



Public Health
England

Summary Oral Health Needs Assessment:

- Bath and North East Somerset (BANES), Gloucestershire, Swindon, and Wiltshire
- Bristol, North Somerset, Somerset and South Gloucestershire
- Devon, Cornwall and Isles of Scilly

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Summary document: Key points for Area Teams

Aims

This resource aims to provide a review of the oral health needs and dental services in the South West area. It is intended that the results of this Oral Health Needs Assessment (OHNA) will inform the planning and implementing of appropriate services, and oral health improvement strategies targeted at those at specific risk, or in underserved population subgroups.

Objectives

- To identify and gather sources of existing and relevant data and information which support the needs assessment process
- To research and describe the oral health characteristics of the population and identify their needs
- To measure the capacity of existing service provision to meet need
- To identify aspects of service provision where investigation/analysis may be needed

Proposed output

The proposed output from this OHNA is a reference document produced for the three individual Area Teams:

- Bath and North East Somerset (BANES), Gloucestershire, Swindon and Wiltshire **(BGSW)**.
- Bristol, North Somerset, Somerset and South Gloucestershire **(BNSSSG)**.
- Devon, Cornwall and Isles of Scilly **(DCIoS)**.

Specific and tailored sections will be developed for Local Authorities, where oral health priorities are aligned to other local issues.

How to use this document

This document provides a summary of the main OHNA report, both Part 1 (oral health status) and Part 2 (service provision and access). It is designed to be utilised as a stand alone document. Should further information or explanation be required, this is provided in the respective main reports. A full literature review; local level data analysis at lower and upper tier authority level, with supporting graphs and maps are presented in the main reports.

The next stage

The results of the OHNA will support the development of needs based recommendations for the oral health strategy, which would subsequently inform commissioning priorities in the local Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing board (JHWB) strategies.

There is currently little clarity about the commissioning of oral health improvement programmes across the South West. Historical “groupings” currently exist, which are based around the current sources of the commissioned service ie providers on the ground, as opposed to local authority geographical boundaries.

The next stage will thus subsequently involve an analysis of current oral health improvement programme service provision (including commissioning status), a review of the evidence base, and the development of needs based recommendations for an oral health strategy. This will form part of an overarching process to inform the JSNA, and input into the JHWB strategy. There may be a greater emphasis placed at this stage upon community and stakeholder engagement on information regarding both problems and possible solutions.

Key points

Disease burden

Oral health in the South West is generally good. This, however, masks oral health inequalities and a small number of people bear the greatest burden of disease. They are children and adults living in material and social deprivation and people in at risk groups, such as older people, and people living with a disability or in long term institutional care. This health divide is of concern.

Data

Information about services, and the quality of these services, is limited. Only local data on the oral health of children is available. No local data exists on the oral health of adults or vulnerable population groups.

Access:

Access to a range of dental services is variable, and for some marginalised groups, access is poor. Across the South West, dental service provision bears little relation to oral health need. This is especially in terms of the provision of domiciliary; anxiety management and urgent care services where there are discrepancies between the provision and availability of services, and need.

Vulnerable groups:

People in marginalised or deprived groups are more likely to have poor oral health and less likely to access services. Not much is known about how these individuals access services; how accessible patients find them or if these services are meeting their

needs. At present these inequities in service provision have the potential to increase rather than decrease oral health inequalities

Prevention in primary care

Opportunities to prevent oral health problems in vulnerable adults and children are not being maximised in primary care settings across the South West. Preventative interventions such as scale and polishes; fluoride varnish applications and fissure sealants are generally being delivered at levels considerably lower than national averages in routine care; under sedation and via domiciliary services.

Good oral health is an integral part of general health

The World Health Organisation (2013) defines oral health as being free from diseases and disorders that affect the oral cavity. This includes: chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) diseases, tooth decay and tooth loss.

Oral health is integral to general health and should not be considered in isolation, as many of the key factors that lead to poor oral health are risk factors for other diseases. Chronic non-communicable diseases (NCDs) and conditions such as obesity, heart disease, stroke, cancer, diabetes and oral diseases all share a set of common risk factors including tobacco use, harmful use of alcohol, an unhealthy diet, and lack of physical activity. Furthermore recent research suggests a two-way relationship between periodontal disease and diabetes, where poorly controlled diabetes is a risk factor for developing periodontal disease, and the presence of periodontal disease may contribute to the development of diabetic complications.

It is for these reasons that there is now increasing acceptance that oral diseases cannot be dealt with in isolation from other systemic diseases.

What are oral diseases?

- Tooth decay occurs when acids in the produced from the breakdown of sugars, dissolve the outer layers of teeth. It is entirely preventable, but still the most common chronic childhood disease. Almost a third of all five year olds in England still had tooth decay in 2012.
- Gum or periodontal diseases are caused by inflammation of the gums and bone that support teeth. When severe, it can cause otherwise healthy teeth to be lost. Plaque deposits on the gum margins of teeth are the primary cause of disease. It affects a large proportion of the population and becomes more common with increasing age. Smoking is also a major risk factor in the development of the disease.
- Evidence linking periodontal health and general health is accumulating. Periodontal diseases are associated with coronary heart disease; rheumatoid arthritis;

Alzheimer's disease and adverse pregnancy outcomes. The link between severe periodontal disease and diabetes is the best established.

- Oral cancer comprises a group of cancers including cancer of the lip, tongue, mouth, and the airways. Oral cancer incidence rates have risen by a third in the last decade, making it one of the fastest-growing cancers in the UK. Tobacco and alcohol consumption are major risk factors. Oral cancer is now being increasingly seen in young adults, and has been attributed to increasing rates of infection with the Human Papilloma Virus, reflecting changes in oral sexual behaviour.

The impact of poor oral health

Preventing dental decay is of crucial importance, as the burden of the disease lasts a lifetime. Once the tooth structure is compromised, restoration and additional maintenance will be required throughout the life of the affected tooth.

Children: General health, wellbeing and school readiness

Untreated decay can affect a child's general health and wellbeing. Due to oral pain and difficulties in eating, poor oral health in children is associated with being underweight and a failure to thrive. It also affects a child's confidence as well as ability to sleep, eat, speak, play and socialise with other children

Children with dental problems may not be able to gain the full benefit of their education. Good oral health can contribute to "school readiness", ensuring that all children are able to participate fully in all activities in order to be successful at school. Studies have shown that children with poor oral health have increased school absenteeism, and decreased school performance.

Adults: General health and wellbeing

In adults, poor oral health can lead to oral pain, premature tooth loss, dry mouth, and sleep deprivation. The experience of pain, problems with speaking, eating and chewing, and embarrassment regarding the appearance of their teeth may distract people from performing daily activities and affect their social and psychological wellbeing, and general quality of life.

The economic impact of oral disease

- Oral diseases remain a very significant public health issue for the South West. This is disturbing, given that much of the oral disease burden is due to tooth decay and its complications, which are preventable using cost-effective community-based prevention strategies.
- Global studies have indicated that the mouth is the most expensive part of the body to treat. NHS expenditure on the treatment of oral disease is significant, likely to

exceed that for other diseases, including cancer, heart disease, stroke, and dementia.

- In 2011/12 the total NHS cost of extracting multiple decayed teeth in children in hospitals was approximately £23 million – life threatening treatment for an entirely preventable disease.
- Given that periodontal diseases constitute a major risk factor in the development of Type 2 diabetes, the economic impact of these conditions must also be considered
- Dental disease and its sequelae can impose a significant financial burden to an individual and society.

The oral health of children - tooth decay and dental infections

At a national level, whilst children's oral health has improved over the past 20 years. For each cohort of three, five and twelve year olds the respective surveys have demonstrated that the situation in the South West in terms of decay prevalence for these children is better than the national average.

However, population averages can mask inequalities in oral health. A polarisation in disease experience is now occurring, with an increasing number of children remaining tooth decay free, and the disease becoming concentrated in a diminishing number of social deprived children.

The implications of untreated dental decay are of importance as research suggests that poor oral health in children is associated with being underweight and a failure to thrive. Grossly decayed teeth will often require extraction, usually under a general anaesthesia, exposing children to small, but significant risks of life-threatening complications, for an essentially, entirely preventable disease. Note that the dataset describing the number of hospital-based dental extractions, does not include those extractions carried out by community dental services, which thus means the figures are likely to be an underestimation.

Caution is needed in the interpretation of the data on three year olds due to very wide confidence intervals for this age group, and small sample sizes. This survey includes information early childhood caries. This is an aggressive form of decay that affects upper front teeth, and can be rapid and extensive in attack. It is associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods of the day.

The oral health of children in BGSW

BGSW: three year olds

Dental decay prevalence was higher than the national average of 11.7% in Wiltshire (13.5%), and Gloucestershire (12.6%). The average number of teeth per child affected

by decay (decayed, missing or filled teeth) was just below the national average in Wiltshire.

Analysis shows how the percentage of three year old children with ECC was higher than the average in the South West of 3%, in Wiltshire (3.2%), but lower than the national average (3.9%).

In terms of acute disease, across the South West, an average of 0.2% of three year old children showed signs of sepsis and, as expected, the level was generally higher in those areas where there were higher levels of decay. For example, within the Area Team, the highest levels occurred in Gloucestershire (0.3%).

BGSW: five year olds

In the population of five year olds, dental decay prevalence in Gloucestershire is higher than the England average. At a lower tier level, in the Forest of Dean, and Gloucester, the prevalence and severity of decay are substantially higher than the national averages.

There is an underlying trend of worse decay in those children who have any decay. It appears that in Swindon, and at a lower tier level, Gloucester, those children who have decay, have a higher level of decay than the England average.

In terms of acute disease, in Cotswold and Tewkesbury, the percentage of children with obvious oral abscess/sepsis is higher than the national average.

In Wiltshire, Swindon, and Bath and North East Somerset, the number of children and adolescent hospital admissions, as a percentage of the population, for a dental extraction, is higher than the national average. The most common age for admission is 5-9 years in these areas.

In terms of trend analysis, in the majority of local authorities, the percentage of five year old children with decay experience has decreased when data between the two surveys (2007/08 and 2011/12) is compared.

BGSW: twelve year olds

Within the twelve year old population, in Wiltshire, the prevalence, severity and burden of disease (in those children who already have decay) are higher than the national averages.

The oral health of children in BNSSSG

BNSSSG: three year olds

The oral health of three year olds is generally poorer in Bristol than national averages. Dental decay prevalence was higher in Bristol (15.3%) than the England average of

11.7%. The average number of teeth per child affected by decay (decayed, missing or filled teeth) in Bristol was 0.7, higher than the national average of 0.4. Analysis shows how the percentage of three year old children with ECC was higher than the national average of 3.9% in Bristol (5.7%).

Across England 0.4% of three year old children showed signs of sepsis and, as expected, the level was generally higher in those areas where there were higher levels of decay. For example, the highest levels occurred in Bristol (1%), above the England average.

BNSSSG: five year olds

In the population of five year olds, dental decay prevalence in North Somerset is higher than the England average.

There is an underlying trend of worse decay in those children who have any decay. It appears that those children in West Somerset and Sedgemoor, who have decay, have a higher level of decay than the England average.

In terms of acute disease, the percentage of children with obvious oral abscess/sepsis in Somerset (1.68%), is above the average for the South West (1.57%), and just below the national average of 1.74%. At lower tier level, the percentage of children with obvious abscess/sepsis was higher than the national average (1.74%) in West Somerset (3.2%) and Sedgemoor (3.1%).

In Bristol (0.7%) and North Somerset (0.6%), the number of children and adolescent hospital admissions, for a dental extraction, as a percentage of the population is higher than the national average (0.5%). The most common age for admission is 5-9 years in these areas. In Sedgemoor and West Somerset (0.9% of the population), this occurs at percentages higher than the national average at that age group (0.8%).

In terms of trend analysis, in the majority of local authorities, the percentage of five year old children with decay experience has decreased when data between the two surveys (2007/08 and 20011/12) is compared. The exceptions are in North Somerset and South Gloucestershire where the prevalence has increased.

BNSSSG: twelve year olds

The prevalence of decay was higher than the national average (33.4%) in Bristol (39.8%); Somerset (36.6%); and North Somerset (33.9%). At lower tier authority level, the prevalence of dental decay in twelve year olds was higher than the national average in West Somerset (45.5%); Taunton Deane (40.7%); and Sedgemoor (39.4%). In Bristol (1.06) and Somerset (0.83) the average number of teeth per child affected by decay was above the national average of 0.74.

Those children in Bristol (2.67) and Somerset (2.28); and at a lower tier level, West Somerset (2.6), Sedgemoor (2.51) and Taunton Deane (2.27) who have decay, have a higher level of decay than the England average (2.21).

The oral health of children in DCIoS

DCIoS: three year olds

The oral health of three year olds is generally poorer in Torbay than national averages. Both dental decay prevalence, and the average number of teeth per child affected by decay (decayed, missing or filled teeth) was higher than the England average.

DCIoS: five year olds

Both dental decay prevalence, and the average number of teeth per child affected by decay are higher than the England average in Torbay, and at lower tier level, in North Devon. When 2008/09 and 2011/12 survey data are compared for DCIoS, these are the only two local authorities where the percentage of five year old children with decay experience has increased over this time. Mid Devon and Cornwall have seen the greatest reduction in the percentage of children with decay experience.

There is an underlying trend of worse decay in those children who have any decay. It appears that those children in Cornwall, and at a lower tier level, Torridge and North Devon, who have decay, have a higher level of decay than the England average. In terms of acute disease, the percentage of children with obvious oral abscess/sepsis in Cornwall (6.2%) and Torbay (2.73%) were above the national average. At a lower tier level, the percentage of children with obvious abscess/sepsis was higher than the national average in the South Hams (2.1%).

In Torbay (1.1%) and Devon (0.8%), the number of children and adolescent hospital admissions, as a percentage of the population, for a dental extraction, is higher than the England average of 0.5%. At lower tier local authority level, the equivalent percentages were above the national average in North Devon (1.2%); Exeter (1.1%); Mid Devon (1%); Torridge (0.8%); East Devon (0.7%); Teignbridge (0.7%). The most common age for admission was 5-9 years in all of these local authorities, except for Torridge where it was in the 10-14 age group. In North Devon (2.3%) and Exeter (2.2%), and mid Devon (1.7%), these percentages were substantially higher than the national average for that age group (0.8%).

DCIoS: twelve year olds

In DCIoS, the oral health of twelve year olds is generally poorer than national averages. The prevalence of decay was higher than the national average (33.4%) in Torbay (44.3%); Devon (36.5%) and Plymouth (34.7%). At lower tier authority level, the prevalence of dental decay in twelve year olds was higher than the national average in Teignbridge (45.6%), West Devon (38.7%), Exeter (38.5%), South Hams (38.2%), Mid Devon (37.5%), North Devon (35.7%) and Torridge (33.7%).

In terms of severity of decay, in Torbay (0.97); Plymouth (0.81) and Devon (0.77) the average number of teeth per child affected by decay was above the national average of 0.74. At lower tier level, in Teignbridge (1.06); Exeter (0.84); South Hams (0.8); Mid Devon (0.8); West Devon (0.74) the average number of teeth per child affected by decay was higher than the national average of (0.74).

Those children in Plymouth; Cornwall and the Isles of Scilly; and at a lower tier level, Teignbridge, who have decay, have a higher level of decay than the England average (2.21).

The oral health of adults: tooth decay, gum disease, tooth loss and oral cancer

Tooth decay, gum disease and tooth loss

- The adult dental health survey undertaken in 2009 presents data at a national and regional, Strategic Health Authority level.
- Nationally, there has been a continued improvement in adults' dental health. However, for those who do have decay or gum problems, disease can be extensive, whilst for many people in old age and older middle age, dental needs are very complex. Marked inequalities in oral health also persist according to socio-economic status.
- In terms of loss of teeth, tooth and root decay, periodontal diseases and tooth wear, the oral health of adults in the South West SHA is poorer than the national averages.

Oral cancer

Age standardised oral cancer incidence and mortality rates per 100,000 population by local authority and Area Team, are summarised below:

BGSW

- Highest incidence rate in Gloucestershire (above national average) and lowest incidence rate in BANES.
- Highest mortality rate in Wiltshire (below national average) and lowest mortality rate in Swindon.

BNSSSG

- Highest incidence rate in South Gloucestershire (above national average) and lowest incidence rate in North Somerset.
- Highest mortality rate in Somerset (below national average) and lowest mortality rate in South Gloucestershire.

DCIoS

- Highest incidence rate in Plymouth (above national average) and lowest incidence rate in Torbay.
- Highest mortality rate in Cornwall and Isles of Scilly (above national average) and lowest mortality rate in Torbay.

Deprivation and oral health inequalities

- People living in deprived communities consistently have poorer levels of oral health than people living in more affluent communities. The prevalence of tooth decay, tooth loss, oral cancer and the destructive form of periodontal disease follows the social gradient. The highest levels of disease exist among the most deprived and vulnerable population groups.
- Recent research has highlighted the utility of the IMD score (2010) to be used as a readily available tool where dental caries data are not available.
- Across each Area Team, profound inequalities exist in tooth decay status in children, according to deprivation scores, as evidenced by local surveys. Generally, the more deprived the area, the higher the rate of decay.
- National surveys demonstrate socio-economic variations in the oral health of adults, with individuals from routine and manual occupation households being more likely to have dental decay and periodontal diseases than those from managerial and professional occupational households.
- The risks of developing oral cancer are higher in those of low socioeconomic status, and more than double for men in such groups. In the South West, oral cancer age standardised incidence varies according to deprivation quintile, with higher incidence occurring in the most deprived population groups. In terms of age standardised mortality, generally the oral cancer mortality increases at higher deprivation quintiles.
- 2009 Adult Survey data demonstrate a very clear gradient in oral health related quality of life according to socio-economic position, with lower socioeconomic groups reporting more prevalent and more severe impacts upon their quality of life. This implies that some sections in the adult dentate population may be disadvantaged in terms of their oral health, resulting in a considerable negative impact on their quality of life.

Availability, access and service provision

The way people access services depends on acceptability, affordability, availability, accessibility and the appropriateness of the service offered. A low access rate may not solely be due to a lack of provision; elements such as patient choice for example opting for private treatment can impact this. Similarly, in considering availability of services, a high average distance travelled could reflect a lack of provision in certain areas, but

other factors such as patient choice, ease of travel and locations of large towns nearby need to be considered.

Since 2011/12 the number of dentists per 100,000 population has increased in all Area Teams in the South West, and is above national respective averages.

In each Area Team, for both children and adults patients, the majority reside in, and are treated in the same Area Team boundaries. Relatively low percentages of children and adults patients residing in a given Area Team access treatment within a neighbouring Area Team. This indicates how the local population appear to be able to access local services relatively easily, with minimal impact from non-residents receiving treatment in the area.

Availability of oral health services:

Access to dental services is not just about the location of the practices. Most NHS dental practices are located in the towns and cities. Densely populated areas in appear to be relatively well served by NHS dental services, and there are some services in less populated areas. However, approximately half of the adult population, and just under 70% of children in each Area Team visit the dentist in a two year period.

- **BGSW:** Gloucestershire has a higher level of childhood decay in five year olds than the national average, but has a higher number of dentists per 100,000 population than England.
- **BNSSSG:** North Somerset has a higher level of childhood decay in five year olds than the national average, but has a higher number of dentists per 100,000 population than England.
- **DCIoS:** Torbay, with the highest levels of childhood decay (in five and twelve year olds), had a much higher number of dentists per 100,000 population than England, and the highest number in the South West.

Access to routine and preventive services:

A visit to the dentist provides the opportunity to deliver oral hygiene, diet, lifestyle and smoking cessation advice, alongside preventive interventions such as scaling and polishing, fissure sealants and fluoride varnish applications, which will be missed if access is limited. NHS dental treatment is divided into three Patient Charge Bands depending on the level and complexity of treatment provided. Refer to Glossary for full explanation.

BGSW: Access to routine and preventive services

Children

- Across BGSW, there has been little change in the percentage of the child population visiting the dentist between March 2011 and March 2014, currently remaining stable at 68.7%, and marginally above the national average. In this time period, access rates have decreased in Wiltshire, and locally in Forest of Dean, Stroud. March 2014 access rates were below the national average (68%) in Swindon (65.5%) and Wiltshire (66.5%); Cheltenham (59.6%).
- In the last two years, access rates for the 0-2 age group (18.9%) and 6-12 age group (83.9%) were just below the respective national averages.
- The majority of children who attended a dental appointment (72.7%) receive a Band 1, and a further 22.6% received a Band 2 course of treatment.
- Of the 72% attending for a check-up appointment, the percentage of children who receive a preventive intervention (fissure sealant or fluoride varnish application) is low and about half the national average.
- Analysis of access alongside care index data on five and twelve year olds, indicates that children in Swindon and Wiltshire may not be accessing, nor receiving the dental treatment they require.

Adults

- The percentage of the adult population visiting an NHS dentist in BGSW within the last 24 months has increased from 42.6% to 47.3%, but are still below the national average (51.4%).
- March 2014 access rates were below the national average in Gloucester (47.1%); and Cheltenham and Tewkesbury (37.6%); and Cotswold (38.9%).

BNSSSG: Access to routine and preventive services

Children

- At Area Team level, there has been little change in the percentage of the child population visiting the dentist between March 2011 and March 2014, currently remaining stable at 70.7%, and marginally above the national average. At lower tier authority level, in this time period, child access rates have decreased in South Gloucestershire; South Somerset; Mendip, Taunton Deane and West Somerset.
- March 2014 access rates were below the national (68%) and BNSSSG average (70.7%) in Bristol (67.5%).
- In the last two years, access rates for the 0-2 age group (18.3%) were just below the respective national average.
- The majority of children who attended a dental appointment (70.4%) receive a Band 1, and a further 24.8% received a Band 2 course of treatment.
- Of the 70.4% attending for a check-up appointment, the percentage of children who receive a preventive intervention (fissure sealant or fluoride varnish application) is considerably lower than the national average.

- Analysis of access, alongside care index data, on five and twelve year olds, indicates that children in Bristol may not be accessing, nor receiving the dental treatment they require.

Adults

- The percentage of the adult population visiting an NHS dentist in BNSSSG within the last 24 months has increased from 54.0% to 55.1%, just above the national average (51.4%).
- March 2014 access rates were below the national average (55.1%) in Bristol (50.1%).

DCIoS: Access to routine and preventive services

Children

- There has been little change in the percentage of the child population visiting the dentist between March 2011 and March 2014, currently remaining stable at 71.6%, and marginally above the national average. In this time period, access rates have decreased in Cornwall; Mid Devon; North Devon; South Hams; Teignbridge; Torridge and West Devon.
- March 2014 access rates were below the national (68%) and DCIoS average (71.6%) in Cornwall; Exeter; Isles of Scilly; North Devon and Plymouth.
- In the last two years, access rates for the 0-2 age group (17.4%) were below the respective national averages of 19.9%.
- The majority of children who attended a dental appointment (71.2%) receive a Band 1, and a further 23.9% received a Band 2 course of treatment.
- Of the 71.2% attending for a check-up appointment, the percentage of children who receive a preventive intervention (fissure sealant or fluoride varnish application) is considerably lower than the national average.

Adults

- Overall the percentage of the adult population visiting an NHS dentist in DCIoS within the last 24 months has increased from 51.5% to 54.1%, and has consistently been above national averages. In this time period, access rates have increased in all local authorities, apart from the Isles of Scilly, which have remained relatively stable.
- March 2014 access rates were below the national (51.4%) and DCIoS average (54.1%) in Exeter; Isles of Scilly; Plymouth; and West Devon.
- In March 2014, the highest access rates were for the 25-34 year age group (59.2%). The lowest access rate was for the 75 years + age group.

Access to urgent dental care

Access to urgent care is a priority for the relief of pain and for accidental damage. Patients' use of urgent care services is more complex than just a failure to access preventive or routine care. One in four, (25%), of the adult population in the South West reported that they only went to the dentist when they had a problem (ADHS 2009).

Across the South West, approximately half of the adult population and a third of the child population have not visited the dentist in the last two years, and thus may not have a regular dentist when they have a problem.

BGSW: Access to urgent dental care

Children:

- In 2013/2014 4.1% of all courses of dental treatment provided for children were for urgent care (England average 4.6 %). The most common age group was patients aged 6-12 years.

Adults

- In 2013/2014 10.5 % of all courses of dental treatment provided for adults were for urgent care. This is just below the national average of 11.5%.
- The most common age group was patients aged 25-34 years. Levels for urgent care were higher than the national average in Gloucester (12.9); in Forest of Dean (12%); Swindon 11.8%; and Tewkesbury (11.7%).

BNSSSG: Access to urgent dental care

Children:

- In 2013/2014, 4.2% of all courses of dental treatment provided for children were for urgent care (England average 4.6 %). The most common age group was patients aged 6-12 years.

Adults

- In 2013/2014, 10% of all courses of dental treatment provided for adults were for urgent care. This is just below the national average of 11.5%.
- The most common age group was patients aged 18-24 years. Locally, levels for urgent care were higher than the national average in Sedgemoor (11.6%)

DCIoS: Access to urgent dental care

Children:

- In 2013/2014 4.4% of all courses of dental treatment provided for children were for urgent care (England average 4.6 %). The most common age group was patients aged 6-12 years.

Adults:

- In 2013/2014 11.9% of all courses of dental treatment provided for adults were for urgent care. This is just above the national average of 11.5%.
- The most common age group was patients aged 18-24 years, and this occurred at levels above the national average. Levels for urgent care were higher than the national average in Cornwall and the Isles of Scilly, Plymouth; and locally in Exeter and North Devon.

Access to sedation services

The provision of adequate anxiety control is an integral part of the practice of dentistry. Child dental anxiety, for example, is widespread and many anxious children, and adults, can be satisfactorily treated using behaviour management techniques. Dental anxiety is a potential barrier to those seeking dental care and its association with oral health is of central importance.

Sedation is used to help people feel relaxed and comfortable about having certain dental procedures undertaken. Sedation can be given in many ways; the medication can be taken as a drink, breathed in, intranasal or injected into a vein.

Provision of sedation services across all Area Teams shows a great deal of variation and this may reflect ease of access to NHS services, rather than patient need. It is not known how many patients may visit private providers to use these services.

BGSW: Access to sedation services

Children

- Very few children undergo sedation as part of a course of dental treatment. Only 0.1% of courses of treatment provided for children in BGSW include sedation compared with 0.5 nationally.
- 9.8% of courses of treatment including sedation are provided for children up to the age of five years. Most (48.4%) are provided for children between the ages of six and twelve years and are mostly for fillings (54.9%) and extractions (61.1%). The percentage of courses of treatment involving preventive interventions occurs at a rate far lower than national averages: fissure sealants 1.5% (national average 6%) and fluoride varnish 1.1% (national average 11%).

Adults

- 0.2% of courses of treatment provided for adults in BGSW include sedation compared with 0.3% nationally. Most (29.2%) are provided for those aged between 25-34 years and are mostly for extractions (90.6%), above the national average of 67.3%. Only 8.7% of treatment involves placing fillings, substantially below the national average of 36.8%. Only 0.7% involved root canal treatment (below the national average of 5.1%). The percentage of courses of treatment involving

preventive interventions occurs at a rate far lower than national averages: fluoride varnish 0.1% (national average 2.5%); and scale and polish 4.1% (national average of 19.3%).

BNSSSG: Access to sedation services

Children

- Very few children undergo sedation as part of a course of dental treatment. Only 0.2% of courses of treatment provided for children include sedation compared with 0.5 nationally.
- 11.5% of courses of treatment including sedation are provided for children up to the age of five years. Most (53.3%) are provided for children between the ages of six and twelve years and are mostly for fillings (56.5%) and extractions (62.4%). The percentage of courses of treatment involving preventive interventions such as fissure sealants occurs at a rate far lower than national averages: fissure sealants 2.7% (national average 6%). However, fluoride varnish applications (23.6%) are far above the national average of 11%.

Adults

- 0.3% of courses of treatment provided for adults in BNSSSG include sedation (0.3% nationally). Most (26.7%) are provided for those aged between 25-34 years and are mostly for extractions (80.8%), above the national average of 67.3%. 24.7% of treatment involves placing fillings, below the national average of 36.8%. Only 0.9% involved root canal treatment (below the national average of 5.1%). This could be indicative of substantial levels of decay, which mean that restoration is not an option. Courses of treatment involving preventive interventions occurs at a higher than national averages for fluoride varnish 2.8% (national average 2.5%); but below the national average (19.3%) for scale and polishes (9.4%)

DCIoS: Access to sedation services

Children

- Very few children undergo sedation as part of a course of dental treatment. Only 0.4% of courses of treatment provided for children in DCIoS include sedation compared with 0.5 nationally.
- 20.8% of courses of treatment including sedation are provided for children up to the age of five years. Most (49.6%) are provided for children between the ages of six and twelve years and are mostly for fillings (46.1%) and extractions (67.6%). The percentage of courses of treatment involving preventive interventions such as fissure sealants occurs at a rate above the national averages for fissure sealants 9.4% (national average 6%). However, fluoride varnish applications occurs at a rate (7.9%) below the national average of 11%.

Adults

- 0.2% of courses of treatment provided for adults in DCIoS include sedation (0.3% nationally). Most (25.3%) are provided for those aged between 25-34 years and are mostly for extractions (61.9%), below the national average of 67.3%. 55.9% of treatment involves placing fillings, above the national average of 36.8%. Only 3.7% involved root canal treatment (below the national average of 5.1%). Courses of treatment involving preventive interventions occurs at a higher than national averages for fluoride varnish 2.6% (national average 2.5%); and for scale and polishes (20.8%) above the national average (19.3%).

Inequalities in access to NHS dental services

Accessing routine and preventive services and deprivation

Research has shown that dental disease correlates closely with social and economic deprivation: dental need is greater in more deprived communities. Deprivation can thus impact upon accessing dental services.

Some of the most deprived wards across the South West are relatively underserved by NHS dental services delivering treatment to children and adults. It is unclear whether this mismatch in provision contributes to poor dental health, but should be considered when planning new services.

The access rate for children and adults in the 25% most deprived IMD (2010) quartile in DCIoS and BGSW is below the respective access rates for England. This could suggest that this population group may be experiencing problems in accessing services.

Accessing routine and preventive services and travelling distances

The rural nature of an area, and availability of public transport can also affect peoples' ability to access dental services. However, note that long average travelling distances to access oral health services, could reflect a lack of provision in certain areas, or other factors such as the provision of private dental services, patient choice, ease of travel and locations of large towns nearby.

Child and adult patients residing in local authorities in the following Area Teams have to travel the highest average distances to access dental services:

- **BGSW:** Wiltshire and Gloucestershire (Reference: Page 12 and 50/83 Appendix D)
- **BNSSSG:** West Somerset; Sedgemoor and Bristol (Reference: Page 11 and 42/68 Appendix E)
- **DCIoS:** Cornwall; Torridge; North and West Devon (Reference: 11 and 45/70 Appendix F)

Anxiety management services and deprivation

Nationally, 12% of the adult population is likely to suffer from dental phobia, and avoid dental care as a result. This also varied by socioeconomic status. Adequate provision of anxiety management services, including behaviour management, sedation techniques and even cognitive behavioural therapy are thus important in reducing barriers to accessing dental care as well as reducing the health inequalities associated with deprivation.

The following areas with high deprivation, and consequently higher dental need and higher anxiety levels, have very limited access to sedation services, that are well below national averages and this is of concern.

- **BGSW:** Gloucester, Swindon and Forest of Dean
- **BNSSSG:** West Somerset
- **DCIoS:** Torbay

Oral health in older people

- The burden of oral disease, and its impact on the general health of older people is considerable, particularly in terms of tooth loss, tooth decay, periodontal diseases, dry mouth, and oral cancer.
- A group known as the “heavy metal generation” currently aged between 30 and 65 years who have experienced a lifetime of high levels of treatment involving fillings, and other complex restorations such as crowns, will have challenging needs as they age. This has important service implications for the future, related to the continued maintenance and advanced restorative care amongst a group of adults who are likely to be increasingly frail, and with perhaps complex medical history and difficulties accessing dental services.
- Poor oral health has a disproportionate impact on the quality of lives of older people, compounded by socioeconomic and psychological factors. The resulting pain, discomfort, difficulties in eating, and sleepless nights can lead to increased agitation, anxiety, confusion, malnutrition and dehydration. Poor oral health can reduce self-esteem, adding to the problems of loneliness and isolation in a population already on the margins of society.
- Age related changes can lead to dry mouth (often drug related), root decay, recurrent decay and decreased manual dexterity can lead to reduced plaque control.
- Chronic long-term conditions such as diabetes and Alzheimer’s disease increase the risk of developing periodontal diseases leading to tooth loss and loss of oral function.
- Older people in residential and nursing care generally have poorer oral health than the general population. There are no local data on the oral health needs of this population group.

- Adults living with dementia may experience additional difficulties in maintaining good oral hygiene, and may be reliant on their carers to undertake routine oral hygiene for them.
- There are problems around the inconsistent delivery of oral health care by care home providers. Not all care homes include oral health care as part of their care plans, and there is a lack of staff training in the provision of personal oral care.

Routine and preventive general dental care for older adults

In all Area Teams, older people are less likely to access “high-street” NHS dental care than younger age groups, matching the national picture. In BGSW, however, a lower percentage of older people access care than the England average. This is not the case in DCloS or BNSSSG.

When older people do attend for treatment, they receive a high level of complex restorative treatment, the most out of all age groups. Regarding preventive interventions, however, such as fluoride varnish applications (crucial in the prevention and management of root decay), in each Area Team, this is being delivered at a rate lower than national averages, for all age groups over 65 years.

Access to domiciliary dental services

Domiciliary dental care can be the only care available to patients who are housebound or institutionalised. Poor access to timely domiciliary services has the potential to increase oral health inequalities in the most vulnerable groups of patients, particularly older people and those suffering from dementia. Treatment delivered via domiciliary care provides the opportunity to deliver evidence based preventive and restorative interventions to a vulnerable population group.

In each Area Team, the largest proportion of domiciliary visits was delivered in the 75 years and over age group. In future there may be greater demand for these services as all Area Team population projections indicate increases in the population of adults over 65 years living in the geographic boundaries. Specifically, in every local authority, the total population aged over 65 years and in a residential or nursing home, is set to increase by 41% across the South West.

The level of domiciliary service provision varies across each of the Area Teams, and does not appear to be associated with age; need; numbers of older people in care homes; numbers of people with dementia nor level of deprivation in the population. It is not evident if patients who have the most need of this service are able to access it. This variation is of concern.

Treatment delivered by domiciliary care: Preventative interventions and antibiotic prescriptions

Adults deemed at risk of dental decay should have twice - yearly fluoride applications. In BGSW a far lower proportion of treatment involves these preventive interventions (1.4%) below the national average of 7.5%. This is not the case in BNSSSG (12.0%) nor DCloS (24.2%).

Regarding antibiotics, these are prescribed at a rate above the national average in DCloS (2.6%), above the national average of 1%. This is not the case in BGSW (0.7%) or BNSSSG (0.1%).

Vulnerable children and adults at risk of poor oral health

Children at risk of poor oral health include:

- Those living in areas of material and social deprivation
- Children with disabilities
- Looked after children and children at risk of neglect or abuse

Adults from vulnerable groups are most at risk of poor oral health. They include:

- Adults living in areas of material and social deprivation
- People who have a learning disability
- People with mental illness
- People in long term institutional care, including residential care, psychiatric hospitals
- Prisoners, and people in contact with the criminal justice system
- Homeless people
- The travelling community
- Individual addicted to drugs or alcohol

There is no local data available about the oral health status, needs and service usage of these groups in the population. However a review of the literature suggests that they are likely to have poorer oral health than the rest of the population; have more difficulty accessing dental care; and have worst health outcomes than the general population. Certainly the association between oral health and deprivation is well established, and these population groups will include some of the most deprived individuals in society.

Looked after children

There is a requirement that looked after children have an annual health assessment, and that this should include a dental check-up. This group of children is likely to have poorer oral health and, if they are moved between different carers, more erratic and irregular access to dental care.

Currently in all Area Teams in the South West, this requirement is not being met. In BGSW and BNSSSG, the figures are lower than the national average.

The size of the problem within communities

Although local oral health data is not available, it is possible to understand the size of the problem within communities, and the potential service requirements of these vulnerable population groups by identifying their respective numbers within a local population. A summary is described in Table 1 below. Data is broken down by local authority, and compared against national averages in the main report, and detailed in Appendix C.

Table 1: Numbers of individuals in vulnerable population groups across the South West

Vulnerable population group	BGSW	BNSSSG	DCIOS
Number of children enrolled in state funded special schools (2012/13)	2044	1538	1888
Numbers of persons with diagnosed learning difficulties (aged 18+) (2012/13)	6088	5906	7829
Number of statutory homeless households all ages (2012/13)	490	455	787
Number of Gypsy and Irish Travellers (2011)	1726	1539	1379
Number of Children Looked After by Local Authorities (0-18 years) (2012/13)	1355	1650	1830

The estimated prevalence of opiate and/or crack cocaine users, crude rate per 1,000 population, (aged 15-64) was higher than national averages in BANES; North Somerset; Torbay; Plymouth; and Bristol.

Barriers to care

The barriers to oral health that these population groups experience will vary by age, personal environment and circumstances, and the level of parental or social support received. This will change throughout their life.

Commissioning considerations: a summary

The analysis undertaken in this report has identified a range of common issues. Certain themes may warrant further consideration by their respective Area Team. A summary is provided below, with further explanation and context. Note that there are various limitations in comparing Area Team-level data to national averages, as local-level issues considered in this report may be lost. The red rating in the tables below thus indicates where further investigation may be required, using Area Team data in the summary table as well as the analysis provided in the report.

Table 2: Themes for consideration by Area Team - Children

Theme for investigation	England Average	BGSW	BNSSSG	DCIoS
Children				
Routine and preventive service provision				
% of resident child population NOT accessing dental services in 2014	32	31.3	29.6	28.4
Age group with lowest access rate in March 2014 in South West 0-2 years	19.9	18.9	18.3	17.4
Clinical data set for child dental treatment: antibiotics				
Clinical data set for child dental treatment: fissure sealants				
Clinical data set for child dental treatment: fluoride varnish applications				
High average distances travelled by resident patients to access services				
25% most deprived areas (IMD 2010) with low dental service provision				
Areas with low NHS dental service access rates by resident child patients				
Urgent care				
Percentage of resident child population attending for urgent dental care	4.6	4.1	4.2	4.4
Most common age for urgent treatment in SW (6-12 yrs)	5	4.5	4.6	4.9
Anxiety management services				
% of treatment undertaken involving sedation	0.5	0.1	0.2	0.4
Clinical data set for child dental treatment: Fissure sealants	6	1.5	2.7	9.4
Clinical data set for child dental treatment: Fluoride varnish applications	11	1.1	23.6	7.9
Clinical data set for child dental treatment: Extractions	69.1	61.1	62.4	67.6

Table 3: Themes for consideration by Area Team - Adults

Theme for investigation	England Average	BGSW	BNSSSG	DCIoS
Adults				
Routine and preventive service provision				
% of resident adult population NOT accessing dental services in 2014	48.6	52.7	44.9	45.9
Clinical data set for dental treatment: antibiotic prescription (18-74 yrs)				
High average distances travelled by patients to access dental services				
25% most deprived areas (IMD 2010) with low dental service provision				
Areas with low NHS dental service access rates by resident adult patients				
Percentage of resident adult population attending for urgent dental care	11.5	10.5	10	11.9
Most common age for urgent treatment ¹		18-24	25-34	18-24
Anxiety management services				
% of treatment undertaken involving sedation	0.3	0.2	0.3	0.2
Clinical data set for adult dental treatment: Fluoride varnish applications	2.5	0.1	2.8	2.6
Clinical data set for adult dental treatment: Scale and polish	19.3	4.1	9.4	20.8
Clinical data set for adult dental treatment: Fillings	36.8	8.7	24.7	55.9
Clinical data set for adult dental treatment: Extractions	67.3	90.6	80.8	61.9
Clinical data set for adult dental treatment: Root canal treatment	5.1	0.7	0.9	3.7
Older people: Routine and preventive services				
Access rates to NHS dental services of 75 yrs + age group	44.2	39.3	47.7	45.3
Clinical data set for adults 75+ years only: antibiotics	1.3	1.3	1	1.5
Older people: Domiciliary services				
% of treatment undertaken with a domiciliary visit	0.3	0.2	0.2	0.4
Clinical data set for adult dental treatment: Antibiotics	1.0	0.7	0.1	2.6
Clinical data set for adult dental treatment: Fluoride varnish applications	7.5	1.4	12.9	24.2
Clinical data set for adult dental treatment: Scale and polish	11.5	10.1	22.9	9.1
Clinical data set for adult dental treatment: Fillings	7.7	9.5	15.2	9.8
Clinical data set for adult dental treatment: Extractions	4.4	4.6	6.5	4.7

1: The most common age for attendance for urgent dental treatment was 18-24 years in BNSSSG (12.1%) and DCIoS (16%) against a national average 14.2%); and 25-34 years in BGSW (13.4%) against a national average of 14.3%.

Table 4: Themes for consideration by Area Team – Vulnerable people and general commissioning considerations

Theme for investigation	England Average	BGSW	BNSSSG	DCIoS
Service provision to / usage of NHS dental services by vulnerable population groups				
Access rate of most deprived children to dental services	67.5	66.7	68	66.1
Access rate of most deprived adults to dental services	53.3	53.2	53.6	53.2
% of looked after children who had a dental check 2012/2013	82	78.6	78.1	84.4
Children enrolled in state funded special schools				
People in long term institutional care eg care homes, psychiatric hospitals				
People with mental illness				
Adults diagnosed learning difficulties				
Homeless people				
Gypsy and Irish Travellers				
Opiate and/or crack cocaine users				
Prisoners, and people in contact with the criminal justice system				
General commissioning considerations				
Increasing completion of the ethnicity marker on FP17 forms				
Investigating opportunities to commission specialist primary care based services				
Ensuring appropriate use of skill mix				
Transition to new dental contract				

Commissioning considerations: discussion and explanation

This section summarises where further work may need to be undertaken, dependant on the issues highlighted in the analysis of oral health of the local population, and aspects of service provision.

Access to routine and preventive dental services

High average travel distances

Where patients are travelling significant distances to access dental care, this may require further investigation. A high average distance could reflect a lack of provision in certain areas, but other factors need to be considered to include patient choice, ease of travel and locations of large towns nearby.

Access rates and service provision

Low access rates to dental care, which are below respective national averages, may require further investigation. This is especially for more vulnerable population groups including the very young; older people and socio-economically disadvantaged. Access rates can be influenced by many factors including the amount of dental provision in an area, the oral health needs of population, the deprivation or conversely

the prosperity of the resident population. A low access rate therefore may not solely be due to a lack of provision; elements such as patient choice for example opting for private treatment can impact the rate.

Deprived areas of high dental need and low service provision may also require further investigation.

Access to urgent dental care for adults and children

Higher levels of urgent care can indicate an issue with the quality of diagnosis, and treatment planning, patients not able to access routine dentistry, or patient choice. If levels of provision of urgent care are above national averages, this may require further investigation. This is especially the case for younger age groups eg 25-34 year olds. Patients' use of urgent care services is more complex than just a failure to access preventive or routine care and a range of services should be available to meet the needs of patients who choose to access dental services in different ways.

Access to anxiety management services

The proportions of patients undergoing dental treatment under sedation due to anxiety or dental phobia may require investigation, should there be substantial differences to national averages. Such differences could be indicative of local levels of need, or local provision/uptake of services. If provision is limited in areas with higher deprivation, and consequently higher need and higher anxiety levels, this is of particular concern. The sedation service generally has very limited capacity. The age of patients undergoing treatment in this way may also require analysis. Should large numbers of young adults be receiving treatment under sedation, then further developments to the care pathway may need to be considered to include psychological therapies (including cognitive behavioural therapy) to manage / eliminate the dental phobia, and prevent the same problem from happening again at a later stage. Finally, the type of interventions being undertaken when the patient is sedated needs to be analysed. For patients who are anxious, medically compromised, or cognitively or physically disabled, it is important to maximise the limited opportunities to gain access to the mouth, and undertake the appropriate treatment. This is particularly important for preventive interventions such as scale and polishes, fluoride applications and fissure sealants.

Access to dental services for older people

Adults are now likely to keep some of their (already heavily restored) teeth for life, and require increasingly more complex and advanced restorative dental care. At the same time, this group of elderly patients is more likely to have more difficulty receiving/accessing dental care either due to disability, or complex medical condition. This is particularly the case for older people who live in residential and nursing homes. The level of domiciliary service provision varies across the South West, and does not always appear to be associated with age, nor level of deprivation in the population. It is not evident if patients who have the most need of this service are able to access it. This

variation is of concern and may warrant further investigation, especially if levels of provision of this service vary significantly from national averages. Alongside this, the types and proportions of interventions being undertaken may require analysis, with a particular focus on preventive treatments, should these differ from national averages.

In future there may be greater demand for domiciliary services as population projections indicate that in every local authority, the total population aged over 65 years and in a residential or nursing home, is set to increase by 41% across the South West.

Access to / and provision of services to vulnerable population groups

People in marginalised or deprived groups are more likely to have poor oral health and less likely to access services. In the South West, not much is known about the oral health status of these groups; how these individuals access services; how accessible patients find them, or if these services are meeting their needs.

The main challenges in improving the oral health of these population groups encompass a poor awareness of oral health, outside of the dental community, specifically in terms of oral health education, prevention, and how to access dental services. Furthermore, for those that engage with social services, oral health does not often feature in general care plans.

Alongside a lack of local data, these challenges are underpinned by a lack of evidence base in understanding the causes of poor oral health in these population groups. This needs to be considered in the wider context of the socio-economic determinants of health and oral health, ie the causes of the causes. This data gap needs addressing, possibly through undertaking further epidemiological surveys to understand the patterns of oral health and service demands.

Dental services in prisons and for people in contact with the criminal justice system

Contracts for provision of dental services in prisons may need to be reviewed to ensure provision of high quality services. Patient experience and safety must lie at the heart of service provision and equipment and environment must meet national safety standards. It is well recognised that poor engagement with mainstream community healthcare services leads to high usage of costly emergency services by people in contact with the criminal justice system and their families. There is thus potential to reshape service responses in line with the needs of such socially excluded groups to improve health outcomes and reduce use of expensive crisis services.

There is a need to ensure that all dentists working within the secure environment receive formal induction and undergo core establishment training.

Local dental networks could potentially serve as a route which NHS commissioners may choose to utilise to facilitate engagement with dentists working in prisons.

Patient Charge Bands

Where the percentages of local patients receiving particular bands of treatment are lower than the respective national averages, this may require further investigation. This is especially the case if it is for more vulnerable population groups, including the very young, or older people. Analysis of the numbers and proportions of charge bands can provide insights into the type of treatment being provided in an area, oral health needs (ie are there higher levels of complex treatments) and patient attendance behaviour (ie are there high levels of urgent treatments).

Clinical data set of FP17s

The local clinical data set provides information on the range and number of treatments being provided within the three treatment bands. If this varies considerably from national averages, this may require further investigation. This is particularly the case for variations within more vulnerable population groups, including the very young, or older people. Types of interventions undertaken should also be considered, particularly preventive treatment such as fluoride varnish applications and fissure sealants within these vulnerable population groups. Adults deemed at risk of dental decay should have twice- yearly fluoride applications, whereas high-risk children could receive up to three applications a year from the age of three. Fissure sealants should be undertaken on first permanent molars from the age of six years onwards, should the child be considered at risk for decay.

Dental practices should thus continue to be supported to reorientate towards a preventive approach to treatment. The new dental contract, currently being piloted nationally, will focus on oral health assessment and risk based oral health improvement care pathways.

Antibiotic prescribing

Antimicrobial resistance has become a worldwide problem over the last few decades and now constitutes a major threat to public health. Vulnerable patients who are frequently prescribed antibiotics for a range of conditions, at different times, and by different clinicians within a short timescale are put at greater risk of antibiotics being ineffective due to antibiotic resistance. Dentists working in the NHS in England prescribe nearly 10% of all oral antimicrobials in primary care. Antibiotics should only be prescribed when there is a clear clinical need to do so; and when managing dental infections dentists should avoid prescribing antibiotics as an alternative to definitive clinical treatment. Should analysis of the clinical data set highlight that antibiotic prescribing patterns are higher than national averages, particularly within vulnerable population groups, then this may require further investigation.

Maximising opportunities to commission specialist primary care based services

There is certainly scope to enhance the provision of a range of specialities in a primary care environment, for example specialist Restorative services. It may be that should a need be identified, primary care based services in the monospecialities of periodontics and endodontics from accredited dentists with a special interest could be commissioned. Such a service would need to be underpinned by national guidance (currently in development), with strict acceptance criteria.

It is difficult to quantify the need for advanced restorative care. National adult survey data has confirmed that this need is substantial. In a time of financial constraints, commissioning services according to need will require difficult decisions to be made about how to prioritise and allocate primary care resources. The Local Dental Network will have a key role in guiding these decisions.

Appropriate use of skill mix

It is important to consider the appropriate use of skill mix within the dental team's provision of dental care, particularly in the future with the development of the new dental contract. For example, the majority of Band 1 and 2 treatment interventions (with the exception of diagnosis and endodontic treatment) would be within the remit of a dental therapist.

Dental teams will also be providing oral healthcare to a greater proportion of older patients with a range of complex needs, for which they will require appropriate training and experience.

Adequate training is required for dentists working within dental services in prisons, and also for general dental practitioners, to ensure dental competence meets the specific needs of offenders while in the prison and on release.

It will be important to ensure appropriate training is available and local dental professional networks will need to ensure Local Education and Training Boards (LETBs) are facilitating this.

Average number of UDAs claimed for each patient

The average number of UDAs claimed for each patient is a fundamental measure of the intensity of resource use, and may require further analysis where necessary. High rates could indicate that resources are not being managed in the most cost effective way, and that patient access is being compromised. High rates can result from a combination of causes such as, unusually high frequencies of treatments, an unusual mix of Band 3 treatments compared to other bands, or genuinely high levels of need in that area.

Increasing completion of the ethnicity marker on the FP17 form for child and adult patients

In April 2010 a change was made requiring mandatory completion of the ethnicity marker on the FP17. This information can be used to analyse FP17 data by ethnicity category, to ascertain if all ethnicity categories are being seen by dentists, at a level reflective of population ethnicity percentages. Gaps in provision to certain ethnicity groups can then be identified, and the appropriate services commissioned accordingly. However, given the high percentages of patients either not stating their ethnicity status, or declining to do so, it is not possible to make accurate assumptions regarding the use of dental services by ethnic minority groups

Transition to new dental contract

With the future introduction of a new dental contract it will be important to manage any associated risk to provision and ensure engagement of the profession through transition to the new contractual arrangements.

Glossary of terms

- **Access rates** show the proportion of resident population that attended an NHS dentist in the 24 month period(s) stated.
- **Population density** measures the number of people resident in an area (square kilometre) and therefore the potential need for services in an area.
- **Patient Flow In** details where the patients treated in an area reside. Significant numbers of patients from outside an area can limit access to services for residents. **Patient Flow Out** highlights where the patients living within an area have received their dental treatment. Significant numbers of patients travelling outside may be an indication of poor quality or a lack of services in an area.
- **Patient Charge Bands of FP17s on Patients:** NHS dental treatment is divided into Patient Charge Bands depending on the level and complexity of treatment provided. There are three standard charge bands for all NHS dental treatments:
 - Band 1 course of treatment: covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if needed, and application of fluoride varnish or fissure sealant.
 - Band 2 course of treatment: covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth.
 - Band 3 course of treatment: covers everything listed in Bands 1 and 2 above, plus crowns, dentures and bridges.
 - Urgent care
- Treatment on referral occurs when a patient is in need of specialist dental care for example treatment under sedation. This refers only to treatment on referral in primary care.
- The clinical data set provides information on the range and number of treatments being provided within the three treatment bands. All contractors are required to record details of the treatments provided (including any appliances) for each patient during each course of treatment.
- Sedation is used to help people feel relaxed and comfortable about having certain dental procedures done.
- Domiciliary dental care is dental treatment that is provided in the patient's home. Patients who have severe mobility problems that make it very difficult for them to leave their home for treatment would benefit from domiciliary dental care where a dentist visits their home and provides dental treatment
- The care index is the proportion of teeth with decay that have been filled. It gives an indication of the restorative care received by children with decay by dentists. The higher the care index the more fillings have been undertaken. Analysis of access alongside care index data can indicate if children are accessing, or receiving the dental treatment they require
- The average number of UDAs claimed for each patient is a fundamental measure of the intensity of resource use.

