NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

Photo credit page 1: Sayegh Orthodontics, Edinburgh

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www.nhshealthquality.org
Introduction and acknowledgements

NHS QIS’ vision is of an NHS that achieves excellence in the care of every patient every time. It leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions:

• providing advice and guidance on effective clinical practice, including setting standards
• driving and supporting implementation of improvements in quality, and
• assessing the performance of the NHS, reporting and publishing the findings.

In addition, NHS QIS also has central responsibility for patient safety and clinical governance across NHSScotland.

In November 2007, the Scottish Dental Clinical Effectiveness Programme (SDCEP) published guidance in relation to emergency dental care, incorporating standards for the provision of out-of-hours emergency dental services1 (www.sdcep.org.uk/index.aspx?o=2542). These standards were adapted from the NHS QIS standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours2 published in August 2004.

NHS QIS established an out-of-hours emergency dental service (OOH EDS) project group in February 2008, under the chairmanship of Mrs Anna Lang, General Dental Practitioner (full membership of the project group is given in Appendix 1) to:

• develop a self-assessment framework
• oversee the process of external peer review, and
• report findings to the NHS QIS board.

Peer review visits took place in every territorial NHS board in Scotland between November 2008 and July 2009 to assess performance against the standards for out-of-hours emergency dental care. Local reports outlining the findings of these visits, including a detailed assessment of performance against each standard, have also been published and are available on the website (www.nhshealthquality.org), or on request from NHS QIS.

NHS QIS gratefully acknowledges the work of the OOH EDS project group for overseeing the project from its inception to the publication of this report. In addition, the contribution made by every member of the peer review teams was crucial to the success of the visit programme.
To those NHSScotland staff who contributed to the peer review visits, NHS QIS wishes to record its thanks; in particular, the liaison co-ordinators, local review facilitators and lead clinicians in NHS boards who were responsible for preparing staff locally for peer review visits and for the compilation of comprehensive self-assessment material prior to visits.

This report, based on the NHS QIS local report for each NHS board area, represents a national overview of OOH EDS within NHSScotland, reporting on the performance across Scotland against the standards.
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Executive summary

Introduction

All dentists have to make sure that their patients have access to emergency dental care during and outside normal working hours, and that their patients know how to access this care. However, throughout Scotland and the UK, there is variation in the availability and consistency of advice and care for patients with a dental emergency. Individual dental practices often have policies to deal with emergency patients during the working day, either in an appointments system or allocating time specifically for emergency patients within the appointment system. Access to out-of-hours dental care in Scotland is now mainly provided through NHS 24 who work in partnership with local NHS boards to provide a confidential telephone health advice and information service throughout the country.

Nearly half of the dental calls are received by NHS 24 on Friday, Saturday or Sunday, with peaks of activity at around 6pm on weekday evenings and on Saturday and Sunday mornings. On Saturday mornings, calls reporting dental problems represented a significant proportion of the total NHS 24 call volume. Many of the calls received by NHS 24 are from patients who are not registered with an NHS dentist. In Scotland, almost a third of the adult population and a fifth of children are currently not registered.

This report presents the findings of the first ever comprehensive review of the way emergency dental services are provided out of hours in Scotland. It also highlights good practice and makes recommendations for further improvement to these services.

Background

To date, improving emergency dental care has been a three-step process. The first step to reduce variation in practice was taken in 2004 when SDCEP convened a Guidance Development Group to provide guidance on the provision of emergency dental care in Scotland. This guidance applies to primary dental care providers and those responsible for organising services, and aims to improve patient safety by promoting a consistent standard of care for patients with a dental emergency. The second step was marked by the publication of standards in 2007 (www.scottishdental.org/cep/guidance/emergencycare.htm). This work was led by SDCEP and modelled on the standards developed by NHS QIS for out-of-hours general medical services. The third step has been a baseline review of how NHS boards are performing against these standards. The outcome of this review is already informing further improvement in these services.
The standards

There are three standards:

- **Standard 1** is about accessibility and availability of services at first point of contact. This is the broadest standard and ranges from identifying who might need these services and how these needs will be met, to the detail of how services can be accessed and how the right advice and treatment is provided. A key theme of this standard is effective integration of services across independent contractors and salaried general dental practice, community dental services and hospital dental services.

- **Standard 2** covers safe and effective care. This is the most challenging standard and comprises three elements:
  a) there are governance arrangements to ensure a sound infrastructure is in place and to support those providing clinical services
  b) effective clinical care is provided, and
  c) there are effective information and communication flows to make sure everyone is aware of what is happening, what has been done and what needs to be followed up.

- **Standard 3** covers audit, monitoring and reporting. To chart improvement and identify gaps we need to monitor services and use reporting systems to inform and guide improvement programmes.

Taken together, these three standards provide an effective public health model that can be used to provide a local and national focus on what is needed, how that need should be met and how we measure success and use our knowledge of current services to make further improvement.

Our findings

Detailed findings of this review are given in Chapter 2. Headline findings and our recommendations are given below.

All NHS boards in Scotland are actively working on developing dental services and are well aware of the challenges involved in providing emergency and out-of-hours services, given there are still many people in Scotland not registered with a dentist and the oral health of the population is generally poor.

General medical services, provided by GPs, have used the quality and outcomes element of their contract to drive improvement. General dental services are now working up their approach to developing key performance indicators, including those for emergency out-of-hours services. This is an exciting time for dentistry and NHS QIS is committed to supporting continued improvement through our primary care work programme.
Our recommendations

• Guidance and best practice – Dentists need to be aware of current guidance and best practice, and postgraduate education and training programmes should provide the support for dentists in meeting these requirements.

• Key performance indicators – There is a need to develop appropriate, quantifiable national measures that will help assess progress and identify areas for improvement in emergency dental services.

• Self-management and information – NHS boards should ensure that information is available to patients, and give advice on maintaining good oral health. NHS boards should also ensure that patients are made aware of the appropriate use of out-of-hours emergency dental services.

Our conclusions

Good dental care is critical to our quality of life. It affects our self-esteem, speech, taste, appetite general development and health. For a long time dental care has not been considered as a core element of health care and this is now changing. Increasingly dental services are providing vital information about a range of conditions, including oral cancers.

By reviewing out-of-hours emergency dental services we have raised the awareness and profile of these services NHS board-wide.

The provision of out-of-hours emergency dental care has a challenging improvement agenda and needs to be a shared responsibility among those planning, providing and using services.

Our challenge to NHS boards is to include dental services as fully in their public health programmes as medical services and to make sure clinical governance committees and boards monitor these services and promote their improvement.

What next – Measuring success

The Chief Dental Officer at Scottish Government Health Directorates (SGHD) has a delivery programme in place for dentists providing NHS services. NHS QIS will work with partner organisations such as NHS Education for Scotland to support the delivery of this programme and we will use the findings of this review to shape and inform further development.
Chapter 1

Setting the scene
1 Setting the scene

1.1 Introduction to out-of-hours emergency dental services

Out-of-hours emergency dental care has historically been provided in two distinct ways. Firstly, those patients who were registered with a dentist normally had access to out-of-hours emergency cover provided directly by their dentist or through a co-operative arrangement with other dentists. Secondly, NHS boards often provided out-of-hours emergency clinics – primarily to meet the needs of patients who were not registered. These clinics were usually available for fixed sessions at weekends.

The arrangements across Scotland varied widely, as did the availability and consistency of advice and care given to patients. Following the publication of the Action Plan for Improving Oral Health and Modernising NHS Dental Services in 2005, national targets were set for access to emergency dental services. These were accompanied by increased funding which led to the development of the Scottish Emergency Dental Service (SEDS), in partnership with NHS 24.

Scottish Emergency Dental Service

SEDS was developed as the national primary point of contact for patients with an out-of-hours dental emergency. In September 2009, approximately 93% of the population had access SEDS in their local NHS board area. The level of dental practice participation in SEDS varies from board to board. However, those practices which do not participate in the service are still required to provide their own arrangements for the out-of-hours emergency care of their patients. Local NHS boards should take steps to ensure that suitable arrangements are in place. NHS QIS has developed a monitoring tool for NHS boards to use for this purpose. The SEDS model of out-of-hours emergency dental care is illustrated in Figure 1.
Categories of dental need

In 2003, the Scottish Executive Health Department (now SGHD) issued guidance on emergency dental care which identified three categories of need requiring different levels of care:

- dental conditions which require emergency care
- dental conditions which require urgent care, and
- dental conditions which require routine care or self-help advice.

Following initial telephone contact with out-of-hours emergency dental services, patients are triaged and treated in line with this guidance, according to one of three categories of care, as illustrated in Figure 2.
Figure 2: Out-of-hours emergency dental categories of care

**Emergency Care**
(about 1% of all calls)

Dental conditions include:
- trauma, orofacial swelling that is significant and worsening
- post-extraction bleeding that the patient is not able to control with local measures
- dental conditions that have resulted in acute systemic illness

Timescale:
Patient contact with a clinician within 60 minutes and subsequent treatment within a timescale appropriate to the severity of the condition

**Urgent care**
(about 75% of all calls)

Dental conditions include:
- dental and soft tissue infections without a systemic effect
- severe dental and facial pain that cannot be controlled by the patient following self-help advice

Timescale:
Provide self-help advice and treat the patient within 24 hours

**Routine care/Self-help advice**
(about 24% of all calls)

Dental conditions include:
- mild or moderate pain that responds to pain relief measures
- minor dental trauma
- post-extraction bleeding that the patient is able to control using self-help measures
- loose or displaced crowns
- fractured or loose fitting dentures
- bleeding gums

Timescale:
provide self-help advice and access to care within 7 days, if required
1.2 Frequently asked questions about SEDS

Q What should I do if I have a dental emergency out of hours?

A If you are registered with a dentist you should ring the surgery. If the dentist is part of SEDS, there should be an answer phone message redirecting you to NHS 24. If your dentist does not use SEDS, there should be a local emergency contact number given. If you are not registered with a dentist, you should ring the NHS 24 number 08454 24 24 24.

Q My dentist does not participate in SEDS but I cannot get a reply from the local number. What should I do?

A Each dentist is responsible for making sure that patients for whom they have accepted responsibility have access to emergency dental care, both during and outside normal working hours, and should inform you of how to do this. If, after listening to the entire answer phone message, there is no service available and your symptoms are urgent, then you should ring NHS 24 for advice and inform NHS 24 that you have been unable to contact your dentist.

Q If I have a dental emergency, will I be seen out of hours?

A It depends on how urgent your dental problem is judged to be. You will be assessed by a specially trained and experienced dental nurse advisor who will decide if you need to be seen (and how quickly), whether you can wait until the next day or should simply be given advice on self-care.

Q How do I get an appointment for next-day care?

A If you have been assessed as needing care within 24 hours, a member of staff will contact you to let you know of arrangements. This varies depending on where you live. In some areas you will be given an appointment time and clinic location; in other areas you will be asked to phone for an appointment on the following morning. In all cases, if you have been assessed as needing urgent care, you should be seen within 24 hours. This applies at the weekend as well as during the week.

Q Can I get painkillers out of hours?

A There are always trained NHS 24 staff available who will be able to give you advice on which non-prescription painkillers to use and the correct dose.
1.3 The NHS QIS approach to assessment

NHS QIS uses a methodology which draws upon other quality assurance models to enable it, in partnership with healthcare professionals and members of the public, to develop standards for clinical services and to assess performance across NHSScotland against these standards.

Further information and definitions of the terms used in the standards and in the assessment of performance are contained in Appendices 2 and 5.

1.4 Useful contacts

British Dental Association (Scotland)
Forsyth House
Lomond Court
Castle Business Park
STIRLING
FK9 4TU

Phone: 01786 476040
Website: www.bda.org

NHS 24
Headquarters
Caledonia House
Fifty Pitches Road
Cardonald Park
GLASGOW
G51 4ED

Phone: 0141 337 4501
Website: www.nhs24.com

Scottish Dental Clinical Effectiveness Programme
Dundee Dental Education Centre
Frankland Building
Small’s Wynd
DUNDEE
DD1 4HN

Phone: 01382 425751/425771
Website: www.scottishdental.org/cep
Chapter 2

National performance against the standards
This section presents the findings across Scotland in terms of performance against individual standards.

Fourteen NHS boards were reviewed to assess performance against the standards (see Appendix 3), and this national overview summarises the 14 local reports.
2.1 Detailed findings against the standards

Standard 1: Accessibility and Availability at First Point of Contact

Standard Statement 1(a):
Out-of-hours emergency services* are available and accessible to patients and their representatives (irrespective of their dental registration status).

* ‘Out-of-hours’ is defined in PCA 2003(D)18 as:
  weekdays 5.30pm to 8.30am
  weekends from 5.30pm Friday to 8.30am Monday

1(a) 1 Arrangements are in place to identify the needs of those potentially using these services.

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All NHS boards recognised the importance of identifying the needs of those potentially using the OOH EDS. Ten NHS boards had arrangements in place to identify the needs of all potential service users. Three NHS boards had a number of arrangements in place to identify the needs of some population groups in their area, while one NHS board had no clear system in place for assessing the needs of those using the service.

Prior to the introduction of the new OOH EDS, NHS boards had collected a wide range of historical data on: population projections; breakdowns of the population by ethnicity; dental registration rates; recalled attendance figures; availability of dental services, and information on dental advice line enquiries.

These data were collated, analysed and reviewed in identifying the needs of some specific population groups. This was evident in some of the NHS board areas that had large remote and rural populations.
Some areas of good practice were noted where NHS boards had undertaken work to identify the needs of particular groups, for example, homeless, socially excluded and ethnic minority groups.

1(a) 2 Arrangements are in place to meet the needs of those potentially using these services.

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All services had arrangements in place to meet the needs of most of those potentially using the service. Careful consideration had been given by all NHS boards to the location and number of OOH EDS sites.

Many NHS boards reported that a large percentage of general dental practitioners (GDPs) participate in the OOH EDS, recognising that the service helped meet the needs of their patients and helped them to fulfil their obligations to their patients for access to out-of-hours emergency dental care and advice.

1(a) 3 Arrangements are in place for patients or their representatives to access care by telephone (in the first instance).

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All services have arrangements in place during out-of-hours periods for patients, their representatives or carers to access care by telephone in the first instance. When patients call their dentist out of hours, the practice telephone is either automatically diverted to NHS 24 or has an answer phone message to advise them to ring NHS 24. In the event of a telephone system failure, NHS
NHS 24 has contingency plans in place to reroute calls. It was recommended that NHS boards establish a dedicated daytime dental advice line to inform the ongoing development of their out-of-hours service.

1(a) Following triage, patients receive advice and care from a suitably trained health professional, appropriate to the degree of urgency of their condition.

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Systems are in place in all services to ensure that, following triage, patients receive advice and care from a suitably trained healthcare professional, appropriate to the degree of urgency of their condition. Most services had clear, concise, robust and formalised triage pathways in place for all patients accessing out-of-hours care in the emergency, urgent and routine categories. However, in a few services, the patient pathway following triage was not always clear and some confusion existed in relation to responsibility for the patient during the transfer from NHS 24 to the OOH EDS. The range of reasonable and effective local options for patients requiring emergency care includes:

- direct appointment into a local out-of-hours clinic if one was operational.
- direct referral to an oral and maxillofacial surgery (OMFS) department.
- referral to an accident and emergency (A&E) department where the A&E team on duty assesses and treats the patient. If appropriate, the on-call oral and maxillofacial surgeon is contacted to provide treatment or advice.
- referral to an on-call dentist who assesses and arranges treatment in accordance with SDCEP guidelines.

A few services have established a system to follow up patients assessed during triage as requiring emergency and urgent care. This has involved developing close links with A&E and OMFS departments. It was recommended that NHS boards take steps to formalise processes to follow up patients referred from the OOH EDS into medical pathways.
All services had effective local arrangements in place to ensure that patients requiring urgent care were seen within 24 hours; for example, appointments in an out-of-hours clinic or with a participating GDP in the patient’s own practice, or a call-back from the on-call dentist who will arrange to see the patient in an appropriate clinic. Some services offered non-registered patients information about dentists in their local area who were accepting new patients and also added them to a dental waiting list.

All services demonstrated effective arrangements for patients triaged in the routine category of care. Patients are provided with self-help advice and, where appropriate, assisted in accessing dental care. Patients in this category, who are registered with a dentist, were advised to contact their own GDP.

One NHS board had established a professional-to-professional priority telephone helpline used by doctors, dentists, pharmacists and dental nurses to share information about patients and to facilitate safe, prompt and appropriate care. This was also used to fast track patients from one service to another.

1(a) 5 Access to, and delivery of, services is not compromised by physical (including medical conditions) language, cultural, social, economic or other barriers.

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All NHS boards provided access to translation services, and the Language Line telephone translation service was used by the majority of services. Some NHS boards used language identification cards and one NHS board has a translation flow chart available for staff to refer to, when required. Some services had also used Babel Fish, a web-based language facility. BrowseAloud speech enabling software can also be accessed through NHS board websites.

While the OOH EDS is delivered in most NHS board areas from sites that are compliant with the Disability Discrimination Act (DDA) 2005, some NHS boards had still to undertake a full DDA assessment across all OOH EDS sites. For patients with sensory impairment, service provision was also variable. NHS 24 and a few NHS boards use the Typetalk service which is a communication link used by deaf or speech-impaired patients, and hearing loops were available in many, but not all services. In addition to hearing loop...
facilities, access to language interpreters, lip speakers and electronic note takers was available in some NHS boards. Some services also had access to a list of Sign Language interpreters for face-to-face assistance. One NHS board had carried out an audit of their current communication support systems with particular reference to patients with sensory impairment.

Most NHS boards had not carried out an Equality and Diversity Impact Assessment (EQIA) for their OOH EDS. It was recommended that NHS boards undertake an EQIA for their services.

1(a) 6 Arrangements for access should be integrated across all areas of dental out-of-hours care (general dental practice, community, salaried and hospital dental service), and, where appropriate, with other primary care emergency services.

Although arrangements are in place for all services to ensure that access is integrated across all areas of dental out-of-hours care and, if appropriate, with other primary care emergency services, many of these arrangements are informal.

Most NHS boards demonstrated good working relationships within all branches of the dental profession in the delivery of the OOH EDS, and had reasonable links with key local services and groups. The extent of these formal and informal relationships, reflect local situations and were sufficient in all NHS board areas to support the effective delivery of out-of-hours emergency dental care.

Overall, the collaboration between the OOH EDS and other areas of the dental profession was well developed. Many services are co-located with NHS boards’ out-of-hours medical services. Other services are located within general hospital sites, in close proximity to A&E departments and minor injury units. The co-location of similar services facilitates communication, collaboration and integrated working.
1(a) Information on how to access the service should be available to all and not compromised by physical, language, cultural, social, economic or other barriers.

All NHS boards widely advertised their OOH EDS in a variety of ways. This included having patient information leaflets, cards and publicity posters displayed in many settings; for example, doctors and dentists waiting areas, A&E departments, health centres, local pharmacies, libraries and other public areas. Most NHS boards had details of the OOH EDS on their website. In some NHS boards, the patient information leaflet states that advice on the translation of the leaflet in community languages is available through the translation and interpretation service.

Some NHS boards had held awareness-raising sessions and had produced posters specifically targeted towards homeless people and their support workers, advising them about how to access the OOH EDS. Meetings with a variety of ethnic groups had been held in some NHS boards to raise awareness of the OOH EDS and determine the level of interest in having the patient information leaflet translated into other community languages. One NHS board had organised a number of awareness-raising sessions with public partnership forums.

Most NHS boards provided sample messages for GDPs for their practice answer phones. This helped to ensure that the advice on how to access the OOH EDS was accurate and consistent. In most NHS board areas, local newspapers provided details on the hours of operation of the OOH EDS and gave information on how to access care. Some NHS boards also provided information on how to access the service to tourist information offices and local hotels.

Most NHS boards had either established an in-hours dedicated dental telephone advice line or a general telephone advice line to provide patients with advice and guidance on how to access out-of-hours emergency dental care.
The Scottish Dental website (www.scottishdental.org) holds information on how to find a dentist and each NHS board provides a telephone contact number where advice on accessing the OOH EDS can be obtained.

**Strengths**

- There were formal structured systems in place for patients to access the OOH EDS.
- Support and back-up arrangements were established to meet service requirements during periods of high demand.

**Challenge**

- To establish public involvement specific to the ongoing development and improvement of the OOH EDS.

**Recommendations**

Further work is needed in some of the out-of-hours services to ensure that:

- all patient groups are identified and changing demographics are monitored.
- the views and opinions of the local population, as well as the needs of particular groups of potential service users, are identified and considered as part of ongoing service improvement and delivery; for example, the homeless and other vulnerable groups, those living in remote and rural areas, or areas of social deprivation, and ethnic minority groups.
- activity and population data are collected and analysed in detail, and reviewed on a regular basis.
- patient information leaflets and post-operative leaflets are translated into different languages appropriate to the various local populations and are customised to reflect the needs of vulnerable groups.
- the OOH EDS is promoted to all patients including those compromised by physical, language, cultural, social, economic or other barriers.
- induction loops are available in all OOH EDS.
- a process is established for the service to follow up patients who have been referred from the OOH EDS to A&E or OMFS.
- existing links are formalised to ensure access is integrated across all areas of emergency care service provision.
- a register of risks relating to non-compliance with DDA is produced.
Standard 2: Safe and Effective Care

Standard Statement 2(a):
Healthcare Governance: The service provider has a comprehensive patient-focused healthcare governance programme in place.

2(a) 1 Patient Focus: Throughout the service, work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of this work are acted upon and feedback provided to all those involved.

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All services were able to show that they had identified, and were developing partnerships to design, develop and review services. Evidence of partnership working throughout the OOH EDS was demonstrated by some services, while the remaining services had undertaken patient feedback surveys to highlight any strengths or challenges. It is recommended that formal processes are established to ensure the involvement of stakeholders and members of the public in the development and review of out-of-hours services.

2(a) 2 Patient Focus: Information is made available by the provider for the patient and their representatives regarding any care or treatment given.

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In all but one service, verbal instruction was provided to patients and/or their representatives in respect of proposed care and treatment provided. All services
had a variety of post-treatment advice sheets and eight services provided written information for the patient and/or their dentist regarding the treatment given.

2(a) 3 Clinical Governance: There are clear, cohesive plans across the service that direct and support policy development and service delivery internally and through delivery partners.

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While all NHS boards have general clinical governance structures in place, only seven out-of-hours services could demonstrate integration with these structures in respect of establishing cohesive plans for out-of-hours service development and delivery. Some services were taking steps to progress out-of-hours integration into NHS board governance structures, while two services were unable to demonstrate any formal clinical governance reporting structures.

2(a) 4 Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.

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All NHS boards have risk management policies and systems in place. Eight services were able to demonstrate that these systems have been fully implemented across the OOH EDS. The remaining services were actively reviewing their risk management strategies to ensure full implementation. To support full implementation, it was recommended that NHS boards undertake risk assessments and introduce service-specific risk registers for the OOH EDS.
2(a) 5 Clinical Governance: Board clinical governance committees receive regular reports on out-of-hours emergency dental services.

<table>
<thead>
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Eight services have established pathways for reporting into their NHS board clinical governance committees, while two services are in the process of agreeing this following committee restructuring. The other services have no formal pathway in place and establishment of a reporting structure in these areas was seen as a challenge.

2(a) 6 Clinical Governance: Boards have systems in place to ensure that all primary care dental providers have satisfactory arrangements in place for the emergency care of their practice patients.

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All NHS boards have a rolling three-year dental practice inspection programme to ensure that practices have satisfactory arrangements in place for patients to receive out-of-hours care. The majority of services carry out telephone checks on the appropriateness of answer phone messages that are left by GDPs during out-of-hours periods, and follow up any inconsistencies. Six NHS boards have also used the NHS QIS-developed monitoring tool in identifying the out-of-hours arrangements that have been made by non-participating GDPs for their registered patients.
2(a) 7  Clinical Governance: Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.

All services had arrangements in place to interact with key professionals, external parties and voluntary agencies; for example, area dental committees, local dental committees, A&E departments, OMFS departments, and local GPs. While these arrangements were formal in some services, in others the links were informal. However, engagement with the voluntary sector proved more of a challenge.

2(a) 8  Clinical Governance: Systems are in place to ensure that secondary care providers have access arrangements for their patients with dental emergencies.

All but one service demonstrated adequate arrangements for patients in secondary care to access out-of-hours emergency dental care. Some services had protocols in place for the transfer of patients, where deemed necessary, with one service needing to develop a formal pathway of care for serious emergencies. In one service, it was noted that there was no formal process in place for the treatment of OMFS patients during the week.
2(a) 9 Staff Governance: Staff involved in out-of-hours dental care meet employment requirements, including qualifications and training.

All NHS boards were able to demonstrate that appropriate checks are in place to ensure dental out-of-hours staff meet employment, qualification and training criteria. All salaried dentists and staff are employed in line with NHS boards’ recruitment and retention policies. All NHS boards check General Dental Council (GDC) registration and Indemnity for independent contractors, although some only do this through the three-year rolling programme of practice inspections. Disclosure Scotland checks are not carried out for independent contractors in all areas as it is currently not a requirement. However, six NHS boards still made it a condition of employment.
Standard Statement 2(b):
Clinical Care: Clinical guidelines are readily available to support clinical decision-making and facilitate delivery of quality services to patients.

2(b) 1 Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making.

Most services had procedures in place for easy and quick access to evidence-based clinical guidelines to support clinical decision-making. This was generally provided through internet access to relevant websites and hard copies of guidelines which are available at OOH EDS clinic sites; for example: Scottish Intercollegiate Guidelines Network (SIGN) guidelines, Scottish Needs Assessment Programme (SNAP), and SDCEP guidelines.

2(b) 2 Patients are assessed and responded to, based on clinical need and professional judgement.

All services reported that patients were assessed appropriately on the basis of clinical need and professional judgement. Some services had informal processes in place to monitor patient outcomes. The majority of services are developing audit processes around clinical outcomes for patients, while one service had undertaken work to analyse the appropriateness of patient triage. This appeared to be a challenge in nearly all areas.
2(b) 3 Emergency dental services have drugs that are in date, and equipment that is regularly maintained.

In all but two services, NHS boards had formal processes in place to ensure that drugs are in date and that equipment is regularly maintained. In all areas, equipment maintenance was carried out by NHS board estate departments or specialist contractors. In one NHS board area a recommendation was made to establish a formal protocol and monitoring process for out-of-hours drugs management.

2(b) 4 Emergency dental services have effective decontamination procedures in place.

All NHS boards have policies and procedures in place to ensure effective decontamination takes place for OOH EDS clinics. Six services use central sterilising units for the decontamination of instruments. The remaining services use either local or on-site facilities.
2(b) 5 Protocols are in place to address the needs of specific high-risk patient groups.

Half of the services have a range of protocols in place to address the needs of specific high-risk patient groups. One service showed evidence of evaluation and benchmarking leading to continuous improvement. Of the remaining services, action points were identified including: finalising and ratifying local domiciliary policies; revising guidelines for domiciliary visits in respect of dentists being accompanied by a dental nurse; and formalising a process to finalise draft protocols.
Standard Statement 2(c):
Information and Communication: Information gathered during care out of hours is recorded (on paper or electronically) and communicated to the patient’s dentist in addition to any other professionals involved in the patient’s ongoing care when appropriate.

2(c) 1 Systems are in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998.

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All services had systems in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998. Some NHS boards are using electronic records management systems such as Kodak R4. Those services using paper-based systems are at various stages of moving to an electronic system, with the staff training and management challenges that this entails. The use of electronic systems will help with communication and make it easier to audit the record-keeping processes for consistency and accuracy.

2(c) 2 Systems are in place for receiving and communicating information to inform the patient’s ongoing care in a timely manner.

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Ongoing care is provided through a number of different pathways for dental patients. This can prove a challenge as not all patients seen out-of-hours are registered with a dentist and there is no automatic process to communicate
information to support the ongoing care of patients. However, most services have some form of arrangement in place for this. One NHS board has yet to develop a system to pass on information to the healthcare professional that will provide ongoing care, while four NHS boards are in the process of developing a system. One NHS board is doing this effectively and is auditing the outcomes, to ensure the information provided reaches the ongoing care provider and it is useful to them.

2(c) 3 Systems are in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals.

For the NHS boards using SEDS, NHS 24 obtains and records consent to the sharing of information from patients on initial telephone contact. Most services have a system in place to obtain consent from patients for the sharing of their information with other healthcare professionals following their out-of-hours appointment. This is normally arranged on the informal basis of implied consent. An example of this is when the patient is given information to take with them to the ongoing care provider. Some services have more formal arrangements and protocols in place in respect of obtaining consent. A model adopted by some services is to include a specific section on the medical history form that is completed by the patient at the out-of-hours clinic.
Strengths

• Good partnership working was demonstrated by NHS boards in developing their OOH EDS.

• The provision of post-treatment advice to patients and the commitment from NHS boards to gather feedback from patients on the treatment they received was evident.

• NHS boards undertook random checks of dental practice answer phone messages to ensure that accurate information was provided by practices for their patients on how to access out-of-hours emergency dental care.

• The provision of access to secondary emergency care services, eg A&E and OMFS was demonstrated.

• Checks were carried out by NHS boards to ensure new staff meet employment, qualification and training criteria.

• NHS boards had good formal arrangements in place for the decontamination of instruments and sufficient supplies to cover times of high demand and public holidays.

Challenges

• To develop audit processes with regards to monitoring clinical procedures and outcomes.

• To provide training in the use of electronic systems used in EDS clinics and provide secure individual log in and password details to GDPs involved in the OOH EDS who may only be providing a few out-of-hours sessions per year.

• To establish a formal discharge arrangement in respect of the transfer of patient information to the patient’s own dentist.

Recommendations

Further work is required in some NHS board areas to:

• establish processes to ensure GDPs involved in OOH EDS are kept up to date with local/national policies, procedures and any changes in regulations, especially in instances where GDPs are providing, for example, one or two OOH EDS sessions per year.

• ensure risk registers are developed specifically for the OOH EDS.

• formalise arrangements to obtain patient consent regarding the sharing of information about them with other healthcare professionals.
Standard 3: Audit, Monitoring and Reporting

Standard Statement 3(a):
A provider-specific quality assurance framework is in place to support routine audit, monitoring and reporting of performance.

3(a) 1 A set of key performance indicators (patient-focused public involvement, clinical and organisational) are in place.

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Many NHS boards have key performance indicators (KPIs) that apply in some way to general dental services, but only one had a specific set of KPIs to monitor performance in relation to the OOH EDS. This is because the service is in its infancy in many NHS boards, and some were in the process of changing over to provision through SEDS. At the time of the review process, a few NHS boards were using other methods to monitor some aspects of the service provided. However all NHS boards were considering plans to introduce specific KPIs for the OOH EDS. Feedback from many services indicated that there was a preference for KPIs to be developed at a national, rather than local level.
3(a) 2 Comments, complaints and compliments are recorded, regularly reviewed and action taken, if appropriate.

All NHS boards had a system in place to record comments, complaints and compliments. All services investigated complaints in line with local NHS board policies. Most services were able to demonstrate that an appropriate follow-up process was in place to ensure lessons were learned and that outcomes were disseminated to staff as part of the process to positively develop the service. One NHS board was in the process of developing a complaints protocol specific to the OOH EDS and three NHS boards had robust procedures in place to feedback outcomes to staff.

3(a) 3 The service provider takes action to identify patient views and satisfaction levels.

Many services are actively seeking patient views and satisfaction levels through patient surveys and feedback, although some services were undertaking this on an informal basis only, using comment boxes or identifying problems through the official complaints procedure. The majority of services have undertaken initial patient satisfaction surveys and were encouraged to establish an ongoing cycle of surveys to ensure continual improvement of the OOH EDS. However, some services have yet to undertake any surveys. Only one NHS board is fully gathering patient feedback on an ongoing basis and using this to inform service development.
Most NHS boards had not published an annual report on the performance of their OOH EDS. Over half of the services had been established for less than a year and had plans to produce a report following the first full year of operation.

Of the three services that had produced an annual report, one was specific to the OOH EDS, one formed part of an annual report on general dental services, and one was included in a NHS board-wide out-of-hours services annual report.

It was recommended that all NHS boards produce an annual report specific to the OOH EDS and that reports are widely disseminated and available on NHS boards’ intranets and on the internet.

**Strengths**

- Good systems were in place for storing and retrieving patient information.
- All NHS boards had comprehensive policies in place for managing comments, complaints and compliments.

**Challenge**

- To undertake surveys of patient experience and satisfaction levels on a regular basis.

**Recommendations**

Further work is required in some NHS board areas to:

- develop KPIs specifically for the OOH EDS.
- prepare annual reports specifically for the OOH EDS.
Appendix 1: Out-of-hours emergency dental services project group members

Mrs Anna Lang (Chair)
General Dental Practitioner, Glasgow

Mr Michael Arthur
Chair of Scottish Council of the British Dental Association

Mr Graham Ball
Consultant in Dental Public Health, NHS Fife

Mr Mike Devine
Director of Salaried Primary Care Dental Services, NHS Lanarkshire

Ms Catherine Lush
Clinical Dental Director, NHS Highland

Mr Ray McAndrew
Associate Medical Director, NHS Greater Glasgow and Clyde

Mrs Ashley Rennie
Principal Dental Nurse, NHS Fife

Mr David Shaw
Dental Practice Advisor, Care Commission

Ms Gillian Sinclair
General Manager of Scottish Emergency Dental Services, NHS 24

Ms Eileen Wallace
Public Partner, Forth Valley

Ms Valerie White
Specialist Registrar in Dental Public Health, NHS Fife and NHS Lothian

Mr Andrew Yuill
Dental Practice Advisor, NHS Fife and NHS Tayside

Support from NHS QIS (Performance Assessment) was provided by:

Ms Kirsteen Eydmann, Project Officer
Ms Tracey Hannah, Project Officer
Ms Sharon Keane, Programme Manager
Ms Aileen Pollock, Project Administrator
Ms Doris Smith, Lead Project Officer
Mr Steven Wilson, Team Manager
Appendix 2: The quality assurance process

Prior to Visit
- Standards published and issued by SDCEP
- NHS QIS develops and issues self-assessment framework
- NHS board completes self-assessment and submits with evidence to NHS QIS
- NHS QIS sends information from self-assessment submission to peer review team
- Review team analyses submission and meets for discussion one day prior to visit

During Visit
- NHS board presentation to review team covering local service provision
- Review team meets stakeholders to discuss local services and validate content of submission
- Review team assesses performance in relation to the standards based on the submission and visit findings
- Review team feeds back findings to NHS board

After Visit
- NHS QIS produces draft local report and sends to review team for comment
- NHS QIS sends draft local report to NHS board to check for factual accuracy
- NHS QIS publishes local report
- NHS QIS out-of-hours emergency dental services project group considers findings of all local reviews and drafts national overview
- NHS QIS PUBLISHES NATIONAL OVERVIEW
Appendix 2: The quality assurance process

Standards
The guidance published in November 2007 by the SDCEP in relation to emergency dental care, incorporated standards for the provision of out-of-hours emergency dental services (www.scottishdental.org/cep/guidance/emergencycare.htm). These standards were adapted from the NHS QIS standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours published in August 2004. All standards set by NHS QIS comprise a standard statement and related criteria.

Standard statement
Describes the agreed performance for the specific area, determined by those who are involved in the delivery/receipt of the service.

Criteria
State exactly what must be done for the standard to be reached.

Self-assessment
Each set of standards has an accompanying self-assessment framework. This framework gives guidance about the type of evidence required to demonstrate performance against the standards. It is completed and submitted to NHS QIS prior to a peer review visit, together with extensive additional documentation. The evidence obtained from this self-assessment exercise comprises the main source of written evidence considered by each peer review team.

Peer review
Peer review is the process by which a multidisciplinary review team, including members of the public, carries out an NHS board visit to validate the quantitative data submitted through the self-assessment. This is done by means of gathering qualitative information through discussions with staff and evidence submitted by NHS boards.

The composition of each team varies, and members are not employed by the NHS board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS board and another.

In order to determine performance against each criterion, the review team needs to identify evidence on a variety of levels. For example, to demonstrate that a particular issue is addressed in a local protocol, evidence is sought during the peer review process as follows:
• description of the issue and how it should be managed in a local written protocol (submitted as part of the self-assessment)
• confirmation of awareness of the location and content of the protocol through staff interviews
• evidence of a process in place for the protocol to be regularly updated, and
• collection of data through an integrated care pathway/audit sheet, leading to provision of collated audit data confirming compliance with the local protocol.

During each review visit, the review team is guided by a team leader from the project group to ensure a multidisciplinary consensual assessment is reached. At the conclusion of the review, the review team provided feedback to the NHS board giving a broad overview of its assessment, which is based on the written self-assessment, and on evidence obtained during the review visit.

To enhance the consistency of the process, an NHS QIS manager and project officer provided support during each visit.

The schedule for the external peer review visit included:
• dialogue with clinicians, audit staff and managers based on the written evidence
• scrutiny of documentation
• interviews with staff members
• regular team briefings throughout the day to assess progress and to compile the local report, and
• feedback to the NHS board representatives on conclusion of the visit.

In addition, the NHS QIS review team met with patient representatives (where present) of the respective NHS board.
Appendix 2: The quality assurance process

Reports
A local written report is drafted following each visit by NHS QIS. The draft report is then circulated to the review team for comment, and to the NHS board concerned to allow a check for factual accuracy.

On conclusion of the peer review programme, review team leaders reconvened to study the findings and examine trends in order to draw conclusions and make recommendations to NHS QIS.

The responsibility of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet agreed standards, but not to review individual cases or the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered. Where such variation exists between NHS boards (for example between services within an NHS board), this will be stated. Treatment variations will also be reported, but will not identify patients or healthcare professionals.
### Appendix 3: NHS boards reviewed

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</table>
Appendix 4: Out-of-hours emergency dental services review team members

Mr Graham Ball
Consultant in Dental Public Health, NHS Fife

Mrs Lorraine Beresford
Senior Dental Nurse, NHS Lanarkshire

Mr Iain Bovaird
Clinical Director of Salaried Primary Care Dental Services, NHS Grampian

Mrs Mairi Brown
Public Partner, Inverclyde

Mrs Sheena Cochrane
Associate Director of Operations and Nursing, NHS 24

Mr Mike Devine
Director of Salaried Primary Care Dental Services, NHS Lanarkshire

Mrs Sandra Dow
Public Partner, Tayside

Mrs Aileen Duncan
Head of Planning and Health Improvement, NHS Greater Glasgow and Clyde

Mrs Fiona Gibson
Safety, Governance and Risk Co-ordinator, NHS Tayside

Mr Jeff Hamilton
Public Partner, Moray

Mrs Claire Hosie
Safety, Governance and Risk Support Officer, NHS Tayside

Mrs Janice Houston
Associate Director of Operations and Nursing, NHS 24

Mr David Howie
General Dental Practitioner, NHS Tayside

Mrs Kim Jakobsen
Dental Services Manager, NHS Dumfries & Galloway

Miss Michele Jamieson
Associate Director of Nursing, NHS 24
Mr Colwyn Jones  
Consultant in Dental Public Health, NHS Lothian and NHS Borders

Mrs Anna Lang  
General Dental Practitioner, Glasgow

Mrs Lynn Lawson  
Senior Dental Nurse, NHS Forth Valley

Mrs Cathy Lush  
Clinical Dental Director, NHS Highland

Mrs Denise Marshall  
Clinical Governance Officer, NHS Tayside

Mr William May  
Public Partner, Glasgow

Mr Ray McAndrew  
Associate Medical Director (Dental), NHS Greater Glasgow and Clyde

Mrs Joanna McGregor  
Public Partner, Highland

Ms Marion McLoone  
Quality and Effectiveness Manager, NHS Greater Glasgow and Clyde

Mr Martyn Merret  
Consultant in Dental Public Health, NHS Tayside

Ms Alison Moss  
Clinical Governance Facilitator, NHS Tayside

Mrs Patricia Murray  
Public Partner, Grampian

Mrs Anne Palmer  
Clinical Governance Facilitator, NHS Borders

Mr James Purdie  
Public Partner, Fife

Mrs Julie Reilly  
Project Manager, NHS Greater Glasgow and Clyde

Mrs Ashley Rennie  
Principal Dental Nurse, NHS Fife
Appendix 4: Out-of-hours emergency dental services review team members

Mrs Janice Rollo  
Clinical Governance Co-ordinator, NHS Grampian

Mr David Shaw  
Dental Practice Advisor, NHS Grampian

Mr Terry Simpson  
Clinical Effectiveness Advisor, NHS Lothian

Ms Gillian Sinclair  
General Manager for Emergency Dental Services, NHS 24

Mrs Hilary Stevens  
Senior Dental Nurse, NHS Shetland

Mrs Gill Stillie  
Director of Service Delivery, NHS 24

Mr Euan Thomson  
Dental Practice Advisor, NHS Highland

Mrs Sheila Tunstall-James  
Public Partner, Tayside

Ms Eileen Wallace  
Public Partner, Forth Valley

Ms Valerie White  
Specialist Registrar in Dental Public Health, NHS Fife and NHS Lothian

Mr Andrew Yuill  
Dental Practice Advisor, NHS Fife and NHS Tayside
Appendix 5: Performance of NHS boards against the
out-of-hours emergency dental services standards

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</tr>
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<td>NHS Highland</td>
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<td>5</td>
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</tr>
<tr>
<td>NHS Lanarkshire</td>
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<td>6</td>
<td>22</td>
<td>0</td>
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<tr>
<td>NHS Lothian</td>
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<td>7</td>
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<td>0</td>
</tr>
<tr>
<td>NHS Orkney</td>
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<td>4</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>6</td>
<td>14</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>NHS Tayside</td>
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<td>0</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>1</td>
<td>10</td>
<td>17</td>
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</table>

**Assessment categories**

Each review team assessed performance using the categories ‘aware’, ‘focusing’, ‘practising’ and ‘optimised’:

- **aware** applied where the NHS board was aware of the issues to be addressed but was unable to demonstrate actions taken to deal with them
- **focusing** applied where the NHS board recognised the key issues and had taken steps to identify, prioritise and develop practical applications to take these forward
- **practising** applied where the NHS board demonstrated significant evidence of practical application across the service
- **optimised** applied where the NHS board had a well-developed service with evidence of evaluation and benchmarking leading to continuous improvement.
Appendix 6: References


<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>accessibility</td>
<td>Accessibility includes an obligation to let people know about out-of-hours services and how to contact them, and to ensure that services can be accessed.</td>
</tr>
<tr>
<td>assessment</td>
<td>The process of measuring patients’ needs and/or the quality of an activity, service or organisation.</td>
</tr>
<tr>
<td>audit</td>
<td>The process of setting or adopting standards and measuring performance against those standards with the aim of identifying both good and bad practice and implementing changes to achieve unmet standards.</td>
</tr>
<tr>
<td>audit (clinical)</td>
<td>Systematic review of procedures used for diagnosis, care, treatment, rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.</td>
</tr>
<tr>
<td>benchmarking</td>
<td>Use of a standard or point of reference for the purpose of comparison, usually in the context of improving performance.</td>
</tr>
<tr>
<td>carer</td>
<td>A person who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.</td>
</tr>
<tr>
<td>CHP</td>
<td>See community health partnership.</td>
</tr>
<tr>
<td>clinical care</td>
<td>The assessment and treatment of patients by healthcare professionals.</td>
</tr>
<tr>
<td>clinical governance</td>
<td>Ensures that patients receive the highest quality of care possible, putting each patient at the centre of his or her care. This is achieved by making certain that those providing services work in an environment that supports them, and that the organisation places safety and quality of care at the top of its agenda. Risk management at an organisational level is an important aspect of clinical governance. It recognises that risk can arise at many points in a patient’s journey, and that aspects of how organisations are managed can systematically influence the degree of risk.</td>
</tr>
<tr>
<td>clinical governance committee</td>
<td>NHS boards are required to work within a framework through which NHS organisations are accountable for both continuously improving the quality of their services and safeguarding high standards of care. Clinical governance committees have a duty to oversee delivery in these areas.</td>
</tr>
<tr>
<td>clinical need</td>
<td>Healthcare decisions can be said to be made necessary, or justified, by the specific physical or mental problems of a patient, or what is described as their clinical need.</td>
</tr>
<tr>
<td>clinical outcome</td>
<td>An indication of the level of improvement in the patient/client’s symptoms, as defined by a healthcare professional.</td>
</tr>
<tr>
<td>clinical risk</td>
<td>Risk arising directly from the provision and delivery of healthcare. This includes clinical errors and negligence, healthcare associated infection and failure to obtain consent.</td>
</tr>
<tr>
<td><strong>community health partnership (CHP)</strong></td>
<td>Established through the NHS Reform (Scotland) Act 2004, CHPs are committees or sub committees of NHS territorial health boards. They provide the focus for the integration between primary care and specialist services and with social care, to ensure that local population health improvement is at the centre of service planning and delivery. CHPs have a key role in the local authority-led community planning process. A CHP covers a geographical area within a NHS board area, and the number of CHPs within an NHS board area depends on the distribution and size of the population and boundaries within local authorities. Website address: <a href="http://www.show.scot.nhs.uk/sehd/chp/index.htm">www.show.scot.nhs.uk/sehd/chp/index.htm</a></td>
</tr>
<tr>
<td><strong>contracting</strong></td>
<td>A person who is contracting is someone who is responsible for securing a contractor to deliver a service.</td>
</tr>
<tr>
<td><strong>criterion/criteria</strong></td>
<td>A rule/rules giving the detailed and practical information on how to achieve a standard.</td>
</tr>
<tr>
<td><strong>diagnosis</strong></td>
<td>The identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and possible causes for the symptoms.</td>
</tr>
<tr>
<td><strong>Disability Discrimination Act (DDA) 1994</strong></td>
<td>The Disability Discrimination Act (DDA) 1994, extended by the Disability Discrimination Act 2005, gives disabled people rights in the areas of: employment; education; access to goods, facilities and services, including larger private clubs and land-based transport services; buying or renting land or property, including making it easier for disabled people to rent property and for tenants to make disability-related adaptations; and in relation to the functions of public bodies, for example, the issuing of licences. The Act requires public bodies to promote equality of opportunity for disabled people. It also allows the government to set minimum standards so that disabled people can use public transport easily.</td>
</tr>
<tr>
<td><strong>Disclosure Scotland</strong></td>
<td>An official body whose aim is to enhance public safety and help employers and voluntary organisations in Scotland to make safer recruitment decisions. Three levels of criminal history system check known as ‘disclosures’ are provided to registered agencies, and individual applicants on submission of a fee. Website address: <a href="http://www.disclosurescotland.co.uk">www.disclosurescotland.co.uk</a></td>
</tr>
<tr>
<td><strong>equality and diversity impact assessment (EQIA)</strong></td>
<td>A systematic way of looking at an organisations’ policies, functions and practices to determine the effect these have on diverse groups. It is a way of making sure that NHS QIS policy developers, project managers and other staff members think carefully about the likely impact of their work on NHS service users and staff and take action to be as inclusive as possible.</td>
</tr>
<tr>
<td><strong>ethnic minority</strong></td>
<td>A group of people who have a different ethnicity, religion, language or culture to that of the majority of people in the place where they live.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>evaluation</td>
<td>The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.</td>
</tr>
<tr>
<td>follow-up</td>
<td>Where a patient receives continuing care after the initial episode of care and/or where the outcome of initial care is checked up.</td>
</tr>
<tr>
<td>General Dental Council (GDC)</td>
<td>The regulatory body for all dentists (private and NHS) as well as professionals complementary to dentistry (hygienists and dental therapists) in the UK. Website address: <a href="http://www.gdc-uk.org">www.gdc-uk.org</a></td>
</tr>
<tr>
<td>general dental practitioner (GDP)</td>
<td>A registered dental surgeon who provides dental treatment for patients either within the NHS General Dental Services or on a private (fee paying) contract basis.</td>
</tr>
<tr>
<td>guidelines</td>
<td>Systematically developed statements which help in deciding how to treat particular conditions.</td>
</tr>
<tr>
<td>healthcare professional</td>
<td>A person qualified in a health discipline.</td>
</tr>
<tr>
<td>implementation</td>
<td>Carrying out and completing a task, action or project.</td>
</tr>
<tr>
<td>multidisciplinary</td>
<td>An approach combining the knowledge, skills and expertise of a range of professionals.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service.</td>
</tr>
<tr>
<td>NHS board</td>
<td>There are 22 NHS boards in Scotland. Fourteen are territorial boards responsible for healthcare in their areas. The remainder are special health boards which offer supporting services nationally. See NHS board (territorial).</td>
</tr>
<tr>
<td>NHS board (territorial)</td>
<td>There are 14 territorial boards, the mainland being covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three. They are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each NHS board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. NHS boards work together in regional planning arrangements for those services which require that wider perspective. See community health partnership. Website address – board directory: <a href="http://www.show.scot.nhs.uk/organisations/orgindex.htm">www.show.scot.nhs.uk/organisations/orgindex.htm</a></td>
</tr>
<tr>
<td>NHS QIS</td>
<td>See NHS Quality Improvement Scotland.</td>
</tr>
</tbody>
</table>
### NHS Quality Improvement Scotland (NHS QIS)
NHS QIS is a Special Health Board whose purpose is to advise, support and assess NHS boards in order to help improve the quality of healthcare for the people of Scotland. We have a lead role in supporting NHS boards and their staff in achieving this goal and do this by: providing advice and guidance on effective clinical practice, including setting standards; driving and supporting implementation and improvements in quality; and assessing the performance of the NHS, reporting and publishing our findings. We also have central responsibility to support NHS boards to deliver patient safety and clinical governance across Scotland. Website: www.nhshealthquality.org

### outcome
The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.

### out-of-hours
The out-of-hours period means: (1) the period beginning at 5.30pm on any day from Monday to Thursday and ending at 8.30am the following day; (2) the period between 5.30pm on Friday and 8.30am on the following Monday; and (3) Christmas Day, New Year’s Day and other public or local holidays.

### patient
A person who is receiving care or medical treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by them when necessary. Sometimes referred to as a user.

### patient focus and public involvement
A framework for change which aims to support NHS staff and NHS organisations to develop services in partnership with those who use them.

### peer review
Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS QIS approach, all members of a review team are equal.

### point of contact
The framework for involving patients and the public in the design, development and delivery of patient-focused NHS services.

### policy
An operational statement of intent in a given situation.

### prescription
Usually a written recipe of treatment.

### protocol
Operational instructions which relate and direct activity. Protocols may be national, or agreed locally to take into account local requirements.

### quality assurance (QA)
Improving performance and preventing problems through planned and systematic activities including documentation, training and review.

### quality assurance framework
A model used to define and monitor the standard of care that is required and provided.
| **referral** | The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment. |
| **reporting** | The effective presentation and dissemination of information collected through monitoring processes. |
| **representative** | A person acting on behalf of the patient. |
| **review** | See peer review. |
| **risk management** | The systematic identification, evaluation and treatment of risk, a continuous process with the aim of reducing risk to organisations and individuals alike. The ‘culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.’ (Australian/New Zealand Risk Management Standard 4360:2004). |

**Salaried Primary Dental Service**

Services delivered by salaried primary care dentists working in dental practices, dental access centres, health centres, and the patient's own home. It provides access to NHS general dental services where there is a local shortage of dentists offering NHS treatment.

**Scottish Dental Clinical Effectiveness Programme (SDCEP)**

An initiative of the National Dental Advisory Committee in partnership with NHS Education for Scotland. The primary aim of the programme is to support dental teams nationally by providing guidance on topics identified as priorities for dentistry in Scotland, developed by the profession for the profession. Website address: www.sdcep.org.uk

**Scottish Emergency Dental Service (SEDS)**

Service designed to ensure that any patient with a dental emergency out of hours is objectively assessed and receives appropriate care within target timescales. It is based on a model of service that has been developed since 2001, offers a single point of access through NHS 24 and, where required, can offer confirmed patient booking made during the out-of-hours period.

**Scottish Intercollegiate Guidelines Network (SIGN)**

To help improve the quality of healthcare, SIGN develops national clinical guidelines aimed at reducing variations in clinical practice and in outcomes or patients. Founded in 1993 by the Academy of Royal Colleges and Faculties in Scotland, SIGN became part of the national clinical effectiveness body, NHS QIS, on 1 January 2005. The evidence base for many of the clinical standards developed by NHS QIS has been drawn from SIGN guidelines. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA. Website address: www.sign.ac.uk

**secondary care**

Hospital-based (acute) health services which are provided on an inpatient or outpatient basis.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>self-assessment</td>
<td>Assessment of performance against standards by the individual/clinical</td>
</tr>
<tr>
<td></td>
<td>team/NHS board providing the service to which the standards relate.</td>
</tr>
<tr>
<td>stakeholders</td>
<td>People and organisations who may affect, be affected by or perceive</td>
</tr>
<tr>
<td></td>
<td>themselves to be affected by a decision or activity.</td>
</tr>
<tr>
<td>standard</td>
<td>Agreed level of performance.</td>
</tr>
<tr>
<td>standard statement</td>
<td>An overall statement of required performance.</td>
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</table>
The Scottish Health Council, the Scottish Intercollegiate Guidelines Network (SIGN) and the Healthcare Environment Inspectorate are also key components of our organisation.