



SCOTTISH EXECUTIVE

Health Department
Directorate of Primary Care and Community Care

Dear Colleague

REVIEW OF PRIMARY CARE SALARIED DENTAL SERVICES IN SCOTLAND

1. At the beginning of 2002 the Chief Dental Officer asked Margie Taylor, a Consultant in Dental Public Health with NHS Lanarkshire, to Chair a Group to undertake a thorough review of the salaried dental sector in Scotland.
2. The Group has now produced its Final Report and a copy is attached to this circular, for information. The Minister has accepted the recommendations of the Report in full and the intention is to use these as the basis for future planning of salaried dental services in this country.
3. Boards are asked to bring this Report to the attention of all staff with an interest in salaried and community dentistry in their areas, including dentists and dental nurses, hygienists and technicians and in particular Clinical Directors, Consultants in Dental Public Health and Community Health Partnerships.
4. A bound copy of the Report will be available in due course and can be requested by contacting the Executive at the address opposite.
5. The Scottish Executive will start discussions in the near future with the service and the British Dental Association and other professional representative organisations with a view to implementing the recommendations of the Report. Further information about the timetable for implementation will be published in due course.

Yours sincerely

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13 October 2006

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**Review of
Primary Care Salaried Dental Services
in Scotland**

Foreword

The Community Dental Services and the Salaried General Dental Services have both contributed considerably to the care of people of Scotland over many years. There was widespread support for both services during our consultation on modernising dental services and improving oral health in Scotland, especially as a means of delivering a comprehensive service to remote and rural areas where independent dental practice did not seem to be a sustainable model of care. Many managers and professionals from island and other remote communities consider that these salaried services enable them to design a comprehensive public dental service for their area matching need and demand.

These services are both directly managed by NHS Boards and enable Boards to use these staff to the maximum benefit of the community, especially where services are not available through NHS independent contractors.

This report now sets a clear way forward for the development of the salaried dental services in Scotland with a merging of the two services into one managed dental primary care service for Scotland.

I would like to pay tribute to all those who contributed, to the members of the Working Group and in particular to Marjory Taylor who Chaired the Group and steered the process throughout.

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1. REMIT

The remit of the group was to review the role, remit and structure of primary care salaried dental services and identify an effective and efficient service for the new millennium in Scotland.

2. METHODOLOGY

2.1 An initial meeting was held with the Clinical Directors of the CDS in Scotland to:

- discuss the remit of the group;
- gather views on the process of undertaking the review;
- agree the representation of the Clinical Directors on the group;
- gather initial thoughts on the important factors to be considered in the review.

2.2 The group was formed involving members of the following disciplines:

- Community Dental Service (CDS)
- Salaried General Dental Service (GDS)
- Independent Contractor General Dental Service (GDS)
- Professionals Complementary to Dentistry (PCDs)
- Local Health Care Co-operatives (LHCC)
- Local Health Council
- Academia
- Health Economics
- Dental Public Health
- Information Services Division of National Services Scotland (ISD)

An effort was made to ensure that there was adequate geographical spread of representation across Scotland in order to ensure that a wide cross section of opinion was canvassed and that the remote and rural dimension was addressed appropriately.

2.3 The chair of the group agreed with the then secretary of the BDA in Scotland the process of its involvement. It was agreed that following initial discussions of the working group and when there were draft recommendations to consider, the views of the community accredited representatives (CARs) would be sought. In addition, a SWOT analysis was carried out with the CARs.

2.4 The chair of the working group was invited by the senior clinicians group of the CDS as part of their routine meetings to discuss the project with them. This session took the form of a SWOT analysis and helped inform the ongoing work of the group. The views of the group were sought again when the recommendations were being formed.

2.5 Following an initial meeting of the group it was agreed that there was sufficient expertise within the group from the CDS. Due to the diverse nature of the salaried GDS however and the fact that the service was relatively new and changing very quickly, it was agreed that there had to be an increased effort to engage with this sector. All the salaried GDS dentists were invited through their Clinical Directors to attend

meetings with representatives of the working group. Consequently two meetings were held in Edinburgh and one in Inverness. These meetings took the form of a SWOT analysis and were facilitated by the chair of the group.

- 2.6 A summary of the results of the SWOT analysis exercises were combined and considered by the group. (Appendix 1)
- 2.7 Baseline data was collected on the oral health of the population, staffing and activity levels. In addition, the relevant Scottish Executive Circulars informed the discussions.
- 2.8 The group met on 14 occasions.
- 2.9 Conclusions and recommendations were circulated widely for comment prior to the completion of the document.
- 2.10 As a result of the consultation, the comments received were considered and the document amended accordingly.
- 2.11 During the process, at the request of the Chief Dental Officer, a subgroup was appointed to look at the options for developing a targeted, or a comprehensive, children's service.

3. ORAL HEALTH OF THE POPULATION OF SCOTLAND

This chapter gives a brief overview of the epidemiology of dental disease in the population highlighting the oral health of the population of Scotland.

3.1 Children

3.1.1 Epidemiology

Dental decay is one of the major causes of ill health in the community and is the main cause of hospital admission for general anaesthesia among the 0-14 year old age group in Scotland. It is associated with considerable pain, discomfort and loss of function. Its treatment represents a major cost to the NHS in Scotland.⁽¹⁾

The distribution of dental decay in the child population is linked to socio-economic status and the distribution of dental decay in society is skewed, with a small proportion of children experiencing the majority of the disease.⁽²⁾

As has been demonstrated in past surveys, children living in the most disadvantaged areas have 3 times the number of diseased teeth compared to those in more affluent communities; additionally, only 20% remain free of dental decay by 5 years of age compared with over 60% of those from the most affluent areas.⁽³⁾

The national target detailed in *An action plan for improving oral health and modernising NHS dental services in Scotland*⁽⁴⁾ states that “60% of 5 year old children will have no signs of dental disease by 2010”. The results of the Scottish 2003 NDIP⁽²⁾ survey confirm that 45% of 5 year olds had no obvious decay but there is considerable progress required for all NHS Boards to achieve this national target by 2010, despite a general improvement in dental health between 1994 and 2004. (Figure 1)

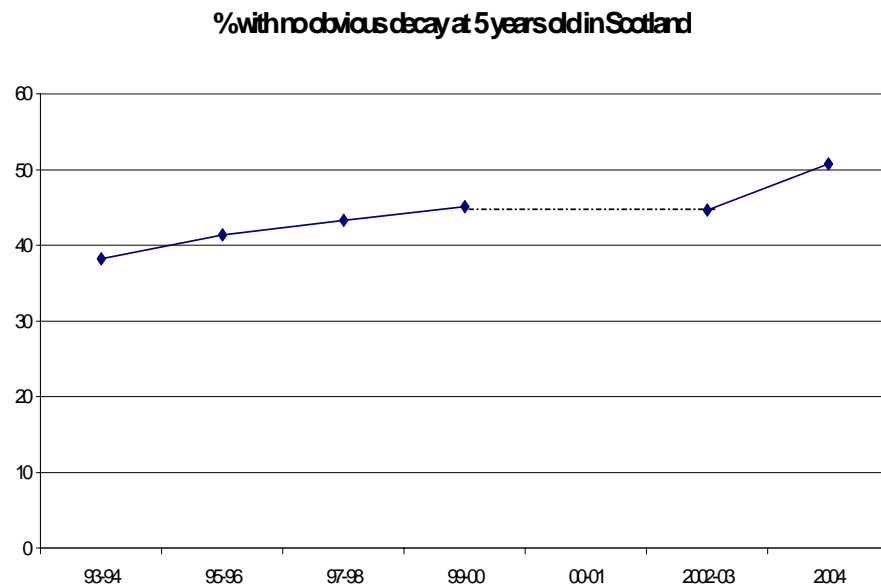
In the Scottish Health Boards’ Dental Epidemiology Programme (SHBDEP) survey of 14 year old children carried out in 1998/9, it was shown that more than two-thirds of 14 year olds (68%) were found to have already experienced decay in their permanent teeth,⁽⁵⁾ while in a previous survey carried out in 1996/7, 58% of 12 year-olds had experienced decay.⁽⁶⁾ Although both of these figures were improvements over previous years, they still show that marked progress will be needed to reach the target of 60% of Primary 7 children with no signs of dental disease in their permanent teeth.

As with diet, the oral hygiene practices and dental attendance patterns of children are closely associated with those of their parents and carers. Mothers who are irregular attenders are less likely to take their children to the dentist at an early age and children who attend a dentist regularly

have better dental health than those who attend irregularly or not at all. Children from more disadvantaged areas are less likely to have their teeth brushed from the time teeth erupt and are less likely to have their toothbrushing supervised.⁽⁷⁾

The main cause of dental decay is a diet high in sugars, especially frequent consumption of sweets, confectionery and high-sugar fizzy drinks. Next to diet, good dental hygiene is a major factor in preventing the onset of dental decay in children. Twice daily tooth brushing with a fluoride toothpaste is proven to reduce significantly dental decay. The application of fissure sealants to the biting surfaces of permanent molar teeth soon after they come through is an effective means of reducing dental decay in young people.⁽⁸⁾

Figure 1 - Percentage of 5 year olds with no obvious decay in Scotland by year



Source: SHBDEP and NDIP

----- Full data not available for year 2000/01

3.1.2 Treatment of Decayed Teeth

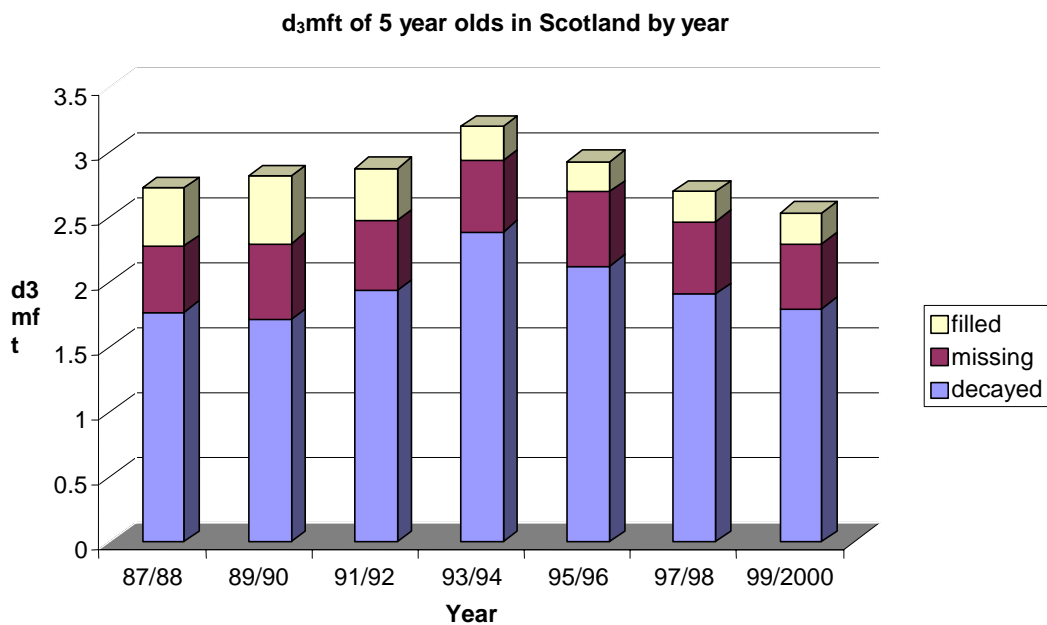
Trends in the level of restorative care received by children in the UK since epidemiological surveys began are well documented.^(2,5,6,9) The capitation system of remunerating general dental practitioner, which existed between 1990 and 1996, combined with other changes in primary care dental services, appear to have failed in addressing the restorative needs of children of all ages.

In 1996, item of service payments were re-introduced within the GDSs for certain aspects of treatment, including fillings and extractions, and

were linked to a modified capitation system. Further incentives to register young children in deprived areas were introduced in 1998.

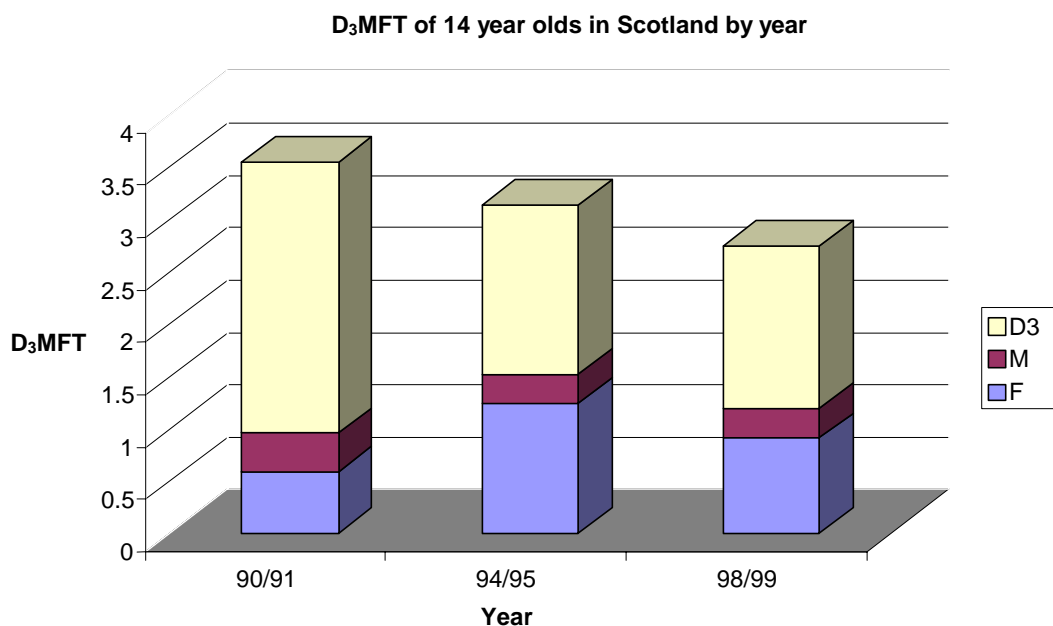
The Care Index is used to describe the level of restorative care a child receives. The NDIP results for 2003⁽²⁾ show that only 9% of decay had been treated and Figures 2 and 3 show the small percentage of filled teeth compared to the decayed and missing components in 5 and 14 year olds in Scotland. The vast majority of dental decay in the teeth of 5 year old children therefore remains untreated, with the majority of the remainder being treated by extraction. The reasons behind this are complex and not fully understood but cannot only be attributed to the dental remuneration system or access to services and registration rates. Given the highly skewed prevalence of dental decay described above and the fact that the most disadvantaged children have the majority of the disease, it is likely that those most in need of dental treatment are the least likely to be registered or become regular attendees.

Figure 2 - d₃mft of 5 year olds in Scotland by year



Source: SHBDEP

Figure 3 – D₃MFT of 14 year olds in Scotland by year



Source: SHBDEP 90/01, 94/95, 98/99

3.2 Adult Oral Health

3.2.1 Epidemiology

Oral health in older adults in Scotland is poorer than in other parts of the UK.⁽¹⁰⁾ However, despite 18% of Scottish adults having no natural teeth, there have been steady improvements in adult oral health since 1968.⁽¹¹⁾ The number of Scottish adults retaining 21 teeth or more (the number considered necessary to provide a functional dentition) has risen substantially. Deprivation and the low priority sometimes afforded to oral health by individuals, carers and family, contribute to poor oral health.⁽¹⁰⁾ For older adults who retain some natural teeth, root caries and advanced periodontal disease are more common than in younger adults.

Increased life expectancy in Scotland has focussed interest in healthcare provision for older people. There is an expectation that appropriate healthcare, including oral healthcare services, should be an essential part of healthy ageing and should contribute positively to the enjoyment of older age. However, there is currently considerable variation in the pattern of older people to accessing and utilising health

services, particularly with respect to functionally frail older adults, who may experience difficulty when seeking to meet oral health needs.

Adults over 60 years of age, who currently make up a fifth of the UK population, will constitute one-third by 2030; in Scotland, those aged 65 and over will increase by just over 50%, with those over 80 years of age representing the section of the population with the greatest increase in numbers.⁽¹²⁾

The impact of factors such as systemic disease, poor nutritional status and drug associated changes in the oral tissues, together with the potential impact of disability, all have an important influence on the ability of older people to maintain good oral health.⁽¹³⁾

Conversely, poor oral health may impact significantly upon general health by impairing the ability of individuals to maintain an adequate diet, resulting in reduced overall well-being for affected individuals.⁽¹⁴⁾

Recent work by Steele *et al.*,⁽¹⁵⁾ which examined UK adult dental health survey data, indicated that the number of adults retaining natural teeth is likely to grow substantially. There are clear inequalities in the dental health of adults, with a smaller proportion of those from more deprived areas (DEPCAT 5, 6, 7)⁽¹⁶⁾ retaining their own teeth.

Many factors are implicated in the reduction of edentulousness. There have been changing attitudes towards oral health and dentistry among the general population, and these have been influenced to some degree by advances in restorative dentistry and changing treatment patterns of dental practitioners.^(17,10) The increased use of fluoride, including fluoride toothpaste, has also had an impact.

The Action Plan⁽⁴⁾ has set a target that by 2010, 95% of 45 to 54 year olds should retain some natural teeth. In 1998, 87% of this age group had some natural teeth and among the age cohort (35 to 44 year olds) who will be 45-54 in 2010, 96% had retained some natural teeth.⁽¹⁰⁾ Progress is, therefore, being made towards the national target. The proportion of adults with 21 or more natural teeth (the number consistent with a functional dentition) has risen from 64% in 1972 to 78% in 1998.

Adults living in disadvantaged areas have fewer natural teeth, more actively decayed teeth and fewer restored teeth. In Scotland 41% of adults with some natural teeth report having had pain in the previous 12 months. Furthermore, 30% percent of dentate adults in Scotland report feeling self-conscious or tense because of their teeth, mouth or denture in the previous 12 months and just over 20% find that their oral condition causes them embarrassment and makes it difficult to relax.⁽¹⁰⁾

Predictions of future total teeth loss have been made, and assuming no increase in the incidence of total tooth loss, the proportion of adults

with no natural teeth can be expected to continue to fall, and to reduce to single figure percentages in all age groups up to the age of 74 by 2008.

In older people, studies have shown that untreated caries was most commonly found on the crowns of the teeth (25%), although a substantial number (18%) also had root caries.⁽¹⁰⁾ One longitudinal study of caries in older adults has found that over three years, caries developed on an average of 2.4 coronal surfaces and 1.1 root surfaces per person per year. For older adults who are functionally frail and unable to manage oral hygiene measures independently, the rates are much higher. Recent UK data indicate that, in adults over the age of 65, an average of 10.6 teeth were vulnerable to root surface caries and a third had existing root caries lesions.⁽¹⁸⁾

The second most prevalent oral disease involves the gums. Periodontal (gum) conditions in the form of pocketing are seen in over half the adult population. The prevalence of pocketing, loss of attachment and calculus increases with age with 85% over the age of 65 affected.⁽¹⁰⁾

Over 500 new cases of oral cancer are diagnosed each year in Scotland and there are about 230 deaths. The incidence in Scotland is approximately 13 per 100,000 while the incidence in England and Wales is about 7 per 100,000. Within Scotland there was a rise of over 40% in the incidence of oral cancer between 1985 and 1996. While approximately 85% of new cases occur in those aged 50 and over, a trend of increasing prevalence has been most apparent in the younger age groups.⁽¹⁹⁾

In addition to ageing, there are other well-recognised risk factors for oral cancer, the most significant of which are tobacco and alcohol use. One large case-control study showed⁽²⁰⁾ that the risk of oropharyngeal cancer increased more than 35 times in individuals who consumed two or more packs of cigarettes and more than four alcoholic drinks per day.

There is evidence linking oral cancer to the use of smokeless tobacco products, the use of which is common among South Asian populations of the UK. Moreover, there is extensive misinformation and lack of awareness about the risk factors and early signs of oral cancer in this population.⁽²¹⁾

As with other oral and dental diseases, the occurrence of oral cancer is associated with deprivation and deaths from such cancers are three times greater in those from deprived areas, compared with those from affluent areas. Early diagnosis is essential, as treatment of early lesions requires a less radical approach and has better survival rates.

4. CURRENT SALARIED SERVICES

This chapter describes the current primary care salaried dental services, explaining the remit, function, distribution and activity of the CDS and the primary care Salaried GDS.

4.1 Community Dental Service (CDS)

4.1.1 Remit

The CDS is a directly managed service in which staff are remunerated by salary. Its role and remit were defined in 1989⁽²²⁾ and updated in 1997.⁽²³⁾

These circulars identify a Public Health function to include screening, health promotion and preventive public health programmes for children and adults with special needs. The service undertakes annual inspections of children's oral health as part of the National Dental Inspection Programme.

The second function is the treatment objective of the service, providing a complementary service to the GDS by identifying special needs groups. More recently there has been an increased commitment to act as a safety net treatment service for those patients who do not obtain treatment from the GDS.

4.1.2 Client groups

As indicated above, the CDS provides a full range of treatment services, for those with special needs (community care groups) and an enhanced 'safety-net' role for those patients of any age who cannot or will not obtain treatment from the GDS.

In most NHS Board areas, the CDS provides a service to older people, especially those in residential or nursing care, or who have impaired mobility. This service complements the care provided by the GDS. The definition of "special needs" is not easily defined and currently encompasses both people whose special needs refer to their social or emotional needs but have routine dental problems, and also to people whose systemic conditions render dental treatment more demanding and time consuming.

During the review process, the group attempted to define 'special needs'; the definition however seems to be inconsistent across the country, but the definition from the joint Advisory Committee for Special Care Dentistry documents "Training in Special Care Dentistry" (2003) and "A Case of Need for Special Care Dentistry" (2003) is cited for guidance. (Appendix 2)

The treatment of special needs groups is often more complex and time consuming than the routine provision of treatment due to, for example, complex medical histories of the client group, or behavioural aspects arising from their condition.

As more adults retain some natural teeth into later years, complexity of treatment increases accordingly. Furthermore, as patient expectations of treatment rise, there is a growing need for appropriately equipped and accessible dedicated dental care facilities for the treatment of older adults with complex treatment needs. Such facilities could be used by both general and community dental practitioners where local agreement is reached.

4.1.3 Distribution

Between 1980 and 2004 the number of Whole Time Equivalent Community Dental Officers in Scotland reduced from 278 to 192⁽²⁴⁾. In contrast, the number of Senior Dental Officers, who have greater experience and skills in the complex management issues associated with Community Care, has risen from 6.5 WTE to 37.2 WTE in the same period. Although this reflects the general trend, the group felt that the WTE figure of the Community Dental staff may not be absolutely accurate.

4.1.4 Activity

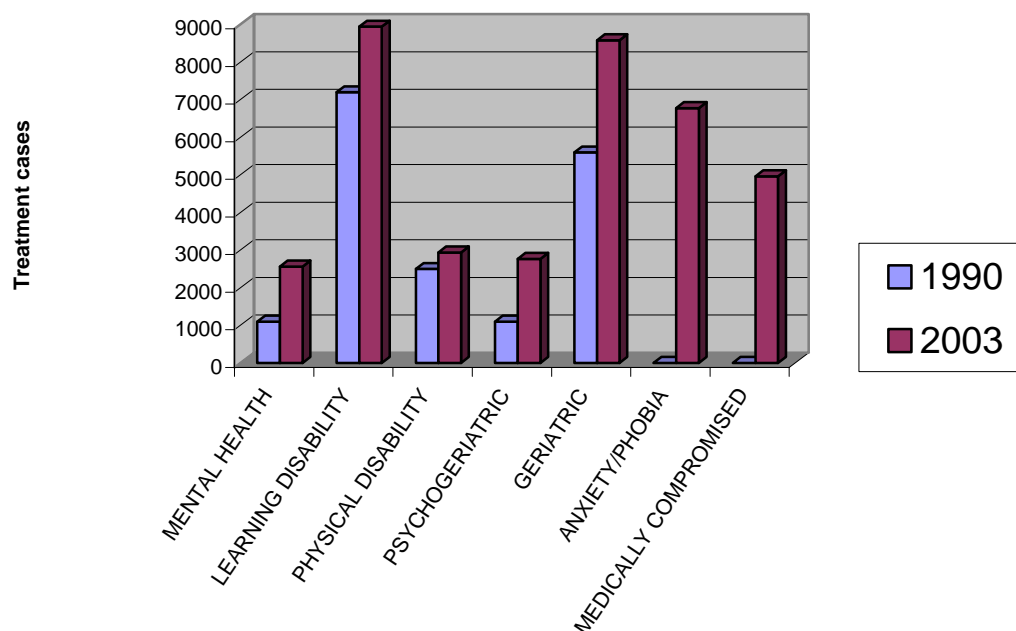
4.1.4.1 Clinical Activity

Activity in the CDS is monitored by completion of SMR 13 forms, which is a patient based system recording the clinical activity and courses of treatment carried out in the service. The forms are processed and summarised by Information Services Division (ISD), and distributed quarterly.

Overall activity within CDSs in Scotland is detailed in Appendix 3. While the overall number of courses of treatment appears to have reduced over the years, it should be noted that the proportion of adults (with more complex treatment needs) has increased during this time.

CDS activity under the special needs categories for Scotland is detailed Figure 3.

Figure 3. Activity in the CDS under special needs categories for Scotland



Source: PHIS needs assessment report on 'Community Care and Oral Health April 2002'

The pattern of provision of domiciliary care for community care groups has changed over the last decade. In 1991/92 there were approximately 3,000 domiciliary cases treated in the CDS and in the year 2003, there were 9,700 cases. This has implications for staff and patients in terms of time commitment, health and safety issues, quality of treatment outcomes and what aspects of dental care can appropriately be provided on a domiciliary basis.

In summary, the activity in the CDS has changed markedly over the last couple of decades with a reduction in staffing levels, a concomitant reduction in patient numbers, and within that an increase in the proportion of adults being seen and a greater emphasis on clients with special needs.

The provision of domiciliary care for community care groups has implications for staff and patients in terms of time commitment, health and safety issues, quality of treatment outcomes and what aspects of dental care can appropriately be provided on a domiciliary basis.

4.1.4.2 Inspections and screening

CDSs in Scotland have established good working relationships with local authorities and undertake NDIP inspections in primary schools in Scotland.

Inspections are undertaken as a means of making an initial assessment of oral health needs and identifying individuals requiring further treatment. NDIP provides basic dental inspections for Primary 1 and Primary 7 children annually, informing parents of their child's dental status. Detailed inspections are carried out every year in Primary 1 and Primary 7 in alternate years, enabling NHS Boards to direct services and oral health promotion initiatives to areas with the greatest need.

Within Scotland, oral health inspections are also carried out for people cared for in residential settings, with limited screening being undertaken in smaller units such as group homes, and day and resource centres. Some children attending special schools or special units within mainstream schools also receive dental inspections from the CDS.

4.1.5 Monitoring Clinical Standards

Currently there are no nationally agreed protocols for monitoring clinical standards in the CDS. All dentists are required to undergo continuing professional development and this is monitored by the GDC.

4.1.6 Out-of Hours Service

Staff of the CDS do not have a contractual obligation to provide a service for their patients out of working hours. There is however a 'professional obligation for dentists to make adequate provision for their patients' and many CDS staff are involved in an out of hours rota for an agreed fee.⁽²⁵⁾

4.1.7 Patient Charges

Children attending the CDS and GDS are not charged for their treatment, adults who would normally be eligible to pay under the GDS Regulations are subject to charges on a limited basis i.e. dentures, bridges.

4.1.8 Career Structure

The CDS does not have a formal career structure but there are many frameworks in place addressing the career pathway for dentists. Many Community Dental Services in Scotland are involved in the VT/GPT schemes, crosslinked to the Hospital and GDSs. Dentists who are

employed by the service are encouraged, but not obliged, to work towards a second degree in Public Health or Community Medicine, or a second qualification, for example, MFDS/MSND. Dentists with a second degree, and an appropriate amount of clinical experience are then entitled to apply for a senior post.

There is also the possibility of developing, within the CDS, a special interest in one particular branch of dentistry which can complement their general dental skills.

4.1.9 The Wider Dental Team

In addition to dentists, the CDS employs a wide team of dental nurses, hygienists, therapists, oral health promoters, oral health educators and administration staff. This team contributes to the overall care of the patient and the wider community, as well as the professional development of one another. Since the only Dental Therapy School in the UK closed several years ago, the number of therapists has dwindled. Recently, however, their scope for carrying out a wide range of procedures has increased. With the increasing awareness of the PCDs' role in contributing to improving oral health, there should be the opportunity not only to make better use of their skills, but to ensure that the dentists employed in the service are able to maximise their own potential.

4.2 Salaried General Dental Service (Salaried GDS)

4.2.1 Remit

The remit of the Salaried GDS is the same as that of overall GDS, except that Salaried GDPs are remunerated on a salaried basis, rather than item of service and are managed as part of the Salaried Dental Services. The remit of the General Dental Service is described in 5.1.

Salaried GDPs are usually recruited to areas where access to NHS GDS is limited, often due to retiring practitioners being unable to sell their practices or where dentists have moved into the private sector.

Whilst difficulties in selling dental practices has historically been mainly a rural issue, it is now becoming a problem in more populated areas. The consequential gap in the capacity of GDS services necessitates the appointment of salaried practitioners in some towns and cities.

4.2.2 Client groups

Salaried GDPs are permitted to treat all categories of patients, as do independent NHS general dental practitioners as detailed in section 5.1.

4.2.3 Distribution

Recent figures indicate that there are currently 81 Salaried GDP posts established in Scotland. Due to recruitment difficulties not all these posts are filled. There is no recognised appropriate level of dentist to population ratio across Scotland so levels of salaried practitioners will depend on local circumstances, influenced by demand and need.

4.2.4 Activity

Table 1 shows the activity of salaried dentists for year ending March 2004. The table which shows a wide variation of registered patients per practitioner provides a head count, but not the whole time equivalent figure. The table also shows a wide variation in numbers of registered patients per dentist and this reflects the differing practices across the country. The group felt that it was influenced by the following issues:

- dentists may be taking patients on referral from colleagues and are not registering them;
- the GP17 forms may not be routinely completed;
- in areas where demand is high, and supply is low, patients may be being seen on a casual basis and therefore are not being registered;
- if demand is too high there is little incentive to re-register patients.

The activity data collected for the Salaried GDSs is lower in some cases than the activity in the GDS. Suggestions as to why this might be were put forward by the group:

- patients typically seen by this service are made up of a higher proportion of children than would normally be seen;
- patients requiring more time consuming treatment plans (anxious and special needs patients)
- some practitioners have long distances to travel before being able to start work
- practitioners carry out many treatments for which there is no item of service to claim on the GP17 form, for example, review appointments and preventive treatments, so there is an element of under-counting when analysing their activity.

Table 1 – Activity of salaried dentists, year ending March 2004

	Forms processed	Number of dentists ^{1,2}	No. of registrations ³	
			Children	Adults
Scotland	62,165	81	13,704	35,783
Argyll & Clyde	9,079	8	1,666	3,959
Ayrshire & Arran	6,190	7	1,287	3,281
Borders	2,834	4	739	1,907
Dumfries & Galloway	2,173	3	616	1,425
Fife	0	1	36	1,258
Forth Valley	950	1	369	448
Grampian	7,813	9	439	4,503
Greater Glasgow	0	0	10	35
Highland	13,308	18	3,320	8,726
Lanarkshire	275	1	0	5
Lothian	7,329	9	1,206	3,620
Orkney	4,095	7	880	2,324
Shetland	6,997	9	3,123	2,965
Tayside	0	0	6	19
Western Isles	1,122	4	7	1,308

¹ Excludes dentists who hold both salaried and non-salaried list numbers in the GDS; this is to avoid counting them twice, as they are already counted as non-salaried dentists.

² The number of salaried dentists active at 31 March 2004.

³ The number of registrations at 31 March 2004.

Source: Scottish Dental Practice Board Annual Report 2003/04

4.2.5 Monitoring Clinical Standards

All dentists are required to undergo continuing professional training and this is monitored by the GDC. Clinical standards are monitored by the Practitioners Services – Dental (PSD) in relation to Salaried GDS.

4.2.6 Out of Hours

Under their NHS terms of service, Salaried GDPs are obliged as part of their contract to make arrangements to ensure that their NHS registered patients have access to emergency treatment. This service can be provided by individual dentists, or by groups of practices.

4.2.7 Patient Charges

Patients attending the primary care Salaried GDS are subject to the same charges for their treatment as those treated under the GDS generally. Salaried dentists are required to collect patient charges in accordance with the regulations and to remit all charges collected to the health board. Salaried dentists are required to use the standard NHS claim forms for the treatment of patients and submit these to the PSD. The PSD processes the claims for care and treatment provided

but because salaried dentists receive a set salary, they are not entitled to receive the scheduled fees.

4.2.8 Career Structure

There is no formal career structure within the salaried GDS, although there are options open to dentists for higher training and promoted posts are available.

4.2.9 Wider Dental Team

The dentists who work in the GDS or the salaried dental services work as part of a wider dental team made up of dental nurses, dental hygienists, therapists and administration staff. Currently therapists are being trained in Scotland and in the future they will be able to contribute to the work of the team by providing an extensive range of clinical procedures.

4.3 Joint and “Combined” (or split) GDS/CDS posts

These terms have evolved to describe practitioners whose remit is neither wholly in the CDS, nor in the GDS. Special terms and conditions have been developed to allow practitioners to respond to local need. They have, however, evolved in two ways and these are explained here.

4.3.1 Joint posts

These posts arose from the occasional necessity of community dental officers to provide GDSs in areas that could not access dental services routinely. The spirit of the post remained essentially within the CDS and the revenue consequences of the salaried portion remained with the cash-limited budgets of health boards. The salary scale is the same as that for CDS, plus an additional responsibility allowance, the latter comes from the non-cash-limited GDS budget.

A major anomaly arises in the responsibility allowance associated with joint posts, which is paid in order to reflect the GDS element of the job. However, this is not reflected in other salaried posts.

4.3.2 Combined (or split posts)

Combined or split posts were created in order to address more serious problems of access to primary dental care services in areas where the population levels made it more realistic for a single practitioner to take on the roles of both a salaried dental officer (GDS) and that of a community dental officer, albeit with a relatively small element of CDS activity. However, in this case, the emphasis is heavily weighted towards GDS. The CDS element in many cases is present to ensure that school inspection programmes are implemented. The budgetary

split is dependent on the individual Board need. Dental officers work within the GDS regulations in a family setting, but also implement the school dental inspection programme in their area, thus performing a public health role within a GDS framework.

5. GDS (INDEPENDENT CONTRACTORS)

This chapter briefly describes the current independent contractor GDS in order to provide a context for the report.

5.1 Remit

The General Dental Practitioner service is the main primary care dental service and the majority of General Dental Practitioners are independent contractors. As such they can choose whether or not to treat people under the National Health Service. In addition, there is no restriction on where a dentist may practise and this is often dictated by market forces. Due to these factors, it is therefore difficult to plan GDSs to reflect the needs of the community.

The monitoring and authorisation of payments is carried out for the service by PSD on behalf of the Scottish Dental Practice Board (SDPB). Practitioners may also treat people on an 'occasional' basis, usually for emergency problems.

Individual General Dental Practitioner contracts are held by the NHS Boards.

5.2 Client Groups

5.2.1 Children

NHS GDPs treat children and young people below 18 years of age under a hybrid capitation agreement. In September 1996 the original capitation contract was replaced with a modified contract in which the capitation payment is supplemented by item-of-service fees for certain treatment procedures. This agreement allows for the provision of a full range of free dental care including examination, curative and preventive treatments as well as some more complex restorative and orthodontic procedures.

GDPs currently are paid a basic capitation payment for patients under 18 years of age to secure and maintain oral health for each patient. However, in order to encourage registration of children, they receive an enhancement of the capitation fee, which increases as the deprivation category of the dental practice increases, when the patient is aged 0-2 years old. Where the patient is aged 3-5 years old, the dentist receives an enhancement of the capitation fee if the post-code of the practice falls into Deprivation Categories 6 and 7⁽¹⁶⁾. For children aged 6 and 7 years old, they receive similar enhancements, also according to the post-code of the practice. Dentists receiving the enhanced capitation fee are required to assess the patients' caries risk, render the child dentally fit and seal the first permanent molar teeth as soon as possible after eruption.

5.2.2 Adults

General dental practitioners are remunerated by a combination of a capitation system, known as Continuing Care, and a fee for item of service. Routinely, adults have to meet 80% of the cost of NHS treatment up to a maximum charge. If patients fall into one of several exemption categories, e.g. expectant or nursing mother, receiving family credit or income support, or incapacity benefit they are entitled to free NHS care.

5.3 Additional allowances

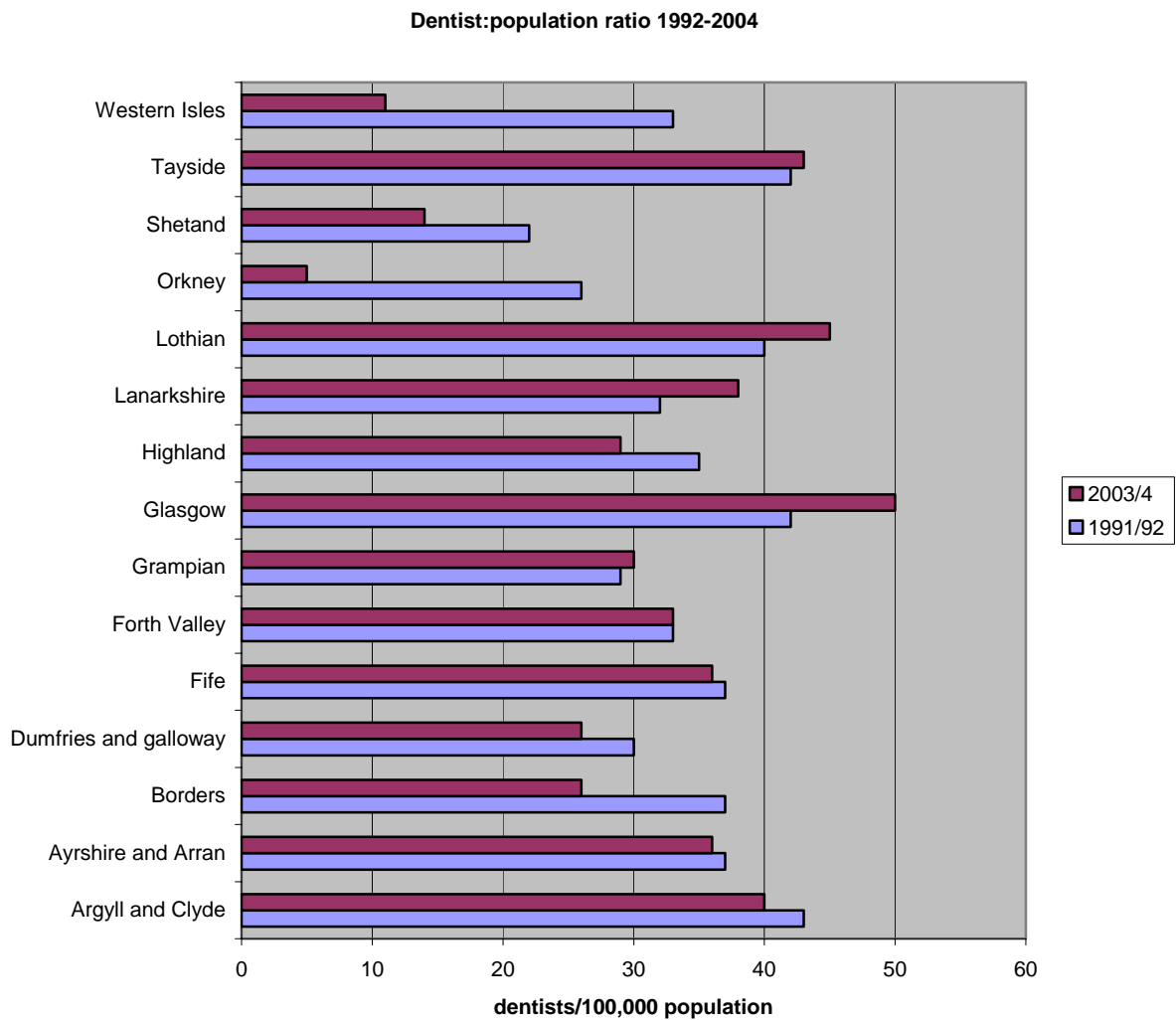
In recent years, additional allowances have been introduced, for instance, to help pay for practice improvements, to act as incentives to attract practitioners to remote and rural areas, and to encourage newly qualified practitioners to stay in Scotland.

5.4 Distribution

The provision of GDS varies across Scotland and has changed over the last decade. Although there have been increases in the dentist to population ratio in Lothian, Lanarkshire and Glasgow, in the Western Isles, Shetland, Orkney, Highland, Dumfries and Galloway and Borders, there has been a reduction.

Figure 4 shows the distribution of dentists by NHS Board in Scotland and highlights the variation in concentration of dentists from the remote and rural areas, such as Orkney and Shetland where there is a very low concentration, to Glasgow and Lothian, where there is a much higher number of dentists per head of population.

Figure 4 – Dentist: Population ratio by NHS Board 1991/02 and 2003/04



Source: SDPB Annual Report 1991/02, 2003/04

5.5 Activity

The activity in the GDS is recorded by a patient based form, known as the GP17 form. This is the same form as used by the Salaried GDP service and is similar to the system in the CDS. However, as well as monitoring the clinical activity, the GP17 is also used by the PSD facilitating payment for the dentist.

The overall number of dental examinations undertaken in Scotland by general dental practitioners is shown in Table 3 and has remained relatively stable in the past 4 years. The number of examinations has increased since the early 1990's with 1.96 million examinations undertaken in 1991/92 and over 2 million in recent years.

Table 3 – Number of examinations in Scotland; year ending March 2004
(non-salaried GDS only)

	2000	2001	2002	2003	2004
No. of examinations (000s)	2,214	2,189	2,185	2,213	2,168

Source: Scottish Dental Practice Board Annual Report 2003/04

The overall proportion of the Scottish population registered with a general dental practitioner is detailed in Appendix 4 (pages 40,41) and the trends in child and adult registrations are described in more detail in subsequent sections of this report. As can be seen registrations peak among the 6-12 and 35-44 year old age groups.

Trends show that, overall registrations in Scotland among adults have increased only slightly from 47% in 1991/92⁽²⁶⁾ to 49% in 2003⁽¹⁾. Registration levels fall dramatically in older age groups with only 28% of adults over 75 years of age being registered in Scotland and is shown in Appendix 4(i).

Trends in the proportion of children registered with a general dental practitioner in Scotland is shown Appendix 4(ii).

Since the early 1990's the proportion of children registered has risen from a Scottish average of 54% in 1991/92 to 66% in 2004, although in recent years this figure has plateaued. It is encouraging to note that the proportion of very young children entering general dental care (0-2 year olds) has increased from 15% in 1996 to 35% in 2004, but again these figures have plateaued in recent years.

Child dental registrations continue to peak in the 6-9 and 10-14 year old age groups.

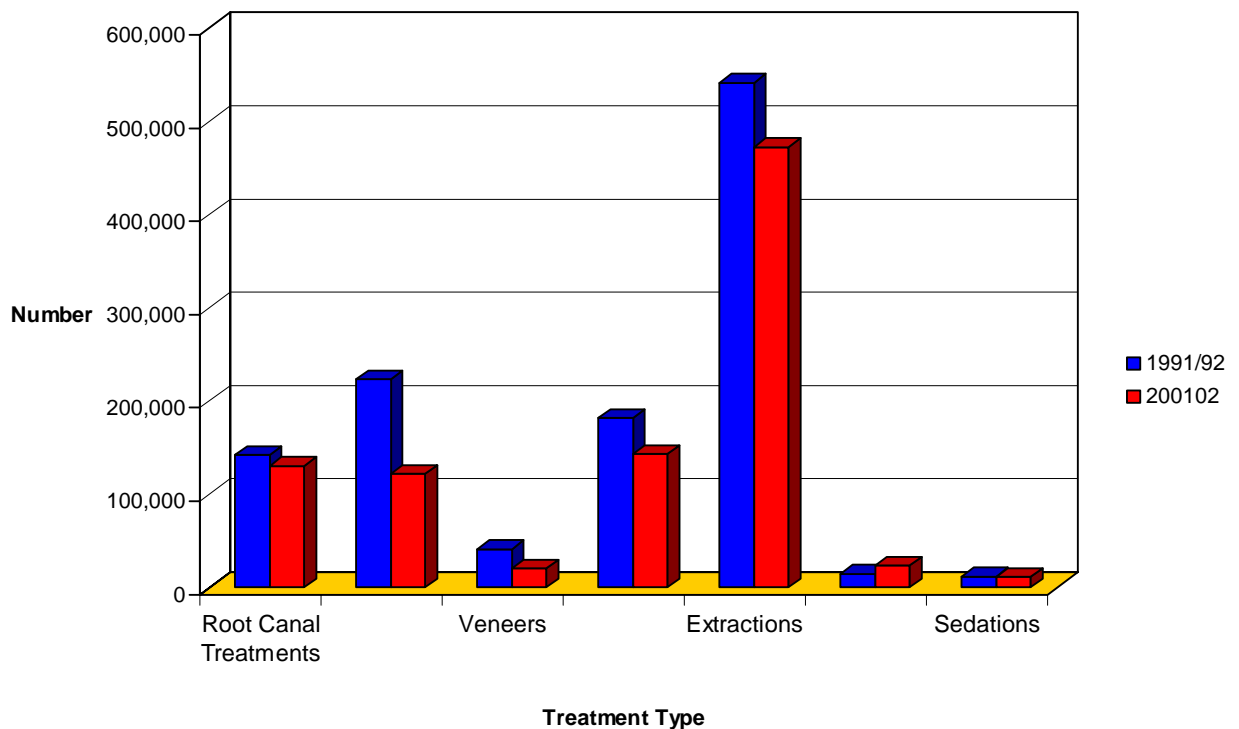
Figure 5 shows the pattern of activity by item of service in GDS over the 10 year period until 2001/02. Proportionately, the biggest change has been in the provision of crowns, which has reduced, but there has also been a reduction in the numbers of tooth extractions. Other items of service have changed less.

General dental practitioners can also provide home (domiciliary) care to patients confined to their place of residence because of their physical or mental condition. The majority of these visits are for older adults either living at home or in care establishments.

The vast majority of domiciliary dental care currently involves dental check ups and the provision, repair or alteration of dentures and extractions. These aspects of dental treatment require less dental equipment to be transported to the individual's home, in comparison to restorative treatment, of which relatively little is provided on a domiciliary basis.

The number of domiciliary courses of treatment and visits in NHS GDSs in Scotland rose during the 1990's but has now significantly reduced to 511 visits in year 2003/04 compared to 24,000 visits in 2001/02.

Figure 5 – Activity by item of service 1991/92 and 2001/02



Source: SDPB

6. WORKFORCE ISSUES

The ability to deliver oral healthcare services to an increasingly dentate population depends on the existence of an appropriately trained dental workforce. Pressures on the dental workforce have a direct bearing on the increasing demand on oral health services for older people. Workforce modelling, carried out by Scottish Council for Postgraduate Medical and Dental Education (SCPMDE, now known as NHS Education for Scotland), identified that the current rate of increase of 1.9% each year since 1995 was not sustainable and would lead to a significant shortfall in the future, unless action was taken.

Key factors influencing supply include the following:

- Increased early retirement
- Increased part-time working
- Increased proportion of women in the dental workforce
- Increase in non-NHS working

There has been a recent increase in “private” activity in the GDS, and while it is considered a significant proportion at 15% of the activity, it is still limited. A gap still exists between the supply and demand of NHS dentistry.

Despite several recent initiatives to address retention of the dental workforce in Scotland, there are recognised problems in the future supply of dentists at a time when there are very significant pressures to increase demand for dental treatment, including care for older people. The recent assessment of the dental workforce in Scotland,⁽²⁷⁾ Workforce Planning for Dentistry in Scotland. NES/ISD, has found that the key factors increasing the utilisation of dental services are: increasing proportion of older people in the population, together with increasing tooth retention in this group. An increasing demand for dental services is compounded by an increasing restriction on provision of NHS dentistry in some parts of Scotland.

A recent development, that may partially help to alleviate the loss to the dental workforce, is the decision to extend the duties of Professionals Complementary to Dentistry (PCDs) and expand the number being trained in Scotland.

7. SUMMARY

The group discussed in detail why and how the services could best meet the needs of the population, taking into account the access problems in some parts of the country for primary and secondary dental care. It was recognised that in some areas this has led to increased demands on the service and some unnecessary referrals to secondary care.

7.1 CDS remit

The remit of the CDS has changed over the last 20 years as it has responded to the need to provide a complementary service to the independent contractor GDS. The *'Action Plan for improving oral health and modernising NHS dental services in Scotland'* document has recognised the need to concentrate on prevention in dentistry, whilst also maintaining a treatment service.

The CDS has adapted to meet the demands of patients with special needs, primarily those with complex clinical conditions and/or challenging behaviour. Consequently there has been a reduction in numbers of routine child patients treated by the CDS, the extent of which varies from area to area. There has been a rise in the number of adult patients treated, with a concentration on the client groups who have special needs. The dental public health role has been maintained and, with the recent introduction of the National Dental Inspection Programme, this has strengthened.

7.2 Provision of salaried GDS

The provision of GDS is often driven, in the main, by market forces and will, therefore, encourage dentists to provide services in areas with dense population levels. Consequently when there is a shortage of dentists, remote areas, with low population density, are likely to be adversely affected.

The availability of NHS GDS has decreased over time and in an attempt to meet demand there has been an increase in the numbers of salaried general dental practitioners, particularly in rural areas. In some areas the demand for such services has given rise to long waiting times.

There are no targets for levels of manpower in relation to need for care so provision across Scotland is ad hoc.

7.3 Special needs patients

The definition of 'special needs' is inconsistent across the country. There appears to be a continuum of clinical need across a very broad spectrum. At one end of the continuum there are patients with profound problems whose need for advanced clinical skills is obvious.

At the other extreme however there are patients whose needs are routine but are classified by clinicians, or classify themselves, as 'special needs' in order to access care from the CDS. This is a significant issue where access to routine GDS is restricted but in normal circumstances the patients would have been able to be seen by general dental practitioners. The threshold therefore for special needs services is influenced by the accessibility of GDS locally.

It is recognised that people with special needs are less likely than routine patients to be able to make their demands heard and therefore their ability to access the care they require may be compromised. This is a particular problem in areas where other routine/more able/more demanding patients are competing for a limited service.

7.4 Targeted versus comprehensive children's dental service

A comprehensive children's service was defined as one which was dedicated to this client group and separate from other dental services. Targeted children's service was defined as that which would be complementary to the other services which children could attend. It was considered that there were pros and cons in both models, but in the former the issues of lack of continuity of care, lack of numbers of dentists willing to restrict their practice to children, the disincentive to the "family" approach to dental attendance, and organising this service within the school environment would be considered major barriers.

7.5 Joint/split/CDS/GDS posts

In some areas the duties of the CDS practitioners and those of the salaried GDS practitioner have been merged. Under this system dentists either operate under two separate contracts or one combined contract. The result in both cases is that each practitioner has the flexibility to operate under either the CDS or the GDS system.

7.6 Information management systems

There are two sources of relevant activity data; the form used by the CDS (SMR 13) which is usually completed at the end of treatment for each patient and the equivalent in the GDS, which is the GP17. In addition the 'joint' CDS/GDS clinicians and clinicians occupying 'split' CDS/GDS posts may use both. As a result it is difficult to measure accurately the activity levels in each service, the collection of data is unnecessarily complex, its validity is compromised and any comparisons across the services are impossible.

7.7 Monitoring of clinical standards

The system for the monitoring of clinical standards for each of the salaried services is different. Whilst the salaried GDS is subject to the monitoring system applied to independent contractors the CDS has no national standard provision.

7.8 Out-of-hours service

Out-of-hours dental provision is different in each of the services. Whilst there is a contractual obligation placed on Salaried GDPs to provide emergency cover for their registered patients there is no equivalent obligation on CDS staff. This has led to locally negotiated agreements that have, in the main, been voluntary in nature. Consequently there is a lack of uniformity across the services.

7.9 Patient charges

There are different rules for patient charges, depending on whether the treatment was carried out by the CDS or the salaried GDS.

7.10 Career structures

Career structures exist in the CDS with financial recognition being given for additional skills and responsibility. In the salaried GDS there is no clear means of career advancement and in neither is there a recognised training pathway.

7.11 The Wider Dental Team

For the purposes of this report the wider dental team includes PCDs (Professionals Complementary to Dentistry), Oral Health Educators and dental administrative and clerical staff. The planned increased role for the wider dental team is a welcome development and could contribute towards increasing dental workforce and to the movement of emphasis towards preventive dentistry.

There is a lack of uniformity across Scotland in relation to pay grading for staff and currently there are limited career structures and opportunities for staff development.

8. RECOMMENDATIONS

8.1 New Scottish Public Dental Service

The current CDS and Salaried GDS should combine to form a new Scottish Public Dental Service.

This service should:

- provide care for people with special needs
- complement the current GDS and specialist services, especially in remote and rural areas
- have a public health role and oral health promotion targeted both at populations and individuals
- make greater use of specialists
- make greater use of professionals complementary to dentistry both clinically and for the public health role, i.e. NDIP.

8.2 Special needs patients

The needs of patients with ‘special needs’ should be safeguarded particularly where local access to GDS is limited.

The definition of ‘special needs’ should be clarified and the needs of the client group quantified to ensure that adequate provision is made for people with the greatest needs.

8.3 Children’s service

The service to children should be an integral part of the public dental service, complementing the role of the GDS and targeted to areas, or groups, of high need.

8.4 Provision of GDSs

Appropriate levels of NHS dental provision per population in each CHP should be quantified and targets developed by NHS Boards.

8.5 Information Management Systems

The process of data collection should be uniform across the service, recorded electronically, and should provide data on waiting times and outcomes comparable with other services.

8.6 Healthcare governance

Systems should be developed for monitoring clinical standards to ensure a consistently high level of care for patients as set out in the

Quality Improvement Scotland Dental Standards using dental reference officers with appropriate experience relevant to the client groups.

8.7 Out-of-Hours Services

Provision should be made by NHS Boards for an out-of-hours dental service involving all relevant staff ensuring the availability of those with appropriate experience of the varying client groups to meet local needs.

8.8 Patient Charges

The new service should apply a uniform charging system for all clients, which would be the same as applied to those attending the GDS.

8.9 The Wider Dental Team

The skills of PCDs, Oral Health Educators, administrators and clerical staff should be deployed in the new salaried dental service to contribute to dental workforce levels, and to move the emphasis towards health improvement.

8.10 Career structures

8.10.1 Dental Practitioners

In order to provide the skills to maximise the amount of care available in the primary care setting there should be a career structure that encourages advancement and provides the opportunity to develop appropriate skills. The recommended structure takes into account the need to have intermediate grades of staff between the pure generalist and the specialist. (Appendix 5)

The career grade level would be similar to the current community dental officer/salaried general dental practitioner grade.

There should be an advanced level of practitioner (senior dental officer/dentists with special interest), who would have experience in certain aspects of clinical practice or would for instance practice in a remote setting where the threshold of referral to a secondary care setting is higher than would be normally expected of a CDO/GDP. These posts would be quality assured and would recognise expertise that practitioners have built up through years of practice or through training programmes organised possibly on a secondment basis.

There should be an Associate Specialist grade, which would require greater competency in certain areas of clinical practice. These may relate to:

- treating client groups whose medical condition requires the practitioner to have greater skills, experience or knowledge than would be expected of a CDO/GDP;
- management;
- skills in a recognised specialty.

The specialist practitioner and the consultant grades would require the clinician to follow the recognised training pathways already in existence.

The training pathways for the new integrated services should take account of the skills of those currently in service when attributing a grade in the future.

8.10.2 The Wider Dental Team

Career pathways should be developed for the wider dental team (PCDs, Oral Health Educators, administrators and clerical staff).

8.11 Training role

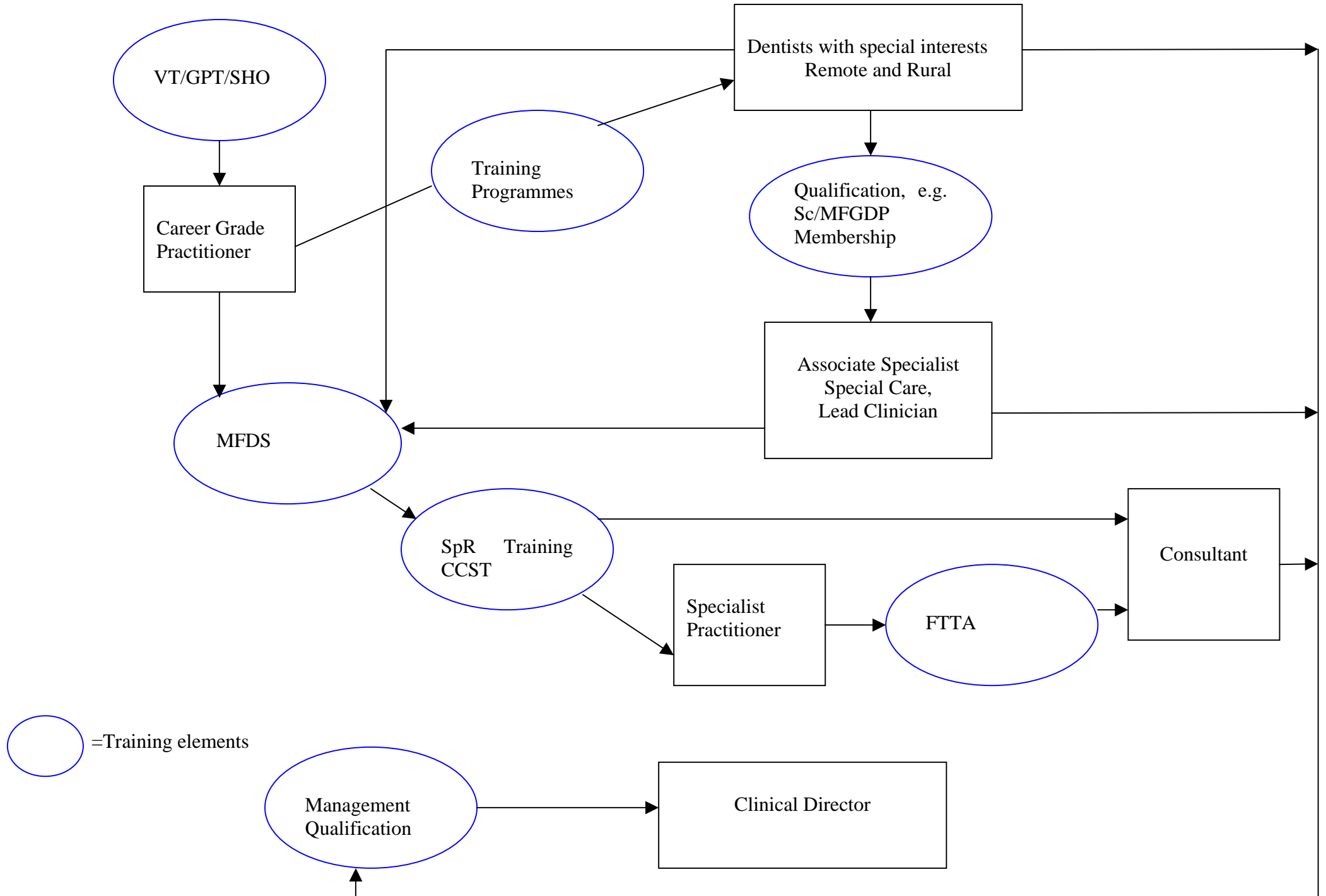
The training role of the new public dental service will be two-fold. There will be the opportunity for the service to provide training for practitioners who will be making a career within the service, and also for practitioners who require to enhance particular skills only available in the public dental service. To meet these needs a formal training pathway and suitable infrastructure will be required.

<p><u>STRENGTHS</u></p> <p>Financial – e.g. guaranteed income, access to funding, paid leave, not profit motivated therefore less pressure financially, pension scheme.</p> <p>Personal/Career – e.g. training and education accessible and supported, personal development through CPD and special interest, good support network and contact with peers, job satisfaction.</p> <p>Organisation/Management Structure – e.g. Time to look into issues such as prevention/quality/cross infection, clinical freedom, freedom to use and purchase equipment/sundries, access to skilled staff (PCDs).</p> <p>Patient Services – e.g. patient led approach, filling a gap geographically, contributing to the community, safety net for emergencies and providing hospital based service, raised awareness in areas of need and with health professionals, access for unregistered/poor attendees, out-of-hours access, ethical, patient needs put before business.</p>	<p><u>WEAKNESSES</u></p> <p>Financial – e.g. less cost effective than NHS practice, not enough or no senior salaried GDPs, undercounting of salaried GDP activity, lack of equity with independent GDPs pensions, limitations of fee scale and lack of opportunity to undertake private work, poor salary, no uniform system of on-call payment.</p> <p>Personal/Career – e.g. feeling undervalued, no appropriate measure of performance, multiple responsibility and lack of clarity, lower professional standing, no career progression/structure, on-call burden and high responsibility level especially in remote areas and community, overworked.</p> <p>Organisation/Management Structure – e.g. lack of clarity over role/management structure, lack of flexibility, difficulty in recruitment especially remote areas, variation of clinical standards, poor management, poor housekeeping, policy decisions impact on clinical freedom.</p> <p>Patient Services – e.g. no long term gain for patient, waiting lists problematic, less links to specialists, difficult to accommodate people due to work pressures.</p>
<p><u>OPPORTUNITIES</u></p> <p>Financial – e.g. move to single salaried dental service, link payments to patients seen, golden ‘hello’s’, funding for on-call, question free dentistry, delegated financial responsibility.</p> <p>Personal/Career – e.g. better career progression, team approach encompassing CDS and salaried GDS, development of performance indicators, ability to treat without regulations, provide incentives to recruit more staff (flexible working patterns) staff appraisal, managers visit salaried GDP in place of work, supported career development, incentive to return with new skills, create a network for salaried GDS, representation on ADC, integrate CDS and salaried GDS.</p> <p>Organisation/Management Structure – e.g. develop clinical interests, develop oral health strategy for practice, take us out of NHS, more use of PCDs, streamline administration, promote service to undergraduates, integrated and improved IT, formal training for dental managers, better communication with public health and independent contractors, universal on-call system.</p> <p>Patient Services – e.g. target areas of greatest need, look at service from patients perspective, emphasise prevention and patient responsibility, respond to patient demand for solution to immediate problems (access), meeting needs of older people/housebound, target specific unregistered groups, making better use of existing clinics.</p>	<p><u>THREATS</u></p> <p>Financial – e.g. Fee scale/grossing not a good measure, move to a ‘cash limited budget’, people moving to earn more money (loss of personnel), resources allocated to dentistry.</p> <p>Personal/Career – e.g. perception of independent GDPs (unfair competition), PCDs taking dentist jobs (future), lack of performance indicators, more practitioners going private (increased work pressure), stress due to workload, frustration will drive people to leave, core service may not be attractive service to practitioners, more on-call service requirement, perceived value of salaried dentistry by GDP and public.</p> <p>Organisation/Management Structure – e.g. low level of available workforce, lack of commitment by government to provide comprehensive dental service, inappropriate comparisons made with other areas/services, imposition of core service, demise of ordinary GDS, lack of appropriate use of PCDs, recruitment and retention difficulties, service vulnerable to political policy, unattractive to new graduates and negative influence on undergraduates, status quo ‘not an option’.</p> <p>Patient Services – e.g. knock on effect to time availability for special needs patients, continued poor diet/habits from general public.</p>

Special Care Dentistry

Special care Dentistry is concerned with providing and enabling the delivery of oral care for people with an impairment or disability, where this terminology is defined in the broadest of terms. Thus Special Care Dentistry is concerned with the improvement of oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often a combination of a number of these factors. It requires an holistic approach.

From the joint Advisory Committee for Special Care Dentistry documents “training in Special Care Dentistry” (2003) and “A Case of Need for Special Care Dentistry” (2003).



Children - GDS registrations; by age group

Registrations at 31 March	2000	2001	2002	2003	2004
Children : number registered	754,545	743,469	733,743	725,494	716,070
0-2	61,003	59,751	56,986	55,262	54,879
3-5	125,788	122,660	120,653	117,498	113,089
6-9	200,196	195,013	189,076	185,397	182,167
10-14	240,277	239,549	240,614	239,688	238,524
15-17	127,281	126,496	126,414	127,649	127,411
Children : % registered	66%	65%	65%	66%	66%
0-2	34%	34%	34%	34%	35%
3-5	67%	67%	67%	68%	66%
6-9	77%	75%	72%	75%	76%
10-14	74%	73%	74%	74%	74%
15-17	66%	67%	67%	66%	65%

Source: ISD Scotland Website

While all age groups may access dental care from the GDSs (GDS). NHS dental registration has been shown to decline progressively with increasing age. In addition, access to dental services is known to be problematic in certain parts of Scotland, notably in rural and remote areas.

Adults – GDS registrations; by age group

Appendix 4 (ii)

Registrations at 31 March	2000	2001	2002	2003	2004
Adults : number registered	1,972,310	1,969,008	1,960,605	1,959,293	1,935,634
18-24	238,545	235,130	230,455	228,271	222,325
25-34	426,800	406,644	385,933	368,146	346,805
35-44	459,284	461,512	461,971	461,636	454,726
45-54	352,630	359,879	358,401	358,714	358,377
55-64	242,149	246,387	257,660	268,918	274,343
65-74	162,324	165,968	169,700	174,686	177,667
75 and over	90,578	93,488	96,485	98,922	101,391
Adults : percentage registered	50%	49%	49%	49%	49%
18-24	53%	52%	51%	52%	50%
25-34	54%	53%	52%	53%	52%
35-44	60%	59%	58%	59%	58%
45-54	53%	54%	53%	52%	53%
55-64	46%	46%	48%	49%	48%
65-74	37%	38%	39%	39%	40%
75 and over	26%	27%	28%	27%	28%

Source: ISD Scotland Website.

Appendix 4(iii)

Adults registered by age group; by Health Board area

	% registered	Total adults	18-24	25-34	35-44	45-54	55-64	65-74	75 +
Adult registrations at 31 March 2004									
Scotland	49%	1,935,634	222,325	346,805	454,726	358,377	274,343	177,667	101,391
Argyll & Clyde	50%	163,341	18,881	27,681	38,103	30,376	23,858	15,653	8,789
Ayrshire & Arran	52%	150,707	16,946	24,376	32,724	28,215	23,496	15,686	9,264
Borders	46%	38,571	3,562	5,399	8,224	7,110	6,416	4,795	3,065
Dumfries & Galloway	40%	46,858	5,014	6,795	10,057	8,411	7,866	5,386	3,329
Fife	51%	139,338	15,211	23,147	32,390	26,693	21,340	12,909	7,648
Forth Valley	50%	107,855	12,623	19,152	26,112	20,230	15,412	9,445	4,881
Grampian	40%	163,700	20,617	29,226	38,811	32,556	23,236	12,968	6,286
Greater Glasgow	53%	361,949	43,574	71,466	87,764	64,479	44,617	30,846	19,203
Highland	30%	49,427	6,224	7,208	11,093	9,410	7,706	5,043	2,743
Lanarkshire	48%	206,386	25,110	39,523	50,520	37,740	27,536	17,274	8,683
Lothian	51%	314,549	34,722	62,070	75,746	56,309	42,408	27,497	15,797
Orkney	19%	2,809	242	429	720	575	448	268	127
Shetland	45%	7,532	619	1,354	1,851	1,688	1,218	537	265
Tayside	57%	173,440	18,227	27,528	38,566	32,773	27,237	18,353	10,756
Western Isles	44%	9,172	753	1,451	2,045	1,812	1,549	1,007	555

Source: ISD Scotland Website.

Children registered by age group; by Health Board area

	% registered	Total children	0-2	3-5	6-9	10-14	15-17
Child registrations at 31 March 2004							
Scotland	66%	716,070	54,879	113,089	182,167	238,524	127,411
Argyll & Clyde	64%	58,507	4,353	8,908	14,949	19,539	10,758
Ayrshire & Arran	69%	54,864	4,649	8,155	13,233	18,497	10,330
Borders	61%	13,849	1,022	2,094	3,340	4,776	2,617
Dumfries & Galloway	63%	19,638	1,193	2,906	5,069	6,704	3,766
Fife	62%	47,758	3,822	7,573	11,993	15,584	8,786
Forth Valley	68%	42,027	3,175	6,772	10,872	14,192	7,016
Grampian	60%	66,745	4,293	10,603	16,804	22,652	12,393
Greater Glasgow	71%	129,787	10,895	20,505	33,196	42,585	22,606
Highland	62%	28,058	1,825	4,318	7,227	9,514	5,174
Lanarkshire	61%	76,125	5,176	12,425	19,582	25,623	13,319
Lothian	71%	113,157	9,868	18,628	28,862	36,830	18,969
Orkney	27%	1,161	24	159	410	416	152
Shetland	59%	3,153	313	550	818	1,021	451
Tayside	74%	59,595	4,156	9,215	15,388	20,095	10,741
Western Isles	30%	1,646	115	278	424	496	333

Source: ISD Scotland Website

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