	13 (3%)	40 (9%)	8 (2%)	26 (6%)	6 (1%)	2 (0.5%)
Dentist – Associate	13 (3%)	13 (3%)	13 (3%)	25 (6%)	3 (0.7%)	0
Dentist – Assistant	0	1 (0.2%)	1 (0.2%)	2 (0.5%)	0	0
Dentist – Hospital Dental Service	0	2 (0.5%)	0	5 (1%)	2 (0.5%)	0
Dentist – Public Dental Service	2 (0.5%)	11 (3%)	8 (2%)	10 (2%)	3 (0.7%)	2 (0.5%)
Dental Care Professional	1 (0.2%)	9 (2%)	7 (2%)	13 (3%)	2 (0.5%)	0
Other	4 (0.9%)	6 (1%)	1 (0.2%)	12 (3%)	0	1 (0.2%)
Declined to specify	0	0	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 3a: In the future it would be beneficial to introduce an Oral Health Risk Assessment. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**55 (13%)**	**2 (0.5%)**	**7 (2%)**	**16 (4%)**
Individual	**242 (57%)**	**42 (10%)**	**59 (14%)**	**4 (0.9%)**
Member of the public	32 (7%)	5 (1%)	8 (2%)	0
Dentist	28 (7%)	2 (0.5%)	1 (0.2%)	3 (0.7%)
Dentist – Practice Owner	60 (14%)	18 (4%)	17 (4%)	0
Dentist – Associate	39 (9%)	9 (2%)	19 (4%)	0
Dentist – Assistant	3 (0.7%)	0	1 (0.2%)	0
Dentist – Hospital Dental Service	8 (2%)	1 (0.2%)	0	0
Dentist – Public Dental Service	28 (7%)	1 (0.2%)	6 (1%)	1 (0.2%)
Dental Care Professional	25 (6%)	5 (1%)	2 (0.5%)	0
Other	18 (4%)	1 (0.2%)	5 (1%)	0
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 3b: If the Scottish Government introduced OHRAs, at what age should patients first receive an OHRA? (Please indicate a preferred option)

Responding as	18 years of age	21 years of age	25 years of age	Other	Not answered
Organisation	**17 (4%)**	**0**	**2 (0.5%)**	**43 (10%)**	**18 (4%)**
Individual	**149 (35%)**	**16 (4%)**	**11 (3%)**	**144 (34%)**	**27 (6%)**
Member of the public	27 (6%)	1 (0.2%)	2 (0.5%)	12 (3%)	3 (0.7%)
Dentist	14 (3%)	1 (0.2%)	0	17 (4%)	2 (0.5%)
Dentist – Practice Owner	39 (9%)	3 (0.7%)	4 (0.9%)	45 (11%)	4 (0.9%)
Dentist – Associate	28 (7%)	4 (0.9%)	4 (0.9%)	22 (5%)	9 (2%)
Dentist – Assistant	1 (0.2%)	0	0	3 (0.7%)	0
Dentist – Hospital Dental Service	3 (0.7%)	1 (0.2%)	1 (0.2%)	4 (0.9%)	0
Dentist – Public Dental Service	14 (3%)	3 (0.7%)	0	15 (4%)	4 (0.9%)
Dental Care Professional	13 (3%)	2 (0.5%)	0	15 (4%)	2 (0.5%)
Other	9 (2%)	1 (0.2%)	0	11 (3%)	3 (0.7%)
Declined to specify	1 (0.2%)	0	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 3c: How often do you think OHRAs should be repeated? (Please indicate a preferred option)

Responding as	Every 5 years	Every 10 years	Other	Not answered
Organisation	**18 (4%)**	**1 (0.2%)**	**45 (11%)**	**16 (4%)**
Individual	**128 (30%)**	**11 (3%)**	**180 (42%)**	**28 (7%)**
Member of the public	25 (6%)	1 (0.2%)	18 (4%)	1 (0.2%)
Dentist	8 (2%)	0	24 (6%)	2 (0.5%)
Dentist – Practice Owner	30 (7%)	5 (1%)	51 (12%)	9 (2%)
Dentist – Associate	22 (5%)	4 (0.9%)	32 (7%)	9 (2%)
Dentist – Assistant	1 (0.2%)	0	3 (0.7%)	0
Dentist – Hospital Dental Service	6 (1%)	0	3 (0.7%)	0
Dentist – Public Dental Service	12 (3%)	1 (0.2%)	17 (4%)	6 (1%)
Dental Care Professional	14 (3%)	0	18 (4%)	0
Other	9 (2%)	0	14 (3%)	1 (0.2%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 4a: Complex treatments should be delivered more frequently by a local dental practice. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**37 (9%)**	**5 (1%)**	**19 (4%)**	**19 (4%)**
Individual	**185 (43%)**	**68 (16%)**	**89 (21%)**	**5 (1%)**
Member of the public	27 (6%)	6 (1%)	11 (3%)	1 (0.2%)
Dentist	16 (4%)	6 (1%)	10 (2%)	2 (0.5%)
Dentist – Practice Owner	47 (11%)	19 (4%)	28 (7%)	1 (0.2%)
Dentist – Associate	40 (9%)	12 (3%)	15 (4%)	0
Dentist – Assistant	3 (0.7%)	1 (0.2%)	0	0
Dentist – Hospital Dental Service	3 (0.7%)	2 (0.5%)	4 (0.9%)	0
Dentist – Public Dental Service	20 (5%)	10 (2%)	5 (1%)	1 (0.2%)
Dental Care Professional	16 (4%)	7 (2%)	9 (2%)	0
Other	12 (3%)	5 (1%)	7 (2%)	0
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 4b: Which treatments should be delivered this way? (Please tick all that apply)

Responding as	Domiciliary Care	Oral Surgery	Restorations	Sedation	Orthodontics	Other	Not answered
Organisation	**31 (7%)**	**37 (9%)**	**37 (9%)**	**35 (8%)**	**37 (9%)**	**20 (5%)**	**28 (7%)**
Individual	**179 (42%)**	**222 (52%)**	**197 (46%)**	**194 (45%)**	**185 (43%)**	**42 (10%)**	**41 (10%)**
Member of the public	22 (5%)	28 (7%)	25 (6%)	19 (4%)	20 (5%)	6 (1%)	4 (0.9%)
Dentist	16 (4%)	22 (5%)	19 (4%)	20 (5%)	19 (4%)	3 (0.7%)	5 (1%)
Dentist – Practice Owner	51 (12%)	63 (15%)	53 (12%)	53 (12%)	56 (13%)	11 (3%)	17 (4%)
Dentist – Associate	36 (8%)	48 (11%)	42 (10%)	42 (10%)	35 (8%)	6 (1%)	3 (0.7%)
Dentist – Assistant	2 (0.5%)	1 (0.2%)	3 (0.7%)	2 (0.5%)	1 (0.2%)	0	1 (0.2%)
Dentist – Hospital Dental Service	6 (1%)	5 (1%)	6 (1%)	6 (1%)	6 (1%)	2 (0.5%)	0
Dentist – Public Dental Service	15 (4%)	26 (6%)	23 (5%)	23 (5%)	22 (5%)	5 (1%)	3 (0.7%)
Dental Care Professional	21 (5%)	18 (4%)	15 (4%)	15 (4%)	15 (4%)	5 (1%)	2 (0.5%)
Other	10 (2%)	11 (3%)	10 (2%)	13 (3%)	11 (3%)	4 (0.9%)	6 (1%)
Declined to specify	0	0	1 (0.2%)	1 (0.2%)	0	0	0

Note: Percentages do not total 100 as more than one option could be selected.

Question 5: The existing system of NHS dental charges needs to be simplified. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**44 (10%)**	**8 (2%)**	**10 (2%)**	**18 (4%)**
Individual	**200 (47%)**	**83 (19%)**	**61 (14%)**	**3 (0.7%)**
Member of the public	29 (7%)	4 (0.9%)	12 (3%)	0
Dentist	21 (5%)	8 (2%)	3 (0.7%)	2 (0.5%)
Dentist – Practice Owner	58 (14%)	21 (5%)	15 (4%)	1 (0.2%)
Dentist – Associate	27 (6%)	30 (7%)	10 (2%)	0
Dentist – Assistant	1 (0.2%)	3 (0.7%)	0	0
Dentist – Hospital Dental Service	7 (2%)	1 (0.2%)	1 (0.2%)	0
Dentist – Public Dental Service	25 (6%)	4 (0.9%)	7 (2%)	0
Dental Care Professional	18 (4%)	9 (2%)	5 (1%)	0
Other	13 (3%)	3 (0.7%)	8 (2%)	0
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 6: A range of 'shared services', currently provided by NHS Boards, should be provided by a national body. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**25 (6%)**	**8 (2%)**	**26 (6%)**	**21 (5%)**
Individual	**102 (24%)**	**84 (20%)**	**134 (31%)**	**27 (6%)**
Member of the public	11 (3%)	4 (0.9%)	18 (4%)	12 (3%)
Dentist	15 (4%)	4 (0.9%)	13 (3%)	2 (0.5%)
Dentist – Practice Owner	23 (5%)	39 (9%)	29 (7%)	4 (0.9%)
Dentist – Associate	19 (4%)	23 (5%)	25 (6%)	0
Dentist – Assistant	0	0	3 (0.7%)	1 (0.2%)
Dentist – Hospital Dental Service	4 (0.9%)	2 (0.5%)	3 (0.7%)	0
Dentist – Public Dental Service	12 (3%)	5 (1%)	16 (4%)	3 (0.7%)
Dental Care Professional	11 (3%)	6 (1%)	14 (3%)	1 (0.2%)
Other	6 (1%)	1 (0.2%)	13 (3%)	4 (0.9%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 7: Which duties could be taken on by this national body? (Please note that this table only refers to the options that could be selected on the platform and not the manual recalculation of choices)

Responding as	Dental lists	Practice inspection	Discipline and Tribunals	GDC referrals	Other	Not answered
Organisation	**9 (2%)**	**6 (1%)**	**7 (2%)**	**5 (1%)**	**24 (6%)**	**29 (7%)**
Individual	**59 (14%)**	**50 (12%)**	**36 (8%)**	**32 (7%)**	**70 (16%)**	**100 (23%)**
Member of the public	6 (1%)	10 (2%)	5 (1%)	2 (0.5%)	4 (0.9%)	18 (4%)
Dentist	3 (0.7%)	5 (1%)	5 (1%)	2 (0.5%)	8 (2%)	11 (3%)
Dentist – Practice Owner	14 (3%)	8 (2%)	11 (3%)	6 (1%)	31 (7%)	25 (6%)
Dentist – Associate	16 (4%)	4 (0.9%)	7 (2%)	8 (2%)	16 (4%)	16 (4%)
Dentist – Assistant	0	0	1 (0.2%)	1 (0.2%)	0	2 (0.5%)
Dentist – Hospital Dental Service	2 (0.5%)	2 (0.5%)	1 (0.2%)	2 (0.5%)	2 (0.5%)	0
Dentist – Public Dental Service	8 (2%)	4 (0.9%)	4 (0.9%)	4 (0.9%)	3 (0.7%)	13 (3%)
Dental Care Professional	7 (2%)	13 (3%)	0	4 (0.9%)	1 (0.2%)	7 (2%)
Other	3 (0.7%)	4 (0.9%)	1 (0.2%)	3 (0.7%)	5 (1%)	8 (2%)
Declined to specify	0	0	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 8: A formal contract should be introduced between NHS Boards and the practice owner(s). Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**32 (7%)**	**3 (0.7%)**	**22 (5%)**	**23 (5%)**
Individual	**140 (33%)**	**88 (21%)**	**94 (22%)**	**25 (6%)**
Member of the public	23 (5%)	3 (0.7%)	6 (1%)	13 (3%)
Dentist	16 (4%)	7 (2%)	8 (2%)	3 (0.7%)
Dentist – Practice Owner	18 (4%)	49 (11%)	27 (6%)	1 (0.2%)
Dentist – Associate	22 (5%)	21 (5%)	24 (6%)	0
Dentist – Assistant	2 (0.5%)	0	1 (0.2%)	1 (0.2%)
Dentist – Hospital Dental Service	6 (1%)	1 (0.2%)	2 (0.5%)	0
Dentist – Public Dental Service	19 (4%)	2 (0.5%)	11 (3%)	4 (0.9%)
Dental Care Professional	18 (4%)	4 (0.9%)	9 (2%)	1 (0.2%)
Other	15 (4%)	1 (0.2%)	6 (1%)	2 (0.5%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 9: Patients should be registered with the dental practice. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**39 (9%)**	**8 (2%)**	**11 (3%)**	**22 (5%)**
Individual	**215 (50%)**	**70 (17%)**	**37 (9%)**	**25 (6%)**
Member of the public	29 (7%)	0	3 (0.7%)	13 (3%)
Dentist	21 (5%)	9 (2%)	2 (0.5%)	2 (0.5%)
Dentist – Practice Owner	44 (10%)	37 (9%)	12 (3%)	2 (0.5%)
Dentist – Associate	39 (9%)	14 (3%)	11 (3%)	3 (0.7%)
Dentist – Assistant	2 (0.5%)	1 (0.2%)	0	1 (0.2%)
Dentist – Hospital Dental Service	9 (2%)	0	0	0
Dentist – Public Dental Service	27 (6%)	3 (0.7%)	4 (0.9%)	2 (0.5%)
Dental Care Professional	25 (6%)	4 (0.9%)	3 (0.7%)	0
Other	18 (4%)	2 (0.5%)	2 (0.5%)	2 (0.5%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 10: Patients should have a responsible dentist. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**50 (12%)**	**2 (0.5%)**	**7 (2%)**	**21 (5%)**
Individual	**252 (59%)**	**31 (7%)**	**41 (10%)**	**23 (5%)**
Member of the public	31 (7%)	1 (0.2%)	2 (0.5%)	11 (3%)
Dentist	27 (6%)	1 (0.2%)	4 (0.9%)	2 (0.5%)
Dentist – Practice Owner	69 (16%)	7 (2%)	17 (4%)	2 (0.5%)
Dentist – Associate	50 (12%)	7 (2%)	9 (2%)	1 (0.2%)
Dentist – Assistant	3 (0.7%)	0	0	1 (0.2%)
Dentist – Hospital Dental Service	7 (2%)	1 (0.2%)	1 (0.2%)	0
Dentist – Public Dental Service	21 (5%)	10 (2%)	2 (0.5%)	3 (0.7%)
Dental Care Professional	25 (6%)	2 (0.5%)	5 (1%)	0
Other	19 (4%)	2 (0.5%)	0	3 (0.7%)
Declined to specify	0	0	1 (0.2%)	0

Note: Percentages may not total 100 due to rounding.

Question 11: The provision of earnings and expenses information should be a terms of service requirement. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**19 (4%)**	**13 (3%)**	**23 (5%)**	**25 (6%)**
Individual	**99 (23%)**	**130 (30%)**	**86 (20%)**	**32 (7%)**
Member of the public	15 (4%)	7 (2%)	9 (2%)	14 (3%)
Dentist	10 (2%)	9 (2%)	12 (3%)	3 (0.7%)
Dentist – Practice Owner	10 (2%)	70 (16%)	14 (3%)	1 (0.2%)
Dentist – Associate	18 (4%)	23 (5%)	23 (5%)	3 (0.7%)
Dentist – Assistant	3 (0.7%)	0	0	1 (0.2%)
Dentist – Hospital Dental Service	4 (0.9%)	2 (0.5%)	3 (0.7%)	0
Dentist – Public Dental Service	14 (3%)	7 (2%)	9 (2%)	6 (1%)
Dental Care Professional	16 (4%)	5 (1%)	10 (2%)	1 (0.2%)
Other	9 (2%)	7 (2%)	5 (1%)	3 (0.7%)
Declined to specify	0	0	1 (0.2%)	0

Note: Percentages may not total 100 due to rounding.

Question 12: GDC-registered practice owners or GDC-registered directors of a dental practice should be required to provide a minimum number of hours of NHS clinical care per week in each practice location. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**19 (4%)**	**20 (5%)**	**18 (4%)**	**23 (5%)**
Individual	**151 (35%)**	**130 (30%)**	**41 (10%)**	**25 (6%)**
Member of the public	26 (6%)	3 (0.7%)	4 (0.9%)	12 (3%)
Dentist	16 (4%)	10 (2%)	6 (1%)	2 (0.5%)
Dentist – Practice Owner	27 (6%)	58 (14%)	9 (2%)	1 (0.2%)
Dentist – Associate	27 (6%)	30 (7%)	10 (2%)	0
Dentist – Assistant	2 (0.5%)	1 (0.2%)	0	1 (0.2%)
Dentist – Hospital Dental Service	3 (0.7%)	4 (0.9%)	2 (0.5%)	0
Dentist – Public Dental Service	15 (4%)	10 (2%)	5 (1%)	6 (1%)
Dental Care Professional	22 (5%)	7 (2%)	3 (0.7%)	0
Other	12 (3%)	7 (2%)	2 (0.5%)	3 (0.7%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 13: Bodies corporate must list with the NHS Board for the provision of GDS. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**44 (10%)**	**1 (0.2%)**	**13 (3%)**	**22 (5%)**
Individual	**236 (55%)**	**14 (3%)**	**70 (16%)**	**27 (6%)**
Member of the public	17 (4%)	1 (0.2%)	14 (3%)	13 (3%)
Dentist	28 (7%)	0	3 (0.7%)	3 (0.7%)
Dentist – Practice Owner	66 (15%)	7 (2%)	21 (5%)	1 (0.2%)
Dentist – Associate	55 (13%)	4 (0.9%)	8 (2%)	0
Dentist – Assistant	1 (0.2%)	0	2 (0.5%)	1 (0.2%)
Dentist – Hospital Dental Service	8 (2%)	0	1 (0.2%)	0
Dentist – Public Dental Service	27 (6%)	0	4 (0.9%)	5 (1%)
Dental Care Professional	19 (4%)	2 (0.5%)	10 (2%)	1 (0.2%)
Other	14 (3%)	0	7 (2%)	3 (0.7%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 14: There should be a reduced set of allowances, including a new practice allowance and GDP allowance, that reward the level of NHS commitment and quality of service provided. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**27 (6%)**	**8 (2%)**	**21 (5%)**	**24 (6%)**
Individual	**130 (30%)**	**85 (20%)**	**103 (24%)**	**29 (7%)**
Member of the public	15 (4%)	3 (0.7%)	14 (3%)	13 (3%)
Dentist	14 (3%)	5 (1%)	13 (3%)	2 (0.5%)
Dentist – Practice Owner	27 (6%)	35 (8%)	30 (7%)	3 (0.7%)
Dentist – Associate	18 (4%)	28 (7%)	20 (5%)	1 (0.2%)
Dentist – Assistant	2 (0.5%)	0	1 (0.2%)	1 (0.2%)
Dentist – Hospital Dental Service	3 (0.7%)	2 (0.5%)	4 (0.9%)	0
Dentist – Public Dental Service	20 (5%)	2 (0.5%)	9 (2%)	5 (1%)
Dental Care Professional	19 (4%)	7 (2%)	5 (1%)	1 (0.2%)
Other	12 (3%)	3 (0.7%)	6 (1%)	3 (0.7%)
Declined to specify	0	0	1 (0.2%)	0

Note: Percentages may not total 100 due to rounding.

Question 15: There should be a new qualification criteria to determine which practices are NHS committed. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**31 (7%)**	**5 (1%)**	**19 (4%)**	**25 (6%)**
Individual	**162 (38%)**	**58 (14%)**	**96 (22%)**	**31 (7%)**
Member of the public	22 (5%)	3 (0.7%)	7 (2%)	13 (3%)
Dentist	16 (4%)	5 (1%)	10 (2%)	3 (0.7%)
Dentist – Practice Owner	37 (9%)	26 (6%)	29 (7%)	3 (0.7%)
Dentist – Associate	28 (7%)	14 (3%)	23 (5%)	2 (0.5%)
Dentist – Assistant	3 (0.7%)	0	0	1 (0.2%)
Dentist – Hospital Dental Service	4 (0.9%)	2 (0.5%)	3 (0.7%)	0
Dentist – Public Dental Service	18 (4%)	2 (0.5%)	11 (3%)	5 (1%)
Dental Care Professional	16 (4%)	5 (1%)	10 (2%)	1 (0.2%)
Other	17 (4%)	1 (0.2%)	3 (0.7%)	3 (0.7%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 16: The control of funding for NHS dental services should be gradually devolved to HSCPs. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**8 (2%)**	**26 (6%)**	**22 (5%)**	**24 (6%)**
Individual	**34 (8%)**	**152 (36%)**	**133 (31%)**	**28 (7%)**
Member of the public	8 (2%)	3 (0.7%)	20 (5%)	14 (3%)
Dentist	3 (0.7%)	17 (4%)	12 (3%)	2 (0.5%)
Dentist – Practice Owner	3 (0.7%)	59 (14%)	30 (7%)	3 (0.7%)
Dentist – Associate	3 (0.7%)	35 (8%)	28 (7%)	1 (0.2%)
Dentist – Assistant	0	0	3 (0.7%)	1 (0.2%)
Dentist – Hospital Dental Service	1 (0.2%)	6 (1%)	2 (0.5%)	0
Dentist – Public Dental Service	5 (1%)	16 (4%)	12 (3%)	3 (0.7%)
Dental Care Professional	6 (1%)	9 (2%)	16 (4%)	1 (0.2%)
Other	5 (1%)	6 (1%)	10 (2%)	3 (0.7%)
Declined to specify	0	1 (0.2%)	0	0

Note: Percentages may not total 100 due to rounding.

Question 17: There should be a Director of Dentistry with oversight of all aspects of dental services and oral health improvement at NHS Board level. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**39 (9%)**	**7 (2%)**	**14 (3%)**	**20 (5%)**
Individual	**175 (41%)**	**61 (14%)**	**81 (19%)**	**30 (7%)**
Member of the public	20 (5%)	4 (0.9%)	7 (2%)	14 (3%)
Dentist	18 (4%)	6 (1%)	8 (2%)	2 (0.5%)
Dentist – Practice Owner	45 (11%)	21 (5%)	25 (6%)	4 (0.9%)
Dentist – Associate	32 (7%)	16 (4%)	18 (4%)	1 (0.2%)
Dentist – Assistant	2 (0.5%)	0	1 (0.2%)	1 (0.2%)
Dentist – Hospital Dental Service	9 (2%)	0	0	0
Dentist – Public Dental Service	18 (4%)	5 (1%)	9 (2%)	4 (0.9%)
Dental Care Professional	19 (4%)	4 (0.9%)	9 (2%)	0
Other	11 (3%)	5 (1%)	4 (0.9%)	4 (0.9%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 18: The Scottish Government proposes to review the remit of the Scottish Dental Practice Board. In your view should the SDPB be:

Responding as	Revised remit	Different host	Abolished	Retain exiting remit	Other	Not answered
Organisation	**16 (4%)**	**3 (0.7%)**	**14 (3%)**	**7 (2%)**	**11 (3%)**	**29 (7%)**
Individual	**139 (33%)**	**5 (1%)**	**42 (10%)**	**76 (18%)**	**29 (7%)**	**56 (13%)**
Member of the public	14 (3%)	0	2 (0.5%)	6 (1%)	5 (1%)	18 (4%)
Dentist	14 (3%)	0	7 (2%)	7 (2%)	4 (0.9%)	2 (0.5%)
Dentist – Practice Owner	33 (7%)	0	11 (3%)	32 (7%)	8 (2%)	11 (3%)
Dentist – Associate	27 (6%)	3 (0.7%)	9 (2%)	20 (5%)	4 (0.9%)	4 (0.9%)
Dentist – Assistant	2 (0.5%)	0	0	0	0	2 (0.5%)
Dentist – Hospital Dental Service	3 (0.7%)	0	1 (0.2%)	2 (0.5%)	2 (0.5%)	1 (0.2%)
Dentist – Public Dental Service	20 (5%)	0	3 (0.7%)	3 (0.7%)	1 (0.2%)	9 (2%)
Dental Care Professional	19 (4%)	1 (0.2%)	3 (0.7%)	2 (0.5%)	3 (0.7%)	4 (0.9%)
Other	6 (1%)	1 (0.2%)	6 (1%)	4 (0.9%)	2 (0.5%)	5 (1%)
Declined to specify	1 (0.2%)	0	0	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 19: In view of the proposal to introduce a new preventive care pathway, a new 'enhanced' Clinical Quality Monitoring Service for patients would be required. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**41 (10%)**	**4 (0.9%)**	**15 (4%)**	**20 (5%)**
Individual	**179 (43%)**	**70 (16%)**	**67 (16%)**	**31 (7%)**
Member of the public	21 (5%)	4 (0.9%)	5 (1%)	15 (4%)
Dentist	20 (5%)	7 (2%)	5 (1%)	2 (0.5%)
Dentist – Practice Owner	35 (8%)	29 (7%)	26 (6%)	5 (1%)
Dentist – Associate	30 (7%)	21 (5%)	16 (4%)	0
Dentist – Assistant	3 (0.7%)	0	0	1 (0.2%)
Dentist – Hospital Dental Service	7 (2%)	2 (0.5%)	0	0
Dentist – Public Dental Service	23 (5%)	3 (0.7%)	7 (2%)	3 (0.7%)
Dental Care Professional	22 (5%)	3 (0.7%)	6 (1%)	1 (0.2%)
Other	17 (4%)	1 (0.2%)	2 (0.5%)	4 (0.9%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 20: The Scottish Government proposes developing, and rolling out across Scotland, a national database of key indicators of quality. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**46 (11%)**	**2 (0.5%)**	**13 (3%)**	**19 (4%)**
Individual	**183 (43%)**	**61 (14%)**	**75 (18%)**	**28 (7%)**
Member of the public	24 (6%)	5 (1%)	3 (0.7%)	13 (3%)
Dentist	20 (5%)	4 (0.9%)	8 (2%)	2 (0.5%)
Dentist – Practice Owner	44 (10%)	24 (6%)	23 (5%)	4 (0.9%)
Dentist – Associate	30 (7%)	20 (5%)	16 (4%)	1 (0.2%)
Dentist – Assistant	2 (0.5%)	0	1 (0.2%)	1 (0.2%)
Dentist – Hospital Dental Service	5 (1%)	2 (0.5%)	2 (0.5%)	0
Dentist – Public Dental Service	21 (5%)	4 (0.9%)	9 (2%)	2 (0.5%)
Dental Care Professional	21 (5%)	2 (0.5%)	8 (2%)	1 (0.2%)
Other	15 (4%)	0	5 (1%)	4 (0.9%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 21: The Scottish Government proposes the development of a process that will make protected learning time available for dentists and practice staff. Agree or Disagree?

Responding as	Agree	Disagree	Neither agree nor disagree	Not answered
Organisation	**53 (12%)**	**3 (0.7%)**	**5 (1%)**	**19 (4%)**
Individual	**275 (64%)**	**21 (5%)**	**27 (6%)**	**24 (6%)**
Member of the public	28 (7%)	0	4 (0.9%)	13 (3%)
Dentist	31 (7%)	0	1 (0.2%)	2 (0.5%)
Dentist – Practice Owner	72 (17%)	13 (3%)	8 (2%)	2 (0.5%)
Dentist – Associate	57 (13%)	4 (0.9%)	5 (1%)	1 (0.2%)
Dentist – Assistant	3 (0.7%)	0	0	1 (0.2%)
Dentist – Hospital Dental Service	9 (2%)	0	0	0
Dentist – Public Dental Service	30 (7%)	2 (0.5%)	2 (0.5%)	2 (0.5%)
Dental Care Professional	27 (6%)	1 (0.2%)	4 (0.9%)	0
Other	17 (4%)	1 (0.2%)	3 (0.7%)	3 (0.7%)
Declined to specify	1 (0.2%)	0	0	0

Note: Percentages may not total 100 due to rounding.

Question 22: If you would like to provide any further thoughts or comments, please do so in the box below.

Responding as	Provided Comments	Not answered
Organisation	**75 (18%)**	**5 (1%)**
Individual	**248 (58%)**	**99 (23%)**
Member of the public	27 (6%)	18 (4%)
Dentist	25 (6%)	9 (2%)
Dentist – Practice Owner	79 (19%)	16 (4%)
Dentist – Associate	46 (11%)	21 (5%)
Dentist – Assistant	1 (0.2%)	3 (0.7%)
Dentist – Hospital Dental Service	7 (2%)	2 (0.5%)
Dentist – Public Dental Service	27 (6%)	9 (2%)
Dental Care Professional	16 (4%)	16 (4%)
Other	19 (4%)	5 (1%)
Declined to specify	1 (0.2%)	0

Note: Percentages may not total 100 due to rounding.

This publication is available at **www.gov.scot**

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