National Oral Health Policy: Dr. Dympna Kavanagh, Chief Dental Officer, Department of Health.

Introduction

Thank you, Chairman, for inviting me here today to outline the key aspects of Smile agus Sláinte, the National Oral Health Policy, which was launched by the Ministers for Health and for Employment Affairs and Social Protection on 3rd April this year.

This is a comprehensive and evidence-based policy, informed by extensive research and consultation. It will facilitate better oral health for everyone and will also support continued professional development for the profession. It is a transformative programme, introducing and managing a series of changes over eight years.

The policy is aligned with other Government policies, including Sláintecare, Healthy Ireland and the First Five Years whole of government strategy for babies, young children and families, as well as the national strategies on disability and mental health. It conforms to international policies of the World Health Organisation (WHO) and the European Union (EU). The policy embraces the "no child is left behind" principle in the First Five Years and education policies.

This is the first major oral health policy statement in 25 years. Much has changed in Ireland in that period, including the standard of general and oral health, materials and technology in dentistry, and the types of services we aim to provide. In developing the policy, we have ensured that it is supported by up-to-date information about the oral health of the population, as well as

appropriate international evidence. A broad range of stakeholders were consulted, including those who use the services and those providing care.

Our current oral healthcare system is out-of-step with other health services. There are gaps in routine dental care for the very young and the vulnerable, including people in residential care, people with disabilities and older people. Smile agus Sláinte reorients how care is provided, in line with Sláintecare, so that most dental care is provided in people's own communities, as close as possible to where they live. This is beneficial for service users and allows acute services to focus on more complex care.

What is described in Smile agus Sláinte is not a demand led service but instead enables the Irish public to access services and to forge a relationship with their chosen dental practice - their dental home. To support this universal primary care approach, a safety net system will identify those who do not or cannot attend their local dentist. This safety net is part of a surveillance system for vulnerable children and adults, ensuring the most vulnerable, including those on lower incomes, will be supported and that they receive the same quality of service as the rest of the population.

The existing Public Dental Service will be stronger. A key service will be to identify, support and deliver care for vulnerable children and adults, when it cannot be provided in a local dental practice. The measures set out in this policy will also provide professional opportunities for staff in areas, including health promotion, special care services and public health.

Key Policy Strategies/Proposals

The policy has three key strategic pillars: oral health promotion and protection programmes, service provision and an evaluation and surveillance programme.

Key features of the Policy include

- Water fluoridation remains a cornerstone of oral health policy.
- Health promotion programmes to support the whole population will be developed, in parallel with programmes targeted to the most vulnerable. Integrated care will include support of general health initiatives such as HPV vaccine for adolescents.
- Most care for children and eligible adults will be in local dental practices.
- Packages of care for children from birth to 16, delivered in local dental practices, will over time replace the existing school programme, targeting three classes - 2nd (over 6 years of age), 4th and 6th.
- For the first time, under 6s, teenagers and adults will have lifetime access to multiple prevention interventions, such as fissure sealants and fluoride varnishes, from their local dentist, in line with best international practice. Expansion of primary care is also proposed across the whole life course.
- Improving access for vulnerable groups, including low income, rural dwellers and people with disabilities, to local dental practices is key. A safety net service, identifying their needs and care that is not available locally, will ensure they receive comprehensive care and address inequalities.
- Advanced care centres will provide specialist services including dental general anaesthesia.
- Monitoring systems will identify people not taking up services, overall dental needs and the policy's impact - the surveillance programme in the policy.
- There will be a full review of undergraduate dental education, in tandem with career-long professional mentoring for dentists

The Development of Policy

The Policy was informed by oral healthcare professionals, through a series of working groups and consultations. A key working group was the Academic Reference Group, which drew from expertise in Irish Universities. These experts assessed current needs and how best to meet them. In addition, an external independent panel, were appointed. They are international leaders in different aspects of policy development. Recommendations of the reference group and research was quality-assured in line with international standards. All research undertaken, including the additional FACCT study analysis, was robust, representative, ethically compliant and externally quality assured.

During policy development, letters inviting comments was sent to all dental registrants (over 5000). A stakeholder day was held in 2015 with over 70 attendees. There was also one-to-one engagement on specific topics with dental practitioners in independent practice and in the Public Dental Service. Overall, their views highlighted an appetite for change in oral healthcare services, while emphasising the challenges of such changes.

The Dental Council, and training bodies including the RCSI and The Expert Body on Fluorides and Health were also consulted.

These engagements informed the direction of policy in key aspects of service provision and training for professionals.

Consultation – Key findings

Public

- The current system is complex and difficult to navigate. People are worried about the cost of care, especially for children and have difficulty accessing care especially in non-urban areas.
- Young children rarely attend before 6 years of age.
- Over 55, there is a decline in quality of life especially in later years. Older people with total tooth loss are especially affected.
- Overall, all age groups and social classes perceived their main access to care is via general dental practice.

Stakeholders and Practitioners

- Very early childhood care is needed, as well as special care services for the vulnerable.
- They expressed frustration with barriers to accessing care for patients and an out-dated state payment state system.
- There is a greater need for an emphasis on primary care in the profession.
- The Public Dental Service wanted to emphasise prevention, and have opportunities to expand their skills.

From the consultations:

- Leadership roles in primary care, to refocus the profession and facilitate leadership from within the profession is a key action.
- The policy includes very early intervention for children to give the best start, with comprehensive support for the most vulnerable through a specific support service within a reoriented PDS.
- With the policy action, a career long mentoring framework, like professions such as social work and psychology will be put in place.
- Undergraduate and graduate education is a priority within the policy, with an emphasis on training in primary care.
- The policy includes review of dental technology and clinical dental technology training to ensure that a sustainable workforce is available for those older persons with total tooth loss.

Policy Implementation

I know members will be particularly interested in the Department's plans to implement the policy.

The overview document, which we have shared with the committee sets out forty-one (41) actions and the priority for each over the next eight years. This implementation period is needed to commit actively to engagement on significant and complex issues.

Firstly, it is intended to build a framework to support long term sustainability, such as the education review, mentoring framework and a focus on legislative issues. The Department has already begun to discuss the priorities with key agencies and we are agreeing targets and timescales.

For instance, a priority, as Action 29 in the policy, the National Plan for Amalgam phasedown, with our colleagues in DCCAE, and key stakeholders is being finalised in line with Ireland's EU legislative obligations to publish the National Plan on July 1st, 2019 and submit to the EU for August 1st, 2019.

A full review of undergraduate training, graduate mentoring programmes and upskilling for graduate dentists are key immediate actions for this change. (Policy actions 24 and 27). The Dental Council, through the Irish Committee of Specialist Training in Dentistry (ICSTD), will lead in developing the Advanced Centres of Care framework. We are convening in July to commence our work, with explicit support from the ICSTD.

The First Five Years, the Department of Children, is working with the Department of Health to support the framework for the under 6s policy programmes of health promotion and services, (Action 3).
The Department met with the Clinical Dental Technicians Association (Actions 19 and 21) and have its support to assess dental technology training a key priority.

Water fluoridation (Action 2) and simplifying and securing its resources are being reviewed. The Department will engage in July with the Expert Body on Fluorides and Health about their work programme to support policy in relation to fluorides (Action 31).

The HSE have two main service focuses. Epidemiology data indicates that those in residential settings require urgent attention and support. The reoriented PDS, the community oral health care services, will identify their needs and put in place a treatment programme for those who cannot use primary care. The second priority is initially on the very young up to 6 years old to 'receive

‘packages of preventive and primary’ care. This is in line with Healthy Ireland and The First Five Years strategies.

Implementation of a transformative policy like Smile agus Sláinte will present challenges. However, those challenges will present opportunities for the staff in private practice and the public dental service. It is important that implementation is owned by the profession, listening to the voice of the public. To achieve these priorities, we need key leadership roles, both operational and in dental schools. Primary care, special care, advanced or specialist care delivery and public health leaders must be in place so that implementation is sustainable and placed where it belongs in the services.

Conclusion

Thank you, Chairman, for this opportunity to outline Smile agus Sláinte and we look forward to working with the HSE services, the professionals and key stakeholders.