

Oral Health Needs
Assessment for
Oxfordshire Primary Care Trust

October 2010

<p>Kate King, Health Improvement Principal</p>

Executive Summary

There have been general improvements in the UK over the past 30 years in relation to oral health. The UK has one of the best rates of oral health in Europe and in many sectors of society within the UK oral health is good. Oral disease such as mouth cancer and dental disease such as caries and periodontal disease are largely preventable.

However, despite improvements in general oral health many people (adults and children) who are vulnerable, disadvantaged and socially excluded tend to have increased problems and levels of disease and are more at risk of serious consequences or death as a result of oral disease.

Since 2006, primary care trusts have had responsibility for commissioning primary care dental services to reflect local needs and priorities. This means that primary care trusts now have an integrated responsibility for commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, in community-based salaried services, or in hospitals.

A number of key documents have been produced in recent years linked to NHS dental services and key themes of these documents include:

- Improving equity of dental access for everyone
- Trying to reduce oral health inequalities
- Reorientation of dental care to a more preventative focus
- Engaging and involving the community in determining policy
- Integrating dentistry within the NHS family

In line with national policy and local priorities Oxfordshire PCT has developed a 'Strategic Commissioning Framework for Dental Services for Oxfordshire (2008-2013)' which is an integral part of the PCT commissioning and primary care strategy Oxfordshire: This framework proposes six commissioning outcomes to be achieved by the PCT including:

- Improved access to NHS dentistry
- Improved oral health for the local population
- Reduce health inequalities relating to dental care, with a priority focus on children, older people and vulnerable groups
- Improved patient experience in dental care
- To get best value and make best use of the dental budgets and make the case for future investment
- To develop specialist dental services and where appropriate develop alternative provision in primary care settings

The current dental service provision in Oxfordshire includes Primary Care Dental Services such as General and Salaried Dental Services, Out of Hours Emergency Dental Services and Oral Health Promotion. The PCT also commissions more specialist dental services from both primary and secondary care including:

- Prison dentistry
- Special care dentistry
- Paediatric dentistry
- Domiciliary services
- Orthodontics
- General anaesthetic and sedation services
- Minor oral surgery
- Restorative dentistry

An Oral Health Needs Assessment was carried out from January 2010 – May 2010 and the final report was completed in September 2010. It aims to inform the delivery of oral health promotion and dental treatment services in Oxfordshire from 2010

Key findings:

- Studies have shown that there are higher levels of oral disease in populations which are socio-economically deprived. While Oxfordshire is a relatively affluent county and the majority of areas are in the least deprived quartile for England, there is 3% of the county which features in the most deprived quartile. Key wards within Oxford City and Banbury have higher levels of social deprivation and child poverty.
- Oxfordshire has an ageing population. By 2031 there could be an additional 61,500 people in Oxfordshire aged over 65, and 18,400 more people aged 85 years and over. As oral health continues to improve it is expected that by 2026, only 4% of adults will have no natural teeth. This has significant implications on dental services as more people will be maintaining teeth that have already been heavily restored.
- Key populations within Oxfordshire are at risk of poor oral health due to poor diet and nutrition, poor oral hygiene, lack of exposure to fluoride, tobacco and alcohol use and injury. Other public issues such as obesity or alcohol share these risk factors and their underlying determinants and therefore the common risk factor approach provides a rationale for linking oral health improvement into other joint strategic health improvement work and working in partnership to ensure consistent messages are relayed to the public.
- In Oxfordshire, access to NHS Dental services is improving and mosaic data would suggest that services are addressing the needs of people who are more socially deprived. However, access for adults still lags behind other PCT's in the South Central region and the rest of England and Oxfordshire PCT is ranked 124th out of 152 Primary Care Trusts in terms of its access for adults.
- Key population groups including older people, rural populations, children in deprived areas, certain ethnic minorities and vulnerable groups such as people with learning disabilities, drug and alcohol users and travellers continue to be at risk of poor oral health due to a number of factors including lifestyle behaviours, a lack of oral hygiene and less frequent use of dental services. Common barriers include lack of awareness of local NHS dental services or a lack of NHS services, distance to travel, language & cultural differences
- A good range of services are now delivered in primary care and by salaried dental services, meeting the needs of a diverse range of patients and there is ongoing work to develop a clinical network to ensure that treatments such as restorative dentistry including endodontic treatment continues to be available in primary care. GDP's and salaried services should ensure that they stress the importance of regular dental check ups and preventative care for all and are sensitive to the cultural norms of different ethnic groups. More should be done to ensure that all GDP's are easily accessible to populations at risk, to reduce inequalities in oral health.

A number of recommendations have been made as a result of the findings from this needs assessment and are included towards the end of the report.

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Kate King,
Health Improvement Principal, Public Health
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1 Introduction

Oral health refers to the health of people's teeth, gums, supporting bone, and the soft tissues of the mouth, tongue and lips¹. Good oral health is an important part of general health and wellbeing as it allows people to eat and enjoy a variety of foods, speak and communicate effectively and socialise without pain, discomfort or embarrassment. It is linked to overall quality of life, self-esteem and confidence and overall physical and mental wellbeing.

There have been general improvements in the UK over the past 30 years in relation to oral health. The UK has one of the best rates of oral health in Europe² and in many sectors of society within the UK oral health is good. Oral disease such as mouth cancer and dental disease such as caries and periodontal disease are largely preventable

However, despite improvements in general oral health many people (adults and children) who are vulnerable, disadvantaged and socially excluded tend to have increased problems and levels of disease and are more at risk of serious consequences or death as a result of oral disease.

While dental treatment has become more acceptable and accessible it is expensive for individuals, for the NHS and generally to society. Oxfordshire PCT has a net budget of £22.24 m for providing NHS dental care services. However, this does not include the private cost to the individual of NHS or private treatment or account for the time lost to individuals and businesses in regards to time out of education or work.

Primary Care Trusts are now required, by the Department of Health to plan and meet the health needs of their Primary Care Trust populations. As part of this PCT's currently have the responsibility of providing, as a statutory duty, local dental health services and ensuring that there is a broad and integrated approach to prevention of oral health disease.³

Part of planning involves assessing and understanding the health needs of a population. A health needs assessment is a systematic process of examining the health issues of a population which then can be used to direct the process of priority setting and the allocation of resources during commissioning in order to improve health and reduce inequalities. Oxfordshire PCT as part of its commissioning of Oral Health services has undertaken this process focusing on oral health. This document will outline the findings from this assessment.

2 Broader Context

2.1 National

2.1.1 Overarching NHS Priorities

The NHS Operating Framework

The Department of Health (DH) published *The NHS in England: the operating framework for 2010-11* in December 2009⁴. This is an overarching document that frames the direction of the whole NHS over the next three years, that also includes guidance specifically for NHS dentistry. The five national priorities across the NHS remain the same, including, improving access and patient experience, keeping people well, improving health and reducing health inequalities. More specifically the framework reinforces the existing commitment that everyone seeking NHS dental services has access to them. To provide a consistent measure of whether PCTs maintain this aim, a new indicator of public experience of accessing dental services is being introduced from 1st April 2011. PCT's are also being asked to want to take into account the recommendations of Professor Jimmy Steele's independent review of NHS dental services in England.

18 week patient pathway

Improving access to services remains a NHS priority and the principle of the 18-week patient pathway is that patients should receive high quality care without unnecessary delay. In practice, this means that any patient pathways that involve, or could potentially involve, consultant-led care should begin treatment within 18 weeks of the date of referral. In terms of dental referrals, the 18-week rule applies to the following:

- Referrals to a consultant-led service in either secondary or primary care.
- Referrals for a general anaesthetic (GA) service, eg extractions under GA provided by a salaried dental service.
- Referrals for care by postgraduate dental students and Specialist Registrars.
- Referrals processed through a referral management service or clinical assessment service

High Quality Care for All: NHS Next Stage Review Final Report (2008)

Lord Darzi's Next Stage Review⁵ final report sets out a new foundation for an NHS that empowers staff and gives patients choice. It ensures that health care will be personalised and fair, include the most effective treatments within a safe system, and help patients to stay healthy.

Patients will have more say through initiatives such as care plans for those with long term conditions, a guarantee that the most effective drugs are available to all and providing the right to choose care providers, including GPs. Personal budgets will be piloted for 5000 patients with complex conditions and Oxfordshire PCT is one of the participating pilot sites

People will be helped to stay healthy through investment in well being and prevention services, for example the new "Reduce Your Risk" campaign intends to raise awareness of free vascular checks for 40-74 year-olds.

Front line staff will be enabled to initiate and lead change that improves quality of care for patients. There will be no new targets from the centre, with service providers accountable to patients and the public. There will be a clinical voice at every level of the service, and investment in new programmes of clinical leadership

2.2 Dental Strategic Priorities

2.2.1 The New Dental Contract

Since 1 April 2006, under a national dental contract, primary care trusts have had responsibility for commissioning primary care dental services to reflect local needs and priorities. The new contract was designed to allow primary care dentists to work in line with evidence-based practice by focusing on prevention and health promotion and carrying out fewer interventions. These policy changes represented a major overhaul of primary care dental services and comprised of three key issues:

- Responsibility for planning and securing NHS dental services was devolved to local PCT's and they now have an integrated responsibility for commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, in community-based salaried services, or in hospitals
- The system of patient charges was changed, resulting in a reduction in the possible number of charges from around four hundred to three
- The mechanism by which dentists are paid to deliver NHS services was changed from one based on fees for items of service to one where providers are paid an annual sum in return for delivering an agreed number of 'course of treatment' weighted by complexity.

Independent contractors working in the 'General Dental Service' still provide the vast majority of dental services and after the new contract was introduced some chose to convert to providing only private care. Historically, these dentists have been free to choose where to provide services and an inverse care law (whereby those most in need of services are least likely to receive them) has been the result. Under the new contract PCT's have control over funding, allowing them more flexibility to match service provision to the needs of the local population.

2.2.2 NHS Operating Framework

The emphasis of increasing access to NHS dentistry in *The NHS in England: the operating framework for 2009-10* confirms the Government's commitment to maintain dentistry within the mainstream NHS. It states "The NHS is committed to the aim of ensuring that by March 2011 everyone seeking NHS dental services has access to them "

Since the introduction of the national dental contract in 2006 access to NHS dentistry has become and remains a national priority and PCTs' will continue to have a legal duty to provide or commission dental services to meet all reasonable requirements for the foreseeable future.

The DH guidance *Commissioning NHS primary care dental services: meeting the NHS operating framework objectives*, which was launched in January 2008, emphasised the need to expand NHS dental services and increase access year on year through robust local commissioning.⁶

PCT commissioning plans should be based on local needs, oral health needs and access requirements and should lead to:

- Year on year improvements in the number of patients accessing local dental services
- High quality services which achieve improved oral health.
- Commissioned services which prioritise prevention as well as treatment.
- Services that are tailored to need with special attention paid to hard to reach groups.
- Improved patient information about what services are available and how to access them

The Government's commitment to NHS dentistry was reinforced with an 11% increase in PCT ring-fenced dental funding in 2008-2009. The government has also committed to extending the ring-fencing of the NHS dentistry budget from 2009- 2011.

2.2.3 Choosing Better Oral Health

An oral health strategy document *Choosing Better Oral Health. An Oral Health Plan for England* was published by the Department of Health in 2005.⁷ This document was designed to complement the public health white paper *Choosing Health; making healthier choices easier* and provide a good practice framework for tackling oral health inequalities.⁸

The plan aimed to reduce oral health inequalities and achieve sustained oral health improvements within the new contractual arrangements for NHS Dentistry. At the core of the plan was the need to integrate oral health into the wider public health agenda.

Oral health should be considered part of general health, addressed through evidence-based interventions focusing on the underlying factors that put people at risk of disease.

A key aim of the action plan is to reduce both the prevalence of oral disease and oral health inequalities across all age groups in England by providing the NHS, dental practices and other organisations with the information and guidance needed to improve oral health.

2.2.4 Supporting documents to Choosing Better Oral Health

The Department of Health has published a number of supplementary guidance documents to support the implementation of the oral health strategy document *Choosing Better Oral Health*. The documents include:

***Smokefree and Smiling (2007)* - Guidance for dental teams to support patients who wish to quit tobacco⁹**

Key recommendations include:

- All dental patients should have their smoking status (current, ex-, never smoked) established and checked at regular intervals
- All smokers and chewers of tobacco should be advised both of the value of stopping, and of the health risks of continuing.
- All smokers should be advised of the value of attending their local NHS Stop Smoking Services for specialised help in going smokefree.
- Dental teams should be offered appropriate cessation training, and local systems of referral should be established.

***Valuing People's Oral Health (2007)* - A good practice guide for improving the oral health of disabled children and adults¹⁰**

Key recommendations

- Assess need through local surveys and ensure that disabled children and adults, and those involved in their care, receive the necessary information, advice, support and resources so that they have the best opportunity to achieve and maintain optimal oral health
- Design and implement effective preventive actions and programmes
- Ensure consistency of messages across all health and social care boundaries. Use national support groups to promote consistent oral health messages and ensure that up-to-date information is available for local branches
- Build competence through training and sharing of knowledge
- Include oral health in every care plan
- Ensure there are responsive, needs-led treatment and specialist care services
- Provide multilingual information or translation as appropriate

Delivering Better Oral Health (2009) – An evidence based toolkit prevention (second edition) was first published in 2007 and has been updated and republished in 2009¹¹

This is a simple reference guide on evidence-based prevention designed to be actively used by the entire primary care dental team to deliver a more preventive approach. In the past, primary care general dental services have been incentivised to be treatment focused and the potential benefits of a more preventive approach have not been realised. *Delivering Better Oral Health* complements the new dental contract and the overarching oral health strategy document *Choosing Better Oral Health as it* encourages oral health professionals to give preventive oral health messages that are in line with generic health promotion:

The summary guidance is broken down into the key messages by age group and subject areas include increasing fluoride availability including the application of fluoride varnish, healthy eating advice, identifying sugar-free medicines and stop-smoking guidance

2.2.5 Water Fluoridation

Fluoride occurs naturally in all drinking water and is added to some toothpaste products. It helps protect teeth against decay by strengthening the surface of the tooth. Fluoridation is the process of raising the concentration of fluoride within the water supply to the optimum level deemed appropriate for improving dental health (approximately one part per million). In areas of the UK, such as Birmingham, where water supplies have been fluoridated for 40 years, the dental health of five-year-olds is noticeably better than in non-fluoridated Manchester, a city of similar size and social makeup.

Best practice guidance on the *Fluoridation of Drinking Water* ¹² was published by DH in February 2008. This guidance describes the legislative framework for water fluoridation, the evidence base of water fluoridation and the process to follow when planning a water fluoridation scheme, including technical considerations and how to conduct a local consultation. The previous Labour Government called for fluoride to be added to England's water supplies as a key means of tackling tooth decay and the DH guidance encouraged SHAs and PCTs to consider water fluoridation as a strategy for reducing oral health inequalities. It also emphasised the requirement to assess the specific oral health needs of their population before reaching this decision.

With the abolition of SHA's and PCT's by 2013 it remains to be seen if and how these proposals will be taken forward.

2.2.6 NHS dental services in England – An independent review led by Professor Jimmy Steele

An independent review was commissioned to identify ways in which the Government and local NHS could work together with dentists and other providers to:

- increase access to dental services and improve the quality of services
- reduce inequalities in oral health and ensure that dentists and other dental professionals can provide appropriate levels of preventive work
- recommend how funding for dentistry should be allocated to Primary Care Trusts to support these aims and meet the needs of local populations
- identify developments in workforce planning, training and regulation to support the provision of high quality NHS dental services and enhance the working lives of dental professionals
- recommend how the Government could best address the issues raised in the Health Select Committees 2008 report

The report was published in June 2009 and made a number of recommendations ¹³including:

- that the NHS dental access programme use the opportunity for new procurement to pilot some of the key components of the reviews recommendations
- that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality
- that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality and that these are piloted and then nationally applied

3 Broader Context: Local Priorities

3.1 SHA Priorities

NHS South Central covers the counties of Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight.

The local vision for the South Central Health Authority - 'Towards a healthier future,'¹⁴ was developed as part of the NHS Next Stage Review and is based on the work of over 160 local clinicians who have been looking at how the NHS can raise the quality of services to world class standards across eight clinical pathways ranging from Maternity and Newborn to End of Life Care. The views of over 10,000 local people were gathered ensuring that 'Towards a healthier future' addresses the needs and concerns of local people.

The document, which was published in 2008 describes a ten year vision for healthcare across NHS South Central and is the result of one of the largest engagement exercises ever undertaken across the local NHS.

There are 8 ambitions which include:

Ambition 1: We will maximise the potential for health by ensuring that risk of illness is regularly and systematically evaluated for all in order to identify the need for preventative care.

Ambition 2: We will ensure that every clinical or social care encounter provides an opportunity for prevention as well as treatment.

Ambition 3: We will encourage patients to be partners in their care, taking responsibility for their own health and treatment with the guidance and help of professionals.

Ambition 4: We will commission services that are based on the best evidence and practice to ensure high quality care and good outcomes for patients.

Ambition 5: We will engage the public in decision-making about priorities in healthcare provision. This may result in legitimate geographical variations in services.

Ambition 6: We will offer real choice to patients within the framework of services we commission. We will support patients in exercising choice by providing better access to clinical and other information to help them make decisions that will achieve the best care and outcome for them.

Ambition 7: We will ensure that all healthcare settings are safe and clean and offer a high standard of personalised care.

Ambition 8: We will ensure that patients have access to services through a singlepoint and that they are not left alone to manage their care; they will have a key professional assigned to coordinate their care and to help them navigate seamlessly.

The SHA also has a number of overarching objectives, including improving the health & wellbeing of the population and reducing health inequalities. The plan for 2009/2010 includes supporting PCT's to address inequalities in oral health, including by fluoridation of water supplies if appropriate. At the moment the only area identified for fluoridation is Southampton.

3.2 PCT Priorities

Oxfordshire PCT serves a population of approximately 600,000 and is ambitious about improving the health and wellbeing of local people. The vision for the PCT¹⁵ is that by 2013, the people of Oxfordshire will:

- Be healthier – particularly if they are vulnerable or live in our most deprived communities
- Be working with the PCT to promote physical and mental well being and prevent ill health
- Be actively supported to manage their own health and care needs at home, when this is appropriate
- Have access to high quality, personalised, safe and appropriate health services
- Get excellent value for money from their local health services
- Have a PCT which is a high performing organisation

The PCT has the following strategic goals:

A) To ensure that the core services purchased from Primary and Secondary Care providers continually improve to meet changing health needs, giving patients optimum access to satisfactory, timely, high quality care that also offers good value for money.

B) To improve health outcomes and promote independence for the following key population groups:

- older people
- those with long term conditions
- people with mental health problems
- children and families living in areas of deprivation

C) To improve access to health services by increasing the commissioning of integrated whole care pathways that create a proportionate and appropriate shift of activity from hospital into primary and community care settings.

D) To help more local people of all ages to make sustainable healthy lifestyle choices.

E) To reduce health inequalities in Oxfordshire by improving health outcomes for people living in wards with the highest mortality rates at a greater rate than for the PCT population as a whole.

The PCT has developed a '**Strategic Commissioning Framework for Dental Services for Oxfordshire (2008-2013)**'¹⁶ which is an integral part of the PCT commissioning and primary care strategy.

In line with the strategic direction for the PCT this framework contributes to the organisational priorities by supporting people to:

- be healthier by preventing oral health problems
- improve their well being through improving their oral health
- manage their own oral health in association with skilled dental care professionals
- have access to high quality, personalised safe and appropriate dental care
- get excellent value for money from NHS dental services.

This framework proposes six commissioning outcomes to be achieved by the PCT:

- Improved access to NHS dentistry
- Improved oral health for the local population
- Reduce health inequalities relating to dental care, with a priority focus on children, older people and vulnerable groups
- Improved patient experience in dental care
- To get best value and make best use of the dental budgets and make the case for future investment
- To develop specialist dental services and where appropriate develop alternative provision in primary care settings

3.3 Annual Public Health Reports 2007/2008/2009/2010

The DPH in Oxfordshire is a joint appointment between Oxfordshire County Council and Oxfordshire. Each year the DHP produces an independent annual review on the health of the local population.

Successive annual reports have identified the five main long-term threats to Oxfordshire as:

- Breaking the cycle of deprivation in children and families
- The Demographic Time bomb affecting older people
- Mental health and wellbeing
- The rising tide of obesity
- Fighting killer infections

Alcohol abuse was identified as a new threat in the 2010 annual report

4 Population and Demography of Oxfordshire

4.1 General Characteristics

Oxfordshire has a population of 639,800 and is a predominately rural county in the South East of England, bordering on Northamptonshire, Buckinghamshire, Berkshire, Wiltshire, Gloucestershire, and Warwickshire. Almost half of the population in Oxfordshire lives in settlements of less than 10,000.

There is a two tier government system and Oxfordshire County Council provides certain services for the whole county whilst District Councils provide local services to the population.

Oxfordshire Primary Care Trust (PCT) is responsible for commissioning local health services (Until 2012) and the PCT boundaries are largely the same as the County Council (excluding the towns of Thame & Shrivenham). The PCT serves a population of approximately 600,000 and commissions services from independent contractors, including 82 GP practices, 98 pharmacies, 100 dental providers and 75 optometry practices.

There are five local district councils: Oxford, Cherwell, Vale of White Horse, West Oxfordshire and South Oxfordshire. Oxfordshire County Council is responsible for providing social care services across the area.



The main centre of population is the city of Oxford. Other significant settlements are Bicester, Banbury, Kidlington, and Chipping Norton to the north of Oxford; Witney to the west; Thame and Chinnor to the east; and Abingdon, Wantage, Didcot and Henley-on-Thames to the south. Future population growth in the county is expected to be concentrated around Banbury, Bicester, Didcot, Witney and Grove.¹⁷

Children aged under 17 years comprise more than 20% of the population and 15% of the population are over 65. In general, Oxfordshire is representative of the rest of England although in Oxford the age profile differs from the rest of the county (and from England as a whole), with a higher proportion of people under 65. This is due to the large number of students and ex students living in the city which creates a bulge in the 20 – 24 population.¹⁸

In general the population is healthy and compares well with the South East region and the rest of the country. Average life expectancy for both men and women in Oxfordshire is now 1 year and 3 months longer than the rest of England. Local people have lower rates of diabetes, there are fewer hospital admissions related to alcohol harm and fewer early deaths (i.e. under 75 years of age) from heart disease and stroke. Early deaths from cancer are also in general lower than the England average. However, there are health inequalities across the county with some wards experiencing poor health

outcomes for a range of measures relating to health and wellbeing including, life expectancy, mortality, long-term illnesses, hospital admissions, mental illness, rates of smoking and so on. The same group of wards which tend to come to the fore are wards within Oxford City and Banbury.¹⁹

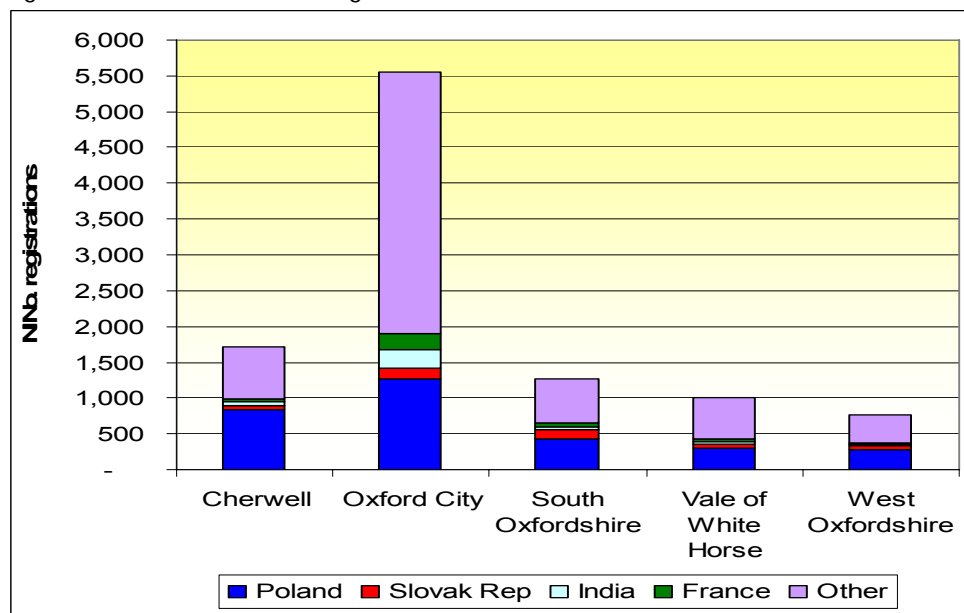
4.2 Ethnicity

In 2007 it was estimated that around 7% of Oxfordshire's population was non-British, with Oxford having the most ethnically diverse population with 17% of people from non white ethnic groups. Asian or Asian British and Chinese accounted for the largest non-white ethnic groups.²⁰

Information on ethnicity has largely been based on the 2001 Census which no longer reflects the ethnic mix effectively. Other sources of information have been considered, revealing an upward (and then levelling) trend of inward migration since 2003/2004. Data from the National Insurance Recording System show the changes in inward migration in Oxfordshire. In 2007/08, some 9,150 non-UK nationals in Oxfordshire registered for National Insurance numbers, a 100% increase from 2003/04 to 2007/08.

A large percentage, over half of these migrants, registered in the Oxford City area, 18% registered in the Cherwell district area and the remaining 10% registered in each of the other districts. The main groups of migrants were from Poland (30%) (in the Cherwell, almost half of all registrations were by Polish nationals). People from France, India and Slovak Republic made up less than 4% of the migrant groups in Oxfordshire. 10% of registrations in South Oxfordshire were by Slovak nationals which was 2½ times the South East average.

Figure 1: Non-UK nationals registered in Oxfordshire 2007/2008



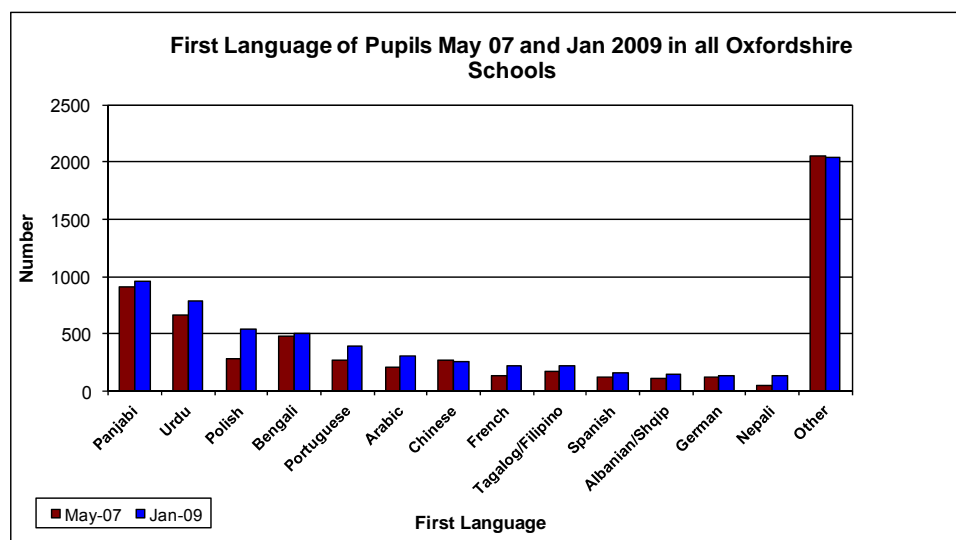
Source: Extract from National Insurance Recording System

There needs to be caution noted with these statistics as an assessment within Oxfordshire concluded that national data sources on inward migration were inadequate. This makes it difficult to see if Oxfordshire reflects the nationally-reported picture where there was a fall in 2008 where migration from new EU countries dropped back to 2004 levels. This may well be reflected in future statistics.

Some local data is also available, for example school census, first collected in May 2007 shows how new ethnic groups have arrived in local schools and some population groups such as those from the Polish community have increased over time. It is seen, from the last census, in January 2009, that there is an emergence of a Nepalese community as well as growing Arabic and Portuguese communities. There have been distinct rises in the number of French and Spanish native speakers

but the largest increase in numbers between 2007 and 2009 was in Polish speakers and for the first time there were more Polish speakers than Bengali.

Figure 2: First language spoken by school pupils in Oxfordshire May 2007 – Jan 2009



Source: School Census (May 2007 & Jan 2009) – Oxfordshire County Council

Table 1: First language spoken by school pupils in Oxfordshire May 2007 – Jan 2009

Language	May 07	Jan 09	% change 2007 – 2009
Panjabi	913	958	5%
Urdu	657	788	20%
Polish	286	539	88%
Bengali	482	508	5%
Portuguese	269	386	44%
Arabic	207	306	48%
Chinese	270	261	-3%
French	136	218	60%
Tagalog/ Filipino	171	217	27%
Spanish	117	163	39%
Albanian/ Shqip	111	149	34%
German	117	135	15%
Nepali	44	130	195%
Other	2,054	2,040	-7%

Source: School Census (May 2007 & Jan 2009) – Oxfordshire County Council

A mosaic profiling tool has been used to help identify which areas in Oxfordshire have higher or lower proportions of black and minority ethnic groups. Mosaic profiling of the BME population reflects the information from the National Insurance Recording System and School Census Data that the majority of the BME population in Oxfordshire is resident in Oxford, followed by Cherwell and South Oxfordshire.²¹

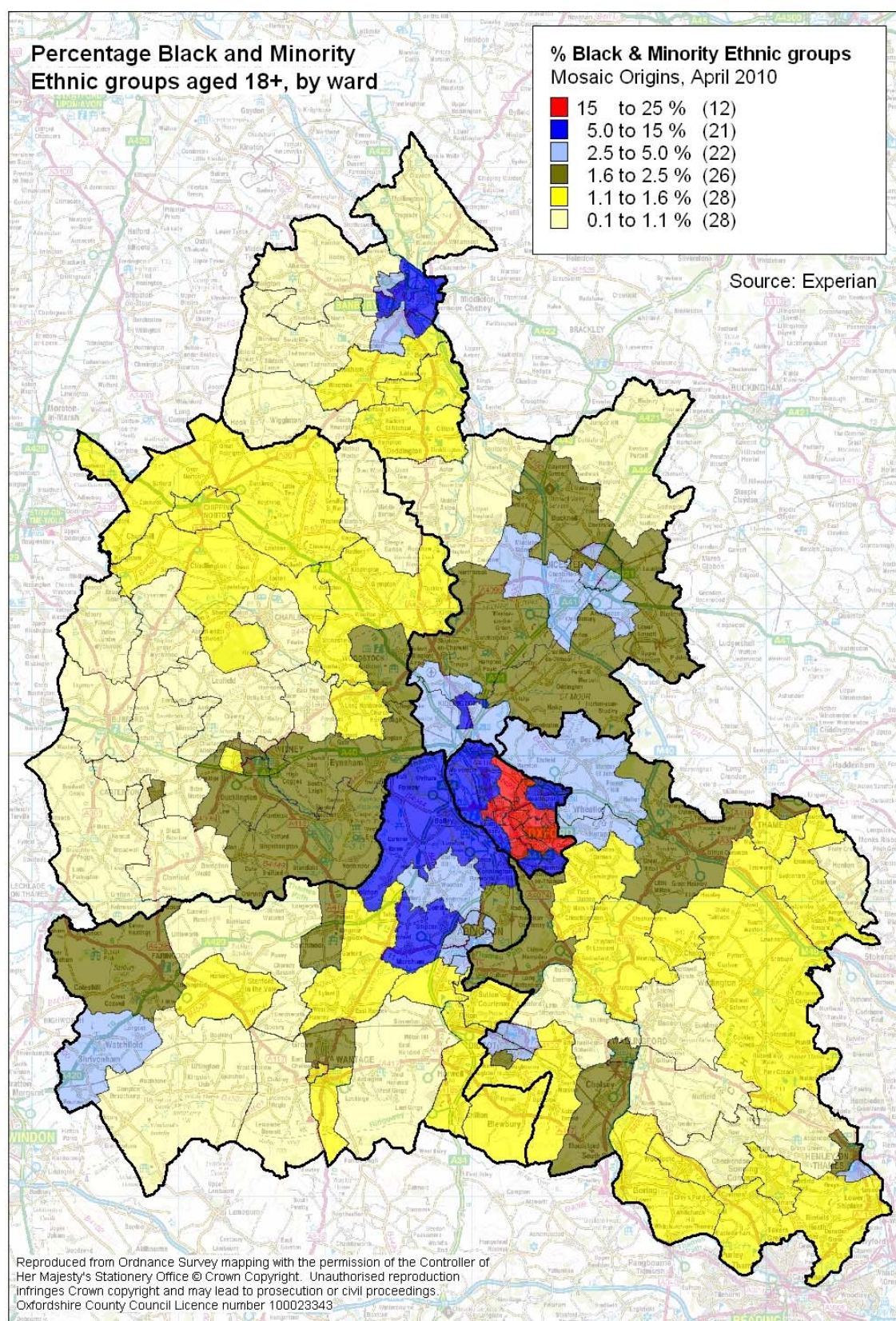


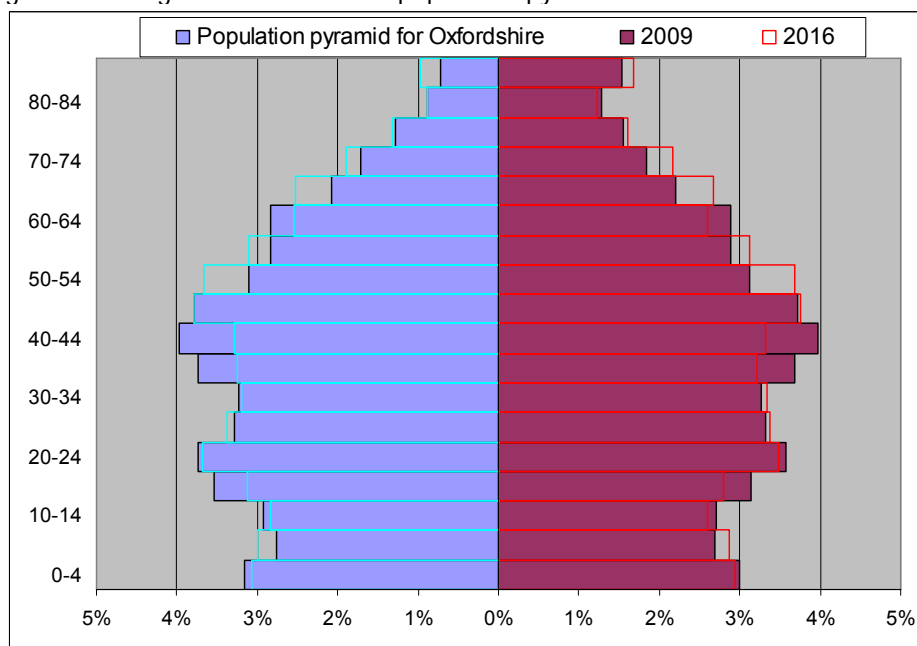
Figure 3: Percentage of Black and Minority Ethnic groups, 18 or over, by ward in Oxfordshire using mosaic profiling

4.3 Population Growth

Oxfordshire has a steady population growth which is predicted to reach 680,000 by 2016.²² Oxfordshire also has an aging population with the largest growth expected to be within older age groups²³. The population of over 50's is predicted to rise over the next ten years by 27.5%. By 2031 there could be an additional 61,500 people in Oxfordshire aged over 65, and 18,400 more people aged 85 years and over.²⁴ As oral health continues to improve it is expected that a decreasing number of older adults will have no natural teeth. This has significant implications on dental services as more people will be maintaining teeth that have already been heavily restored.

Projections up to 2016 show that while there will be an expansion of the over 50 year olds there will be some contraction of the population under 50 .

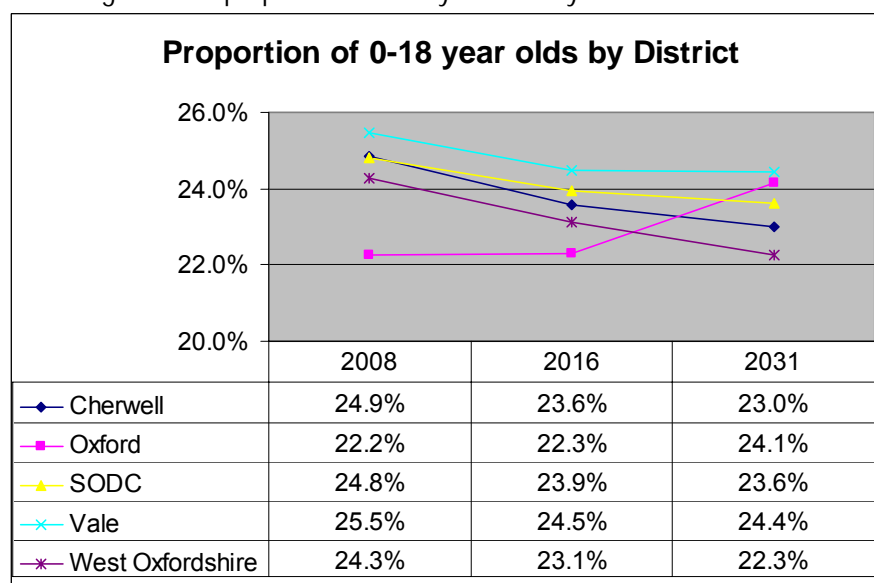
Figure 4: Changes to Oxfordshire's population pyramid 2009-2016



Source: OCC Greater London Authority (Data Management and Analysis Group) Ward Forecast 2008

Population growth is not predicted to be the same across all local authority areas. Within Oxford, for example, there will be a steady growth in the number of children while in the more rural districts there are predicted decreases within this age group, more reflective of the aging population profile.

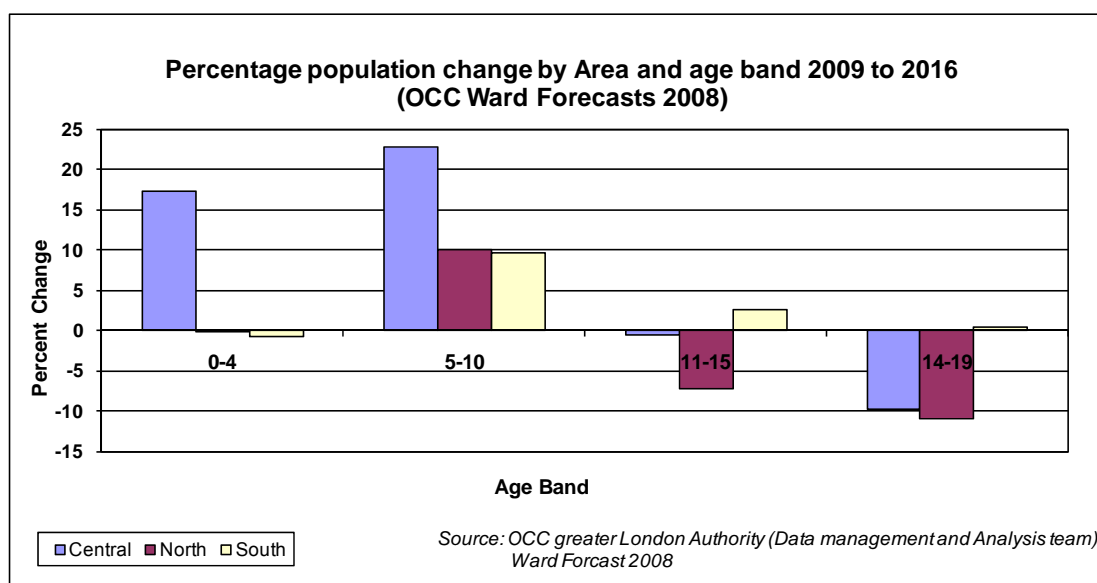
Figure 5: Changes to the proportion of 0-18 year olds by District



Source: Office for National Statistics (ONS) 2007 mid year estimates.

Population projections are sensitive to any changes in underlying national assumptions i.e. birth rates and local changes within each area; this includes any proposed housing developments. In the 2009 Joint Strategic Needs Assessment (JSNA) for Oxfordshire it has been identified that there will be some changes expected within the next five years in the Oxford City area, there are significant plans at present for Barton and Sandhills. In West Oxfordshire, Witney is also a focus for growth. In South Oxfordshire and the Vale of White Horse areas, the new Didcot West development will increase housing and therefore population growth.

Figure 6: Percentage population change by area and age band 2009 to 2016 Children and Young People.



Source: OCC Greater London Authority (Data Management and Analysis Group) Ward Forecast 2008

Data analysed for the 2009 JSNA within four key age groups indicates the potential impact on dental services for children and their families. The groups identified are: pre-school (under-fours), primary (five-10 years), secondary (11-15 years) and 16-19 year olds. There is predicted a large growth within the pre-school population in the central Oxfordshire area, with a 17% increase. The other two areas (north and south) should remain stable. All of Oxfordshire will see pressure on the primary school age population; a 23% increase in the central area and 10% rises in the other two areas. The 11-15 and 16-19 year bands are both predicted to decrease by up to 10%, although the south may see a 2.5% rise in secondary population over the next seven years.

4.4 Deprivation in Oxfordshire

It is widely accepted that there are socio-economic inequalities in oral health²⁵ and it has been argued that it is important to target dental and oral health programmes to our most at risk populations.^{26,27}

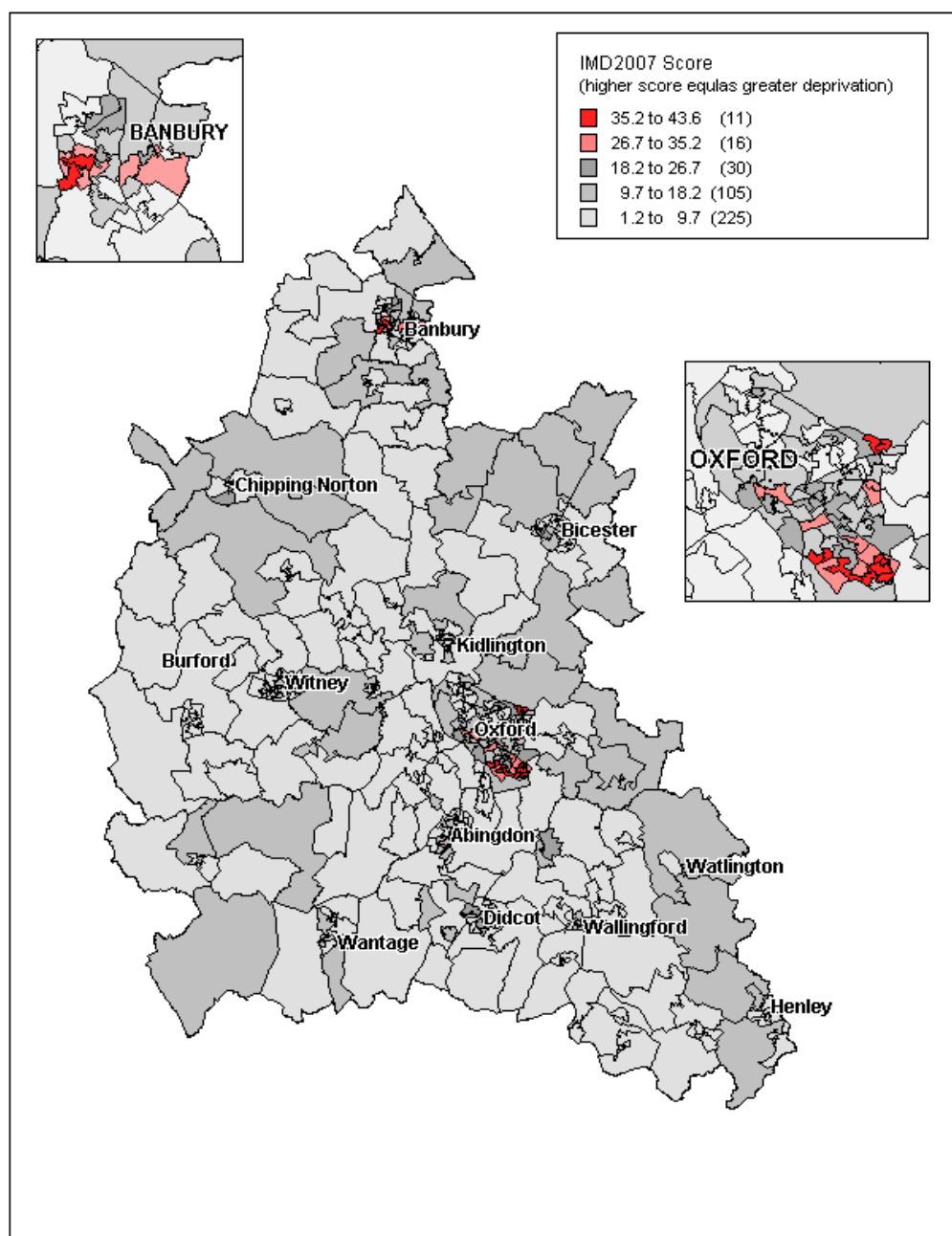
²⁸Studies have shown that there are higher levels of oral disease in populations which are socio-economically deprived. While Oxfordshire is a relatively affluent county and the majority of areas are in the least deprived quartile for England, there is 3% of the county which features in the most deprived. These are illustrated in Figure 7. Key wards within Oxford City and Banbury have higher levels of social deprivation.

The Child Poverty or Material Wellbeing index identifies the proportion of children experiencing income deprivation in a small area. It does this by measuring the percentage of children under 16 living in families reliant on various in-work and out-of-work means-tested benefits. The material wellbeing domain is the same as the separate 'Income Deprivation Affecting Children Index' (IDACI), published alongside the IMD 2007²⁹

Figure 8 shows that within Oxfordshire, most children are living in families where they have a relative amount of income to ensure what they need to live and have a level of wellbeing. There are however areas of deprivation in some of the urban areas, especially Oxford and Banbury. Five wards in particular have more than a third of children living in poverty (Northfield Brook, Blackbird Leys, Churchill, Barton & Sandhills, and Rose Hill & Iffley). When total numbers of children are considered, both Northfield Brook and Banbury Ruscote are identified as the two wards with significantly higher numbers of children living in poverty. If these figures are considered in terms of the 13 children's localities, both Oxford South East and Banbury stand out with having more poverty than other areas. It is important to note however that numbers at ward level are small.

Identifying these areas are essential for these children and families are those who are most affected by lifestyle and are most likely to experience poorer health and wellbeing, both now as children and also their health and well being opportunities as adults. In the 2009 JSNA it was identified that there had been an increase of child poverty in Oxfordshire by just over 1% over the last year, from 12,880 to just over 13,000.

Oxfordshire PCT Index of Multiple Deprivation



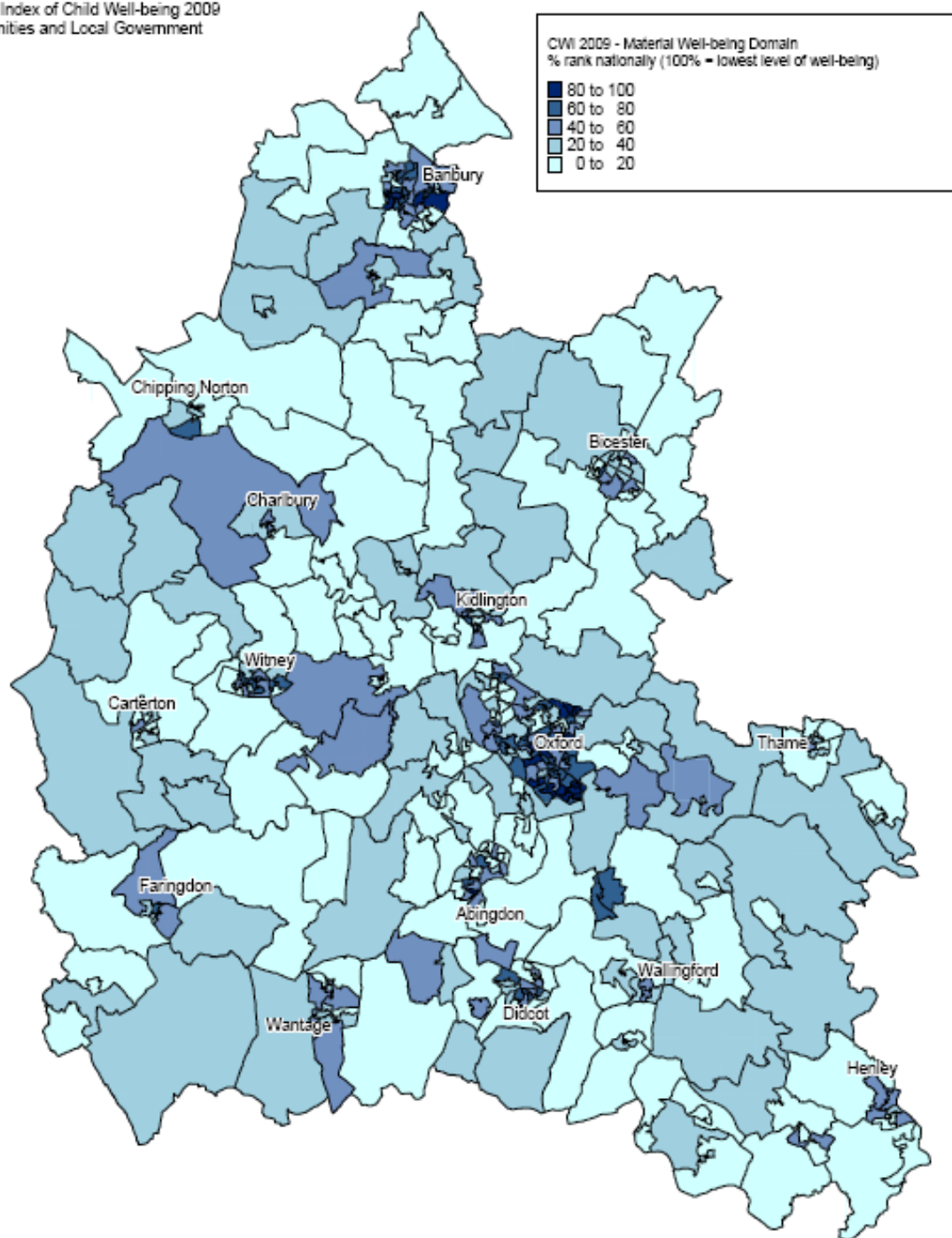
Mapping produced using AA and 2001 Census data
with licensed permission. Crown Copyright 2003.
IMD 2007 Data.Decision Support.PNA. 052010. IF

Fig 7: Oxfordshire's PCT Index of Multiple Deprivation (2007)

Child Well-being Index 2009 - Material Well-being Domain

SOAs ranked across England

Source: Index of Child Well-being 2009
Communities and Local Government



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Source: Index of Child Well-being 2009, Community and Local Government

Fig 8: Oxfordshire's material wellbeing (a domain of CWI) 2009

5 Common Oral Diseases and their Causes

5.1 Definitions of Common Dental Diseases

5.1.1 Dental Decay (Caries)

Dental caries, or tooth decay or cavities (holes in the teeth) are caused when bacteria in the mouth damage the hard tooth structures; the enamel, dentine and cementum of the tooth.

Dental caries are caused when there is a build up of bacteria in the mouth which respond to dietary sugars and then produce acids which cause demineralisation of teeth tissues. Dental decay is one of the most common chronic diseases of oral health.

Within the UK the majority of the population consumes more sugar than is recommended, and evidence has shown that sugars are the biggest factor in dental decay. While the sugars naturally present in whole fruit, vegetables and milk are not harmful to teeth “free sugars” are.

5.1.2 Gum (Periodontal) Disease

Periodontal or gum disease affects a large percentage of the, mainly, adult population. It is where inflammatory disease affects the peridontium; the tissue which surrounds and supports the teeth. This overtime can cause the foundations for the teeth to become loose or unstable and result in eventual loss of teeth. Periodontitis is caused by microorganisms that adhere to and grow on the tooth's surface, along with an aggressive immune response to these microorganisms.

Periodontitis is caused by a build up of dental plaque and can be largely prevented by good oral hygiene. Several conditions and diseases, including Downs syndrome, diabetes, and other diseases that affect one's resistance to infection also increase susceptibility to periodontitis.

Periodontitis is very common, and is widely regarded as the second most common disease worldwide, after dental decay

5.1.3 Oral Cancer

Oral cancer is a generic term that is used to describe all malignancies of the oral cavity, oropharynx and hypopharynx (such as squamous cell carcinoma of the lip and tongue).

In the UK in 2006, 5,325 people were diagnosed with an oral cancer and in the UK, along with most other countries; oral cancers are more common in men than women. Incidence increases with age and studies of oral cancer incidence in minority ethnic populations in Britain have reported high rates in south Asian and Chinese populations in which the habit of areca nut or betel quid chewing is still prevalent.

Almost all oral cancers are thought to be preventable. An estimated 80% are caused by tobacco (smoking or chewing), alcohol or a combination of the two. Although tobacco and alcohol are independent risk factors, their combined effect is greater than the sum of the risks from exposure to either on its own.³⁰ An estimated 10-15% of oral cancers may be caused by unhealthy diets.³¹

5.1.4 Malocclusion and Orthodontics

Malocclusion is not a disease but the collective term given to natural variations from the 'ideal' in the relationships of the teeth and jaws. Its presence is not synonymous with a need for treatment. There is a lack of evidence to suggest that malocclusions have a detrimental effect on oral health, although by affecting facial appearance malocclusions can have an impact on psychological well-being and quality of life^{32, 33}. Because malocclusion is not a disease and orthodontic treatment carries risks (e.g. root resorption, decalcification and non-improvement)³⁴ it is particularly important to evaluate the risk-benefit balance of any possible treatment.

In the UK, need for orthodontic treatment in the NHS is assessed using the 'Index of Orthodontic Need' (IOTN). The IOTN incorporates both an aesthetic and dental health component. Both of these aspects of a malocclusion are clinically assessed to determine whether a patient is likely to benefit from treatment. The clinician assigns a dental health component grade of treatment need between 1 and 5 (with 5 representing greatest need) and an aesthetic component grade of treatment need between 1 and 10. Under the current regulations, a patient is entitled to NHS orthodontics if their malocclusion has been graded as follows:

- Grade 4 or 5 of the Dental Health Component of the Index of Orthodontic Treatment Need.
- or
- Grade 3 of the Dental Health Component of that Index with an Aesthetic Component of 6 or above

5.2 Biological Determinants (Risk Factors) or Oral Disease

The factors that are concerned with the development of poor oral health are generally well known to the public and the underlying science is well researched and understood.

The main risk factors include:

1. **Poor diet and nutrition:** Frequent and high consumption of sugar and fizzy drinks is the major cause of dental decay and erosion. Soft drinks, confectionery and biscuits are the main sources of sugars in the diet. There is particular concern about the high levels of consumption among pre-school children, adolescents and older people particularly those living in institutions.
2. **Poor oral hygiene:** Oral health can be compromised when teeth and gums are not brushed regularly and dental plaque accumulates. Oral hygiene practices are best learnt in early childhood as part of body hygiene and cleanliness.
3. **Lack of exposure to Fluoride:** Since the 1970s, fluoride has been added to most toothpastes and this is the main reason for the improvement in oral health seen in the UK and Europe. Fluoride helps the teeth to 'repair' after damage caused by a build up of acids and in areas with high levels of disease, water fluoridation is an effective and safe public health measure to reduce decay and more beneficial than the use of just fluoride toothpaste alone
4. **Tobacco and alcohol:** Tobacco use, especially smoking, increases the prevalence and severity of periodontal disease and is the greatest risk factor for oral cancer. Excessive alcohol consumption, particularly spirits, is a further risk factor for oral cancer, especially when combined with smoking and a poor diet.
5. **Injury:** Dental injuries may occur for a variety of reasons including playing contact sports, violence and falls. Binge drinking, violence and non accidental injury are also causes of facial injury and broken teeth.

5.3 Social Determinants of Oral Disease and the Common Risk Factor Approach

The provision of accessible, high quality dental services is only one aspect of the public health action needed to improve oral health and reduce oral health inequalities. Dental services despite moving towards a more preventive focused approach are still more treatment focused and cannot eliminate oral health inequalities alone, no matter how accessible or effective they may be.

The DOH strategies 'Choosing Health' and 'Choosing Better Oral Health' encourage PCT's to take a more common risk factor approach to tackling diseases which have the same underlying causes. The common risk approach recognises that chronic non-communicable diseases and conditions such as obesity, heart disease, stroke, cancers, diabetes, and oral diseases share a set of common risk conditions and factors. These common risk factors include tobacco use, poor diet, stress, high alcohol consumption, poor hygiene, injuries and a sedentary lifestyle.

The key concept of the integrated common risk approach is that by directing action on these common risks and their underlying social determinants, improvements in a range of chronic conditions will be achieved more efficiently and with greater effectiveness. The common risk approach provides a rationale for linking oral health improvement into other joint strategic health improvement work and working in partnership to ensure consistent messages are relayed to the public.

5.4 Common Risk Factors

5.4.1 Obesity

It has been calculated that approximately 116,660 adults (24%) are obese in Oxfordshire and over 60% of the adult population are either overweight or obese.³⁵

There appears to be an association between dental caries and obesity, although evidence to support this link is limited. Oxfordshire PCT has developed a 'Commissioning Strategy for the Prevention and Treatment of Obesity in Oxfordshire'³⁶ and efforts to tackle obesity include promoting the 'Balance of Good Health', providing weight management programmes for obese adults and more general efforts in the community to reduce fat & sugars in the diet. All health professionals, including dental teams should play an active role in promoting healthy food choices and it is important that consistent nutritional messages are given to patients and clients.

5.4.2 Smoking

In the South East Region it is estimated that the current proportion of adults who smoke is 19%, lower than the England average of 21%. In Oxfordshire this equates to approximately 97,000 people who are at increased risk of poor oral health due to their smoking habit.

More men than women smoke, and smoking rates are highest in the population aged 20 to 24 and 25 to 34. Prevalence is lower in the older population of those aged over 60. There are socio economic differences in smoking prevalence with more smokers coming from the lower socio-economic groups. Most long term smokers started to smoke before they were 18 years old. Currently 6% of school pupils are regular smokers, and currently more girls are smoking than boys.³⁷

Smoking or chewing tobacco can affect oral health in a number of ways including increased risk of oral cancers and precancers, increased severity of gum disease, premature tooth loss and poor wound healing. In May 2007, the Department of Health published *Smokefree and Smiling: helping dental patients to quit tobacco* as part of their ongoing campaign to involve dental teams in supporting people to stop using tobacco.

Oxfordshire PCT commissions a local Smoking Advice Service which operates a hub and spoke model of provision. The service offers bespoke training to dental teams to provide brief advice and signpost patients to appropriate 'stop smoke' support services in the community, some dental staff have also been trained as Level 2 advisors

5.4.3 Alcohol

Nationally in 2008 20.6% of over 16's consumed alcohol at hazardous levels and 17.3% were binge drinking (defined as double the daily recommended maximum of 3-4 units per day for men and 2-3 units per day for women).³⁸

The Health Survey for England suggests that 23.3% of adults in Oxfordshire are binge drinkers, which is higher than the national average.³⁹ There is a well-recognised relationship between alcohol misuse and oral disease and excessive alcohol use is also a significant risk factor for oral cancer. Of particular concern is the synergistic action of excessive alcohol consumption with tobacco (smoked and chewed), which when used together, can lead to a 30 times greater risk developing oral cancer.

5.4.4 Drug Abuse

Regular drug use is associated with poor oral health, in particular dental decay and periodontal disease. This is likely to be due to a combination of a number of factors, which include poverty, self-neglect and unhealthy behaviours such as poor diet, consumption of high sugar foodstuffs, poor oral hygiene and alcohol abuse.

A recent study in the USA found that, 40% of methamphetamine abusers had severe oral health problems. Those who injected methamphetamine had more severe dental health problems compared with those who snorted or smoked the substance.⁴⁰

In comparison with the general population, drug users tend to have poorer oral health and display lower utilisation of dental services. In Oxfordshire, it is estimated that there are 2,660 problematic drug users (PDU's), 60% of which are in treatment services.⁴¹ Almost half of the PDU's in treatment live in Oxford City and 25% in Cherwell district. The remainder are spread between the other three districts.

In Oxfordshire Drug & Alcohol Treatment services are commissioned by the Drug and Alcohol Action Team (DAAT) and influenced by NHS Oxfordshire and partners. Treatment services include Brief Interventions delivered over a series of appointments and some more specialist services including for offenders.

5.5 Vulnerable Groups

Despite substantial improvements in the oral health of the population in the last 30 years, marked inequalities remain. Socially deprived and/or vulnerable groups in society tend to have poorer oral health and poorer access to oral health care services. Groups of people particularly at risk from oral diseases include the following:

5.5.1 Elderly people with dementia and/or living in residential care

The dental problems associated with aging, especially for people with neurocognitive impairments include but are not limited to a decrease in oral hygiene; difficulty in controlling and retaining dentures; xerostomia, which often is drug-associated, and consequential root caries, recurrent decay, and purposeless chewing.

By 2029 people aged 85+ will increase in number by around 150% in Cherwell, Vale and West Oxfordshire, by around 125% in South Oxfordshire and by around 70% in Oxford City. The number of people over 65 with dementia in Oxfordshire in 2007 was estimated to be 6,828; this is predicted to increase by 20% in 2016. ⁴² As the older adult population increases in Oxfordshire, a greater number of patients with these diagnoses will require dental care, much of which will be restorative.

A recent dental screening pilot of 65 older people living in residential care in Oxfordshire found that that 35% of residents examined needed some form of dental treatment. ⁴³Of those, the dental team felt that 13% would benefit from some oral hygiene intervention. 57% required extractions or restorations and 52% needed denture treatment, be it new dentures or repair or relining of their existing ones.

The pilot project, which included clinical measurements of residents and education of care staff also revealed a high level of edentulous patients with inadequate oral hygiene. Whilst teeth/denture cleaning was widely offered in the homes many key oral health issues were not addressed such as the formulation of oral health policies and care plans, ensuring regular dental checks, interdental cleaning and labelling of dentures. As the number of dentate residents' increases, with more adults retaining their teeth for longer, there is the potential for oral health complications to rise significantly if the daily oral health care needs are not adequately met. Baseline knowledge measurements suggested that care staff were ill equipped to deal with such rising demands unless positive steps are taken to introduce key oral health promotion messages into current practice

Overall, the pilot demonstrated that the elderly population who reside in communal establishments have oral health and dental needs that are not being met by staff or local dental services and the presence of advanced restorative work in a fifth of the population means that this unmet need is likely to increase in the future. However, it was also noted that many of the treatment needs perceived by the dental team might not actually be desired by the patient and of any treatments offered to care home residents; denture work would likely to be in greater demand. The report from this pilot is available as an Appendix A.

5.5.2 People from black and minority ethnic groups

Data on the oral health of ethnic minorities are not routinely collected in the UK; therefore knowledge of the oral health status of different groups is limited. The inequality that exists in the oral health of people from black and minority ethnic groups has been documented since the 1970s with the South Asian community being the group most investigated in terms of ethnic differences. There is little literature on oral health within the new migrant communities from Eastern Europe or for any minority ethnic groups who do not live in deprived areas⁴⁴

The main conclusion from the available evidence is that dental caries, as a lifestyle disease, has marked social and ethnic inequalities with lower social class groups and some South Asian groups experiencing more disease. The following ethnic groups are likely to be at greater risk of poor oral health due to a higher known prevalence of common risk factors:

- **Obesity:** Bangladeshi and Chinese men are around four times less likely to be obese than men in the general population. Obesity prevalence is higher for Black Caribbean, Black African and Pakistani women
- **Smoking:** Smoking rates for men are particularly high in the Bangladeshi (40%), Irish (30%) and Pakistani (29%) populations compared to the national average of 24%, Black Caribbean (24%) and Irish (26%) women also smoke more
- **Consumption of fruit and vegetables:** is reportedly low in Bangladeshi communities.
- **Alcohol:** Irish men and women more likely than any other ethnic group to drink in excess of recommended guidelines

There is further evidence to suggest that, despite high levels of dental need, minority ethnic groups experience barriers to accessing oral health care. These include language, a mistrust of dentists, cost, anxiety, cultural misunderstanding and concern about standards of hygiene, although perceived barriers differ across ethnic groups.⁴⁵ It is therefore important to consider the cultural characteristics of each subgroup when designing treatment services and oral health promotion and activities for diverse ethnic groups.

5.5.3 People living in areas of deprivation

Studies, including local and national data have shown that there are higher levels of oral health disease in populations which are socio-economically deprived and that these patients are less likely to have a regular dentist and/or access routine dental services

Data from the Index of Multiple Deprivation shows that Oxfordshire is relatively well off on average and scores better than most places. However, distribution of wealth is uneven across the county and there are pockets of deprivation. 10 super output areas are in the 20% most deprived nationally and these areas are in Oxford City and Banbury.⁴⁶

Inequalities in dental health in Oxford City and Banbury is reflected in the last national survey of five year olds (2007/2008) which indicated that children living in Oxford City and Cherwell Vale had higher than average levels of tooth decay (measured in number of teeth decayed, missing or filled teeth -

dmft) than children in other areas of the county; 1.32 and 1.2 compared to 0.63 in West Oxfordshire, 0.59 in the Vale of White Horse and 0.47 in South Oxfordshire. In addition, Blackbird Leys and the surrounding area also accounted for the highest number of children and young people attending for extractions under general anaesthetic – 21% of all cases.

5.5.4 People who have learning disability

About 2% of the population have a learning disability, approximately 12,800 people in Oxfordshire. In 2009 there were 1269 social care clients with a learning disability at Oxfordshire County Council.⁴⁷ The number of adults with learning disabilities over 60 is predicted to increase in future years.

Poor oral health is one of the most frequent health problems for an individual with a learning disability—one study found that 86% of people with a learning disability had dental disease⁴⁸. They have poor oral hygiene, untreated dental caries and more extractions than the general population⁴⁹. Access to oral health care is affected by where people with learning disabilities live: evidence suggests that adults with learning disabilities living in the community have greater unmet oral health needs than their residential counterparts and are less likely to have regular contact with dental services.

In June 2010 a dental screening pilot was carried out to:

- Assess the oral health needs of people with learning disabilities
- Provide oral health training to staff working with tenants and service users to access if this resulted in increased oral health knowledge.⁵⁰

Oral Health Promotion training sessions were delivered to staff at three identified sites in Oxfordshire and a dentist/dental nurse team carried out dental checks on 20 people with learning disabilities living in residential care and at home in the community.

Due to consent the sample size was smaller than anticipated limiting the conclusions that can be drawn from this pilot. The clinical results showed that 83.9% of the people seen were already accessing primary care dental services but that 58% still required some form of dental treatment i.e. scale & polish or fillings.

The main oral health issues for this group were debris, plaque and calculus present in the mouth and 9/20 seen required a scale and polish. This problem could be prevented or improved by implementing oral hygiene regimes in both residential homes and day centres.

The number of carious and mobile teeth was low in the people seen. An explanation for this may be that many of the patients seen in this pilot were patients seen regularly at a local Dental Clinic. It was noted that the patients were more compliant and receptive to the dental checks in their own environments compared to in the clinic.

The pilot also found that almost one third of care staff believes the willingness of tenants to allow oral care influences the oral care provided. A small number of care staff believes oral care is influenced by time constraints, lack of confidence and lack of equipment. The programme significantly improved the knowledge of care staff and was well received by them. Although a small minority of care staff believe training would improve the oral care they provide, base line knowledge results show that many carers are unaware of key oral health care messages such as correct use of fluoride, length of time spent brushing and oral care for tenants who are parenterally fed. The interim report from this pilot is available as an Appendix B.

5.5.5 People from the travelling community

There is very little published literature on the oral health of Travellers. While there are no robust data on the prevalence of oral disease in this population, it seems reasonable to assume that disease levels will be relatively high, as this is a socially deprived group who have poor access to health care.

A small study in a rural county in the early 1990s found that travellers had a high level of unmet dental need, low levels of dental registration and very little use of preventative services.⁵¹ A Health Needs Assessment for Gypsy and Traveller Communities in Oxfordshire was undertaken in 2006-2007. The health needs and issues identified in interviews with both Gypsies/Travellers and key workers were; mental health, domestic violence, alcohol, diet, physical activity, immunisations, infant feeding (including breastfeeding), smoking; care for the elderly, palliative care, preventive care, screening, women's health, men's health, oral health and child safety. A more recent Health Equity Audit of the Oxfordshire Health Advocacy Service found that in this community there are many wider health determinate issues that impact on health and therefore identified health needs, such as poor oral health, should be addressed in a more holistic and joined up way.⁵²

5.5.6 People living in secure closed communities (prisons)

Prisoners usually experience significantly poorer physical health than the rest of the population.⁵³ There are two closed prisons in Oxfordshire (one adult, one young offender) and one immigration removal centre. From 18th of October 2010 HMP Huntercombe will become an adult male (over 25's) category C prison with capacity for 350 inmates.

Until June 2010 Huntercombe was a young offender's institution with capacity for 360 young people from 15 to 18 years of age. The average duration of stay was 6 months with the yearly prison turnover being approximately 969. Huntercombe was ethnically diverse with figures for September 2008 showing 62% of young people being classed as BME.⁵⁴ A Health Needs Assessment in 2008 found that young people had to wait an average of 4 days for an urgent appointment and 10.5 days for a non urgent appointment with the Dentist.

Bullington Prison operates jointly as a local and category B/C training prison for adult males. The prison has the operational capacity for 963 prisoners and takes in approximately 4650 new arrivals per year. The prison has its own health care cover with an establishment of 23 beds. A Health Needs Assessment of Bullington Prison in 2008⁵⁵ found that poor dental health was one of the most frequent health problems observed by staff amongst prisoners.

Campsfield is an Immigration Removal Centre in Kidlington, Oxfordshire which holds approximately 200 male detainees. As well as asylum seekers it holds foreign born people with immigration offences or serving prison sentences or completed and awaiting deportation. Unmet oral health needs in this group are high and in a recent needs assessment of detainees 14% of a sample of residents reported dental problems or toothache.⁵⁶

On the whole prisoners tend to have more decayed teeth, fewer filled teeth and less natural teeth than the general population, even when social class is taken into account (adults in social classes IV and V have been shown to have fewer decayed or unsound teeth than the prison population).⁵⁷ Evidence suggests that there is a substantial amount of unmet need in British prisons.

5.5.7 Homeless

Homeless people experience significantly poorer physical health than the rest of the population. They have a much greater prevalence of skin diseases, respiratory problems, traumatic injuries, poor health of feet and teeth and infectious diseases.⁵⁸

The homeless population can be characterised as predominantly male, white and mostly over the age of 25. Between ¼ and 1/3 have been in local authority care. Around 70% misuse drugs, 50% are alcohol reliant and between 30% and 50% suffer with mental health problems.⁵⁹ Many suffer with dual diagnoses of mental health disorders and substance misuse.

The average life expectancy of homeless people is 42 years, compared to the national average of 74 for men and 79 for women. Homeless people are 35 times more likely to kill themselves than the general population, and four times more likely to die from unnatural causes, such as accidents, assaults, murder, drug or alcohol poisoning.⁶⁰

Data on the oral health status of homeless individuals is limited; however studies consistently report a high clinical need for oral health care within this population⁶¹. They have a higher dmft (decayed, missing and filled teeth) than the general population and there is a greater prevalence of dental pain and periodontal (gum) disease. Homeless people tend to have fewer remaining teeth and heavy plaque accumulation. Despite these high levels of need, homeless people experience difficulty in accessing dental services.⁶²

In Oxford City there are approximately 16 rough sleepers on any one night and around 50 - 55 people who are known to be homeless by a process of client information sharing.⁶³ Luther Street Medical practice offers a one day a week dental service for its homeless registered patients (no: 600) . A health needs assessment carried out in 2008⁶⁴ found that the vast majority of clients questioned were aware that there was a dentistry service available at Luther Street. A total of 10 clients had used the service of which 8 were positive about the service. The two who were equivocal about the service were dissatisfied with the waiting times and the second was very nervous around dentistry and didn't feel at ease. Several clients also commented that they felt there is a need for the dentistry service to be available for more than one day a week as there is easily the demand for it.

6 Epidemiology of Oral Disease

The key surveys that provide information on trends in oral disease at a national level are the Adult Dental Health Survey and Children's Dental Health Survey. At a local level, the British Association for the Study of Community Dentistry (BASCD) have been responsible for co-ordinating regular surveys of children's teeth. This responsibility has now been handed over to the NHS Dental Epidemiology Programme provided by the Dental Observatory⁶⁵.

The purpose of the surveys are to provide information on the current state of adults' and children's teeth and oral health in the four countries of the UK and to measure changes in oral health over time.

Dental caries (a common method of benchmarking dental health) is measured using the dmft index, which is a record of the number of decayed, missing and filled teeth (dmft). These surveys have shown that the dental health of both adults and children has improved significantly in recent years however population averages mask oral health inequalities. A well-recognised association exists between socio-economic status and oral health, and trends suggest that oral disease is increasingly concentrated in the lower income and more excluded groups.

7 Oral Health in Adults

7.1 A picture of improving oral health in adults

The first survey of adult dental health was in 1968 when almost half of the population had no teeth at all and many people wore complete dentures. Over the last 50 years the use of fluoride toothpaste and the availability of NHS treatment have transformed the oral health of the population to the extent where people are now keeping many of their natural teeth well into old age.⁶⁶

The most recent survey in 1998 identified three distinctive groups within the adult population. Older age groups who were dominated by people who had no teeth at all and a need for complete dentures, a younger group (under 30's) with lower levels of oral decay and lower restorative needs and the 30 – 65's who had high levels of disease and had been treated with fillings and other restorations.⁶⁷ This final group has significant implications on dental services as more people will be maintaining teeth that have already been heavily restored.

7.2 Dental Health in Adults in Oxfordshire

Local data on adult oral health are not routinely collected in the UK. There is a lack of local information on adult oral health so measures of child dental health are the most commonly used indicators of dental disease. The findings of the most recently published adult survey (1998) suggests that oral health inequalities are geographically clustered; adults in the South of England tend to have better oral health than adults in the North.⁶⁸ The results of the most recent adult dental survey which was carried out in 2009 are expected to be published towards the end of 2010.

7.3 Oral Cancer in Adults

The prevalence of oral cancer had been declining steadily over the past few decades, but it has recently begun to rise.⁶⁹ In England in 2007, 4,261 persons were diagnosed with an oral cancer and in the following year there were 1,444 deaths. Across countries in the UK, the highest incidence, for both males and females, is in Scotland. Oral cancer incidence is strongly related to social and economic deprivation, with the highest rates occurring in the most disadvantaged sections of the population. The association is particularly strong for men.

In the UK and most other countries, oral cancer is more common in men than women. However, the sex ratio in the UK has decreased rapidly from around 5:1 fifty years ago to less than 2:1. Today the risk of

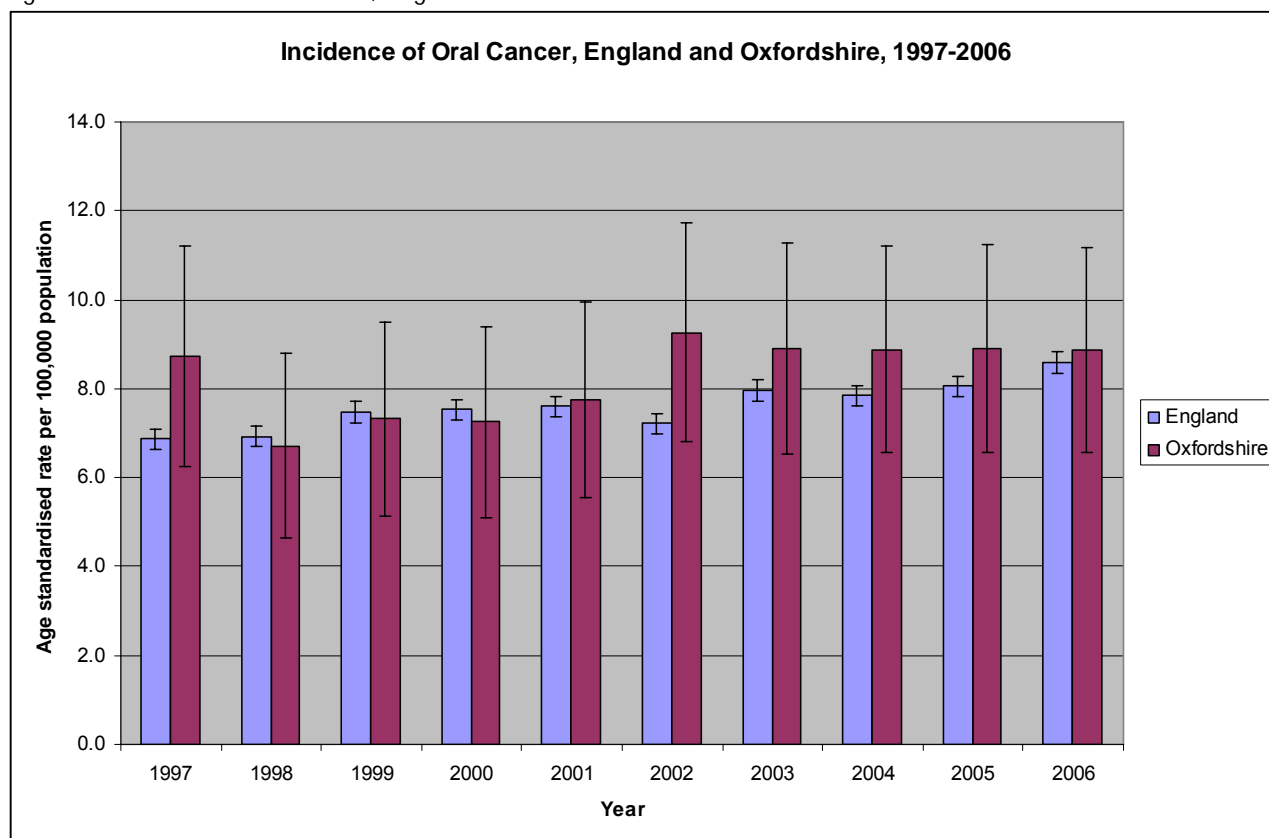
developing oral cancer increases with age and in the UK the majority of cases (87%) occur in people aged 50 or over.

For men over 80, the incidence of oral cancer has more than halved since 1975, while rates for men in their 70's have remained relatively stable. However, there have been large increases in the incidence of oral cancer diagnosed in men in their 40s and 50s whose rates have more than doubled from 3.6 to 9.3 per 100,000 for men aged 40-49 and from 11.5 to 29.7 for men aged 50-59. Rising trends of oral cancer in young and middle-aged men, particularly of cancer of the tongue, have been reported in other European countries and the USA.⁷⁰

7.4 Prevalence of Oral Cancer in Oxfordshire

In Oxfordshire in 2008-2009 161 patients were treated for head & neck cancers which include oral cancer and in the following year, 2009-2010, there were 147 patients. Oxfordshire rates of oral cancer do not vary significantly from the England average, see Figure 9. Due to the low numbers involved it is not possible to look at the data by ward or district area.

Figure 9: Incidence of Oral Cancer, England and Oxfordshire 1997-2006



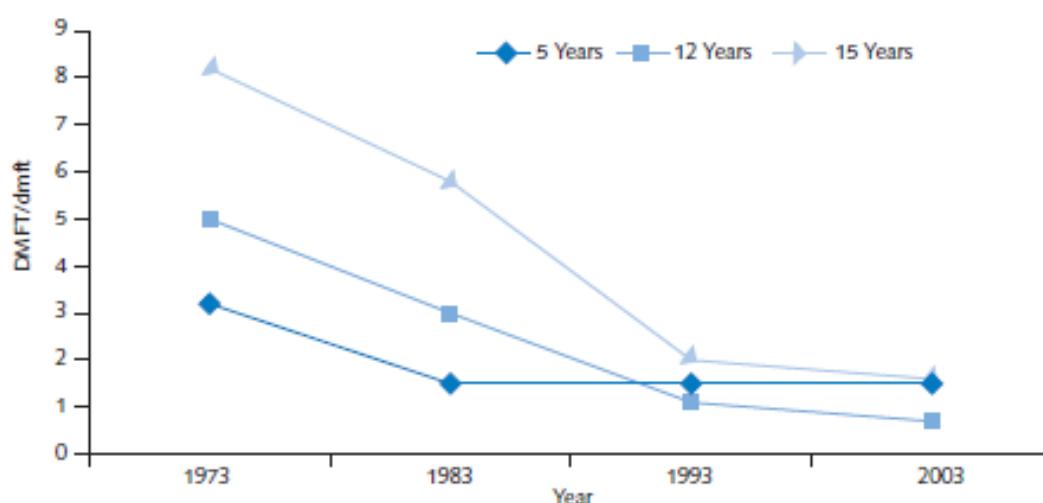
Source: UDS_SUS (February 2008)

8 Oral Health in Children

8.1 Dental Health in Children

National surveys of children's oral health are undertaken every ten years with more frequent NHS surveys coordinated by the NHS Dental Epidemiology Programme in between. The last national survey was in 2003. These surveys show that the dental health of children (measured by mean number of decayed, filled or missing teeth) has largely improved over the past 40 years ⁷¹ and that the greatest improvements have been in older children.

In younger children, the greatest improvement in the decay experience was seen between 1973 and 1983, during which time the mean number of decayed, missing and filled teeth (dmft) per child halved and the percentage of children without any caries (caries free) doubled. (Figure 10)



Source: National Children's Dental Health Surveys 1973 to 2003. Harker R and Morris J (2005). Office for National Statistics, London.

Source: National Children's Dental Health Surveys 1973 to 2003. Harker R and Morris J (2005). Office for National Statistics, London. In *Choosing Better Oral Health*, Department of Health (2005): <http://www.dh.gov.uk/assetRoot/04/12/32/53/04123253.pdf>

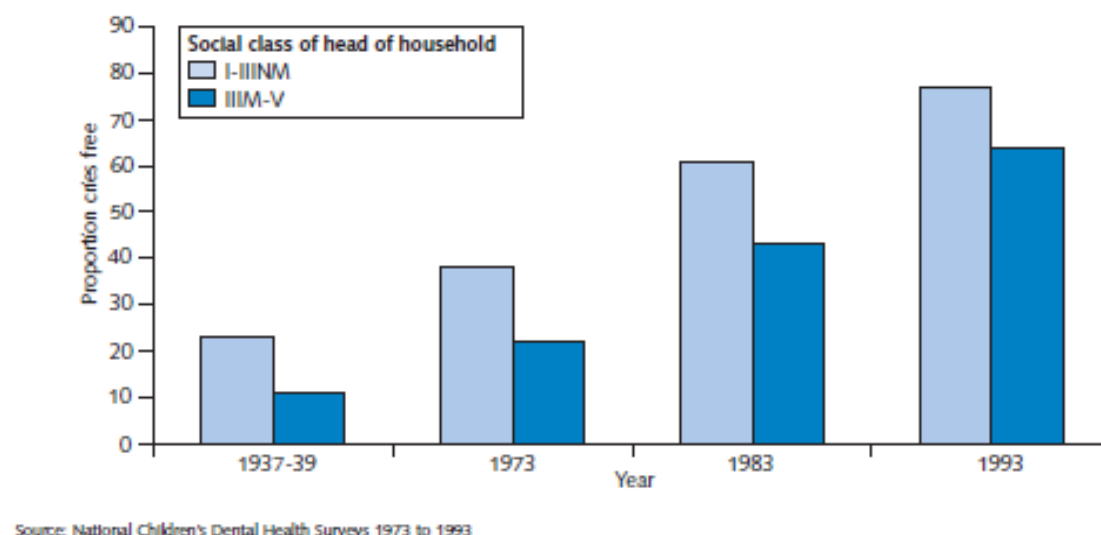
Figure 10: Improvements in oral health (measured by dmft) in Children & Young People, 1973-2003

Since 1983, the trend in the oral health of five-year-olds seems to be one of modest worsening following a long plateau. If the burden of disease in young children is rising, this is a cause of some concern which requires more action.

8.1.1 Inequalities in Dental Caries in Children

Despite improvements in children's oral health, inequalities remain between those children in lower socio-economic groups when compared with those children in the highest socioeconomic groups. Figure 11 shows that a greater proportion of children in the higher socio-economic groups remain free from dental decay. In addition, those children with decay will, on average have between 3 and 4 decayed teeth which is significantly higher than the overall average of 1-2 decayed teeth. Therefore, the actual burden of disease in children from lower socio-economic groups is greater than may first appear when looking at the data.

Figure 11: Inequalities in children oral health 1937 - 1993



8.2 Oral health in Children in Oxfordshire

8.2.1 Dental Caries and Health Inequalities in Children Oral Health

The dental health of children in Oxfordshire is relatively good, but in areas of Oxford and Cherwell social deprivation is reflected in poor dental health. Local data on the oral health of five-year-olds is regularly collected through the NHS Dental Epidemiology Programme provided by the Dental Observatory. In the last survey of 5 year olds in 2007/8, a sample of schools was selected throughout Oxfordshire PCT with a total of 1,499 children examined. In this survey the results were broken down at local authority area rather than PCT and some of the methodology around the data collection has changed since the previous survey in 2005/06. Therefore, these latest data are not directly comparable with previous years. The next survey of 5 year olds will be in 2010/2012.

In 2007-2008, children in the Oxford area had the highest dmft in Oxfordshire (1.32) followed by children in Cherwell (1.2). Lower dmft were recorded in West Oxfordshire (0.63), the Vale of White Horse (0.59) and in South Oxfordshire (0.47). These three districts in Oxfordshire performed better than the England average. The mean dmft for Oxfordshire was 0.86 which was also lower than the SHA average (1.0) and the England average (1.11). No further breakdown in the number of dmft in children with decay was available for this report. However, it is likely that in those children with decay on average each have around 3 decayed, missing or filled teeth compared to the highest local value of 1.32 in Oxford. This is an example of how averages hide oral health inequalities and the fact that a small proportion of the population experiences a high proportion of dental disease.

Table 2: Results of the child's dental health survey 2007-2008, Oxfordshire

Local Authority	Local value dmft	England average	England worst	England best
Cherwell Vale	1.2	1.11	2.50	0.48
Oxford	1.32	1.11	2.50	0.48
South Oxfordshire	0.47	1.11	2.50	0.48
Vale of White Horse	0.59	1.11	2.50	0.48
West Oxfordshire	0.63	1.11	2.50	0.48
PCT	0.86	1.11	2.50	0.48

In the previous survey in 2005-2006, the mean dmft for Oxfordshire was recorded as 1.07 (SD 2.05). Although there were wide variations in dmft nationally this figure compares favourably with national levels with a mean of 1.47 across England.

Figure 13 gives the dmft by the 5 previous PCT areas in Oxfordshire. The dmft shows variations over the last 4 years across Oxfordshire. There seems to be an indication of rising dmft in South Oxfordshire, but it is not possible to compare this data with the most recent survey due to the change in methodology outlined above. In 2005/06 the Oxford area had the highest dmft in Oxfordshire (1.3) and the lowest proportion of children who were caries free (60%). This figure is poorer than the corresponding figure for England (62%). There were wide variations in dmft nationally with a mean of 1.47 across England.

Data from 1985–2005 is shown in Figure 12, and demonstrates the dmft variations in Oxfordshire over 10 years. The dmft in the last few years appears to be more stable across the county. However, there are limitations of pooling the data as it can disguise variations within different areas within the county. Future needs assessments will be able to track any changes at a district level, however there is a risk that pooling will still disguise inequalities within district boundaries.

On 10th November 2010 The North West Public Health Observatory and The Dental Observatory announced the publication of the results of the Oral Health Survey of 12 year old Children 2008 / 2009, as part of the NHS Dental Epidemiology Programme.

In Oxfordshire, on the whole, 12 year old children enjoy good oral health and this compares favourably with the rest of England. 77.6% are caries free compared with 66.4% for England and the mean dmft for Oxfordshire is 0.52 compared with 0.74 for England. They are also more likely to receive care and this is reflected in findings of the care or restorative index which is a useful guide to the patterns of treatment provision. The number of filled teeth is divided by the total number of decayed, missing and filled teeth and multiplied by 100 to give a percentage. If the final percentage is high then most of the decayed teeth have been filled. If it is low then most of the decayed teeth have been left unfilled or extracted. For Oxfordshire this figure is 57% compared with an England average of 47%.

However some 12 year old children are still experiencing significant levels of decay. When children who are decay free are excluded the average dmft for children with one or more decayed teeth is 1.89 compared with an England average of 2.21. Poor oral health is linked with socio economic deprivation and it is possible that a polarisation in caries experience is occurring with an increasing number of children remaining caries free and the disease becoming concentrated in a diminishing number of socially deprived children.

Figure 12: Mean dmft in Oxfordshire 1985-2005

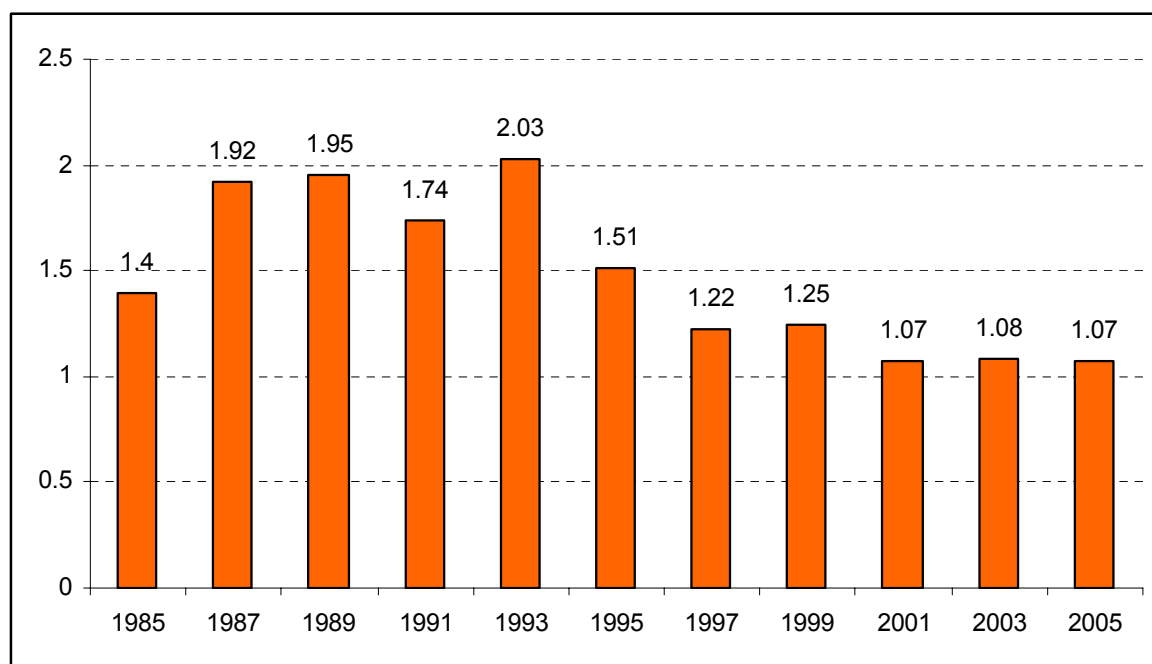
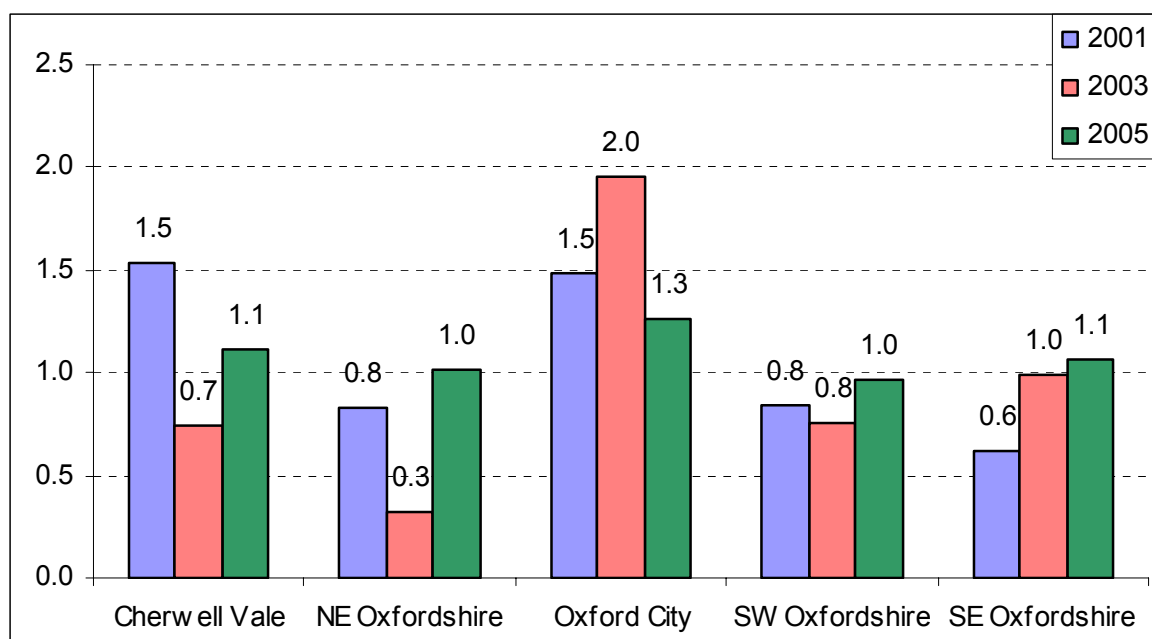


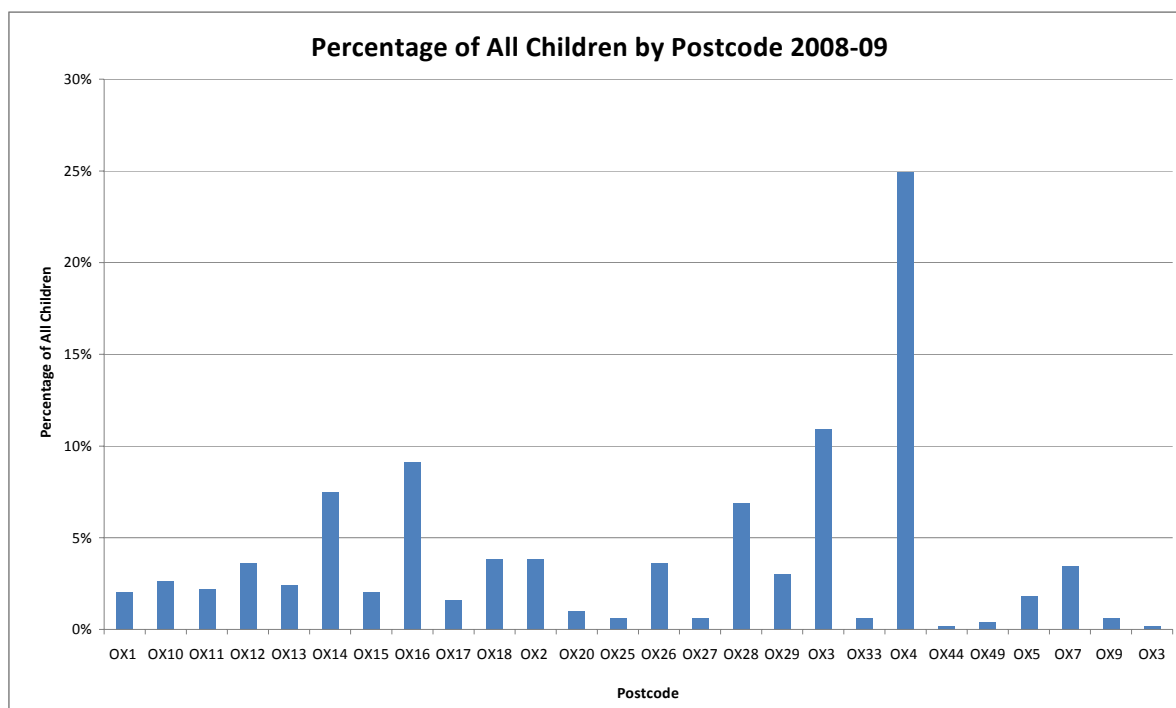
Figure 13: Mean dmft of Oxfordshire PCTs, 2001-2005



8.2.2 Extraction of Childrens teeth under general anaesthetic

An additional marker of children's oral health is the number of children who have their teeth extracted under general anaesthetic by the primary care dental services in the community. In 2008-2009, 493 children had teeth extracted under general anaesthetic. Blackbird Leys and surrounding areas (OX4) had the highest number of children and greatest proportion of children from an area requiring dental extractions (25%) (Figure14)

Figure 14: Childrens dental extractions by postcode 2008-2009



In 2009-2010, 545 children had teeth extracted under general anaesthetic. (Figure15) Blackbird Leys and surrounding areas (OX4) still had the highest number of children and greatest proportion of children from an area requiring dental extractions (22%). However, there was a marked increase in the number and proportion of children from Banbury and the surrounding areas (OX16), numbers almost doubled from the previous year.

Care needs to be taken in interpreting this increase, as new dental services have recently been commissioned in the area which may have identified more children earlier. Looking back over previous years OX4, OX16 and OX3 (North East Oxford) are consistently areas where the proportion of children requiring dental extractions are higher. This is expected and supports the fact that children living in areas of deprivation have poorer oral health outcomes than those who don't.

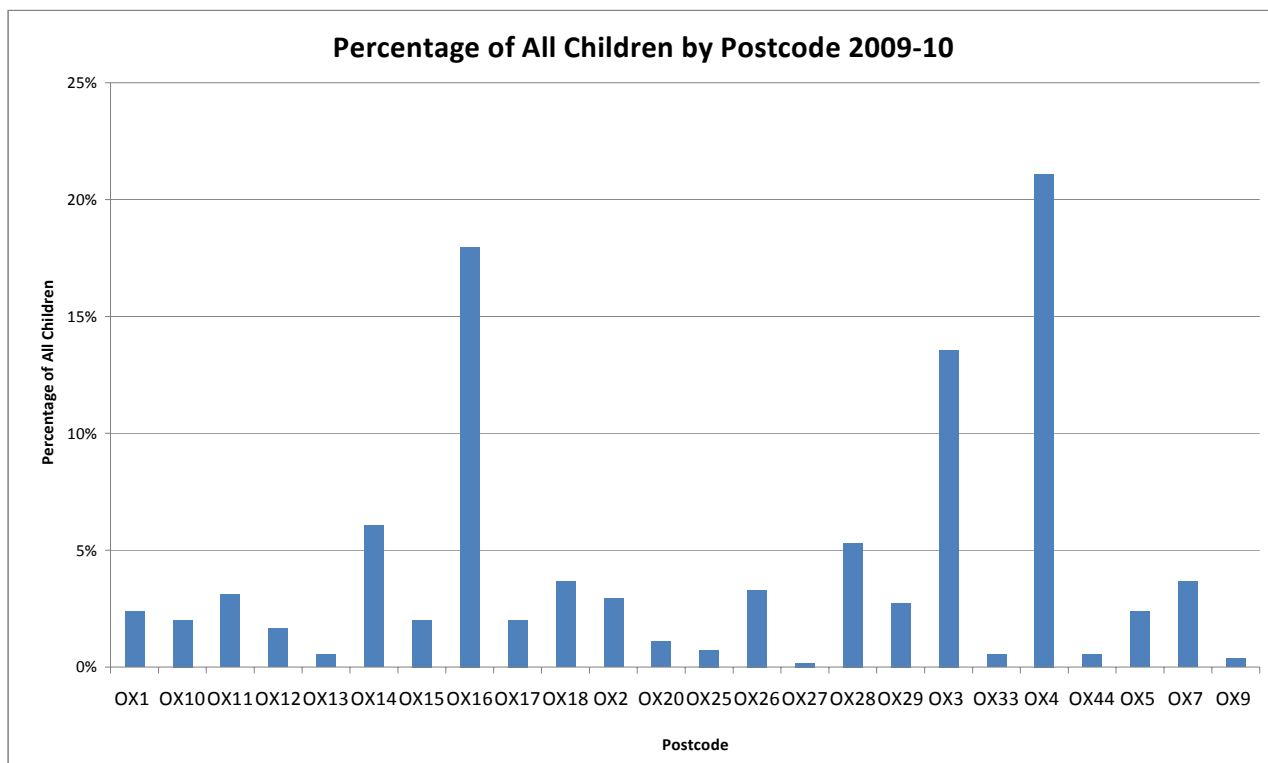


Figure 15: Childrens dental extractions by postcode 2009-2010

Recommendations:

- Ensure that commissioned services prioritise prevention as well as treatment
- Actively prevent oral disease through community and practice based prevention
- Disease should be actively prevented in children and vulnerable groups through delivery of fluoride toothpaste and fluoride varnish at a community level
- Ensure that commissioned services are child/family friendly and provide some level of outreach in areas of high need
- Continue to undertake epidemiological surveys as part of the DH programme
- Consider undertaking local epidemiological surveys for example adult dental health surveys to better inform commissioning of dental services

8.2.3 Orthodontic Treatment Need

The most recent Children's Dental Health Survey in 2003 found that 35% of 12-year-olds in England would benefit from orthodontic treatment.⁷² In Oxfordshire this would equate to 3,088 children in 2010 rising to 3,403 by 2020. However, it would be wrong to assume that all of these children will be seek, accept, be eligible or suitable for orthodontic treatment.

Orthodontic need is measured using the Index of Orthodontic Treatment Need (IOTN). Only children with high degree of treatment need currently classified as IOTN 4 or 5 and above are automatically eligible for NHS orthodontic treatment. Patients with IOTN 3.6-3.9 may be considered by the PCT as an individual case. The PCT routinely commissions treatment from orthodontists for patients with an Index of Orthodontic Treatment Need (IOTN) of 4 or 5, in line with Priorities Forum policy 96 - Orthodontic thresholds February 2007.

The prevalence of malocclusion does not vary between genders or social classes but there have historically been inequalities in the receipt of orthodontic treatment⁷³, e.g. girls receive more treatment than boys and adolescents in deprived areas are more likely to have untreated malocclusion.⁷⁴ Local data on the prevalence of malocclusion are not routinely collected; however, the most recent survey of 12 year olds (not yet published) includes a section on orthodontics which will provide some specific

information for Oxfordshire that can be used to inform future needs assessments and provision of services.

Recommendation:

- Ensure local specialist services such as orthodontics are audited regularly to assess quality and value for money

9 Current Service Provision

9.2 General Dental Services

9.1.1 National Activity

With the introduction of the new dental contract in April 2006 came a fundamental reform in the remuneration system for dentists. Under the previous systems, dentists were paid a fee for each item of treatment, while under the new contract; dentists are paid an agreed contract on the basis of completed courses of treatment (CoTs). Each course of treatment is allocated a number of Units of Dental Activity (UDA's) which accumulate to meet the dentists contractually agreed level of activity.

The three NHS charge bands are as follows:

- Band 1: £16.50. This charge includes an examination, diagnosis and preventive advice. If necessary, it also includes X-rays, scale and polish and planning for further treatment.
- Band 2: £45.60. This charge includes all the necessary treatment covered by the £16.50 charge, plus additional treatment, such as fillings, root canal treatment or extractions.
- Band 3: £198. This charge includes all the necessary treatment that is covered by the £16.50 and £45.60 charges, plus more complex procedures, such as crowns, dentures and bridges

With the new contract and charging system came changes in dental unit activity patterns. It has been reported elsewhere that the amount of Band 3 or more complex, time consuming activity fell when the new contract was introduced. However, due to amendments in the methodology of collecting data current activity levels can not be compared directly with levels before the new contract was introduced. Therefore, activity data before 2006 has been omitted from this report.

National Facts and Figures: In 2008/09, 37.4 million CoTs were delivered in England, an increase of 1.4 million (4.0 %) on the previous year and 2.4 million (7%) since the first year of the contract. The percentage change in the number of CoTs delivered in each band in the previous year varied from a 10.4 per cent increase in Band 3 treatments to a 2.7 per cent increase in Band 1 treatments. In 2008/09 more than half of the CoTs delivered in England were treatment Band 1 and only 5% were for treatment Band 3 (Figure 16). The treatment band with the highest proportion of UDAs in 2008/09 was Band 2 (42%) and Band 3 treatments increased by 1.2 %, from 26.3 % in 2007/2008 to 27.4 % (Figure 17). The proportion of UDA's in Band 3 has been slowly increasing relative to Bands 1 & 2 since 2006/07. The remaining 5.9 per cent of UDAs in 2008/09 were for Urgent and Other treatments ⁷⁵

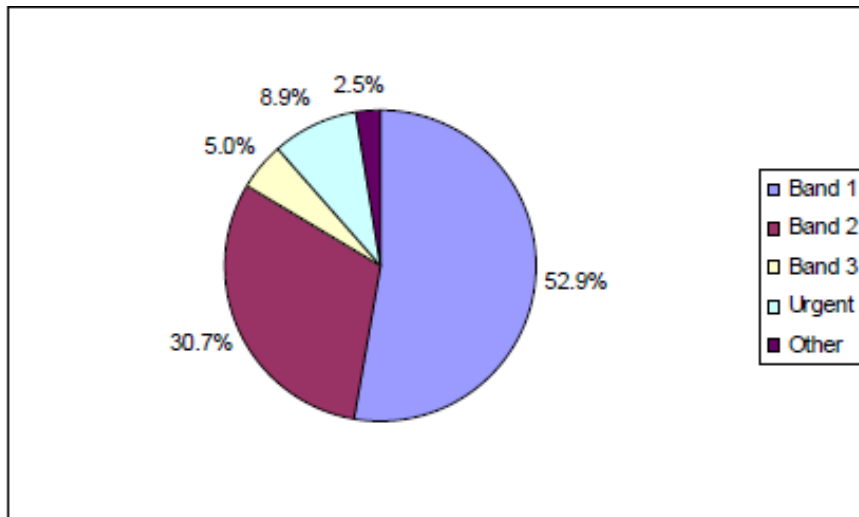
Patients: In 2008/09 the number of patients seen as a proportion of the population was 53.8 per cent. This is 1.9 percentage points lower than in the 24 month period ending 31 March 2006, but an increase of 0.4 percentage points when compared to the 24 month period ending 31 December 2008. ⁷⁶

The number of patients seen increased in all SHAs from the number of patients seen in the 24 month period ending 31 December 2008. This ranged from a 1.1 per cent increase in London SHA (to reach 3.7 million, equivalent to 49.3 per cent of the population) to 0.4 per cent increase in North East SHA (to reach 1.6 million, equivalent to 61.1 per cent of the population). ⁷⁷

Workforce: 21,343 dentists performed NHS activity during 2008/09. This is an increase of 528 (2.5 per cent) on 2007/08. The proportion of female dentists has risen to 41.2 per cent from 40.1 per cent in 2007/08. This is a 5.4 per cent increase in the number of female dentists (to 8,798).

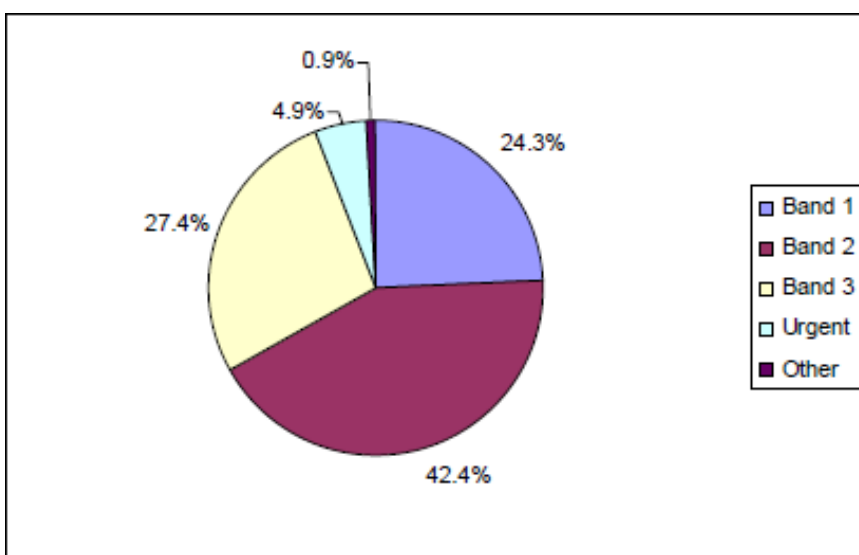
The number of dentists has increased in every SHA between 2007/08 and 2008/09. The increase varied from 5.6 per cent in North East SHA (to reach 1,108 dentists) to 1.7 per cent in East Midlands SHA (to reach 1,770 dentists).

Figure 16 - Proportion of CoTs in each treatment band in England 2008-2009



Source: NHS Information Centre

Figure 17 – Proportion of UDA's by treatment band, 2008 - 2009



Source: NHS Information Centre

These national data (Figures 16 & 17) show that majority (53%) of courses of treatment on patients are in Band 1 but nearly 75% of the units of dental activity commissioned are used for urgent or more complex treatments in Band's 2 & 3 and other.

9.1.2 Local General Dental Service Activity

At the outset of the new dental contract a baseline figure was taken to track future utilisation of the service. In 2006 in Oxfordshire, 49.5% of the population, 299,592, were seen at least once by an NHS dentist in the previous 24 months. In the following two years there was a fall, nationally and locally in the number of patients being seen by NHS dentists and by April 2008, only 46% of the population in Oxfordshire had accessed NHS dental services in the previous 24 months. We do not have any data available to show how many patients continued to be seen by a private dentist. (Table 3)

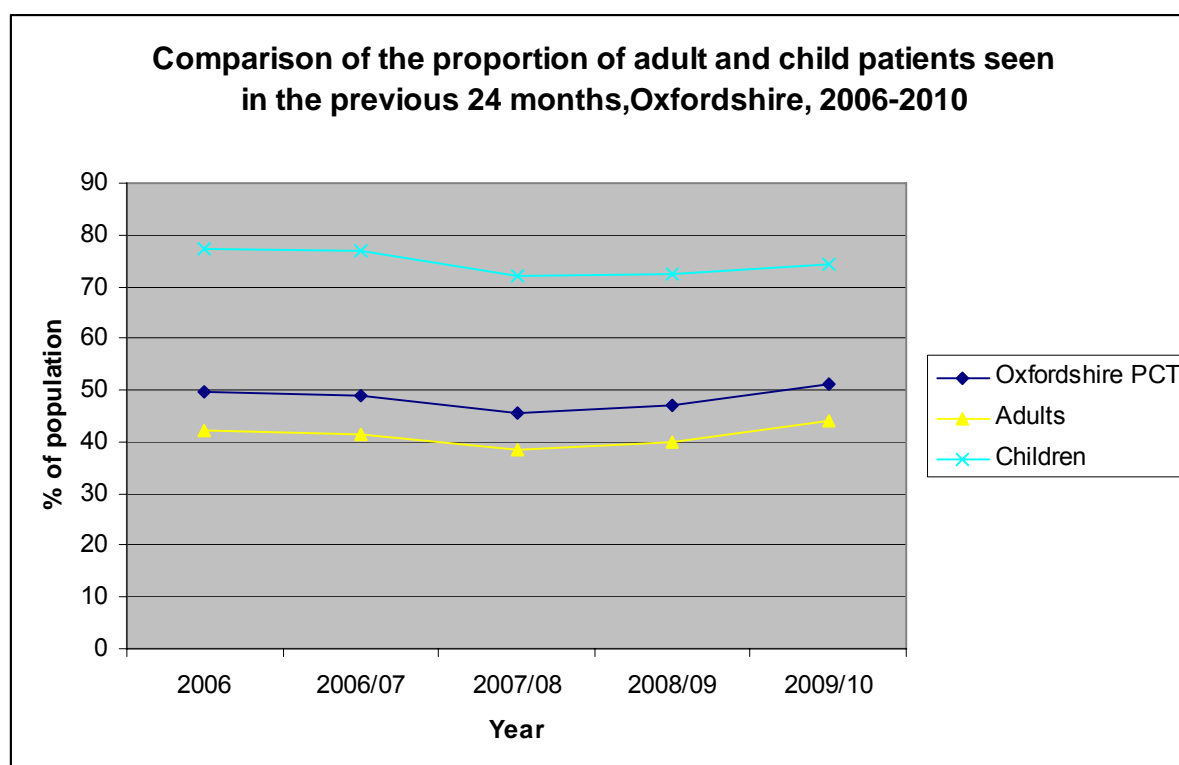
Table 3: Comparison of the proportion of patients seen (adult/children) at local, regional and national levels, in the previous 24 months, 2006-2010

	Baseline	2006/07	2007/08	2008/09	2009/10
Oxfordshire PCT	49.5	49.1	45.7	47	51
SHA	47.3	47.4	44.2	45.5	47
England	55.8	55.7	54.9	53.8	55.1

Sources: NHS Information Centre & Business Service Authority, Dental Services Division. Quarterly Vital Signs Reports

The fall was largely perceived to be due to the reduction in the availability of NHS services when some GPs decided to only treat private patients and withdraw from their NHS contracts. However, between 2008-2009 and 2009-2010 the data show that utilisation of the service increased by 4% to reach 51%. As at 31st March 2010 Oxfordshire PCT is ranked 124th out of 152 Primary Care Trusts for this access target.

Figure 18: Comparison of the proportion of adult and child patients seen in the previous 24 months, April 2006 - March 2010



Sources: NHS Information Centre & Business Service Authority, Dental Services Division. Quarterly Vital Signs Reports

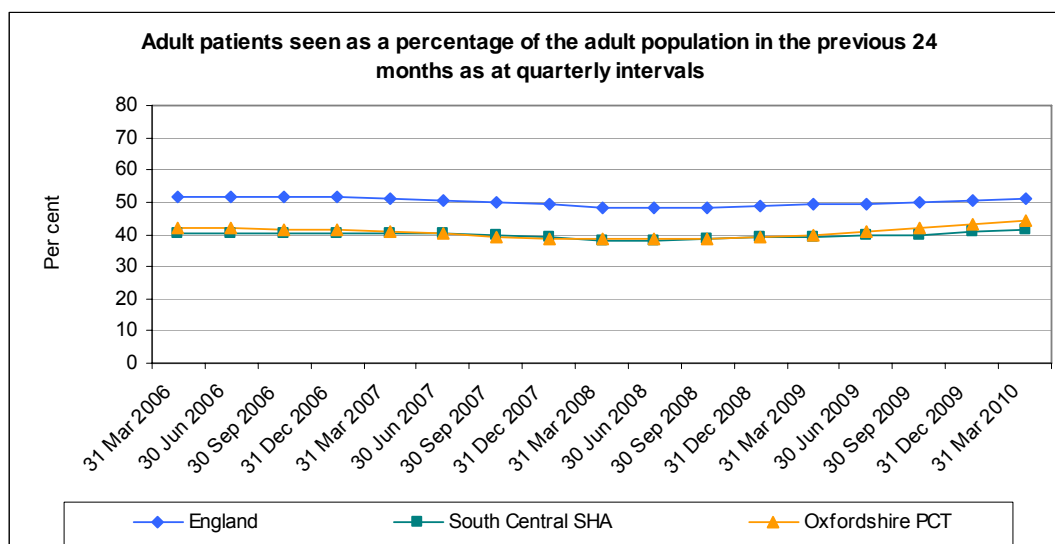
Table 4: Comparison of the proportion of adults and children seen in Oxfordshire in the previous 24 months, 2006-2010

	Baseline	2006/07	2007/08	2008/09	2009/10
Oxfordshire PCT	49.5	49.1	45.7	47	51
Adults	42.2	41.4	38.5	40.1	44.2
Children	77.4	76.8	72.2	72.5	74.3

Sources: NHS Information Centre & Business Service Authority, Dental Services Division. Quarterly Vital Signs Reports

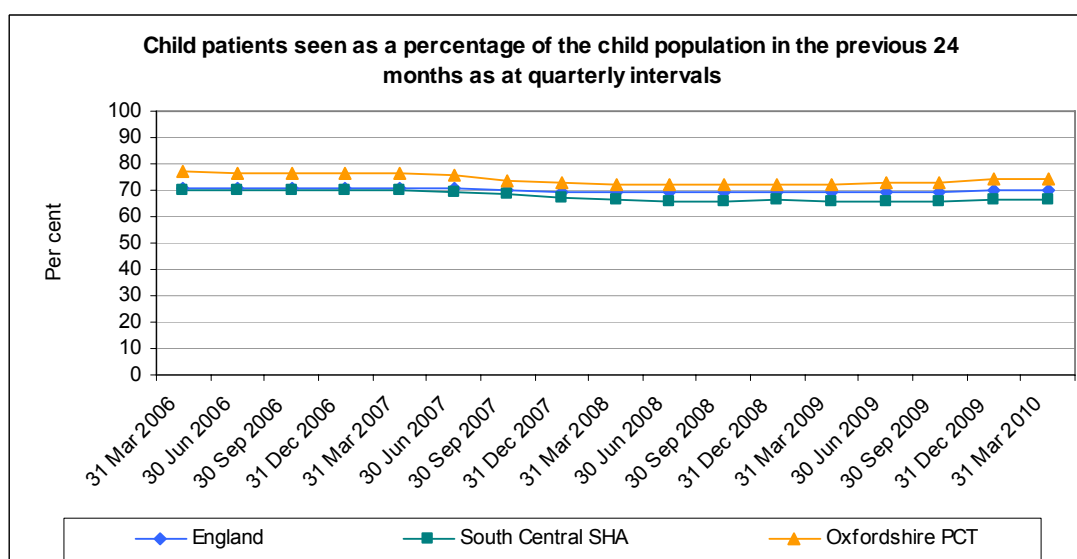
Looking at the same data by adults and children (Table 4) show that the fall in dental access in Oxfordshire has been greater in children (as a proportion of the population) than adults. They also show that service utilisation by children does not appear to be recovering at the same rate as adults.

Figure 19: Adult patients seen as a percentage of the adult population, March 2006–March 2010



Source: NHS Information Centre

Figure 20: Child patients seen as a percentage of the child population, March 2006–March 2010



Source: NHS Information Centre

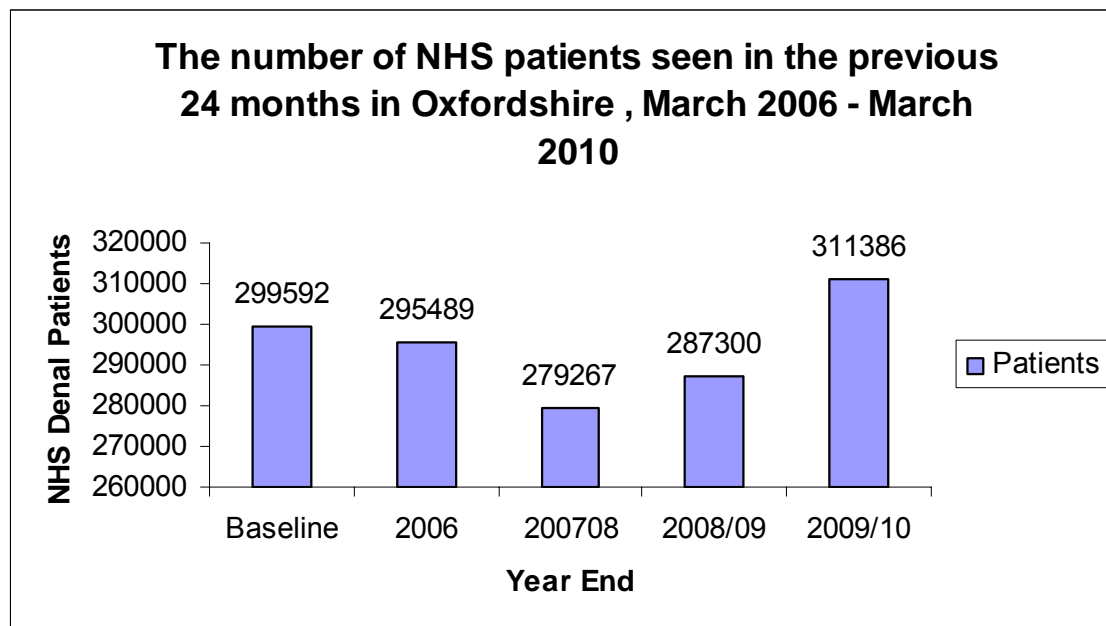
Overall access for children remains higher in Oxfordshire than the England average and Oxfordshire PCT ranks 51st out of 152 Primary Care Trusts in terms of its access for children. Improving access for adults lags behind other PCT's in the South Central region and the rest of England and PCT is ranked 124th out of 152 Primary Care Trusts in terms of its access for adults.

In 2005/2006 Oxfordshire had 43 dentists with NHS activity per 100,000 of the population and this figure had increased to 51 dentists per 100,000 by 2008/2009. Oxfordshire appears to be reasonably well supplied with NHS dentists per head of population in comparison with the rest of the SHA and England. However, these data do not reflect the number of hours they work or the level of NHS contacted activity those dentists are willing to or have been commissioned to perform. In addition, the increased complexity of patient's dental problems has also resulted in patients having longer courses of dental treatment and this will have a negative impact on the levels of access capacity in the system.

Since April 2008 and the introduction of the strategic Framework for Commissioning Dental Services in Oxfordshire, the PCT has taken significant actions to improve access to NHS dental care by increasing capacity, developing the local market and commissioning additional services. A range of measures have been deployed including supporting GDP's to expand their surgery capacity, performance management of under performing contracts, the introduction of a patient dental access line, engaging new performers; extending opening hours and developing new providers.

As a result of this activity the number of patients seen had risen to 311,386 by March 2010, a 3.9% increase from the 2006 baseline (299,592). However, in 2009/10 alone there had been an 8.4% increase in the number of patients seen from the previous year. The PCT has a target to increase utilisation of the service to 58% of the population by March 2013.

Figure 21: The number of NHS patients seen in the previous 24 months, Oxfordshire.



Sources: NHS Information Centre & Business Service Authority, Dental Services Division. Quarterly Vital Signs Reports

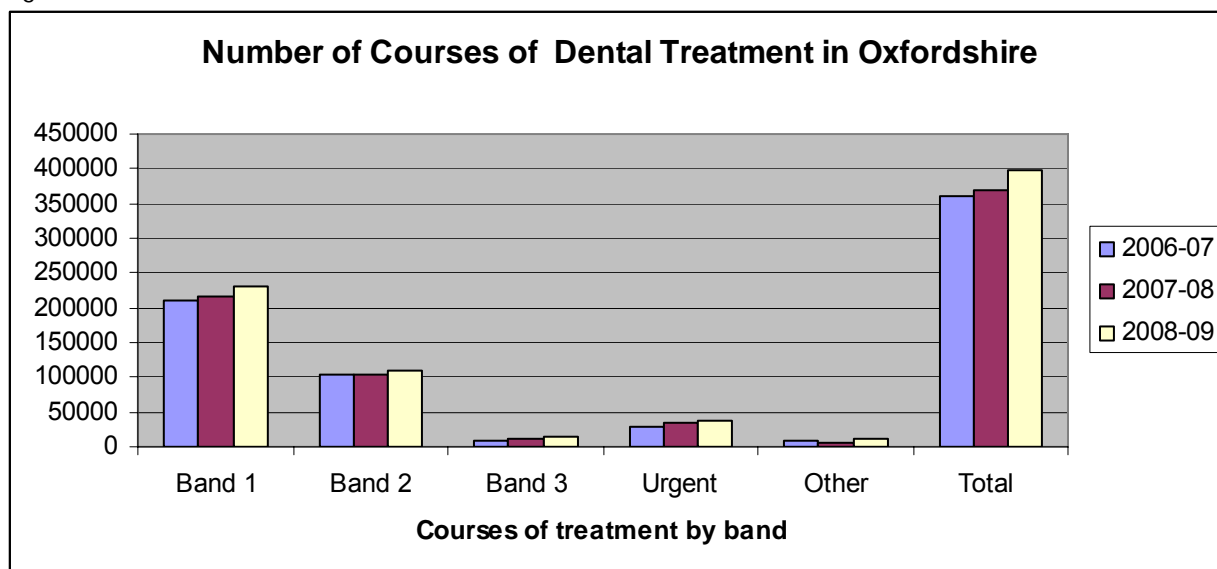
Recommendation:

- Ensure year on year improvements in the number of patients, particularly from harder to reach groups, accessing local NHS dental services

9.1.3 Courses of Treatment Performed by Treatment Band

In 2008/09, nearly 400,000 CoTs were delivered in Oxfordshire, an increase of 7.4% on the previous year and 10.5% since the first year of the contract. The percentage change in the number of CoTs delivered within each band of treatment varied from a 51% increase in 'other', 41% increase in Band 3 treatments to a 9% increase in Band 1 treatments from 2006/2007 to 2008/2009.

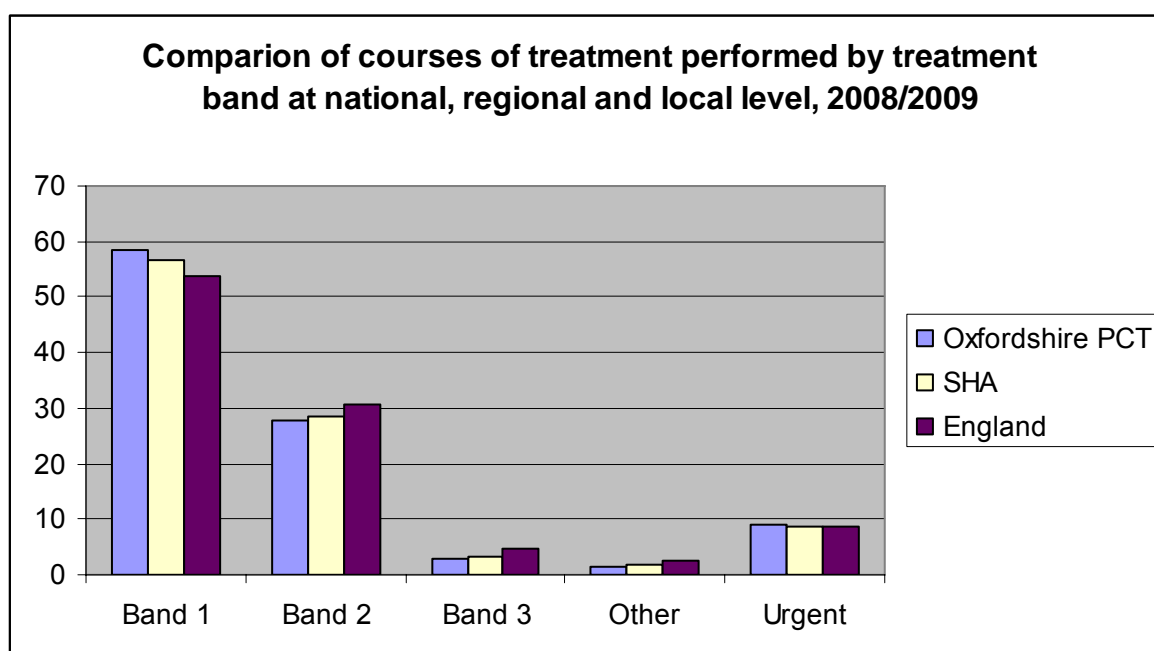
Figure 22: Number of courses of dental treatment in Oxfordshire, 2006-2009



Source: NHS Information Centre

In 2008/09 the highest proportion of COT's delivered (number 229,629) was in Band 1 (number 229,629) and the lowest proportion of COT's was in Band 3 (13,683) and 'other' (4,126). Urgent treatments accounted for 9% of the COT's in that year. Oxfordshire has a higher portion of COT's in Band 1 compared to the SHA and England averages and also a lower proportion of COT's in Bands 2 & 3 than the SHA and England averages.

Figure 23: Comparison of the courses of treatment performed by treatment band, national, regional & local



Source: NHS Information Centre

A higher portion of COT's in Band 1 and a lower proportion of courses of treatment which fall into Bands 2 & 3 may well be a reflection of the good oral health of the local population. However, there may also

be other underlying causes for fewer courses of Band 2 & 3 treatments such as patients being confused about the charging structure or unwilling to pay for complex treatment and/or dentists being reluctant to treat patients with more complicated needs as they are time consuming and taking actions such as referring patients to a non-NHS providers. Where there is mixed economy of NHS and private provision within a practice this may be an issue.

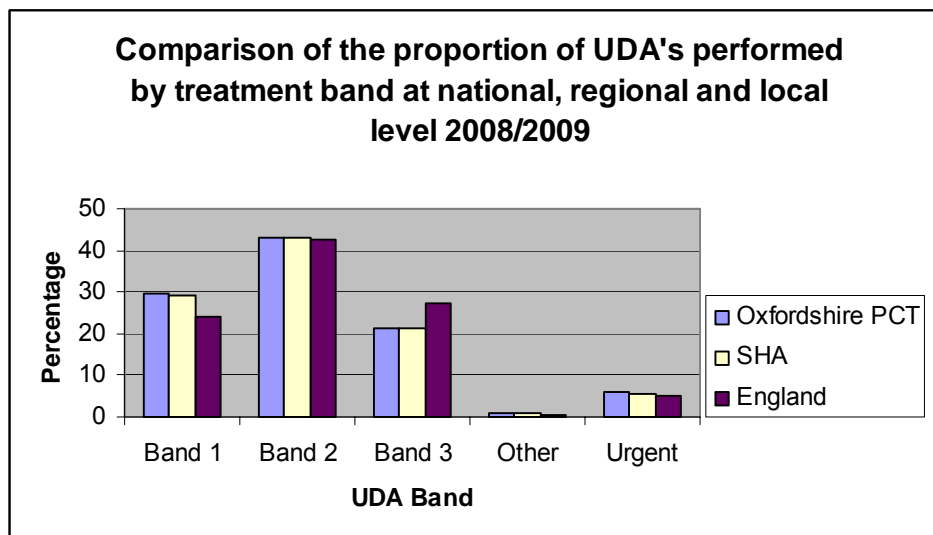
In 2008-2009, almost half of the dental activity (UDA's) performed by NHS dental providers in Oxfordshire was in Band 2 i.e. people who need some intervention such as fillings, root canal treatments etc. This trend is similar to that of the SHA and England as a whole. The higher proportion of treatment being in Band 2 compared to Band 1 is a reflection of the populations oral health needs. The proportion of patients requiring secondary prevention is still too high and these patients are likely to need treatment for the rest of their lives. As the oral health of the population improves the PCT would expect to see the proportion of patients receiving Band 2 & 3 treatments falling and increase in those in Band 1 if primary prevention is working. However, with an 'Ageing Population' Band 2 & 3 treatments may be expected to remain high for sometime.

Table 5: Proportion of units of dental activity (UDA's) performed by treatment band in 2008-2009

	Band 1	Band 2	Band 3	Other	Urgent
Oxfordshire PCT	29.6	42.9	21.1	0.9	5.8
SHA	29.2	42.9	21.5	0.8	5.6
England	24.3	42.4	27.4	0.6	4.9

Source: NHS Information Centre

Figure 24: Comparison of the proportion of UDA's performed by treatment band national, regional & local



Oxfordshire has similar proportions of UDA activity to the SHA region, with a higher proportion of UDA's in Band 1 than the England average and a lower proportions in Band 3. However, with an ageing population, as we have in Oxfordshire the PCT could expect Band 3 treatments to be higher and to remain relatively high despite preventative approaches. These data may reflect a lack of access to appropriate NHS dentistry services for older people in Oxfordshire such as domiciliary care. Oxfordshire PCT and the SHA region have a higher proportion of urgent treatment than the England average. Again, this may reflect poorer access to NHS dentistry, a lack of continuity of care or reluctance on the part of the patient to seek treatment earlier and adhere to regular dental screening and advice.

9.1.4 Mapping of General Dental Services Provision Including Access and Use

Historically, dental practices, which are independent businesses, have been established in more affluent areas of Oxfordshire leaving the more deprived areas with less provision. Poor oral health is linked to deprivation and therefore the inverse care law has always applied to dental services, there being less access to services for those with the greatest need. Following the 2003 Social Care Act, PCT's held the whole of the dental budget with responsibility for commissioning new services. However, the distribution of UDA's in 2006 was still based on the historical map and use of services by patients and therefore the inverse care law has still applied.

When the new contract was implemented in 2006 Oxfordshire PCT had 298 dentists with NHS activity and 106 dental performing providers in Oxfordshire. By 2007/2008 the number of NHS dentists had dropped to 289 but increased again to 309 the end of 2009.

Over the last four years the PCT has begun to reshape the provision of services across Oxfordshire by commissioning new dental services in areas such as Blackbird Leys and Banbury where there is a greater proportion of deprivation and higher oral health needs. The PCT has also commissioned existing providers to extend their NHS provision and take on more patients or extend opening hours and change service provision to improve access and reflect patient needs. By 2008/2009 the map of dental provision had already begun to change and there were 111 dental performing providers in Oxfordshire and 406 dental performers.

The maps below were prepared in 2008-2009 by NHS Dental services to support PCT's in improving local access to services. Figure 25 shows the treatment access rate by wards in Oxfordshire 2008-2009. Areas in red and orange in North & North West Oxford including Carfax, St Margarets, St Mary's, and St Clements and other more rural wards in West Oxfordshire, Chewell and Vale of White Horse have the lowest rate of access to NHS dental services and areas in blue and yellow such as Crowmarsh and East & West Bicester have higher rates of access.

Figure 26 shows the average distance travelled by patients accessing NHS dental services. It shows that patients from at least 17 wards in Oxfordshire have to travel, on average, more than 12 miles from home to access an NHS dentist. If these journeys have to be taken by one or more forms of public transport, for example if someone can no longer drive or does not have access to a car, then it is reasonable to assume that this distance will be a barrier to accessing services.

Figure 25 shows the units of general dental activity by ward population. There is a tendency for a greater use of UDA's per population in areas where there are dental practices closer by. This is the case in 38 wards in and around Banbury, Bicester, North and South East Oxford. There are also other areas such as Berinsfield, Cromarsh, Sunningfield and Wooton where there are higher rates of dental UDA's per person.

There are 40 wards with fewer than 1.31 UDA's per head of population. These include most of the more rural wards such as those in the Vale of White Horse and West Oxfordshire & Cherwell where patients would have to travel further to see a dentist. However, these also include some of the densely populated areas in Wantage, Grove and areas of Oxford where there are dental practices near by.

Recommendation:

- Improve the uptake of services from people living in rural areas and explore how best to deliver these services
- Tailor commissioned services to local need with special attention paid to harder to reach groups

Figure 25: Oxfordshire PCT Treatment Locations and Ward level Access, 2008-2009

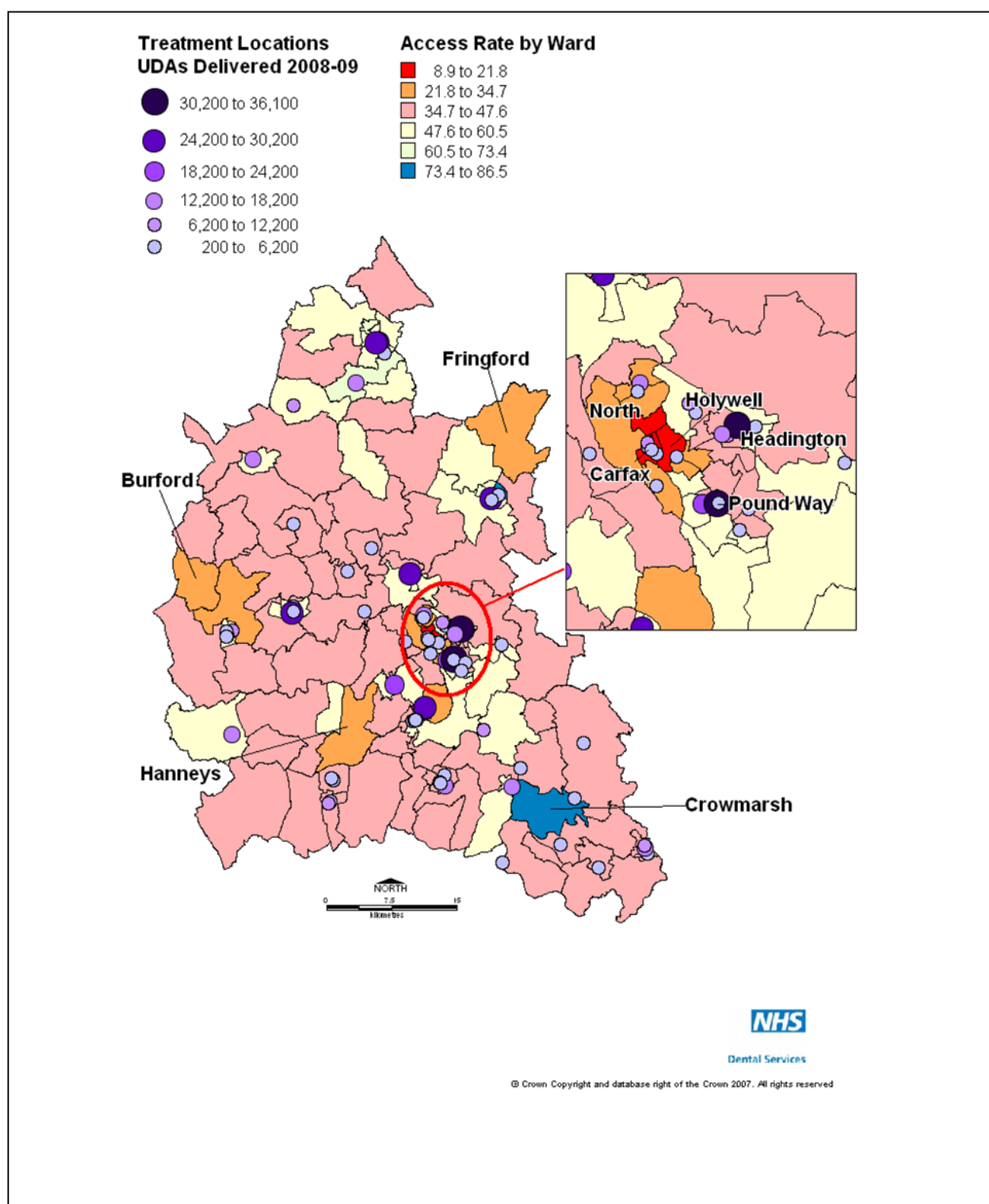


Figure 26: Average Distance Travelled & Treatment Locations

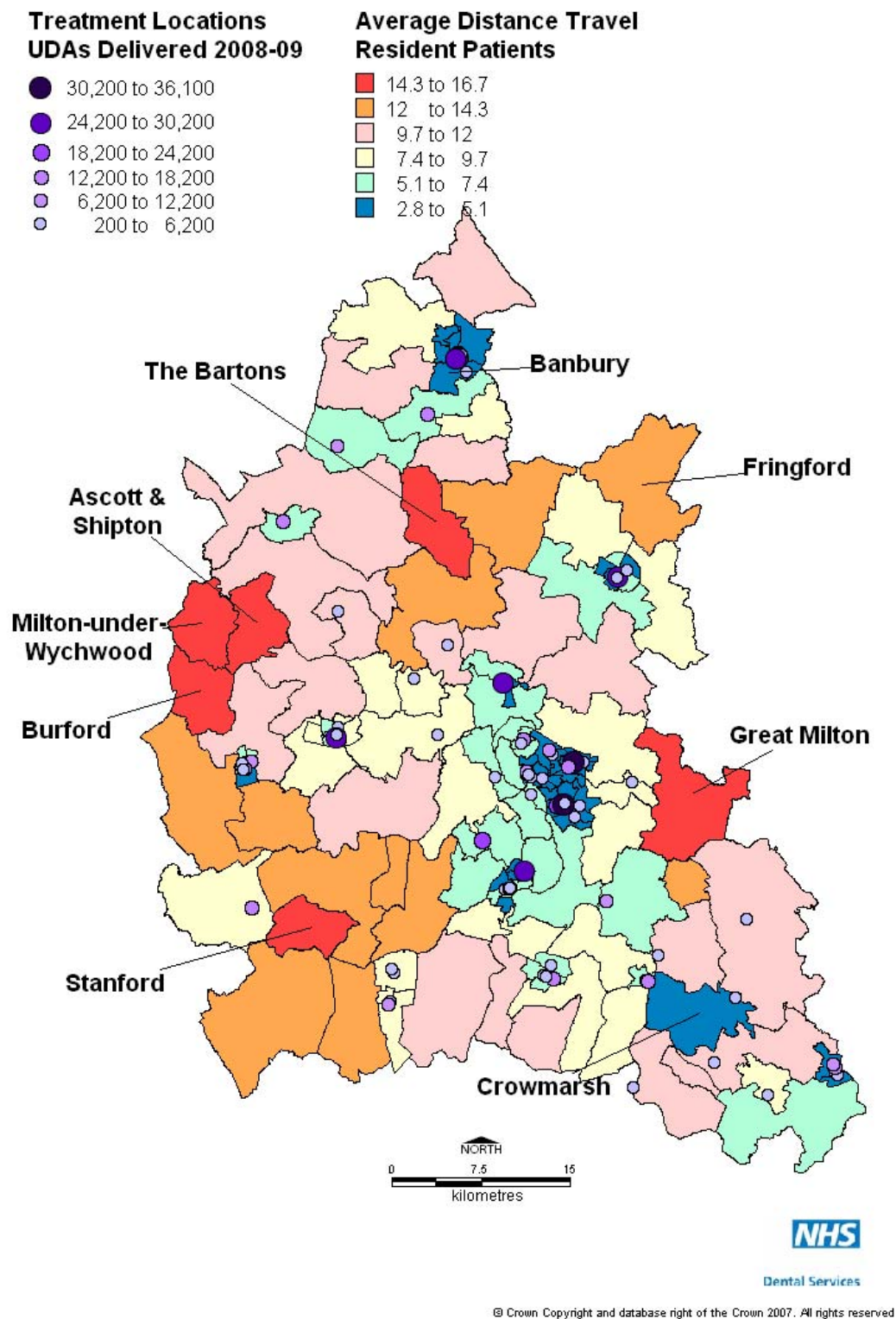
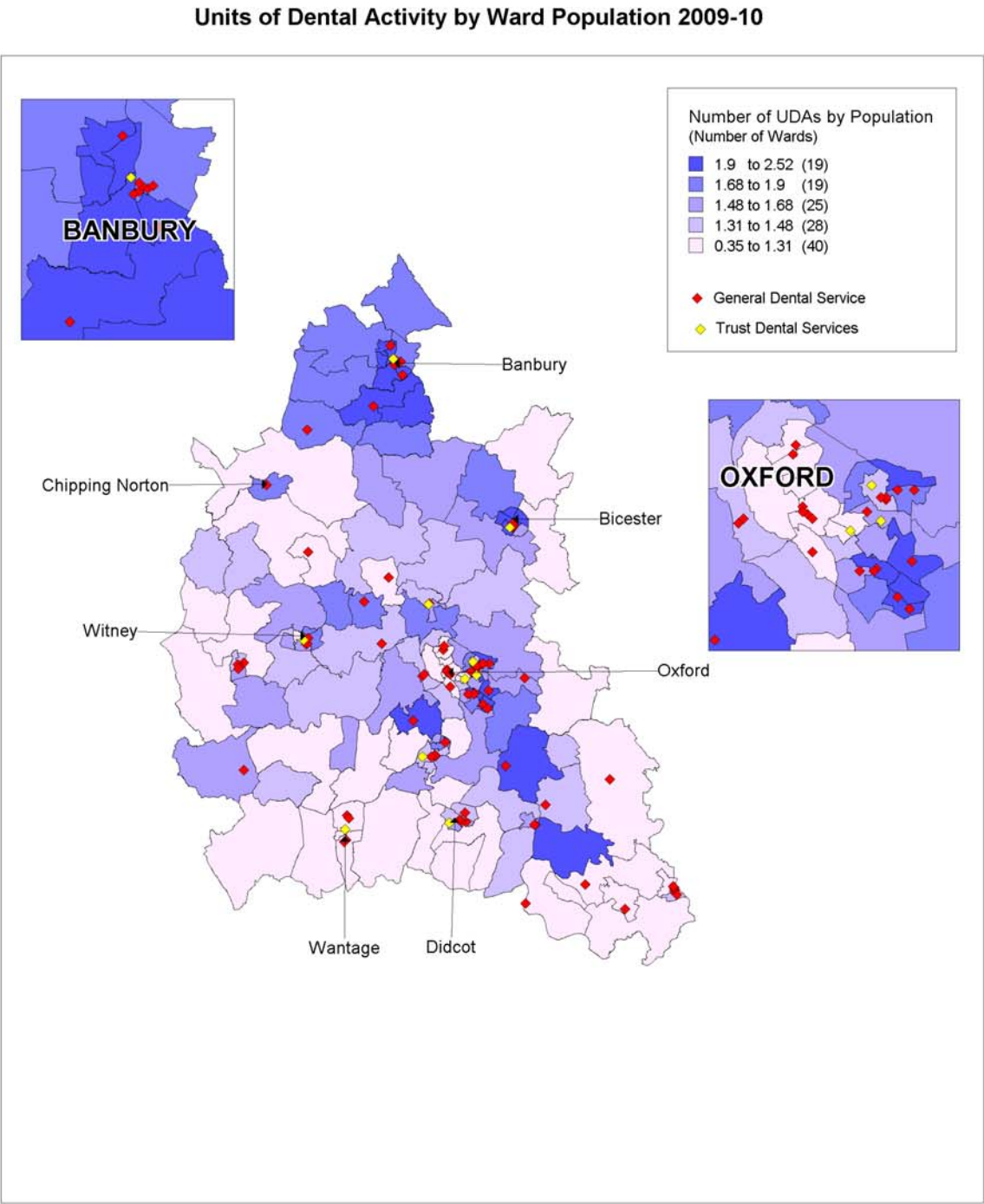


Figure 27: Units of Dental Activity 2009-2010



Mapping produced using AA and 2001 Census data with licenced permission. Crown Copyright 2003.
UDA and UOA by Ward using E-Reporting extract.
Ward population using ONS Projections.
Health Informatics & Intelligence. OHNA. 092010. IF.

The PCT runs a Dental Access Line for patients who are experiencing problems in accessing a dentist or would like more information about dental services in Oxfordshire. This enables the PCT to direct patients to practices who are accepting NHS patients and helps identify unmet needs. An audit of the calls to the line in 2009 found that there were 1447 requests during the year and the most frequently requested areas were Oxford City Centre, Headington, Abingdon, Witney, Blackbird Leys and Wantage.

Figure 28: Calls to the Oxfordshire Dental helpline and area where an NHS Dentist was requested

	Q1	Q2	Q3	Q4	Total (n)	Total (%)
Abingdon	18	37	31	20	158	11%
Banbury	13	7	11	4	42	3%
Bicester	9	8	5	8	37	3%
Benson	0	0	0	3	6	0.4%
Berinsfield	0	0	0	1	3	0.2%
Carterton	1	4	7	6	34	2%
Chipping Norton	7	4	6	5	24	2%
Dental Access Centre	0	0	4	0	4	0%
Didcot	4	9	18	9	66	5%
Eynsham	1	2	1	1	7	0%
Faringdon	1	3	9	1	21	1%
Henley On Thames	2	3	13	3	27	2%
Non-Oxfordshire PCT Area	0	1	8	6	18	1%
OX1 - City Centre	33	15	55	34	190	13%
OX2 - Botley	7	3	11	14	49	3%
OX2 - Summertown	11	17	17	11	87	6%
OX3 - Headington	19	54	30	20	169	12%
OX4 - Blackbird Leys	15	14	30	25	125	9%
OX4 - Rose Hill	22	4	1	0	27	2%
OX5 - Kidlington	3	5	9	4	32	2%
Thame	2	0	2	2	7	0%
Wallingford	4	0	12	7	30	2%
Wantage	21	26	25	20	119	8%
Wheatley	2	4	1	2	15	1%
Witney	22	23	41	16	140	10%
Woodstock	0	0	6	1	10	1%
Totals:	217	243	353	223	1447	

Source: Oxfordshire PCT

Figure 29: Areas in Oxfordshire where a NHS Dentist was supplied

Area Supplied	Total (n)	Total (%)
OX3 - Headington	266	15.30%
OX1 - Oxford City Centre	235	13.60%
Abingdon	230	13.30%
Didcot	166	9.60%
Witney	155	8.90%
OX4 - Blackbird Leys	140	8.10%
OX2 - Summertown	78	4.50%

Source: Oxfordshire PCT

These data show that the PCT is able to respond to the most requests for NHS dental services in 5/6 most requested areas apart from Wantage. The PCT is in the process of commissioning additional NHS services and dental capacity in the Wantage & Grove area of Oxfordshire to help address this unmet need.

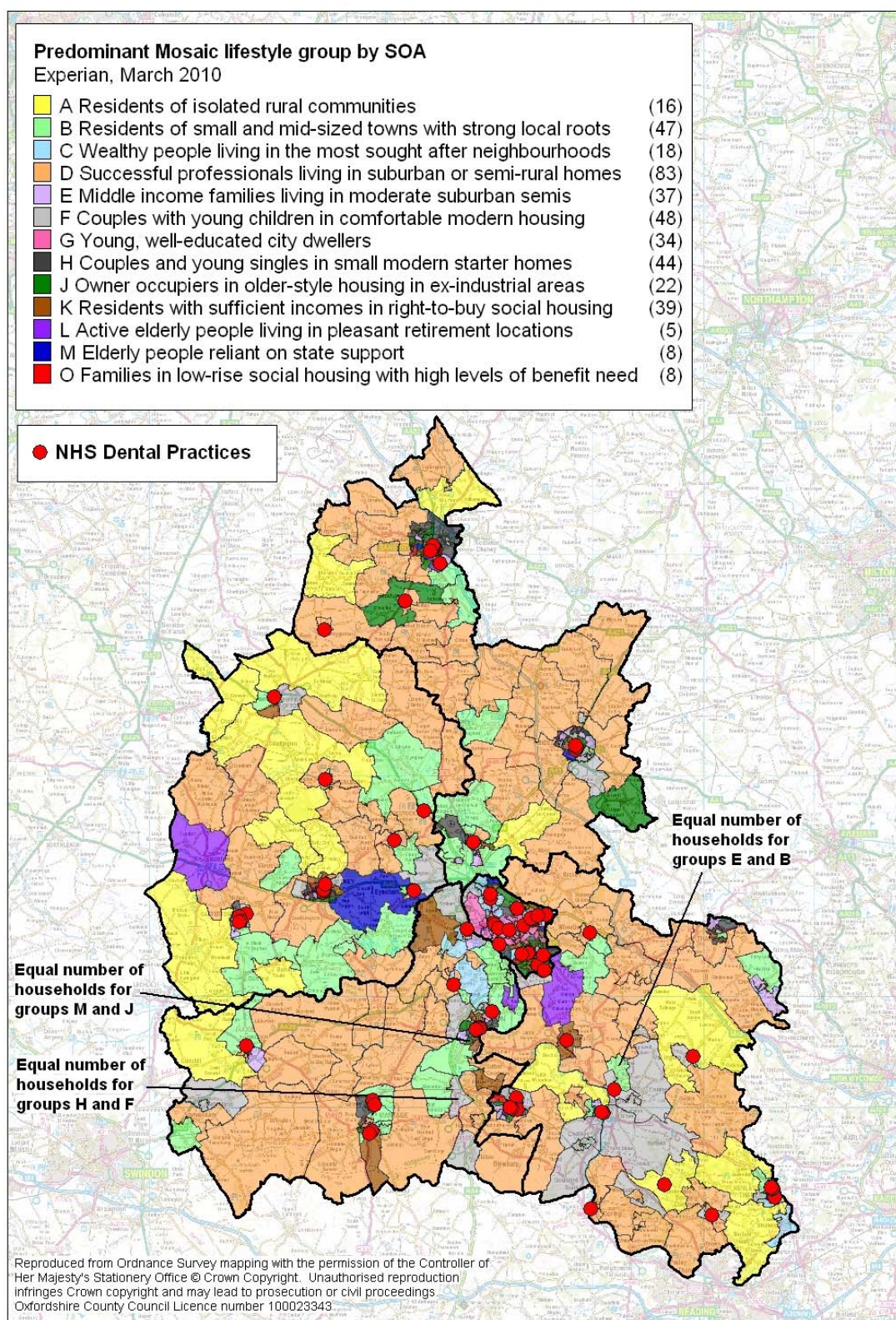


Figure 30: Map showing the predominant Mosaic lifestyle groups by SOA in Oxfordshire

A mosaic profiling tool has been used to help identify which 'mosaic groups' in Oxfordshire are less likely to be accessing local NHS services. Mosaic combine's a number of public and business sector databases to create profiles of people in the UK. It has a number of profile Groups (see A – O in the map above) and sub groups (called Types) which have been developed on the basis that people live in the same area have similar characteristics. The predominate lifestyle groups by Super Output Area in Oxfordshire are represented in the map above.

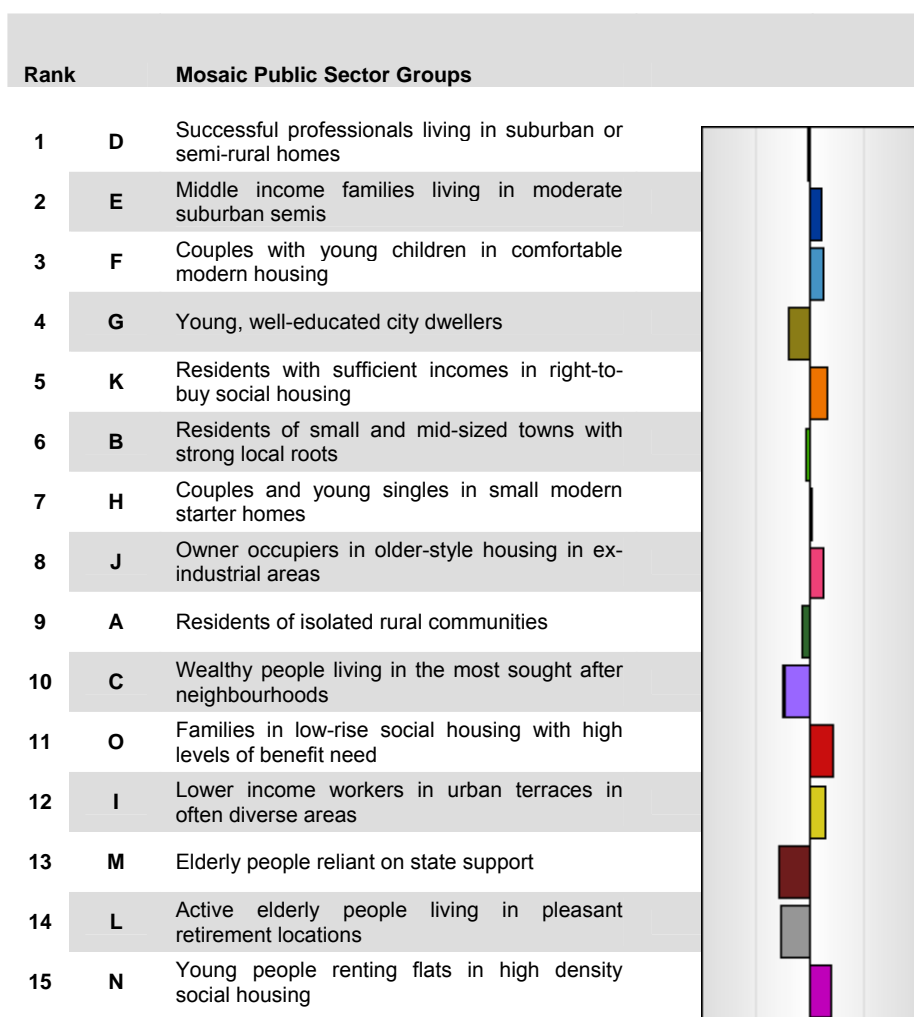


Figure 31: Most and least common Mosaic groups represented as users of NHS dental services

The tool was used to compare the users of dental services (in the previous 24 months) with the general population in Oxfordshire to identify which 'Groups' and 'Types' were more commonly represented than others. The chart above ranks the groups from (1) the most common to (15) the least commonly represented users of NHS dental services. The bar to the side denotes whether each group is more (to the right) or less (to the left) represented as users of services than would be expected as a proportion of the population. The data show that Groups G, C, M & L are the most under represented users of NHS dental services and that groups K, O, I & N are over represented.

Groups K, O, I & N are more likely to be lower incomes or economically/socially deprived so it is positive to see that these groups are over represented as users of services.

To improve access the PCT could focus its interventions on the groups that are more common but relatively under represented as users of services, such as young, well educated city dwellers. However, older people who are underrepresented such as people living in social accommodation designed for older people or less mobile older people requiring a degree of care would be a more appropriate group to target as their needs will be greater.

Recommendation: Develop interventions which target older people living in social accommodation or less mobile older people requiring a degree of care to reduce health inequalities and improve access to and use of NHS dental services. Where appropriate improve access to domiciliary care.

9.1.5 Out of Hours Dental Care in Oxfordshire

From April 2006 the provision of Out of Hours (OOH) care has been the responsibility of the Primary Care Trust. In Oxfordshire the OOH's service is managed by the Salaried Dental Service. The service operates extended opening hours including weekends and bank holidays. The service is accessed by a single telephone number to the Oxfordshire communications hub, hosted by Oxfordshire Ambulance Trust.

Following initial receipt of call, in which patient details are logged into the OOH information system, a dental nurse calls the patient back to undertake clinical triage. Telephone advice is given to patients who require it, by the nurse or dentist. If immediate treatment is indicated (or within 24-48 hours at weekends or bank holidays) the patient will be given an appointment at the OOH surgery, but if the patient can suitably be seen the next working day, they will be advised how to access an in-hours urgent appointment (e.g. at a dental access centre or a local dental practice providing emergency access slots in hours).

The OOH service provides urgent care, specifically:

- Treatment for severe dental and facial pain not controlled by over the counter preparations
- Dental and soft tissue acute infection
- Treatment as necessary as a result of alveolar dental trauma

The service is available to the population of Oxfordshire, temporary residents and those visitors requiring urgent dental treatment. In 2009/2010 the service received 7439 calls and reported treating 3357 patients. There was a fall in calls and numbers treated compared to the previous year.

Table 6: Number of calls and number of patients treated in Out of Hours Service 2006 - 2010

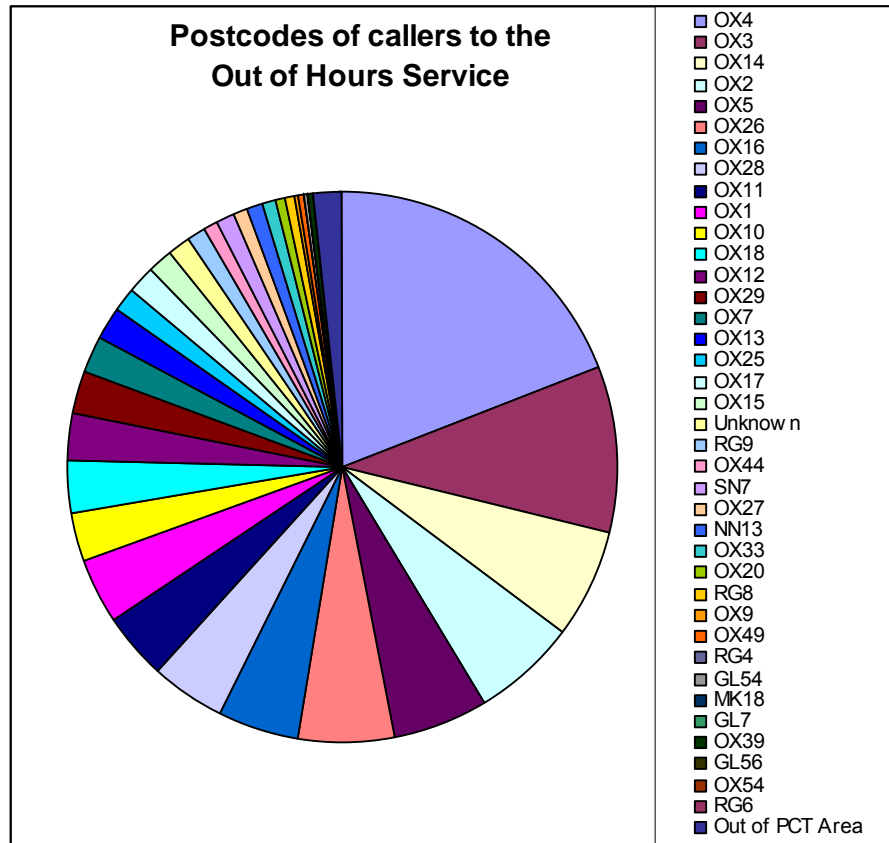
	Avg monthly calls	Total calls for year	Avg monthly treated	Total treated for year
2006-7	567.25	6807	234.25	2811
2007-8	650.83	7810	277.66	3332
2008-9	622.41	7469	284.58	3415
2009-10	619.91	7439	279.75	3357

Source: Oxfordshire Salaried Primary Care Dental Service

In 2009-2010 the average wait for treatment was 3 hours, 30 minutes and all patients were seen within 24 hours from the time of triage. No patient exceeded the 48 hour timescale. 109 patients did not attend their appointment after they had been triaged and the rate of triage to treatment across the year was 45.12%. The PCT also commissions services to enable patients to access emergency dental care in normal working hours. This provision of unscheduled emergency care is provided by the Salaried Primary Care Dental Service from 9 dental clinics and also from some practices within the General Dental Service.

The data show that the 5 most common postcodes for emergency dental access include OX4 (East Oxford, Blackbird Leys and the surrounding area), OX3 (North East Oxford, Headington), OX14 (Abingdon), OX2 (North & North West Oxford) and OX5 (Kidlington). Out of area represent 1-2% of the overall calls

Figure 32: Postcodes of calls to the Out of Hours service 2009-2010



Source: Oxfordshire Salaried Primary Care Dental Service

Recommendations:

- Provide better patient information about what services are available and how to access them
- Target advertising of the dental helpline number and the availability of local NHS dental services more widely in OX4 ,OX3, OX14, OX2 and OX5 making use of existing services and local community groups and organisations

9.2 Specialist Services

9.2.1 Primary Care Dental Services

The term 'primary care' refers to the work undertaken by dentists and other dental care professionals both in general practice (under General Dental Service Regulations or Personal Services regulations) or in community services run by PCT's or other trusts.

9.2.2 Salaried Primary Care Dental Services

The PCT has a contract with Community Health Oxfordshire to provide a salaried primary care dental service. Historically, these services have intended to be complementary to high street dental provision and have had two major components

- Access centres that provide oral health advice and ready access to dental care for people within the county who can not secure care from a NHS general dental practice. They also play a key role in the provision the PCT's dental out of hour cover
- Specialised Dental Services

Since October 2006 their roles are provided under the powers of the Health & Social Care (Community Health and Standards) Act 2003. Their role includes:

- Delivering public health programmes, including epidemiological surveys;
- Providing dental care for patients who because of disability have need for specialised dental care;
- Providing general primary care dentistry for patients of all ages;
- Providing specialised dental services, as required locally, for example general anaesthesia in a hospital setting, orthodontics

Oxfordshire Salaried Primary Care Dental Service provides a number of services to the PCT including:

- Dental Referral Bureau
- Out of hours emergency dentistry
- In-hour emergency care
- Special care dentistry
- Paediatric dentistry
- Oral Surgery
- Restorative dentistry
- General anaesthetic and sedation services
- Orthodontics
- Domiciliary Services
- Oral Health Promotion

9.2.3 Dental Referral Bureau

In 2008/2009, referral guidelines for secondary care and specialist services were reviewed and a referral triage system (Dental Referral Bureau) was established to manage patients where possible outside of secondary care settings. The Dental Referral Bureau provides a clinical and administrative function that triages referrals from a range of referring practitioners across health & social care. The objective of the service is to provide a clinical triage and administrative function to:

- Receive and triage dental referrals from all Designated Referrers within agreed timescales
- Arrange patient appointments, if appropriate, in tier 2 services within agreed timescales
- Pass suitable secondary care referrals via Choose and Book within agreed timescales

- Ensure systems are in place to make certain that the process is completed for every referral
- Maintain record of activities undertaken to support monitoring of contract and investigation of complaints

In 2009- 2010 there were 7511 referrals via the dental referral bureau, of which 4786 were triaged to the Salaried Dental Service, 2316 were triaged to secondary care and 409 were inappropriate referrals.

9.2.4 Salaried Dental Service clinics

The service operates 10 dental clinics across the county. There are 6 multi-surgery clinics and 4 satellite clinics located county wide which offer a full of range of routine or specialised dental treatment in the community. The service is available for special care (see below) patients, for urgent care patients who have experienced difficulty in obtaining treatment in the General Dental Services (GDS) and for patients whom there are reasonable grounds for considering that they would not seek treatment from a GDP.

9.2.5 Special Care Dentistry

Special care dentistry is defined as the improvement of oral health of individuals and groups in society who have physical, sensory, intellectual, mental, medical, emotional or social impairments or disability or, more often, a combination of these factors. These patients may include some paediatrics, homeless people, drug and alcohol users and patients with mental, physical or learning disabilities.

The provision of care for these patients is often more time consuming and complex and issues of informed consent can present an additional challenge. GDP's and other health care professionals will commonly refer patients with more specialist needs and these patients are triaged via the Dental Referral Bureau. There are many factors that are likely to add to both the need and demand for Special Care Dentistry. These principally relate to changes in the demography of the population, public values and expectations, reconfiguration of health services delivery and dental service developments. (British Society for Disability and Oral Health, 2006)

Special care patients can require the use of a variety of treatment modalities including the use of cognitive behaviour therapy, behaviour management, inhalation sedation, intravenous sedation and treatment under general anaesthesia. Within the OSPCDS special care patients are seen and treated by all the dentists. There are three specialists in special care dentistry working within the service who provide treatment for more special care patients with more complex needs.

9.2.6 Oral Surgery

The salaried service provides minor oral surgery in primary care for patients who are eligible at 3 sites in Oxfordshire. It includes a patient examination, diagnosis, investigation, management, treatment and after care as appropriate. The service is also responsible for the triage of Oral Surgery referrals: identification of those patients suitable for treatment within this service, those patients requiring secondary care and those able to be treated under the standard GDS contract.

In 2009/2010 there were 3957 referrals received for oral surgery and oral medicine and of these 1641 were deemed appropriate for treatment within Primary Care. The remainder were sent for treatment in Secondary Care predominantly at the John Radcliffe Hospital.

Within the Salaried service a team of two Oral Surgery Specialists carried out 203 sessions of care and 1323 patients were seen assessed and treated. This compares to 171 sessions of Minor Oral Surgery provided in primary care in 2008/2009 where 1114 patients were treated. In July 2010 waiting times for treatment were 11 weeks East Oxford and 22 weeks Banbury.

9.2.7 Restorative Dentistry

Restorative Dentistry is concerned with the restoration of diseased, injured or abnormal teeth to normal function and includes the mono-specialities of:

- Periodontics (diagnosis and treatment of diseases of the gums and tissues supporting teeth)
- Endodontics (includes root canal treatment)
- Prosthodontics (provision of crowns, bridges and dentures)

Many aspects of restorative dentistry should be routinely managed in primary care by GDPs, but where patients present with more complex problems referral to a more specialist service maybe indicated.

An Advanced Restorative Dentistry Service is provided by the Salaried Primary Care Dental Service at East Oxford Health Centre. The service operates from East Oxford Dental Clinic, 2 days a week and is commissioned by the PCT to provide: a triaging service for advanced restorative dental referrals, advice, diagnosis and treatment for referred patients for dental practitioners. In addition the service offers supervision and provision of treatment to patients requiring advanced restorative care including:

- complex periodontics (gums),
- endodontics (root canal treatment)
- fixed prosthodontics (crowns and bridges)
- removable prosthodontics (dentures)

In the 2007/2008 year 368 patients were seen by the service for restorative dental treatment and advice to practitioners. The service has the capacity to see 140 new patients per year (12 a month) and 720 contacts or equivalent to 164 sessions.

Since 2007/2008 demand has increased and the service receives in the region of 40 new referrals each month; just over half of these are for root treatments that are beyond the skills of most general dental practitioners. Many overseas dentists do not have experience in the provision of endodontic treatments. Most patients will need two appointments of up to 90 minutes each to complete the treatment for a single tooth. Many PCTs do not have such a service and patients either have the option for an extraction or private endodontic treatment. Other PCTs often refer their patients who have challenged their lack of service provision to the NHS service in Oxfordshire.

By April 2010 there were almost 200 patients with booked appointments until September 2011. The PCT is currently exploring a proposal to develop dentists with a special interest in Endodontics to make full use the skills and competencies of the local workforce and enable the development of a managed clinical network to develop audits and measure outcomes for patients of endodontic treatment.

9.2.8 General anaesthetic and sedation services

Dental sedation is the procedure of relaxing dental patients using drugs without inducing the complete loss of consciousness. Sedation services are currently offered at 5 sites across Oxfordshire. Dental sedation maybe used due to levels of high patient anxiety and as an alternative to a General Anaesthetic (GA).

In 2007/2008, there were 253 courses of treatment recorded for sedation and in 2009/10, there were 289. The primary care sedation service for both Inhalational Sedation and Intravenous Sedation has been expanded dramatically and helps reduce the necessity for patients both children and adults to be treated under GA. From 385 contacts in 2007/8, rising to 666 contacts in 2008/9 with the launch of a comprehensive IV service, in the last year 2009/10 there was 832 contacts on 487 patients.

Procedures under general anaesthetic take place at the Churchill Hospital (Oxford) and the Horton (Banbury). The table below shows the number of patients treated by the salaried dental service under GA. In 2009/10 541 children and 80 adults were treated under general anaesthesia.

Table 7: Number of primary care procedures under general anaesthetic 2007-2010

	Children	Adults
2007/2008	448	65
2008/2009	486	54
2009/2010	541	80

Source: Oxfordshire Salaried Primary Care Dental Service

9.2.9 Paediatric Dentistry

The dental speciality of Paediatric Dentistry aims to provide specialist knowledge and experience in the oral and dental care of children, including anxious children and those with special medical or dental need. This includes children with behavioural disorders, autistic spectrum disorder, cerebral palsy, severe learning difficulties, heart disease, bleeding disorders, malignant disease etc. Paediatric dental specialists accept referrals and provide care for many children primary care general dental practitioners are unable to treat and in Oxfordshire are employed by the salaried dental service as a community based specialist but with links to hospital based clinical teams eg cleft palate teams, organ transplant teams and genetic teams They also provide specialised behavioural management techniques and provide dental sedation and care under general anaesthesia as well as a role in educating other dental professionals and providing support and advice as a consultation service to the General Dental practitioners.

In addition Primary Care Paediatric specialists support the wider health care team including paediatricians, surgeons and other key health care professionals and effectively link the speciality from primary to secondary care seamlessly.

9.2.10 Domiciliary Services

Domiciliary care is provided by the Salaried Dental Service for housebound patients who are unable to obtain care from general dental practitioners. In 2008/2009, there were 347 domiciliary visits by the service and in 2009/2010 this had risen to 390. New domiciliary referrals also increased in the same period from 89 to 152.

9.2.11 Oral Health Promotion

PCT commissions the Salaried Dental Service to provide an Oral Health Promotion Service (all ages) across Oxfordshire. The Oral Health Promotion team consists of three staff members working 2 wte in total.

The team works in partnership with other professional groups across the county to implement the **Oral Health Promotion Framework** which has been agreed between the service and the PCT. This framework includes both clinical and non clinical aspects of oral health promotion targeting those populations with the poorest oral health.

The areas of work covered by the framework include:

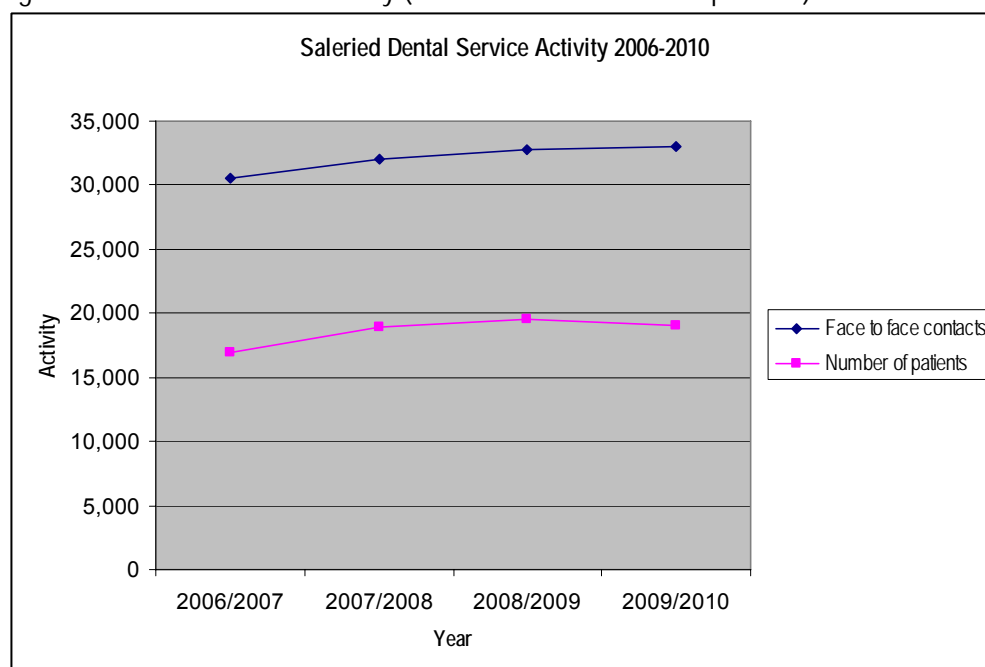
1. Improving diet and reducing frequency of sugar intake
2. Encouraging preventative dental care by appropriate oral hygiene
3. Increasing fluoride exposure
4. Reducing smoking and alcohol misuse
5. Reducing dental trauma
6. Early detection of mouth cancer

9.2.12 General Activity and Performance

In 2009- 2010 there were 7511 dental referrals via the dental referral bureau, of which 4786 were triaged to the OSPCDS, 2316 were triaged to secondary care and 409 were inappropriate referrals. In comparison, in 2008/2009 there were 3639 referrals via the dental referral bureau, of which 520 were inappropriate referrals. A comparison of referrals to secondary care between both years is not available. This increase in referrals reflects the introduction of the Dental Referral Bureau, the aim of which was to introduce demand management of referrals into secondary care. As a result more patients are now being treated in primary care and the number and proportion of inappropriate referrals appears to be falling.

The graph below shows general activity by the salaried dental service from 2006-2010. The number of face to face contacts and the number of patients seen by the salaried dental service increased between 2006/2007 and 2008/2009. The figures for the number of patients represent the number of new patients seen during the financial year. They do not include patients that are already known to the service and have been seen previously.

Figure 33: Salaried service activity (face to face contacts and patients) 2006-2010



Source: Oxfordshire Salaried Primary Care Dental Service

Performance data from the Salaried Dental Service show that the number of service contacts and first contacts has increased over the last two years, although the number of new patients has remained consistent.

Table 8: Salaried service performance data 2008-2010

Salaried Service Data	Year	
	2008-9	2009-10
No of contacts	32916	34733
First Contact	28468	30511
New Patients	8551	8535
DNA's	4723	4559
Cancellations	9624	8082
Average waiting time (non emergency)	2.75 weeks	2.7 weeks

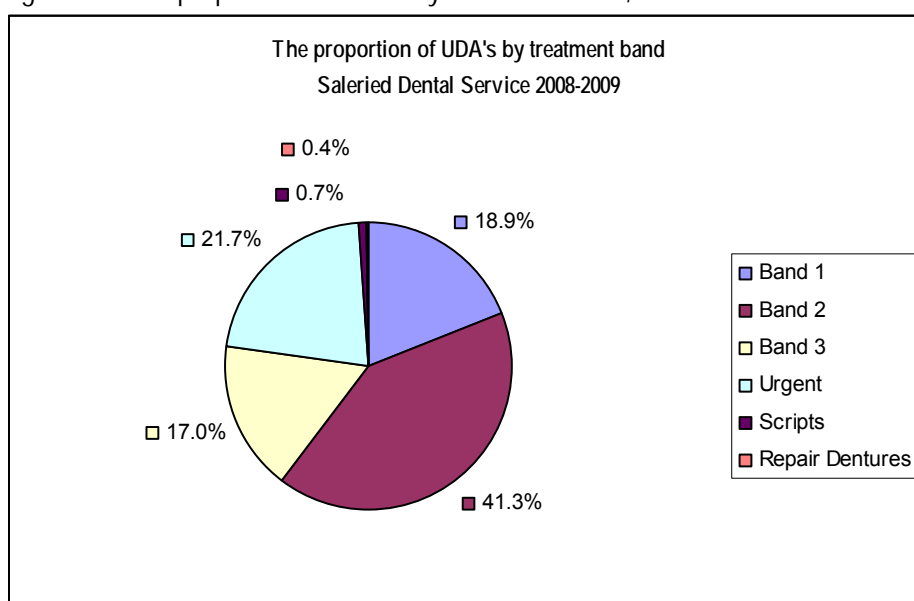
Source: Oxfordshire Salaried Primary Care Dental Service

DNA's and cancellations have also fallen in number and as a proportion of the service contacts, 44% down to 36%. The average waiting time for a routine appointment with the salaried dental service in 2009/2010 was 2.7 weeks and 24 hours for an urgent appointment.

Recommendation: Actions should be taken to reduce DNA's and cancellations to ensure the service is fully utilised.

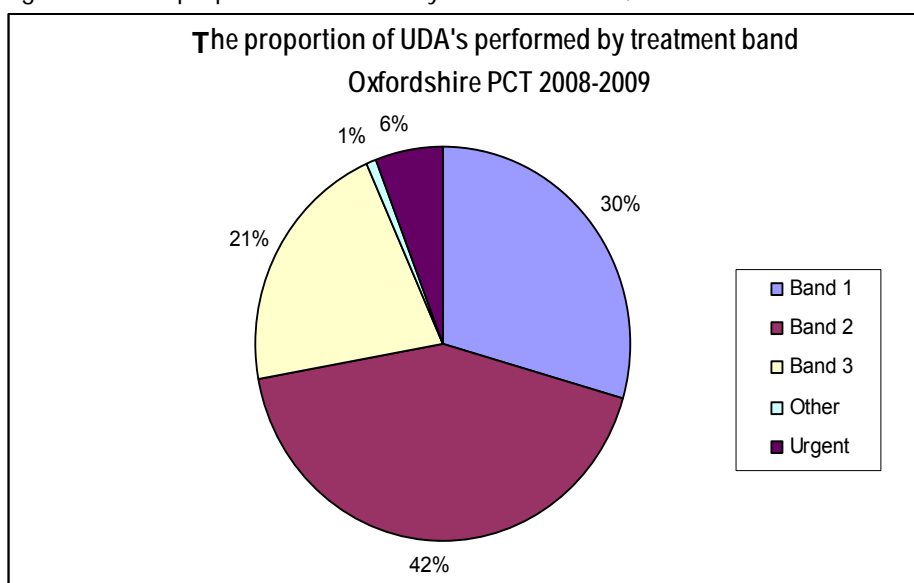
The salaried services also report units of dental activity by UDA Band. The chart below indicates that the greatest proportion of UDA's in 2008/2009 were in Band 2, followed by urgent care and Band 3. Compared with data for all providers in Oxfordshire, the salaried service performs fewer Band 1 treatments and significantly more Band 3 treatments. This confirms the view that patients under the care of salaried service will have higher oral health needs, are more complex to treat and will require more specialist treatment and support than the majority of patients being seen by GDP's.

Figure 34: The proportion of UDA's by treatment band, Salaried Dental Service 2008-2009



Source: Business Service Authority, Dental Services Division

Figure 35: The proportion of UDA's by treatment band, Oxfordshire PCT 2008-2009



9.2.13 Primary Care Orthodontics

Orthodontics is the branch of dentistry concerned with the development and management of irregularities and abnormalities of the teeth, jaws and face. Its aim is to produce a healthy functional bite, creating greater resistance to disease and improving personal appearance.

There are currently eight primary care Orthodontic Providers who receive referrals from GPs for assessment and if appropriate orthodontic treatment with braces etc. Within the OSPCDS there is an orthodontic specialist based at Banbury Dental Clinic that provides a service four days per week. The remaining orthodontic specialists are based within the GDS.

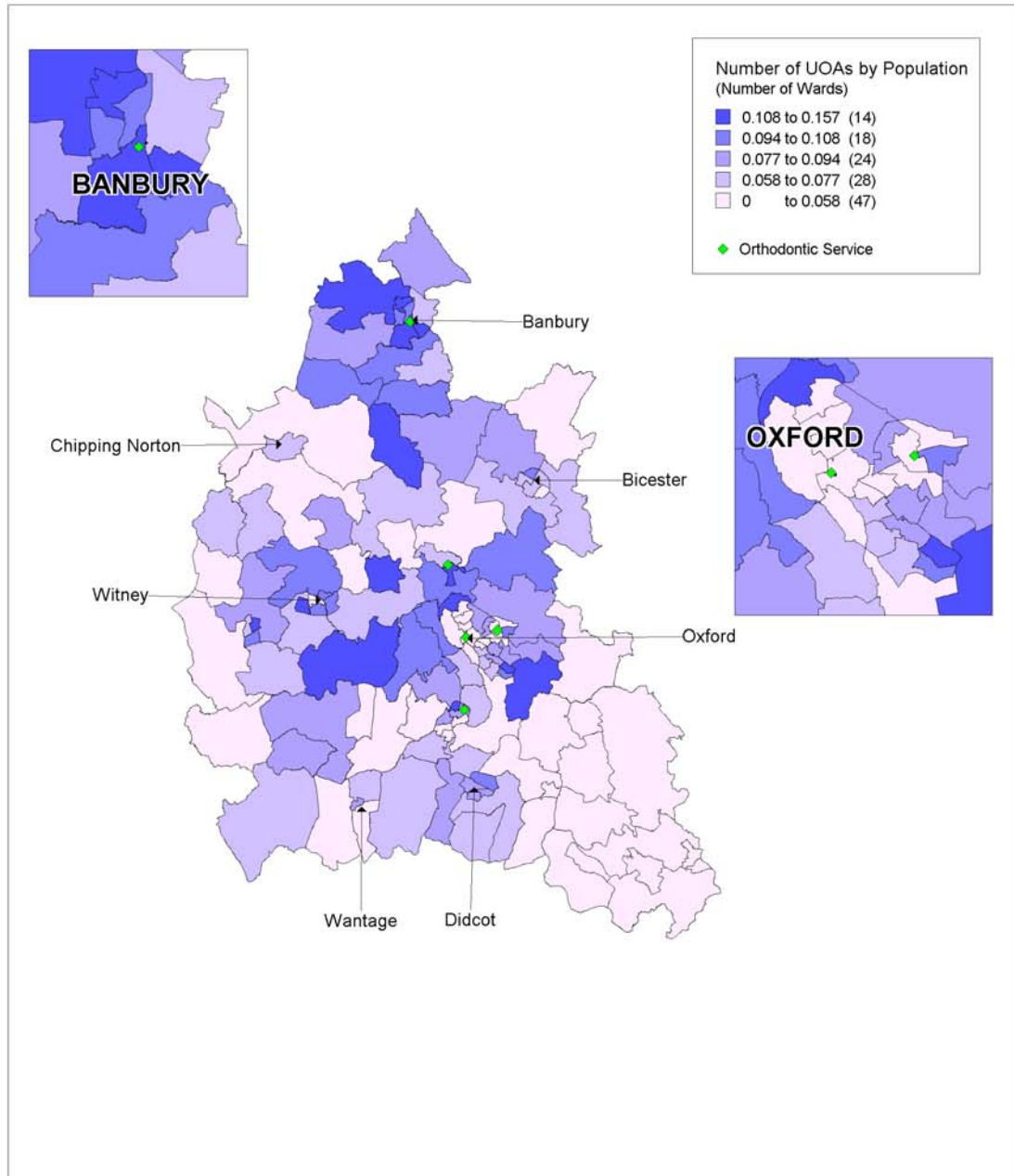
Following national guidance the PCT only routinely commissions treatment from orthodontists for patients with an Index of Orthodontic Treatment Need (IOTN) of 4 or 5, in line with Priorities Forum policy 96 - Orthodontic thresholds February 2007. For those below this score the PCT reviews patients on an individual case review basis.

In 2008-2009 the PCT contracted 40,595 Units of Orthodontic activity, a slight reduction from the previous year 2007-2008 (41,060). In 2009-2010, this had risen to 58,518. (Table 9). In 2009-2010, 8,651 patients were treated in Oxfordshire. Figure 36 shows units of orthodontic activity by ward population. Areas in and around Banbury and Abingdon have a higher proportion of activity when compared with some areas of Oxford City. Many rural wards in South & West Oxfordshire have very little orthodontic treatment per head of population.

Table 9: Primary Care Orthodontic Activity 2008- 2010

Orthodontic Patients	2008-2009	2009-2010
Patients treated	8,045	8,651
Orthodontic activity (UOA)	40,595	58,518
Orthodontic activity scheduled(UOA)	42,776	48,831
Assess and Accept / start treatment Number of Patients	1,830	2,094
Assess and Refuse Number of Patients	908	865
Treatment Completed Number of Patients	1,434	1,568

Units of Orthodontic Activity by Ward Population 2009-10



Mapping produced using AA and 2001 Census data with licenced permission. Crown Copyright 2003.
 UDA and UOA by Ward using E-Reporting extract.
 Ward population using ONS Projections.
 Health Informatics & Intelligence. OHNA. 092010. IF.

Figure 36: Units of Orthodontic Activity by ward population 2009-2010

9.2.14 Prison Dentistry

HMP Huntercombe is a young offender's institution and has capacity for 360 young people from 15 to 18 years of age. The prison provides two dental clinics per week (2 days), staffed by a dentist and dental nurse. A Health Needs Assessment in 2008 found that young people had to wait an average of 4 days for an urgent appointment and 10.5 days for a non urgent appointment with the Dentist. From 18th of October 2010 HMP Huntercombe will become an adult male (over 25's) category C prison with capacity for 350 inmates.

Bullington Prison operates jointly as a local and category B/C training prison for adult males. The prison has the operational capacity for 963 prisoners and takes in approximately 4650 new arrivals per year. The prison has its own health care cover with an establishment of 23 beds.

A Health Needs Assessment of Bullington Prison in 2008 found that poor dental health was one of the most frequent health problems observed amongst prisoners. While it was acknowledged the dental service at the prison provided good oral health advice, the capacity of the service to extend its OHP function was limited. The report recommended that:

- The dental contract should be enhanced with increased treatment, oral health promotion and admin capacity
- There should be oral health promotion cascade training for staff and prison health trainers
- There should be an automatic dental triage for prisoners seen by the GP requiring analgesia or antibiotics for dental health problems
- Improvements to internal data systems and processes

Table 10: Number of dental patients in Oxfordshire prisons per annum

	2006-2007	2007-2008	2008-2009	2009-2010
HMP Bullington	626	Not available	713	765
HMP Huntercombe	600	Not available	660	400

Source: Oxfordshire PCT

Recommendations:

- The PCT should ensure that the recommendations from the previous health needs assessment in HMP Bullington have been implemented
- The new dental contract at HMP Huntercombe should include provision for improving oral health and managing high need patients in addition to sufficient treatment available for those who need it
- There should be provision of oral health promotion training in both prisons to healthcare staff and oral health promotion cascade training for other appropriate staff (such as drug or addiction workers) and prison health trainers

9.3 Secondary Care

9.3.1 Hospital Dental Services

The principal hospital dental specialties are orthodontics and oro-maxillofacial surgery. Other specialties provided in hospital may include paedodontic and restorative dentistry. All referrals into secondary care are now subject to the 18-week rule. The Operating Framework for the NHS 2009 - 2010 still has as one of its targets: Improving access through achievement of the 18-week referral to treatment pledge. These principles apply to pathways that involve or could potentially involve care led by a dental consultant. This includes oral surgery, orthodontics, paediatric dentistry, periodontics, prosthetics, endodontic oral medicine, and dental and maxillofacial radiology.

To support the demand management focus of the PCT all referrals to secondary care, other than accident and emergency admissions OOH's, are now triaged by the Dental Referral Bureau. The aim of this is to manage patients where possible outside of secondary care settings.

9.3.2 Oral and Maxillofacial Surgery Services (OMFS)

The majority of inpatient activity takes place at the Oxfordshire Radcliffe Hospitals Trust. Oral and Maxillofacial Surgery represents the biggest proportion of activity (Table 11).

The Department of Oral and Maxillofacial Surgery at the ORH offers a comprehensive service relating to conditions of the face, mouth and jaws, including a routine assessment and treatment service for common oral surgical conditions. The OMFS departments see patients requiring more complex care who are triaged by the Dental Referral Bureau, but also via the accident and emergency route. This includes reconstruction of the mouth and jaws, oral cancer, treatment of patients with cleft lip and palate and facial trauma.

Table 11: Inpatient activity (oral surgery, paediatric dentistry and maxillofacial surgery) for residents of Oxfordshire PCT 2009/2010

Provider Trust	ORAL SURGERY	PAEDIATRIC DENTISTRY	MAXILLO-FACIAL SURGERY	Total Activity
OXFORD RADCLIFFE HOSPITALS NHS TRUST	1171		53	1224
ROYAL BERKSHIRE NHS FOUNDATION TRUST	48			48
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	13			13
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	2	1	4	7
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	8		2	10
BUCKINGHAMSHIRE HOSPITALS NHS TRUST	14			14
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2	1		3
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	6			6
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	2			2
ROYAL SURREY COUNTY NHS FOUNDATION TRUST			4	4
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4	1		5
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2			2
Other	36		15	51
Grand Total	1308	3	78	1389

Source: SUS (U_R) 30/06/2010

Table 12: Inpatient activity (oral surgery, paediatric dentistry and maxillofacial surgery) in Oxfordshire 2007–2010

Inpatient Activity	ORAL SURGERY	PAEDIATRIC DENTISTRY	MAXILLO-FACIAL SURGERY	Total Activity	Total Cost
2007/8	1611	7	33	1651	£1,709,916
2008/9	1503	2	56	1561	£1,636,204
2009/10	1308	3	78	1389	£1,660,149

Source: SUS (U_R) 30/06/2010

Table 12 shows that inpatient activity for paediatrics and oral surgery has fallen since 2007, however, maxillo-facial surgery has increased. The fall in oral surgery inpatient activity reflects the increase in the amount of minor oral surgery being carried out in primary care.

Despite a fall in overall inpatient activity of 16% annual cost has only fallen by £49, 767 or 3% over the 3 years.

Table 13 below gives a breakdown of the inpatient activity by most common procedures in 2009/2010.

Oral surgery represents a significant proportion of hospital inpatient activity, the majority of which are intermediate mouth procedures on adults (over 19) and young people (under 19). There are very few paediatric admissions as most of this work is carried out by the paediatric team in primary care. The data show that there has been an increase in maxillo facial surgery over the three years and this may be due to a number of reasons, many of which may not be due to oral health problems or conditions i.e. reconstructive surgery following head & neck injuries. However, this increase should be investigated and understood further.

Oral Surgery and Orthodontics represent the biggest proportion of outpatient activity and outpatient activity represents a cost of nearly £2.3 million to the PCT. (Table 14). The majority (85%) of outpatient activity also takes place at the Oxfordshire Radcliffe Hospitals Trust. (Table 15).

The data show that there has been an increase in maxillo facial surgery over the three years, while overall inpatient activity has fallen. Despite the fall in inpatient activity, inpatient costs fell and then increased in 2009/2010.

Recommendation: Ensure local specialist and secondary care services are audited regularly to assess quality and value for money.

Table 13: Inpatient activity by most common procedures in 2009/2010

HRG code	HRG Description	ORAL SURGERY	RESTORATIVE DENTISTRY	PAEDIATRIC DENTISTRY	MAXILLO-FACIAL SURGERY	Total Activity
CZ02Y	Intermediate Mouth Procedures 19 years and over...	482	11		13	506
CZ02T	Intermediate Mouth Procedures 18 years and unde...	248		1	3	252
CZ01T	Minor Mouth Procedures 18 years and under witho...	59		1	6	66
CZ17Y	Intermediate Maxillo-facial Procedures 19 years...	54			5	59
WA14Z	Planned Procedures not carried out	51			1	52
CZ02X	Intermediate Mouth Procedures 19 years and over...	50				50
CZ03Y	Major Mouth Procedures 19 years and over withou...	27				27
CZ16Q	Minor Maxillo-facial Procedures without CC	24			3	27
CZ18R	Major Maxillo-facial Procedures 19 years and ov...	24			3	27
JC15Z	Skin Therapies level 3	24			5	29
CZ01Y	Minor Mouth Procedures 19 years and over withou...	22	2	1	1	26
CZ22Y	Intermediate Head, Neck and Ear Disorders 19 ye...	18			3	21
CZ21Y	Minor Head, Neck and Ear Disorders 19 years and...	16			7	23
BZ08A	Orbits / lacrimal category 3: 19 years and over	14			1	15
JC04C	Intermediate Skin Procedures without CC	13			6	19
CZ17U	Intermediate Maxillo-facial Procedures 18 years...	11			2	13
OTHER		171	0	0	19	190
TOTAL		1308	13	3	78	1402

Source: SUS (U_R) 30/06/2010

Table 14: Outpatient secondary care activity appointment time and cost 2009-2010

Provider Trust	ORAL SURGERY	RESTORATIVE DENTISTRY	PAEDIATRIC DENTISTRY	ORTHODONTICS	MAXILLO-FACIAL SURGERY	Total Activity
OXFORD RADCLIFFE HOSPITALS NHS TRUST	7,597	678		5,863	386	14,524
ROYAL BERKSHIRE NHS FOUNDATION TRUST	733			245		978
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	11	151	11	90	9	272
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	22	112	7	13		154
SOUTH BIRMINGHAM PCT	38	92	8	21		159
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	83			43		126
BUCKINGHAMSHIRE HOSPITALS NHS TRUST	67			34		101
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	33	35	10	14	3	95
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	27			27		54
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	5	59	16	15	6	101
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	34			47		81
Other	146	59	4	163	75	447
						0
Grand Total	8,796	1,186	56	6,575	479	17,092

Source: SUS (U_R) 30/06/2010

Table 15: Outpatient activity analysis by Provider and Speciality 2009-2010

Treatment Function	1st Attendance	Follow Up Attendance	Total Activity	Total Cost
ORAL SURGERY	4819	3977	8796	£1,072,536
RESTORATIVE DENTISTRY	282	904	1186	£183,491
PAEDIATRIC DENTISTRY	7	49	56	
ORTHODONTICS	941	5634	6575	£962,986
MAXILLO-FACIAL SURGERY	339	140	479	£56,756
Grand Total	6388	10704	17092	£2,275,769

Source: SUS (U_R) 30/06/2010

9.3.3 Orthodontics

For patients who are referred to secondary care The Orthodontic Department at the ORH offers a comprehensive orthodontic service for Oxfordshire and the surrounding area, including a joint restorative clinic, a joint orthognathic clinic, cleft and craniofacial clinics. Oxford is a regional centre for cleft lip and palate, and is one of four craniofacial units.

A variety of conditions are treated, including:

- severe malocclusions
- interceptive orthodontics
- impacted teeth
- hypodontia
- cleft lip and palate
- craniofacial anomalies

Table 16 below illustrates the units of Orthodontic activity in secondary care between 2007-2010. In 2009 -2010 the ratio of First Appointments to Follow Ups for secondary care orthodontics was 1:6; this compares to ratios of 1:9 and 1:10 of First Appointments to Follow Ups in 2007-2008 and 2008-2009 respectively.

Table16: Secondary Care Orthodontic Activity 2007-2010

Treatment Function	1st Attendance	Follow Up Attendance	Total Activity	Total Cost
ORTHODONTICS (2007-2008)	600	6074	6674	£921,437
ORTHODONTICS (2008-2009)	655	6069	6734	£930,887
ORTHODONTICS (2009-2010)	941	5634	6575	£962,986

Source: SUS (U_R) 30/06/2010

Table 17: Secondary Care Orthodontic Activity by Provider 2010

Provider Trust	ORTHODONTICS
OXFORD RADCLIFFE HOSPITALS NHS TRUST	5,863
ROYAL BERKSHIRE NHS FOUNDATION TRUST	245
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	90
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	13
SOUTH BIRMINGHAM PCT	21
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	43
BUCKINGHAMSHIRE HOSPITALS NHS TRUST	34
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	14
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	27
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	15
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	47
Other	163
Grand Total	6,575

Source: SUS (U_R) 30/06/2010

The majority of patients (89%) are treated by Oxfordshire Radcliffe Hospitals Trust at a cost of £962,286 per annum. Although the number of patients has fallen since the previous year, costs have increased.

Recommendation: The change in the ratio of 1st appointment to follow up and 43% increase in 1st attendances in 2009/2010 from the previous 2 years may warrant further investigation.

9.3.4 Restorative

Restorative dentistry involves the care of patients who require the restoration of the oral and dental tissues. Priority is given to certain patient groups, namely congenital cleft lip and palate, craniofacial and oncology. The Orthodontic department at the ORH is specialist in the following areas:

- Fixed and removable prosthodontics
This deals mainly with the prosthetic replacement of hard and soft tissues using crowns, bridges, dentures and implants, such as post cancer/radiotherapy, management of cleft lip and palate defects, severe hypodontia (more than six congenitally missing teeth) and treatment of severe tooth wear
- Periodontology
This includes the treatment of patients with severe gum disease, bone and soft tissue grafting around teeth and dental implants, and drug-induced gingival overgrowth
- Endodontics
The branch of dental sciences dealing with health, injuries to and diseases of the pulp and periradicular region and their relationship with systemic well-being and health

Restorative dentistry accounts for approximately £180k (8%) of the secondary care dental budget and 43% of patients are seen outside of Oxford (predominately at London Hospitals). There is also capacity in Advanced Restorative Dentistry Service in primary care for 140 new patients per annum however; waiting times for restorative services in primary care currently exceed 60 weeks.

Table 18: Secondary Care Restorative Activity 2007-2010

Treatment Function	1st Attendance	Follow Up Attendance	Total Activity	Total Cost
RESTORATIVE DENTISTRY 2007-08	318	830	1148	£176,044
RESTORATIVE DENTISTRY 2008-09	274	788	1062	£150,079
RESTORATIVE DENTISTRY 2009-10	282	904	1186	£183,491

Source: SUS (U_R) 30/06/2010

Table 19: :Secondary Care Restorative Activity by Provider 2010

Provider Trust	RESTORATIVE DENTISTRY
OXFORD RADCLIFFE HOSPITALS NHS TRUST	678
ROYAL BERKSHIRE NHS FOUNDATION TRUST	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	151
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	112
SOUTH BIRMINGHAM PCT	92
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	
BUCKINGHAMSHIRE HOSPITALS NHS TRUST	
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	35
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	59
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	
Other	59
Grand Total	1,186

Source: SUS (U_R) 30/06/2010

Recommendation: Ensure local specialist and secondary care services are audited regularly to assess quality and value for money.

10 Prevention Services

10.1 Oral Health Promotion Service

PCT commissions the salaried dental service to provide an Oral Health Promotion Service (all ages) across Oxfordshire.

The team works in partnership with other professional groups across the county to implement the **Oral Health Promotion Framework** which has been agreed between the service provider and the PCT. This includes clinical and non clinical oral health promotion which targets those populations with the poorest oral health.

10.2 High Needs and Oral Health Promotion Pilots

The PCT also commissioned the following work in 2010-11:

- An oral health improvement programme including the topical fluoride application in schools (pilot study to be delivered in two schools in Oxfordshire over 2 years)
- A Drugs and Alcohol users oral health improvement study in conjunction with the DATT
- A pilot to assess the current levels oral health knowledge amongst care staff and of dental disease and subsequent treatment needs across a sample of dependent elderly residents in care home facilities in Oxfordshire
- A pilot to assess the current levels of oral health knowledge amongst care staff and of dental disease and subsequent treatment needs across a sample of learning disability residents living in care and in the community
- A high needs pilot across 16 practices to identify & treat high needs patients, using a traffic light system to monitor patient's progress toward improved oral health outcomes.

10.3 Water fluoridation

Work with NHS South Central and other neighbouring PCTs, to assess the feasibility of water fluoridation has been put on hold awaiting the outcome of the judicial review in Southampton before developing an options paper. There has been other work to increase exposure to fluoride including, promoting the use of topical fluoride application in primary care, campaigns to raise public awareness and the pilots identified above.

Recommendation: Review oral health promotion services and programmes to ensure they are effective

11 Public Voice

11.1 National Surveys

11.1.1 Dentistry Watch

In 2007, the Commission for Patient and Public Involvement (PPI) in Health conducted a national survey to find out what patients think about NHS dental services. Members from local Patient and Public Information Forums asked a total of 5,212 patients for their views on crucial issues regarding dental services between July and September 2007. The *Dentistry Watch* report was published in October 2007.⁷⁸ The main findings of this survey were that:

- 93% of NHS patients were happy with the treatment they received
- Almost a fifth of patients had gone without treatment because of the cost
- Almost half of all NHS patients did not understand NHS dental charges
- 78% of patients using private dental services were doing so because either their dentist stopped treating NHS patients (49%), or because they could not find an NHS dentist (29%)

In the local area PPI Forum members handed out questionnaires in ten market towns in Oxfordshire during October 2007 as part of the national Dentistry Watch report. There were 384 responses, most of them fully completed. The towns surveyed were: Wantage, Grove, Faringdon, Witney, Henley, Abingdon, Burford, Didcot, Wallingford, and Goring (all in the south of the county). A summary of the local results is below:

Status: 54% were private patients, 30% NHS and 16% were not registered with a dentist

Length of time using current practice: 68% had been with their present practice for more than 2 years

Waiting for a NHS place: Most people did not have to wait to get on a list

Frequency of visits: 81% saw their dentists every six months, and 81% had to travel under five miles to get there, 3% travelled over 100 miles to see an NHS dentist

Satisfaction: 90% of those surveyed were happy with the treatment they had received, and 85% preferred to see the dentist they had previously seen

Reasons for not using the NHS: 62% of people not registered said there were no available NHS dentists near where they lived

Reasons for using private care:

- 9% thought it gave better treatment
- 51% said they wanted to stay with their dentist even though he/she went private
- 48% said they could not get an NHS dentist

Emergency treatment: Half the respondents were uncertain about knowing where to go for emergency treatment, but many had been to their GP or dentist with dental pain. 93% said they had never gone to A & E with dental problems.

Complaints: 78% did not know how to complain and most had never complained; but of those that did, 73% did not get a satisfactory answer.

Children's dental services: Although a larger proportion of children than adults were having NHS care, there was great concern about the availability of orthodontics, and the access to the service. Treatment in the private sector was seen to be very expensive and there was a strong feeling that children were not always having orthodontic treatment when they needed it for their future dental health.

Charges in NHS dentistry: No obvious concern was expressed about the possibility that Practitioners would run out of money before the end of the year.

- 97% of respondents reported that this was not a concern
- 30% of respondents did not know whether or not charges were displayed in their surgeries
- 80% paid less than £100 per year for their treatment
- 66% did not understand how charges were applied and therefore could not know whether they were getting value for money. Cost had not been a deterrent from seeking treatment, although treatment had sometimes been delayed for that reason

Charges in private dentistry: For 59% of respondents the average costs were over £150 per year with 40% paying over £200 per year. There was a general concern about what is perceived as over charging for private dentistry. The question of costs is a constant theme in the comments made. Market forces do not seem to apply in this matter, and costs are very variable.

11.1.2 Patients Association Report

The Patients Association published their report, *The New Dental Contract - Full of Holes and Causing Pain*,⁷⁹ on the new dental contract in March 2008. A questionnaire was sent by the Patients Association to the Chairman and Dental Commissioner of each of the 150 PCTs in England on 5th October 2007. Answers were requested under the Freedom of Information Act by the 28th November, 2007. The questionnaire was divided into 5 sections – funding, access to NHS treatment, orthodontic treatment, dentists, and general comment. 112 were completed and returned by PCT's.

The report found the following:

- The NHS dentistry service provided by PCTs varies from PCT to PCT creating a 'postcode lottery'
- Patients are confused about how to access dental services in their locality
- Patients are at risk of inadequate care because 'UDAs, rather than patient need, is being funded
- Prevention of oral disease is at risk under the new contracting system

11.2 Local Surveys

Patient Satisfaction Questionnaires

As part of its Risk Management role the Dental Services Division of the NHSBSA writes to a random sample of (primary care) patients asking them to complete a brief questionnaire. The responses inform the monitoring of the quality and integrity of NHS dentistry services at both a local and national level. The PCT receives a summary report of the results of the questionnaires on a quarterly basis.

Up to March 2010, 990 patients in Oxfordshire had responded to the national patient questionnaire for 2009/10 and 91.5% of them reported being satisfied with the treatment they had received. In the same year, 88.9 % reported that they were satisfied with the time they had to wait for an appointment.

Oxfordshire Oral Health Needs Assessment Survey (August 2010)

An oral health needs survey was developed as part of this piece of work to ask people in Oxfordshire (their carers or parents), about the dental care they have received over the past few years; whether they could access an NHS dentist; dental hygiene and habits affecting oral health.

The survey was publicised on 'Talking Health', the PCT's online consultation tool which is available on the PCT's website. This enabled patients to answer the survey on line and also add in any additional comments. Paper copies of the survey were also received and included into the online consultation tool. The survey was publicised in the media, through dental surgeries, libraries and PCT staff attended community settings to share information and collate feedback. It was also communicated via the Staff Bulletin and on the PCT's intranet page.

A full report, including the survey questions is available as Appendix C.

Results Summary:

- 332 patients responded to the survey
- The majority of patients felt that dental checks were important to have teeth checked for cavities, or to detect or prevent gum disease
- Pain/sensitivity to hot and cold food or drinks was the biggest problem that patients were experiencing
- Patients stated the following reasons why they could not access an NHS dentist in their area:
 - *There is only emergency treatment available*
 - *I cannot afford treatment*
 - *The waiting list is too long*
 - *My NHS dentist went private*
 - *Some patients in the Chinese community experienced difficulty due to the language barrier*
 - *Prisoners on remand only receive emergency dental treatment*
- Respondents felt there were not enough NHS dentists in the following areas: Banbury, Chinnor, Chipping Norton, Henley, Oxford, Wallingford, Wantage and Witney
- Patients would either call NHS Direct or go to their local hospital to receive emergency treatment
- The majority of patients used fluoride toothpaste however, they did not know how much fluoride (ppms) it contained
- The majority of patients who wore dentures used toothpaste to clean them regularly

Oxfordshire Oral Health Needs Assessment Survey - Ipsos MORI's report

As part of this work the PCT also commissioned Ipsos MORI's to explore the experiences and needs of three distinct groups across Oxfordshire. These were identified as groups whom were harder to reach as part of the consultation process:

- people with learning difficulties
- BME residents, namely Bangladeshi, Pakistani and new Polish migrants; and
- Gypsies and travellers

In line with the patient survey, this qualitative project focused on exploring people's experiences and needs in relation to:

- their dentist (regularity, experience, reason for visit)
- condition of their teeth (problems and barriers to treatment);
- access to dental care (ease of access, experience and barriers to service)
- how they care for their teeth (including potentially damaging diet and lifestyle choices) and
- dentures (where applicable)

Fieldwork took place in Oxfordshire between 16 June and 5 July 2010. One to one face-to-face interviews were carried out with all participants. All interviews were carried out in the participant's homes except in the case of those with learning difficulties where research took place at the City Day Service in Albion House, Oxford. A full report from this research is available as Appendix D.

Results Summary:

People with learning difficulties

- People with learning difficulties, in line with many others across this research, would only go to the dentist when they had experienced pain and not simply for a check up or visit to the hygienist.
- They experienced problems with their teeth as many people had fillings and some had missing teeth or dentures but were less likely to report problems.
- Overall, access to dentists is good as most people were registered with a regular dentist.
- Many people with learning difficulties did not take very good care of their teeth. Several people brushed their teeth just once a day and one just once a week. Many people also enjoyed sweet drinks and foods. In addition, most people do not go for regular check ups.
- Most people were aware of the importance of taking care of one's teeth but often forgot when they were alone or away from day care or respite carers.

BME residents, namely Bangladeshi, Pakistani and new Polish migrants

- Most of the Bangladeshi and Pakistani participants were currently registered with dentists as they had happened to have recent treatment. Prior to this many of them, particularly older people had not previously been registered with a dentist
- They tended to be less likely to have a regular dentist or see the importance of check ups. This was a common finding across the research, but was particularly pronounced amongst Bangladeshi and Pakistani participants
- People's teeth tended to be in good condition with no one reporting any current problems. Culturally, people tended to avoid sugar foods and drinks (especially older people) which may help to explain the good quality of people's teeth
- Most people took good care of their teeth through regular brushing and avoiding sugar foods and drinks. There was something of a generational divide with older people being more likely than the young to see a strong link between sugary foods and poor teeth
- Overall, Pakistani and Bangladeshi people had a number of positive factors supporting seemingly good standards of oral health: diet, lifestyle and regular brushing

BME residents, Polish migrants

- Polish migrants tended to visit the dentist when they experience pain rather than for routine check ups. They did however see routine check ups as important in principle.
- There were no current dental problems but they had had fillings and root canal work in the past.
- Access to dentists was particularly good amongst the two Polish people that were interviewed. Their level of spoken English was good and they could easily find themselves a dentist if required.
- The research suggested that new Polish migrants may well be registered with a dentist in the UK but perhaps return to Poland for treatment if this is convenient to them. They viewed treatment in Poland as preferable as it was cheaper and often perceived as superior to treatment on the NHS in the UK.
- There seems to be good awareness of the link between certain foods, drink and habits and poor dental hygiene. In part, this is due to formal education and fluoridation treatment they received at school.
- However, the two people interviewed for the study mentioned that they had adopted more westernised attitudes to sugary foods, drink, alcohol and cigarettes since moving to the UK. In

addition, brushing their teeth could be irregular as a result of the long hours and shift work our participants tended to be engaging in.

Gypsies and travellers

- Akin to other groups in the research gypsy and travellers tended to use dentists only when they needed treatment for something specific and were less likely to be registered with a practice. They are likely to be in some pain before they start thinking about finding a dentist
- Gypsies and travellers mentioned that access to a dentist was a problem. In general, few people knew where to access services and were unsure about the closest dentist to them. Several had also been 'barred' from former dentists for missing appointments, further decreasing their access to local dentists.
- Some people had no problems with their teeth. Many others had dental problems, only some of which were currently being treated. We found people with badly stained teeth, missing teeth, painful teeth and a man currently getting dentures fitted. Taken as a group, gypsies and travellers had the poorest teeth across the research and are something of a cause for concern.
- Many gypsies and travellers brushed their teeth twice a day and some occasionally used mouthwash. Many, however, brushed their teeth infrequently, often forgot or would just brush once a day.
- Women and mothers tended to place a greater importance on dental hygiene and regular treatment both for their own appearance and wellbeing and that of their children.

12 Recommendations

Improve access to NHS dentistry

- Ensure year on year improvements in the number of patients, particularly from harder to reach groups, accessing local dental services
- Improve the uptake of services from people living in rural areas and explore how best to deliver these services
- Improve data collection to include sex, age, ethnicity of patients accessing NHS services to inform future needs assessment and achieve a more accurate assessment of the service provision for older people and harder to reach groups
- Provide better patient information about what services are available and how to access them
- Target advertising of the dental helpline number and the availability of local NHS dental services more widely in OX4, OX3, OX14, OX2 and OX5 making use of existing services and local community groups and organisations
- Ensure NHS dental practices have access to and make use of language line/translation services

Improve oral health for the local population

- Ensure that commissioned services prioritise prevention as well as treatment
- Actively prevent oral disease through community and practice based prevention
- Disease should be actively prevented in children and vulnerable groups through delivery of fluoride toothpaste and fluoride varnish at a community level
- Dental practices should routinely implement the prevention toolkit *Delivering Better Oral Health*.
- The new dental contract at HMP Huntercombe should include provision for improving oral health and managing high need patients in addition to sufficient treatment available for those who need it.
- There should be provision of oral health promotion training in both prisons to healthcare staff and oral health promotion cascade training for other appropriate staff (such as drug or addiction workers) and prison health trainers
- Continue to undertake epidemiological surveys as part of the DH programme.
- Consider undertaking local epidemiological surveys for example adult dental health surveys to better inform commissioning of dental services

Reduce health inequalities relating to dental care, with a priority focus on children, older people and vulnerable groups

- Tailor commissioned services to local need with special attention paid to harder to reach groups
- Develop interventions which target, older people living in social accommodation or less mobile older people requiring a degree of care to reduce health inequalities and improve access to and use of NHS dental services
- The PCT should ensure that the recommendations from the previous health needs assessment in HMP Bullingdon have been implemented
- Establish closer links for multidisciplinary working, for example ensuring good oral health is a part of drug & alcohol, diet or smoking strategies and interventions as part of a common risk factor approach
- Ensure that oral health is incorporated into the care plans of vulnerable clients and patients

Improve patient experience in dental care

- Ensure that commissioned services are child/family friendly and provide some level of outreach in areas of high need

- Involve carers and/or care services in the dental treatment plans of patients to improve self care and compliance with checkups and appointments etc
- Where appropriate improve access to domiciliary care
- Consult with local support agencies when planning any dental healthcare campaigns or interventions with harder to reach groups – for example Gypsies and Travellers

Get best value and make best use of the dental budgets and make the case for future investment

- Review oral health promotion services to ensure they are effective
- Undertake contractual and clinical reviews of oral and maxillofacial surgery services to ensure they are delivering against agreed acceptance criteria

Develop specialist services and where appropriate develop alternative provision in primary care settings

- Ensure local specialist services such as orthodontics are audited regularly to assess quality and value for money
- Ensure that there is equity of access for all specialist dental services.
- Develop a greater range of specialist or special interest services in community settings, according to population oral health needs e.g. paediatric dentistry and minor oral surgery

FINAL REPORT

**Oral health promotion training pilot for staff working in
nursing and residential care environments for older adults in
Oxfordshire.**

Heather Duignan
Health Improvement Practitioner (Advanced),
Oxfordshire Salaried Primary Care Dental Service

September 2010

Proposed start and finish March 2010 – July 2010

Background

The oral health of older adults living in nursing and residential care environments is known to be poor. Programmes of education and training for care staff have been attempted in other countries and counties with varying degrees of success.

Project aim

The aim of the pilot was to provide accurate and evidence based information to staff involved in improving the oral health of older adults living in 3 nursing/residential care environments.

Design

Sites were selected randomly for an initial survey of nursing and residential home managers. Pilot sites were selected to represent the North, the South and the City. The impact of the programme was evaluated by assessing the effect on knowledge among the nursing and care staff.

Setting

Nursing and Residential care homes in Oxfordshire.

Interventions

A programme was developed for care staff using the experience of Health Improvement Practitioners specialising in oral health and health education.

The programme consisted of:

- A survey of 10% of Managers working in nursing and residential care environments in Oxfordshire to ascertain current attitudes and behaviour
- The selection of 3 pilot sites and a survey of staff involved in oral health care delivery to ascertain current attitudes and knowledge
- Baseline measurements of oral health of older adults resident in the 3 pilot sites
- The provision of 2 in house training sessions to nurses and care staff involved in the delivery of oral care in the 3 pilot sites, offered at flexible convenient times
- The evaluation of post training knowledge retention and training methods immediately following training
- A survey of staff 3 months post training to ascertain post training attitudes and retention of knowledge

Main outcome measures

Key outcomes assessed were:

- Attitudes and behaviour of Managers
- Attitude of care staff
- Knowledge level changes among care staff
- Evaluations of the programme by care staff
- Clinical measurement.

Results

a. *Baseline survey of managers*

A structured initial interview was undertaken between a member of the oral health promotion team and the manager of the home and the following results were obtained. (For detailed results see Appendix 1). Of the 16 nursing and residential care homes:

25%	do not include oral checks in initial assessment on admittance to the home
54%	do not ask the date of the resident's last dental check
31%	do not check whether the resident is registered with a dentist
100%	report assisting residents with teeth/denture cleaning
69%	report using oral sponges to provide oral care
13%	report interdental cleaning of residents' teeth
94%	do not routinely label dentures on admission
50%	report having a written oral care policy
56%	report having a written plan of oral health care for each patient
94%	reported that none of their staff had received oral health care training
100%	believe staff would benefit from training in oral health care
6%	report having no access to dentistry for their residents
75%	report having residents who currently have a dental problems requiring attention
94%	volunteered to take part in the pilot programme

The implications of these results were incorporated into the carer training programme.

b. *Baseline attitude of care staff*

Prior to training care staff were invited to complete a short questionnaire. (For detailed results see Appendix 2). Of the 46 care staff:

39%	believe time constraints influence the oral care provided to residents
35%	believe lack of confidence to provide oral care influences the oral care provided to residents
24%	believe lack of correct equipment influences the oral care provided to residents
26%	believe that resistance from the resident influences the oral care provided to them
41%	believe training would help them to care for residents' oral health

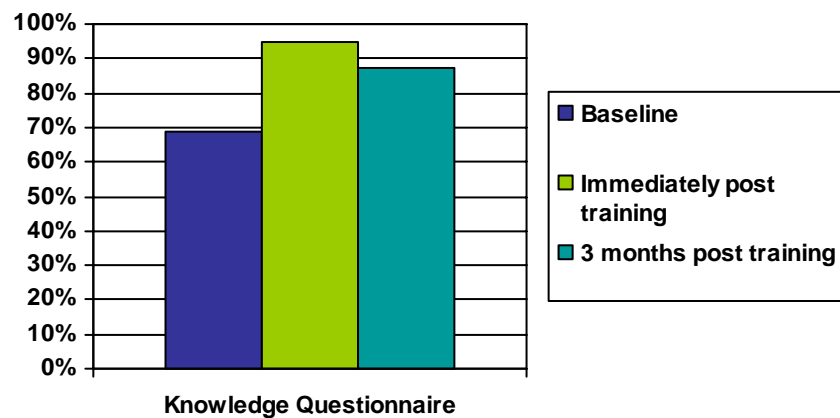
c. *Baseline, initial post training and 3 months post training knowledge of care staff*

Before, immediately after and 3 months after training care staff were invited to complete a knowledge questionnaire. (For detailed results see Appendix 3 and Appendix 4). Carers were asked:

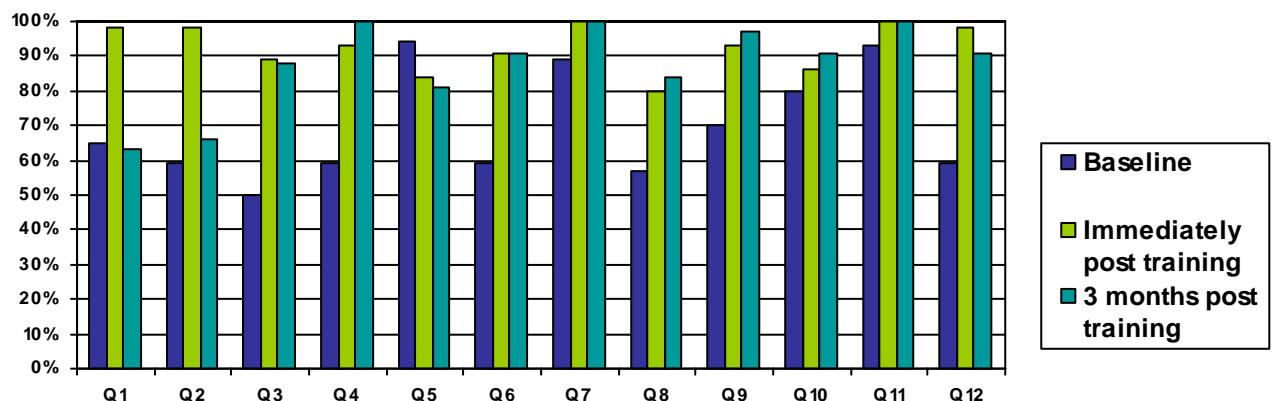
- Q1 Teeth/dentures should be brushed:
Once a day twice a day three times a day
- Q2 Brushing should take:
1 minute 2 minutes three minutes
- Q3 If the gums bleed you should stop brushing:
Yes No
- Q4 Toothpaste should contain:
No fluoride less than 1350ppm fluoride at least 1350ppm fluoride
- Q5 Overnight dentures should be:
Left in the mouth cleaned and left in a dry container
Cleaned and soaked in cold water
- Q6 Those who are PEG fed should have oral care:
Once a day 3 – 4 hourly oral care isn't needed
- Q7 Those with no natural teeth should have dental checks:
Yes No
- Q8 Drinks labelled No Added Sugar are safe for teeth
Yes No
- Q9 It is best to eat sugary foods:
At mealtimes at different times throughout the day
At night before going to bed
- Q10 Medicines cannot damage teeth
Yes No
- Q11 Smoking and drinking too much alcohol can cause mouth cancer
Yes No
- Q12 Gum disease caused by poor health can lead to pneumonia:
Yes No

The knowledge questionnaires were marked out of 12 and the mean average calculated and expressed as a percentage.

Graph 1 shows the mean average of correct answers before and after training



Graph 2 shows the mean average of responses to individual questions before and after training



Immediately post training the greatest range from baseline was seen in questions 2, 3 and 12. The least range was seen in question 10. Question 5 produced a negative effect.

3 months post training the greatest range from baseline was seen in question 4. The least range was seen in questions 2 and 11. Questions 1 and 5 produced a negative effect.

d. ***3 months post training attitude of care staff***

3 months post training care staff were invited to complete the short questionnaire. (For detailed results see Appendix 5). Of the 32 care staff who returned questionnaires:

- 59% believe time constraints influence the oral care provided to residents
- 6% believe lack of confidence to provide oral care influences the oral care provided to residents

13%	believe lack of correct equipment influences the oral care provided to residents
38%	believe that resistance from the resident influences the oral care provided to them
6%	believe training and updates would help them to care for residents' oral health
9%	believe the provision of equipment would help them to care for residents' oral health
34%	believe that compliance from the residents would help them to care for residents' oral health

e. *Evaluation of the programme by care staff*

Following training care staff were invited to complete a training evaluation questionnaire. (For detailed results see Appendix 6 and testimonials see Appendix 7). Of the 44 evaluations completed:

89%	reported the session met their expectations completely
91%	rated the content of the session as very good
84%	rated the presentation as very good
82%	rated the interest as very good
89%	rated the relevance as very good
70%	rated the timing as very good
84%	did not suggest any improvements to the session

f. *Clinical measurements*

Current levels of dental disease and subsequent treatment needs were measured. For clinical report by Joanna Russell – Lead Clinician see Appendix 8)

Conclusions

There is great variation among nursing/residential homes as to what constitutes oral health care and the provision of such care. Whilst teeth/denture cleaning is widely offered many key oral health issues are not addressed such as the formulation of oral health policies and care plans, ensuring regular dental checks, interdental cleaning and labelling of dentures. A large majority of care staff have received no training in oral health care and managers believe that staff would benefit from training. Most managers expressed an interest in working with Community Health Oxfordshire to improve oral care provision.

Baseline data suggests many care staff believe the main influences on the provision of oral care to be time constraints and lack of confidence. Approximately one quarter of care staff also believe lack of equipment and the compliance of the resident influence the oral care provided. Although less than half of care staff believe training would improve the oral care they provide, base line knowledge results show that many carers are unaware of key oral health care messages such as frequency and duration of brushing, early treatment of gum disease, use of topical fluoride and links between oral health and systemic disease.

3 month post training data suggests that confidence to provide oral care has improved significantly. Time constraints remain the primary influence on oral care delivery with considerably more care staff identifying this influence when compared to baseline data. Although baseline data suggests training would help care workers to care for residents' oral health, data obtained 3 month post training suggests that what would help care staff the most is improved compliance by the resident. This could indicate that more care staff are now attempting to provide oral health care than prior to training due to increased confidence and knowledge.

The programme significantly improved the knowledge of care staff and was well received by them. Knowledge assessments of the first session revealed an area of confusion concerning the soaking of dentures. Within the programme carers were advised not to soak dentures in denture cleaner overnight. Immediate post training knowledge data revealed carers misunderstood this message and related it to soaking dentures in water overnight. Further clarity was given to this message in later sessions producing more accurate recall. However, despite later improvements the initial confusion has lead to a negative result which remained at the 3 month evaluation. 3 month post training knowledge data revealed a good retention of knowledge in most areas and in some areas knowledge had continued to improve during the 3 month period. The longer term retention of knowledge in relation to questions 1 and 2 did not follow the general trend of the other questions. Although immediately post training almost all care staff answered correctly regarding how many times a day teeth should be brushed and for how long, during the proceeding 3 months this acquired knowledge does not appear to have been retained with the percentage of correct responses returning to the baseline level. It should however be noted that most of the incorrect responses showed teeth being cleaned more often and for longer than advised.

Clinical measurements reveal a high level of edentulous patients with adequate oral hygiene. As the number of dentate residents' increases, with more adults retaining their teeth for longer, there is the potential for oral health complications to rise significantly if the increasing daily oral health care needs are not adequately met. Baseline knowledge measurements suggest that care staff will be ill equipped to deal with such rising demands unless positive steps are taken to introduce key oral health promotion messages into current practice.

APPENDIX 1

Nursing/Residential Care Home Survey (16 countywide sites)			
Question No	Question	Answer	%
1	Is an oral assessment of residents oral health needs performed on entry to the home?		
	Yes	12	75
	No	3	18.75
	Sometimes	1	6.25
2	If 'yes' who carry's out the assessments?		
	Nurse	7	53.8
	Care manager	4	30.8
	Key Worker	1	7.7
	Don't know	1	7.7
3	What areas are covered in the oral assesments?		
	Denture Wearer	13	100
	Problems with eating	13	100
	Soft tissue problems	10	53.85
	Presence of pain	12	92.31
	Natural teeth present	12	92.31
	Problems wearing dentures	13	100
	Ability to brush teeth/clean dentures	12	92.31
	Current registration with a dentist	9	69.23
	Date of last dental check	6	46.15
4	Are your residents helped with their daily oral care if required?		
	Yes	16	100
	No		

APPENDIX 1 cont'd

5	What daily oral care is provided?		
	Toothbrushing	16	100
	Mouth rinse	15	93.75
	Denture Cleaning	16	100
	Oral Sponges	11	68.75
	Pineapple Juice	1	6.25
	Chlorhexadine	1	6.25
	Glycerine sticks	1	6.25
	Floss	2	12.5
6	Do you label residents dentures on entry to the home?		
	Yes	1	6.25
	No	11	68.75
	Sometimes	4	25
7	Does the home have a written oral care policy?		
	Yes	8	50
	No	6	37.5
	Don't know	2	12.5
8	Is there a written plan of oral health care for each patient?		
	Yes	9	56.25
	No	7	43.75
9	Have your staff had any training in oral healthcare?		
	Yes	1	6.25
	No	15	93.75

APPENDIX 1 cont'd

10	Do you feel your team would benefit from receiving training in oral health care?		
	Yes	16	100
	No		
11	To what types of dental care do residents have access?		
	Routine (in dental surgery)	13	81.25
	Emergency (in dental surgery)	10	62.5
	Domiciliary (home visit)	5	31.25
	None	1	6.25
12	Do you feel that any of your residents currently have a dental problem requiring attention?		
	Yes	12	75
	No	4	25
13	Are you interested in taking part in a Pilot training programme		
	Yes	15	93.75
	No	1	6.25

APPENDIX 2

Pre-Training Attitudes Assessment

What influences the oral care you provide? More than 1 answer permitted

Time constraints	39%
Lack of confidence to provide oral care	35.00%
Lack of correct equipment	24%
Compliance of resident	26%

What would help you to care for residents' oral health? More than 1 answer permitted

Better equipment	9%
Training	41%
Modifications to diet	2%
Regular dental checks	4%
Written guidance/protocol	4%
More time	4%

APPENDIX 3

Pre and Post Training Knowledge Assessment

	Pre-training (46)	Post-training (44)
Average mark of participants out of 12	8.3	11.4
Expressed as a percentage	69.00%	95.00%

Breakdown of Knowledge Assessment Questions

Question No	Question	Pre-training (46)					Post-training (44)					
		A	B	C	No answer	% correct	A	B	C	No answer	% correct	
1	Teeth/dentures should be brushed A - once a day B - twice a day c - three times a day	0	30	16	0	65%	0	43	0	1	98%	↑ 33%
2	Brushing should take A - 1 minute B - 2 minutes C - 3 minutes	5	27	14	0	59%	0	43	1	0	98%	↑ 39%
3	If the gums bleed you should stop brushing A - Yes B - No	21	23		2	50%	3	39		2	89%	↑ 39%

APPENDIX 3 cont'd

4	Toothpaste should contain A - No fluoride B - Less than 1350ppm fluoride C - At least 1350ppm fluoride	0	15	27	4	59%	0	3	41	0	93%	↑ 34%
5	Overnight, dentures should be A - Left in the mouth B - Cleaned and left in a dry container C - Cleaned and soaked in cold water	0	3	43	0	94%	0	7	37	0	84%	↓ 10%
6	Those who are PEG fed should have oral care A - once a day B - 3 - 4 hourly C - oral care isn't needed	12	27	1	3	59%	4	40	0	0	91%	↑ 32%
7	Those with no natural teeth should have dental checks A - Yes B - No	41	5		0	89%	44	0		0	100%	↑ 11%
8	Drinks labelled No Added Sugar are safe for teeth A - Yes B - No	19	26		1	57%	9	35		0	80%	↑ 23%

APPENDIX 3 cont'd

9	It is best to eat sugary foods	A - at mealtimes											
		B - at different times throughout the day											
		C - at night, shortly before going to bed	32	12	1	0	70%	41	3	0	0	93%	↑ 23%
10	Medicines cannot damage teeth	A - True											
		B - False	9	37		0	80%	5	38		1	86%	↑ 6%
11	Smoking and drinking too much alcohol can cause mouth cancer	A - True											
		B - False	43	3		0	93%	44	0		0	100%	↑ 7%
12	Gum disease caused by poor oral health can lead to pneumonia	A - True											
		B - False	27	16		3	59%	43	1		0	98%	↑ 39%

APPENDIX 4

Pre and 3 Months Post Training Knowledge Assessment

	Pre-training (46)	Post-training (32)
Average mark of participants out of 12	8.3	10.5
Expressed as a percentage	69.00%	87.5%

Breakdown of Knowledge Assessment Questions

Question No	Question	Pre-training (46)					3 Months Post-training (32)					
		A	B	C	No answer	% correct	A	B	C	No answer	% correct	
1	Teeth/dentures should be brushed A - once a day B - twice a day c - three times a day	0	30	16	0	65%	0	20	12	0	63%	↓ 2%
2	Brushing should take A - 1 minute B - 2 minutes C - 3 minutes	5	27	14	0	59%	2	21	9	0	66%	↑ 7%
3	If the gums bleed you should stop brushing A - Yes B - No	21	23		2	50%	4	28		0	88%	↑ 38%

APPENDIX 4 cont'd

4	<p>Toothpaste should contain</p> <p>A - No fluoride</p> <p>B - Less than 1350ppm fluoride</p> <p>C - At least 1350ppm fluoride</p>	0	15	27	4	59%	0	0	32	0	100%	↑ 41%
5	<p>Overnight, dentures should be</p> <p>A - Left in the mouth</p> <p>B - Cleaned and left in a dry container</p> <p>C - Cleaned and soaked in cold water</p>	0	3	43	0	94%	0	6	26	0	81%	↓ 13%
6	<p>Those who are PEG fed should have oral care</p> <p>A - once a day</p> <p>B - 3 - 4 hourly</p> <p>C - oral care isn't needed</p>	12	27	1	3	59%	3	29	0	0	91%	↑ 32%
7	<p>Those with no natural teeth should have dental checks</p> <p>A - Yes</p> <p>B - No</p>	41	5		0	89%	32	0		0	100%	↑ 11%
8	<p>Dinks labelled No Added Sugar are safe for teeth</p> <p>A - Yes</p> <p>B - No</p>	19	26		1	57%	5	27		0	84%	↑ 27%

APPENDIX 4 cont'd

9	It is best to eat sugary foods	A - at mealtimes												
		B - at different times throughout the day												
		C - at night, shortly before going to bed	32	12	1	0	70%	31	1	0	0	97%	↑ 27%	
10	Medicines cannot damage teeth	A - True												
		B - False	9	37		0	80%	3	29		1	91%	↑ 11%	
11	Smoking and drinking too much alcohol can cause mouth cancer	A - True												
		B - False	43	3		0	93%	32	0		0	100%	↑ 7%	
12	Gum disease caused by poor oral health can lead to pneumonia	A - True												
		B - False	27	16		3	59%	29	3		0	91%	↑ 32%	

APPENDIX 5

3 Months Post Training Attitudes Assessment

What influences the oral care you provide? More than 1 answer permitted

Time constraints	59%
Lack of confidence to provide oral care	6%
Lack of correct equipment	13%
Compliance of resident	38%

What would help you to care for residents' oral health? More than 1 answer permitted

Better equipment	9%
Training	6%
Improved compliance of resident	34%

APPENDIX 6

Nursing/Residential Care Home Training Evaluations			
Question No	Question	Answer	%
1	How much did this session meet your expectations?		
	Completely	39	88.6
	Mostly	5	11.4
	Partly	0	0
	Not at all	0	0
2	How do you rate the content of the session:		
	Very good	40	90.9
	Good	4	9.1
	Average	0	0
	Poor	0	0
	Very poor	0	0
3	Was the presentation:		
	Very good	37	84.1
	Good	6	13.6
	Average	1	2.3
	Poor	0	0
	Very poor	0	0
4	How do you rate the session for interest?		
	Very good	36	81.8
	Good	8	18.2
	Average	0	0
	Poor	0	0
	Very poor	0	0
5	How do you rate the session for relevance?		
	Very good	39	88.6
	Good	5	11.4
	Average	0	0
	Poor	0	0
	Very poor	0	0
6	How do rate the timing of the session?		
	Very good	31	70.4
	Good	12	27.3
	Average	1	2.3
	Poor	0	0
	Very poor	0	0
7	How could the session be improved?		
	No suggestions	37	84.1
	More pictures	3	6.8
	More activities	1	2.3
	Latest research findings	1	2.3
	Make it shorter	1	2.3
	Make it longer	1	2.3

APPENDIX 6 cont'd

8	What were the most useful aspects of the session?		
	The importance of oral hygiene	13	29.5
	Food and drink	1	2.3
	Pictures of oral diseases	11	25
	The effects of medicines	2	4.5
	Everything	13	29.5
	Group work	2	4.5
	Practical brushing techniques	6	13.6
	Signposting to dental services	1	2.3
	PowerPoint presentation	4	9.1

APPENDIX 7

Testimonials

“Brilliant course – much needed”

“It was an excellent presentation”

“More interesting than I expected”

“A very enjoyable and informative session”

“Really interesting and informative”

“It was a great session and will improve our understanding and knowledge about oral health”

“Well done and much appreciated”

“Enjoyable, relaxed environment”

“Keep up the good work”

“Very interesting”

“Brilliant”

“It was very interesting training”

“The information given will be used. Thank you.”

“It was very interesting and helpful”

“Needs more classes, at least every year”

“Now I’m trained I feel confident”

APPENDIX 8

Residential home screening pilot- clinical aspect

Aim

The aim of this pilot was to assess the current levels of dental disease and subsequent treatment needs across a sample of dependent elderly residents in care home facilities in Oxfordshire.

Method

This survey was part of a wider pilot programme which combined an oral health promotion initiative, designed to raise awareness and understanding of oral care amongst care staff, with dental screening of elderly patients in residential care.

A random selection of twenty homes was taken from a database of nursing and residential homes in Oxfordshire. The initial phase of this study comprised a brief telephone questionnaire which was conducted by a member of the oral health promotion team. Wherever possible, this interview took place with the manager or a senior member of staff. The questionnaire format remained largely unchanged from previous surveys, to allow comparisons to be made. At the end of the telephone interview, managers were asked if they were interested in being involved with phase two of the pilot; the oral health promotion training for their staff and dental screening for their residents. Of those who responded positively, three were selected to represent the north, middle and south of the county. Those who had small numbers of residents were excluded, as were those whose residents were largely independent and mobile.

The three selected homes were given information about the dental screening and oral health promotion training and dates to visit were agreed for each aspect.

Prior to the dental screening visit, the care homes were sent a letter describing the requirements for the visit alongside a two page screening form for each resident. The home were asked to complete the first page, which covered basic details about the resident including their medical history and dental status, prior to the dental team's visit.

On the day of the screening the team set up their equipment in a designated room with a sink and power supply. Residents were asked if they wanted to participate in the screening. Those that declined or who were uncooperative at examination were excluded. Mobile residents were brought to the room and the screening carried out. Residents were asked if they had any problems before an oral examination was conducted. Soft tissue disease, oral hygiene status, presence of caries, tooth

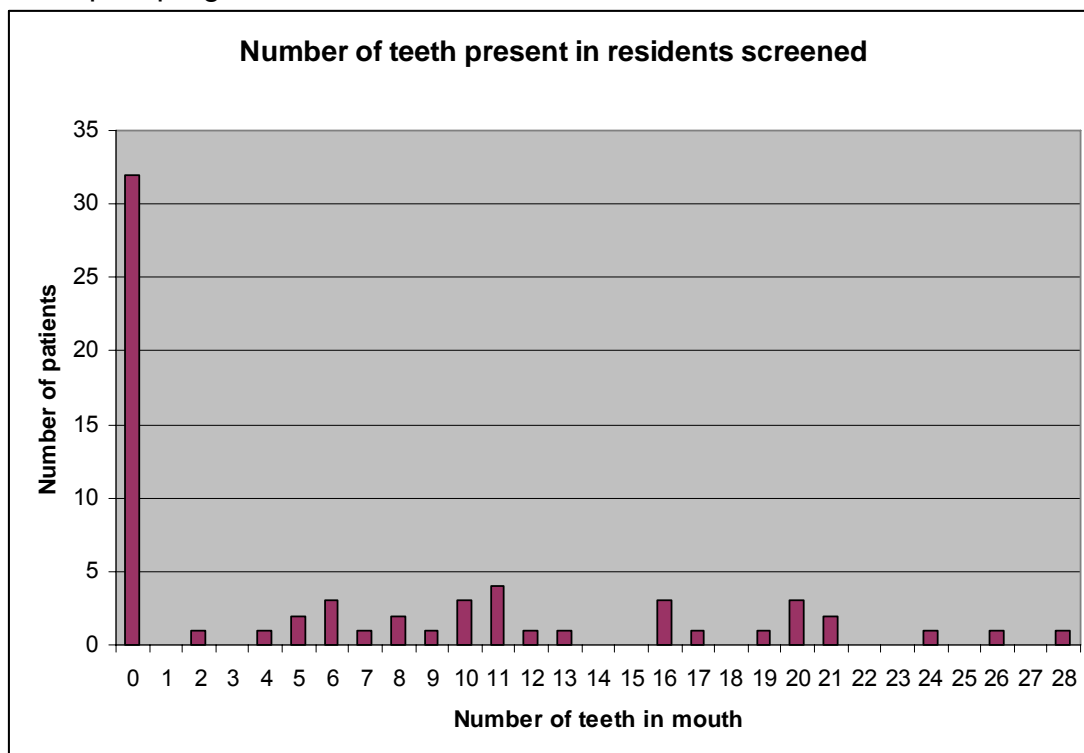
mobility and the adequacy of dentures were assessed. Any subsequent treatment needs were then recorded and categorised in terms of both treatment type and urgency.

Results

The three participating residential homes housed a total of 71 adults. 65 of these were screened during the pilot, with 6 refusing to take part.

51% of the residents examined were dentate and 49% were edentulous. Amongst the dentate patients, there was a wide variety in the number of teeth per patient, ranging from 2 to 28, with an average of 13 teeth per dentate mouth. See figure 1.

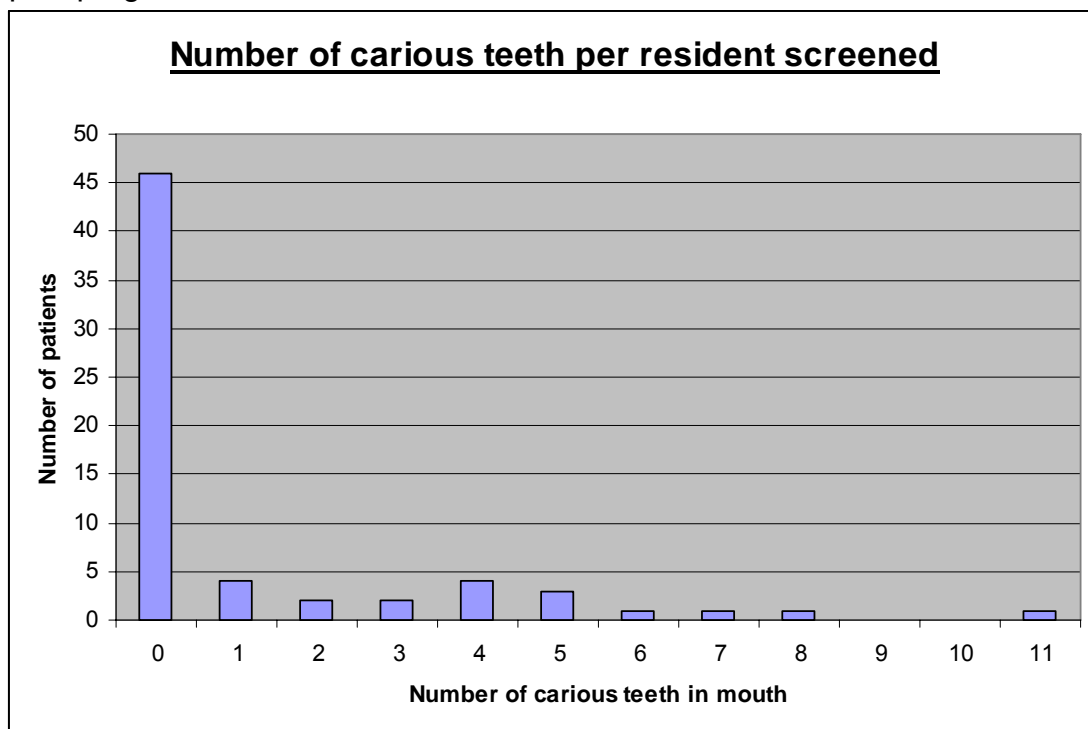
Figure 1. The number of teeth present in each resident screened during the residential home pilot programme.



The oral hygiene status of residents was noted, with 42% having plaque and food debris and 3% having plaque and food debris and calculus. 55% of residents were noted to have clean mouths.

29% of all residents had active caries and 11% were found to have mobile teeth. However, of the dentate patients, over half were found to have caries (56%), ranging from 1 to 11 carious teeth with an average of 4 per dentate mouth (see figure 2). Similarly, in dentate patients, 1 fifth (21%) had experience of mobile teeth, ranging from 1 to 4, with an average of 2 per mouth. Only 32% of dentate patients have functional posterior contacts, where molar or premolar teeth are in contact with a tooth in the opposite arch. 17% of the residents examined had evidence of complex restorative dentistry, namely fixed bridges and implants.

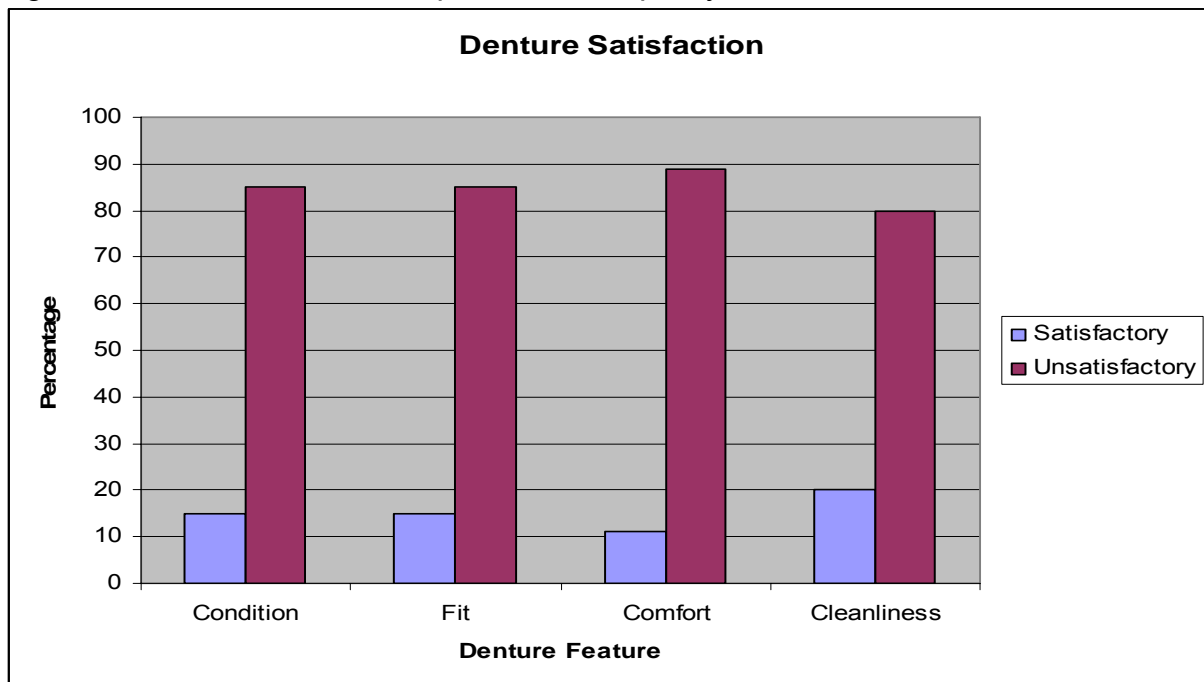
Figure 2. The range in number of carious teeth per adult screened during the residential home pilot programme.



Almost three quarters of residents examined (71%) were denture wearers though of these, 20% have dentures but don't wear them. The fit, condition, cleanliness and comfort of the dentures were assessed and rated satisfactory or unsatisfactory (see figure 3). The dental team felt that 15% of residents had dentures that were poorly fitting. 15% of

dentures also seemed to be in poor condition (very worn or fractured) whilst 20% of them were considered unsatisfactory in terms of their cleanliness. From the patients point of view, 11% of residents who wore dentures felt that they were uncomfortable though 89% were satisfied with the comfort of their dentures. In residents who wore dentures, nearly half of those dentures (46%) were found to be unsatisfactory in one or more category, either cleanliness, comfort, fit or condition.

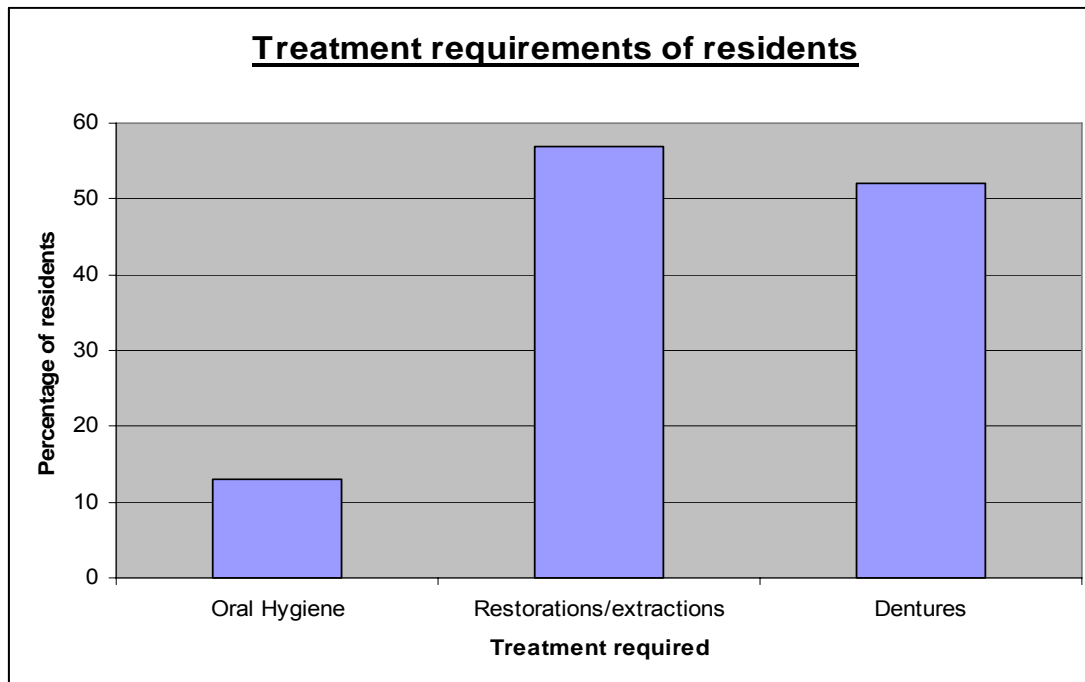
Figure 3. Patient/dental team opinion on the quality of different denture features.



The dental team felt that 35% of residents examined needed dental treatment (see figure 4). Of those, the team felt that 13% would benefit from some oral hygiene intervention. 57% required extractions or restorations and 52% needed denture treatment, be it new dentures or repair or relines of their existing ones.

Of the total resident population examined, 20% needed restorations or extractions and 18% needed denture work

Figure 4. Percentage of each type of treatment needed in patients who had a treatment requirement.



Discussion

It is clear that the elderly population who reside in communal establishments have dental needs that are not being met. The 50:50 ratio of dentate to edentulous patients will only increase in future as more adults retain their teeth for longer. The presence of advanced restorative work in a fifth of the population also presents difficult treatment challenges and this is again, a proportion that is likely to increase in the future.

Overall, it was felt that about a third of residents had treatment needs that required intervention. This is less than had been anticipated prior to the survey. In addition, many of the treatment needs perceived by the dental team might not be desired by the patient. It was felt that over half the patients needing treatment required restorations or extractions. However, only a very small proportion of residents complained of problems with their teeth and most declined the offer of such treatment. The team tried to record residents' self-perception of dental problems but this was inadequately reported and thus discarded. On the whole, it appeared that residents seemed more likely to complain about their dentures, possibly because they were examined more thoroughly, than their teeth and there was therefore a higher uptake for denture work.

INTERIM REPORT

Oral health promotion training pilot for staff working in supported living and day care environments for adults with learning disabilities in Oxfordshire.

Heather Duignan
Health Improvement Practitioner (Advanced),
Sarah Buckingham
Specialist in Special Care Dentistry
Oxfordshire Salaried Primary Care Dental Service

June 2010

Proposed start and finish April 2010 – August 2010

Background

Oral health inequalities exist for people with learning disabilities with the oral health of individuals with learning disability being generally poorer than that of individuals without learning disability.¹ *Valuing people*² and *Valuing people's oral health*³ encourage choice and inclusion for people with learning disability.

In the UK there are over 950,000 adults registered as having a learning disability. Currently patients with learning disability are seen in both specialist and general dental services depending on their need.⁴ By 2021 it is predicted that there will be more than one million people with learning disabilities in the UK.⁵ It is therefore important that with increasing numbers of people with learning disability and the inequalities that currently exist dental services are adapted to meet this need.

In response to this programmes of education and training for care staff have been attempted in other counties with limited evaluation.

Project aim

The aim of the pilot was to provide accurate and evidence based information to staff involved in improving the oral health of adults with learning disabilities living in 3 supported living environments and 1 day care centre in North Oxfordshire.

Design

Sites were selected by the Oral Health Promotion team based on their close proximity to one another and small clusters of teams. The impact of the programme was evaluated by assessing the effect on knowledge among the care staff.

Setting

Supported living environments and a day centre in Oxfordshire.

Interventions

A programme was developed for care staff using the experience of Health Improvement Practitioners specialising in oral health and health education.

The programme consisted of:

- The selection of 3 pilot sites and a survey of staff involved in oral health care delivery to ascertain current attitudes and knowledge
- Baseline measurements of oral health of tenants residing in the 3 residential pilot sites and service users of the day centre
- The provision of 2 in house training sessions to care staff involved in the delivery of oral care in the 3 residential pilot sites, and involved in the promotion of oral health in the day centre, offered at flexible convenient times
- The evaluation of post training knowledge retention and training methods immediately following training
- A survey of staff 3 months post training to ascertain post training attitudes and retention of knowledge

Main outcome measures

Key outcomes assessed were:

- To assess oral health and dental need of tenants and service users
- To assess number of tenants and service users currently accessing dental care
- To provide signposting and access to dental services
- Attitude of care staff
- Knowledge level changes among care staff working in supported living environments
- Knowledge level changes among care staff working in a day centre for adults with learning disabilities
- Evaluations of the programme by care staff working in supported living environments
- Evaluations of the programme by care staff working in a day centre for adults with learning disabilities

Interim results

a. Baseline attitude of care staff

Supported Living Environments

Prior to training care staff working in supported living environments were invited to complete a short questionnaire. (For detailed data see Appendix 1). Of the 14 care staff:

- | | |
|-----|----------------------------------------------------------------------------------------------|
| 14% | believe time constraints influence the oral care provided to tenants |
| 14% | believe lack of confidence to provide oral care influences the oral care provided to tenants |
| 14% | believe lack of correct equipment influences the oral care provided to tenants |
| 29% | believe that resistance from the tenant influences the oral care provided to them |
| 7% | believe training would help them to care for tenants' oral health |

Day Centre

In relation to the day centre aspect of the pilot, due to unexpected staffing issues, only 5 members of staff were able to take part on the agreed date. The small sample size reduced the significance of the results. However, for information purposes the data can be found in Appendix 2).

b. Baseline and initial post training knowledge of care staff

Supported Living Environments

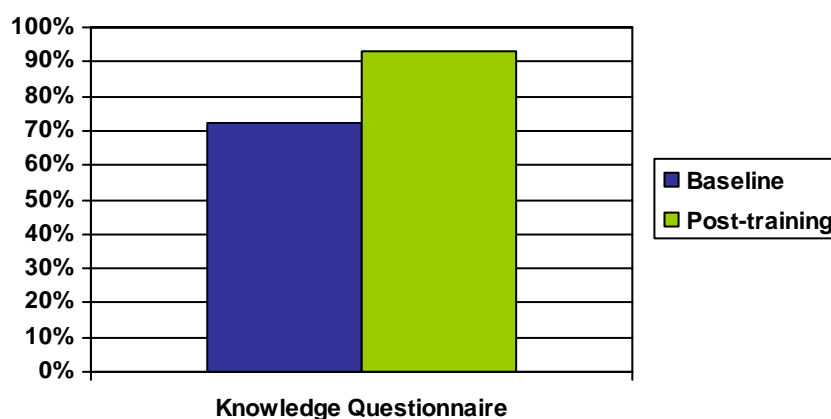
Before and after training care staff were invited to complete a knowledge questionnaire. (For data see Appendix 3). Carers were asked:

- Q1 Teeth/dentures should be brushed:
 Once a day twice a day three times a day

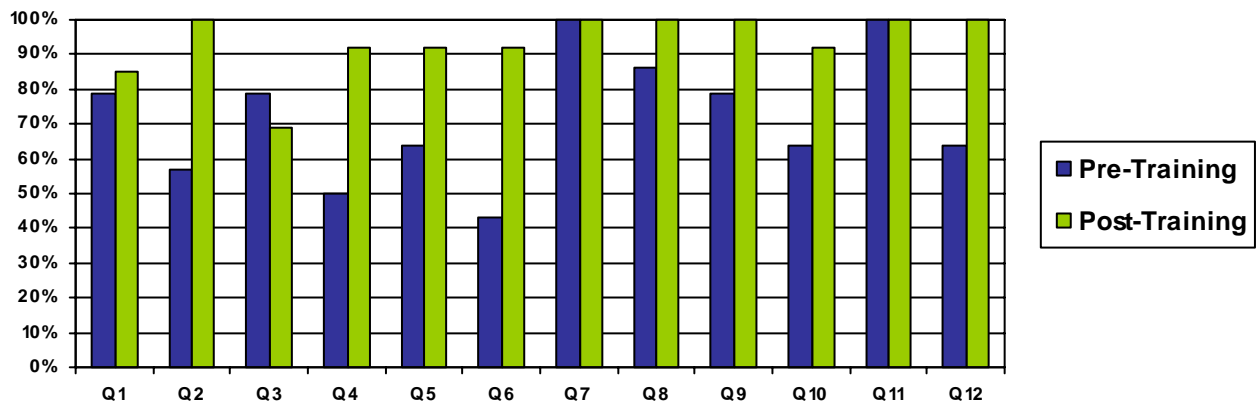
- Q2 Brushing should take:
1 minute 2 minutes three minutes
- Q3 If the gums bleed you should stop brushing:
Yes No
- Q4 Toothpaste should contain:
No fluoride less than 1350ppm fluoride at least 1350ppm fluoride
- Q5 Overnight dentures should be:
Left in the mouth cleaned and left in a dry container
Cleaned and soaked in cold water
- Q6 Those who are PEG fed should have oral care:
Once a day 3 – 4 hourly oral care isn't needed
- Q7 Those with no natural teeth should have dental checks:
Yes No
- Q8 Drinks labelled No Added Sugar are safe for teeth
Yes No
- Q9 It is best to eat sugary foods:
At mealtimes at different times throughout the day
At night before going to bed
- Q10 Medicines cannot damage teeth
Yes No
- Q11 Smoking and drinking too much alcohol can cause mouth cancer
Yes No
- Q12 Gum disease caused by poor health can lead to pneumonia:
Yes No

The knowledge questionnaires were marked out of 12 and the mean average calculated and expressed as a percentage.

Graph 1 shows the mean average of correct answers before and after training



Graph 2 shows the mean average of responses to individual questions before and after training



The greatest range was seen in questions 6. The least range was seen in question 1. Questions 7 and 11 scored optimal results pre and post training. Question 3 produced a negative effect.

Day Centre

Due to the small sample size the significance of improvements to day centre knowledge results is reduced, however the greatest range was seen in questions 2, 4 and 12. Questions 7, 9 and 19 scored optimal results pre and post training. Question 8 produced a negative effect. (For data see Appendix 4)

c. Evaluation of the programme by care staff

Supported Living Environments

Following training care staff completed a training evaluation questionnaire. (For data see Appendix 5 and for testimonials see Appendix 6). Of the 13 evaluations completed:

- 76.9% reported the session met their expectations completely
- 76.9% rated the content of the session as very good
- 84.6% rated the presentation as very good
- 53.8% rated interest as good
- 69.2% rated the relevance as very good
- 70.9% rated the timing as very good
- 69.2% did not suggest any improvements to the session

Day Centre

Due to the small sample size the significance of the day centre evaluations is questionable. However data is attached for information purposes in Appendix 7.

d. Clinical measurements

Current levels of dental disease and subsequent treatment needs were measured. For clinical report by Sarah Buckingham – Specialist in Special Care Dentistry see Appendix 8)

Conclusions and Recommendations

Supported Living Environments

Almost one third of care staff believes the willingness of tenants to allow oral care influences the oral care provided. A small number of care staff believes oral care is influenced by time constraints, lack of confidence and lack of equipment. The programme significantly improved the knowledge of care staff and was well received by them. Although a small minority of care staff believe training would improve the oral care they provide, base line knowledge results show that many carers are unaware of key oral health care messages such as correct use of fluoride, length of time spent brushing and oral care for tenants who are parenterally fed.

Day Centre

Although the sample size was small the percentage increase pre and post training in the knowledge questionnaire was similar to that of staff working in the supported living environment.

Clinical measurements

The main oral health issues were debris, plaque and calculus present in the mouth. Such problem could be prevented or improved by implementing oral hygiene regimes in both residential homes and day centres.

The number of carious and mobile teeth was low which was surprising. However, many of the patients seen attended regularly at a local Dental Clinic. It was noted that the patients were more compliant and receptive to the dental checks in their own environments compared to in the clinic, which could indicate the usefulness of domiciliary dental visits.

When developing future programmes with this patient group the following should be considered:

- Clear communication between the dental team and the managers of the residential homes/day centres.
- Improved communication between the home and day centre managers with carer/relatives of people with learning disability.
- Ensure that signing of consent forms is carried out by either the person or their carer prior to dental visits.

- Day centres are the preferred site to provide dental visits on people that are able to consent for themselves i.e. people with mild learning disability.
- Residential homes are preferred sites to provide dental visits for people with moderate-severe learning disability as they can be consented for in advance if organised adequately by the home managers.
- To increase access to people's homes for domiciliary dental checks as people that do not visit day centres or live in residential homes will be excluded.
- To re-pilot the study in an area that does not have an OSPCDS clinic in close proximity.
- Use a larger sample size and focus on either residential homes or day centres rather than try to combine the various sites in the same study.
- Follow up on signposting to assess if people currently not accessing dental services start after they have been seen by the dentist.

APPENDIX 1

Pre-Training Attitudes Assessment (Sample size 14)		
What influences the oral care you provide? More than 1 answer permitted		
Time constraints	2	14%
Lack of confidence to provide oral care	2	14.00%
Lack of correct equipment	2	14%
Compliance of resident	4	29%
Lack of specific training	1	7%
What would help you to care for residents' oral health? More than 1 answer permitted		
Better equipment	1	7%
Training	4	29%
Regular dental checks	1	7%

APPENDIX 2

Pre-Training Attitudes Assessment (sample size 5)

What influences the oral health promotion you provide? More than 1 answer permitted

Time constraints	2
Lack of correct equipment	1
Not considered to be part of role	1
No answer provided	1

What would help you to promote oral health? More than 1 answer permitted

Better equipment	2
Appropriate resources	1
No answer provided	2

APPENDIX 3

Breakdown of Knowledge Assessment Questions											
Question No	Question	Pre-training (14)				% correct	Post-training (13)				% correct
		A	B	C	No answer		A	B	C	No answer	
1	Teeth/dentures should be brushed A - once a day B - twice a day C - three times a day	0	11	2	1	79%	0	11	2	0	85% ↑ 6%
2	Brushing should take A - 1 minute B - 2 minutes C - 3 minutes	1	8	5	0	57%	0	13	0	0	100% ↑ 43%
3	If the gums bleed you should stop brushing A - Yes B - No	3	11		0	79%	0	9		4	69% ↓ 10%
4	Toothpaste should contain A - No fluoride B - Less than 1350ppm fluoride C - At least 1350ppm fluoride	0	5	7	2	50%	0	0	12	1	92% ↑ 42%

APPENDIX 3 cont'd

5	Overnight, dentures should be A - Left in the mouth B - Cleaned and left in a dry container C - Cleaned and soaked in cold water	2	1	9	2	64%	0	0	12	1	92%	↑ 28%
6	Those who are PEG fed should have oral care A - once a day B - 3 - 4 hourly C - oral care isn't needed	5	6	0	3	43%	1	12	0	0	92%	↑ 49%
7	Those with no natural teeth should have dental checks A - Yes B - No	14	0		0	100%	13	0		0	100%	0%
8	Dinks labelled No Added Sugar are safe for teeth A - Yes B - No	1	12		1	86%	0	13		0	100%	↑ 14%
9	It is best to eat sugary foods A - at mealtimes B - at different times throughout the day C - at night, shortly before going to bed	11	1	0	2	79%	13	0	0	0	100%	↑ 21%

APPENDIX 3 cont'd

Question	Correct Answer	Incorrect Answer	Correct Answer Count	Incorrect Answer Count	Correct Answer Percentage	Incorrect Answer Percentage	Change
10 Medicines cannot damage teeth	A - True	B - False	4	9	64%	36%	↓ 28%
11 Smoking and drinking too much alcohol can cause mouth cancer	A - True	B - False	14	0	100%	0%	↑ 28%
12 Gum disease caused by poor oral health can lead to pneumonia	A - True	B - False	9	3	64%	36%	↑ 36%

APPENDIX 4

Breakdown of Knowledge Assessment Questions										
Question No	Question	Pre-training (5)				Post-training (5)				
		A	B	C	No answer	A	B	C	No answer	
1	Teeth/dentures should be brushed A - once a day B - twice a day C - three times a day	0	4	4	0	0	5	0	0	↑ 1
2	Brushing should take A - 1 minute B - 2 minutes C - 3 minutes	1	2	1	0	0	5	0	0	↑ 3
3	If the gums bleed you should stop brushing A - Yes B - No	1	3		1	1	4		0	↑ 1
4	Toothpaste should contain A - No fluoride B - Less than 1350ppm fluoride C - At least 1350ppm fluoride	0	3	1	1	0	1	4	0	↑ 3

APPENDIX 4 cont'd

5	Overnight, dentures should be A - Left in the mouth B - Cleaned and left in a dry container C - Cleaned and soaked in cold water	0	0	4	1	0	0	5	0	↑ 1
6	Those who are PEG fed should have oral care A - once a day B - 3 - 4 hourly C - oral care isn't needed	2	3	0	0	1	4	0	0	↑ 1
7	Those with no natural teeth should have dental checks A - Yes B - No	5	0		0	5	0		0	
8	Dinks labelled No Added Sugar are safe for teeth A - Yes B - No	0	5		0	1	4		0	↓ 1
9	It is best to eat sugary foods A - at mealtimes B - at different times throughout the day C - at night, shortly before going to bed	5	0	0	0	5	0	0	0	

APPENDIX 4 cont'd

10	Medicines cannot damage teeth A - True B - False	<div><div></div><div>4</div><div></div></div>	1	1	<div><div>4</div><div></div></div>	0	
11	Smoking and drinking too much alcohol can cause mouth cancer A - True B - False	<div><div>4</div><div>0</div><div></div></div>	1		<div><div>5</div><div>0</div><div></div></div>	0	↑ 1
12	Gum disease caused by poor oral health can lead to pneumonia A - True B - False	<div><div>2</div><div>1</div><div></div></div>	1		<div><div>5</div><div>0</div><div></div></div>	0	↑ 3

APPENDIX 5

Learning Disability Supported Living Training Evaluations (13)			
Questions No	Question	Answer	%
1	How much did this session meet your expectations?		
	Completely	10	76.9
	Mostly	3	23.1
	Partly	0	0
	Not at all	0	0
2	How do you rate the content of the session:		
	Very good	10	76.9
	Good	3	23.1
	Average	0	0
	Poor	0	0
	Very poor	0	0
3	Was the presentation:		
	Very good	11	84.6
	Good	2	15.4
	Average	0	0
	Poor	0	0
	Very poor	0	0
4	How do you rate the session for interest?		
	Very good	6	46.2
	Good	7	53.8
	Average	0	0
	Poor	0	0
	Very poor	0	0
5	How do you rate the session for relevance?		
	Very good	9	69.2
	Good	4	30.8
	Average	0	0
	Poor	0	0
	Very poor	0	0
6	How do rate the timing of the session?		
	Very good	10	76.9
	Good	3	23.1
	Average	0	2.3
	Poor	0	0
	Very poor	0	0
7	How could the session be improved?		
	No suggestions	9	69.2
	More activities	2	15.4
	More discussion	1	7.7

APPENDIX 5 cont'd

8	What were the most useful aspects of the session?		
	The importance of oral hygiene	6	46.2
	Food and drink	1	7.7
	Pictures of oral diseases	3	23.1
	The effects of medicines	1	7.7
	Everything	2	15.4
	Groupwork	1	7.7
	Practical brushing techniques	4	30.8

APPENDIX 6

'Very interesting. All team members to attend training'

'Very good'

'Very good presentation with time allowed'

'Thank you. I hope to support service users each day with cleaning teeth'

'Good subject to have a little more knowledge on'

APPENDIX 7

Questions No	Question	Answer
1	How much did this session meet your expectations?	
	Completely	3
	Mostly	2
	Partly	0
	Not at all	0
2	How do you rate the content of the session:	
	Very good	4
	Good	1
	Average	0
	Poor	0
	Very poor	0
3	Was the presentation:	
	Very good	4
	Good	1
	Average	0
	Poor	0
	Very poor	0
4	How do you rate the session for interest?	
	Very good	3
	Good	2
	Average	0
	Poor	0
	Very poor	0
5	How do you rate the session for relevance?	
	Very good	3
	Good	2
	Average	0
	Poor	0
	Very poor	0
6	How do rate the timing of the session?	
	Very good	3
	Good	2
	Average	0
	Poor	0
	Very poor	0
7	How could the session be improved?	
	More activities	2
	Make it longer	3

APPENDIX 7 cont'd

8	What were the most useful aspects of the session?	
	The importance of oral hygiene	1
	Food and drink	1
	Pictures of oral diseases	2
	Everything	1

APPENDIX 8

Learning Disability Pilot - May/June 2010

Background

Oral health inequalities exist for people with learning disabilities with the oral health of individuals with learning disability being generally poorer than that of individuals without learning disability.¹ *Valuing people*² and *Valuing people's oral health*³ encourage choice and inclusion for people with learning disability.

In the UK there are over 950,000 adults registered as having a learning disability. Currently patients with learning disability are seen in both specialist and general dental services depending on their need.⁴ By 2021 it is predicted that there will be more than one million people with learning disabilities in the UK.⁵ It is therefore important that with increasing numbers of people with learning disability and the inequalities that currently exist dental services are adapted to meet this need.

In May/June 2010 a pilot was carried out in North Oxfordshire to assess the oral health of people with learning disabilities and to provide oral health training to staff working with tenants and service users to find out if this resulted in increased knowledge

The Oral Health Promotion team provided training sessions to the staff at each of these sites and a dentist/dental nurse team carried out dental checks. The pilot was then evaluated to see if the knowledge of carers had changed. Any person that was seen for a dental check for the pilot was provided with signposting to dental services if required.

Aims

The aims of the pilot were as follows:

- To assess oral health and dental need of tenants and service users
- To assess number of tenants and service users currently accessing dental care
- To provide signposting and access to dental services
- To assess attitude of care staff
- To assess knowledge level changes among care staff working in supported living environments
- To assess knowledge level changes among care staff working in a day centre for adults with learning disabilities
- To evaluate the training programme by care staff working in supported living environments
- To evaluate the training programme by care staff working in a day centre for adults with learning disabilities

Selection of the pilot sites

The OHP team attended meetings with the learning disability nurses in each of the three localities across Oxfordshire – North, City and South. It was decided to carry out the pilot in the North of the county. The sites were geographically situated close together and the degree of learning disability

ranged from mild to severe/profound. The teams working with these individuals seemed relatively established and they were keen to take part in the pilot.

Method

The pilot took place across three sites over May/June 2010.

- A day centre
- Residence A
- Residence B (incorporating 2 dwellings)

The OHP team arranged the dates for the training sessions and the dentist arranged the dates for the dental checks. The training sessions were held on different days to the clinical visits to enable as many staff as possible to attend the training sessions and for them to be available to support the clinical visits.

Prior to the dentist visits letters were sent to the managers at each of the sites providing information on the dental checks. The managers at each site were asked to distribute the letters to everyone that would be having a dental check. The letter contained a consent section to be completed by the person if they were able or by a relative or carer if not. Although nobody but the person having the dental check can legally provide consent it is good practice that the relative or carer is involved in the consenting process and to act for the patient's best interests.⁶

Residence A:

There were two residents in this house both with severe learning disability. Letters were sent to the residents for their carers and also to the staff at the site so that a suitable area could be used to carry out the dental checks. The consent forms were filled in prior to arrival of the dentist and the completed forms given to the dentist at the session. See Appendix B

Residence B:

There were 12 residents living in these houses all with moderate to severe learning disability. Letters were sent to the managers in each of the houses and they were asked to distribute them to the resident's relatives and carers. These letters contained a consent section which was to be completed prior to the dental visit and then given to the dentist on the day.

Day Centre:

People with learning disability attend this day centre weekly with many of the sessions attracting up to 50 service users. The majority of these people had moderate-severe learning disability. Letters were sent to the day centre for distribution to the service users in advance of the session with the date that the dentist would be attending. This letter also contained a consent section. See Appendix A

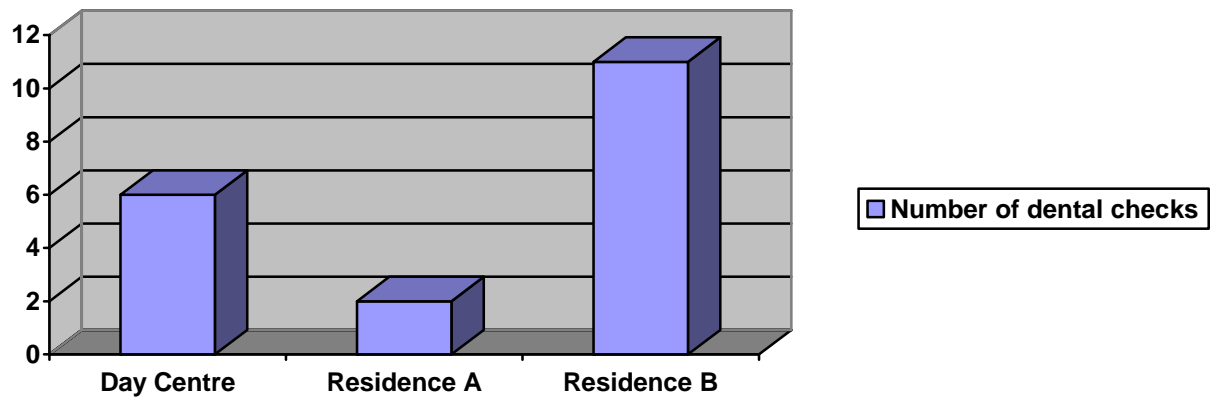
The completed consent forms were collected by the manager at the day centre and given to the dentist on the day.

The dentist/dental nurse attended the centre between 10am and 3pm. The number of service users was unknown prior to the day. The day centre agreed

to carry out some publicity prior to dental visit to raise awareness and try to encourage as many people as possible to come along.

Results

Number of dental checks



Residence A:

A total of 2 residents were seen by the dentist both with severe learning disability.

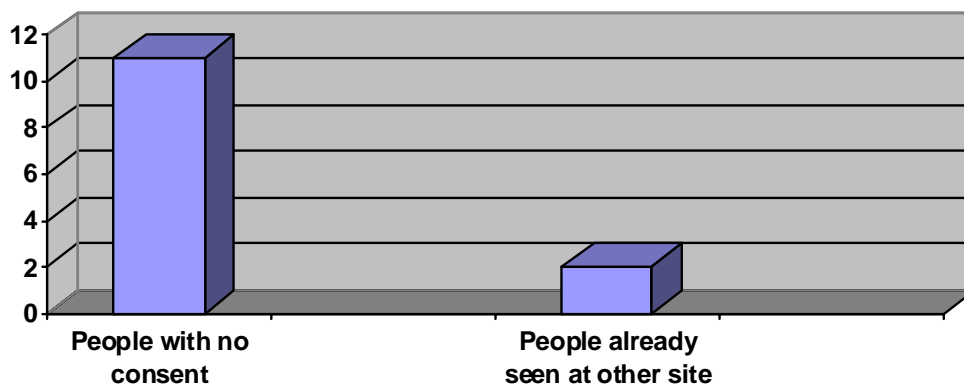
Residence B:

A total of 12 residents with moderate to severe learning disability were seen by the dentist in these houses.

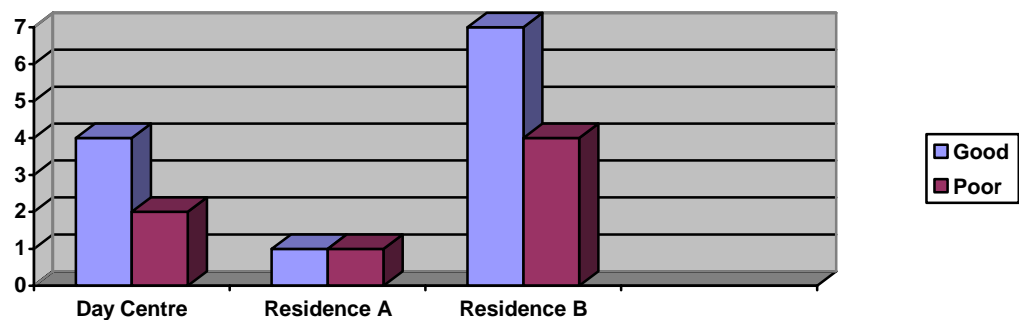
Day Centre:

The total number of patients attending the session was 19. Of these only 6 were seen by the dentist for a dental check because either the consent section on the paperwork had not been filled in prior to the dental visit or the person had been seen previously at Residence A or B. People that were able to consent for themselves on the day or came with a carer/relative who could 'consent' on their behalf were seen by the dentist.

The chart below shows that 2 people that attended the Day Centre for a dental check had already been seen at either Residence A or B. The dentist was unable to see a further 11 people because the consent forms had not been completed prior to the visit.



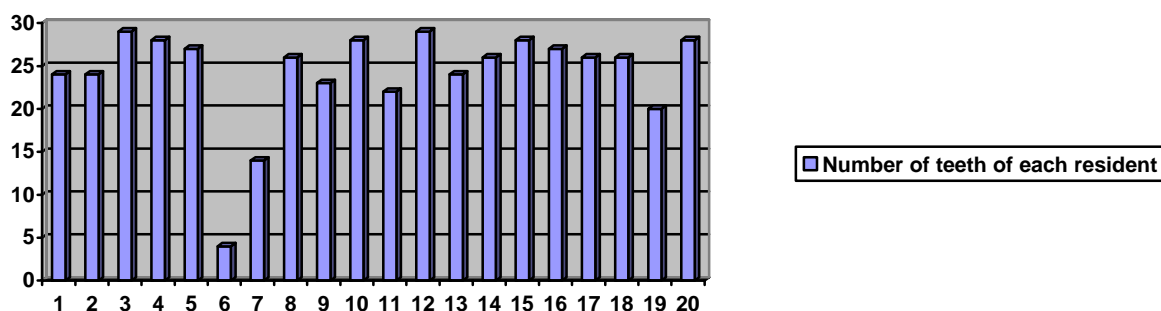
Oral hygiene status



The majority of the people (63%) had good-fair oral hygiene with approximately under half the people seen (37%) having poor oral hygiene.

Number of teeth

All of the residents screened had average of 24.2 natural teeth. None of the residents wore dentures.



Number of carious teeth

The number of carious teeth was zero.

Number of mobile teeth

1 (0.05%) person had mobile teeth.

Number of residents requiring dental treatment

2 (10.5%) people had dental problems requiring dental treatment.

9 (47%) people required a scale and polish

Therefore 58% of the people seen required dental treatment.

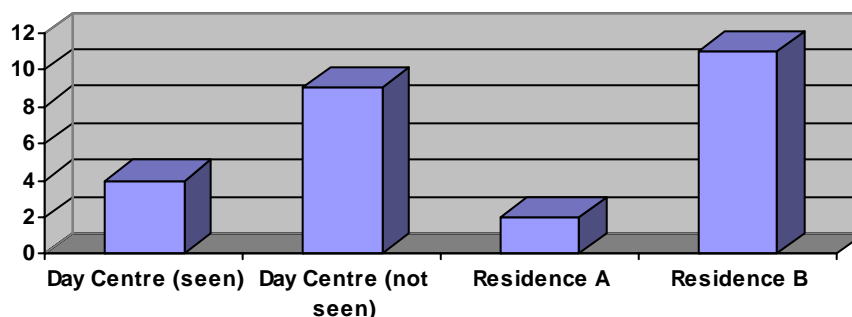
Number of people already accessing dental care

11 (92%) Residence B residents are seen regularly at a local Dental Clinic.

2 (100%) Residence A residents currently access dental care in the OSPCDS.

4 (67%) of the people seen at Day Centre currently access dental care in the OSPCDS

9 (82%) of the people not seen at the Day Centre (excluding the 2 people that had already been seen at either Residence A or B), access a local Dental Clinic for continuing care.



In total 83.9% are seen regularly in the OSPCDS for continuing care.

Outcomes of the pilot

The results for the clinical outcomes that the pilot aimed to measure are listed below:

- To assess oral health and dental need in LD population – there is a definite need for dental care within this patient group. The results from the pilot showed that 83.9% of the people seen were already accessing dental services and that 58% needed some form of dental treatment i.e. scale & polish or fillings.
- To assess number of individuals currently accessing dental care – from the sample of people used in the pilot 83.9% were already accessing dental services
- To provide signposting and access to dental services – this was offered to the people that were identified as currently not accessing any dental services

The following outcomes were measured using the results from the Oral Health Promotion teams component of the pilot –

- To assess attitude of care staff
- To assess knowledge level changes among care staff working in supported living environments
- To assess knowledge level changes among care staff working in a day centre for adults with learning disabilities
- To evaluate the training programme by care staff working in supported living environments
- To evaluate the training programme by care staff working in a day centre for adults with learning disabilities

Discussion

Overall the results from the pilot were very positive. The staff were receptive to the dental visits and keen to assist where required. The dental team was made to feel welcome at each of the three sites.

There were some common problems with the paperwork and consent at the sites. The paperwork has not been distributed adequately to the carers or relatives in both the residential homes and the day centre which resulted in 11 people not being seen by the dentist in the day centre. One of the houses in Residence B had no problem with the paperwork and it had all been fully completed prior to the dentist's arrival. This may be due to poor communication between the dental teams and the home managers or the home managers and their staff.

There was a degree of overlap with the visits as some of the people due to be seen at the Day Centre had already been seen either Residence A or B. Dental checks were not repeated on people that had already been seen at the

other sites. This resulted in the total number of people being seen by the dentist being reduced.

The main oral health issues were debris, plaque and calculus present in the mouth. 9 of the residents required a scale and polish. This problem could be prevented or improved by implementing oral hygiene regimes in both residential homes and day centres.

The number of carious and mobile teeth was low in the people seen. This is surprising as the figures were expected to be higher. An explanation for this may be that many of the patients seen in this pilot were patients seen regularly at a local Dental Clinic. It was noted that the patients were more compliant and receptive to the dental checks in their own environments compared to in the clinic.

The majority of the people seen in the pilot were already accessing dental services. Information was provided to those that were not accessing dental services.

Recommendations

The main problems highlighted by this pilot were consent issues and sample size. It is also likely that the results are biased as the majority of the people seen in this pilot are already being seen regularly in the OSPCDS.

The following recommendations should be considered prior to the development of any future programmes with this patient group.

- Clear communication between the dental team and the managers of the residential homes/day centres.
- Improved communication between the home and day centre managers with carer/relatives of people with learning disability.
- Ensure that signing of consent forms is carried out by either the person or their carer prior to dental visits.
- Day centres are the preferred site to provide dental visits on people that are able to consent for themselves i.e. people with mild learning disability.
- Residential homes are preferred sites to provide dental visits for people with moderate-severe learning disability as they can be consented for in advance if organised adequately by the home managers.
- To increase access to people's homes for domiciliary dental checks as people that do not visit day centres or live in residential homes will be excluded.
- To re-pilot the study in an area that does not have an OSPCDS clinic in close proximity.
- Use a larger sample size and focus on either residential homes or day centres rather than try to combine the various sites in the same study.

- Follow up on signposting to assess if people currently not accessing dental services start after they have been seen by the dentist.

References

1. Department of Health (2005) Choosing Better Oral Health
2. Department of Health (2001) Valuing People. A new strategy for learning disability for the 21st century
3. Department of Health (2007) Valuing people's oral health. A good practical guide for improving the oral health of disabled children and adults.
4. Owen J, Dyer T.A, Mistry K. People with learning disabilities and specialist services. BDJ 2010; 208: 203-205
5. Institute for Health Research. Estimating future need/demand for supports with for adults with learning disabilities in England. Lancaster University 2004
6. Mental Capacity Act 2005

Appendix A

Oxfordshire Salaried Primary Dental Care Service

Astral House
Granville Way
Bicester
OX26 4JT

Free Dental Examinations at Day Centre

The Oxfordshire Salaried Primary Dental Care Services are planning to visit the Day Centre on Tuesday 4th May to offer free oral health checks and signposting to dental services for clients.

Dental examinations are an integral part of a person's well being and should be performed regularly. They are important for everyone, including those with no natural teeth of their own. A full exam not only identifies problems with the teeth, but also examines the gums and other tissues for diseases such as oral cancer.

Our experienced dental team will shortly be visiting your Day Centre. All individuals will be invited to see the team for a free dental examination. The dentist will let you know if there are any oral health problems that require attention. They will also make specific recommendations regarding your oral care if necessary.

If you would like to see the dental team when they visit, then please inform a member of the Day Centre staff. Some background information regarding your medical history will need to be collected before the dental visit and the staff will liaise with you regarding this.

For clients unable to provide consent for themselves please can the section below be completed and brought with the client on the day -

To the best of my knowledge, the client has not refused to have an oral health check in a valid advance directive. I believe the oral health check to be in the client's best interests because:

Name

Relationship to client

Address (if not the same as the client)

.....
.....
.....

SignatureDate

Any other comments (including any concerns about the oral health check):

If you have any questions, then please ask a staff member for more details.

Oxfordshire Salaried Primary Dental Care Service

Appendix B

Oxfordshire Salaried Primary Dental Care Service

Astral House
Granville Way
Bicester
OX26 4JT

Free Dental Examination for Care Home Residents

The Oxfordshire Salaried Primary Dental Care Services are planning to visit local residential homes to offer free oral health checks and signposting to dental services for clients.

Dental examinations are an integral part of a person's well being and should be performed regularly. They are important for everyone, including those with no natural teeth of their own. A full exam not only identifies problems with the teeth, but also examines the gums and other tissues for diseases such as oral cancer.

Our experienced dental team will shortly be visiting your home. All residents will be invited to see the team for a free dental examination. The dentist will let you know if there are any oral health problems that require attention. They will also make specific recommendations regarding your oral care if necessary.

If you would like to see the dental team when they visit, then please inform a member of the care home staff. Some background information regarding your medical history will need to be collected before the dental visit and the staff will liaise with you regarding this.

For clients unable to provide consent for themselves please can the section below be completed -

To the best of my knowledge, the client has not refused to have an oral health check in a valid advance directive. I believe the oral health check to be in the client's best interests because:

Name

Relationship to client

Address (if not the same as the client)

.....
.....
.....

SignatureDate

Any other comments (including any concerns about the oral health check):

If you have any questions, then please ask a staff member for more details.

Oxfordshire Salaried Primary Dental Care Service

References

1. Department of Health (2005) Choosing Better Oral Health
2. Department of Health (2001) Valuing People. A new strategy for learning disability for the 21st century
3. Department of Health (2007) Valuing people's oral health. A good practical guide for improving the oral health of disabled children and adults.
4. Owen J, Dyer T.A, Mistry K. People with learning disabilities and specialist services. BDJ 2010; 208: 203-205
5. Institute for Health Research. Estimating future need/demand for supports with for adults with learning disabilities in England. Lancaster University 2004

Consultation Report

Oral Health Needs Assessment

Author(s)	Josephine Wilkes, Communications & Engagement Officer Sarah Adair, Head of Communications & Engagement
Status	Final
Date	August 2010

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1. About NHS Oxfordshire

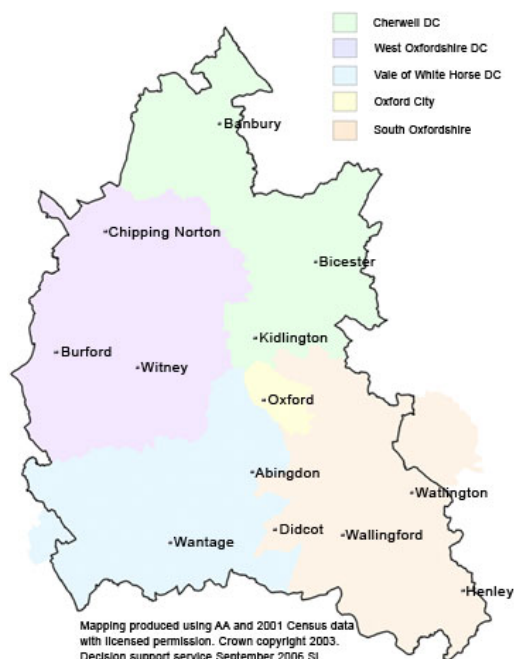
NHS Oxfordshire is a Primary Care Trust (PCT) and serves a population of around 600,000.

We are ambitious about improving the health and wellbeing of local people. NHS Oxfordshire intends that, by 2013, the people of Oxfordshire will:

- be healthier, particularly if they are vulnerable or live in our most deprived communities
- be working with NHS Oxfordshire to promote physical and mental wellbeing and prevent ill health
- be actively supported to manage their health and care needs at home when this is appropriate
- have access to high quality, personalised, safe and appropriate health services
- get excellent value from their local health services
- have a PCT which is a high performing organisation.

Oxfordshire is the most rural county in south east England and has a large geographical area to cover as well as a diverse population to serve. The population of Oxfordshire ranges from a predominantly older, white population in the rural areas to very ethnically diverse populations in Banbury and Oxford city where one third of the population are students.

NHS Oxfordshire works with our communities and our partners to improve health in the area and to make sure that local people's needs are being met. We also work with organisations from the voluntary, private and community sectors so that we can make sure that the organisations providing health and social care services are working effectively.



Area covered by NHS Oxfordshire

Oxfordshire PCT serves a population of approximately 630,000 and covers the areas of Cherwell Vale District Council, Oxford City, South Oxfordshire, Vale of White Horse District Council and West Oxfordshire District Council.

2. Executive Summary

2.1 Purpose of the oral health needs assessment

NHS Oxfordshire requires a comprehensive oral health needs assessment to inform the commissioning and delivery of oral health promotion and dental treatment services in Oxfordshire. The focus is to improve our understanding of the oral health needs of the population, specifically older people, vulnerable groups (seldom heard groups ie. gypsies and travellers), black and minority ethnic groups, people with learning difficulties, parents and children. It will assist in planning services and addressing health inequalities.

NHS Oxfordshire is committed to improving NHS dental services for people in the county; thereby we need to fully understand people's oral health needs as well as identifying areas of unmet need. The following report explains how the PCT has identified and collated relevant local views on oral health promotion needs and gaps in provision.

2.2 Process & Methodology

An oral health needs survey was developed to ask people in Oxfordshire (their carers or parents), about the dental care they have received over the past few years; whether they could access an NHS dentist; dental hygiene and habits affecting oral health.

The survey was publicised on 'Talking Health', the PCT's online consultation tool and is available on the PCT's website. This enabled patients to answer the survey on line and also add in any additional comments. Paper copies of the survey were also received and included into the online consultation tool.

332 patients responded to the survey.

The survey and the Oral Health Needs Assessment ONA was publicised in the media, through dental surgeries, libraries and PCT staff attended community settings to share information and collate feedback. It was also communicated via the Staff Bulletin and on the PCT's intranet page.

Separate to this report, but to be included in the ONA, is work undertaken by Ipsos Mori to gain a deeper understanding of the oral health needs of black, ethnic and minority groups, people with learning disabilities and gypsies and travellers.

2.3 Key findings

Analysis of the consultation findings from the on-line survey are below:

- The majority of patients felt that dental checks were important to have teeth checked for cavities, or to detect or prevent gum disease.
- Pain/sensitivity to hot and cold food or drinks was the biggest problem that patients were experiencing.
- Patients stated the following reasons why they could not access an NHS dentist in their area:

- *There is only emergency treatment available*
 - *I cannot afford treatment*
 - *The waiting list is too long*
 - *My NHS dentist went private*
 - *Some patients in the Chinese community experienced difficulty due to the language barrier*
 - *Prisoners on remand only receive emergency dental treatment*
- Respondents felt there were not enough NHS dentists in the following areas: Banbury, Chinnor, Chipping Norton, Henley, Oxford, Wallingford, Wantage and Witney.
 - Patients would either call NHS Direct or go to their local hospital to receive emergency treatment.
 - The majority of patients used fluoride toothpaste however, they did not know how much fluoride (ppms) it contained.
 - The majority of patients who wore dentures used toothpaste to clean them regularly.

2.4 Conclusion and recommendations

The aim of this oral health survey is to provide feedback from the public and service users to be included in a comprehensive assessment of the oral health needs of the resident population in Oxfordshire. The ONA would identify areas of unmet need which will help inform the local commissioning of Oral Health services.

The following are recommendations to be considered for inclusion in the ONA:

- Publicise the emergency treatment facility.
- Signpost to appropriate services.
- Raise awareness of how to alleviate pain and sensitivity to hot and cold food or drinks.
- Investigate availability of appointments at NHS dentists in Banbury, Chinnor, Chipping Norton, Henley, Oxford, Wallingford, Wantage and Witney. If identified that there is sufficient NHS dentistry provision in these areas, a publicity campaign to raise awareness of dentist services may be useful.
- Ensure NHS dental practices have access to language line/translation services.

3. Background

Since 2006, primary care trusts have had responsibility for commissioning primary care dental services to reflect local needs and priorities. This means that primary care trusts now have an integrated responsibility for

commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, in community-based salaried services, or in hospitals.

The current dental service provision in Oxfordshire includes Primary Care Dental Services such as General and Personal Dental Services, Out of Hours Emergency Dental Services and Oral Health Promotion. The PCT also commissions more specialist dental services including:

- Prison dentistry
- Dental services for patients with special needs
- Domiciliary services
- Orthodontics
- Conscious Sedation & dental treatment under General Anaesthetic
- Minor Oral surgery
- Restorative Dentistry

A number of key documents have been produced linked to NHS dental services and key themes of these documents include:

- Improving equity of dental access for everyone
- Trying to reduce oral health inequalities
- Reorientation of dental care to a more preventative focus
- Engaging and involving the community in determining policy
- Integrating dentistry within the NHS family

In 2008 NHS Oxfordshire (PCT) published the Strategic Commissioning Framework for Dental Services for Oxfordshire to support improvement in oral health of the population in Oxfordshire. In line with the strategic direction for the PCT, the framework contributes to the organisational aims by supporting people to:

- be healthier by preventing oral health problems
- improve their well being through improving their oral health
- manage their own health in association with skilled dental care professionals
- have access to high quality, personalised safe and appropriate dental care
- get excellent value for money from NHS dental services

These themes have been explored as part of the local needs assessment.

3.1 Why do we need an oral health needs assessment?

NHS Oxfordshire required a comprehensive oral health needs assessment to inform the commissioning and delivery of oral health promotion and dental treatment services in Oxfordshire. The focus is to improve our local understanding of the oral health needs of the population and will assist in planning services and addressing health inequalities.

3.2 How will feedback be used?

All ONA responses will be evaluated and will assist in planning services and addressing health inequalities in Oxfordshire. Feedback from the survey will

be used to make recommendations that will be considered for inclusion in the ONA.

4. Stakeholders for oral health needs assessment

The stakeholders for the oral health needs assessment are patients, their families and carers in Oxfordshire who shared their views on oral health promotion needs and gaps in provision.

4.1 Stakeholders

The key stakeholders identified for this consultation were:

NHS Dentists

All NHS Dentists in Oxfordshire were sent copies of the survey inviting patients/carers to comment via 'Talking Health'.

Baby Cafes

Parents and grandparents with children under five years old in Barton and Headington.

Older people

In residential settings, in the community with long term conditions. – Age Concern and day centres.

Vulnerable people

Prisoners in HMS Bullingdon.

Military Personal

Families of military personnel at RAF Brize Norton and Bicester Hive Garrison.

BME Groups

Chinese community in Banbury and members of the Asian community in Oxfordshire.

Families

Parents with young children at Marston North, North Oxford and Barton family centres.

Young people

Sweatbox young people's group, 11-17 years old.

NHS Oxfordshire staff

Staff were engaged via the internet and the intranet.

Media

The local media were notified of the consultation which helped to increase awareness of NHS dentistry in Oxfordshire. The PCT lead in Public Health gave an interview to BBC Radio Oxford, highlighting the ONA and how local people can get involved.

Other

The survey was also discussed at the Young People's Oxfordshire Parliament group. An article was featured in the following local newsletters; Wallingford,

Kidlington, Watlington, North Aston, Blewbury, Marcham, Benson and Peppard. 43 libraries in Oxfordshire received posters highlighting the 'Talking Health' website for on-line completion of the survey.

5. Engagement process

Efforts were made to engage with and facilitate feedback from patients, families and carers using the methods below:

5.1 Oral Health Needs Assessment – Online engagement

NHS Oxfordshire Talking Health website

A structured survey for the oral health needs assessment was set up on the Talking Health website which enabled patients, families and carers in Oxfordshire to state their views on their oral health needs and identify any gaps in provision. In total 332 questionnaires were inputted manually onto the talking health website.



NHS Oxfordshire Website

A news release featured on NHS Oxfordshire's website, highlighted how to access the survey on the Talking Health website.



NHS Oxfordshire Intranet

NHS Oxfordshire intranet was used to communicate the oral health needs survey highlighting the Talking Health website.

All Staff email

The ONA was communicated widely to all NHS Oxfordshire staff via the everyone@... email facility and weekly bulletin.

5.2 Engagement Findings – Talking Health

The survey was completed by 332 patients living in the following areas in Oxfordshire; Abingdon, Banbury, Bicester, Chipping Norton, Didcot, Henley, Kidlington, Oxford, Watlington, Wantage, Witney and Wallingford.

A diversity of patients, families and carers including representation from the Chinese and Asian communities engaged in the survey. 50 surveys were completed by the Chinese community ranging from ages 45-74.

Analysis of the consultation findings from the OHN survey are outlined below:

Experience of the dentist:

- 88% of patients in Oxfordshire, who responded to the questionnaire, had their own dentist.
- 75% patients who completed the survey had registered with an NHS dentist. There were small groups in Bicester and Banbury who did not have any access to any dentist, NHS or private.
- 66% patients had visited their dentist within the last six months and 10% had not seen a dentist for two years or longer.
- Of the 332 patients surveyed, 99% stated that dental checks were important; to have their teeth checked for cavities, or to detect or prevent gum disease.

Condition of teeth:

- 42% patients described the condition of their teeth as good and 33% reported they were neither bad nor good.
- Pain and sensitivity to hot and cold food or drinks was the biggest problem that 24% of patients experienced.
- Below are some of the reasons why 33% of patients felt they needed to see a dentist but were unable too:
 - *I have no trust in dentists, they are not efficient*
 - *I am scared of pain*
 - *My teeth and mouth take a long time to recover after treatment*
 - *My NHS dentist is going private*

Access:

- 65% knew how to access an NHS dentist in their area. However, 29% had difficulty because of the following reasons:

- *Only emergency treatment was available*
 - *I cannot afford treatment*
 - *The waiting list is too long*
 - *My NHS dentist went private*
 - *No disability access*
 - *Some patients in the Chinese community experienced difficulty due to the language barrier*
- 40% patients felt that there were not enough NHS dentists in the following areas; Banbury, Chinnor, Chipping Norton, Henley, Oxford, Wallingford, Wantage and Witney.
 - 46% patients do not know how to access emergency dental treatment and 33% patients who did would either call NHS Direct or telephone their local hospital.

Care of teeth:

- 46% patients clean their teeth in the morning and 41% clean their teeth in the evening.
- 85% patients use fluoride toothpaste; however, they do not know how much fluoride (ppm) they use.
- In terms of diet 25% patients ate sugary foods and 40% patients drank water regularly.
- 62% patients were advised by their dentist on how to care for their teeth and mouth.

Dentures:

- 63% patients said their dentures were comfortable and 41% use toothpaste to care for their dentures morning and evening.

Additional comments below:

- *The survey is well designed*
- *Private dentists are expensive*
- *A lot of dentists are not culturally sensitive when a patient cannot speak English very well*

6. Next Steps

By collating this information we will be able to commission (purchase) the right dental services for patients in Oxfordshire. Oral and dental health affects everyone and therefore the survey covered a wide range of areas. Feedback from the survey will be used to make recommendations that will be considered for inclusion in the ONA. The ONA will be published on the PCT website: www.oxfordshirepct.nhs.uk

7. Thanks

Thanks to all the patients in Oxfordshire who have responded to this consultation which will help to shape services and identify gaps in service provision

Supporting information

Glossary

NHS	National Health Service
PCT	Primary Care Trust
Intranet	A private computer network open to users working within an organisation to share information, news and documents
Talking Health	NHS Oxfordshire's consultation and engagement area on our public website
BME	Black & Minority Ethnicity
ONA	Oral Health Needs Assessment

8. Appendix – Oral Health Needs Assessment Survey



Oral Health Survey

Thank you for taking the time to complete this survey on oral health. The survey should take about 15 minutes to complete.

What is this survey?

This survey will ask you or the person you care for about the dental care you have received over the past few years; whether you can access an NHS dentist; your dental hygiene and habits affecting your oral health.

Please note – all your answers will be treated in the strictest confidence

Why are we doing this?

NHS Oxfordshire is committed to improving NHS dental services for people in Oxfordshire, but we need your help to make sure we fully understand people's oral health needs as well as identifying areas of unmet need. By collating this information we will be able to commission (purchase) the right dental services for people in the county. Oral and dental health affects everyone and therefore this survey covers a wide range of areas.

Survey

Please let us know whether you are:

Providing your own response.	[]
A parent responding on behalf of your child	[]
A carer responding on behalf of someone else	[]

If you are responding on behalf of someone else please give the age of that person in section 7.

Section 1: Your Dentist

1.1	Do you have your own dentist?
	Yes <input type="checkbox"/> No <input type="checkbox"/>
1.2	If yes, are they an NHS dentist or private dentist
	NHS <input type="checkbox"/> Private <input type="checkbox"/>
1.3	When did you last go to the dentist?
	Within the last 6 months <input type="checkbox"/>
	Within the last 12 months <input type="checkbox"/>
	1-2 years ago <input type="checkbox"/>
	Two years or longer <input type="checkbox"/>
	Never <input type="checkbox"/>

1.4	If you haven't been to the dentist recently, why not?	
	I can't find a NHS dentist	<input type="checkbox"/>
	I don't like dentists	<input type="checkbox"/>
	I can't afford to go	<input type="checkbox"/>
	I forget to go	<input type="checkbox"/>
	I haven't got time to go	<input type="checkbox"/>
	I can't travel to a dentist	<input type="checkbox"/>
	The available times/locations are inconvenient for me	<input type="checkbox"/>
	There is nothing wrong with my teeth	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
	Not applicable to me	<input type="checkbox"/>
	Other	

1.5	Do you think dental checks are important?	
	Yes <input type="checkbox"/> If yes, please tick all your reasons	No <input type="checkbox"/> If no, please go to section 2
	To have teeth checked for cavities	<input type="checkbox"/>
	To prevent toothache	<input type="checkbox"/>
	To detect or prevent gum disease	<input type="checkbox"/>
	To prevent bad breath	<input type="checkbox"/>
	To detect skin and mouth disorders including cancers	<input type="checkbox"/>
	To maintain or improve my appearance	<input type="checkbox"/>
	Other	

Section 2: Your Teeth:

2.1	Which of the following, if any, is applicable to you?	
	My teeth have not yet grown (parents to answer on behalf of their child) <input type="checkbox"/>	
	I have all my own teeth	<input type="checkbox"/>
	I have some missing teeth	<input type="checkbox"/>
	I have dentures	<input type="checkbox"/>
	I have both dentures and my own teeth	<input type="checkbox"/>
	I have no teeth	<input type="checkbox"/>

2.2	How would you describe the condition of your mouth and teeth?	
	Very good	<input type="checkbox"/>
	Good	<input type="checkbox"/>

	Neither good nor bad	<input type="checkbox"/>
	Bad	<input type="checkbox"/>
	Very bad	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
	Other	

2.3	Do you currently have any problems with your mouth and teeth?	
	Yes <input type="checkbox"/> Please go to Q2.4	No <input type="checkbox"/> Please go to section 3

2.4	If YES, what sort of problems are you experiencing?	
	Toothache	<input type="checkbox"/>
	Pain/sensitivity to hot and cold food or drinks	<input type="checkbox"/>
	Bad breath	<input type="checkbox"/>
	Painful gums	<input type="checkbox"/>
	Bleeding gums	<input type="checkbox"/>
	Stained teeth	<input type="checkbox"/>
	Other.....	

2.5	Do you think you need to see a dentist?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/> Please go to section 3	Not sure? <input type="checkbox"/>

2.6	If YES, what is preventing you from seeing a dentist?	
	I don't know how to access a NHS dentist	<input type="checkbox"/>
	I don't like dentists	<input type="checkbox"/>
	I can't afford to go	<input type="checkbox"/>
	I forget to go	<input type="checkbox"/>
	I haven't got time to go	<input type="checkbox"/>
	I can't travel to a dentist	<input type="checkbox"/>
	The available times/locations are inconvenient for me	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
	Other	

Section 3: Access

3.1	Do you know how to access a NHS dentist?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I think so/not sure <input type="checkbox"/>

3.2	Have you ever experienced problems with accessing a NHS dentist?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

3.3	If yes, what problem(s) did you face and what was the outcome?		

3.4	Do you think there are enough NHS dentists in the area where you live?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>

3.5	If you <u>do not</u> have a regular dentist, do you know how to get dental treatment?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I think so/not sure <input type="checkbox"/>

3.6	If yes, how and where would you access this dental treatment?		

3.7	Do you know where to get emergency dental treatment when your dentist is closed?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I think so/not sure <input type="checkbox"/>

3.8	If yes, please state how you would access this service?		

3.9	Have you ever consulted your GP about your teeth?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I don't think so/not sure <input type="checkbox"/>

Section 4: Care of your Teeth

4.1	When do you clean your teeth?
	In the morning <input type="checkbox"/>
	Before I go to bed <input type="checkbox"/>
	After eating <input type="checkbox"/>
	Never <input type="checkbox"/>
	At random points in the day <input type="checkbox"/>
	Other <input type="checkbox"/>

4.2	Do you use fluoride toothpaste
	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/not sure <input type="checkbox"/>

4.3	Do you know how much fluoride is in your toothpaste?
	No <input type="checkbox"/>
	Less than 1000ppm <input type="checkbox"/>
	1000-1500ppm <input type="checkbox"/>
	More than 1500ppm <input type="checkbox"/>

4.4	Do you use dental floss?
	No <input type="checkbox"/>
	Yes, daily <input type="checkbox"/>
	Yes, weekly <input type="checkbox"/>
	Occasionally <input type="checkbox"/>
	Other:

4.5	Do you do any of the following regularly? (every day or every other day)
	Smoke <input type="checkbox"/>
	Chew tobacco <input type="checkbox"/>
	Drink alcohol <input type="checkbox"/>
	Drink alcohol and smoke together <input type="checkbox"/>
	Eat sugary foods <input type="checkbox"/>
	Drink sugary drinks <input type="checkbox"/>
	Drink water <input type="checkbox"/>

4.6	When you last visited your dentist did they advise you about how to care for your teeth and mouth?
	Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure/can't remember <input type="checkbox"/>

Section 5: Dentures (please only answer if you have dentures)?

5.1	Are your dentures comfortable?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fairly <input type="checkbox"/>

5.2	Are your dentures loose?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Slightly <input type="checkbox"/>

5.3	Are your dentures broken?	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>

5.4	Do you take your dentures out at night?			
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mostly <input type="checkbox"/>	Sometimes <input type="checkbox"/>

5.5	What do you use to clean your dentures?	
	Toothpaste	<input type="checkbox"/>
	Milton or Sterilising Fluid	<input type="checkbox"/>
	Denture Cleaning solution	<input type="checkbox"/>
	Soap	<input type="checkbox"/>
	Other:	

5.6	When do you clean your dentures?	
	In the morning	<input type="checkbox"/>
	Before I go to bed	<input type="checkbox"/>
	After eating	<input type="checkbox"/>
	Never	<input type="checkbox"/>
	Other	

Section 6: Further comment

	Would you like to add any other comments?

Section 7: Personal Details:

We would be grateful if you would provide the following information – it will help us know if we have received responses from a representative group of people.

Age Range

- Under 8 ☐
9-15 ☐
16-24 ☐
25-34 ☐
35-44 ☐
45-54 ☐
55-64 ☐
65-74 ☐
Above 75 ☐

Gender

- Male ☐ Female ☐ Prefer not to say ☐

Ethnicity

- White ☐
Mixed ☐
Asian or Asian British ☐
Black or Black British ☐
Chinese ☐
Other
Prefer not to say ☐

Do you consider yourself to have a disability?

- Yes ☐ No ☐

Please can you give your full postcode below? This will be used to assess where we are receiving responses from across the Oxfordshire area.

Postcode: []

Please return the survey by **Tuesday 22 June 2010** to the FREEPOST address below. No stamp is needed:

FREEPOST RRK-BZBT-ASXU
Josephine Wilkes
Communications and Engagement Directorate
NHS Oxfordshire
5510 John Smith Drive
Oxford Business Park South
Oxford OX4 2LH

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Oral health needs assessment qualitative research

for **NHS Oxfordshire**

15th July 2010

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Introduction

Introduction

Background to the Research

Since 2006, primary care trusts have had responsibility for commissioning primary care dental services to reflect local needs and priorities. This means that primary care trusts now have an integrated responsibility for commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, in community-based salaried services, or in hospitals.

The current dental service provision in Oxfordshire includes Primary Care Dental Services such as General and Personal Dental Services, Out of Hours Emergency Dental Services and Oral Health Promotion. The PCT also commissions more specialist dental services including:

- Prison dentistry
- Dental services for patients with special needs
- Domiciliary services
- Orthodontics
- Conscious Sedation & dental treatment under General Anaesthetic
- Minor Oral surgery
- Restorative Dentistry

A number of key documents have been produced linked to NHS dental services and key themes of these documents include:

- Improving equity of dental access for everyone
- Trying to reduce oral health inequalities
- Reorientation of dental care to a more preventative focus
- Engaging and involving the community in determining policy
- Integrating dentistry within the NHS family

In 2008 Oxfordshire PCT published the "Strategic Commissioning Framework for Dental Services for Oxfordshire" to support improvements in oral health of the population in Oxfordshire. In line with the strategic direction for the PCT the framework contributes to the organisational aims by supporting people to:

- be healthier by preventing oral health problems;
- improve their wellbeing through improving their oral health;
- manage their own oral health in association with skilled dental care professionals;
- have access to high quality, personalised safe and appropriate dental care; and

- get excellent value for money from NHS dental services.

These themes needed to be included and explored as part of the local needs assessment.

Aims and objectives of qualitative research

Against this background, Oxfordshire PCT is carrying out a comprehensive oral health needs assessment (HNA) to inform the commissioning and delivery of oral health promotion and dental treatment services in Oxfordshire. Ipsos MORI's role was to explore the experiences and needs of three distinct groups across Oxfordshire:

- people with learning difficulties;
- BME residents, namely Bangladeshi, Pakistani and new Polish migrants; and
- Gypsies and travellers.

Structure of the discussion groups & interviews

In line with the wider oral health survey, this qualitative project focused on exploring people's experiences and needs in relation to:

- their dentist (regularity, experience, reason for visit);
- condition of their teeth (problems and barriers to treatment);
- access to dental care (ease of access, experience and barriers to service);
- how they care for their teeth (including potentially damaging diet and lifestyle choices); and
- dentures (where applicable)

Fieldwork took place in Oxfordshire between 16 June and 5 July 2010. We carried out one to one face-to-face interviews with all participants. In the case of several of the gypsy and traveller interviews more than one person took part in the interviews. Each interview lasted between 10 and 25 minutes. All interviews were carried out in the participant's homes except in the case of those with learning difficulties where research took place at the City Day Service in Albion House, Oxford.

Participant profile & recruitment

In total we carried out the following interviews

Group	Subgroup	Number of interviews
People with learning difficulties	Learning difficulties	6
Gypsies and travellers	Gypsy	4
	Traveller	4
Black and minority ethnic groups	Bangladeshi	2
	Pakistani	2
	New Polish Migrants	2
Total		20

People with learning difficulties would be described as having moderate or mild learning difficulties. The manager of the day care centre we visited was present through the interviews with people with learning difficulties.

We aimed to achieve at least six interviews with each profile. They were an even mix of ages and genders. Participants were aged between 19 and 68.

Two interviews were carried out with people of Bangladeshi origin in Oxford and two were with people of Pakistani origin. One participant from each group was born abroad. Both Polish participants were born overseas in Poland and had been in the UK for at least two years.

Presentation and interpretation of the data

It is important to note that where the primary methodology for data collection has been qualitative, the findings are intended to be illustrative rather than statistically representative. These findings provide insight into *why* people hold views, rather than conclusions from a robust, valid sample. In addition, it is important to bear in mind that we are dealing with people's perceptions, rather than facts.

Throughout the report, use is made of verbatim comments from participants. Where this is the case, it is important to remember that the views expressed do not always represent the views of

the group as a whole, although in each case the verbatim is representative of at least a small number of participants.

Publication of data

Our standard Terms and Conditions apply to this, as to all studies we carry out. Compliance with the MRS Code of Conduct and our clearing is necessary of any copy or data for publication, web-siting or press releases which contain any data derived from Ipsos MORI research. This is to protect your reputation and integrity as much as our own. We recognise that it is in no-one's best interests to have findings published which could be misinterpreted, or could appear to be inaccurately, or misleadingly, presented.

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Checked & Approved:

Anna Carluccio, Research Director

Joe Lancaster, Senior Researcher

Findings of the research

Residents with learning difficulties

Experience of the dentist

Most of the participants with learning difficulties were registered with a dentist. Several were registered with a specialist NHS service at the Manzil Way Health Centre¹, and another used the NHS dentist based inside his council estate. Whilst no one was registered with a private dentist, the centre manager commented that service user's families often used their own private dentist.

"I've got a good dentist in Manzil Way but I have to use my manual wheelchair when I go inside. My dad has to lift me into the dentist chair. I really like the hygienist there she's very nice to me."

Man with learning difficulties

We found that people who had had treatment recently were more likely to be registered with a dentist or be aware of where they could get treatment if they needed. In addition, if people had recently seen a dentist they were more likely to have received an invite to a check up which helped to maintain their relationship with a particular dentist.

Many had been to the dentist within the last 12 months. Several, however, could not recall when they had last seen a dentist, estimating that this was not for two to three years. One participant with dentures had not been to the dentist since she had her remaining teeth removed in 1968.

In general, we found that people were driven to visit the dentist by a specific need such as a pain in the gums or teeth. Most people's last visit to the dentist was to have treatment for a cavity rather than for a routine check up. Only one participant saw check ups as important and visited the dentist even if they didn't have any symptoms.

Condition of teeth

Most people described the condition of their teeth as good and did not currently have any problems. One of the participants was receiving regular treatment for the formation of his teeth that were clearly misaligned. He visited a dental hygienist once a month for a clean and was expecting to have a brace fitted shortly.

¹ Cowley Road, Oxford Contact: 01865 264980

Access

Most people had a relationship with a dentist; they either knew they were registered or knew of a dentist where they had received treatment in the past. Many had long standing relationships with their dentists and did not report any problems relating to access.

Just one person had needed emergency dental treatment, but this was taken care of by their regular dentist during normal office hours.

A number of factors help to explain people's seemingly good access to dental care. Firstly, and most importantly, people with learning difficulties are supported by various carers who can help them with their healthcare needs. The people we met have conditions such as downs syndrome (extra chromosome), autism, and cerebral palsy. Clinically, they would be described as having moderate or mild learning difficulties. This network of carers works on their behalf to seek out and find appropriate dental care, remember the appointment and take them to the dental surgery.

"If I have any problems with my teeth I would just ask my dad to take me (to the dentist)"

Woman with learning difficulties

"I live with three carers so if I have any problems I just ask them to help me"

Man with learning difficulties

Secondly, some people were registered with a dentist in Manzil Way who ran a specialised service for people with learning difficulties. The building has wheelchair access, their staff are receptive, and they can schedule appointments outside of normal office hours for people who found the waiting room experience made them overly anxious. As they offered a specialist service this dentist stood out from others; it is the 'go-to' service for people with learning difficulties.

It should be noted that wheelchair access would need to be an essential feature of any dentist able to serve physically disabled people. Similarly, people who use a wheelchair may need helping into the dentist's chair. In the case of one participant his father helped him with this. It is clear that dentists would need to be able and comfortable for this to take place. Discussing these features illustrates that dentists that cannot support these needs would not be suitable as they would be less accessible

Care of teeth

Most people cleaned their teeth only once a day and in one case just once a week. Of those that cleaned daily, some would clean in the morning and others in the evening. Cleaning your teeth was not something everyone did automatically, and many mentioned that their parents or other carers had a role in reminding them to clean their teeth. The participant who cleaned his teeth weekly did so only when he came to the day care centre.

"I sometimes forget to clean my teeth but when I'm here (at the day care centre) or at respite (care centre) they always remind me"

Man with learning difficulties

People with learning difficulties tended to care for their teeth by using toothpaste and a toothbrush. No one used mouthwash or floss. One participant, however, had regular treatment with the dental hygienist on a monthly basis.

In terms of diet, it seems that fizzy drinks were quite commonly consumed by our participants. Whilst it was important to the day care centre we visited to offer people 'healthy choices' that avoided fizzy drinks, other carers did not discourage service users from drinking fizzy drinks. It is notable that most people brushed their teeth on a daily basis and yet were also likely to have a fizzy drink at some point during the day. Only one participant drank alcohol and none smoked cigarettes or chewed tobacco.

"I have a Coke maybe a few times a week when I'm in respite care"

Woman with learning difficulties

None of the people we spoke to could recall advice their dentist had given them about how best to care for their teeth and mouth. It should be noted that several people had not been to the dentist for some years, and that most had not been for many months (but less than a year).

Carers also seem to have a role in helping people take care of their teeth. Carers can work hard at reminding people about the importance of dental hygiene, watching out for any pain or discomfort they may have, and supporting a healthy diet. Equally, where carers do not fulfil this role, and do not see the importance of dental hygiene, people may not take good care of their teeth. We found that some carers were not reminding people of the importance of check ups and avoiding sugary foods or fizzy drinks.

"My dad tells me that if I don't brush my teeth then they'll fall out"

Man with learning difficulties

Dentures

Our sole participant who wore dentures was very satisfied with them and found them very convenient to clean. She had no issues with them and they were in good condition despite not having been changed or maintained since 1968.

She removed her teeth each evening and put them into a Steradent solution overnight. On a monthly basis she said they needed cleaning with a brush, by which time they could be quite dirty and 'needed doing'.

Bangladeshi, Pakistani and new Polish residents

We have reported on Bangladeshi and Pakistani people in the same section of the report as there are a number of similarities between their situations. Bangladeshi and Pakistani people are South Asian and share similar attitudes and behaviours in relation to diet and lifestyle. Their experiences also differ from the experience of new Polish migrants who are culturally different and have a different attitude towards food and alcohol, for example. For clarity, we have focused upon these two groups separately throughout the report.

Experience of the dentist

All of the Bangladeshi and Pakistani people in the research were currently registered with a dentist. However, prior to needing recent treatment, two of them (at the ages of 22 and 68), had just been to the dentist for the first time. All had used an NHS dentist.

"I have had good teeth all my life. I have taken good care of my teeth so I have not gone to the dentist. I have never had any problems with them. I went recently as I had a little pain but not too much. They said that it was not a problem and I did not need any treatment"

Bangladeshi woman

One person had not been to the dentist for a long time, perhaps five years or more. He commented that as there was nothing wrong with his teeth at present and had no need to go.

Condition of teeth

People described their teeth as being in good condition and not experiencing any pain. One had had treatment in the past for a wisdom tooth, and another had had a filling when she was younger.

A few of the people who had been to the dentist recently had their attitudes to dental care changed somewhat. Visiting the dentist or needing treatment had motivated them to take better care of their teeth and begin to see the dentist for regular check ups.

"I had to spend a lot of money on treatment for my teeth and I thought well I better take better care of them in the future so I don't have all this cost again...I spoke to the dentist about how best to care for my teeth and he told me about electric toothbrushes and mouthwash and floss that I now use every day"

Pakistani man

Many people did not see the value of dental check ups and would go to the dentist only when absolutely necessary that is when in pain. This view was a strongly held view, illustrated by the 68 year old woman who had recently been to the dentist for the first time.

Access

Two participants had recently been through the process of finding a dentist for the first time. In each case they had relied heavily on word of mouth recommendations of where to go for treatment over other searches. They had not seen information regarding local dentistry services and neither of them had used the internet to find a list of local dentists.

Whilst most people spoke good conversational English, one of the Bangladeshi participants found it more challenging. When she went to the dentist she took a friend with her who could translate where necessary. She had been prompted to visit a dentist after being given a leaflet by someone street marketing for that dentist.

Care of teeth

Two participants took good care of their teeth by brushing them twice a day. One person had had expensive treatment recently and was motivated to avoid problems with his teeth. To that end he had sought advice on how best to care for his teeth and appeared to be following this advice; he now used an electric toothbrush, brushed twice a day (rather than once), used mouthwash daily and also flossed regularly.

A younger Bangladesh girl brushed her teeth twice a day, and occasionally after meals that left her teeth feeling unclean in some way. She also used to use mouthwash and floss regularly but had lapsed recently.

Other people tended to rely solely on brushing their teeth just once a day and did not use floss or mouthwash.

Both Bangladeshi and Pakistani people saw a strong relationship between sweet and sugary foods and poor teeth, recognising the impact they could have. A few people explained that sugary foods and fizzy drinks were not a common part of their culture's diet and that they were far more commonplace in the West. People tended to recognise that a good diet, free from sugary foods, contributed towards good teeth. Older people, in particular, and their parents, were likely to advocate a diet free from sugary foods and drinks.

"We don't eat all these sweets you see it's a Western thing. We did not have sweets like this when we were growing up at home. Here they are everywhere and the children they always want them and are complaining to their mothers that they want sweets. We would have a sweet but like just a little bit and only maybe two or three times a year."

Pakistani woman

In addition, participants with a Muslim background are also less likely to drink alcohol and smoke cigarettes.

Dentures

None of the Bangladeshi and Pakistani people wore dentures.

Polish residents

Experience of the dentist

Both of the Polish participants had recently been to a dentist in the UK within the last six months. They had had treatment following initial assessment visits at different locations.

They had both arranged to visit a dentist as they had had toothache which they wanted treated. They did see the value of going for a check up and were not opposed to it, but neither of them had firm plans to visit the dentist for a check up in the future, and one of them had already missed his post-treatment check up.

Condition of teeth

Both of the Polish people described their teeth as being in good condition and were not experiencing any pain or discomfort. One of them had several chipped teeth as the result of a fall when mountain biking. He also had some discolouration of the teeth.

One of the men had severe toothache which led him to find a dentist. The dentist explained that he would need a wisdom tooth removed. When checking his teeth, the dentist also noticed two other teeth that needed fillings. He recommended treatment for each of these teeth.

The other man had recently had treatment for a filling. He had also had more recent treatment for root canal work.

Access

Both men had not encountered any issues in finding a dentist when they looked for one. They both used word of mouth networks to help them identify a dentist. One of the men also asked his work based medical centre if they could recommend a dentist. Their level of English was good and they had no problems searching for a dentist or making an appointment.

It is notable that the man who had pain in his wisdom tooth initially went to the hospital for treatment. The hospital suggested he make an appointment with a regular dentist and take painkillers until he could get treatment. This incident suggests that there may be less awareness of established pathways to dental care.

"I just trust the doctors in the hospital more than some of the dentists so I just went there"

Polish man

A key point of difference amongst new Polish migrants is the availability and value for money of dental care in Poland. One of the men we interviewed received treatment for his wisdom teeth and fillings in a private clinic in Poland. He visited a British dentist for an assessment of the work he needed and a quote on what this would cost him. He explained to us that he could fly home to Poland, be treated in an excellent private clinic and visit family at the same time, for a far lower price than treatment at an NHS dental surgery here.

Part of the appeal of treatment in Poland is the perceived standard of excellent care at a private dental clinic. Both men felt that the standard of treatment and care they could receive in Poland would be higher than in the UK and cost less. Equally, they tended to perceive NHS care as lower quality than private care. They explained that this was heavily influenced by their negative experiences of public dental care when they were younger in Poland.

"With a public dentist in Poland you have to ask for anaesthetic. They will not give it to you automatically....All private healthcare clinics will give you an aesthetic when you have treatment."

Polish man

"I remember the dental nurse when I was at school when I was a kid and he would be smoking and then putting his hands in my mouth and it tasted awful."

Polish man

Whilst they viewed the standard of NHS dental treatment in Britain in general to be better than public dental treatment in Poland, they maintained their general view that private dental care is superior to public. Dental treatment in Poland therefore can represent excellent value for money.

"I've learned one thing and that's the public health care in Poland and here sucks"

Polish man

Value for money is a deciding factor in how new Polish migrants access dental treatment and convenience is another. The other Polish man received treatment here in the UK as he could not get the time off work and did not have any more holiday time that he could use for a trip home for treatment. He also explained that his root canal work and filling would necessitate several trips to the dentist and that returning home to Poland for treatment was not practical despite the value for money Polish dental treatment represents.

"If I had the holiday (time) and I was going home anyway then maybe it would have made sense to go home for treatment. But as I couldn't and I eventually found a good dentist here I was happy to go back for the treatment even if it was more expensive"

Polish man

Care of teeth

Both of our participants aimed to brush their teeth twice a day. They did not use floss or mouthwash. They explained that as they would often work long hours or varied shift work (three evening shifts followed by three day shifts) they could find it hard to brush twice daily as their routine was changeable.

"Now in my bag I have my toothbrush and toothpaste packed so I can brush my teeth at work. But you know I'm about to be at work for 24 hours and I don't always think about it."

Polish man

They explained that as children they received a lot of positive guidance on good dental hygiene at school in Poland. Their school dentist showed them how to brush their teeth properly and the children also had fluoride treatment whilst they were at the school. Looking after your teeth was also encouraged by their parents and in wider culture, emphasising the importance of daily brushing and avoiding damaging sugary drinks or food.

“They would tell you that eating apples and carrots is good for your teeth”

Polish man

Their lifestyle had changed considerably on coming to Britain. They mentioned that in Poland they earned less and therefore had less disposable income to spend on sweets, treats, cigarettes and alcohol. Here in Britain however they had far greater disposable income for all of these products. They were a stable part of their diet and lifestyle despite knowing they were damaging to their teeth.

Dentures

Neither of the Polish participants wore dentures.

Gypsies and travellers

Experience of the dentist

Many had been to the dentist within the last 3 years. Two had been for treatment in the last six months. One had not been for many years.

In general, however, the experience of gypsies and travellers could be described as irregular at best. Most had not been to the dentist recently, and would only seek treatment when they were in pain. They did not go for check ups and were unlikely to be registered with a particular dentist. Several people had only been to the dentist on a few occasions in their lifetime.

Condition of teeth

Many people would describe the condition of their teeth as good and did not report any current issues. They therefore did not see any need to go to the dentist.

Most people had not visited the dentist for several years, since they last happened to need treatment. Travellers and gypsies also tend to move around between sites across Oxfordshire and beyond. Most did not therefore have a current relationship or history with a particular dentist.

"I once had to go to a dentist out in Reading but that was really far away. Then the other day as my tooth was paining me and I was out getting my hair done in Killington I saw an advert for a dentist so I just went in and made an appointment but they couldn't see me for two weeks"

Female traveller

Two people who had had recent treatment were currently in touch with a dentist and could turn to them as they needed.

Several women wanted to see the dentist specifically for whitening treatments. They wanted to have the treatment, but could not afford it at that time. They mentioned that it would be ideal if they could pay for this treatment in instalments.

One family had particularly poor dental health. The grandmother (aged 40) had approximately five teeth remaining in her lower set, and three in her upper set of teeth. All were visibly blackened. She had worn dentures for a period of time but she had an infection and had not worn them since then. Whilst her son currently had no problems with his teeth, he had used pliers to remove two

lower back teeth that had been painful. Remarkably he had not had any pain or problems since then. He explained that, like his mother, he had a strong aversion to needles and at the time was in a lot of pain, unregistered with a dentist, and acted on impulse. In addition, his partner currently had pain in a tooth and was keen to try and find a dentist to treat her.

"I don't even know where to start with something like this. I don't know where to look for a dentist. I know I need to get them looked at because it's hurting right now. More than anything I need to see a dentist because of my kids. I need to know if their teeth are supposed to fall out like that and when I should get them checked, how often I should take my kids to be seen"

Female gypsy

Access

Awareness of dental practices was a cause for concern amongst gypsy and traveller groups. With the exceptions of two people who had recently had treatment at a dentist, most people were not aware of a dentist near to them. Two people also mentioned that in the past they had travelled to Reading in order to receive treatment (over 30 miles away from them).

Caravan sites tend to be outside small towns and away from urban centres; this added distance may also act as barrier.

Several people had also been 'barred' from a dentist in the past as they had missed appointments. The impact of this is particularly severe for gypsy and traveller groups as they are often less likely to know where else to go to.

"They don't understand that they give you an appointment at ten in the morning and then you've got to try and get your kids up and out there and then you end up missing it and you're like well where do I go now"

Female traveller

Many people did not know how to go about finding a dentist and accessing services. When people were looking for a dentist they would ask around their family and friends. In general, they did not use web searches, the Phone Book, or go through their GP in search of a dentist.

"I asked my sister about a dentist but she hasn't been since they lived in Wales so she doesn't know anyone."

Female gypsy

Many people did not, therefore, have a regular dentist. In addition, they often did not know how to access emergency dental care if they needed it. Two people had had toothache and not known how to find a dentist to treat them. As mentioned, one young man in his twenties removed two of his own teeth that were painful.

“I was in the pub and they were hurting and hurting me. They’d hurt for days and I just thought well enough of this so I just got some pliers from my mate’s van and just whipped them out myself. They haven’t bothered me since then.”

Male gypsy

Family connections and word of mouth networks seemed to be particularly strong amongst gypsy and traveller groups. However, at the moment, there appeared to be a clear lack of information amongst the groups we spoke to at the two sites we visited in Oxfordshire. Word of mouth networks would clearly be one way to disseminate information across gypsy and traveller sites.

It is notable that gypsy and traveller groups receive a certain amount of targeted support. Certain professionals such as health workers, educationalists and site managers are dedicated to supporting people on gypsy and traveller sites. They look out for their safety, health and wellbeing. It was clear, however, that none of these outreach workers are getting key messages across about caring for your teeth or how to access dental services. In the ‘Welcome Pack’ distributed to all caravans on the site there are contact numbers for a range of services and agencies, legal process and welfare entitlements but nothing on local dental services or entitlements. Based on our interviews with site residents and the site support officer it seemed that dental care was not part of the support agenda for agencies that look after gypsy and travellers.

Care of teeth

Most people took care of their teeth with regularly brushing. One person also used mouthwash. Many people brushed twice a day, but several brushed their teeth once a day. One woman, with few remaining teeth, did not brush her teeth at all, commenting that she did not have any left to brush. No one we spoke to used dental floss.

It is notable that our interviews suggest that women and mothers tended to attach more importance to dental hygiene than men. Women seemed to take greater pride in the appearance of their teeth and comment that taking care of their teeth was important to them. They were often also more likely to go for routine check ups. Women with children also tended to take an interest in dental care because of their children. They wanted to take good care of their children and saw it as important that they take them for regular check ups and treatment. Young children also lose their

milk teeth which can stimulate parents into thinking about their dental care and potential need for dental services for their family.

Drinking alcohol, smoking, eating sugar drinks and foods were all a normal part of gypsies and travellers' diets. They would therefore consume these things on a daily or weekly basis. Unlike other groups, there was little spontaneous mention of the link between diet and poor dental health.

Dentures

Two of the participants had experience of dentures.

One elderly male had part dentures on his lower set and was current receiving treatment to get full dentures for his upper set. He was very happy with the treatment he was getting and did not complain of any issues with his dentures. He cleaned his dentures once a day, in the morning with toothpaste.

Conclusions and recommendations

Conclusions and recommendations

People with learning difficulties

Conclusions

We found that people with learning difficulties, in line with many others across this research, would only go to the dentist when they had experienced pain and not simply for a check up or visit to the hygienist. Greater awareness of preventative care through routine treatment and checks may help to raise the standard of oral health of people with learning difficulties.

Generally, people's teeth were in good condition and people did not report any current problems. However, people clearly do experience problems with their teeth as many people had fillings and some had missing teeth or dentures.

Overall, access to dentists is good as most people are registered with a regular dentist. Some people are patients at specialist services who have designed services for people with learning difficulties. People's various conditions mean that they have several others supporting them such as carers or healthcare professionals looking after their wellbeing. When they need a dentist their carers are on hand to make an appointment, remind them of the visit and take them to the dentist. Access to dentists seemed to be good amongst the people we interviewed at a day care centre.

Many people with learning difficulties did not take very good care of their teeth. Several people brushed their teeth just once a day and one just once a week. Many people also enjoyed sweet drinks and foods. In addition, most people do not go for regular check ups. Most people, however, were aware of the importance of taking care of one's teeth but often forgot when they were alone or away from day care or respite carers. In home carers have an important role in reminding people to brush their teeth and avoid sugary drinks and food.

Recommendations

An aim for improving the oral health of people with learning difficulties could be to raise the importance of different aspects of care amongst carers and recipients. Firstly, greater importance could be attached to going for routine check ups or visits to the hygienist as part of taking preventative care of one's teeth. Secondly, there is a need to increase the frequency and standard of people's dental hygiene. People could also take better care of their teeth by more regular brushing, using mouthwash and flossing.

A key target for these messages could be the carers of people with learning difficulties. Carers play an important role in educating and reminding the care recipient of how to best look after themselves. Information could perhaps be disseminated through day care and respite care centres, or through engaging with carers associations. For example, getting carers to see routine checks ups as important would likely translate into the care recipient going for more routine treatment.

People with learning difficulties also have a number of healthcare professionals around them looking out for their healthcare needs. Encouraging those with a duty of care to see oral health as equally important to other aspects of their wellbeing could be a significant step. The manager of the day care centre mentioned that all the people we interviewed had a Care Health Action Plan. This is a plan of care outlining their particular needs and requirements to support them. Targeting this document may help to disseminate messages and information on how to improve the oral health of people with learning difficulties.

On a practical note, the day care centre manager mentioned to us that private dentists could do more to keep carers in the loop, by including them in correspondence with the patient and passing on check up reminder letters. This message could be passed on to dentists across Oxfordshire.

Pakistani and Bangladeshi people

Conclusions

Most of the Bangladeshi and Pakistani participants were currently registered with dentists as they had happened to have recent treatment. Prior to this many of them, particularly older people, had not previously been registered with a dentist. They tended to be less likely to have a regular dentist or see the importance of check ups. This was a common finding across the research, but was particularly pronounced amongst Bangladeshi and Pakistani participants. Work is needed to encourage Pakistani and Bangladeshi people to pay regular visits to the dentist.

People's teeth tended to be in good condition with no one reporting any current problems. Culturally, people tended to avoid sugar foods and drinks (especially older people) which may help to explain the good quality of people's teeth.

Whilst people did not report any particular problems with finding a dentist this process could perhaps be made easier for those unused to the process. Older people, in particular, are perhaps more likely to find English a challenge. They may also be trying to find a dentist and booking an appointment for the first time. Some support may be required to guide people through the process and encourage them to seek out care and treatment.

Most people took good care of their teeth through regular brushing and avoiding sugar foods and drinks. There was something of a generational divide with older people being more likely than the young to see a strong link between sugary foods and poor teeth. A few older people would only brush their teeth once a day, but perhaps this is less of a concern as they are also less likely to abstain from eating damaging foods.

Overall, Pakistani and Bangladeshi people had a number of positive factors supporting seemingly good standards of oral health: diet, lifestyle and regular brushing. We might argue that these supportive factors associated with their culture makes them quite independent and less accustomed to making use of dental services. The key cause for concern, as discussed above, is that people may not be registered with dentists and do not view regular check ups as important. This trend may perhaps be more evident amongst older Bangladeshi and Pakistani people.

Recommendations

Encouraging a greater sense of awareness amongst Bangladeshi and Pakistani people of the importance of regular check ups at the dentist is key. Pointing out the link between preventative care and maintaining good oral hygiene may resonate well amongst an ethnic group that already place importance on looking after one's teeth.

Information and messages could be targeted at Pakistani and Bangladeshi community groups and health centres. The aim here would be to encourage people who have not visited a dentist for some time or at all, to make an appointment.

Equally, Oxfordshire dentists or GPs could have a role in explaining to Pakistani and Bangladeshi people the importance of regular check ups.

In order to simplify the process of finding a dentist, information detailing local dentists could be distributed amongst the Pakistani and Bangladeshi community. Information and flyers could be distributed amongst Pakistani and Bangladeshi areas of Oxfordshire. The relative strength of family and word of mouth networks should help to increase the spread of this information.

Polish people

Conclusions

In line with most other groups across the research new Polish migrants tended to visit the dentist when they experience pain rather than for routine check ups. They did however see routine check ups as important in principle.

There were no current dental problems but they had had fillings and root canal work in the past.

Access to dentists was particularly good amongst the two Polish people we interviewed. Their level of spoken English was good and they could easily find themselves a dentist if required. Our research suggests that new Polish migrants may well be registered with a dentist in the UK but perhaps return to Poland for treatment if this is convenient to them. They viewed treatment in Poland as preferable as it was cheaper and often perceived as superior to treatment on the NHS in the UK.

The fact that new Polish migrants are not registering with dentists in the UK is a possible cause for concern. As they can go back to Poland for treatment, they may not see the value in registering with a dentist here. There might come a time when they need emergency treatment or be in pain and they may not have previously considered how to get treatment or where to go. For example, one man went to A&E when in pain from his wisdom tooth.

There seems to be good awareness of the link between certain foods, drink and habits and poor dental hygiene. In part, this is due to formal education and fluoridation treatment they received at school. However, the two people we interviewed mentioned that they had adopted more westernised attitudes to sugary foods, drink, alcohol and cigarettes since moving to the UK. In addition, brushing their teeth could be irregular as a result of the long hours and shift work our participants tended to be engaging in.

Recommendations

The new Polish migrants presented little cause for concern in terms of their oral healthcare needs. Their awareness of best practice in oral hygiene was good, and they reported few problems in relation to access. The one slight area for concern may be people not registering with a dentist until they need treatment. While this is not unusual it is worth bearing in mind that these migrants are new to Britain and may not be aware of how and where to access dental services.

We suggest encouraging a greater awareness amongst Polish people of the need to register with a dentist in the UK should they need emergency treatment, so have an established pathway to care.

You may wish to consider targeting employers or areas of Oxfordshire that are known to have higher levels of new Polish migrants.

Gypsy and travellers groups

Conclusions

Akin to other groups in the research gypsy and travellers tended to use dentists only when they needed treatment for something specific. They are likely to be in some pain before they start thinking about finding a dentist. As people tended to move around and be less aware of how to access dentists, they were less likely to have a regular dentist or be registered with a practice.

Some people had no problems with their teeth. Many others had dental problems, only some of which were currently being treated. We found people with badly stained teeth, missing teeth, painful teeth and a man currently getting dentures fitted. Taken as a group, gypsies and travellers had the poorest teeth across the research and are something of a cause for concern.

Gypsies and travellers mentioned that access to a dentist was a problem. In general, few people knew where to access services and were unsure about the closest dentist to them. As caravan sites tend to be outside of urban centres, people mentioned that this distance could be a barrier to getting regular treatment. Several had also been 'barred' from former dentists for missing appointments, further decreasing their access to local dentists.

Many gypsies and travellers brushed their teeth twice a day and some occasionally used mouthwash. Many, however, brushed their teeth infrequently, often forgot or would just brush once a day.

Women and mothers tended to place a greater importance on dental hygiene and regular treatment both for their own appearance and wellbeing and that of their children.

Recommendations

Gypsies and travellers clearly have some way to go in order to improve their oral hygiene, access to care and not suffer with painful teeth. It is notable that a couple of people in this group were currently in pain and that one young man removed his own painful back teeth.

A core part of the problem is a lack of awareness of how to get treatment at local and convenient services. A simple solution to this is to publicise dentists local to the various gypsies and traveller caravan sites across Oxfordshire. A hard copy, paper document would probably serve best, showing where each dentist is on the map in relation to each caravan site so that people can easily see which the most local service is. Such a document should also contain contact telephone numbers and opening hours and might contain information on local bus services.

Another core issue faced by gypsies and travellers is lack of awareness of good oral hygiene and the importance of taking care of one's teeth. This could be addressed in a number of ways. Firstly, information could be distributed across gypsy and traveller sites encouraging them to take better care of their teeth and approaches they could take. This approach might choose to focus on men who would often attach less importance to dental care than women. One way of targeting women in the household could be through outreach health workers who tend to visit babies and young children on the site. In addition, it is notable that as not all children are in education they may not be receiving oral health guidance in schools.

Another approach might be to offer dental checks, services or information directly on caravan sites. Some people suggested that dental outreach workers could make dental care assessments and refer people for treatment to dentists near caravan sites. Dental outreach workers might also be able to demonstrate to people how to take better care of their teeth. Such an approach might stimulate interest in dentistry, inform people of local services and raise the importance of taking care of one's teeth.

As gypsies and travellers are relatively closed groups, we would suggest consulting with support agencies when planning any healthcare interventions. We found the Oxfordshire Gypsy and Traveller Services useful and supportive in planning our research project and making introductions. We would recommend using existing channels and networks when planning care for gypsies and travellers.

Appendix

Appendix

A. Discussion guide

NHS Oxfordshire – Oral Health Needs Assessment

Depth interview discussion guide

Final

16/06/10

1. Introduction and warm-up

- *Introduce self, thank participants for attending – mention that discussion should last for about 10-15 minutes/ 1 hour as applicable.*
- *Research is on behalf of the NHS Oxfordshire, the NHS body that looks after healthcare services in the region. They would like to find out their experiences of oral healthcare with a view to understanding and improving these services.*
- *Underline Ipsos MORIs impartiality and independence from government, local services and the NHS.*
- *Stress there are no right or wrong answers – we are just interested in finding out their views and opinions*
- *Reassure participants of anonymity – MRS code of conduct – also, no comments will be linked back to participants*
- *Permission to record – for analysis purposes only*
- *Tell me a bit about yourself? Work? Free time? Lifestyle?*

2. Your dentist

- *Are you registered with a particular dentist? Are they NHS/ private?*
- *How do you feel about going to the dentist? PROBE: nervous, scared etc*
- *If you've not been lately, why is that? PROBE: cost, timing, dislike of dentists, nothing wrong?*
- *Tell me about the last time you went to the dentist? When was this?*
- *What happened? Why did you go? What symptoms did you have? What happened?*
- *Did your dentist give you any advice on how to look after your teeth?*

- How typical was this of your experiences with dentist?
- What about other times? When was this/ what happened?
- What makes you to go to the dentist? What would make you go?
- What about check ups? How important is this? Why?
- PROBE: To have teeth checked for cavities, prevent toothache, detect or prevent gum disease, prevent bad breath, detect skin and mouth disorders including cancers, maintain or improve my appearance

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3. Your teeth

- How are your teeth at the minute? Do you think that your dentist would agree with that?
- Do you ever have any problems? Toothache, pain/sensitivity to hot and cold food or drinks, bad breath, painful gums, bleeding gums, stained teeth
- Are you planning on getting any treatment? What will you do?

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4. Access

- How would you go about getting treatment if you needed any? where would you go? How do you feel about that?
- Do you know where you'd go for treatment outside of the normal dentist hours?
- Have you ever had dental treatment outside of the dentist? Tell me more about this? Why did you go to that particular dentist?
- Have you wanted to go to the dentist lately but then not been able to? Tell me more about this?
- Have you been to a GP/ hospital for dental work?

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5. Care of your teeth

- When do you think about your teeth?
- How do you look after your teeth? What exactly does this involve? Eg flossing, brushing, mouthwash? How often? When exactly. ENCOURAGE OPEN RESPONSE
- Do they use fluoride toothpaste?
- What kind of food and drink did you have today/ yesterday? How typical is this? PROBE: sugary drinks and sugary foods, how often do you have these?
- Do you smoke? Drink? How often? How many cigarettes a day? How much do you drink in a typical day or evening?

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And, only if they have dentures...

6. Dentures

- How comfortable are your dentures?
- Are they loose?
- Are they broken?
- When do you remove them? PROBE in the evening?
- How do you clean your dentures? PROBE: Toothpaste, Milton or sterilising solution, soap, denture cleaning solution?
- How often do you clean your dentures? When exactly do you do this?

Thank and close

Glossary

Caries	Medical term for decay, cause by decalcification of the enamel and disintegration of the dentin by acid producing bacteria
Common risk factor approach	An approach to promoting general health by controlling a small number of risk factors can have a large impact on a number of diseases. This is a cost effective alternative to disease specific approaches.
Contract holder	The signatory to the contract. This person may be, but does not have to be, a dentist.
CoT	Course of treatment – this may include: <ul style="list-style-type: none"> • Examination of a patient • An assessment of a patient's oral health • Planning of any treatment to be provided as a result of an examination or assessment • The provision of planned treatment (including any treatment planned at a time other than the time of the initial examination)
DMFT/dmft	An indication of the level of decay measured by counting the decayed, missing or filled teeth (dmft). DMFT refers to the decay in the secondary dentition, dmft refers to the levels of decay in the primary dentition.
Dental performers list	A list of general dental practitioners prepared in accordance with the Regulations 28X of the NHS Act 1977
Denate	Having some or all of ones natural teeth present
Dentist with Special Interest (DwSI)	A dentist who works in a primary care setting who provides services, which are in addition to his or her primary care role and may have previously been carried out in a secondary care setting
Dental Care Professionals	The term commonly refers to members of the wider dental team such as therapists, hygienists, nurses
Dental caries	The material remaining after tooth substance has been destroyed as a result of attack by acid produced by plaque bacteria from sugars in the diet. Commonly referred to as tooth decay
Dental sealants	Placing sealants involves the application of a clear resin over the biting surfaces of teeth to prevent decay and to protect the teeth especially in children
Dental trauma	Tooth loss or damage caused by physical injury
Domiciliary services	A course of treatment (or part of a course of treatment) provided at a location other than a prison, a practice premises or a mobile surgery
Enamel	The hard, white shiny surface of the crown; composed of 95% calcium hydroxyapatite
Endodontic	Endodontic treatment removes infected or damaged tissue from inside a tooth. This tissue, called the pulp, contains nerves and blood vessels that help nourish the tooth. After the pulp is removed, the pulp chamber and root canals are cleaned, disinfected, filled and sealed. Endodontic treatment saves teeth that would otherwise need to be extracted
Edentulous	Having no natural teeth remaining
Erosion	Chemical dissolution of teeth
Fluoride	A chemical compound that helps to prevent dental caries
Fluoride varnish	Topical application of a fluoride gel or liquid that prevents decay
Water fluoridation	Addition of fluoride to a population's drinking water to reduce tooth decay. Fluoride may be added to other substances eg milk, toothpaste
Fissure sealants	A plastic-like material placed in the grooves and pits of the biting surfaces of the back teeth to prevent decay starting in these susceptible sites

IOTN	Index of orthodontic treatment need: has two components – dental (score 1-5) and aesthetic (score 1-10). Dental scores 4 and 5 represent a definite need for treatment
JSNA	Joint Strategic Needs Assessment
Maxillo-facial surgery	Surgical specialty concerned with the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck
MOS	Minor oral surgery
NHS Dental Services	NHS Dental Services (part of the Business Services Authority) is a statutory body that administers the general dental services on behalf of the NHS, and acts as the paymaster to dentists on behalf of PCTs in England
Occlusion	The relationship of the teeth in a closed position in both the maxillary and mandibular arch
Oral cancer	Malignant tumour of the mouth
Oral mucosa	The mucous membrane lining the mouth
Periodontics (perio)	The treatment of diseases of the gum
Performer	A person who provides services under a contract, and who • may also be a contract holder • may be employed by the contract holder
Periodontal disease	Disease of the gums and supporting structures of the teeth. Commonly referred to as gum disease
Restorative dentistry	Process of restoring missing, damaged or diseased teeth to normal form and function
PCT	Primary Care Trust.
Sedation services	A course of treatment provided to a patient during which the contractor administers one or more drugs to the patient, which produce a state of depression of the central nervous system to enable treatment to be carried out, and during and in respect of that period of sedation:a) the drugs and techniques used to provide the sedation are deployed by the contractor in such a way that ensures loss of consciousness is rendered unlikely; andb) verbal contact with the patient is maintained as far as possible
SHA	Strategic Health Authority
Orthodontics	Branch of dentistry dealing with irregularities of the teeth(orthodontic services) and their correction
UDA	Unit of Dental Activity – contract currency used to express the amount and measure, the provision of mandatory and advanced mandatory services
UOA	Unit of Orthodontic Activity – contract currency used to express the amount and measure the provision of orthodontic services
Urgent Treatment	A course of treatments that consists of one or more treatments listed in Schedule 4 of the NHS Charges Regulations that is provided where a)prompt treatment is needed because the persons oral health is likely to deteriorate significantly (or the patient is in severe pain cause by his oral condition) and b) treatment is provided only to the extent to prevent that deterioration or address that severe pain

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