Wiltshire Council

AGENDA

Meeting: **Health Select Committee**

Place: **Kennet Room - County Hall, Bythesea Road, Trowbridge, BA14 8JN**

Date: **Thursday 8 June 2023**

Time: **10.30 am**

Please direct any enquiries on this Agenda to Cameron Osborn, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line or email Cameron.Osborn@wiltshire.gov.uk

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Membership:

Cllr Johnny Kidney (Chairman)
Cllr Gordon King (Vice-Chairman)
Cllr David Bowler
Cllr Clare Cape
Cllr Mary Champion
Cllr Dr Monica Devendran
Cllr Howard Greenman
Cllr Tony Pickernell
Cllr Horace Prickett
Cllr Pip Ridout
Cllr Tom Rounds
Cllr Mike Sankey
Cllr David Vigar

Substitutes:

Cllr Liz Alstrom
Cllr Trevor Carbin
Cllr Mel Jacob
Cllr Jack Oatley
Cllr Ian Thorn
Cllr Kelvin Nash

Stakeholders:

Irene Kohler — Healthwatch Wiltshire
Diane Gooch — Wiltshire Service Users Network (WSUN)
Mary Reed — Wiltshire Centre for Independent Living (CIL)

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AGENDA

1 **Election of Chairman**

To elect a Chairman for the forthcoming year.

2 **Election of Vice-Chairman**

To elect a Vice-Chairman for the forthcoming year.

3 **Apologies**

To receive any apologies or substitutions for the meeting.

4 **Minutes of the Previous Meeting** *(Pages 5 - 12)*

To approve and sign the minutes of the meeting held on 28 February 2023.

5 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

6 **Chairman's Announcements**

To note any announcements through the Chairman.

7 **Public Participation**

The Council welcomes contributions from members of the public.

Statements
If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named on the front of the agenda for any further clarification.

Questions
To receive any questions from members of the public or members of the Council received in accordance with the constitution.

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Thursday 1 June 2023** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **Monday 5 June 2023**. Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior

to the meeting and made available at the meeting and on the Council's website.

8 **Wiltshire Health and Care Service Update**

To receive a presentation from Wiltshire Health and Care on how they have delivered services in the community over the previous 12 months. This update was requested by the committee in June 2022 and includes an update on how the long covid service has developed.

9 **Dementia Care Strategy**

To receive a presentation on the progress that has been made in developing a Dementia Care Strategy for Wiltshire.

10 **Measuring Performance in Adult Social Care**

To receive a presentation of the set of metrics used by Wiltshire Council and shared with Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board to evidence performance in Adult Social Care. The committee is to consider whether these are the metrics it will use to scrutinise adult social care services and the method for scrutiny.

11 **Avon and Wiltshire Mental Health Partnership Trust**

To receive a presentation from Avon and Wiltshire Health Partnership Trust on the progress it has made over the previous 12 months in developing and delivering its transformation programme.

12 **Rapid Scrutiny Report - NHS Dental Services** *(Pages 13 - 282)*

To report the findings and recommendations of a Rapid Scrutiny Exercise reviewing the provision of NHS Dental Services in Wiltshire.

13 **RUH & Salisbury NHS Foundation Trust - Quality Accounts** *(Pages 283 - 434)*

The committee is invited to comment on the quality accounts submitted by the hospital trusts. A formal response will be completed by the Chair and Vice Chair by 16th June.

14 **Forward Work Programme** *(Pages 435 - 438)*

The Committee is invited to review its forward work programme in light of the decisions it has made throughout the meeting.

15 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

16 **Date of Next Meeting**

To confirm the date of the next meeting as 10:30am on 4 July 2023.

Wiltshire Council

Health Select Committee

MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 28 FEBRUARY 2023 AT KENNET ROOM - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:
Cllr Johnny Kidney (Chairman), Cllr Gordon King (Vice-Chairman), Cllr David Bowler, Cllr Clare Cape, Cllr Mary Champion, Cllr Dr Monica Devendran, Cllr Howard Greenman, Cllr Pip Ridout, Cllr Mike Sankey and Cllr David Vigar

Also Present:
Mary Reed, Diane Gooch, Irene Kohler, Kate Blackburn and Emma Legg

15 **Apologies**

Apologies were received from Councillors Anthony Pickernell, Pauline Church and Caroline Corbin.

16 **Minutes of the Previous Meeting**

Resolved:

To approve the minutes of the previous meeting held on 18 January 2023 as a true and correct record subject to the inclusion of Councillor Mike Sankey in the list of attendees.

17 **Declarations of Interest**

There were no declarations of interest.

18 **Chairman's Announcements**

The Chairman expressed his condolences to the friends and family of the late Helen Jones, former Director of Commissioning and Procurement, noting her important contribution to the Committee.

The Chairman updated the Committee on the previously agreed-upon discussion between the Chairman and Vice-Chairman of the Committee and their counterparts from B&NES and Swindon Borough Council over the programme of health and social care integration and opportunities for collaboration. The Chairman notified the Committee that due to the upcoming elections for those two councils in May, those discussions have been postponed until June 2023.

The Chairman noted two upcoming briefings for Committee members in March 2023. He encouraged members to attend and participate in both the Carers'

Support Strategy and Service Commissioning briefing on 10 March 2023 and the Good Lives Alliance Framework Retender on 17 March 2023.

The Chairman advised that Committee that they were expecting to receive Quality accounts from health providers for review in May 2023.

The Chairman congratulated Emma Legg on her recent appointment as Director for Adult Social Care.

19 **Public Participation**

There was no public participation.

20 **Joint Strategic Needs Assessment 2022**

Kate Blackburn, Director of Public Health, presented an overview of Wiltshire's Joint Strategic Needs Assessment (JSNA) from 2022.
In particular, the Director commented on population and deprivation, life expectancy and causes of death, diseases and ill health, alcohol, drugs, smoking, weight and physical activity, education and employment, and housing, crime, and the environment.
Members discussed whether data was available for local areas, as that was often what interested the public the most. The Director confirmed that publication of detailed data was due in late Autumn 2023. The Committee also asked about the status of smoking across the County and drew attention to the disparity between the average life healthy expectancy (which was confirmed as a self-reported and subjective metric) of deprived and non-deprived residents. Members discussed how the JSNA was a statutory requirement and would be used to inform decision and strategy in Wiltshire, although not as part of Bath, Swindon and Wiltshire (BSW). Finally, the Committee asked about whether the report factored in any sort of plan for a potential future pandemic, to which the Director replied that while the report does not cover that specifically, it is considered elsewhere in Public Health.

Resolved:

- **To note the content of the Joint Strategic Needs Assessment 2022**
- **To ensure the findings of the Joint Strategic Needs Assessment 2022 informs the work of the Committee.**
- **To review the trends for Wiltshire in 12 months' time.**

Councillor Clare Cape joined the meeting at 10:47am.

21 **Draft Joint Local Health and Wellbeing Strategy 2023-2032**

David Bowater, Senior Corporate Manager for Levelling Up, then presented a draft of the Joint Health and Wellbeing Strategy.

The Senior Corporate Manager explained that along with the JSNA, the Joint Local Health and Wellbeing Strategy (JLHWS) provides the foundation upon which the health and wellbeing board exercises its shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education. An effective JLHWS should enable commissioners to plan and commission integrated services that meet the needs of their whole local community, particularly those of the most vulnerable individuals and the groups with the worst health outcomes. The Senior Corporate Manager stated that the recently updated JSNA had informed the development of the draft JLHWS together with the workshop held on 1 December 2022 and input from a steering group incorporating public health, social care, NHS and Healthwatch Wiltshire representatives.

The Committee discussed the integration of services, recruitment, and staffing concerns, as well as the potential for partnership with the private sector to work on preventative measures. The Senior Corporate Manager explained officers' plan for targeted outreach and expressed a reluctance to become fixated on potentially changeable data. Members also asked about how the strategy might be evaluated, to which the Senior Corporate Manager responded that more so than through Key Performance Indicators (KPIs), outcomes ought to be measured through the JSNA.

Resolved:

- **To note the draft Joint Health and Wellbeing Strategy for consultation**
- **To review the implementation plan and monitor performance**
- **To receive a progress report 12 months after publication, to review progress against the objectives of the strategy.**

22 **Integrated Care Strategy for B&NES, Swindon and Wiltshire**

Introducing the next item, the Chairman reminded the Committee that in January 2023, they received an update on plans for an Integrated Care Strategy (ICS) for Bath & North East Somerset, Swindon and Wiltshire (BSW). He then introduced Fiona Slevin-Brown, Place Director for Wiltshire on the BSW Integrated Care Board (ICB) and William Pett, Associate Director of Policy and Strategy at the Integrated Care Board, to present the draft strategy.

The Associate Director then presented an update on BSW's draft ICS. He explained that the ICS was intended to encapsulate enabling, organisational, service and place-based strategies, warning that there was no legal enforcement behind the strategy and was therefore dependent on buy-in and support from partners. He clarified for the Committee that the fundamental purpose of the ICS was to support integration to meet local healthcare, social care and public health needs in such a way as to address local needs, engage a broad range of people, communities and organisations, address complex problems that require a system response and multiple partners, and to create space to address population health and wellbeing and support socio-economic development. The Associate Director also pointed to the challenges facing the

ICS, including ensuring the strategy is driven by community and resident engagement, co-owned and developed with partners across the system, and sufficiently robust in spite of a short development window.

Members observed that the document at present was too technical and jargon-heavy to be accessible to the general public and questioned the use of the term "left shift" to describe their migration away from hospital care. They also discussed utilising social media and video content to better promote and communicate the Strategy, as well as working alongside other companies like local sports teams through the Integrated Care Partnership. Members expressed concern over how easy it would prove to move away from spending so much on acute care, having been attempting to do so for so long already. The Associate Director replied that the Strategy did not indicate an abandonment of the Life Cycle approach but expressed a hope that through the new model of a legal structure for bringing systems together rather than relying on market competition (which he personally considered a barrier to success), they might finally make more progress. He also explained that it was important for the Strategy to be measurable and assured members that a progress report after 12-14 months would be wholly achievable. Questions were asked about the potential for an increase in community care funding and the possibility of reopening community hospitals like in Melksham. The Place Director stated that NHS estates should be enablers, and that the Strategy would seek to utilise them by either reopening them, refurbishing them, or rebuilding on them. On a similar note, the Vice-Chairman asked about the Peasedown St. John Diagnostic Centre, to which the Place Director advised that the Committee should bring that item back to a future agenda for a full update.

Resolved:

- **To note the draft BSW Integrated Care Strategy and**
- **To request the implementation plan**
- **To receive annual updates to follow progress including a rapid scrutiny in 14 months' time.**

23 **Hearing and Vision Service Update**

Councillor Jane Davies, Cabinet Member for Adult Social Care, SEND and Inclusion, then introduced Emma Townsend, Head of Hearing and Vision Services, who proceeded to present an update on the work of her team as requested by the Committee.
The Head of Hearing and Vision Services presented on the prevalence of visual impairment in Wiltshire, the structure of the Hearing and Vision Services team, the role of Rehabilitation Officers and the areas of development, including an action plan.

Members asked about the state of the waiting list and learned that the list was risk-based as well as chronological, and that sometimes patients defer their own appointments, giving the appearance of longer waiting times. The Committee also asked about who funds the service, to which The Head of Hearing and Vision Services responded that as the service is believed to actually deliver

significant financial benefits, the Council factor it into their Adult Social Care offer. The availability of Rehabilitation Officers for the Visually Impaired (ROVIs) was also discussed, as well as personal assistants and access to employment through partnerships with job centres. Councillor Davies informed the Committee that the County was currently above the national average for employment in the deaf community, although more could still be done. The risks and challenges of the proposed ROVI apprenticeship position were also discussed. The Chairman asked about what work is being done to preserve aural health in Wiltshire, to which the Director of Public Health advised that there was next to no work being done at present besides nation-wide campaigns, such as the current awareness campaign associating hearing loss with dementia.

Resolved:

- **To note the content of the detailed presentation**
- **To receive the findings of the upcoming review of the hearing and vision service.**

24 **Market Sustainability Plan for Wiltshire**

Commissioning Manager Jessica Chapman, Head of Commissioning for Adults SEC Melania Nicolaou and Head of Finance for Adults and Health Sarah Rose then joined the meeting remotely to present a progress report on the Market Sustainability Plan for Wiltshire.

The Commissioning Manager explained the purpose of the plan and the allocated funding and issues it will be used to address. She described how the Plan needed to revolve around an assessment of the current sustainability of local care markets, an assessment of the each's service market's future changes before October 2025 and a plan for each market to address sustainability issues, where identified. She explained that the next steps for the plan focused on further provider engagement and fee-setting, with a final Market Sustainability Plan due to be presented to Cabinet on 28 March 2023.

The Committee sought reassurance that the market was indeed sustainable, which the Commissioning Manager was able to provide. She also elaborated on the premise behind block care beds and their merits. The discussion then turned to the challenges in presenting a career in care as a viable and attractive option to young people entering work, both through an appealing pay rate and effective promotion. Members also remarked upon the difficulties facing carers when it came to undertaking training to advance their careers, while also observing that there are some positive examples of career progression in the Council and that not all carers are interested in career progression. Councillor Davies was keen for Committee members to advocate shared lives caring in their communities, while Mary Reed spoke on the importance of forming meaningful relationships, and that those relationships were important to the carers as well.

Resolved:

To note the development of the Market Sustainability Plan for Wiltshire.

25 **Inquiry Session into Challenges being experienced with patient flow through hospitals**

The Chairman acknowledged the programme for the upcoming Inquiry Session included in Appendix 1 for approval, noting that the programme would be further developed in collaboration with health and social care staff and with the Committee.

Councillor Cape advised that she had submitted several comments on the programme in advance of the meeting via the Vice-Chairman, and the Chairman confirmed that those comments had been received by the Senior Scrutiny Officer Julie Bielby and would be duly considered. Councillor Cape suggested that an earlier date would be preferable to a later one; the Committee touted a date in spring as being the most favourable option.

Resolved:

To approve the draft programme and its further development and publish the date before the next meeting.

26 **Forward Work Programme**

The Chairman noted that the Forward Work Programme (FWP) would be amended to include the proposal to carry out a Rapid Scrutiny into NHS Dental Services, for which, as of April, the ICB would become the new commissioning body.

Irene Kohler raised the recent presentation on maternity services by Lucy Baker and requested feedback on those strategies. Similarly, Councillor Howard Greenman asked for an update on diagnostic provision.

Diane Gooch enquired about the Council's dementia strategy, to which the Director of Adult Social Care advised that the Council was still early in its development of the strategy but could request that a draft be brought into the FWP.

Diane Gooch made the point that prior to the Directors involvement, the Committee had been directly involved in the development of such strategy. Irene Kohler suggested that it would be preferable for the Committee to see an early draft as well, rather than seeing it for the first time after it had been finalised. The Director responded that she warmly welcomed the input of the Committee and expressed a desire to involve and consult as widely as practicable in the strategy's development.

Resolved:

- **To approve the inclusion of a Rapid Scrutiny into NHS dental services on the Forward Work Plan**
- **To add the actions raised during discussion at this meeting**
- **To add an update on the Maternity Services Transformation from January's meeting to understand the impact of the transformation on services**
- **To add an update on the integrated care centres**
- **To ensure HSC and community stakeholders are involved in development of dementia care strategy at an early stage.**

27 **Urgent Items**

There were no urgent items.

28 **Date of Next Meeting**

The date and time of the next meeting was confirmed as 8 June 2023 at 10:30 am.

(Duration of meeting: 10.30 am - 1.20 pm)

The Officer who has produced these minutes is Cameron Osborn of Democratic Services, e-mail Cameron.Osborn@wiltshire.gov.uk

Press enquiries to Communications, direct line 01225 713114 or email communications@wiltshire.gov.uk

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Wiltshire Council

Health Select Committee

8 June 2023

Rapid Scrutiny Exercise:
NHS Dental Services in Wiltshire

Purpose

1. To present the findings and recommendations of a rapid scrutiny exercise on the provision of NHS Dental Services in Wiltshire.

Background

2. The Health Select Committee (HSC) agreed at its meeting, 18 January 2023, to request an update on the current provision of NHS Dental Services in Wiltshire.

3. The Committee learned that responsibility for the commissioning of NHS dental services would be transferred from NHS England to the BSW ICB (Bath & North East Somerset, Swindon, and Wiltshire ICB Integrated Care Board) in April 2023.

4. At its meeting on 28 February, the Committee agreed to carry out a rapid scrutiny exercise before the transfer took place to understand service levels before this transfer, in order to inform future scrutiny of NHS dental services. The rapid scrutiny proposal was approved by the Chair and Vice-Chair of the Committee (Appendix 1).

5. The rapid scrutiny exercise took place on 29 March 2023 with representatives from BSW ICB and NHS England attending and also providing a briefing paper (Appendix 2).

6. Further supporting reports outlining the experience of residents accessing NHS dental services were provided by Healthwatch Wiltshire before the meeting.

Terms of Reference (TOR)

7. To investigate how NHS dental services are delivered in Wiltshire to include the following:
    - The current availability of NHS dental services for Wiltshire residents;
    - The extent to which the service is meeting the needs of Wiltshire residents;
    - Identification of any gaps in service.

8. In light of these findings, to consider appropriate future scrutiny of NHS dental services in Wiltshire.

Membership

9. The membership of the rapid scrutiny exercise comprised:
   Cllr Johnny Kidney (lead member)
   Cllr Gordon King
   Cllr Monica Devendran
   Cllr Anthony Pickernell
   Cllr David Vigar

Witnesses

10. The rapid scrutiny group are grateful for the attendance of the following witnesses:
    Jo Lawton, Programme Manager, Dental Health Services, (Gloucestershire, BSW & BNSSG), NHS England – Southwest
    Jo Cullen, Director of Primary Care, NHS BSW ICB
    Cllr Ian Blair-Pilling, Cabinet Member for Public Health, Wiltshire Council (observer)

Summary of Findings

Transfer of Commissioning

11. NHS England and BSW ICB have been working together for the last 9-10 months to prepare for the transfer of commissioning responsibilities and will continue to collaborate. NHS England will still be involved in delivery and will maintain their expertise and knowledge of the network of dental practices (referred to as contractors).

12. The commissioners anticipated that the transition would be smooth, and that contractors and residents would not notice any difference. The impact of the change in commissioning represented a shift to a more localised approach with an increased capacity to work closely with stakeholders including the Public Health team at Wiltshire Council to develop decision making based on local needs assessments.

Current service levels

13. NHS dental services had been impacted by social distancing measures over the previous 3 years and there was still a recovery plan in place with the aim of achieving pre-Covid levels of service. While infection prevention measures had reduced, practices were still not achieving the same throughput they previously had.

14. There has been a shift in activity with contractors moving towards more private work and less NHS contracted work. Some have terminated their NHS contracts entirely.

15. Commissioners are limited in their flexibility to respond to these trends. Dental contracts are commissioned in units of dental activity (UDA) and there is a variance of unit rate across England, which were last set in 2006.

16. The briefing document revealed access levels to NHS dental service in Wiltshire to be behind national levels. In 2022 only 32.7% (nationally 37.4%) of adults and 42.2% (nationally 46.9%) of children. 'Access' was defined for members as 'attended an appointment with an NHS dentist.'

17. Pre-Covid statistics on access to services were requested and provided after the meeting (Appendix 3). They illustrate that access rates were below the national average before Covid too.

18. NHS dentistry typically funds 50% of dental care. People are not 'registered' with a dental practice for NHS dental care. The NHS website says 'There is no need to register with a dentist in the same way as a GP because you are not bound to a catchment area... Once you find a dental surgery, you may have to fill in a registration form at your first visit, which is just to add you to their database. **But that does not mean you have guaranteed access to an NHS dental appointment in the future.'**

19. Members felt there was scope for improving communication with the public about NHS dentistry. From their own experience and through discussion with constituents, members knew that expectations about the levels of service were high. However, dentists operating under an NHS contract are limited in their capacity to meet those expectations. An increase in demand for urgent dental care will mean that contractors have reduced capacity to provide routine appointments.

20. Members queried access to urgent care, citing examples from a Healthwatch report (Appendix 5) of people contacting 111 multiple times and not being treated. From the NHS' perspective, anyone calling 111 would be triaged and prioritised according to clinical need. However, people could be put on a waiting list if urgent appointments have all been allocated. It was suggested that this could be an area to explore further.

21. Responsibility for providing information about a dental practice is the responsibility of the contractor. It is up to practices to keep their profile up to date, including whether they are accepting NHS patients, and the commissioning body does not monitor practices in this respect.

Impact of limited access to regular check ups

22. The rapid scrutiny group were concerned about the impact on the general health, as well as dental health, of people not accessing a dentist regularly because of limited availability. They were also concerned about the NHS not covering treatment and the cost of private care being prohibitive.

23. Most periodontal diseases are not apparent until at an advanced stage.

24. Limited access to primary care (high street dentists), is leading to a demand for urgent care, thereby reducing the availability of routine check-ups.

Initiatives to improve access

25. In 2020 NHS England instigated a workshop in the South West to review NHS dentistry, which resulted in three workstreams with the aim of reforming provision:
    - Access to dentistry
    - Workforce
    - Oral Health Improvement

26. Two practices in Wiltshire are undertaking a stabilisation pilot aimed at preventing individuals making repeat visits to urgent care services. Stabilisation provides a more permanent solution to a dental problem. If this pilot proves successful, more funding could be put into extending the scheme's delivery.

27. Another pilot scheme is underway to identify dental practices that could offer dental and oral care to children. The practices would receive support to tailor their services, as general dental practitioners are often wary of treating children.

28. As improvement initiatives were in pilot stage it would take time to assess the outcomes. Clinical networks will inform the ICB in the development of dental services. Further information about clinical networks was provided following the meeting (see link below).

    NHS England — South West » Managed Clinical Networks

29. A review is being carried out on pathways to services, to standardise people's access to dental care.

Workforce

30. Attracting and retaining staff (not just dentists but hygienists and support staff) is a key issue in improving access to NHS dental services.

31. It is difficult attracting staff to Wiltshire and the South West as the region is seen as less attractive than some other regions to young professionals.

32. The group queried if the most was being made of having a training hospital (Bristol) in easy reach of West Wiltshire.

33. There are a range of initiatives planned as part of the dental transformation programme and detailed in the NHS Dentistry in Wiltshire (Appendix 2).

Tracking Gaps in Provision

34. The Oral Health Needs Assessment (Appendix 4a) is the tool used by commissioners to inform procurement.

35. It is, however, the Public Health team who have the local knowledge to identify pockets of deprivation and disadvantaged groups and work at community level to support take up of health services, including dental services.

Special Focus on Inequalities

36. Health inclusion groups are looking at how to improve access for disadvantages communities, for example, asylum hostels, refugees, travellers, often tapping into the work of the voluntary sector with hard-to-reach groups. The Joint Strategic Needs Assessment provides evidence to support this work.

37. The ICB are also aware that military families can experience difficulties accessing NHS dental services.

38. The ICB will have a more local focus when it takes on commissioning responsibility, which should, ideally, support the development of local priorities and strategies.

39. Health visitors reach out to parents of new babies, encouraging them to take babies when they visit the dentist to help familiarise them with the environment. There is also work in school and pre-school settings.

40. No examples were given of initiatives for adults who were phobic about attending a dentist.

41. The cost of living is impacting on dental health to the extent that buying toothbrushes is seen as an unaffordable luxury for some households.

42. There are varied reasons why people do not readily access healthcare and services need to look at ways of making this easier and making every contact count.

Conclusions

43. Wiltshire residents need to have greater access to NHS dental services than is currently the case.

44. The group recognises that the ICB, supported by NHS England, faces significant challenges in improving the offer to Wiltshire residents, however they would like reassurance that improving access to dental services is a priority.

45. The provision of NHS dental services is a complex issue and while the rapid scrutiny exercise has provided an insight, the group need further information to better appreciate the issues and to fully understand the challenges and how access to NHS dental services could be improved.

Recommendations

The Health Select Committee (HSC):

i) **Requests regular performance updates from BSW ICB to monitor improvements to residents' access to NHS dental services in Wiltshire.**

ii) **Requests a report from the council's Public Health team about the work to improve access to health services in areas of higher deprivation, including NHS dental services.**

Cllr Johnny Kidney, Lead Member for the Rapid Scrutiny Exercise – NHS Dental Services in Wiltshire

Report author: Julie Bielby, Senior Scrutiny Officer, 01225 718702,
julie.bielby@wiltshire.gov.uk

Appendices

Appendix 1 – NHS Dental Services Rapid Scrutiny Proposal
Appendix 2 – Wiltshire Dentistry Briefing paper
Appendix 3 – Access to NHS dental services statistics, 2018-2020
Appendix 4a – Oral Health Needs Assessment - BSW
Appendix 4b – Oral Health Needs Assessment – South West
Appendix 5 – Southwest Healthwatch presentation 2021

Background documents

Healthwatch Report – Military Families Experience of Health & Care Transition

Wiltshire Council

Health Select Committee

28 February 2023

Rapid Scrutiny Exercise: NHS Dental Services in Wiltshire

Purpose

1. To present an outline proposal for a Rapid Scrutiny Exercise looking at NHS Dental Services in Wiltshire.

Background

2. The Committee agreed, at their meeting in January 2023, to request an update on the current provision of NHS Dental Services in Wiltshire. Responsibility for dental services in Wiltshire will be transferred from NHSE to the Bath & North East Somerset, Swindon and Wiltshire Integrated Care Board in April 2023.

3. It would be helpful for the Committee to understand service levels before this transfer in order to plan future scrutiny of service development and improvements.

4. The proposal is to carry out a rapid scrutiny exercise before the transfer takes place, and findings of the exercise reported to the Health Select Committee on 8 June 2023.

Proposed Terms of Reference for the Rapid Scrutiny Exercise

5. To investigate how NHS dental services are delivered in Wiltshire to include the following:
   - The current availability of NHS dental services for Wiltshire residents.
   - The extent to which the service is meeting the needs of Wiltshire residents
   - Identification of any gaps in service

6. In light of these findings, to consider appropriate future scrutiny of NHS dental services in Wiltshire.

Evidence

7. The Rapid Scrutiny Exercise may want to consider evidence from
   - Commissioning bodies
   - Dental practitioners
   - Organisations representing patient interests.

Proposal

8. Health Select Committee to establish a rapid scrutiny exercise as set out in the report.

Report author: Julie Bielby, Senior Scrutiny Officer, julie.bielby@wiltshire.gov.uk, 01225 718702

Dental Access for Adults and Children in Wiltshire

March 2023

1. Background

NHS England is responsible for the commissioning of dental services across England, having taken over from primary care trusts when the NHS was reorganised in 2013. NHS England's offices in the South West region manage these contracts locally. From April 2023 the Integrated Care Board will take on responsibility for commissioning NHS dentistry, supported by NHSE Commissioning hub.

Dental services are provided in Wiltshire in three settings:

1. Primary care – incorporating Orthodontic treatment
2. Secondary care
3. Community services – incorporating Special Care dentistry

2. Primary care (high street dentistry)

The dental practices are themselves independent businesses, operating under contracts with NHS England. Many also offer private dentistry. All contract-holders employ their own staff and provide their own premises. Some premises costs may be reimbursed as part of their contract.

Dental contracts are commissioned in units of dental activity (UDAs). To give context, the table below sets out treatment bands and their UDA equivalent:

Band	Treatment covered	Number of UDAs
1	This covers an examination, diagnosis (including x-rays), advice on how to prevent future problems, a scale and polish if clinically needed, and preventative care such as the application of fluoride varnish or fissure sealant if appropriate.	1
2	This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work, removal of teeth but not more complex items covered by Band 3.	3
3	This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges, and other laboratory work.	12

4	This covers emergency care in a primary care NHS dental practice such as pain relief or a temporary filling.	1.2

3. Access rates to high street dentistry

The table below shows the number of people in Wiltshire who have been able to access an NHS dentist for routine care.

Access rate	June 2021	June 2022
Adults	36.1%	32.7%
Children	33.2%	42.2%

For example, the total number of adults seeing an NHS dentist in Wiltshire has decreased from 36.1% of the population in June 2021 to 32.7% of the population in June 2022.

The access rate for the adult population of Wiltshire (32.7%) is lower than the access rate for England as a whole (37.4%).

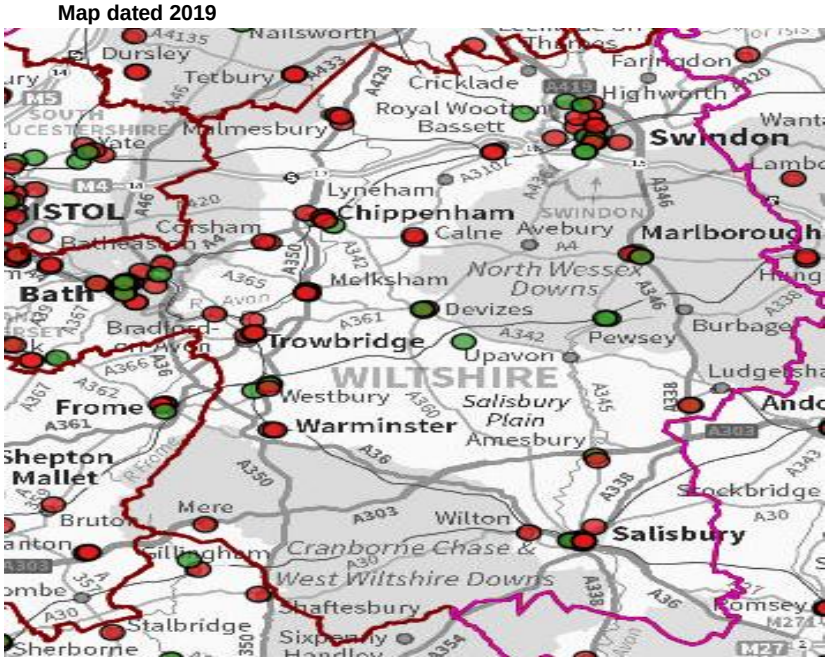
The number of children who have seen a dentist in Wiltshire has increased from 33.2% in June 2021 to 42.2% in June 2022.

The access rate for the child population of Wiltshire (42.2%) is lower than the access rate for England as a whole (46.9%).

For further details on these statistics, please see:
https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/dentistry

4. Commissioned Dental Activity

Map dated 2019



There are 62 practices in Wiltshire providing general dental services, as indicated in the above map of the Wiltshire area. There are a further 55 practices in BaNES and Swindon.

NHS England has commissioned dental activity from these providers in Wiltshire as follows:

- 22/23 total UDAs commissioned 576,320 – value £17,054,342.20. Total number of UOAs commissioned 28,970 – value £1,902,487.96.

5. Orthodontics

Orthodontics is a dentistry specialty that addresses the diagnosis, prevention, and correction of mal-positioned teeth and jaws, and misaligned bite patterns. A procurement exercise to secure new contracts was completed in 2019. These new contracts provide improved services for people. For example, under the new contracts' practices now have to provide 30% of appointments outside of school hours which may include after-school, at weekends and during school holidays.

Post Covid, orthodontic services have been able to return to normal levels of activity more rapidly than high street dentistry and normal contract volumes are in place for 2022/23

6. Urgent dental care

Great Western Hospital NHS Foundation Trust host the Community Dental Services that manage in and out of hours (weekends and Band Holiday) appointments for patients experiencing dental pain.

Access to urgent dental care would normally be expected to be available within 24 hours of contacting the service. Appointments are provided from sites in both Chippenham and Salisbury.

Only those people with a significant dental emergency, such as facial swelling affecting the airway, uncontrolled bleeding, or facial trauma, would be expected to be treated at accident and emergency departments.

The South West dental commissioning team have launched an initiative to increase the number of urgent care treatment slots by asking practices to provide additional urgent care sessions. There are currently 2 practices within Wiltshire who have signed up to the initiative, seeing a total of 11 patients per week.

7. Stabilisation

One of the exciting pieces of work currently underway is the dental stabilisation programme:

Throughout the pandemic there was a focus on urgent dental care and demand for urgent care remains high. Historically, urgent care was confined to the immediate urgent issue.

Anyone requiring further work to stabilise other dental issues that were less urgent, but likely to become so if left unattended, would need to receive that in a general dental practice.

Stabilisation would provide a more permanent solution to the dental problem, stabilising oral health leading to reduced likelihood of pain and recurrence of accessing the urgent care system, or of accessing other support (i.e., via ED or the GMP). This programme offers a more permanent solution that is better for patient outcomes and is more satisfying for clinicians.

Two practices are providing stabilisation in Wiltshire offering 5 sessions per week, this is accessed via triage through NHS 111.

8. Child Focused Dental Practices (CFDP)

This is an innovative scheme being piloted to address the current shortage of access to quality assured dental care for children under the age of 16. The goal is to improve access to dental and oral care for children in primary care, thus reducing the number of referrals to specialist paediatric dental services largely in hospital settings but also in community clinics.

There are a number of reasons for general dental practitioners (GDPs) feeling uncomfortable treating children in primary care. Of these, confidence and competence play a key role resulting in a referral being made as opposed to an attempt to treat the child.

The scheme aims to improve access by identifying GDPs interested in offering dental and oral care to children. The dental practitioners are supported in their journey of upskilling using different methods, thus giving them confidence in offering care to these patients. These practices are called 'Child Focused Dental Practices' (CFDPs) and a structured programme of learning and pathways for referral to the practices have been established and agreed.

The emphasis will be to offer children dental and oral care timely and efficiently within local settings. The target being upon completion, the patient will be discharged to the care of the referring GDP.

In Wiltshire there is currently one dental practice participating in the pilot scheme, GDPs are able to refer patients to the practice.

9. Workforce

A key factor affecting access to NHS dentistry across the country is limited workforce. The lack of dentists in the area undermines the ability of high street practices to fulfil their contractual required activity.

Recruitment in the South West is challenging and the unwillingness of dentists to come to the area is not necessarily different to those affecting other sectors of the health and social care system.

The lifestyle choices offered to both the medical and dental profession in terms of training opportunities and proximity mean that the younger generation often tend to favour the larger city of Bristol. Recruitment in the more rural areas can be more challenging.

Further training opportunities tend to be aligned with the big teaching hospitals. While we do have a highly successful dental school in Bristol, the need to train and retain dentists in the area outstrips its capacity.

Foundation dentists, who are undergoing further training for a year after graduation, tend to relocate at the end of their foundation year; very few of the annual cohort go on to practice in the South West. Many move out of the area to follow training pathways or to take hospital-based jobs.

Reasons for established dentists leaving include the challenges of working in pressurised NHS practices and the opportunities in private care. Anecdotally, it also seems that some EU dentists are leaving and fewer are arriving.

The SW dental transformation programme includes a range of initiatives to address the workforce gap and associated access issues.

10. Improving access to primary care for people in Wiltshire

- Running a South West recruitment day supported by the British Dental Association and dental providers to try and attract all practitioners to move into the region.
- Working with dental providers to ensure existing contracts are delivering to their maximum potential.
- Reviewing under and over performance of dental contracts on a regular basis and, as part of reconciling activity to contract payment, explore with those contractors with the most variance what they are doing to address under performance.
- Issuing new contracts for NHS primary care dental activity in areas of greatest need, we are having conversations where we can adjust activity and reallocate the activity where necessary,
- Developing plans to commission dental services in areas where there is inequality in access, within available resources. We are working closely with dentists, public health, and the dental school to develop referral pathways and identify initiatives to increase dental capacity across the region through the South West's Local Dental Network and six Managed Clinical Networks for dentistry.
- In collaboration with Health Education England and the Universities of Plymouth and Bristol, we are offering funding to dentists working in the South West who are undertaking post-graduate courses in Restorative; Periodontal; Endodontic and Oral Surgery to increase the number of local specialists within our region.
- Working towards further innovation with existing providers to address regionalised concerns. This includes adjusting contract activity, allowing for reinvestment. Any schemes will take into account national initiatives and regional priorities, e.g., Dental Checks by 1 campaign (to ensure all children see a dentist as their teeth come through, or by their first birthday, at the latest) or increasing urgent care sessions for patients who do not have a regular dentist.

The SW Dental Team has commissioned additional mandatory dental services across the region. Priority areas have been identified focused on replacing activity which has ceased within this financial year. Contract performance criteria for these new contracts included the measurement and assessment of the number of additional new patients accepted for treatment and delivery against the Starting Well Core initiative, which aims to increase access for 0–2-year-olds, promoting early attendance at a dental practice and offering preventative care.

11. Secondary care provision

NHS England contracts with Great Western Hospital NHS Trust, Salisbury NHS Foundation Trust, and Royal United Hospitals NHS Foundation Trust in Bath to provide secondary care dentistry for people living in Wiltshire.

As with other services, secondary care was greatly impacted by the pandemic as services initially ceased to funnel additional clinical capacity to treat covid patients in hospitals. All services have now been resumed, but in some cases the frequency of clinics has been reduced due to continued stretched capacity at the hospital sites. This has led to an increase in waiting list for some specialities. Work continues with providers to support a reduction in waiting times.

12. Community services

Great Western Hospitals NHS Trust is commissioned by NHS England to provide a range of community dental services including special care dental. They operate from the following sites across Swindon and Wiltshire.

- Chippenham Dental Access Centre
- West Swindon Health Centre
- Swindon Health Centre
- Salisbury Central Health Clinic

Special care dentistry is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional, or social impairment or disability; or, more often, a combination of these factors.

Some of the people using the services include:

- People suffering from anxiety and/or extreme phobia of dental treatment
- People with learning difficulties and/or autism
- People with physical disabilities
- People suffering from dementia
- Patients needing bariatric equipment
- People undergoing chemotherapy
- Some homeless people

People are referred to the service from several routes including:

- High street dentists
- GPs
- School nurses
- Social workers
- Care workers
- Voluntary organisations

Special care dental providers are currently experiencing difficulties in recruiting to specialist posts. Measures are in in place, supported by the Special Care Managed Clinical Network, to provide cover from out of county specialists.

We know that our special care dental services provide an invaluable service to some of our most vulnerable people. Our ambition is to ensure that the services are as good and as accessible as possible.

13. Dental Reform Strategy for the South West

Actions Planned for 22/23 Onwards

For the last two years we have been working with the dental practitioners and community representatives such as Healthwatch and NHSE SW's public and patient voice partners, to understand the oral health needs of the population, the reasons why it is difficult to recruit and retain dental practitioners in the region and what factors would support recruitment and retention. Now that we have a more thorough understanding of the issues, where need is greatest and what current students and the dental community suggest would make them more likely to work for the NHS in the South West, we have established three working groups to focus on improving 1) access to dental provision; 2) oral health promotion and 3) workforce gaps and building the architecture needed to support the dental community (such as the development of the previously mentioned LDN and MCNs and the inclusion of Healthwatch members in local dental committees).

Each working group has developed a workplan for the coming years. The following action plans are subject to change as we continue to consider new ideas and suggestions and learn from the pilot projects we have commissioned to determine what works best.

Programme Commitments

In expanding on its objectives, the reform programme has developed a range of commitments related to the workplan.

13.1 Access

The following summarises the commitments and actions that the dental reform programme will complete over the next year to improve access to NHS dental services in the South West: Below are some of the initiates we have progressed

- The Urgent Care Managed Clinical Network are working to finalise aspirational pathways for future commissioning of urgent care and stabilisation.
- Dental helpline, 111 pathways are being reviewed, developing standardised access routes.

- Stabilisation pilot programme is currently being commissioned and will run until March 24.
- Starting Well Core aims to increase access for 0-2 years, launched October 2022. This now forms part of the criteria for the newly procured dental contracts.
- Welfare checks are taking place for under eighteens waiting for dental general anaesthetic is ongoing.
- Improved access for Armed Forces families review (via MDS procurement and stabilisation) is due to start quarter 4.
- Domiciliary care review has been completed, and suggestions for change have been agreed, which will increase the number of older people accessing dental.

13.2 Workforce

- Dental Stakeholder Conference to was held in January 2023.
- Website signposting to dental vacancies and training opportunities is ongoing.
- Dental workforce data review to support the development of the workforce action plan, is ongoing.
- PLVE - The Performers List Validation by Experience programme enables the NHS to employ overseas dentists. There are now discussions underway with both the Professional Standards Team and Health Education England to look at ways in which criteria, process and regulations can be improved to increase access for overseas dentists.
- Mapping utilisation of dental chairs is taking place to better understand were there may be capacity, is ongoing.
- South West Dental Education Review programme stakeholder group, started in October and is being led by Health Education England.
- Tier 2 accreditation panel has been established work is ongoing.

13.3 Oral Health

- Supervised Toothbrushing – pilot in progress and approval to expand across the SW for 4- and 5-year-olds – Bids are currently be evaluated.
- Task and finish group to review oral health among older population, has started with a piece of work in care homes.
- Task and finish group to review green impact on dentistry and rollout of national toolkit, is awaiting feedback from national colleagues.

14. Summary

Wiltshire scrutiny colleagues are asked to:

- Consider the underlying causes of the access difficulties that people are experiencing in Wiltshire and across the country.
- Consider the ongoing work of NHS England South West dental reform programme board to address these and improve the oral health of our population.
- Work in partnership with NHSE South West dental reform team to consider ways to market Wiltshire to attract the dental and other clinical workforce that it needs and encourage more young people in Wiltshire's schools and colleges to consider a career in the NHS

Access rates Pre Covid

Access rates for Wiltshire from March 2018 to March 2020 are as follows:

Patient cohort	**March 2018**	**June 2018**	**Sept 2018**	**Dec 2018**	**March 2019**	**June 2019**	**Sept 2019**	**Dec 2019**	**March 2020**
Adults	44%	44%	43%	42.7%	42.2%	42.1%	41.5%	41.7%	41.4%
National average	50.9%	50.7%	50.6%	50.4%	51.1%	50.9%	49.5%	49.3%	49.3%
Children	53%	53%	52.1%	52.3%	52.1%	51.9%	51.9%	51.9%	51.7%
National average	58.4%	58.6%	58.7%	58.6%	59.5%	59.5%	58.5%	58%	58.3%

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NHS ENGLAND AND NHS IMPROVEMENT

ORAL
HEALTH NEEDS ASSESSMENT

SOUTH WEST OF ENGLAND

January 2021

APPENDIX 6 BATH AND NORTH EAST SOMERSET, SWINDON AD WILTSHIRE STP ANALYSIS

Ottaway Strategic Management

www.ottawaystrategic.co.uk

NHS England and NHS Improvement
Oral Health Needs Assessment
South West of England

January 2021

Appendix 6 Bath and North East Somerset, Swindon and Wiltshire OHNA STP Appendix

Contents

1 Summary

Highlighted oral health needs and priorities.

1.1 This appendix to the OHNA for the South West has identified a series of factors that impact on the oral health needs and the provision of dental services in Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW). Some of these issues relate to the whole population, for example risk factors that determine the oral health of the population, epidemiological research and the context of current provision.

1.2 Additionally, engagement has taken place with stakeholders in the STP area particularly patients, the general public and providers of oral health services locally. Clear themes emerge from this engagement as well as clear implication for the findings of this local appendix.

1.3 Bath and North East Somerset, Swindon and Wiltshire has a population 912,166 people. Its population consists of more females (51%) than males (49%) - a gender profile that is consistent with the population of England. Compared with England as a whole, there is a slightly lower proportion of people of working age and slightly more people of retirement age as well as a slightly higher proportion of children and young people in Bath and North East Somerset, Swindon and Wiltshire. The BAME population in Bath and North East Somerset, Swindon and Wiltshire is 5% compared to 4% in the South West and 14% in England.

1.4 Population growth is a significant factor for oral health services and in particular primary care dentistry. By 2028 the total population of Bath and North East Somerset, Swindon and Wiltshire will have grown by 7% (an additional 60,052 people), the child population will have decreased by -1% (-1.310) and the older adult (65+) population will have grown by 23% (an additional 40,882 people). From an oral health service perspective, this significant increase in the older demographic will result in services needing to meet a greater level of older people's dental needs. The shift in the child population suggests that there will be less child patients, although this is unlikely to impact on the oral health needs of children in the STP area.

1.5 With regards to the Index of Multiple Deprivation, details are different in the three component areas of this STP. As a whole, Bath and North East Somerset remains one of the least deprived local authorities in the country ranking 269 out of 317, compared to a rank of 247 in 2015. IMD 2019 show that Swindon in general is 157th in the deprivation table across England, and 10th in the South West. 9% of its individual neighbourhoods, one in 11, are in the highest 10% of deprived areas. The rankings use the most up-to-date data on income, employment, education, health. Wiltshire is less deprived than many other local authority areas in England.

Over 70% of local authority districts in England are more deprived than Wiltshire. There have been minimal changes to Wiltshire's relative deprivation ranks since the last publication of the IMD in 2015. 39 of the 285 LSOAs in Wiltshire (14%) are in the 40% that are nationally most deprived.

1.6 The mortality rate for cardiovascular disease is lower in BaNES and Wiltshire than the national and South West rates[1]. In Swindon, the mortality rate for cardiovascular disease is higher than the England and South West rates. The mortality rates for respiratory disease in BaNES and Wiltshire are lower than the rates in England and the South West, whereas in Swindon they are higher. The prevalence of diabetes in BaNES (5.1%) is lower than the South West (6.5%) and England profile (6.9%). The profile for Wiltshire (6.8%) is higher than the South West but lower than England. The profile for Swindon at 7.7% is higher than the South West and England.

1.7 Most recent data suggests the level of physical activity varies within the STP area with BaNES having 72% active levels (undertaking 150* minutes per week), which is above the national at 64% and the South West profile of 67%. Wiltshire, with 66%, was below the South West rate but above the national. Swindon with 60% is below both the South West and national average. Correspondingly there are lower levels of physical inactivity with 20% inactive in BaNES and 20% inactive in Wiltshire, both below the national profile at 25% and the South West profile at 21%. The inactive profile in Swindon was 25% the same as the national level but above the South West.

1.8 Reception Years data from the national child measurement programme shows that in BaNES, Wiltshire and Swindon the proportion of children that are obese and or overweight are below the national and South West levels. The prevalence of obesity or overweight in the adult population is lower in BaNES at 51% and Wiltshire with 60% are both are below the national (62%) and regional (61%) level. However, Swindon has a rate of 65%, which was higher than the South West and the national rate. The GP Survey in 2018-2019 showed that 14.5% of over 18-year olds in England were smokers compared to 13.7% in the South West, 12.4% in BaNES, 12.7% in Swindon and 12.% in Wiltshire.

1.9 The patient and public survey completed as part of this OHNA suggests that 64% of patients travel to their dentist by car. However, there are lower numbers of households with access to a car or van, particularly in rural areas. This suggests that many patients would find it difficult to access healthcare services including dentistry.

[1] PHE Fingertips: Rate per 100,000 of deaths from Respiratory Disease among people aged 65 years and over 2016-18

1.10 The recent Adults in practice national dental epidemiological survey was not completed for BaNES in the STP. Reasons for this are unclear, but efforts should be made to secure this important epidemiological data to better understand the impact of oral health on the residents of the area. However, from previous child surveys, the data for Bath and North East Somerset, Swindon and Wiltshire shows a higher level of 3-year-old dental decay in Wiltshire (13.5), when compared to national (11.7%) and regional (10.4%) findings. In Bath and North East Somerset, Swindon and Wiltshire the data for 5-year-old dental decay is lower in Wiltshire at 13.1%, when compared nationally (23.4%) and the South West (20.4%). BaNES with 20.8% and Swindon with 28.9%, however, were both above the national and South West percentages. For 12-year-olds the level of dental decay in Bath and North East Somerset, Swindon and Wiltshire was lower in BaNES with 27.3% and Swindon with 28.1% when compared to the national (33.4%) and South West (33.3%) levels. However, for 12-year-olds the percentage in Wiltshire at 34.1% was greater than both the nation and South West percentages.

1.11 From a dental care service provision perspective, Bath and North East Somerset, Swindon and Wiltshire, in 2019-2020 had 111 dental practices commissioned to deliver 1,171,905 UDAs. This represented 446 dentists delivering NHS dentistry. Indeed, Bath and North East Somerset, Swindon and Wiltshire saw a decrease of 1 dentist in 2019-20 to the year before, a -0.2% decrease. The average UDAs per person was higher than the South West rate at 1.28 UDA/person as compared to 1.52 UDA/person.

1.12 In terms of access to dentistry the percentage of children that accessed NHS dentistry in the last 12 months was 68% in BaNES, which was above the South West (54%) percentage and England (53%)[2]. In Swindon, 54% of children accessed NHS dentistry which is above national and consistent with regional access levels. In Wiltshire 47% of children accessed an NHS dentist which was below both the national and South West level. The percentage of adults that accessed NHS dentistry in the last 24 months was 46.7% in BaNES and Swindon and 40.3% in Wiltshire, both below the South West level (47.3%) and above the national level (47.1%).

1.13 Underperformance against contracted dental activity for Bath, Gloucestershire, Swindon and Wiltshire have been made in the last three years, as was the case across the South West, but was particularly high in 2019-2020 with £4,093,366.

1.14 65% of treatments were Band 1, 23% Band 2, 3% Band 3 and 9% urgent treatment. This shows comparable levels of Band 1, 2 and 3 treatments and a higher level of urgent treatment when compared to national and regional levels. More urgent care tends to reflect lower levels of regular routine dentistry. It may also reflect the difficulty some people face in accessing NHS dentistry. Further

[2] NHS Dental Services, NHS Business Services Authority (BSA).

examination of urgent care shows a higher proportion of non-paying adults (16%) than paying adults (11%) accessing urgent care.

1.15 Fluoride varnish application rates are higher than the rate in the South West with 45% of the child population in Swindon, but lower in Wiltshire with 39% and lower still in BaNES with 9.2%. The rate of oral Cancers rates in BaNES is 13.83 per 100,000 - higher than the South West rate and lower than the England rate. In Wiltshire this is 12.34 per 100,000 and in Swindon it is 12.07 per 100,000 - both are lower than the England and South West rates.

1.16 Data suggests some key areas for prioritisation, this includes:

- Projected increase in the older adult age groups may result in an increase in demand for fillings and bridges (restorative treatments). Many may already have a heavily restored dentition and treatment may be complex especially if they are taking multiple medications or require domiciliary care.
- Pockets of deprivation across the STP area suggest the potential need for targeted interventions where possible and feasible.
- Obesity: joint working between stakeholders to tackle obesity; support the development of healthy eating policies in school and preschool settings.
- Stakeholders might wish to explore the issues around the participation in National Dental Epidemiological Surveys for Bath and North East Somerset, Swindon and Wiltshire.
- There is a need to support to NHS dental service providers to increase delivery of contracted activity.

1.17 The key priorities emerging out of both Healthwatch in BaNES, Swindon and Wiltshire and the patient and public surveys are summarised below. These provide commissioners with real insight into the priorities and concerns of patients in the area:

  - Access to NHS dentistry should be made easier
  - Better dentist allocation across the area (see 1.18 for details)
  - NHS dentistry should be affordable
  - Finding a private dentist is easy, there need to be more NHS dentists
  - Improve the quality of care
  - Increase capacity in all areas
  - NHS Dentistry should provide all services provided by private dentists
  - Reduce waiting times
  - Urgent appointments should be easier to get for broken teeth and infections
  - Work with young people to promote life-long good oral health.

Key Priorities

1.18 The levels of **access to NHS dentistry** in Bath and North East Somerset, Swindon and Wiltshire STP are generally below the regional and national average for both children and adults but there is there is significant variability between more affluent and more deprived areas:

1.18.1 NHS Digital data for 2019-2020 shows that access for adults in Wiltshire Council (40.3%) was below England (47.1%) and the South West (47.3%) average. The same was valid for children (47.1%) compared to regional (54.1%) and national (52.7%) averages.

1.18.2 Stakeholder engagement has strongly supported this, highlighting significant barriers for accessing dental care as poor public transport links and lack of car ownership in more deprived, rural areas.

1.18.3 The population in Bath and North East Somerset, Swindon and Wiltshire STP is set to grow by 7% (an additional 60,052 people) in the next 8 years. The highest growth is projected to be in the older adult (65+) group, which will increase by 23% (an additional 40,882 people).

1.18.4 The UDA rate per person in the STP (1.28) was lower than the South West rate (1.52), this may require the apportionment of UDAs to those people in greatest need of NHS dentistry. There is significant variability of UDAs values with an average of £25.67 (Lowest £19.35 to highest £37.90).

1.18.5 Although, Bath and North East Somerset are among the least deprived local authorities in England, there are pockets in areas like Swindon and Wiltshire affected by significant levels of inequalities. For example, Penhill, Pinehurst and Park South and North are among the most deprived in the country.

1.19 There is a need to **support dental care services for older people**. This is emphasised for a number of reasons.

1.19.1 By 2028 the older adults (65+) population in Bath and North East Somerset, Swindon and Wiltshire STP area will have grown by 23% (an additional 40,882 people).

1.19.2 The projected increase in the proportion for older adults may have implications for the increase of demand for treatment.

1.20 There is a need to **support the recruitment and retention of dentists** providing NHS services.

1.20.1 Stakeholder feedback has highlighted recruitment and retention concerns for dentist in rural and coastal areas.

1.20.2 Joint action with local partners (LDN/LDC, HEE, local authorities) to facilitate recruitment of dentists and other members of the dental team in rural areas.

1.21 There is evidence that there is **difficulty being experienced by dentists in meeting their contractual targets.**

1.21.1 The underperformance against contracted activity resulted in recovery of £4,093,366 in 2019-2020.

1.21.2 There is a risk for future service provision because of the commercial viability of certain contracts.

1.21.3 General dental practitioners responding to the Stakeholders surveys from Bath and North East Somerset, Swindon and Wiltshire STP identified concerns regarding the GDS contract and the fulfilment of UDA targets.

1.22 There are a range **of further oral health priorities** that have emerged through this OHNA. Many of these will require support from key partners and in some cases, they would be best served through partnership work. These include:

1.22.1 Carers of children and adults with learning disabilities may require additional training and support in techniques to help support the oral health of those they care for.

1.22.2 Promoting early dental attendance and supporting programmes like Dental Check by One (DCb1)[3].

1.22.3 Having been unable to carry out/complete and or report recent national dental survey responses there is a critical need to ensure that future epidemiological surveys are carried out for the STP area.

1.23 There are a range of **other oral health priorities** that have emerged through this OHNA. Many of these will require support from key partners and in some cases they would be best served through partnership work. These include:

[3] https://dentalcheckbyone.co.uk/

1.23.1 The area presents moderate prevalence of smoking, alcohol consumption and obesity. NHSE&I may wish to develop and strengthen the integration of dental services with local authority commissioned oral health improvement programmes in line with the Making Every Contact Count[4] (MECC) model.

1.23.2 Carers of adults with learning disabilities to be supported and given training in techniques to help support the oral health of those they care for. Most understand the importance but it can be challenging to get compliance from this patient groups.

1.23.3 The OHNA has highlighted the need to support residents who are in domiciliary care and to ensure that services providing for them are based on evidence-based interventions and that training programmes for health, social care and domiciliary care staff should be available[5].

1.23.4 Promote early dental attendance and support programmes like Dental Check by One (DCb1)[6].

1.23.5 Target resources to those areas of higher deprivation that are prevalent across the STP area. These targeted interventions could include joint interventions with local authority partners such as:

- Supervised toothbrushing programmes for nurseries and primary schools in areas where children are at high risk of poor oral health.
- Provision of toothbrushes and toothpaste by health visitors and by post.
- Targeting of oral health programmes for key vulnerable groups in the community including the substance misusing population, those who are homeless, the traveler and gypsy community, older people, migrant communities and those who are deemed to be socially isolated.
- Developing the capacity of the oral health improvement workforce as well as the health, social care and educational professionals.
- Reorientating the dental practices towards prevention.
- Multiagency working to develop and strengthen healthy eating policies in school and preschool settings.

1.23.6 To address the National Dental Surveys, a joint approach between NHSE&I, local authorities, PHE regional dental epidemiology coordinator and fieldwork teams might help identify the issues around the provision

[4] https://www.makingeverycontactcount.co.uk/
[5] https://www.e-lfh.org.uk/
[6] https://dentalcheckbyone.co.uk/

of these services. Certain areas in the country have successfully implemented joint commissioning between neighbouring areas as well as tendering contracts for multiple years making them more commercially attractive to providers.

2 Introduction

2.1 Bath, North East Somerset, Swindon and Wiltshire is a Sustainability and Transformation Partnership comprising of three distinct areas of the unitary authorities of Bath and North East Somerset, Swindon and the County of Wiltshire.

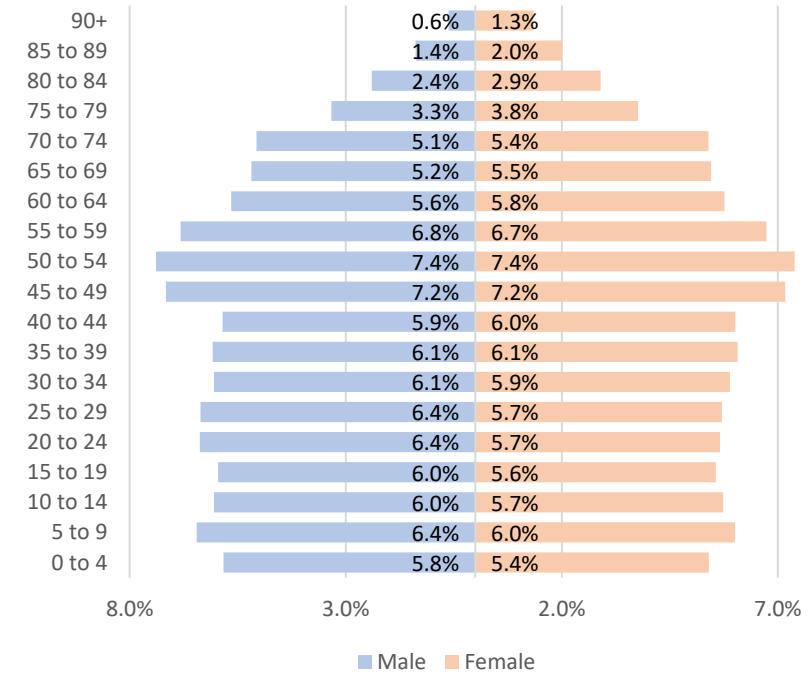
2.2 This section will set out the oral Health needs and profile for Bath, North East Somerset, Swindon and Wiltshire. It will start with its demographics, risks and determinants of poor oral health, relevant national epidemiology research findings, and review local oral health services, oral health improvement programmes and key findings for the oral health of the local population.

3 Demographics

Gender and Age

3.1 The population of Bath & North East Somerset, Wilshire and Swindon is an estimated 912,106[7]. Over half (55%) of the total population live in Wiltshire. The population of Bath & North East Somerset, Wilshire and Swindon consists of more females (51%) than males (49%) - a gender profile is consistent with the population of England. The age and gender profile of the population of Bath & North East Somerset, Wilshire and Swindon is set out in the population pyramid below.

Chart 1: Gender and Age BaNES, Swindon and Wiltshire: ONS Mid -18 Estimates



[7] ONS mid-2018 estimates

3.2 62% of the population of Bath & North East Somerset, Wilshire and Swindon are of working age (16 to 64 years), 19% are of retirement age (65 years and over) and 19% are children and young people (aged under 16 years). This is broadly consistent with this age profile for England as a whole. The proportion of the population for each local authority that falls into either of these age categories varies. The population of Wiltshire has a higher proportion of people of retirement age (21%) and Swindon has a higher proportion of children and young people (20%). The age profile is set out in the table below.

Table 1: Age profile compared BaNES, Swindon and Wiltshire, South West and England ONS 2018

	Children and young people (under 16 years)		Working-age population (16-64 years)		Retirement age population (65 years and older)		Total population
	(n)	(%)	(n)	(%)	(n)	(%)	(n)
Bath & North East Somerset	32023	17%	123823	64%	36260	19%	192106
Swindon	45407	20%	141415	64%	35174	16%	221996
Wiltshire	94516	19%	297711	60%	105837	21%	498064
South West	986908	18%	3382627	60%	1230200	22%	5599735
BaNES, Swindon and Wiltshire	171946	19%	562949	62%	177271	19%	912166
England		18%		64%		18%	

Population projections

3.3 A review of the subnational population project for England (2018)[8] indicates the potential future populations for English local and health authorities. The data below for Bath and North East Somerset, Swindon and Wiltshire has been taken from the CCG dataset. This data set has been broken down by total population shift and shifts in the child (0-15) population and the older population (65+). It is defined by total counts, the additional numbers of people in each category and the level of growth based on a percentage (%) against the 2018 figure.

Table 2: NHS BaNES, Swindon and Wiltshire Population Projections 2018-2043

Population growth	2018	2023	2028	2033	2038	2043
Total Population shift	918428	954337	978480	998027	1015475	1032995
Additional people		35909	60052	79599	97047	114567
% Growth		4%	7%	9%	11%	12%
0 to 15 population shift	173376	177366	172066	167919	169391	174050
Additional Young people		3990	-1310	-5457	-3985	674
% Growth		2%	-1%	-3%	-2%	0%
65+ population shift	178290	196115	219172	243479	261973	269430
Additional older People		17825	40882	65189	83683	91140
% Growth		10%	23%	37%	47%	51%

3.4 What is evident from this analysis is that by 2028 the total population of Bath and North East Somerset, Swindon and Wiltshire will have grown by 7% (an additional

[8] Subnational population Projections for England 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2018based

60,052 people), the child population will have only declined by 1% (5,457) and the older adult (65+) population will have grown by 23% (an additional 40,882 people). This demographic change may inform the planning of dental services around the increase for older people's dental needs. The shift in the child population suggests that there will be marginally less child patients, which may not impact on the oral health needs of children in the STP area.

Ethnicity

3.5 There is less ethnic diversity in the population of Bath & North East Somerset, Wiltshire and Swindon compared to England, 5% of the population from BAME groups whilst across England this group represent 15%. The proportion of the population that are from BAME groups in Bath & North East Somerset, Wiltshire and Swindon is the same as it is across the South West. There are some variations in the ethnic profile at local authority area level – the highest BAME population is in Swindon (10%).

Chart 2: Ethnic profile compared BaNES, Swindon and Wiltshire, South West and England ONS 2011

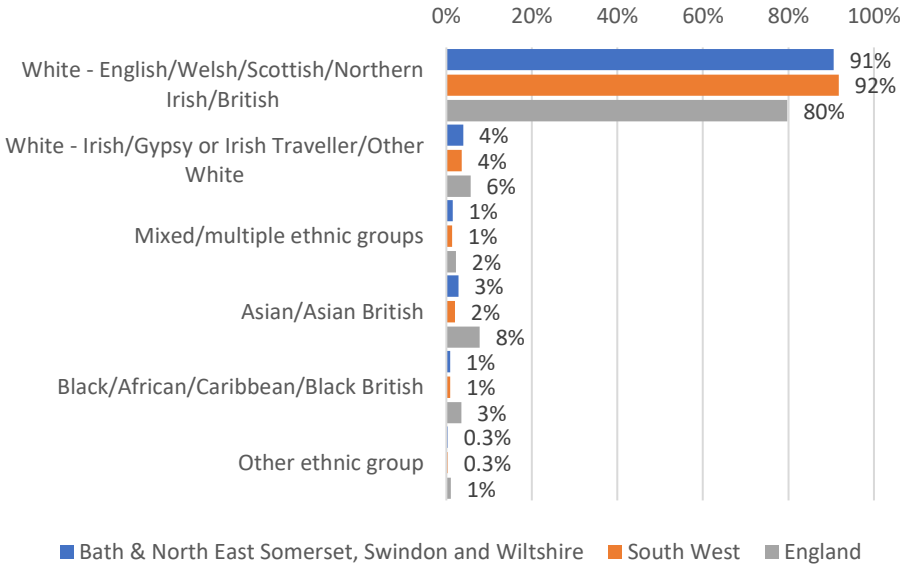


Table 3: Ethnic profile compared BaNES, Swindon and Wiltshire, South West and England ONS 2011

	White - English/ Welsh/ Scottish/ Northern Irish/ British	White – Irish/ Gypsy or Irish Traveller/ Other White	Mixed/ multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic group	BME (total)	BAME (total)
Bath and North East Somerset	90%	4%	2%	3%	1%	0%	10%	5%
Swindon	85%	5%	2%	6%	1%	0%	15%	10%
Wiltshire	93%	3%	1%	1%	1%	0.2%	7%	3%
Bath & North East Somerset, Swindon and Wiltshire	91%	4%	1%	3%	1%	0.3%	9%	5%
South West	92%	4%	1%	2%	1%	0.3%	8%	4%
England	80%	6%	2%	8%	3%	1%	20%	14%

Deprivation

Bath and North East Somerset

3.6 Bath and North East Somerset[9] remains one of the least deprived local authorities in the country, ranking 269 out of 317 and compared to a rank of 247 in 2015. BaNES continues to become relatively less deprived over time. However, within some areas inequality is widening and deprivation remains significant. There are now two small areas within the most deprived 10% nationally: Twerton West and Whiteway.

Swindon

IMD 2019 show that Swindon in general is 157th in the deprivation table across England, and 10th in the South West. 9% of its individual neighbourhoods, one in 11, are in the highest 10% of deprived areas. The rankings use the most up-to-date data on income, employment, education, health and crime, as well as housing services and the environment, to assess more than 32,800 small areas or neighbourhoods across England. Swindon is a mostly prosperous town, but some of its areas, Penhill, Pinehurst and Park South and North are among the most deprived in the country.

Wiltshire

3.7 Wiltshire is less deprived than many other local authority areas in England[10]. Over 70% of local authority districts in England are more deprived than Wiltshire. There have been minimal changes to Wiltshire's relative deprivation ranks since the last publication of the IMD in 2015. 39 of the 285 LSOAs in Wiltshire (14%) are in the 40% that are nationally most deprived. This is the same proportion as in 2015. One area (Trowbridge John of Gaunt - Studley Green) is in the most deprived 10% of LSOAs in England.

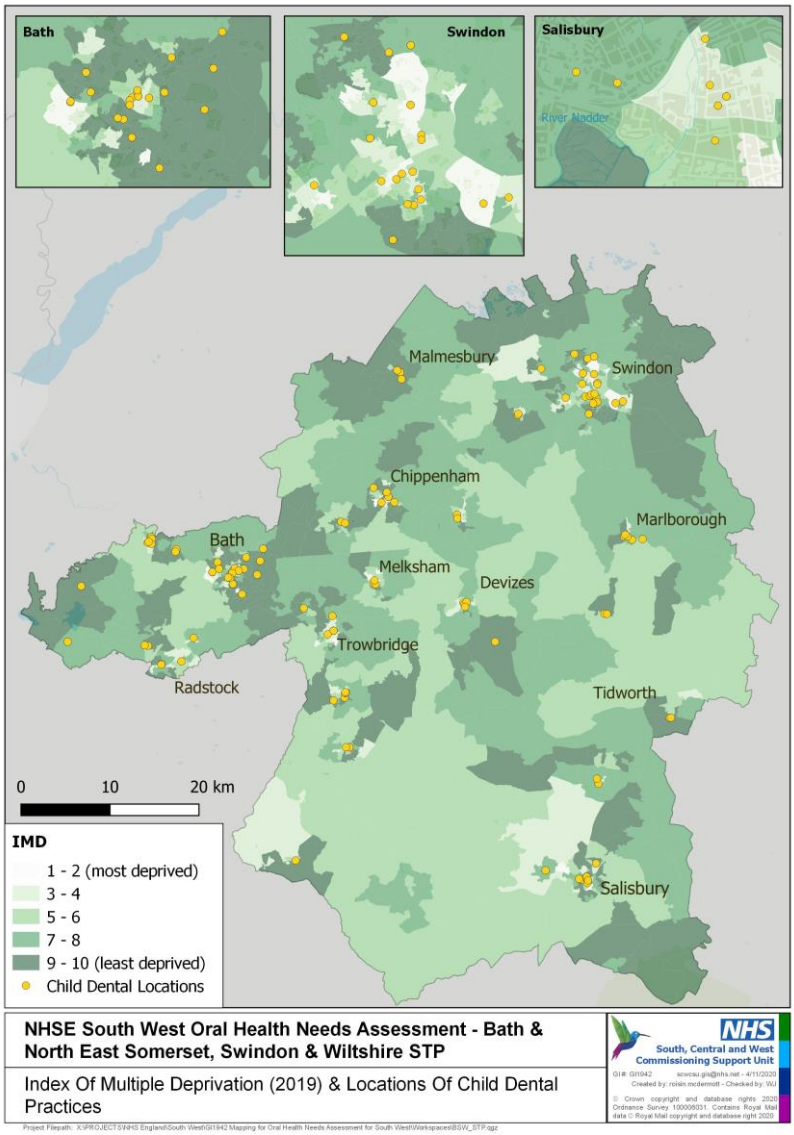
3.8 When looking at the specific domains of deprivation, less than 20% of Wiltshire's LSOAs are in the most deprived national 40% of LSOAs in the Income,

[9] https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/socio-economic-inequality
[10] https://www.wiltshireintelligence.org.uk/wp-content/uploads/2019/12/IMD-2019-report.pdf

Employment, Health and Crime domains. Around 30% of Wiltshire's LSOAs are in the most deprived 40% in the Education (29%) and the Living Environment (31%) domains, while 47% of Wiltshire's LSOAs are in the most deprived 40% in the Barriers to Housing and Services domain. Wiltshire's high deprivation in the Barriers to Housing and Services domain can largely be attributed to the longer than average distance to services in Wiltshire.

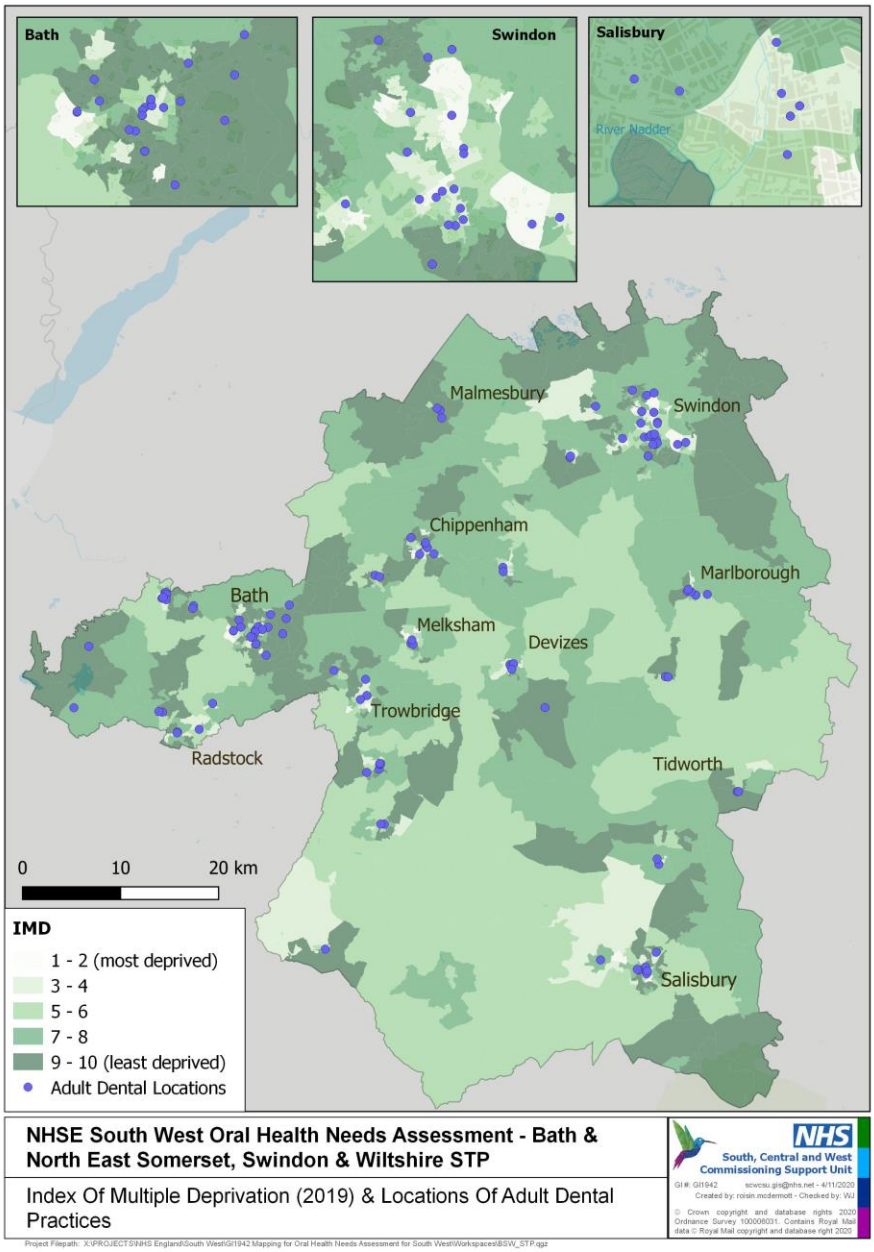
3.9 The maps below describe the index of Multiple Deprivation (2019) and sites the location of dental practices that provide for children.

Map 1: BaNES, Swindon and Wiltshire IMD 2019 Child Dental practices[11]



[11] NHS South, Central and West Commissioning Support Unit Oct 2020

Map 2: BaNES, Swindon and Wiltshire IMD 2019 Child Dental practices[12]



3.10 These maps suggest that there are certain deprived areas requiring additional provision of dental services. This is critical given the established relationship between deprivation and poor oral health. This is particularly the case in Swindon and to a lesser degree parts of Bath and Salisbury.

[12] NHS South, Central and West Commissioning Support Unit Oct 2020

4 Risks and determinants of poor oral health

4.1 Healthy behaviours can contribute to the prevention and control of non-communicable diseases such as cardiovascular diseases, chronic respiratory diseases, diabetes and cancers. PHE Fingertips and NHS Digital monitor trends in the nation's health and health related behaviours. It is important to consider these factors as some chronic conditions share common risk factors with oral disease. Furthermore, the age profile of the region suggests a potential increase of the prevalence of chronic conditions which may have implications for the planning of dental services.

4.2 The under 75 mortality rate, per 100,000 from all Cardiovascular Disease in England in 2016-2018 was 71.7. For the South West, this rate was lower at 61.9. In Swindon, the rate was 73.7, in Wiltshire the rate was 56.6 and in BaNES the rate was 56.1%. The adult populations' diabetes prevalence profile (QoF 2018-19) for England was 6.93% and for the South West this was 6.65%. It was 7.69% in Swindon, 6.77% in Wiltshire and 5.13% in BaNES. The under 75 mortality rate, per 100,000 from a respiratory disease considered preventable in 2016-2018 was 19.2 per 100,000 in England, and 15.6 in the South West. It was 17.9% in Swindon, 11.9% in Wiltshire and 11.3% in BaNES. The proportion of deaths in a person's usual place of residence (DiPUPR) from a respiratory disease in 2016 was 32.17% in England and was 38.25% in the South West. It was 43.46 in Wiltshire, 37.50 in BaNES and 29.50 in Swindon. This data is set out in the table below:

Table 4: Health indicators, Cardiovascular disease, Diabetes prevalence and Respiratory disease, national, regional and local

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Under 75 mortality rate per 100,000 from all cardiovascular diseases[13]	71.7	61.9	56.1	73.7	56.6
Diabetes: QOF prevalence (17+) (%)[14]	6.93	6.65	5.13	7.69	6.77
Under 75 mortality rate per 100,000 from respiratory disease considered preventable (Whole Pop)[15]	19.2	15.6	11.3	17.9	11.9
DiPUPR - Respiratory disease (%), Persons, All Ages.[16]	32.17	38.25	37.50	29.50	43.46

4.3 The key health behaviours reviewed in this OHNA have been healthy eating, physical activity levels (adults), obesity (child and adult), alcohol misuse and

[13] PHE: Public Health Profiles: Fingertips 2016-18
[14] PHE: Public Health Profiles: Fingertips 2018-19
[15] PHE: Public Health Profiles: Fingertips 2016-18
[16] PHE: Public Health Profiles: Fingertips 2016

smoking prevalence. These lifestyle factors are pertinent to general health and wellbeing as well as oral health.

Healthy Eating

4.4 A healthy and balanced diet is critical to preventing ill health and disease. The annual cost of food related ill health to the NHS is estimated at £5.8 billion.[17] A minimum intake of five portions of fruit and vegetables is an important component of a healthy diet and is the measure used for healthy eating. The proportion of the population aged 15 that eat 5 portions of fruit and vegetables is 52.4% in England but higher at 56.5% in the South West. The proportion was 61.8% in BaNES, 58.1% in Wiltshire and 49.9% in Swindon. The proportion of the adult population meeting the recommended 5-a-day on a usual day was 54.61%, although this was greater in the South West with 59.55%, 61.97% in Wiltshire and 59.00% in BaNES. However, it was lower in Swindon with 51.47%.

Table 5: Healthy Eating indicators 5-a-day 15 year olds and adults national, regional and local

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Percentage who eat 5 portions or more of fruit and veg per day at age 15[18]	52.4	56.5	61.8	49.9	58.1
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)[19]	54.61	59.55	59.00	51.47	61.97

Physical activity levels (adults)

4.5 Lack of physical activity is an important risk factor for chronic non-communicable diseases such as ischemic heart disease and stroke with an estimated direct cost to the NHS of £1.1 billion and further cost to the country of £7.4 Billion[20]. Guidelines for physical activity suggest adults (aged 16 and over) should have 150 minutes of activity of moderate intensity a week. The Active Lives Survey[21] commissioned by Sport England and the PHE Physical Activity survey data[22] differ slightly on what is included as activity. PHE include non-recreational exercise i.e. gardening within their assessment of activity. The Active Lives data shows that the South West region has a slightly higher level of active residents with 67.4% as compared to England with 63.6%. In BaNES this was 72.3%, in Wiltshire this was 65.8% and in

[17] The Burden of Food Related Ill Health in the UK; Epidemiology in Community Health Dec 2005
[18] PHE: Public Health Profiles: Fingertips 2014-15
[19] PHE: Public Health Profiles: Fingertips 2018-19
[20] PHE: Everybody active everyday Oct 2014
[21] Sport and physical activity levels Adults aged 16+ Nov 18 – Nov 18 % published Sport England Active Lives 23rd April 2020
[22] PHE: Physical activity levels among adults in England, 2015

Swindon this was 59.7%. Correspondingly the level of inactive residents is 20.8% in the South West as compared to 24.6% for England. In Swindon this was 24.9%, in BaNES this was 20.5% and in Wiltshire this was 19.8%.

Table 6: Physical activity levels national, regional and local

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Active (150+ minutes a week)	63.6	67.4	72.3	59.7	65.8
Fairly Active (30-149 minutes a week)	12.2	11.8	7.2	15.4	14.5
Inactive (<30 minutes per week)	24.6	20.8	20.5	24.9	19.8
% Active (150+ mins a week)	57	59.2	69.5	56.4	60
% Some activity (90-149 mins a week)	6.9	7.1	5.8	7.7	6.8
% Low activity (30-89 mins a week)	7.4	7.3	4.4	8.4	7.5
% Inactive (<30 mins)	28.7	26.3	20.3	27.4	25.7

Obesity (Child and Adult)

4.6 Whilst not actually a health-related behaviour, being overweight or obese is generally associated with unhealthy diet and lack of physical activity. Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Obesity in adults is associated with cardiovascular diseases, diabetes, musculoskeletal disorders and some cancers. It is estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015[23].

4.7 The annual child weight measurement programme is completed locally and is fed into the national database held by PHE. The data set out below is taken from PHE Fingertips data for 2018-2019.

4.8 The South West, BaNES, Swindon and Wiltshire profiles for Reception and Year 6 prevalence of overweight including obesity are slightly below the England prevalence. The South West, BaNES, Swindon and Wiltshire profiles for Reception and Year 6 prevalence of obesity are also below the England prevalence. The South West adult percentage of those classified as overweight and obese is 61.35% compared to England at 62.34%. In Swindon it was 65.05%, in Wiltshire it was 60.33% and in BaNES it was 51.13%.

[23] Health matters obesity and the food environment PHE March 2017.

Table 7: Overweight and Obesity levels children and adults national, regional and local

Indicator[24]	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Reception: Prevalence of overweight (including obesity) (%)	22.59	22.05	21.42	20.78	20.84
Year 6: Prevalence of overweight (including obesity) (%)	34.29	29.88	25.57	33.35	27.80
Reception: Prevalence of obesity (including severe obesity) (%)	9.68	8.74	8.25	9.13	8.63
Year 6: Prevalence of obesity (including severe obesity) (%)	20.22	16.52	13.48	18.87	14.77
Percentage of adults (aged 18+) classified as overweight or obese (%)	62.34	61.35	51.13	65.05	60.33

Alcohol misuse

4.9 Alcohol use can affect health and increases the risks of accidents, injury, and violence. The health harms of alcohol are dose dependent; that is, the risk increases with the amount drunk.

4.10 The recommended limits to avoid the risk of alcohol-related harm are no more than 21 units per week in men and 14 units per week in women. Adults who regularly drink more than these amounts are at increased risk. Men and women who regularly drink more than eight units a day (or 50 units a week) and more than six units a day (or 35 units a week)respectively, are higher risk drinkers who are more exposed to harm. The proportion of adults over the age of 16 years who are higher risk drinkers is described below, with the South West being below England with 3.21% compared 4.04% respectively. The admission episodes per 100,000 for alcohol specific conditions in Swindon was higher than the national and regional rates, however for BaNES and Wiltshire overall the rate was lower than both regionally and nationally. The alcohol related mortality per 100,000 for BaNES, Swindon and Wiltshire were all lower than national and South West rates.

Table 8: Alcohol hospital admissions, mortality rates and consumption rates national, regional and local

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Admission episodes per 100,000 for alcohol-specific conditions[25]	869.25	814.97	722.43	890.83	654.51
Alcohol-related mortality per 100,000[26]	46.54	45.55	39.01	41.27	40.35

[24] PHE: Public Health Profiles: Fingertips 2018-19
[25] PHE: Public Health Profiles: Fingertips 2018-19
[26] PHE: Public Health Profiles: Fingertips 2018

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Admission episodes for alcohol-related conditions (Broad) per 100,000[27]	2367.40	2142.39	1937.63	2422.61	1919.73
Estimated weekly alcohol consumption, by region: More than 14, up to 35/50 units (increasing risk) Age Standardised %[28]	18.18	19.56	Data not available	Data not available	Data not available
Estimated weekly alcohol consumption, by region: More than 35/50 units (higher risk) Age Standardised %[29]	4.04	3.21	Data not available	Data not available	Data not available

Smoking prevalence

4.11 Tobacco use increases the risk of cancers and chronic respiratory and circulatory disease[30]. In England tobacco smoking is the greatest cause of preventable illness and premature death.

4.12 The 2009 Adult Dental Health Survey reported that more men than women smoked, and that smoking was socially patterned, with 8.8% of participants smoking in the least deprived areas compared to 26.4% in the most deprived. The 2018 Health Survey for England shows that 10% of current smokers lived in the least deprived areas whereas 28% of smokers lived in the most deprived areas. This suggests that smoking prevalence is becoming more concentrated within deprived areas.

4.13 The indicators for smoking prevalence show a level of variability from survey to survey. In England just under 10.6% of women were smokers at the time of delivery, this was higher at 10.9% in the South West. In Swindon it was 11.07%, in Wiltshire it was 9.87% and in BaNES it was 6.77%. The prevalence of adult smokers (QoF) 2018 showed that 17.2% of the population were smokers in England, compared to 16.5% in the South West. In Swindon it was 16.80%, in Wiltshire it was 14.68% and in BaNES it was 13.29%. The GP Survey in 2018-2019 showed that 14.5% of over 18 year older were smokers compared to 13.7% in the South West. In Swindon it was 12.77%, in BaNES it was 12.42% and in Wiltshire it was 12.01%.

[27] PHE: Public Health Profiles: Fingertips 2018-19
[28] Health Survey for England 2018
[29] Health Survey for England 2018
[30] WHO

Table 9: Smoking prevalence rates national, regional and local

Indicator	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
Smoking status at time of delivery (%)[31]	10.59	10.91	6.77	11.07	9.87
Estimated smoking prevalence (16+) (QOF)[32]	17.19	16.50	13.29	16.80	14.68
Smoking prevalence in adults (18+) - current smokers (GPPS)[33]	14.46	13.75	12.42	12.77	12.01

Oral hygiene practices

4.14 The most prevalent oral diseases, tooth decay and gum diseases can both be prevented by regular tooth brushing with fluoride toothpaste. The fluoride in toothpaste is the important element of tooth brushing to control, prevent and arrest tooth decay. Higher concentrations of fluoride in toothpaste lead to better control. By contrast, the physical removal of plaque is the important element of tooth brushing to control gum diseases as it reduces the inflammatory response of the gum and its consequences.

4.15 In 2008/2009, most 12-year-old schoolchildren in the South West reported brushing their teeth twice daily (73%), the same figure as n England.

5 Transport and Communications in BaNES, Swindon and Wiltshire

5.1 There are many people across the country who are not able to access important local services and activities, such as jobs, learning, healthcare, food shopping or leisure because of a lack of adequate transport provision[34]. The University of Leeds report demonstrates that mobility and accessibility inequalities are highly correlated with social disadvantage. This means that some social groups are more at risk from mobility and accessibility inequalities, than others:

- Car owners are least mobility constrained across all social groups.
- Lowest income households have higher levels of non-car ownership, 40% still have no car access – female heads of house, children, young and older people, black and minority ethnic (BME) and disabled people are concentrated in this quintile.

[31] PHE: Public Health Profiles: Fingertips 2018-19
[32] PHE: Public Health Profiles: Fingertips 2018
[33] PHE: Public Health Profiles: Fingertips 2018-19
[34] Inequalities in Mobility and Access in the UK Transport Social and Political Science Group, Institute for Transport Studies, University of Leeds March 2019 Systemhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf

- In addition, there are considerable affordability issues with car ownership for many low-income households.

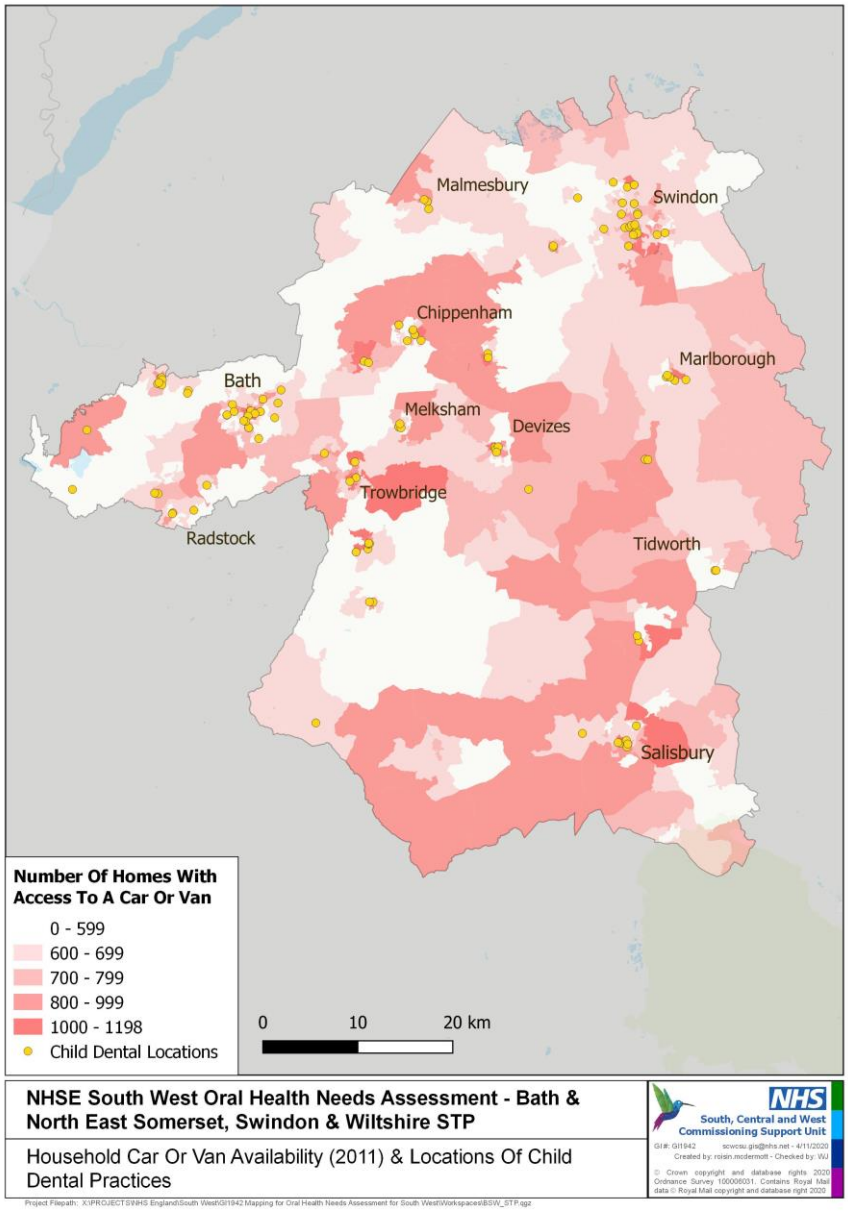
5.2 Inequalities in the provision of transport services are strongly linked with location of residence, this is further exemplified in rural and coastal communities. However, the lack of private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem in many parts of the UK.

5.3 In 2003 the Social Exclusion Unit report 'Making the Connections[35]' identified that two out of five job seekers could not get a job due to a lack of transport, 31% of people without cars could not access a hospital, 16% of households without cars found it difficult to access a supermarket, and 6% of 16- to 18-year-olds turned down training or further education because of travel costs.

5.4 The recent public and patient survey has shown that 64.0% of respondents travelled to their local dentist by car, 9.0% by public transport and 16.0% by walking/bicycle. To support this OHNA we have worked with the NHSE South West Commissioning Support Unit to identify the level to which people across the area have access to a car or a van, this has been overlayed with the location of dental practices which provide for both children and adults.

[35] Social Exclusion Unit 2003 Making the Connections. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_policy/---invest/documents/publication/wcms_asist_8210.pdf

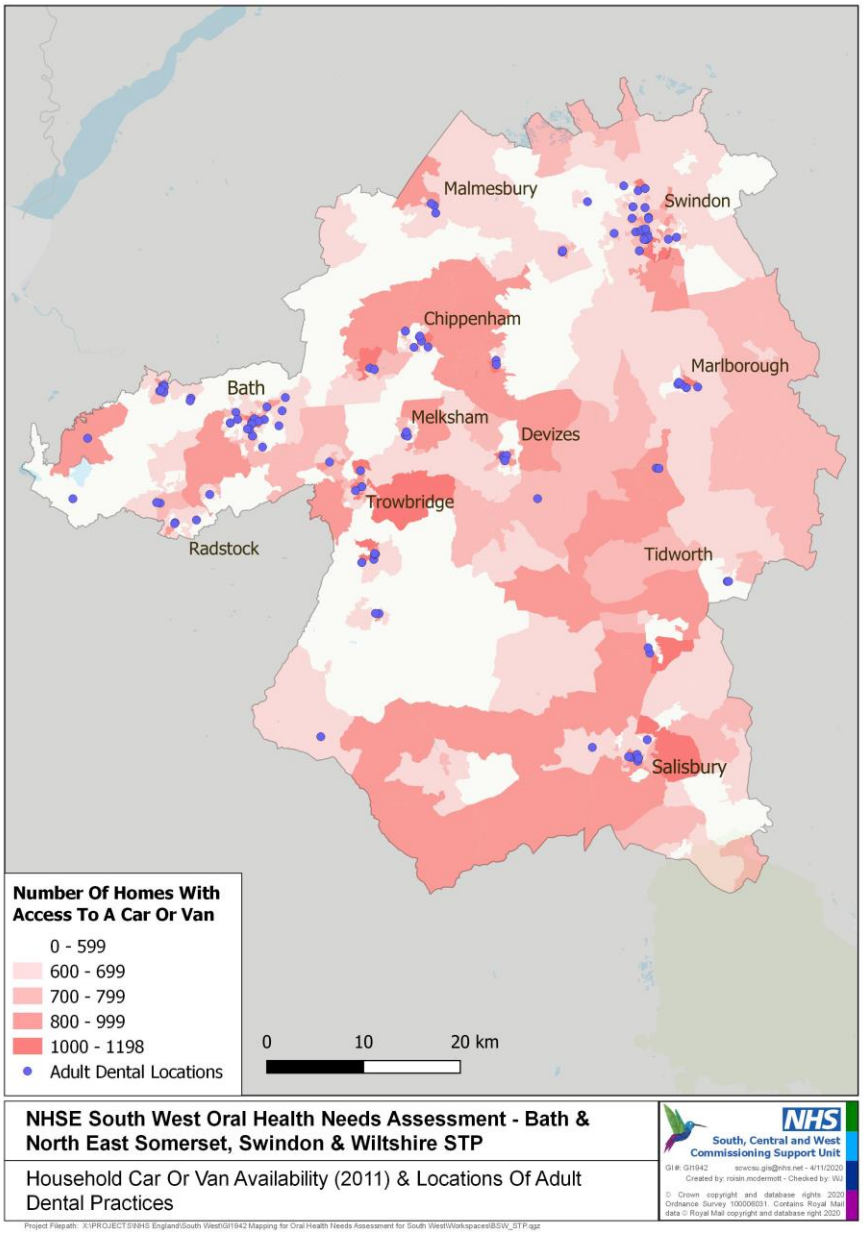
Map 3: Household Car or Van availability (2011) by LSOA and locations of Child Dental Practices[36]



5.5 These maps show that there are key areas across the STP where car ownership is lower and if correlated to existing dental provision can identify those areas where there is priority for investment both due to inaccessibility or low car ownership and due to a lack of high street dentistry.

[36] NHS South Central and West Commissioning Support Unit Oct 2020

Map 4: Household Car or Van availability (2011) by LSOA and locations of Adult Dental Practices[37]



6 National Dental Epidemiology Research Findings

6.1 The table below sets out the headline findings for Bath and North East Somerset, Swindon and Wiltshire from the National Dental Epidemiology programme research undertaken for 3-year-olds (2013), 5-year-olds (2019), 12-year-olds (2008-2009) and adults in Practice (2018). It sets out comparators for England and the South West.

[37] NHS South Central and West Commissioning Support Unit Oct 2020

Table 10: NDEP Headline results for Bath and North East Somerset, Swindon and Wiltshire

3-year-old 2013	England	South West region	Bath and North East Somerset	Swindon	Wiltshire
3-year-old % tooth decay (% d3mft > 0 including incisors)	11.7	10.4	No data	7.9	13.5
3-year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.36	0.31	No data	0.18	0.35
5-year-olds 2019	**England**	**South West region**	**Bath and North East Somerset**	**Swindon**	**Wiltshire**
5-year-old % tooth decay (% d3mft > 0 including incisors)	23.4	20.4	20.8	28.9	13.1
5-Year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.8	0.6	0.5	0.9	0.4
5-Year-old Number of teeth with decay experience (Mean d3mft including incisors) 2017	0.80	0.60	0.7	0.5	0.5
Care Index % (ft/d3mft)	10.3	10.9	10.1	12.9	14.4
12-year-olds 2008-09	**England**	**South West region**	**Bath and North East Somerset**	**Swindon**	**Wiltshire**
12-year-old % tooth decay (% d3mft > 0 including incisors)	33.4%	33.3%	27.3%	28.1%	34.1%
12-year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.74	0.73	0.46	0.61	0.76
12-year-old Care Index % (ft/d3mft)	47%	47%	37%	41.2%	28.6%
Adults in Practice 2019	**England**	**South West region**	**Bath and North East Somerset**	**Swindon**	**Wiltshire**
Adult in Practice % with a functional dentition	81.9	82.2	No data	83.7	80.7
Adult in Practice % with active decay (DT>0)	26.8	31.5	No data	25.6	26.3
Adult in Practice Average number of decayed teeth (for those with active decay)	2.1	1.9	No data	1.5	1.4
Adult in Practice % with filled teeth	90.2	90.8	No data	90.7	93.0
Adult in Practice % with dentures	15.4	14.4	No data	14.0	14.0
Adult in Practice % with bleeding on probing	52.9	69.2	No data	53.5	55.4
Adult in Practice % with PUFA	5.2	6.5	No data	2.3	3.5
Adult in Practice % with any treatment need	70.5	81.9	No data	93.0	77.2
Adult in Practice % with an urgent treatment need	4.9	8.2	No data	4.8	5.3

7 Oral Health Services

7.1 The current primary care NHS dental contracts, the General Dental Service Contract and Personal Dental Service Agreement, were introduced in 2006. The contracting currency for both contracts is the Unit of Dental Activity (UDA). A general dental service provider is contracted for an annual agreed number of units of dental activity.

7.2 Dental practices provide services according to four different bands of care with the provider awarded different numbers of UDAs for each band:

Band 1 Includes an examination, diagnosis and advice. If necessary, it also includes, x-rays, scale and polish, application of fluoride varnish or fissure sealants and preventive advice and planning for further treatment (1 UDA)

Band 2 Includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatments and removal of teeth (3 UDAs)

Band 3 Includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (12 UDAs)

Band 4 urgent Includes urgent care such as removal of the tooth pulp, removal of up to two teeth, dressing of a tooth and one permanent tooth filling (1.2 UDAs).

7.3 Fee paying adults contribute towards the costs of NHS dental treatment with the contribution determined by the band (the patient contribution is the same for Band 1 and Band 4 urgent).

Availability of general dental services

7.4 In 2019/2020, 705 dental practices across the South West were contracted by the NHS to provide a total of 8,520,528 UDAs. In BaNES, Swindon and Wiltshire 111 practices were commissioned to deliver 1,171,905 UDAs. The number of dental practices, contracted activity and delivered activity is shown the table below. The amount dentists were paid per UDA varied considerably from £19.35 to £37.90.

Table 11: Primary Care General Dental Services Provision across the South West

Sustainable Transformation Partnership (STP)	Contracts GDS and Ortho	General Dental Services/Mixed GDS and Ortho	Number of Practices	Commissioned UDAs	Average UDA Value	Ortho Only
Bath and North East Somerset, Swindon and Wiltshire STP	126	115	111	1,171,905	£25.67 (Lowest £19.35 to highest £37.90)	11
Total	748	681	705	8,520,528	-	53

Numbers of Dentists[38]

7.5 In 2019/2020 there were 2,664 dentists in the South West delivering NHS dentistry. This represented 48 dentists per 100,000 population which is slightly higher than the national average of 44 per 100,000 population. In BaNES, Swindon and Wiltshire there were 285 dentists delivering NHS dentistry.

7.6 The average across the South West is 48/100,000, higher than in England at 44/100,000, in BaNES, Swindon and Wiltshire this is 50/100,000. The population per dentist in England is 2,268 which is higher than the population per dentist in the South West of 2,104, in BaNES, Swindon and Wiltshire it is 2,059. In 2019/2020 BaNES, Swindon and Wiltshire saw a decrease of 1 dentist (-0.2%).

Table 12: Number of dentists with NHS activity, for years ending 31 March, England - NHS England region geography and CCG[39]

			2019/20		
Area	Dentists difference 2018/19 to 2019/20	Percentage difference 2018/19 to 2019/20	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]
England	**139**	***0.6***	**24,684**	**2,268**	**44**
South West of England	**8**	***0.3***	**2,664**	**2,104**	**48**
NHS Bath and North East Somerset, Swindon and Wiltshire CCG	**-1**	***-0.2***	446	2,059	49

Average UDAs commissioned per person.

7.7 Based on the numbers of commissioned UDA and comparing this to the general population in each locality across the South West it is possible to assess the average UDAs commissioned per person in the region. This shows a potential disparity in the proportionality of commissioned UDA by the local population sizes in each STP area. What is clear is that there are lower levels per head of commissioned UDAs in BaNES, Swindon and Wiltshire, compared to the average for the South West.

Table 13: Average UDAs commissioned per head of population.

Area	Average UDAs commissioned per person (n)
Bath and North East Somerset, Swindon and Wiltshire	1.28
Average for South West	1.52

[38] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report
[39] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report

Access to Dental Care

Children

7.8 Many children and adults will seek care from an NHS dental practice, with those with additional needs generally being seen in community dental services. According to NICE guidance, adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their level of risk of oral disease[40]. Dental attendance does not necessarily prevent dental disease, but it is important in terms of assessing patient risk to oral diseases and giving appropriate evidence-based advice. Public Health England and NICE have developed specific guidance for dental teams[41]. The indicator used to assess dental access in children is the number of unique people accessing dental services over the previous 12 months.

7.9 From April 2019 to March 2020 access for child patients in the South West was 54.1%. The access levels for child patients is higher than the England average of 52.7%. In BaNES the access level for child patients was 68.2% and in Swindon its was 54.1% both above the South West and England percentages. In Wiltshire it was 47.1%, below both the South West and England percentages.[42]

Adults

7.10 The indicator used to assess dental access in adults is the number of separate people accessing dental services over the previous 24 months. This metric is based upon NICE guidance, which recommends the longest interval between dental recalls[43].

7.11 From April 2019 to March 2020 access for adult patients in the South West overall had fallen by 1.51% to 47.3%. Access levels are slightly below the England average of 47.7% %. In BaNES the access level for adult patients was 46.7%, in Swindon its was 46.7% and in Wiltshire it was 40.3%, all three are below both the South West and England percentages[44].

[40] The National Institute for Health and Care Excellence. Dental checks: intervals between oral health reviews: Clinical guideline [CG19] 2004 [Available from: https://www.nice.org.uk/guidance/cg19]

[41] https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

[42] Source: NHS Dental Services: NHS Business Services Authority: June 2020

[43] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215663/dh_126005.pdf

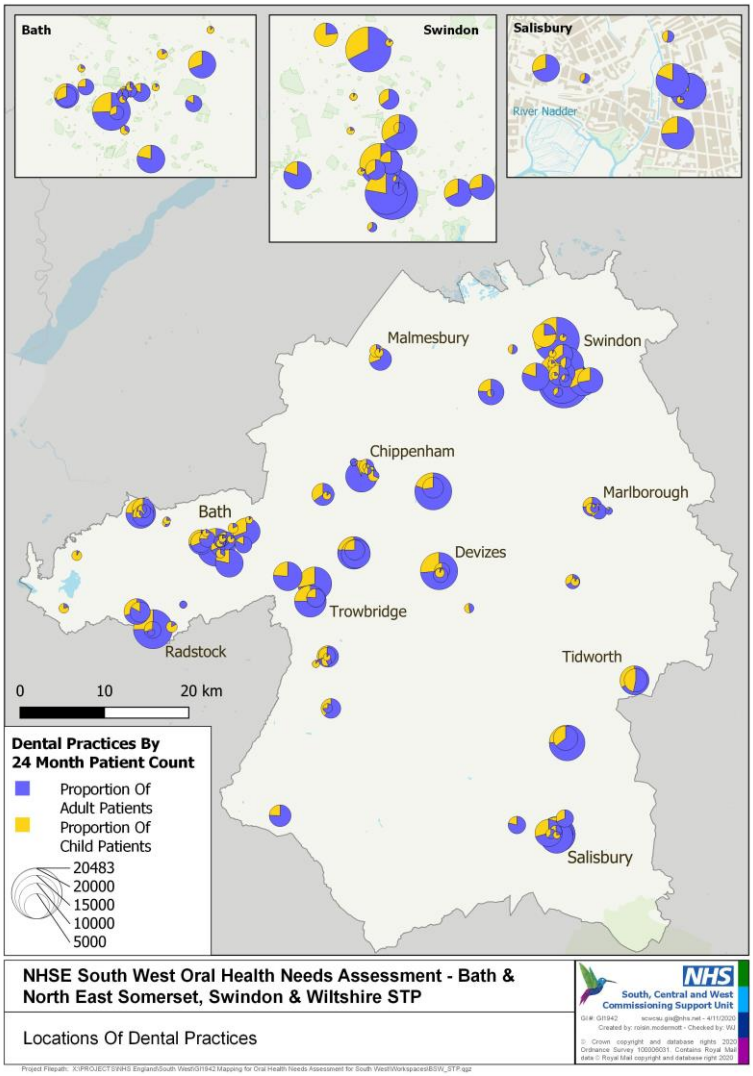
[44] Source: NHS Dental Services: NHS Business Services Authority: June 2020

Table 14: Adult patients seen in the previous 24 months and child patients seen, in the previous 12 months as a percentage of the population, by patient type and LA[45]

Area	Adult % of pop.	Child % of pop
England	47.1	52.7
South West	47.3	54.1
Wiltshire Council	40.3	47.1
Bath and North East Somerset Council	46.7	68.2
Swindon Borough Council	46.7	54.1

7.12 The map below sets out the activity of dental practices based on the count of patients seen - in the case of adults in the last 24 months and in the case of children in the last 12 months - as per the guidelines used by NHS Digital. What the map describes is the location of the practices across the region and the pie charts show the split and size of practice as per the legend.

Map 5: Local of Dental Practices by proportion of Adult and Child Patients[46]

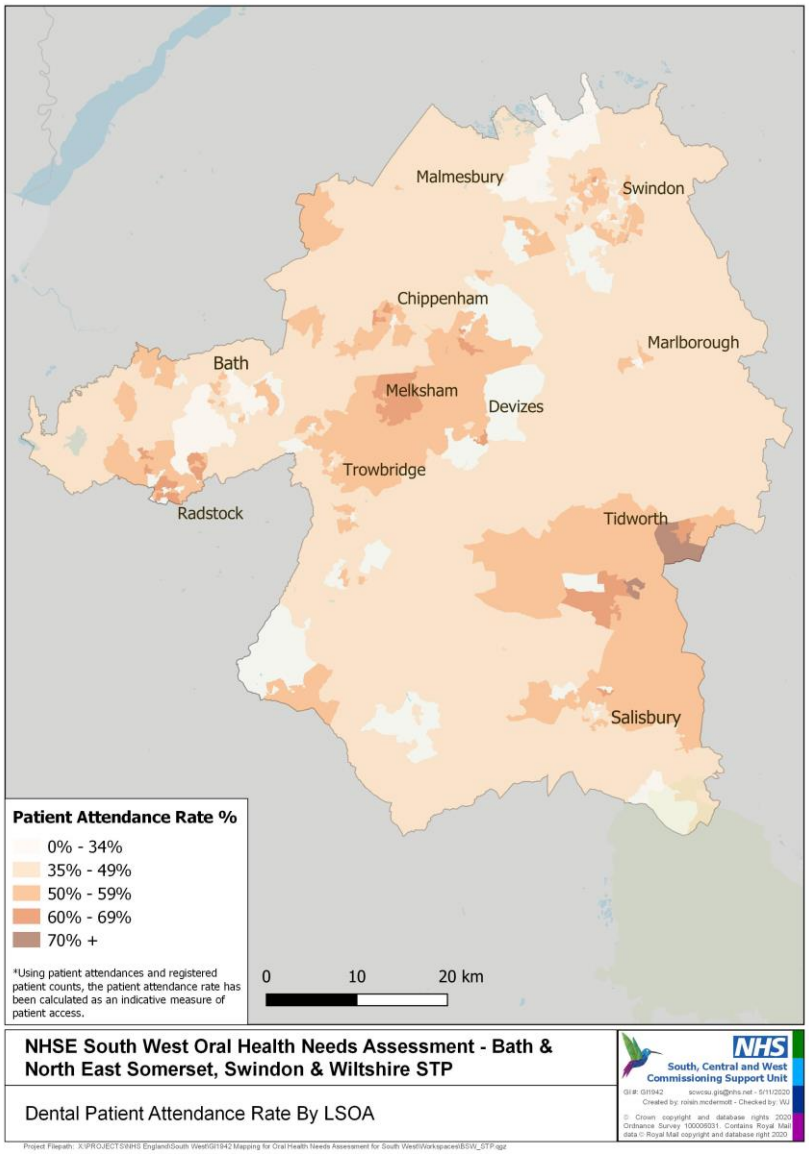


[45] NHS Dental Services, NHS Business Services Authority (BSA).
[46] NHS South, Central and West Commissioning Support Unit Oct 2020

7.13 Considerable concerns were raised through the patient and public survey to suggest that there is great difficulty in accessing NHS dentistry in the county. Practices that see NHS patients are presented in this map. A key issue is the geographical spread of the practices, which inevitably seem to be linked to the major towns across the STP. Moreover, there is no indication as to whether these practices are taking on new patients and for this OHNA there is also no data available on the size and lengths of waiting lists.

7.14 The map below sets out the patient attendance rate as a percentage of the local population. It would seem that most of the county is based on a 50-59% attendance rate but there are some localities where this is significantly lower, even in areas where there is a higher population.

Map 6: Dental Patient Attendance Rate by LSOA (%)[47]



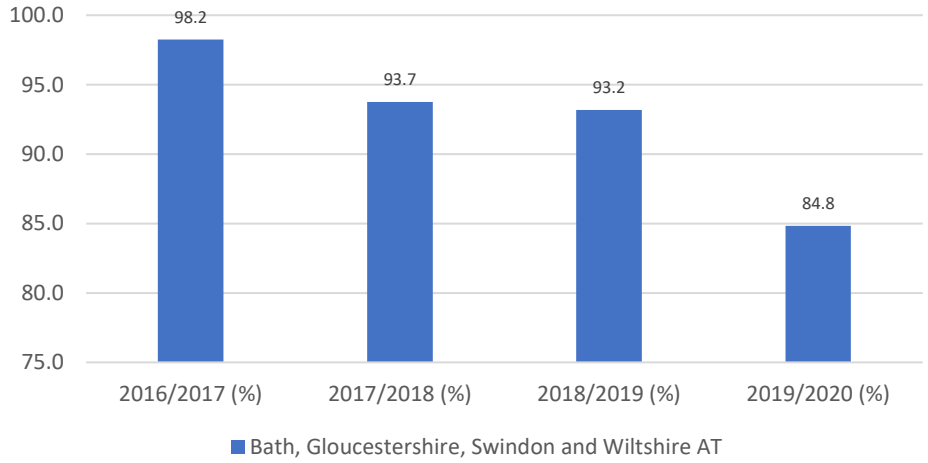
[47] NHS South, Central and West Commissioning Support Unit Oct 2020

UDA/Contract performance

7.15 In England in 2015/2016, £54,505,326 was clawed back from practices who have not met their contractual targets, this increased to £81,506,678 in 2016/2017, £88,774,248 in 2017/2018 and £138,438,340 in 2018/2019.

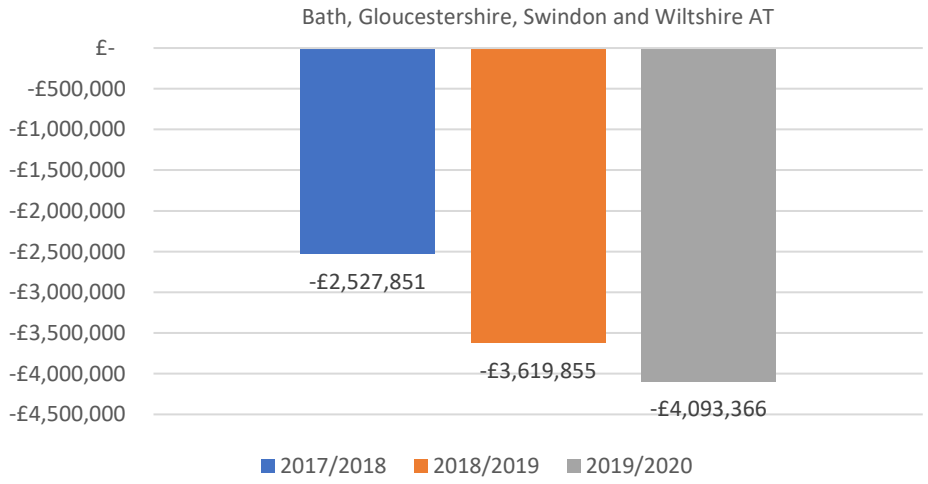
7.16 The chart below presents the achievement against target for dentistry funded through the UDA system for BaNES, Gloucestershire, Swindon and Wiltshire.

Chart 3: Delivered UDAs over last 4 years as % of contracted UDAs by South West Sub Region (Source NHSE Aug 2020)



7.17 The chart below sets out the recovery of funds for undelivered activity in £s by sub-region across the South West. It shows a sizeable level each year, with2019/20 being a particularly significant year with £4,093,366 recovered by the NHS for the under delivery of UDAs.

Chart 4: UDA recovery Value (£) by Subregion 2017-2020 Source NHS England Aug 2020



Cross-Border Flow and Seasonal Variation

7.18 As people may visit a dental practice anywhere in the country, it is useful to explore cross border flows for three reasons. Firstly, large numbers of people accessing services from outside an area can limit access to services for residents. Secondly, such patterns may indicate a lack of service availability or poor service quality in the area. Thirdly, some areas in the South West have seasonal migrant workers and are popular holiday destinations, which may lead to seasonal variations in access to care, especially urgent care.

Complexity of care

7.19 The proportion of people having Band 1 courses of treatments is higher in all areas of the South West relative to the England average. Whereas the proportion of people having Band 2 and Band 3 courses of treatment is relatively lower in all areas of the South West. This picture is most stark in Bath, Gloucester, Swindon and Wiltshire. Therefore, the people attending for dental examination in the region have relatively good oral health and require less complex care. It may also suggest that people needing more complex care may be facing additional barriers to accessing it. Therefore, NHS England and NHS Improvement may want to consider undertaking a health equality audit to ensure the equitable availability and access to NHS primary dental care in the region.

Table 15: Proportion of courses of treatment in each band (adults and children combined)

Area	Band 1	Band 2	Band 3	Band 4 Urgent
NHS BaNES, Swindon and Wiltshire CCG	64.70%	22.79%	3.29%	9.04%
South West	62.24%	24.14%	3.71%	9.58%
England	59.96%	25.48%	4.78%	9.47%

Evidence based prevention and care.

Fluoride varnish application

7.20 Evidence-based guidance recommends application of fluoride every six months for all children aged 3 years and above and more frequently at risk of decay. Fluoride varnish application is also recommended twice a year for vulnerable adults. Fluoride varnish application two-three times a year can reduce tooth decay by 33% in baby teeth and 46% in adult teeth[48].

7.21 In 2018-2019 there were 599,188 fluoride varnish application in the South West, however unfortunately this data is not available for 2019-20220. In 2018-2019 the % of the population that have received fluoride varnish was 42.8% for children and 1.2% of adults. In BaNES there were 21,170 representing 3.5% of the regional applications. 10.4% were for adults and 89.6% were for children. This

[48] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002279.pub2/full

represented 2.3% of the population, 0.3% of adults which is slightly above the South West proportion and 9.8% of children, below the South West proportion. In Swindon there were 25,914 representing 4.3% of the regional applications. 9.6% were for adults and 90.4% were for children. This represented 11.4% of the population, 1.4% of adults which is slightly above the South West proportion and 45.2% of children, above the South West proportion. In Wiltshire there were 46,209 representing 7.7% of the regional applications. 9.4% were adult and 90.6% were for children. This represented 9.3% of the population 1.1% of adults slightly above the South West proportion and 39.6% of children, below the South West proportion.

Table 16: Fluoride varnish application Children and Adults by STO 2018-19

Fluoride Varnish	Fluoride Varnish Count	Population in 2018 (ONS 2018)	Fluoride varnish as a % of the population
South West	599188		
NHS Bath and North East Somerset CCG	21170	918,428	2.3%
Adult (over 18)	2209	724,991	0.3%
Child (u18)	18961	193,437	9.8%
NHS Swindon CCG	25914	228,258	11.4%
Adult (over 18)	2488	176,459	1.4%
Child (u18)	23426	51,799	45.2%
NHS Wiltshire CCG	46209	498,064	9.3%
Adult (over 18)	4339	392,372	1.1%
Child (u18)	41870	105,692	39.6%
South West	599188	6,332,319	9.5%
Adult (over 18)	59207	5,070,946	1.2%
Child (u18)	539981	1,261,373	42.8%

7.22 NICE has published evidence-based guidelines for dental recall intervals. Adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their level of risk of oral disease. Therefore, adults whose care falls under Band 1, that is those people with low levels of disease activity, should usually have a recommended recall interval of 24 months.

7.23 The table below presents the proportion of people re-attending every three months in the South West. The data shows that the proportion of people seen every three months is comparable with the England average. This is despite a greater proportion of Band 1 courses of treatments being provided in the region. What stands-out, is the recall intervals for children compared with the England-average.

Table 17: 3-month recall intervals (high-risk) patients 2019 Source: NHS England

Area	Children (%)	Adults (%)
Bath, Gloucester, Swindon and Wiltshire	6.3	11.5
England	7.0	12.7

Other primary care services

7.24 Primary care activity is also provided at Bristol Dental Hospital and its associated outreach clinics, predominantly by dental students supervised by GDC registered staff.

Domiciliary services

7.25 Domiciliary oral healthcare is provided to those people who cannot visit a dentist. Care is provided where the patient permanently or temporarily resides including patients' own homes, residential units, nursing homes, hospitals and day centres. Adequate provision of these services will ensure the facilitation of a reasonable alternative route for older people and vulnerable groups in accordance with the Equality Act 2010.

7.26 The table below presents the primary care service in BaNES, Swindon and Wiltshire that provides domiciliary care. Data previously outlined in this section, describes the demographic characteristics of the population with more people of retirement age and less people of working age living in BaNES, Swindon and Wiltshire. This may lead to a greater need for domiciliary care. Therefore, commissioners might wish to consider if there is adequate provision of domiciliary dental care in BaNES, Swindon and Wiltshire to meet future need. Work is being done by PHE to review and develop training programmes for staff in the domiciliary and care home sector to support residents to get the best oral health care possible.

Table 18: Domiciliary Care Provision in the South West

Contract type	Area Covered	Annual Delivery Parameters
Secondary Care	Swindon & Wiltshire	849 patients that meet the CDS service criteria

Unplanned dental care

7.27 Access to urgent care is critical to support 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. 25% of the adult population in the South West reported that they only went to the dentist when they had a problem (ADHS 2009). In the recent 2018 Adult in Practice survey, 8.2% of patients in the South West stated they had an urgent treatment need compared to 4.9% across England.

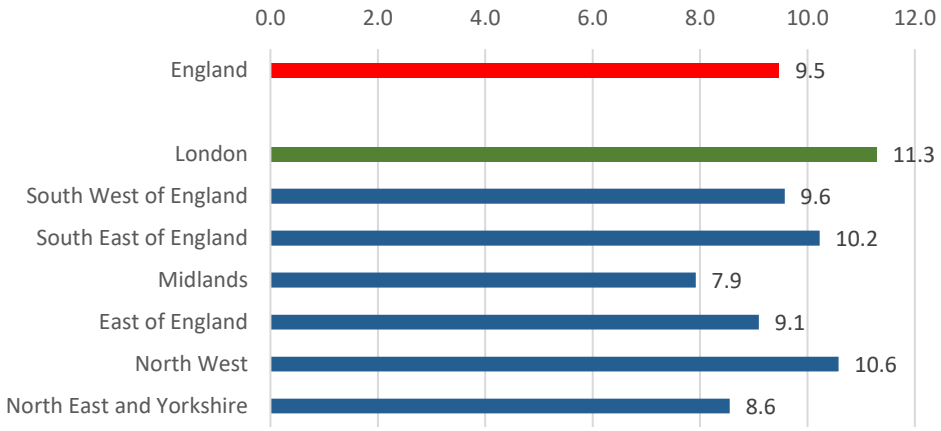
7.28 Across the South West, approximately half of the adult population and a third of the child population have not visited the dentist in the last two years, and thus may not have a regular dentist when a problem occurs.

7.29 Unplanned dental care is best reviewed by assessing the levels of urgent care as per the bands of provision in the dental care system. The table below sets out the number and % of urgent care 2019-2020 by region. It shows that in the south west 9.6% of dental care was urgent care which is slightly above the proportion of urgent care nationally at 9.5%.

Table 19: Number and percentage of Courses of Treatment by NHS Commissioning Region1 and treatment band, 2019-20 (NHS Dental Services, NHS Business Services Authority (BSA))[49]

Org Name	Urgent	Urgent (%)[50]
England (19/20)	3,638,000	9.5%
England (18/19)	3,621,000	9.1%
South West of England (19/20)	370,000	9.6%
South West of England (18/19)	372,000	9.2%

Chart 5: Percentage of Urgent Care Treatment by NHS Commissioning Regions (% of total Bands) 2019-20 NHS Digital



Urgent Dental treatment by type (Child/non-paying Adult/paying Adult)

7.30 Across the South West the profile of urgent care as a proportion of all treatment bands had been taken from the review of treatment bands nationally by region, STP, LA and by Cost of Treatment 2019-2020 (Sum and %).[51]

49 Data is affected by COVID-19.
50 Figures presented are rounded
51 Source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report : NHS Dental Statistics for England - 2019-20: Annex 3 (Activity)

7.31 In the South West region, the level of urgent care for children was 4% (as compared to England at 4.2%), for non–paying adults it was 16.4% (as compared to England at 16.2% and for paying adults it was 10.8% as compared to England at 10.5%

7.32 Across the South West there are some variances in the levels of urgent care between children, non-paying and paying adults. The table below compares this STP with the South West's levels of urgent care activity by type of patient.

Table 20: Review of Urgent care treatment Bands by STP in the South West by Cost of treatment 2019-2020 (Sum and %) NHS Digital 2020

Row Labels	Type	% within Type
NHS Bath and North East Somerset, Swindon and Wiltshire CCG		
Urgent/Occasional	Child	3.6%
	Non-paying adult	15.9%
	Paying adult	10.7%
South West		
Urgent/Occasional	Child	4.0%
	Non-paying adult	16.4%
	Paying adult	10.8%

7.33 In Bath North East Somerset, Swindon and Wiltshire in 2019/2020 3.6% of urgent care was for children compared to 4.4% for the region; 15.9% was for non-paying adults as compared to 16.4% for the region; 10.7% was for paying adults compared to 10.8% in the region.

Oral Cancer

7.34 Mouth cancers make up 2% of all new cancers in the UK[52]. Oral cancer rates in the South West are 14.9 per 100,000 – lower in comparison to England (at a rate of 15.0 per 100,000), in BaNES it is 13.83 higher than the South West rate and lower than the England rate, in Wiltshire it is 12.34 per 100,000 and in Swindon it is 12.07 per 100,000 - both are lower than the England and South West rates.

8 Oral Health Improvement

8.1 Bath and North East Somerset was part of the West of England Oral health Promotion Strategy 2016-2021 whose aim is to improve the oral health of all people in Bristol, Bath and North East Somerset, North Somerset and South Gloucestershire. It aspires to promote the best available oral health across the life

[52] State of mouth Cancer UK Report 2018-2019 https://www.dentalhealth.org/Handlers/Download.ashx?IDMF=21dc592b-d4e7-4fb2-98a9-50f06bed71aa

course, reduce oral health inequalities and lay solid foundations for good oral health throughout life. It also provides an overarching framework for the development of local delivery plans.

8.2 This strategy aims to improve oral health and reduce inequalities by endorsing five strategic priorities, each of which is supported by three objectives. See table below:

Table 21: Oral health Promotion Strategy 2016-2021

Strategic approach to improving oral health			
What we aim to do	*Objectives: How can we do it?*		*Who can do it?*
Promote oral health through healthier food and drink choices	1	Promote oral health by making healthier choices easier though multi-stranded approaches to promote healthier food and drink choices and reduce sugar intake	Local authorities
	2	Commission interventions that encourage and support breastfeeding and healthy complementary feeding (weaning)	Local authorities
	3	Promote healthier food and drink choices that are lower in sugar in settings that the local authority reaches e.g. leisure, education, social and residential care and local food outlets	Local authorities
Promote oral health by improving levels of oral hygiene	4	Commission supervised tooth brushing programmes for pre-school and primary school children at high risk of poor oral health	Local authorities, Dental professionals
	5	Equip the wider health and social care workforce with the knowledge and skills to recognise the link with neglect and complex social circumstances and ensure provision of care for those at high risk of poor oral health	Local authorities Dental professionals
	6*	Commission programmes that provide free toothbrushes and toothpaste to all pre-school and primary school children, prioritising targeted interventions for those at high risk of poor oral health	Local authorities NHS England Dental professionals
Improve population exposure to fluoride	7	Promote the use of fluoride toothpaste among those at high risk of poor oral health	Local authorities Dental professionals
	8*	Commission programmes that provide free toothbrushes and toothpaste to pre-school and primary school children, prioritising targeted interventions for those at high risk or poor oral health	Local authorities NHS England CCGs
	9	Commission fluoride varnishing programmes for young children in areas with high rates of tooth decay	Local authorities Dental professionals
Improve early detection, and treatment, of oral diseases	10	Maximise all opportunities for signposting to local NHS dental services	Local authorities CCGs
	11	Promote the benefits of visiting a dentist throughout the life course	Local authorities Dental professionals CCGs
	12	Raise awareness of eligibility for free check-ups, prioritising those at high risk or poor oral health	Local authorities NHS England
Reduce inequalities in oral health	13	Look for opportunities to embed oral health promotion within all health and wellbeing policies, strategies and commissioning	Local authorities NHS England CCGs
	14	Promote oral health among vulnerable groups; young children, people with diabetes, people who smoke, consume high quantities of alcohol or use drugs, people with learning disability, the elderly and other locally identified vulnerable groups	Local authorities NHS England CCGs

Strategic approach to improving oral health			
What we aim to do	*Objectives: How can we do it?*		*Who can do it?*
	15	Equip the wider health and social care workforce with the knowledge and skills to recognise the link with neglect and complex social circumstances and ensure provision of care for those at high risk of poor oral health.	Local authorities NHS England Dental professionals CCGs

8.3 In Bath and North East Somerset there are oral health action plans that have been supported by PHE, and the University Hospital Bristol Oral Health Promotions team. The plan targets the above oral health strategy priorities by focusing on different time in people's lives and specific group of people. This includes:

- Across life course: specifically addressing the prioritisation of oral health within the JSNA, address oral health in public health strategies, policies and specifications, food policies and reduction in high sugar foods and supporting the wider health and social care workforce and signposting to local NHS dental services.
- Best start in life; including encouraging parents to brush or supervise young children's teeth brushing using fluoridated toothpaste, developing and providing information to promote good oral health, distributing free toothbrush and toothpaste packs to all children defined as at higher risk of poor oral health. A business case for fluoride varnishing and supervised tooth brushing programmes for young children in areas with high rates of tooth decay.
- Interventions supporting adults to improve their oral health; including promoting oral health within healthy lifestyle advice that reaches working adults, promoting visits to the dentist among working age adults and two way referral systems for dentists and dental care practitioners with public health, primary care and healthy lifestyle programmes.
- Targeting people at higher risk of poor oral health; working with partner agencies to provide advice on oral health, advice on the use of fluoride toothpaste, and sign posting to NHS dental services for those who are homeless, people with learning disability, migrants, gypsies and travellers, drug and alcohol users and looked after children.
- Interventions to improve the oral health of people as they age; including oral health of older adults within JSNA and the health and wellbeing strategy, the inclusion of clauses in Local authority care home service specs for oral health assessment of residents and for oral health to be included in their care plans. The training of health and social care staff in the recognition of poor oral health and provide information on how to promote a visit to the dentist and how to brush teeth and care for dentures.

8.4 Swindon's Oral Health Strategy links to Swindon Borough Council's Priority Four: help people to help themselves while always protecting the most vulnerable children and adults. It also links to the Swindon Health and Wellbeing Strategy Outcome 1: every child and young person in Swindon has a healthy start in life, outcome 2: adults and older people in Swindon are living healthy and more

independent lives and outcome 3: improved health outcomes for disadvantaged and vulnerable communities.

8.5 It sets five key outcomes:

- Outcome 1: Ensure oral health is a health and wellbeing priority.
  - Provide a regular report on delivery of Swindon's oral health strategy to the Joint Commissioning group.
  - Form a Swindon oral health steering group to monitor and review Swindon oral health strategy and action plan.
- Outcome 2: Tackle social and lifestyle determinants of disease.
  - Improve the environments in which people live and work by taking action on social determinants of ill health.
  - Making healthy choices easier with regard to healthy, sugar free foods and drinks by developing health supportive environments.
  - Supporting reductions in alcohol misuse, tobacco use and substance misuse.
- Outcome 3: Embed oral health into commissioning.
  - Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children.
  - Embed oral health within public health improvements such as the Swindon Community Health and Wellbeing Hub.
- Outcome 4: Commission oral health improvement interventions
  - Ensure the most cost-effective oral health improvement interventions are being commissioned.
  - Ensure that oral health improvement interventions reduce inequalities by targeting those at greatest risk of poor oral health; including children, older people, people living with a learning disability, people living in poverty, people with lifestyle issues and those who are dependent on others for support.
  - Review the evidence for interventions that improve oral health including those that increase availability of fluoride.
- Outcome 5: Ensure shared ownership of the oral health agenda.
  - Work with NHSE and other partners who manage the provision of dental services and dental professionals.
  - Ensure early years services and schools provide oral health information and advice, with tailored advice for those at high risk.
  - Work with care homes and care providers to raise awareness of oral health.

8.6 In Wiltshire, the Oral Health Promotion Team is a dedicated team of dental care professionals with qualifications in oral health promotion, health education and teaching. They provide Oral Health Improvement Programmes throughout Wiltshire and Swindon and are based at Chippenham Dental Access Centre. Linking with government and local health improvement programmes, the team develops and

delivers projects aimed at improving the dental health of the local population and reducing health inequalities.

8.7 The team work closely with diverse groups including:

- Schools and colleges
- Children's centres
- Postnatal groups
- Nurseries and pre-schools
- Care and residential homes
- Pharmacy staff
- Medical staff
- Skills for life groups
- Special needs schools and care groups

8.8 A key programme is the Big Project for Little Teeth. This project aims to drastically reduce the levels of dental decay in under-fives in Wiltshire over the next five years. The project is funded by Wiltshire Public Health and managed by the Community Dental Service's Oral Health Promotion Team, working in partnership with Wiltshire Public Health Team, Child Health Teams and Children Centres throughout Wiltshire. The project targets parents and care-givers in a number of innovative ways, including oral health open days in Children's Centres, a video aimed at new parents on YouTube, and 'Anyone Can Cook' sessions provided by the award-winning ABC cook. It also works in partnership with the weaning groups run by community nursery nurses.

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NHS ENGLAND AND NHS IMPROVEMENT

ORAL

HEALTH NEEDS ASSESSMENT MAIN REPORT

SOUTH WEST OF ENGLAND

January 2021

Ottaway Strategic Management

www.ottawaystrategic.co.uk

NHS England and NHS Improvement

Oral Health Needs Assessment
Main Report

South West of England

Independently Reported by Ottaway Strategic Management ltd

January 2021

Contents

1 Introduction and context

1.1 This oral health needs assessment (OHNA) was commissioned by NHS England & NHS Improvement in May 2020.

Aims and objectives of this Oral Health Needs Assessment

1.2 The specification within the original brief set the following aims:

- Research and describe the oral health characteristics of the population and identify their needs, including detail for those populations at increased risk of poor oral health.
- Measure the capacity of existing service provision to meet need and identify any areas where additional capacity or provision is required in aim of supporting the oral health needs of the population.
- Identify aspects of service provision where further investigation/analysis may be needed.

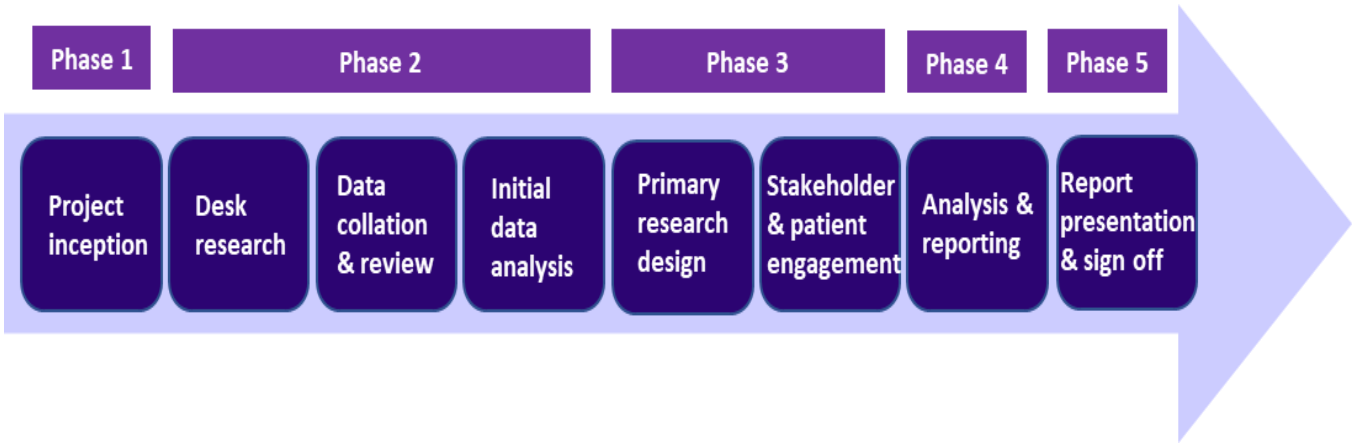
1.3 In addition to these stated aims, discussions with NHSE&I identified the following requirements, for the OHNA to:

- Highlight current service provision and future service models for delivery based on patient need.
- Secure engagement with all demographic groups including vulnerable populations.
- Ensure links with clinical leads and Directors of Public Health (DPHs) (this should be broadened to include ICS/systems).
- Manage the impact of COVID-19 in the delivery of the OHNA, including in the engagement of patients and stakeholders.
- Inform the commissioning intentions of NHSE&I.

1.4 This OHNA has adopted the NICE/PHE guidance for OHNAs[1] and follows the model developed at Cardiff University. We will supplement this approach with the core focus set out in 2.2 and 2.3 above.

[1] https://www.nice.org.uk/guidance/ph55/evidence/report-1-an-overview-of-oral-health-needs-assessments-main-report-pdf-431755885
https://www.gov.uk/government/publications/oral-health-needs-assessment-for-yorkshire-and-the-humber
https://pubmed.ncbi.nlm.nih.gov/30211484/

1.5 As a linear process this OHNA has undergone the following broad sequence of activities:



1.6 A core part of this OHNA has been the collation, review and analysis of relevant data. This includes data that highlights the risks associated with oral health, epidemiological data, data that reviews and describes the provision of oral health services and data that reviews oral health improvement interventions undertaken. In doing this, the analysis seeks to identify levels of need, demand and the supply of provision to address these needs. It also seeks to provide evidence of the gaps in provision and areas for improvement.

1.7 Critical to this approach is the understanding of how this OHNA fits into the commissioning cycle. As can be seen from the diagram below this OHNA will support the strategic planning component (red) of this cycle by providing an assessment of need, reviewing the provision of services and supporting commissioners in prioritisation.

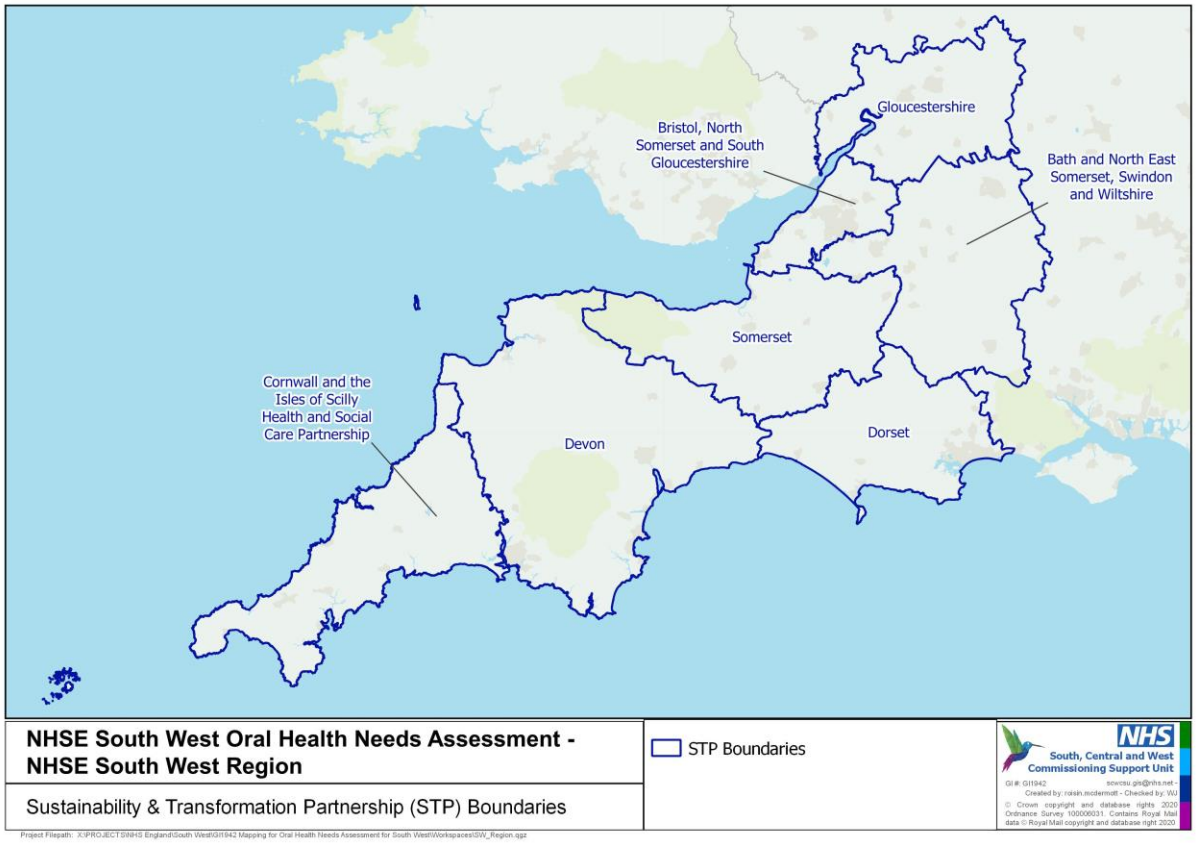
Chart 1: NHS Commissioning Cycle

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

1.8 We will analyse data for each sub region (STP area) across the South West including:

Cornwall and the Isles of Scilly	Devon
Somerset	Gloucestershire
Bristol, North Somerset & South Gloucestershire	Dorset
Bath and North East Somerset, Swindon & Wiltshire	

Map 1: South West Region by STPs[2]



Approach and Methods used to support this OHNA

1.9 In completing this Oral Health Needs Assessment, the team have undertaken a wide range of tasks that aim to secure a better understanding of the supply and demand for oral health services and in particular, the provision of NHS high street dentistry. The needs assessment has undertaken a literature review and has analysed public health data and population-based data sets. Where relevant, these data sets have been broken down into sets which relate to the regions' seven Integrated Care Systems. The OHNA has undertaken a stock take of current oral health services across the region and reviewed NHS England and NHS Improvement and NHS Business Service Authority (BSA) data from current services and service providers.

[2] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/09/stps-split.jpg

1.10 The OHNA has also been supplemented with a range of stakeholder, service user and general public engagement. This has taken the form of targeted interviews with key stakeholders, a survey of stakeholders, surveys of patients and the general public.

1.11 In developing this oral health needs assessment, the national, regional and STP area context has been considered.

1.12 The needs assessment has also followed the guidelines for completing oral health needs assessments and have reviewed the following types of need:

- Normative need (need defined by experts)
- Expressed need or demand (actions taken by service recipients to utilise health services)
- Felt need (perceived needs of lay people or service recipients)
- Comparative need (need between groups of people with similar characteristics) and unmet need (as defined by either group)
- Unmet oral health needs are the gap between service and/or oral health improvement activities and what is considered necessary by providers and recipients.

1.13 Collectively these approaches have enabled a full review of the provision available in the South West and an assessment of the relevance and fulfilment of that provision to the needs being presented by the general population.

1.14 A review of the diversity of needs across the different geographic and demographic profiles of the South West has been completed, alongside an assessment of the social, economic and deprivation needs of the region. This approach has enabled an assessment that will inform the future commissioning of dental services and to help commissioners to develop their intentions in line with the needs being presented.

OHNA Policy backdrop

1.15 This OHNA has been completed in the light of a range of national, regional and local policies for oral health. A summary of these policies is set out in Chapter 18. This includes:

- National background
  - Health and Social Care Act 2012
  - Fair Society Health Lives Marmot Review
  - Marmot Review 10 years on
  - Healthy lives, Healthy people: our Strategy for Public Health in England
  - Healthy Lives, Brighter Futures the strategy for children and young people's health

- Healthy Lives, Healthy People: Improving outcomes and supporting transparency
- The NHS Outcomes Framework Latest and Indicator Releases to August 2020
- Transforming Participation in Health and Care
- Choosing Better Oral Health: An oral health action plan for England
- Delivering better oral health: an evidence-based toolkit for prevention
- Valuing People's Oral health
- Securing Excellence in Commissioning NHS Dental Services
- Local Authorities Improving Oral Health: Commissioning better oral health for children and young people
- Oral Health: approaches for local authorities and their partners to improve the oral health of their communities
    - *Oral Health Approaches for Dental Teams*.
    - *Oral health in nursing and residential care*.
- Delivering Better Oral Health
- Smokefree and Smiling
- NHS dental contract reform programme
- GDS contract and PDS agreement.

- Local Context
    - NHS South West dental commissioning intentions
    - Joint health and wellbeing strategies for the local authorities in the region
    - Integrated Care Systems, Strategic Transformation Partnerships
    - Oral health improvement plans and strategies locally.

2 Population and demographic variations

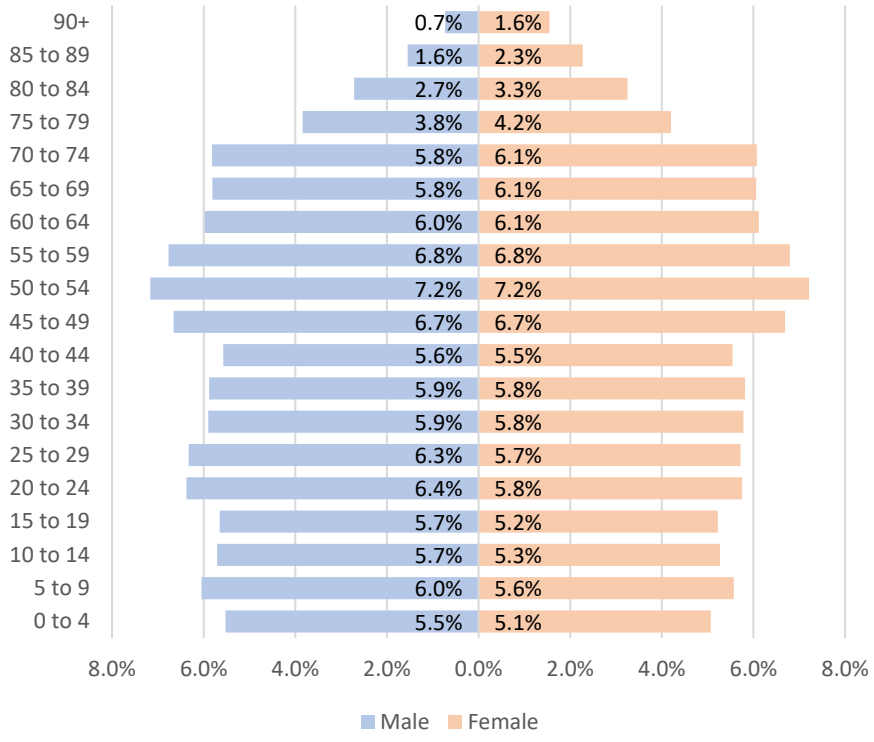
2.1 The demographic characteristics of a population has a significant impact on their oral health needs. This section reviews the make-up of the South West's population in this context and the ramifications for oral health and service provision. This section also reviews the impact of the wider determinants of poor oral health and lifestyle factors in the population and presents their distribution across the South West.

Population of the SW England

Gender and Age

2.2 The population of the South West of England is an estimated 5,599,735[3]. The population of the South West consists of more females (51%) than males (49%) - a gender profile which is consistent with the population of England. The age and gender profile of the population of the South West of England is set out in the population pyramid below.

Chart 2: South West Population Profile by Age and Gender



2.3 There are more people of retirement age and less people of working age living in the South West of England, whilst the proportion of children and young people in

[3] ONS mid-2018 estimates

the South West of England is the same as across England. This is set out in the table below.

2.4 There are some variations at STP level – 25% of the population of Cornwall and Isle of Scilly, and Dorset and 24% of the population of Devon and Somerset are over 65 years of age. This is significantly higher than the average for England of 18% of people at retirement age. At the other end of the age range, 19% of the population of Bath & North East Somerset, Swindon and Wiltshire and 18% of the population of Bristol, North Somerset and South Gloucestershire, Somerset and Gloucestershire are children and young people (under 16 years of age). This is consistent with the England average.

2.5 Additionally, from this population profile it is clear to see that the most populated STP area in the South West is Devon with 1.2M people, this is followed by Bristol, North Somerset and South Gloucestershire with 0.96M people and Bath and North East Somerset, Swindon and Wiltshire with 0.91M people. The STP's with the lowest populations are Somerset with 0.56M and Cornwall and the Isle of Scilly with 0.57M people.

Table 1: The South West's summary age profile by STP[4]

	Children and young people (under 16 years)		Working-age population (16-64 years)		Retirement age population (65 years and older)		Total population
	(n)	(%)	(n)	(%)	(n)	(%)	(n)
Bath & North East Somerset, Swindon and Wiltshire	171,946	19%	562,949	62%	177,271	19%	912,166
North Somerset, Bristol and South Gloucestershire	177,503	18%	618,818	64%	163,647	17%	959,968
Somerset	98,750	18%	323,788	58%	136,861	24%	559,399
Cornwall and Isle of Scilly	96,408	17%	331,594	58%	140,208	25%	568,210
Devon	200,396	17%	709,591	59%	284,179	24%	1,194,166
Gloucestershire	114,229	18%	384,356	61%	134,973	21%	633,558
Dorset	127,676	17%	451,531	58%	193,061	25%	772,268
South West	986,908	18%	3,382,627	60%	1,230,200	22%	5,599,735
England		18%		64%		18%	

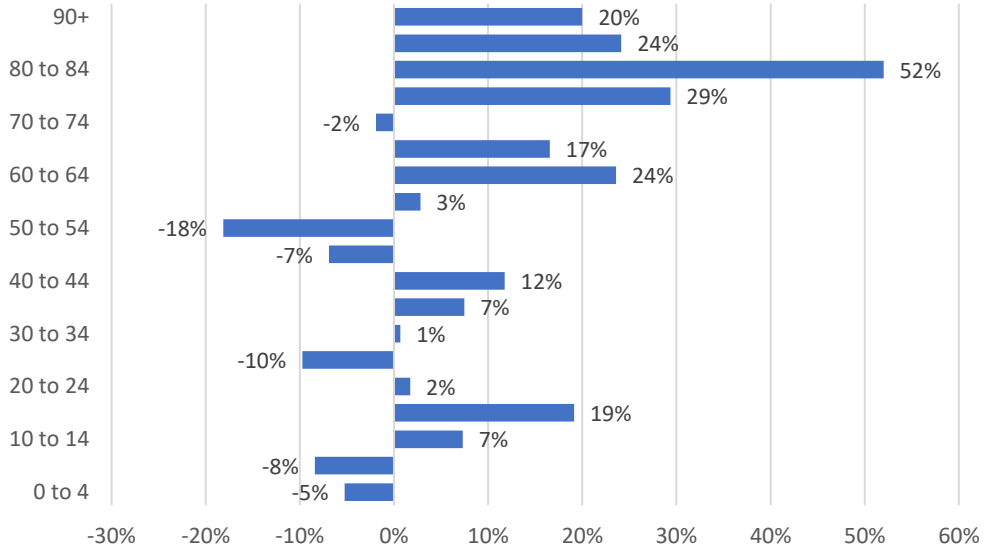
2.6 These populations and their geographic densities are critical details to the distribution and delivery of high street dentistry. Indeed, provision is most likely to be spread across the region based on the clustering of populations in villages, towns and cities across the region and this socio-economic spread of provision is most likely to reflect the distribution of the population across the region.

[4] ONS mid-2018 estimates

Population projections

2.7 The population of the South West of England is projected to increase by 7% over the next 10 years.[5] There are some variations between age groups. Most notably, the largest increase is projected in the older population, with a collective increase of 20% of the population aged 65 and over. In contrast, the rate of increase in children and young people aged under 25 is projected to rise by 3%.

Chart 3: Population projections across the South West[6]



2.8 The population growth in the South West is an important factor in the planning of provision. There will be an overall growth of the population, this is projected to vary in size in different STP areas. Most importantly the increase in older people is likely to be a significant and this will have important ramifications for commissioners of health and in particular oral health services across the South West.

Ethnicity

2.9 There is significantly less ethnic diversity in South West of England population compared to the ethnic profile in the population across England as a whole. The Ethnic Minority[7] population in the South West is 8.2% compared to 20.2% in England (N.B. This includes white Irish, white Gypsy and travellers and white other populations). The Back, Asian and Minority Ethnic Population[8] is 5% compared to 15% in England.

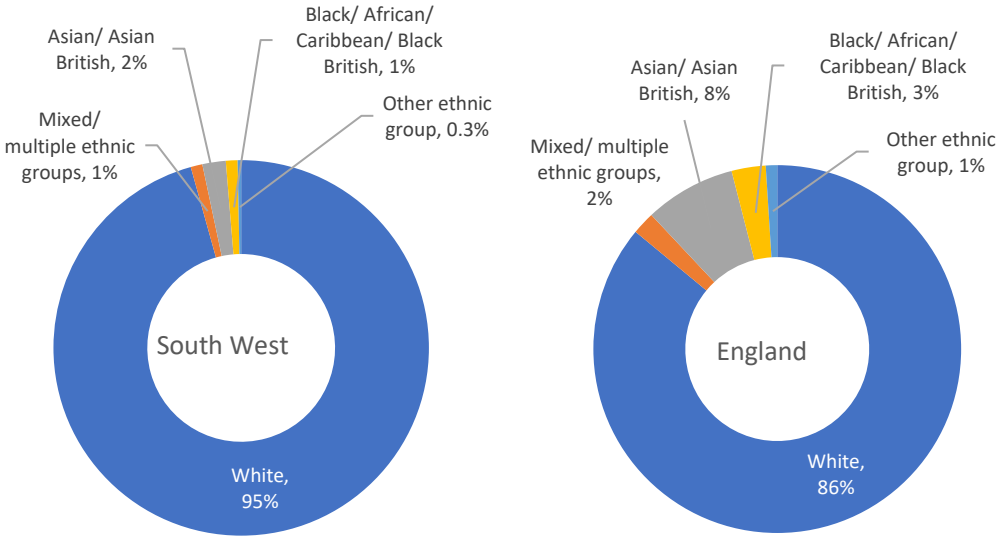
[5] 2018-based subnational population projections regions in England (ONS, 2020)

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/componentsofchangebirthsdeathsandmigrationforregionsandlocalauthoritiesinenglandtable5

[7] Ethnic minority is defined as people who differ in race or colour or in national, religious, or cultural origin from the dominant group of the country in which they live. For the purposes of this EQIA ethnic minority is used where people have not been defined as White British

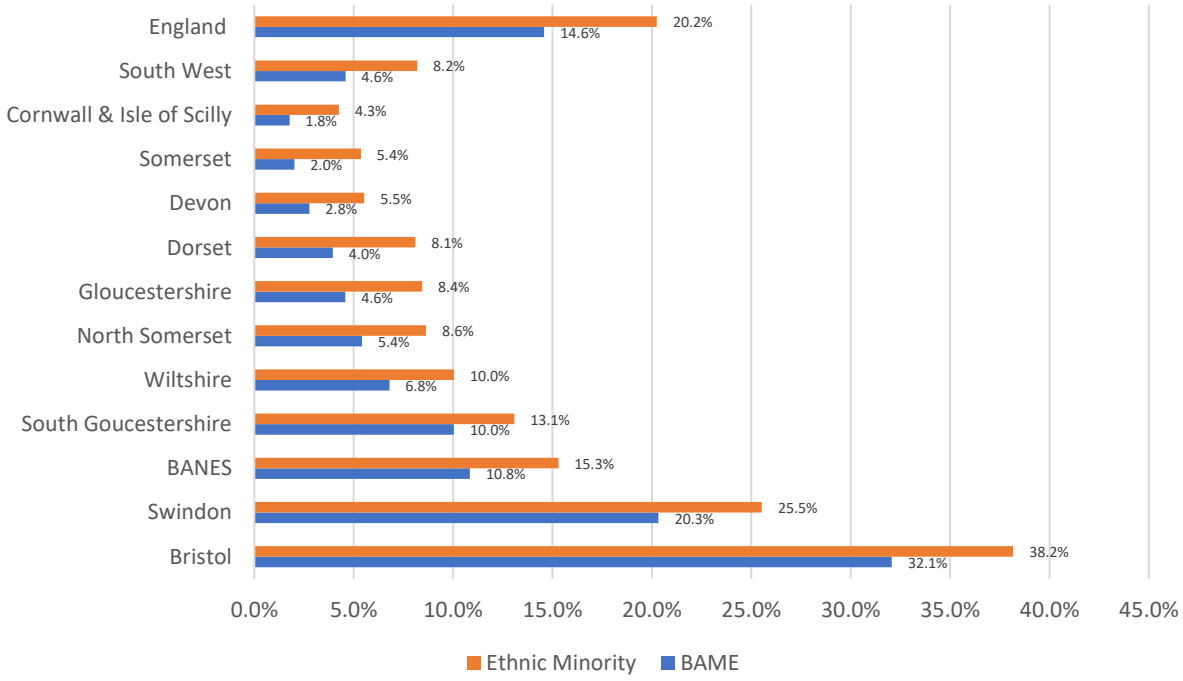
[8] The acronym **BAME** stands for Black, Asian and Minority Ethnic and is **defined** as all ethnic groups except White ethnic groups

Chart 4: Ethnic Profiles South West Compared to England Census 2011



2.10 The Ethnic Minority and Black, Asian and Minority Ethnic Population (BAME) populations vary from area to area across the South West. Indeed, the ethnic minority and BAME populations across the South West are below the national levels apart from the areas of Swindon and Bristol where both the ethnic minority and BAME populations are above the national levels. This clearly demonstrates that there is greater ethnic diversity in the region's urban areas.

Chart 5: BAME and Ethnic Minority Profiles Census 2011



Deprivation

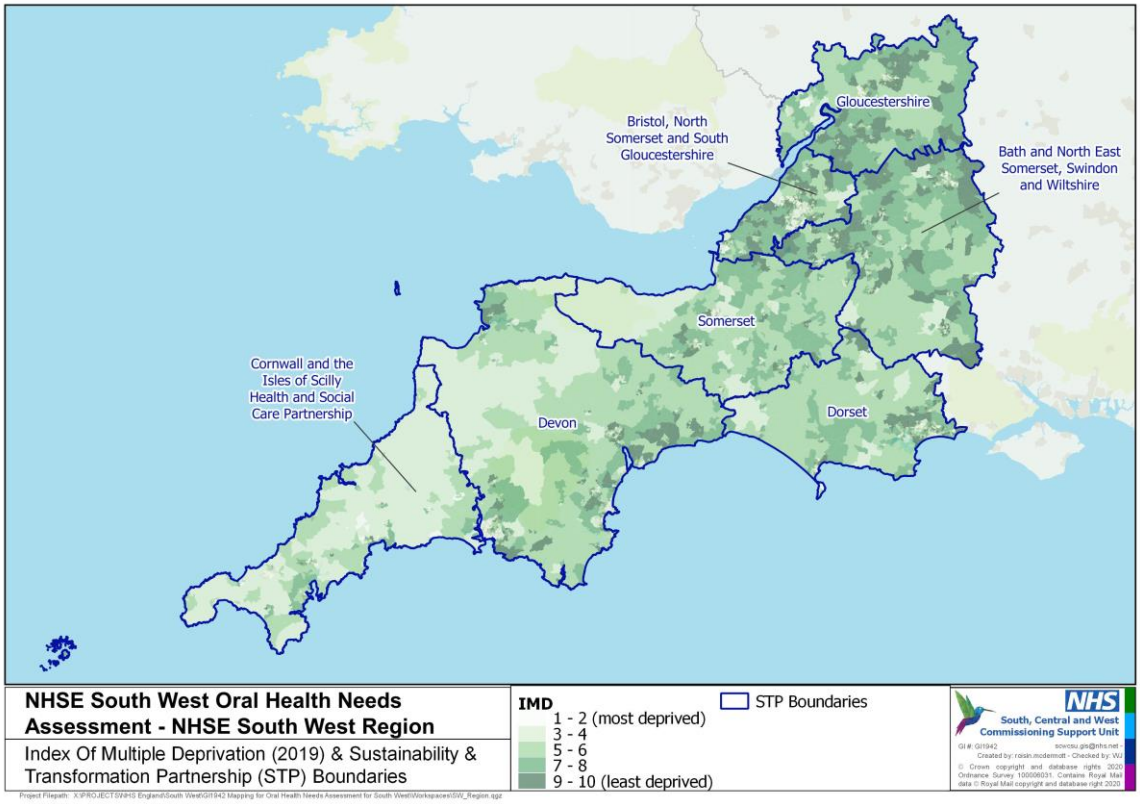
2.11 The data below is taken from the Index of Multiple Deprivation (IMD) 2019 which assess a series of domains and provides weightings to compute the levels of multiple deprivation in Lower-layer super output areas (LSOA's)

2.12 The English Indices of Multiple Deprivation use a collection of indicators grouped into seven deprivation domains to provide a relative estimate of deprivation levels within England. These domains are weighted to indicate their impact on deprivation and are combined into a single Index of Multiple Deprivation (IMD). The domains and their respective weightings are:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

2.13 It should be noted that the Indices of Deprivation are measures of relative deprivation in the sense that they show whether an area has become more or less deprived in relation to other areas over time. Any use of the IMDs for analyses of change over time must accordingly be carried out with care.

Map 2: Deprivation in the South West



2.14 The table below compares the average LSOA scores for each local authority area in the South West and show a real diversity of IMD scores. Those at the top of the list are the least deprived moving to more deprived at the bottom.

Table 2: IMD Ranks in the South West - Local Authority Districts[9]

Local Authority Districts in the South West	National Rank of Average LSOA Score	South West Rank of Average LSOA Score
Stroud	280	30 (least deprived)
Cotswold	277	29
South Gloucestershire	269	28
Bath and North East Somerset	265	27
Isles of Scilly	258	26
Tewkesbury	255	25
East Devon	244	24
Wiltshire	233	23
South Hams	229	22
Cheltenham	219	21
Dorset	199	20
North Somerset	196	19
Teignbridge	194	18
Exeter	189	17
Mendip	184	16
Mid Devon	176	15
South Somerset	172	14
Forest of Dean	163	13
West Devon	162	12
Bournemouth, Christchurch and Poole	160	11
Swindon	157	10
Somerset West and Taunton	146	9
North Devon	132	8
Sedgemoor	125	7
Gloucester	117	6
Cornwall	101	5
Torridge	99	4
Bristol City of	65	3
Plymouth	64	2
Torbay	48	1

2.15 Deprivation and the indices of multiple deprivation are a way to measure need and disproportionality of outcome, both for health as well as other social and economic factors. There is extensive research that confirms the correlation between health need and access to services experienced by those in more and or less affluent

[9] https://www.wiltshireintelligence.org.uk/wp-content/uploads/2019/12/IMD-2019-report.pdf

localities. From an oral health perspective, evaluating deprivation indicators is a strong way to fine-tune services and to prioritise the location of provision.

Health inequalities

2.16 Variations in health follow a continuum between different socioeconomic groups in society. There is much evidence to show that higher socio-economic status groups tend to enjoy the best health whereas those of the lowest socio-economic status experience the worst health. Key health measures are indicators of mortality and life expectancy.

2.17 In the South West life expectancy is higher generally than the England average with men living, on average, to 80.2 years and women to 83.8 years. There are however lower levels of life expectancy than the English average in Bristol, Plymouth and Torbay.

Table 3: Life expectancy of males and females in the South West.[10]

Life Expectancy at birth (Years) 2016-2018	Male	Female
England	79.6	83.2
South West region	80.2	83.8
Bath and North East Somerset	80.7	85.0
Bournemouth, Christchurch and Poole	80.2	83.5
Bristol	78.4	82.6
Cornwall	79.7	83.3
Devon	80.6	84.1
Dorset	80.9	84.6
Gloucestershire	80.2	83.7
Isles of Scilly	No data	No data
North Somerset	80.0	84.0
Plymouth	79.0	82.1
Somerset	80.4	84.1
South Gloucestershire	81.2	84.5
Swindon	80.1	83.3
Torbay	78.6	82.3
Wiltshire	81.0	84.2

2.18 The majority of men and women in most the local authority areas of the South West generally have higher life expectancy than the England average. There is variation in life expectancy across the local authorities; in the case of men from Torbay there is a potential 10.5-year life expectancy variance between the least and most deprived areas. In Bristol this is 9.8 and in Plymouth this is 9.7 years

[10] PHE Fingertips
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2016to2018

difference. In the case of females, the area with the largest variance in life expectancy between the least and most deprived areas is North Somerset with 9.6 years. This is followed by Torbay with 8.1 years and Bristol with 7.7 years life expectancy between those in the most and least deprived areas. This data shows the impact of socio-economic inequalities on life expectancy and their projected implications on the oral health of local people. Furthermore, for those people living longer, it is likely there is a higher prevalence of long-term and/or complex medical conditions.

2.19 The projected increase in the proportion of older adults may result in greater demand for fillings and bridges (restorative treatments). Many may already have a heavily restored dentition and treatment may be complex especially if they are taking multiple medications and require domiciliary care.

Table 4: Gap in life expectancy between men and women in the most deprived areas compared to men and women in the least deprived areas in each STP in the South West[11]

Inequalities in Life Expectancy at Birth	Male	Female
England	9.5	7.5
South West region	7.4	5.7
Bath and North East Somerset	6.8	2.9
Bournemouth	-	-
Bristol	9.8	7.7
Cornwall	6.2	4.5
Devon	6	4.2
Dorset	-	-
Gloucestershire	8.4	5.4
Isles of Scilly	*	*
North Somerset	9.7	9.6
Plymouth	8.6	5.6
Poole	-	-
Somerset	5.5	4
South Gloucestershire	5.7	6.9
Swindon	5.1	7.1
Torbay	10.5	8.1
Wiltshire	4.7	3.1

Scale: Best … Worst

[11] Figures calculated by Public Health England using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation 2010, 2015 and 2019 (IMD 2010 / IMD 2015 / IMD 2019) scores from the Ministry of Housing, Communities and Local Government.

Risks and determinants of poor oral health

2.20 Good oral health is imperative for good general health as it influences general wellbeing and quality of life, by allowing people to eat, speak and socialise without active disease. The World Health Organisation[12] defines oral health as "a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing".

2.21 To achieve sustainable improvements in oral health and reduce inequalities it is necessary to consider the underlying factors influencing poor oral health. A large spectrum of factors have been identified by contemporary public health research as influencing oral health including economic and social policy and individual health behaviours. Individual behavioural change approaches to improving oral health have been shown to have only short-term benefits and focusing on the wider determinants of health is necessary to achieve sustainable improvements in health-related behaviours.

2.22 Many of the risk factors that can lead to oral conditions are also risk factors for other diseases. This highlights the need to include oral health in initiatives designed to promote good health in general. These risk factors include but are not limited to:

- Diets high in sugary foods and drinks, including 'hidden' sugars in those foods generally unexpected to contain sugars
- Inappropriate infant feeding practices
- Poor oral hygiene
- Dry mouth (xerostomia)
- Smoking/use of tobacco and other carcinogenic substances
- Excessive alcohol consumption.

2.23 A 'common risk factor' approach in tackling conditions with the same underlying causes. It is proven to be an effective way of addressing a range of issues within the context of the wider socio-economic environment[13,14]. This means recognising that chronic non-communicable diseases and certain oral diseases share a set of common risk conditions. The common risk factor approach integrates general health promotion by focusing on a small number of shared risk factors that can potentially impact on many different chronic diseases, including oral health complications.

2.24 Healthy behaviours can contribute to the prevention and control of non-communicable diseases such as cardiovascular diseases (CVD), chronic respiratory

[12] https://www.who.int/news-room/fact-sheets/detail/oral-health.
[13] Sheiham A, Watt RG. The common risk factor approach: a rational basis for promoting oral health. Community dentistry and oral epidemiology. 2000;28(6):399-406.
[14] Watt RG, Sheiham A. Integrating the common risk factor approach into a social determinants framework. Community dentistry and oral epidemiology. 2012;40(4):289-96.

diseases, diabetes and cancers. PHE Fingertips and NHS Digital monitor trends in the nation's health and health related behaviours.

2.25 The prevalence of CVD, diabetes and under 75 mortality for respiratory disease in the South West are all below that of the national average for England (Table 5).

Table 5: Health indicators, Cardiovascular disease, Diabetes prevalence and Respiratory disease, national, regional and local

Indicator	England	South West region
Under 75 mortality rate per 100,000 from all cardiovascular diseases[15]	71.7	61.9
Diabetes: QOF prevalence (17+) (%)[16]	6.93	6.65
Under 75 mortality rate per 100,000 from respiratory disease considered preventable (Whole Pop)[17]	19.2	15.6

2.26 The key lifestyle related health outcomes reviewed in this OHNA have been healthy eating, physical activity levels (adults), obesity (child and adult), alcohol misuse and smoking prevalence. These lifestyle factors are pertinent to general health and wellbeing as well as to oral health. The importance of early life interventions for health improvement were highlighted by The Marmot Report Fair Society, Healthy Lives[18].

Healthy Eating

2.27 A healthy and balanced diet is critical to preventing ill health and disease. It is equally important for good oral health. The annual cost of food related ill health to the NHS is estimated at £6.1 Billion[19]. A minimum intake of five portions of fruit and vegetables is an important component of a healthy diet and is the measure most often used for healthy eating. The proportion of the population aged 15 that eat 5 portions of fruit and vegetables is 52.4% in England and slightly higher at 56.5% in the South West. The proportion of the adult population meeting the recommended 5-a-day on a usual day was 54.61%, although this was greater in the South West as a whole at 59.55%.

[15] PHE: Public Health Profiles: Fingertips 2016-18
[16] PHE: Public Health Profiles: Fingertips 2018-19
[17] PHE: Public Health Profiles: Fingertips 2016-18
[18] Marmot MG, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair society, healthy lives: Strategic review of health inequalities in England post-2010. 2010.
[19] March 2017 Health matters: obesity and the food environment – Gov.UK https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

Table 6: Healthy Eating indicators 5-a-day 15 year olds and adults national, regional and local

Indicator	England	South West region
Percentage who eat 5 portions or more of fruit and veg per day at age 15[20]	52.4	56.5
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)[21]	54.61	59.55

Physical activity levels (adults)

2.28 Physical inactivity is an important risk factor for chronic non-communicable diseases, for example Cardiovascular disease, with an estimated direct cost to the NHS of £7billion for England[22]. Guidelines for physical activity suggest adults (aged 16 and over) should have 150 minutes of activity of moderate intensity each week. Th Active Lives Survey[23] commissioned by Sport England and the PHE Physical Activity survey data[24] differ slightly in their definitions of what constitutes an activity. PHE include non-recreational exercise i.e. gardening in their interpretation of activity. The data shows that the South West region has a slightly higher level of active residents with 67.4% as compared to England with 63.6%. Correspondingly the level of inactive residents is 20.8% in the South West as compared to 24.6% for England.

Table 7: Physical activity levels national, regional and local

Indicator	England	South West region
Active (150+ minutes a week)	63.6	67.4
Fairly Active (30-149 minutes a week)	12.2	11.8
Inactive (<30 minutes per week)	24.6	20.8
% Active (150+ mins a week)	57	59.2
% Some activity (90-149 mins a week)	6.9	7.1
% Low activity (30-89 mins a week)	7.4	7.3
% Inactive (<30 mins)	28.7	26.3

Obesity (Child and Adult)

2.29 Being overweight or obese can be associated with an unhealthy diet and lack of physical activity. Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Obesity in adults is associated with cardiovascular diseases, diabetes, musculoskeletal disorders, and some cancers. It

[20] PHE: Public Health Profiles: Fingertips 2014-15
[21] PHE: Public Health Profiles: Fingertips 2018-19
[22] NHS Long Term Plan is a game changer Jan 2019
[23] Sport and physical activity levels Adults aged 16+ Nov 18 – Nov 18 % published Sport England Active Lives 23rd April 2020
[24] PHE: Physical activity levels among adults in England, 2015

is estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015[25].

2.30 The annual child weight measurement programme is completed locally and is fed into the national database held by PHE. The data set out below is taken from PHE Fingertips data for 2018-2019.

2.31 South West profiles for Reception and Year 6 children who are overweight including obesity are slightly below the England average. The South West profile for Reception and Year 6 prevalence of obesity is also below the England prevalence. The South West percentage of those adults classified as overweight and obese is 61.35% compared to England at 62.34%

Table 8: Overweight and Obesity levels children and adults national, regional and local

Indicator[26]	England	South West
Reception: Prevalence of overweight (including obesity) (%)	22.59	22.05
Year 6: Prevalence of overweight (including obesity) (%)	34.29	29.88
Reception: Prevalence of obesity (including severe obesity) (%)	9.68	8.74
Year 6: Prevalence of obesity (including severe obesity) (%)	20.22	16.52
Percentage of adults (aged 18+) classified as overweight or obese (%)	62.34	61.35

Alcohol misuse

2.32 Alcohol misuse can affect health and increase the risks of accidents, injury, and violence. The health harms of alcohol are dose dependent, that is, the risk increases with the amount of alcohol consumed. Alcohol consumption has an association with oral cancers[27].

2.33 The proportion of adults over the age of 16 years who are 'increasing' and 'higher' risk drinkers is presented below.

Table 9: Alcohol consumption rates national, regional and local

Indicator	England	South West
Estimated weekly alcohol consumption, by region: More than 14, up to 35/50 units (increasing risk) - Age Standardised %[28]	18.18	19.56
Estimated weekly alcohol consumption, by region: More than 35/50 units (higher risk) - Age Standardised %[29]	4.04	3.21

[25] Health matters obesity and the food environment PHE March 2017.
[26] PHE: Public Health Profiles: Fingertips 2018-19
[27] https://www.gov.uk/government/publications/oral-cancer-in-england
[28] Health Survey for England 2018
[29] Health Survey for England 2018

Smoking prevalence

2.34 Tobacco use increases the risk of cancers, chronic respiratory and cardiovascular conditions[30]. In England tobacco smoking is the greatest cause of preventable illness and premature death.

2.35 The 2009 Adult Dental Health Survey reported that more men than women smoked, and that smoking was socially patterned, with 8.8% of participants smoking in the least deprived areas compared to 26.4% in the most deprived. The 2018 Health Survey for England shows that 10% of current smokers lived in the least deprived areas whereas 28% of smokers lived in the most deprived areas. This suggests that smoking prevalence is becoming more concentrated in deprived areas.

2.36 The indicators for smoking prevalence show a level of variability from survey to survey. In England just under 10.6% of pregnant women were smokers at the time of delivery this was higher at 10.9% in the South West. The prevalence of adult smokers in 2018 showed that 17.2% of the population were smokers in England, compared to 16.5% in the South West. The GP Survey in 2018-2019 showed that 14.5% of over 18 year olds were smokers compared to 13.7% in the South West

Table 10: Smoking Status PHE Fingertips

Indicator	England	South West region
Smoking status at time of delivery (%)[31]	10.59	10.91
Estimated smoking prevalence (16+) (QOF)[32]	17.19	16.50
Smoking prevalence in adults (18+) - current smokers (GPPS)[33]	14.46	13.75

Oral hygiene practices

2.37 The most prevalent oral diseases - tooth decay and gum diseases can both be reduced by regular tooth brushing with fluoride toothpaste. The fluoride in toothpaste is the important ingredient in toothpaste to control, prevent and arrest tooth decay. Higher concentrations of fluoride in toothpaste lead to better control. By contrast, the physical removal of plaque is the important element of tooth brushing to control gum diseases as it reduces the inflammatory response in the gum tissue and its consequences.

2.38 In 2008/2009, most 12-year-old schoolchildren in the South West reported brushing their teeth twice daily.

[30] WHO
[31] PHE: Public Health Profiles: Fingertips 2018-19
[32] PHE: Public Health Profiles: Fingertips 2018
[33] PHE: Public Health Profiles: Fingertips 2018-19

Table 11: Frequency of tooth brushing among 12-year-olds, 2008/09 Area

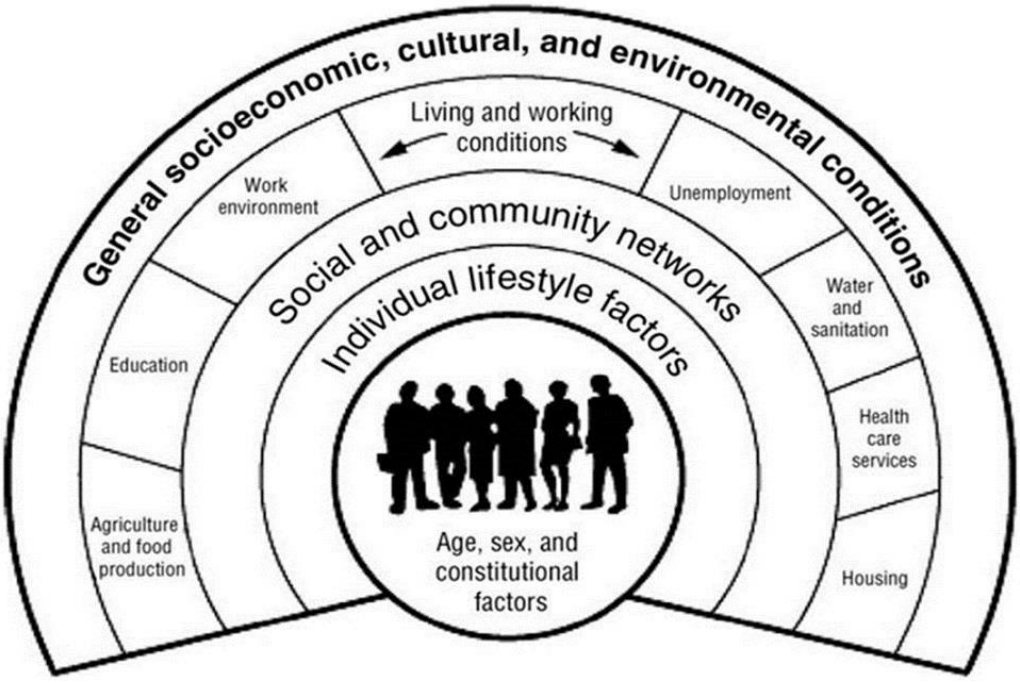
	Never (%)	Once a day or less (%)	Twice daily (%)	More than twice daily (%)
South West	0.3	22.3	74.0	3.1
England	0.2	22.8	72.9	3.7

Social determinants of oral health

2.39 The World Health Organization (WHO) defines the social determinants of health as the environments into which people are born, grow, live, work and age, including the condition of their health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

2.40 The diagram below shows the Dahlgren and Whitehead model of health determinants. It describes the broad social and economic circumstances that together determine the quality of the health of the population. They are known as the 'social determinants of health'.

Chart 6: The Dahlgren and Whitehead model of health determinants (1991)



2.41 This shows:

- Personal characteristics occupy the core of the model and include sex, age, ethnic group, and hereditary factors.
- Individual 'lifestyle' factors include behaviours such as smoking, alcohol use and physical activity.

- Social and community networks include family and wider social circles.
- Living and working conditions include access and opportunities in relation to jobs, housing, education and welfare services.
- General socioeconomic, cultural and environmental conditions include factors such as disposable income, taxation, and availability of work.

2.42 In the UK health inequalities, including within oral health, are a dominant feature both nationally and across all geographical areas. Health inequalities are not inevitable; they stem from inequalities in income, education, employment and neighbourhood circumstances throughout life that can be reduced. Avoidable inequalities are unfair and remedying them is a matter of social justice. Marmot proposed the most effective evidence-based strategies for reducing health inequalities in England.

2.43 The Marmot Report (2010) sets out a strategy on health inequalities that calls for actions that are universal but proportionate. Key messages from the review include:

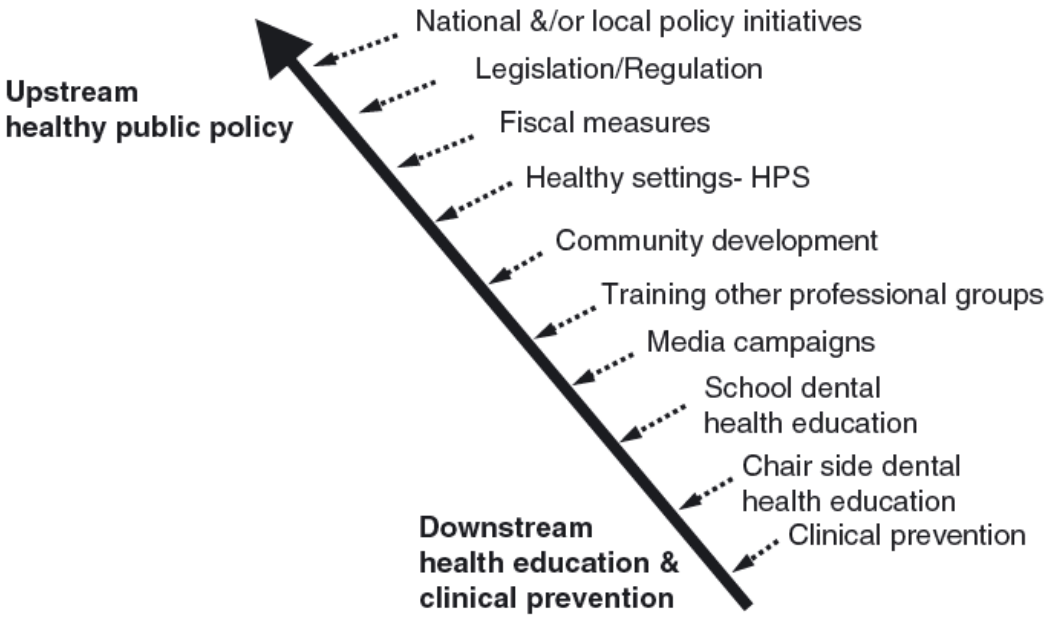
- There is a social gradient in health and the lower a person's social position, the worse his or her health. Action should therefore focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities therefore requires action across all the social determinants of health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage - 'proportionate universalism'.

2.44 The relationships between oral diseases and the social determinants of health are inextricably bound together. As discussed above, it is well-recognised that oral health is influenced by a wide range of social, economic and commercial determinants ranging from individual lifestyle choices, commercial influences and economic capabilities. This has an effect on individual actions through to national policy, for example smoke-free environments and policies tackling alcohol and sugar availability. It is essential that for a successful public health approach, these wider determinants must be focused upon through a partnership approach.

2.45 Oral health improvement can be tackled by upstream and downstream actions (Chart 7). Upstream actions include those undertaken at national and regional level; and downstream actions include dental care provided to patients by dentists and their teams. To improve outcomes NHSE&I may work with systems to facilitate interventions at all these levels: upstream, midstream and downstream.

2.46 A combination of evidence based universal and targeted activities are required to support reducing inequalities in oral health. Upstream interventions should be complemented by downstream interventions. [34]

Chart 7: Upstream-downstream options for oral disease prevention.



Social impacts of oral disease

2.47 Good oral health is essential for good general health and wellbeing. Oral disease may cause pain and discomfort, sleepless nights, loss of function and self-esteem. The discomfort may disrupt family life and lead to time off work or school. Decayed or missing teeth or ill-fitting dentures may lead to social isolation and loss of confidence. Limited function of the dentition may also restrict food choices compromising nutritional status.

2.48 Child oral health: applying all our health[35] states: 'Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Although oral health is improving in England, the oral health survey of 5-year-olds in 2017 showed that just under a quarter have tooth decay (PHE National Dental Epidemiology Programme for England, 2017). Each child with tooth decay will have on average 3 to 4 teeth affected. For those children at risk,

[34] Watt RG. From victim blaming to upstream action: tackling the social determinants of oral health inequalities. Community Dent Oral Epidemiology. 2007;35(1):1-11.
[35] https://www.gov.uk/government/publications/child-oral-health-applying-all-our-health/child-oral-health-applying-all-our-health

tooth decay starts early. The first survey of 3-year-olds in 2014 found that 12% had visible tooth decay, with an average of 3 teeth affected.

Financial impacts of oral disease

2.49 In England in 2018-2019 the spend on NHS dental services[36] was £2.063 billion with a further spend of £856 million in patient charges. The costs locally are detailed in chapter 5. In addition, expenditure on private dentistry outside the NHS is likely to exceed £3 billion in England. The financial impacts are likely to increase as treatment options become more complex and costly for an ageing population, as retaining heavily restored teeth for longer and public expectations regarding maintaining teeth for life increase.

A common risk factor approach

2.50 Oral diseases share risk factors with several other non-communicable diseases such as cancer, cardiovascular disease and diabetes. This presents opportunities for dental teams to contribute to the wider public health agenda by providing their patients with tailored advice and support based on their consumption of sugar, tobacco and alcohol[37,38].

Highlighted Oral Health Needs and Priorities

2.51 Contributory factors to poor oral health are shared by other major public health concerns, as outlined above. A common risk factor approach can be applied to the promotion of general health and wellbeing that supports good oral health for people throughout their life[39]. For example, reducing sugar consumption will have a positive impact on tooth decay[40] and obesity, stopping smoking will reduce oral and lung cancer, gum disease and cardiovascular disease[41].

Summary

- Demographic shifts in population will impact on the commissioning of services. Commissioners will need to address the sizeable population growth over the next 8-10 years. This will apply to the population across all ages, but particularly the older population of patients over 65 years of age.

[36] National Audit office https://www.nao.org.uk/wp-content/uploads/2020/03/Dentistry-in-England.pdf
[37] Watt RG, Sheiham A. Integrating the common risk factor approach into a social determinants framework. Community dentistry and oral epidemiology. 2012;40(4):289-96.
[38] Watt RG, Daly B, Allison P, Macpherson LMD, Venturelli R, Listl S, et al. Ending the neglect of global oral health: time for radical action. Lancet. 2019;394(10194):261-72.
[39] World Health Organisation (2008) Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on social determinants of health*
[40] Public Health England (2014) Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities
[41] Department of Health (2005) Choosing Better Oral Health: An Oral Health Plan for England.

- Within the region there are areas with high and relatively high levels of multiple deprivation. Where appropriate, services are needed in these localities, particularly given the relationship between poor oral health and areas of higher deprivation.
- Health inequalities exist in the South West and there are areas with lower level of life expectancy than others. Detail of these health inequalities are held at a lower sub regional and local authority, ward and sub ward area level.
- Poor oral health leads to social and financial impacts both for the individual and society as a whole.
- The main oral diseases are preventable through optimising exposure to fluoride, limiting consumption of dietary sugars, practicing good oral hygiene and reducing tobacco and alcohol consumption.
- Focusing solely on individual behavioural change has only short term benefits for oral and general health. It is therefore essential to focus on the wider determinants of health and encourage partnership delivery to achieve sustainable improvements.
- Marmot's review of health inequalities advocated six policy actions to reduce health inequalities. All health improvement partnerships should contribute to this agenda addressing the wider determinants of health.
- Diabetic and cardiovascular clinics to provide oral health information for those groups at greater risk.
- Lifestyle choices such as poor diet, poor oral hygiene practices, tobacco and alcohol use all have impacts on oral health and general health.
- Evidence suggests that healthy behaviours in childhood are more likely to be continued in adulthood, therefore oral health improvement interventions should be targeted at children.

Key issue for consideration

- A common risk factor approach focusing on the wider determinants as well facilitating healthy choices will impact not only on oral health but wider general health.

3 Epidemiology of oral disease

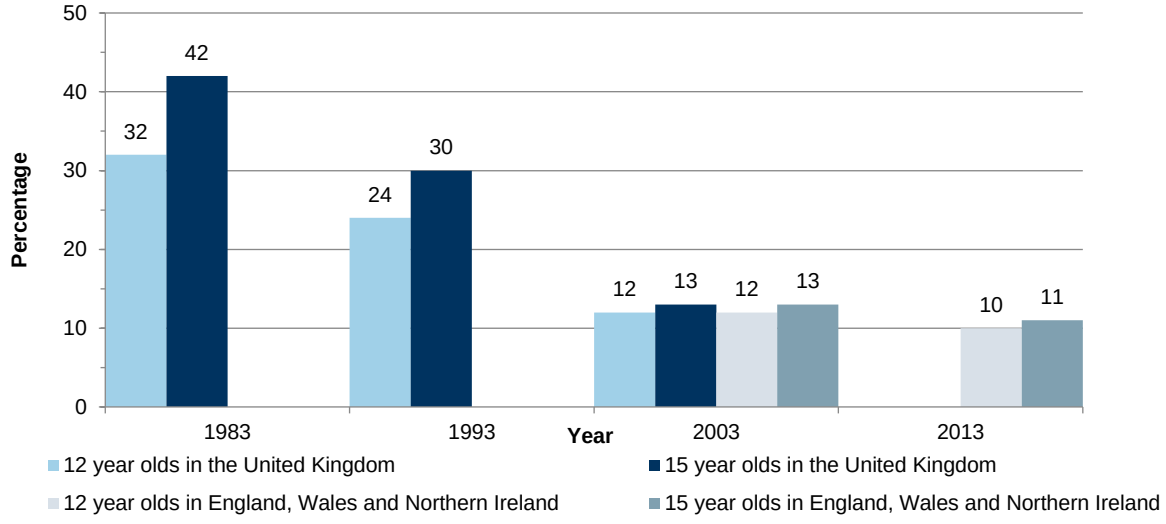
3.1 Nationally there has been a significant improvement in oral health and a decline in tooth decay over the past 40 years. However, a substantial proportion of the population experiences high levels of oral disease, most of which is highly preventable. The main oral diseases and their impacts have been described in Chapter 3. This chapter will describe the common oral diseases in children, adults and vulnerable people using national and local oral health survey data.

Epidemiology of oral diseases in children

3.2 A commonly used indicator of tooth decay and treatment experience, the dmft index, is obtained by calculating the average number of decayed (d), missing due to decay (m) and filled due to decay (f) teeth (t) in a population. In five-year-old children, this score will be for the baby teeth and is recorded in lower case. In 12-year-old children it reports on the adult teeth in upper case (DMFT). As tooth decay in children is highly polarised towards lower socio-economic groups, another useful indicator, dmft>0, demonstrates the proportion of children with obvious tooth decay experience. A further indicator is the proportion of decayed teeth that have been treated by restoration or filling, the Care Index.

3.3 National surveys of the oral health of children have been undertaken on a ten-yearly cycle since 1973. The last national children's survey in 2013 demonstrated a slight but continuing decline in decay experience in the permanent teeth of 12 and 15-year-old children. However, evidence for this in the baby teeth of 5-year-olds was more limited with the improvement seen from 1973 to 1983 having curtailed in this age group.

Chart 8: Percentage of children with any decay excluding visual dentine caries in permanent teeth (United Kingdom 1983-2003; England, Wales and Northern Ireland 2003-2013) Source: H&SCIC 2015



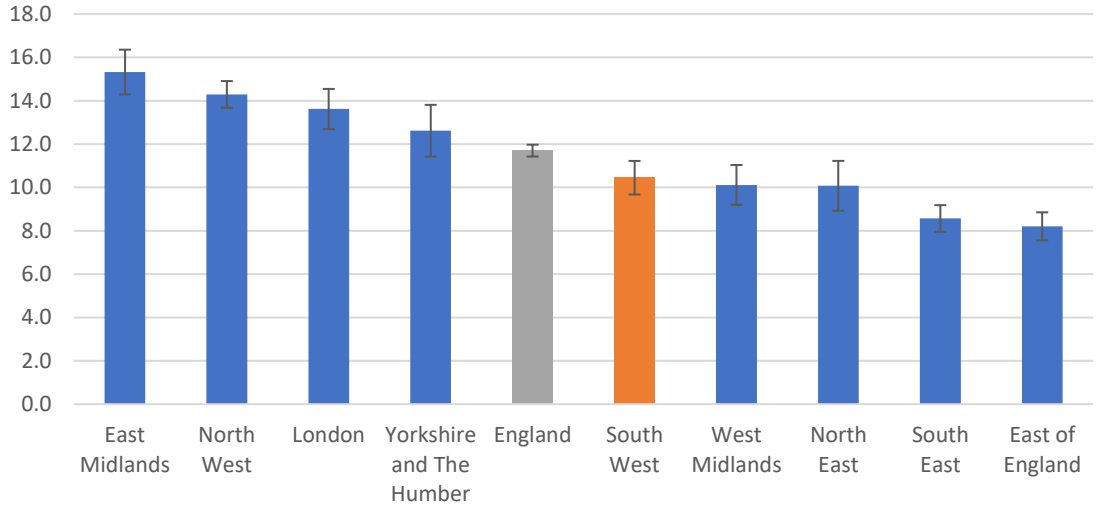
3.4 The same national survey from 2003 also highlighted inequalities by social status in 5-year-old children. Children from the lowest social groups were twice as likely to have tooth decay as children from the highest social group.

3.5 Regular PHE dental epidemiological surveys allow more detailed information at a local level and have provided information on the oral health status of 5, 12 and 14-year-old schoolchildren since 1985. In 2013 a national survey of 3-year-old pre-school children was carried out for the first time.

Tooth decay in three-year-old preschool children

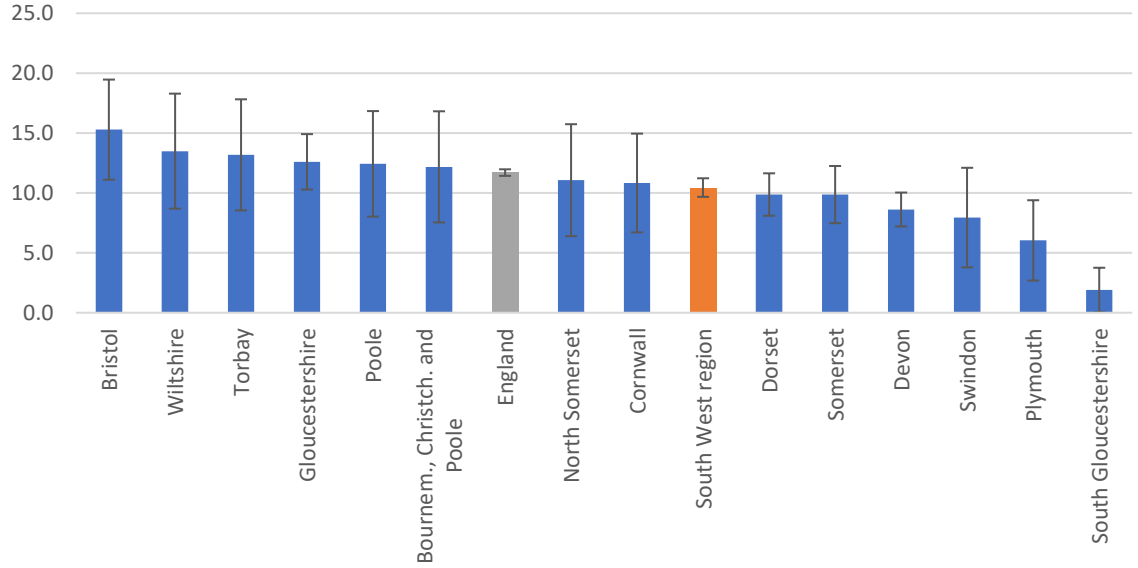
3.6 The 2013 national survey examined 3-year-old children attending private and state funded nurseries and nursery classes attached to schools and play groups. The proportion of 3-year-olds experiencing tooth decay in England was 11.7% and the prevalence in the South West was lower at 10.4%.

Chart 9: Prevalence of tooth decay experience in three-year-old children by area (dmft>0), 2013 Source PHE, 2014



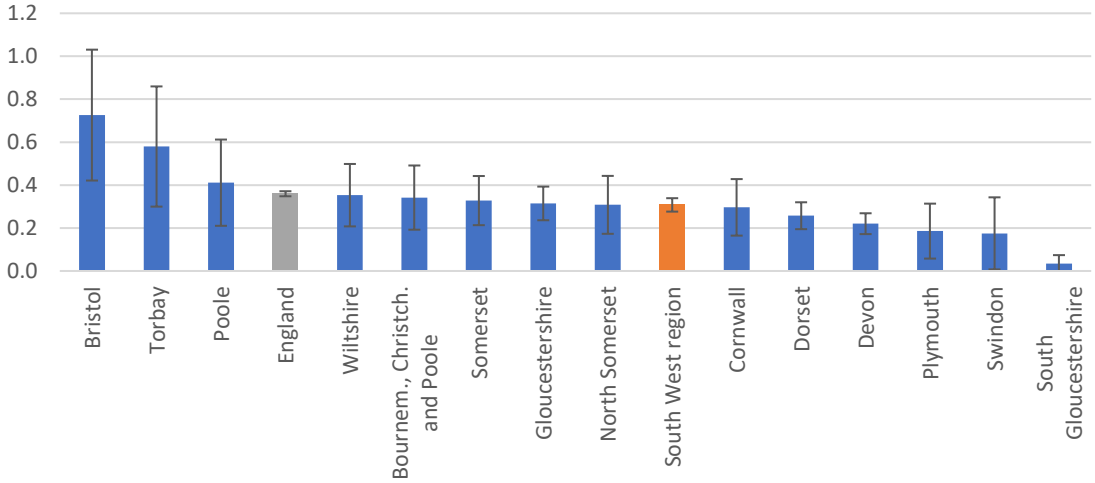
3.7 At local authority level, the proportion of 3-year-olds in the South West who had experienced tooth decay was in general below the national average.

Chart 10: Prevalence of tooth decay in three-year-old children by local authority, 2013 Source: PHE, 2014



3.8 There are some differences in the severity of tooth decay across local authority areas in the South West, but this is further determined by variance in the numbers of children participating.

Chart 11: Severity of tooth decay experience in three-year-old children by local authority, (Mean dmft) 2013 Source: PHE, 2014



3.9 Of the 3-year-old children who had decay, each child had on average three decayed, missing or filled teeth. The numbers of affected children were too low to allow for robust comparison of severity across local authorities. There was a strong association between levels of tooth decay and levels of deprivation. Deprivation explained 19% of the variation in prevalence and 25% of the variation in severity of tooth decay between the highest and the lowest areas. A moderate association was found between prevalence of tooth decay at age 3 and at age 5.

3.10 The data from key weighted measures relating to dental disease taken from the survey results is summarised and compared in the table below.

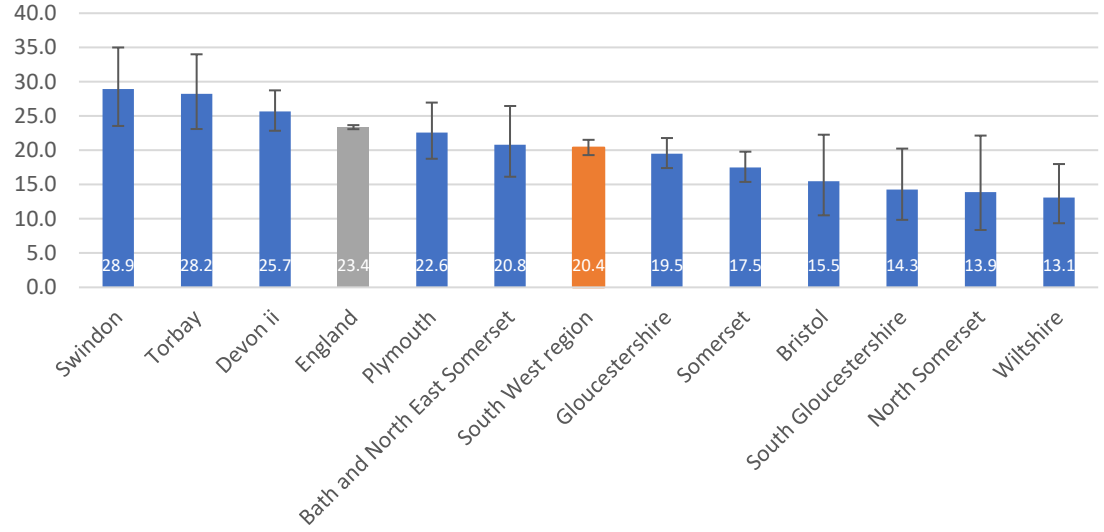
Table 12: South West Dental decay three year old children: Dental Public Health Epidemiology Programme for England, Oral Health Survey of three-year-old children 2013, upper tier local authority (LA)

Upper Tier LA Name	Mean $d_3$mft including incisors	Mean d_3t	Mean mt including incisors	Mean ft	% $d_3$mft > 0 including incisors
England	**0.36**	**0.32**	**0.02**	**0.01**	**11.7**
Bournemouth	0.34	0.34	0.00	0.00	12.2
Bristol, City of	0.73	0.54	0.15	0.04	15.3
Cornwall	0.30	0.19	0.11	0.00	10.8
Devon (data for East Devon, Exeter, Mid Devon, North Devon, South Hams, Teignbridge & Torridge ONLY)	0.22	0.18	0.02	0.02	8.6
Dorset	0.26	0.23	0.02	0.01	9.9
Gloucestershire	0.31	0.30	0.00	0.02	12.6
North Somerset	0.31	0.27	0.01	0.03	11.1
Plymouth	0.19	0.17	0.01	0.00	6.0
Poole	0.41	0.38	0.00	0.03	12.4
Somerset	0.33	0.30	0.01	0.02	9.9
South Gloucestershire	0.03	0.02	0.02	0.00	1.9
Swindon	0.18	0.16	0.01	0.00	7.9
Torbay	0.58	0.50	0.04	0.03	13.2
Wiltshire	0.35	0.33	0.02	0.00	13.5
South West	**0.31**	**0.27**	**0.02**	**0.02**	**10.4**

Tooth decay in five-year-old schoolchildren

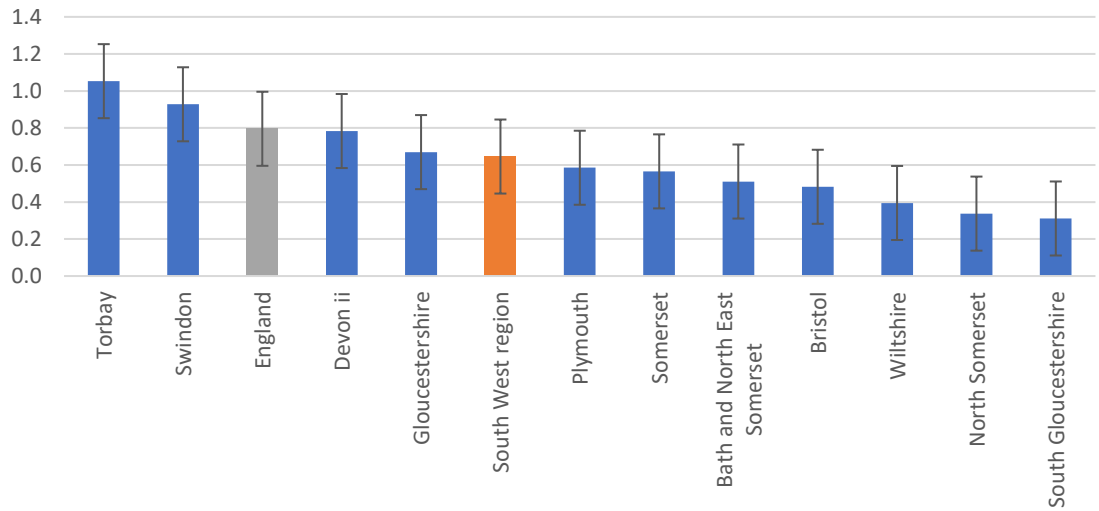
3.11 In 2019, the proportion of 5year-old schoolchildren in the South West with tooth decay (20.4%) was below the national average (23.4%).

Chart 12: Prevalence of tooth decay in five-year-old schoolchildren by local authority, Source PHE 2019



3.12 5-year-old schoolchildren living in Torbay, Swindon and Devon[42] were more likely to experience tooth decay than the average schoolchild in England. Schoolchildren living in Bath and North East Somerset, Bristol, Gloucestershire, Plymouth, Somerset and North Somerset and Wiltshire were less likely to experience tooth decay than the average schoolchild in England[43].

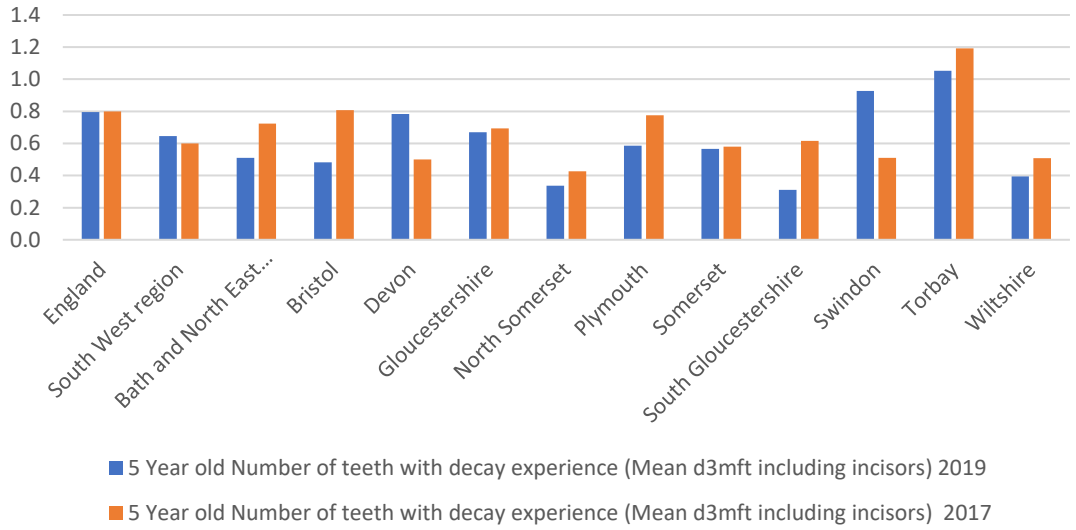
Chart 13: Severity of tooth decay experience in five-year-old schoolchildren, Source PHE 2019



[42] Insufficient numbers examined in East Devon; Mid Devon; West Devon; South Hams; Torridge.
[43] Data excludes Bournemouth, Christchurch and Poole; Cornwall; Dorset; Isles of Scilly.

3.13 Differences in oral health existed at all regions. Children living in Torbay and Swindon had levels of severe tooth decay that were above the English average.

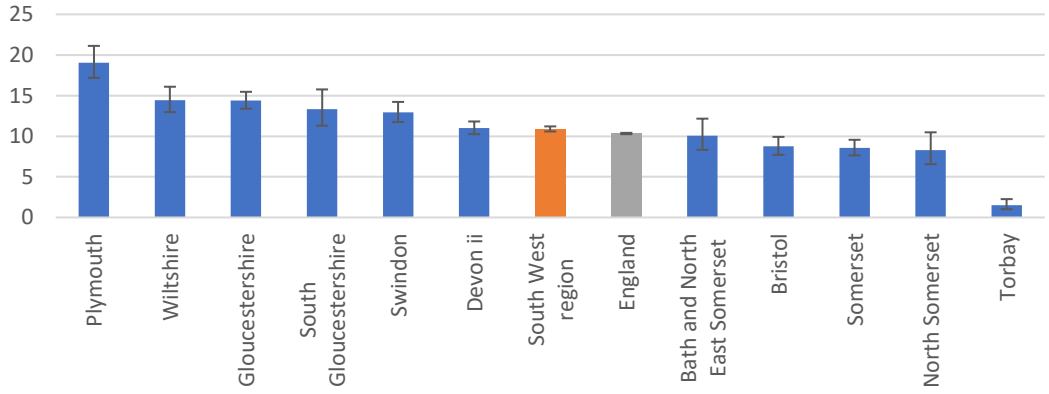
Chart 14: Tooth decay experience in five-year-old schoolchildren in The South West by local authority, 2017 to 2019 compared Source: PHE, 2019



Care Index in five-year-old schoolchildren

3.14 10.9% of children in the South West had their decayed teeth filled - this compares to 10.3% nationally. Children in Gloucestershire, Plymouth, Devon[44], South Gloucestershire, Swindon and Wiltshire had more of their decayed teeth treated with a filling than children at a national and South West level. The localities where children had less decayed teeth treated than the England and South West average were Bath and North East Somerset, Bristol, North Somerset, Somerset and Torbay. NB Data excludes Bournemouth, Christchurch, and Poole; Cornwall; Dorset; Isles of Scilly.

Chart 15: The Care Index in five-year-old schoolchildren, 2019 Source PHE 2019



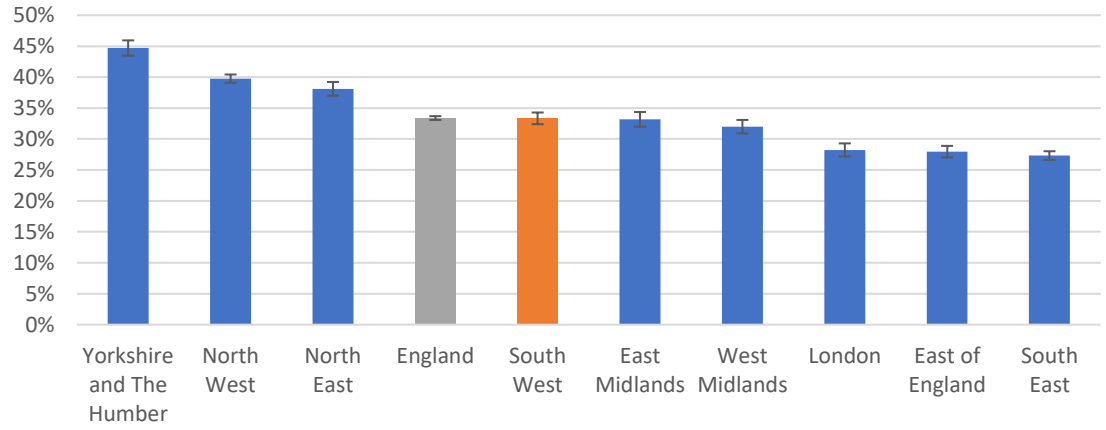
[44] Insufficient numbers examined in East Devon; Mid Devon; West Devon; South Hams; Torridge.

Tooth decay in 12-year-old schoolchildren

3.15 The most recent Oral Health Survey of 12-year-old children as part of the National Dental Epidemiology Programme was carried out in 2008-2009.

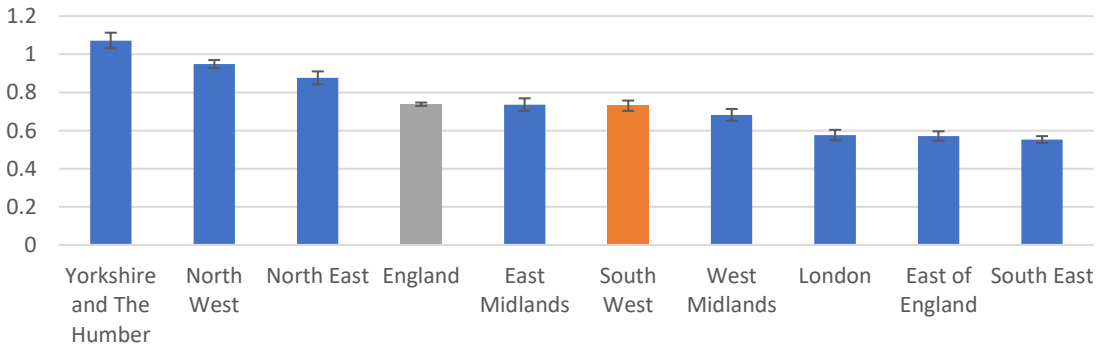
3.16 In 2008/2009 the prevalence of decay in 12-year-old schoolchildren in the South West was marginally lower than nationally. The proportion of 12-year-old schoolchildren in all South West local authorities with experience of tooth decay was 33.3%. The prevalence in the region ranged from 45.6% in Teignbridge to 22.2% in Cotswold.

Chart 16: Prevalence of tooth decay in 12-year-old schoolchildren by region, 2008/09 Source: PHE, 2012



3.17 The average number of those having experienced tooth decay ranged from 1.18 in West Somerset to 0.30 in Cheltenham, demonstrating clear disparities in oral health outcomes across local authority areas.

Chart 17: Severity of tooth decay experience in 12-year-old schoolchildren, 2008/09 Source: PHE, 2012



Inequalities in oral health of 12-year-old schoolchildren

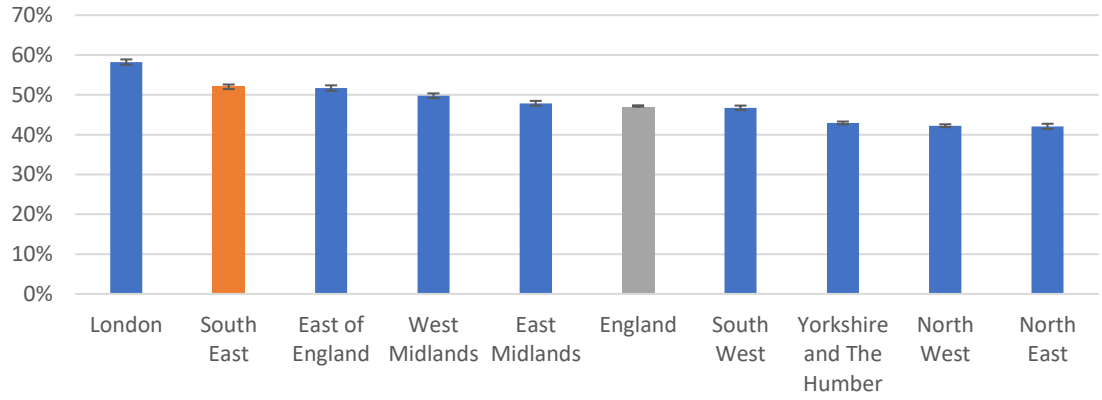
3.18 As for 12-year-old schoolchildren, there was significant disparity in the prevalence and severity of tooth decay, demonstrating that severe tooth decay is experienced

by a small proportion of children (chart above). Children living in more deprived areas were more likely to experience tooth decay and have higher levels of disease.

Care Index in 12-year-old schoolchildren

3.19 The Care Index in the South West (47%) in 2008/2009 was consistent with the national average (47%) amongst 12-year-old schoolchildren. There was a variety of Care Index % scores ranging from 29% in Wiltshire to 60% in South Somerset. Even so, the averages showed that 47% of the decayed permanent teeth had not been filled.

Chart 18: Care Index 12-year-old schoolchildren, 2008/09 Source PHE 2012



Oral hygiene

3.20 The 2008/2009 survey of 12-year-old schoolchildren showed less children (8.8%) in the South West had substantial levels of plaque compared to England (10.5%). 74% of 12-year-old schoolchildren brushed their teeth twice a day in the South West compared to 72.9% in England.

Oral health and child weight

3.21 PHE report: The relationship between dental caries and body mass index[45] reported that children who are very overweight had a higher prevalence of dental caries than children with a healthy weight. There was also a suggestion of a bimodal relationship between weight and prevalence of dental caries with both children who

45 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/844121/BMI_dental_caries.pdf

were overweight and children who were underweight more frequently experiencing the disease.

Dental conditions impacting on child quality of life

3.22 12-year-old schoolchildren in the 2008/2009 BASCD survey were also asked about the impact of oral diseases on their quality of life. Children in the South West were more likely to report problems with speaking, smiling and socialising due to dental problems relative to children in England.

Table 13: Oral health impacts in 12-year-old schoolchildren, 2008/09 Area source BASCD 2011

Region	Eating	Speaking	Cleaning Teeth	Relaxing incl sleeping	Feelings	Smiling/ laughing	School work	Mixing with friends/other people
South West N=4.227	33.1%	5.2%	26.7%	8.9%	14.6%	14.4%	4.1%	4.8%
England N=38,723	34.2%	4.7%	28.1%	7.9%	13.4%	11.7%	3.5%	4.0%

Cleft lip and palate

3.23 Cleft lip and palate is the most common facial birth defect in the UK. One in every 700 babies is born with a cleft. Approximately half of all affected babies are born with a cleft lip and palate, a third with a cleft palate only and 1 in 10 have a cleft lip only or a submucous cleft. A cleft lip or combined cleft lip and palate are more common in boys, but a cleft palate on its own is more common in girls. Clefts occur more frequently in East Asian people and less frequently amongst black people.

Summary of children's oral health

- The prevalence and severity of tooth decay in 3-year-old children in the South West is below national averages.
- 5 and 12-year-old schoolchildren in the South West are less likely to have experienced tooth decay and have less decayed teeth than the same cohorts nationally.
- 5-year-old schoolchildren living in Torbay, Swindon and Devon[46] were more likely to experience tooth decay than the average schoolchild in England.
- Children living in Torbay and Swindon had levels of severe tooth decay above the English average; all other areas were below the English average.
- There are inequalities in levels of tooth decay between and within local authorities in the South West.
- Children in deprived areas experience much greater levels of disease than those residing in more affluent areas.
- 5-year-old schoolchildren in Bath and North East Somerset, Bristol, North Somerset, Plymouth, Somerset, South Gloucestershire, and Wiltshire presented levels of decayed teeth below the average levels of the South West.

[46] Insufficient numbers examined in East Devon; Mid Devon; West Devon; South Hams; Torridge.

- 12-year-old schoolchildren in Bath and North East Somerset, Cheltenham, Christchurch, Cotswold, East Devon, East Dorset, Forest of Dean, Gloucester, Mendip, North Devon, North Dorset, North Somerset, Poole, South Gloucestershire, South Somerset, Stroud, Swindon, Tewkesbury, Torridge and West Dorset were below the average level of decayed teeth in the South West.
- Children who were very overweight had a higher prevalence of dental caries than children with healthy weight.
- Approximately 44,000[47] children in the South West each year are likely to benefit from orthodontic care.
- Approximately 1 in 700 children are born in the South West each year with a cleft lip and/or palate.

Oral Health of Adults

3.24 Information on the oral health of adults has been collected nationally by the Office for National Statistics, who have coordinated socio-dental surveys on a decennial basis since 1968. The survey consists of an interview schedule and a dental examination performed by trained and calibrated dental examiners. The most recent full survey was undertaken in 2009. Although it has its limitations, we have supplemented this with the data from the 2018 Adults in Practice surveys. However, in this survey the data collated for the South West does not include Bournemouth; Cornwall (including Isles of Scilly); Dorset; Plymouth; Poole; South Gloucestershire. Therefore, there are significant gaps in this survey's profile for the South West.

Number of teeth

3.25 In the 2009 national decennial survey, only 6% of adults in England were found to be edentate (having no natural teeth) with this figure being the same in the South West. Edentulousness increases with age and varies by gender (4% male, 7% female) and material deprivation (managerial/professional 2%, intermediate 4% and 10% routine/manual workers). There has been a profound overall decline in edentulousness over the last five decades, with the proportion of edentate adults falling from 37% in 1968 to 6% in 2009. Trends from national and local surveys show that edentulousness is now uncommon amongst people over 65 years of age and even half of the older population that is 85 and over have retained some natural teeth. This data has important future implications. Although it suggests good oral function, there are carries service implications related to the continued maintenance and advanced restorative needs of older adults who are likely to be increasingly frail with complex medical histories and difficulties in accessing care.

[47] 2019-2020 orthodontic patient count NHSBSA Information Services eDEN System Report

Tooth decay

3.26 Between 1998 and 2009 the prevalence of active tooth decay in England fell from 46% to 30%. There were reductions across all age groups, but the largest reduction was amongst those aged 25 to 34 years. The proportion with active tooth decay varied by age with those aged 25 to 34 years having the highest prevalence (36%) and those aged 65-74 years having the lowest (22%).

3.27 Men were more likely than women to have untreated decay as were those from socially deprived households. The average number of decayed teeth in adults in England was 0.8. Men experienced higher levels of tooth decay (1.0) than women (0.6). As adults age the accumulated effects of gum disease may cause exposure of root surfaces, therefore with age the prevalence of decay on the root surface is likely to increase. 7% of adults in England had active decay on one or more root surface, the proportion increasing with age (20% in 75-84 years). as well as being male and experiencing social deprivation[48].

3.28 The 2018 Adults in Practice survey showed that 26.8% of people in England had active tooth decay (DT>0). 31.5% of adults from those practices that engaged and responded to the survey in the South West[49] had active tooth decay. The average number of decayed teeth in England was 2.1 and in the South West it was 2.0.

Gum disease

3.29 Periodontal disease is a complex inflammatory disease that affects the periodontal structures including the gingiva, cementum, periodontal ligament and alveolar bone. Given the ageing population in the UK, with patients retaining teeth for longer, in the future, the prevalence of periodontitis in the UK is likely to increase. Oral healthcare practitioners are in a unique position to influence not only the oral but also the general health of our patients.

3.30 Gum disease is a major public health concern and in its severe form affects approximately 10.8% or 743 million people aged 15–99 worldwide. Trends such as the rise of smoking in developing countries, the obesity and diabetes epidemic, coupled with an ageing population with greater tooth retention, are all likely to increase the burden of periodontitis even further in the UK and worldwide.

3.31 A healthy periodontium is an essential foundation for natural dentition and for successful restorative dentistry. This is becoming increasingly important given the ageing population. Effects of periodontitis within the mouth include tooth loss, pain,

[48] NHS Information Centre. Adult dental health survey 2009. The Health and Social Care Information Centre; 2011
[49] Excludes Bournemouth; Cornwall (including Isles of Scilly); Dorset; Plymouth; Poole; South Gloucestershire

halitosis, aesthetic compromise and reduced masticatory ability, all of which impact negatively upon self-confidence and quality of life.

3.32 Beyond the mouth, periodontitis is significantly and independently linked with chronic inflammatory non-communicable diseases associated with ageing, including cardiovascular disease, diabetes mellitus, rheumatoid arthritis and chronic kidney disease.

3.33 In 2009, 50% of dentate adults in England had periodontal pocketing and loss of attachment (LoA) of 4mm or more. Since 1998, there has been an overall reduction in the prevalence of pocketing of 4mm or more from 55% to 45% signifying an overall reduction in disease. However, for more severe forms of disease an overall increase from 6% to 9% was observed. Proportionately more South Western adults had periodontal diseases relative to the national average as 65% had pocketing of 4mm or more. The 2018 survey assessed the percentage of adults with gingival (gum) bleeding on probing, which in England was 52.9%, however in the South West it was 69.2%

Table 14: Periodontal condition by characteristics of dentate adults Adult Dental Health Survey 2009 (%)

Periodontal condition by characteristics of dentate adults	Any bleeding	Any pocketing 4mm or more	Any pocketing 6mm or more	Any pocketing 9mm or more	*Unweighted Base*	*Weighted Base (000s)*
North East	61	43	12	2	*570*	*1,915*
North West	51	43	7	1	*590*	*5,200*
Yorkshire & The Humber	62	42	10	2	*500*	*3,907*
East Midlands	60	44	8	1	*710*	*3,377*
West Midlands	61	53	10	2	*490*	*3,967*
East of England	32	32	5	1	*650*	*4,434*
London	49	46	10	1	*400*	*6,016*
South East Coast	52	49	9	1	*450*	*3,314*
South Central	64	39	6	1	*610*	*3,194*
South West	57	59	11	2	*660*	*4,005*
England	54	45	9	1	*5,610*	*39,329*

Tooth wear

3.34 The prevalence of tooth wear is reported at three thresholds: any wear, wear that has exposed a large area of dentine on any surface (moderate wear) and wear that has exposed the pulp or secondary dentine (severe wear). The 2009 Adult Dental Health Survey reported more prevalent tooth wear in England from 66% in 1998 to 75%. However, only 15% had moderate and 1% severe wear. Men experienced greater levels of wear than women, however, there were no significant differences with respect to deprivation. In the South West, the prevalence of tooth wear was 82%, 10% moderate and 2% severe wear.

Urgent conditions

3.35 Urgent conditions include dental pain, open dental pulps, oral sepsis (infection) and untreated teeth with extensive tooth decay. In the 2009 Adult Dental Health Survey, 9% of dentate adults reported current dental pain. Older adults and those from routine and manual occupation households were more likely to report pain. Across England 8% of dentate adults reported experiencing oral pain fairly or very often in the previous 12 months. This was 11% in the South West. Women were slightly more likely than men to report this pain.

3.36 Adults had an increased likelihood of both pain and extensive tooth decay or sepsis if they did not attend a dentist for regular check-ups, rarely brushed their teeth or brushed less than once a day, were smokers or had high levels of dental anxiety. In the 2018 Adults in Practice Survey the percentage of patients with an urgent care treatment need in England was 4.9% and in the South West it was 8.2% - the highest in any region.

Levels of restorative care

3.37 This section describes levels of commonly delivered dental treatments reported in the 2009 Adult Dental Health Survey.

Fillings and Crowns

3.38 Fillings and crowns[50] are placed on teeth as a form of treatment after dental disease in an attempt to remove the disease and restore the tooth to normal function. Nationally, the average number of restored teeth fell from 8.1 in 1978 to 6.7 in 2009. However, in 2009, 85% of dentate people had restored teeth, either with a filling or a crown, out of which 26% needed some form of further treatment due to secondary disease or the restoration failing. Most fillings were for people aged 45-54 years, with restorations less common in those under 45 years of age. The mean number of fillings (crown and root surfaces) of dentate adults in England was 7.2 and in the South West it was 7.7.

Dentures

3.39 People wear dentures to replace some or all of their missing teeth. Thus with the decline in the number of people losing all their teeth, fewer people are wearing full dentures, although more may wear partial dentures replacing some missing teeth. In 2009, 19% of people in England wore a denture compared to 21% in the South West. Women were more likely than men to wear a denture, 21% and 17% respectively in England. Also, people in routine and manual jobs were more likely to wear a denture (27%) than people in professional and managerial jobs (17%).

[50] https://www.nhs.uk/common-health-questions/dental-health/what-are-nhs-fillings-and-crowns-made-of/

Dental bridges

3.40 Dental bridges provide an often-preferable alternative to dentures, if the space to be filled is small enough and the surrounding teeth are in reasonable condition. In both England and the South West this figure was 9%. Women were more likely to have a dental bridge than men, 8% and 7% respectively. Those in intermediate jobs were most likely to have a bridge (9%), whilst the prevalence was 8% amongst those in professional and managerial jobs and 7% in those with routine and manual jobs.

Dental implants

3.41 Dental implants are screws made mostly of titanium placed into the jaws to support a crown or a denture. They are an increasingly mainstream part of dental care but are not routinely available on the NHS. In the South West, 1% of the population had dental implants with the prevalence being equal amongst men and women. However, those with intermediate and routine manual jobs were twice as likely to have implants as those with professional and managerial jobs.

Mouth cancer

3.42 Mouth cancers make up 2% of all new cancers in the UK[51]. Historically, mouth cancer has been twice as common in men than women, with cancer incidence also increasing with age. In the UK, the majority of mouth cancers (88%) occur in people aged 50 or over, however mouth cancer is increasingly being seen in younger age groups and recently rates have increased from approximately 5,000 cases per year in the UK to more than 7,000. This has been attributed to HPV transmissions and increased excessive alcohol consumption and smoking amongst women. The risk of developing mouth cancer is greater in people living in areas of deprivation. This may be because people living in more deprived areas are more likely to smoke and have excessive alcohol consumption.

Mouth cancer rates

3.43 Statistic produced by Cancer Research UK (2018) show that mouth cancer now accounts for just over 2% of all cancers, and that mouth cancer is now the 14th most common cancer in the UK[52]. A report by the Oral Health Foundation (2019) indicated that the number of people diagnosed with mouth cancer in the UK continues to increase with the latest figures showing that more than 8,300 people in the UK are diagnosed with mouth cancer each year. The lifetime risk of mouth cancer currently stands at 1-in-75 for men and 1-in-150 for women.

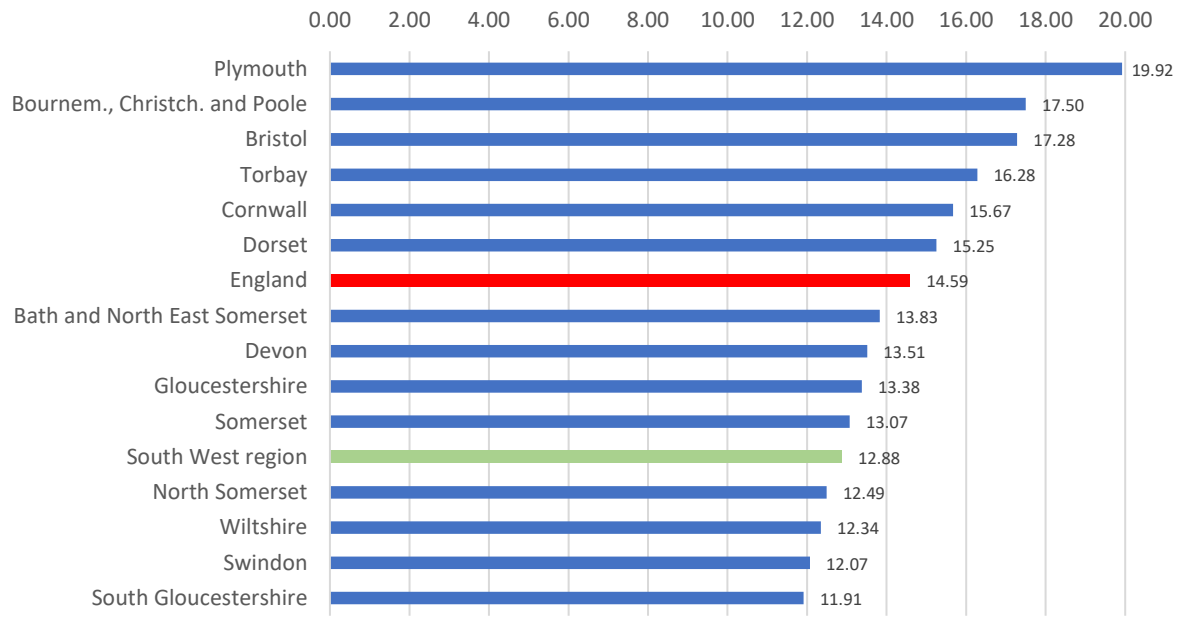
[51] State of mouth Cancer UK Report 2018-2019 https://www.dentalhealth.org/Handlers/Download.ashx?IDMF=21dc592b-d4e7-4fb2-98a9-50f06bed71aa

[52] Head and neck cancers incidence statistics Cancer Research UK (2018)

3.44 The Oral Health Foundation further reports that men are more likely to have mouth cancer than women. More than two-thirds (67%) of all mouth cancer patients are male. Mouth cancer is also strongly related to age. More than 78% of new cases are in those over the age of 55. Living in areas of deprivation is also believed to significantly increase the risk of being diagnosed with mouth cancer. In England, mouth cancer rates increase by 135% for men living in the most deprived areas. For women, the increase is 45%.[53]

3.45 The chart below presents the age-standardised rate for the diagnosis of mouth cancer in people of all ages, per 100,000 in the South West. Mouth cancer rates in the South West are 14.9 per 100,000 – lower in comparison to England (at a rate of 15.0 per 100,000). The highest rates of mouth cancer are in Plymouth (18.6) and Torbay (17.7) whilst the lowest are in South Gloucestershire (11.6) and Wiltshire (12.8).[54] [55]

Chart 19: Oral Cancer registrations in all people, per 100,000 In South West Source PHE Fingertips 2016-18



Mildly dependent older people

3.46 There is an increasing trend towards an ageing population in the UK[56]. Several surveys of older people living in residential and nursing care homes have been undertaken as well as surveys of providers of services for this population. Much can be learned from these responses. However, a far greater proportion of older people

[53] State of Mouth Cancer UK Report 2018-19 Oral Health Foundation (2019)
[54] Oral Cancer Registrations 2016-18, PHE Fingertips
[55] https://www.gov.uk/government/publications/oral-cancer-in-england
[56] https://www.gov.uk/government/publications/oral-health-survey-of-mildly-dependent-older-people-2016

live alone or with family, in their own homes, therefore their oral health needs are unknown. A survey of mildly dependent older people was undertaken in 2015/2016

3.47 Older adults living in supported housing are likely to become more dependent as they age. NHSE&I may wish to encourage interventions to improve their oral health that will avoid more complex problems in the future. Programmes should address a range of issues including improving home care (oral hygiene and diet), awareness of the need for regular dental check-ups, including for those with no natural teeth, awareness of the links between good oral health and general health and promoting better understanding of how to access dental care. Older people with mild dependency who retain their teeth are likely to have heavily restored dentitions and an aspiration to retain these for life. The majority of treatment need identified was for prevention and simple restorative care. NHSE&I together with local authority partners should consider how to increase delivery of preventive care for older people.

Summary of adults' oral health

- The oral health of adults has improved significantly over the last 40 years with more people retaining their natural teeth throughout life.
- In the South West 31.5% of adults had tooth decay and 59% mild gum disease (pocketing 4mm or more) compared to England at 45%. 11% had moderate gum disease compared to 9% in England.
- The percentage of adults with gingival (gum) bleeding on probing, in England was 52.9% and in the South West it was 69.2%.
- The mean number of decayed teeth was higher in the South West (1.1) than England (0.8).
- Men from materially deprived backgrounds were more likely to experience higher levels of tooth decay and gum diseases but least likely to visit a dentist.
- The South West has a higher percentage of dentate adults reporting experiences of oral pain in the previous 12 months fairly or very often.
- The South West's prevalence of tooth wear was 82% (77% England), 10% had moderate (15% England) and 2% severe wear (2% England).
- People in the South West were more likely to wear a denture than nationally.
- The incidence of mouth cancer in Plymouth, Bournemouth, Christchurch and Poole, Bristol, Torbay, Cornwall and Dorset is higher than the national average.

Oral Health of Vulnerable Groups

3.48 Vulnerable groups are those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or presents

challenges for them in accessing dental services. It is not possible to provide a comprehensive list of all these groups, but they include people that:

- Are older and frail
- Have physical or mental disabilities
- Are homeless or frequently move, such as traveler communities
- Have mental health problems
- Are socially isolated or excluded
- From some black, Asian and minority ethnic groups for example, people of South Asian origin
- Have a poor diet
- Are, or who have been, in care
- Smoke or misuse substances, including alcohol
- Have dental anxiety or dental phobia
- Are medically compromised
- Live in a disadvantaged area
- Are from a lower socioeconomic group.

3.49 These groups often require additional support or treatment in a special setting to accommodate their needs. Epidemiological studies such as the ten yearly national dental health surveys of children and adults and the annual children's dental health surveys have not routinely gathered information from children and adults with special care needs[57].

Older people

3.50 The UK population is ageing. Between 2017 and 2040 the population of people aged over 65 is projected to increase by 49%. The numbers of people aged over 85 – the group most likely to need health and care services – is projected to rise even more rapidly, nearly doubling from 1.4 to 2.7 million over the same period.[58]

3.51 More specifically during the next 8 years to 2028, the South West population of people aged over 65 will increase by 20% (circa 255,800 people). This will impact on the amount of adults in nursing homes, the number of patients with dementia and the oral health needs for many in domiciliary care.

Adults in nursing homes

3.52 The care home resident population for those aged 65 and over has remained almost stable since 2001 with an increase of 0.3%, despite growth of 11.0% in the overall population at this age. The resident care home population is also ageing.

[57] https://www.gov.uk/government/statistics/oral-health-of-5-and-12-year-old-children-attending-special-support-schools-in-england-2014
https://www.gov.uk/government/publications/oral-health-surveys-of-adult-subgroups
[58] Briefing: Health and Care of Older People in England (2019) Age UK

The proportion of the older care home population aged 85 and over rose from 56.5% in 2001 to 59.2% in 2011. Data from the 2011 Census is set out below.

Table 15: Care home population aged 65 years and over by age group in England and Wales, 2011
Source: Office for National Statistics, 2011 Census

Age	Care home residents	
	(n)	(%)
65-74	31,000	10.5
75-85	88,000	30.3
85 and over	172,000	59.2
Total 65 and over	291,000	100

3.53 According to Laing and Buisson approximately 418,000 people live in care homes in the UK (Laing-Buisson, survey 2016). At the time of this report, this represented 4% of the total population aged 65 years and over, rising to 15% of those aged 85 or more.[59]

3.54 Of the estimated 418,000 adults living in care homes in the UK, more than half have tooth decay compared with 40% of over 75s and 33% of over 85s who do not live at a care home. Care home residents are more likely to have fewer natural teeth, and those with teeth are less likely to have enough teeth to eat comfortably and socialise without embarrassment.[60]

3.55 There is emerging evidence from recent Healthwatch[61] and CQC[62] reports that people living in care homes have a large amount of unmet oral health need. The CGC inspection of 100 care homes found:

- Most had no policy to promote and protect residents' oral health (52%)
- Nearly half were not training staff to support daily oral healthcare (47%)
- 73% of care plans reviewed only partly covered or did not cover oral health
- It could be difficult for residents to access dental care
- 10% of homes had no way to access emergency dental treatment for residents.

3.56 The Special Care and Paediatric Dentistry South West Needs Assessment (2020) report highlighted that routine domiciliary care is provided differently across the South West. Across the South West region this type of care is provided by the Community Dental Service, apart from Devon, Cornwall and the Isles of Scilly where there are separate contracting arrangements.

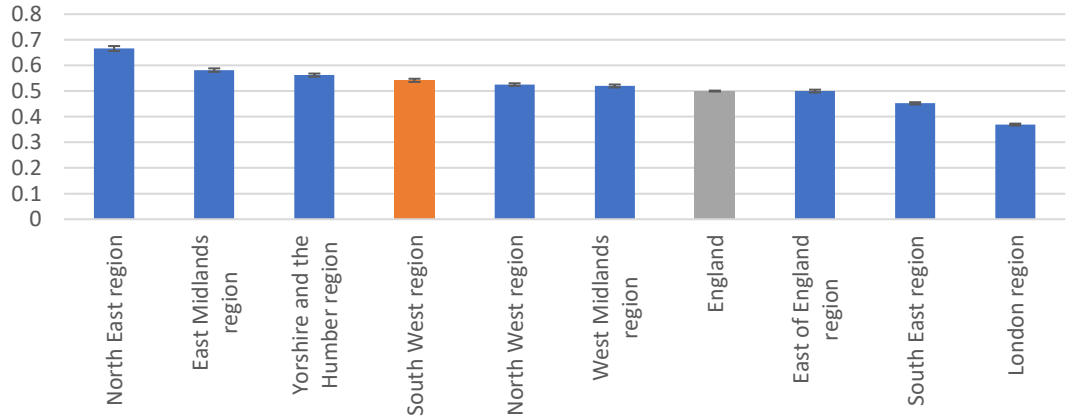
[59] Statistics about older people in the UK, MHA Facts & Stats
[60] Oral Health & Dementia, PHE 2016
[61] Oral Health in Care Homes, Healthwatch Brighton and Hove (2019)
[62] Smiling Matters, Oral Health Care in Care Homes, CQC (2019)

People with learning disabilities

3.57 Both children and adults who have a learning disability experience more oral disease and have fewer teeth than the general population[63]. They also have more unmet dental needs as they experience more difficulty in accessing dental care.[64] 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.[65]

3.58 There is a national and local increase in the number of children and adults with learning disabilities. However, this may be due to improvements in reporting. The NHS Quality and Outcomes Framework (QOF) prevalence of people of all ages with a learning disability shows that 0.50% of all patients are recorded as having a learning disability on the GP QOF register across England. The rate across the South West is slightly higher at 0.54%.[66] The percentage of people recorded with a learning disability on the QOF register is highest in Plymouth and Torbay (0.70% and 0.69% respectively).

Chart 20: QOF Prevalence of Learning Disabilities (all ages), 2018-19 Source: PHE

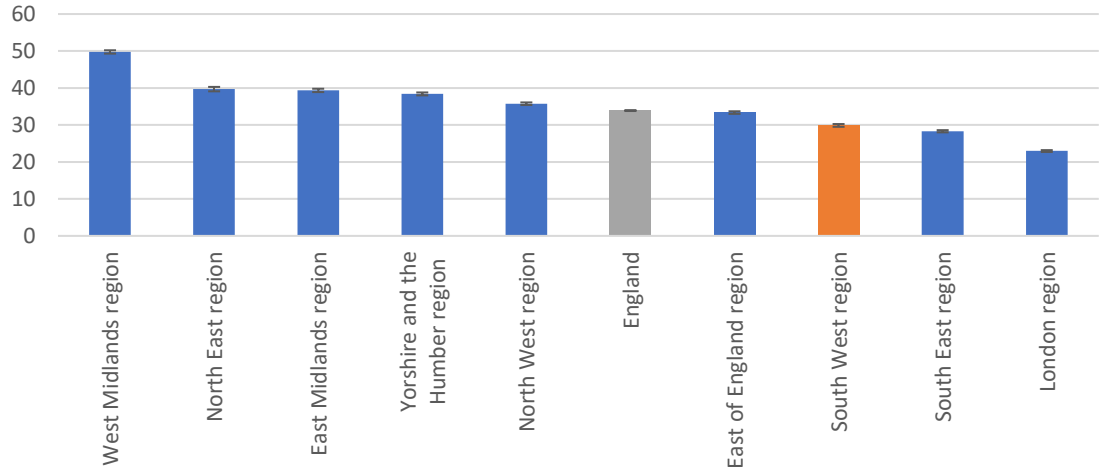


3.59 The 2014-2015 prevalence of children with a learning disability in England was 33.9 per 1,000 children known to schools. Information for this indicator is reported by schools through their school census. It is based on those children attending primary, secondary and special schools and includes all those children that have a school action plan or a statement of need. Learning disabilities may be moderate, severe, profound or multiple. The following figures are not based on a medical

[63] Waldman HG, Perlman SP. Dental care for individuals with developmental disabilities is expensive, but needed. J Calif Dent Assoc. 2002 Jun; 30(6): 427-32.
[64] Glassman P, Miller CE. Preventing dental disease for people with special needs: the need for practical preventive protocols for use in community settings. Spec Care Dentist. 2003 Sep-Oct; 23(5):165-7.
[65] Tiller S, Wilson KI, Gallagher JE. Oral health status and dental service use of adults with learning disabilities living in residential institutions and in the community. Community Dent Health. 2001 Sep;18(3):167-71.
[66] Learning Disabilities (all aged), QOF prevalence, PHE (2018-19) Note - in 2014/15 this changed from only reporting 18+ to all ages

diagnosis and some children may travel to schools outside their area of residence. The South West has proportionately fewer children with learning disabilities than England (at a rate of 29.9 per 1,000 children).[67] The rate of children with disabilities is higher in Gloucestershire (51.9 per 1,000 children) and Swindon (35.9 per 1,000 children) compared to the rate across England and the South West.

Chart 21: Children with learning disabilities known to schools, 2014-15 Source: PHE 2018



3.60 The successful prevention of periodontal disease in patients with learning disabilities relies on the removal of plaques and soft plaque biofilms along with appropriate recall intervals. Effective care and treatment will include resourcing non-direct clinical time, e.g. to encourage service access, including acclimatization visits and use of resources such as 'social stories', family/informal carer/advocacy liaison, and enhanced/assertive communications prior to and following patient appointments in response to individual needs.

3.61 Children with additional needs, such as learning disabilities have similar tooth decay experience but are more likely to have their teeth extracted than their peers. Children with additional needs are more likely to have poorer gum health.[68] [69] Adults with learning disabilities are excluded from national surveys of oral health, therefore there is no national data on the oral health needs of this population.

Homeless people

3.62 Homeless people are a diverse group comprising of those living without a roof over their head and those living in temporary accommodation. Most research has focused on the needs of single men, especially rough sleepers. There is no

[67] Prevalence of Children with Learning Disabilities known to schools, PHE (2018)
[68] Nunn J, Murray J. The dental health of handicapped children in Newcastle and Northumberland. British Dental Journal. 1987 162:9-14
[69] Evans D, Greening S, French A. A Study of dental health of children and young adults attending special schools in South Glamorgan. International Journal of Paediatric Dentistry.1991;1:17-24.

information regarding health problems relating to subgroups such as families with children. Many of the studies conducted have used convenience samples and as so the data may not be representative.

3.63 Evidence suggests that homeless people experience significant levels of health inequalities. Life expectancy in this population is on average 30 years shorter than the national average. The average homeless person has a life expectancy of 47 years compared to 77 for the general population. The life expectancy for women is even lower, at just 43 years[70].

Table 16: Homelessness in England[71]

Total people recorded as homeless as at Q1 2018: Regional	Number of people living in TA	Number of people rough sleeping	Total homeless people	Total people ONS 2017	Homeless rate per 100,000
South East	24,615	1,119	29,591	9.1M	307
South West	7,530	580	10,653	5.6M	522
East	17,166	615	20,135	6.2M	306
East Midlands	5,005	313	7,285	4.8M	655
West Midlands	21,076	295	23,800	5.9M	246
Yorkshire and Humberside	3,015	207	5,664	5.5M	962
North East	920	51	2,273	2.6M	1,163
North West	7,495	434	10,665	7.3M	681
London	164,220	434	167,853	8.8M	53
England	252,850	4,751	276,925	55.6M	201

3.64 The expressed and normative dental needs and attitudes of 70 homeless people living in hostels in Birmingham were examined in 2000.[72] Treatment needs were high. Of those who were edentulous, 68% did not wear dentures. There were also high levels of tooth decay within this sample - the average number of decayed teeth was 15.9. Most participants had one or more teeth with pulpal involvement and half had mobile teeth. This supports findings from earlier studies reporting a high level of normative but low levels of perceived need amongst homeless groups.[73]

3.65 Regarding the main oral health messages, homeless people have difficulty in complying, as healthy eating is a virtual impossibility with meals consisting of cheap snacks that are usually high in sugar and fats. Additionally oral hygiene, and more

[70] Thomas B. Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England 2012 [Available from: https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf.
[71] Shelter; Homelessness in Great Britain – the numbers behind the story 2018
[72] Waplington J, Morris J, Bradock G. 2000. Community Dental Health. The dental needs, demands and attitudes of a group of homeless people with mental health problems;17(3):134-7
[73] Blackmore T, Williams S, Prendergast M, Pope J. The dental health of single male hostel dwellers in Leeds. Community Dental Health. 1995;12:104-9. 84. Daly B, Newton T, Batchelor P and Jones K Oral health care needs and oral health related quality of life (OHIP 14) in homeless people. Community Dentistry & Oral Epidemiology. 2010;38(2):136-44.

specifically plaque control, can be difficult in a homeless setting and the cost of a toothbrush and fluoride toothpaste means that they are often viewed as luxuries rather than essentials. Erratic dental attendance further contributes to poor oral health and increases its impact on the quality of life of homeless people[74,75].

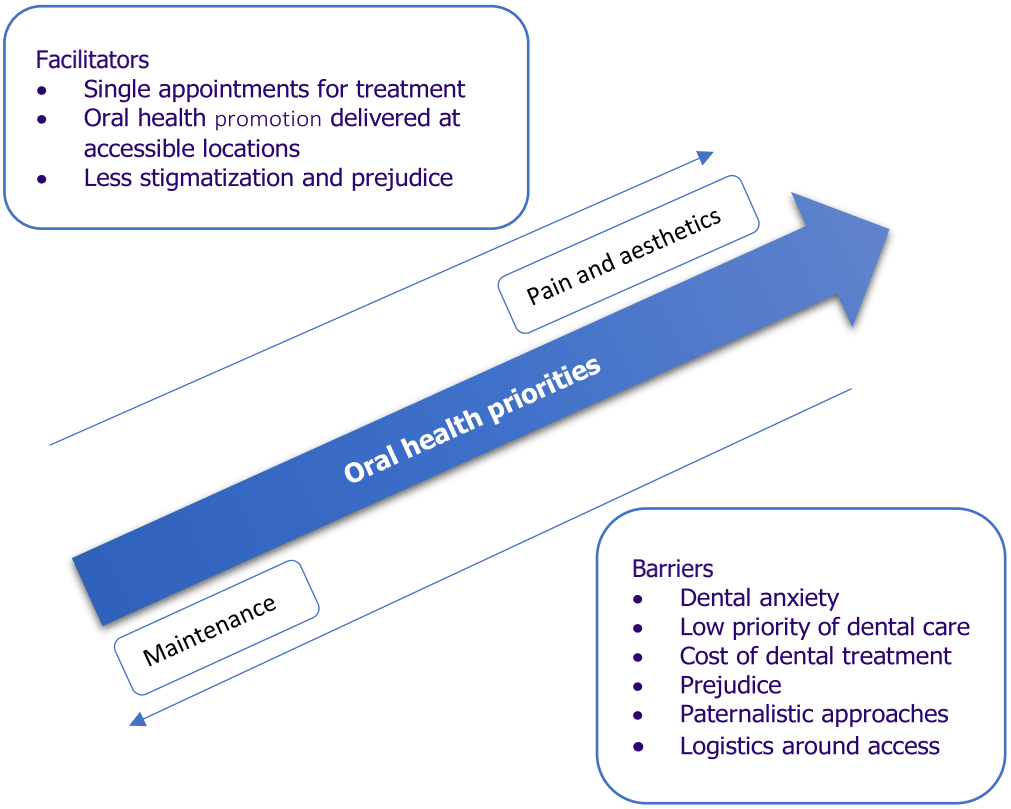
3.66 A recent study conducted by Leeds University has found that the main barriers for homeless people in achieving good oral health were insufficient information on local dental services, negative attitudes of oral health professionals, low priority of dental care, anxiety and cost of dental treatments. Facilitators included single dental appointments, accessible dental locations and being treated with respect[76]. These findings are in line with previously conducted studies in London and Scotland[77].

Table 17: Homelessness in the South West[78]

South West Local Authority those with less than 1 in 1,100 homelessness rate	Number of people living in TA	Number of people rough sleeping	Total homeless people	Total people ONS 2017	Homeless rate
Bristol City of	2,201	86	2,287	459,252	201
Gloucester	506	15	521	129,083	248
Weymouth and Portland	225	18	243	65,751	271
Purbeck	131	1	132	46,756	354
Plymouth	695	26	721	263,070	365
Christchurch	120	5	125	49,616	397
Bournemouth	414	48	462	194,752	422
Exeter	260	35	295	122,891	417
Poole	324	13	337	151,270	449
Torbay	167	24	191	135,247	708
Cornwall	714	68	782	561,349	718
West Somerset	39	4	43	34,865	811
Taunton Deane	117	23	140	117,423	839
South Somerset	152	4	156	167,216	1,072

[74] Conte M, Broder HL, Jenkins G, Reed R, Janal MN. Oral health, related behaviors and oral health impacts among homeless adults. Journal of Public Health Dentistry. 2006;66(4):276-8.
[75] Coles E, Edwards M, Elliott G, Freeman R, Heffernan A, Moore A. Smile4life: The oral health of homeless people across Scotland. 2009.
[76] Csikar J, Vinall-Collier K, Richemond JM, Talbot J, Serban ST, Douglas GVA. Identifying the barriers and facilitators for homeless people to achieve good oral health. Community dental health. 2019.
[77] Beaton L, Anderson I, Humphris G, Rodriguez A, Freeman R. Implementing an Oral Health Intervention for People Experiencing Homelessness in Scotland: A Participant Observation Study. Dentistry journal. 2018;6(4).
[78] Shelter; Homelessness in Great Britain – the numbers behind the story 2018

Chart 22: Barriers and facilitators for achieving good oral health for the homeless population[79]



3.67 More recent studies have also considered the impact of oral diseases on the quality of life of homeless people.[80] As well as high levels of dental treatment need with 76% requiring restorative work, 80% oral hygiene or gum care and 38% needing dentures, 91% experienced at least one oral health impact, with the average number of impacts being six. The most common impacts were pain (65%) and discomfort when eating (62%). Similar observations were made among homeless people at a healthy living centre in Wales. The most reported impacts were toothache, discomfort, ability to relax and feeling ashamed regarding the appearance of their teeth. Rough sleepers experienced significantly higher levels of impact.[81]

People with mental health problems

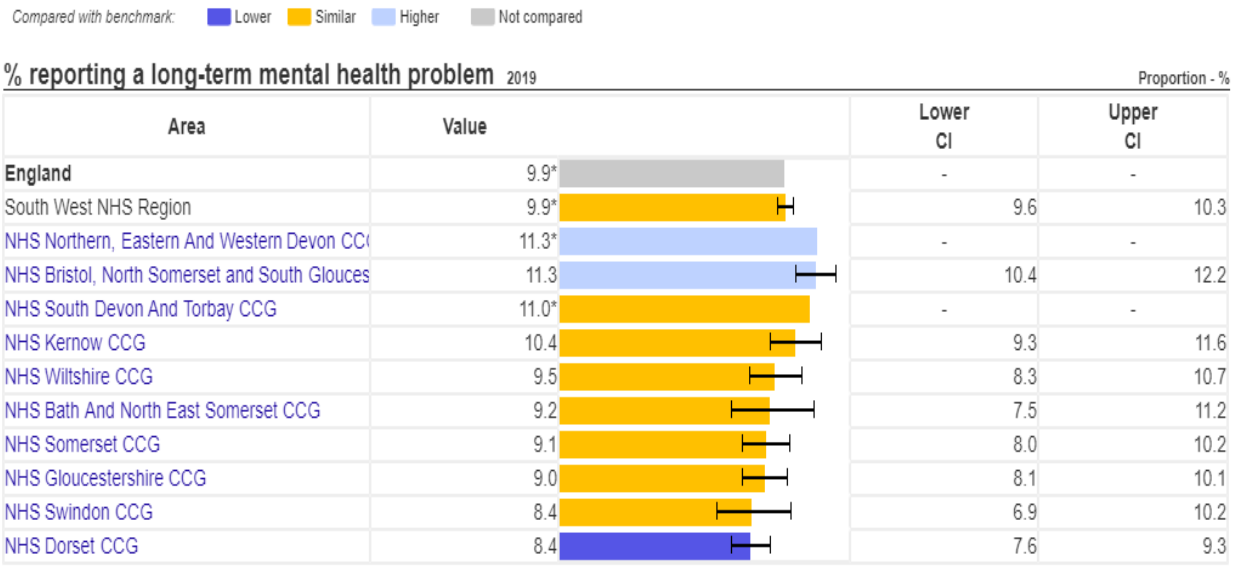
3.68 Mental health problems are common. The classification of mental health problems remains problematic, as some diagnoses are controversial and there is concern that some people may not get the appropriate treatment. The classification is sub-divided into neurotic and psychotic conditions. Neurotic covers those symptoms that

[79] Source: Csikar J, Vinall-Collier K, Richemond JM, Talbot J, Serban ST, Douglas GVA. Identifying the barriers and facilitators for homeless people to achieve good oral health. Community dental health. 2019.
[80] Daly B, Newton T, Batchelor P and Jones K Oral health care needs and oral health related quality of life (OHIP 14) in homeless people. Community Dentistry & Oral Epidemiology. 2010;38(2):136-44
[81] Richards W, Higgs G. An audit of smoking behaviours among patients attending two general dental practices in South Wales: an awareness-raising exercise for the dental team and patients. Primary Dental Care. 2010;17(2):79-82

can be regarded as severe forms of normal emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as neuroses are now more frequently called common mental health problems. Less common are psychotic symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no-one else can.

3.69 Overall, those with a severe mental health problem are likely to die almost 20 years earlier than the rest of the population. Therefore, there has been a drive to improve mental health services as well as the general health of people with mental health problems. There is no national and local data on the oral health needs of people with mental health problems. However, there is a need for dental commissioners to tie oral health into any local commissioning arrangements that are set to improve the physical health of this vulnerable group. The table and chart below set out the percentage of the population reporting a long-term mental health problem and shows that the South West has the same profile as England. There are however areas with a higher profile within the region including Devon, Bristol, North Somerset and South Gloucestershire, and Cornwall.

Chart 23: % reporting Long term mental health problems per 100,000[82]



Area	Value	Lower CI	Upper CI
England	9.9*	-	-
South West NHS Region	9.9*	9.6	10.3
NHS Northern, Eastern And Western Devon CC(	11.3*	-	-
NHS Bristol, North Somerset and South Glouces	11.3	10.4	12.2
NHS South Devon And Torbay CCG	11.0*	-	-
NHS Kernow CCG	10.4	9.3	11.6
NHS Wiltshire CCG	9.5	8.3	10.7
NHS Bath And North East Somerset CCG	9.2	7.5	11.2
NHS Somerset CCG	9.1	8.0	10.2
NHS Gloucestershire CCG	9.0	8.1	10.1
NHS Swindon CCG	8.4	6.9	10.2
NHS Dorset CCG	8.4	7.6	9.3

82 https://fingertips.phe.org.uk/search/mental%20health#page/3/gid/1/pat/44/par/E40000006/ati/154/are/E38000009/iid/93444/age/164/sex/4/cid/4/tbm/1/page-options/ovw-do-0_car-do-1

Socially excluded people

3.70 Socially excluded people are accommodated in prisons, young offenders' institutes, secure children's homes, police custody suites or courts. They often have chaotic lifestyles and low aspirations for optimum health, making it difficult for them to navigate systems and access healthcare. NHSE&I Health and Justice team commission health and dental services for those in custody. However, on release these patients will return to the community and will likely seek dentistry from high street practitioners at some point.

3.71 Socially excluded people are more likely to smoke, misuse drugs and or alcohol, have mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. The health and wellbeing need of offenders in the community are worse than those in custody or the general population with significantly higher premature death rates.

3.72 Since 2013 healthcare services in secure and detained settings have been directly commissioned by NHSE&I Health and Justice in accordance with national service specifications. As part of the commissioning cycle, Health & Justice local area teams periodically procure Health Needs Assessments which are delivered in accordance with a national template (and any additional local requirements).

3.73 A partnership agreement has been in place to support the commissioning and delivery of healthcare in English prisons since the introduction of the Health and Social Care Act (2012). The five Prison Health Partnership members are the Ministry of Justice, Her Majesty's Prison and Probation Service, NHSE&I, Public Health England and the Department of Health and Social Care.

3.74 There are 11 prisons (and young offender institutions) in the region, represented by three PDS contracts:

- Devon: HMP Dartmoor, HMP Channings Wood and HMP/YOI Exeter
- Dorset: HMP Guys Marsh, HMP/YOI Portland and HMP The Verne
- Bristol, South Gloucestershire and Wiltshire: HMP Ashfield, HMP/YOI Bristol, HMP/YOI Eastwood Park (female prison), HMP Erlestoke and HMP Leyhill.

3.75 Commissioning policy aims to deliver an improvement in oral health for people in secure settings, where outcomes for offenders are generally impoverished because of vulnerability, socio-economic and other lifestyle issues, and iatrogenic[83] factors, which account for substantial health inequalities amongst prisoners. The oral health needs of prisoners are complex. Prisoners have considerably higher prevalence of caries and periodontal disease, and more decayed and missing teeth

[83] relating to illness caused by medical examination or treatment.
"drugs may cause side effects which can lead to iatrogenic disease"

than the general population, and this is coupled with more infectious disease, and chronic medical and psychological conditions.

3.76 The prison population is ageing. In 2002, 16% were under the age of 21 compared with 6% in 2020 and the number over the age of 50 has increased from 7% in 2002 to 17% in 2020. Sentences are increasing in length, with now nearly half being over 4 years, which compares to just a third in 2010.

3.77 Prison regime issues (e.g. people movement and other restrictions) can severely limit patient access to dental clinics and complicate the provision of dental care. Patients often experience delays in attending external hospital appointments, often due to inadequate resources and competing security priorities, which can be compounded by prison transfers.

3.78 Service challenges relate to both issues of systems and processes, e.g. continuity of care from reception to post-transfer/release, and issues relating to the negative consequences of inadequate health literacy, behavioural problems and trauma, i.e. progressing from isolated initiatives to promote service access and self-care, towards 'breaking the cycle of decay' through an effective prevention strategy.

3.79 The prison population generally has poor oral health[84], with reports of periodontal disease and dental decay levels around 4 times higher than the general population[85]. People in prisons are more likely to have come from socially excluded or disadvantaged backgrounds and areas with high levels of unemployment[86]. People in prison have lower educational attainment which may relate to learning difficulties, which may be 'hidden' or specific[87]. Studies have shown that oral health is poorer in a population of criminally convicted people before entering prison[88]. Therefore, the oral health needs on admission to prison are high, with significant levels of unmet dental treatment need. Research in North West England showed the decayed, missing and filled (DMFT) scores of people entering prison are around

84 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786782/Survey_prison_dental_services_2018.pdf

85 Harvey S, Anderson B, Cantore S, King E, Malik F. Reforming Prison Dental Services in England- A Guide to Good Practice 2005. Available from: http://www.ohrn.nhs.uk/conferences/past/D160905PCW.pdf

86 Mollen E, Stover L, Jurgen H, R G. Health in Prisons: A WHO guide to the essentials in prisoner health. 2007. Available from: http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf

87 Heidari E, Dickinson C, Newton T. An overview of the prison population and the general health status of prisoners. Br Dent J. 2014;217(1):15-9.

88 Osborn M, Butler T, Barnard PD. Oral health status of prison inmates - New South Wales, Australia. Aust Dent J. 2003;48(1):34-8

twice as high as those of the general population[89]. This has been attributed to lifestyle choices such as drinking alcohol, smoking tobacco, using illicit substances[90],[91] and high sugar diets. Chaotic lifestyles, the lack of oral health literacy and not valuing oral health also have a role (8). There is a higher incidence of learning difficulties and mental health problems in this population, potentially contributing to poorer maintenance of oral hygiene[92].

Gypsy, Roma and Traveler people (GRT)

3.80 GRT communities are significantly disadvantaged in terms of oral health and access to dental care, and a feature of this is the high level of dental issues necessitating complex treatment and multiple extractions in children. There are difficulties experienced in obtaining regular check-ups and on-going treatment, with decreased trust and cultural views reportedly leading to reduced service utilisation and poor health behaviours. Further barriers to access result from mobile lifestyles, with more disadvantage being experienced by Travellers on unauthorised and transit sites. A targeted approach to community outreach, e.g. community advocates, is likely to be the most effective model for change.

Support and Oral Health Education for Carers and Care Homes -

3.81 Whilst commitment and local policies (might) exist in specific care homes, there is a need to raise general standards of dental care for residents of residential and nursing care homes in England, and specifically develop initiatives to promote effective approaches to oral health prevention / oral health promotion and improved access to dental care, in-line with NICE guideline NG48 (Oral health for adults in care homes, 2016).

3.82 The Care Quality Commission report, Smiling Matters: Oral health care in care homes (2019)[93] includes 15 core recommendations concerning the importance of raising awareness of the importance of oral care and NG48, the need for better training, and the need for improved commissioning to meet the needs of people in care homes. It is pertinent that carers receive support, education and training in oral hygiene care.

[89] Jones CM, Woods K, Neville J, Whittle JG. Dental health of prisoners in the north west of England in 2000: literature review and dental health survey results. Community Dent Health. 2005;22(2):113-7
[90] Heidari E, Dickinson C, Newton T. Oral health of adult prisoners and factors that impact on oral health. Br Dent J. 2014;217(2):69-71.
[91] Heidari E, Dickinson C, Wilson R, Fiske J. Oral health of remand prisoners in HMP Brixton, London. British Dental Journal. 2007;202(2):E1
[92] Department of Health, HM Prison Service. Strategy for Modernising Dental Services for Prisoners in England. 2003. Available from: http://webarchive.nationalarchives.gov.uk/20110504020935/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068229.pdf.
[93] https://www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes

Looked after children

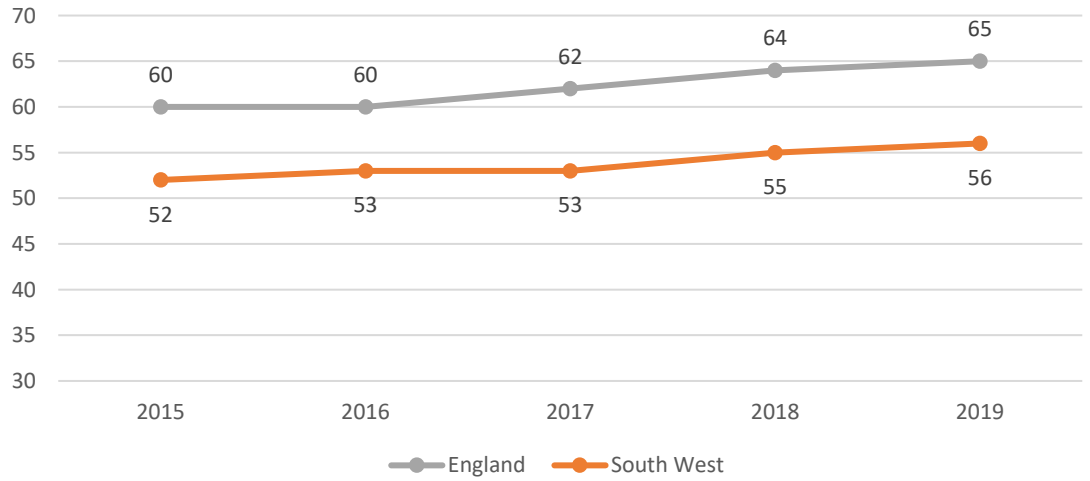
3.83 Looked after children tend to have poorer health and well-being than their peers. Although some national data describes the health needs of looked after children, their oral health needs are not routinely monitored. With regards to the oral health needs of looked after children the Social Care Institute for Excellence (SCIE) and the National Institute for Heath and Care Excellence (NICE) guidelines state that looked-after children and young people's access to dental care is often a major concern. Some of the main barriers for access in this group are:

- Travel to dental care providers
- Capacity of dental care providers to take new patients
- Unplanned placement moves
- Fear, phobia or confidence issues (SCIE NICE Evidence statement C3.12).

3.84 For looked after children, a clear pathway from the point of identification to contact with a dental provider is required.

3.85 Across the South West the number of children in care has been rising, like the increasing trend across England. The latest figures for the South West indicate that in 2019 there were 6,140 children aged under 18 in care; there are proportionately fewer children in care here than across England. In 2019 the rate of children aged under 18 in care in the South West was 56 per 10,000 compared to the rate of 65 across England.[94]

Chart 24: Looked after children, below 18-years-old, per 10,000 population, South West and England, 2019

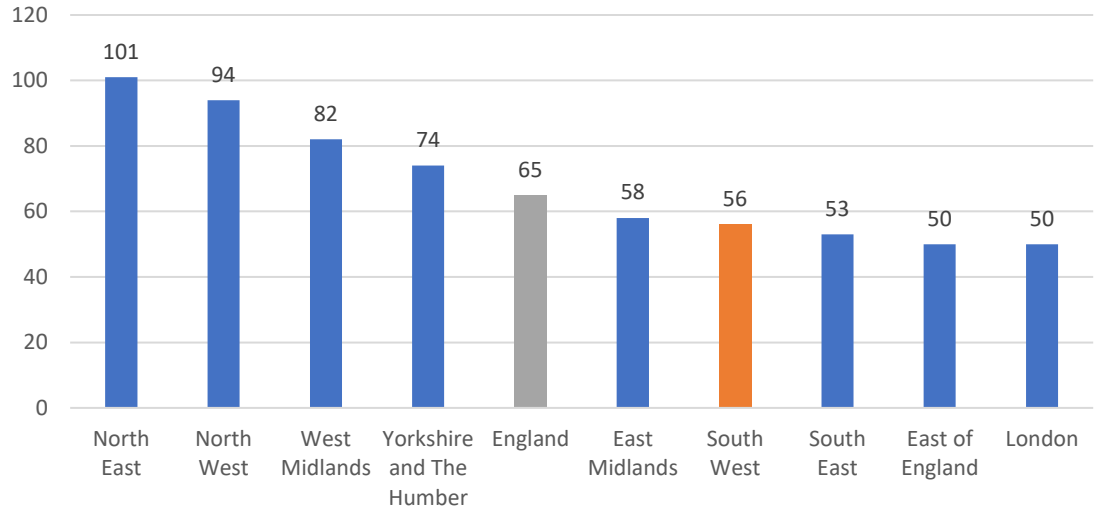


3.86 The chart below illustrates a regional comparison of the rate of children in care. Whilst across the South West the rate is relatively low there are some variations with some parts of the South West. Torbay for example has more the twice the rate of children compared with the South West (142 per 10,000 children under the age

[94] Children looked After in England, Department from Education (2018-19)

of 18). Plymouth, Bournemouth, Swindon and Bristol all have proportionally more children in care when compared to the average across England.

Chart 25: Looked after children, below 18-years-old, per 10,000 population, Regional, 2019



Other vulnerable groups

3.87 There are other potentially vulnerable groups such as migrant workers, refugees and asylum seekers, the medically compromised, as well as those with dental anxiety and dental phobia. All vulnerable groups have the right to good oral health, but they are the very groups in society who are at increased risk of poor oral health and for whom access to dental services is not straight forward.

Summary

- Information describing the oral health of vulnerable groups locally is limited.
- The South West has a lower prevalence of adults and children with learning disabilities relative to the national average.
- Children with learning disabilities are more likely to have teeth extracted than filled and have poorer gum health.
- Adults with learning disabilities are more likely to have poorer oral health than the general population.
- Adults with learning disabilities living in the community are more likely to have poorer oral health than their counterparts living in care.
- Homeless people are more likely to have greater need for oral healthcare than the general population.
- Approximately a quarter of the population experiences some kind of mental health problem in any one year, ranging from anxiety and depression through to more acute needs, however there is no local information on the oral health needs of this group.
- JSNA across the region have prioritized the needs of people with mental health problems. Local commissioning arrangements for people with mental health problems may not consider access to dental services.

- Severely obese people may be at higher risk of oral disease however there are currently few dental services that accommodate severely obese people in the South West.
- Looked after children are likely to have greater oral health needs.
- The South West has a lower proportion of children in care than across England, but there are internal variations, for example Torbay has more than twice the rate of children in care.

Key issues for consideration

- Prevention of tooth decay and identification and restoration of decayed teeth in children's permanent dentitions should be a priority for dental services.
- Oral health improvement strategies should include actions to address the increasing incidence of mouth cancer in these areas.
- Undertaking a more detailed oral health needs assessment of vulnerable groups should be considered by NHSE&I and local authorities.
- Dental services should be easily accessible to people with learning disabilities and provide preventive action and treatment services including urgent care.
- NHSE&I, local authorities, PHE, STPs and clinical commissioning groups should work together to ensure access to dental and oral health improvement services for people with mental health problems.
- Both targeted and universal approaches of prevention to reduce inequalities are critical - these could be measured through the PHE return on investment tool.
- There needs to be continuing cooperation between stakeholders: NHSE&I commissioners, LDN, LDC chairs, LAs, OHAGs to address health inequalities and to target oral health improvement.

4 Oral Health Services

4.1 This section describes current NHS dental service provision in the South West of England. NHSE&I has a statutory duty to secure all NHS dental services[95]. These services must reflect the changes in the oral health needs of the population. Over the last few decades, oral health in England has been improving with more people retaining their natural teeth into older age. Despite these improvements many people continue to experience the pain and discomfort associated with oral diseases, which are largely preventable. At the same time major technical advances enable more complex care with further implications for commissioning. It is recognised that dental services are essentially demand-led, but commissioning policies are moving towards a more targeted approach to those people with higher needs and towards more preventative interventions in order to reduce inequalities.

Primary care dental services

General dental services

4.2 The current primary care NHS dental contracts, i.e. General Dental Service (GDS) Contract and Personal Dental Services (PDS), were introduced in 2006. The GDS is a commercial agreement *for an indefinite* period, sometimes referred to as a 'contract in perpetuity'. The PDS Agreement usually is time limited. A PDS agreement does not always contain 100% of units of dental activity and key performance indicators (KPIs) are used to partially measure performance. Orthodontic PDS agreements contain units of orthodontic activity (UOA). PDS agreements also have an annual contract value. A general dental service provider is contracted for an annually agreed number of units of dental activity.

4.3 The current primary care NHS dental contracts, the General Dental Service Contract and Personal Dental Service Agreement, were introduced in 2006. The contracting currency for both contracts is the Unit of Dental Activity (UDA).

[95] Secretary of State's power to require National Health Services Commissioning Board (NHS Commissioning Board, from 2012) to commission certain health services if required by regulations made under the NHS Act 2006 and HSCA 2012, including Dental services of a prescribed description, Services or facilities for members of the armed forces or their families, and Services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description.

4.4 Dental practices provide services according to four different bands of care, with the provider awarded a number of UDAs for each band:

Band 1 Includes an examination, diagnosis and advice. If necessary, it also includes, x-rays, scale and polish, application of fluoride varnish or fissure sealants and preventive advice and planning for further treatment (1 UDA)

Band 2 Includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatments and removal of teeth (3 UDAs)

Band 3: Includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (12 UDAs)

Band 4 Includes urgent care such as removal of the tooth pulp, removal of up to two teeth, dressing of a tooth and one permanent tooth filling (1.2 UDAs).

4.5 Adult patients will have to make a financial contribution for receiving dental care from the NHS unless they meet certain exemptions. There is a 3-band fixed charge for primary care treatment depending on the care provided by the dental practice. The Patient Charge Revenue contributes approximately £650m to the NHS each year.

Availability of general dental services

4.6 In the financial year 2018/2019, 87.6 million UDAs were commissioned in England[96]; the population in England is currently 56 million. In the same year, 8.5 million UDAs were commissioned in the South West region, which has a population of 5.6 million.

4.7 Across the country the total number of UDAs commissioned fell by 4.5% for 2019/2020 - the details per region were not available to this OHNA.

4.8 In 2019/2020, 705 dental practices across the South West were contracted by the NHS to provide a total of 8,520,528 UDAs. The number of dental practices, contracted activity and delivered activity is shown below (table 16). The amount that dentists were paid per UDA varied considerably from £16.83 to £38.56.

Table 18: Primary Care General Dental Services Provision across the South West

Sustainable Transformation Partnership (STP)	Contracts GDS and Ortho	General Dental Services/Mixed GDS and Ortho	Number of Practices	Commissioned UDAs	Average UDA Value	Ortho Only
Bath and North East Somerset, Swindon and Wiltshire STP	126	115	111	1,171,905	£25.67 (Lowest £19.35 to highest £37.90)	11
Bristol, North Somerset and South Gloucestershire	113	108	105	1,587,814	£25.13 (Lowest £19.71 to highest £34.23)	5
Cornwall and the Isles of Scilly STP	83	80	81	941,961	£26.74 (Lowest £21.25 to Highest £33.04)	2
Devon STP	154	141	150	1,916,776	£27.68 (Lowest £16.83 to Highest £38.56)	13
Dorset STP	113	103	120	1,242,431	£26.66 (Lowest 22.03 to highest 33.52)	6
Gloucestershire STP	95	72	69	798,979	£25.04 (Lowest £20.87 to highest £35.23)	8
Somerset STP	64	62	69	860,662	£25.38 (Lowest £19.89 to highest £33.16)	8
Total	748	681	705	8,520,528	-	53

Workforce

4.9 The majority of primary care dental services are provided by general dental practitioners. The primary care dental workforce consists of dentists and dental care

[96] NHS Dental Commissioning Statistics for England – March 2018, NHS England

professionals. Dental care professionals include dental nurses, hygienists, therapists, orthodontic therapists, and technicians including clinical dental technicians.

4.10 In 2019/2020 there were 2,664 dentists in the South West delivering NHS dentistry. This represented 48 dentists per 100,000 population which is slightly higher than the national average of 44 per 100,000 population. This was a slight increase of 8 dentists regionally which represented a 0.3% growth in number of dentists when compared to the 2018-2019 period[97]. Although the overall number of dentists in the region is above the national average, there are significant differences between and within various STPs with the more rural and coastal areas presenting the most significant challenges in recruiting for and maintaining dental workforce.

4.11 The data in table 19 which is represented by CCG areas, ranges from 58 dentists per 100,000 population in Somerset to 49 in Dorset and in BANES, Swindon and Wiltshire. The population per dentist in England is 2,268 which is higher than the population per dentist in the South West of 2,104. The lowest population per dentist in the STP area is Somerset with 1,716 and the highest in the range is BANES, Swindon and Wiltshire with 2,059.

4.12 The greatest decrease in the number of dentists over the last two financial years was experienced in Devon -16 (-2.6%) and Bristol, North Somerset and South Gloucestershire with -7 (-1.4%). By contrast Cornwall saw an increase of 16 dentists (5.6%) and Somerset saw an increase of 4 dentists (1,2%).

Table 19: Number of dentists with NHS activity, for years ending 31 March, England - NHSE&I region geography and CCG[98]

			2019/20		
Area	Dentists difference 2018/19 to 2019/20	Percentage difference 2018/19 to 2019/20	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]
England	**139**	***0.6***	**24,684**	**2,268**	**44**
South West of England	**8**	***0.3***	**2,664**	**2,104**	**48**
NHS Dorset CCG	**-2**	***-0.5***	376	2,054	49
NHS Gloucestershire CCG	**1**	***0.3***	316	2,005	50
NHS Kernow CCG	**16**	***5.6***	285	1,994	50
NHS Somerset CCG	**4**	***1.2***	326	1,716	58

[97] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report
[98] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report

			2019/20		
Area	Dentists difference 2018/19 to 2019/20	Percentage difference 2018/19 to 2019/20	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]
NHS Bristol, North Somerset and South Gloucestershire CCG	**-7**	***-1.4***	503	1,908	52
NHS Devon CCG	**-16**	***-2.6***	606	1,971	51
NHS Bath and North East Somerset, Swindon and Wiltshire CCG	**-1**	***-0.2***	446	2,059	49

4.13 Stakeholder feedback from Health Education England (HEE) SW suggests that younger dentists often avoid working opportunities in more rural areas such as Devon and Cornwall. Recruitment and retention difficulties are further enhanced by the challenges around encouraging practices to become training sites for dental foundation training.

4.14 In order to address some of these challenges, HEE is exploring options towards developing two-year programmes for dental core training and bursaries for postgraduate training to encourage local specialist Tier 2 provisions. Furthermore, HEE, in partnership with The Peninsula Dental Social Enterprise CIC, has developed various community engagement projects involving foundation dentists working with early years settings and care homes.

4.15 Health Education England is currently undertaking a national workforce review that is due to be published in 2021.

4.16 The issues around recruitment and retention of the dental workforce are not unique to the South West. Nationally, 75% of NHS practices in England struggled to fill vacancies in the previous year. Findings from a survey undertaken by the British Dental Association suggest that nearly 58% of NHS dentists were planning to leave the health service in the next five years. Almost one in ten of those aged under 35 said they planned to quit dentistry altogether, with a similar number hoping to move overseas. Evidence suggests that the shift in working preferences of new dental graduates combined with the historically lower UDA values in certain rural areas makes recruitment and retention of NHS dental workforce increasingly difficult.

4.17 The NHSE&I response to the Health Select Committee inquiry into dental services in 2019 stated "Regional areas are experiencing challenges in recruitment of dentists willing to work under solely or predominantly NHS arrangements." This is important because those regional areas are spreading and the challenges increasing. Coastal

communities are hard hit with some practices handing back contracts. Rural areas are struggling to attract dentists.

4.18 In its' Evidence to the Review Body on Doctors and Dentists Remuneration for January 2020, the British Dental Association wrote: "The prevalence of clawback provides a clear indication of the difficulties practices are experiencing in delivering their contracts, in no small part due to recruitment problems and low morale. The loss of large sums of funding from practices also causes profound difficulties for small businesses to manage and leaves some practices facing existential financial difficulties."

4.19 The NHS Digital Dental Working Hours – 2016/2017 and 2017/2018: Working Patterns and Morale presents findings from a biennial Dental Working Patterns Survey. The Key Facts presented from this survey are that:

- In general, dentists take fewer weeks' annual leave than they did when the survey was first undertaken, and they are working longer weekly hours.
- During the last decade there has been a notable drop in the amount of time dentists spend on clinical work and there has also been a drop in the time they spend on NHS work over the same period.

4.20 NHS Digital Dental Earnings and Expenses Estimates reveal that over 10 years from 2008/2009 to 2018/2019, the gross earnings of practice principals with NHS contracts has reduced by around 7% and practice expenses have increased by 15% (significantly due to the rising cost of indemnity insurance). This has been reflected in a significant reduction in the taxable earnings of associate dentists, who have seen their taxable NHS earnings fall by 15.5%.

4.21 These changes have been accompanied by a gradual reduction in the proportion of working hours on NHS items of treatment, with dentists reporting high levels of work stress and a gradual reduction in morale, and practices reporting growing recruitment and retention difficulties. This is emphasised in the findings of the stakeholder survey, a summary of which is in Section 7 and in detail in Appendix 12.

Potential issues for consideration

- Overall, the North West of England has more dentists per head of population (48/100,000) than the national average (44/100,000) however there is significant variance in the distribution of dentists in the region. More rural

areas around Devon and Cornwall struggle to recruit and retain new dentists.

- The increase in amount of clawback suggests that existing providers struggle to meet their contracted dental activity targets and difficulties around recruitment might present additional challenges.
- Evidence suggests that encouraging the use of full skill-mix in line with the scope of practice of different members of the dental team could provide additional clinical time to facilitate access for new patients.
- Stakeholder feedback suggests that there is a need for additional specialist commissioning Tier 2 and paediatric dentistry to support paediatric specialist training pathway and help retain postgraduate trained staff.
- The particular challenges around the large geographical footprint and rurality of certain areas like the Peninsula may require support for the development of local specialist services to prevent patients requiring travelling long distances (e.g. to Bristol).

Average UDAs commissioned per capita.

4.22 The South West has a higher level of UDAs per capita than England, 1.52 UDAs per person compared to 1.41 UDAs per person. Based on the numbers of commissioned UDAs (2019-2020) and comparing this to the general population[99] in each STP area across the South West, it is possible to assess the average UDAs commissioned per person in the region. This shows a variation of commissioned UDA by the local population, ranging from 1.26 (Somerset) to 1.66 (Cornwall and Isles of Scilly).

Table 20: Average UDAs commissioned per head of population 2019-2020 (NHSE&I)

Area	Average UDAs commissioned per capita (n)
Bath and North East Somerset, Swindon and Wiltshire	1.28
Bristol, North Somerset and South Gloucestershire	1.65
Cornwall and the Isles of Scilly	1.66
Devon	1.61
Dorset	1.61
Gloucestershire	1.26
Somerset	1.54
South West	1.52
England	1.41

[99] ONS data 2019-20 planned commissioned UDA NHSE&I

Access to Dental Care

Children

4.23 The majority of children and adults will seek care from an NHS dental practice, those with additional needs are generally seen in the community dental service. According to NICE guidance adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their individual level of risk of oral disease[100]. Dental attendance does not necessarily prevent dental disease, but it is important in terms of assessing patient risk to oral diseases and giving appropriate evidence-based advice. Public Health England and NICE have developed specific guidance for dental teams[101].

4.24 The British Society of Paediatric Dentistry campaign *Dental Check by One*, which launched in September 2017 in partnership with the Office of the Chief Dental Officer England, aims to increase the number of children who access dental care aged 0-2 years by raising awareness.

4.25 Starting Well[102] is a commissioning approach designed to improve access for children aged 0-5 years, followed by the provision of cost-effective evidence-based prevention activities, such as fluoride varnish and dietary advice. From summer 2020 a number of community dental services were preparing to support the 'First Dental Steps' initiative across the region. This project aims to connect families with very young children at high risk of developing dental decay with services earlier in their lives, i.e. those who may not meet the criteria for access to paediatric dentistry. Thus, the initiative aims to prevent extensive oral disease through early detection/ intervention (e.g. reducing need for extraction of decayed teeth).

4.26 The indicator used to assess dental access in children is the number of unique people accessing dental services over the previous 12 months.

4.27 From April 2019 to March 2020 access for child patients in the South West was 54.1%. The access levels for child patients are higher than the England average of 52.7%[103].

[100] The National Institute for Health and Care Excellence. Dental checks: intervals between oral health reviews: Clinical guideline [CG19] 2004 [Available from: https://www.nice.org.uk/guidance/cg19]
[101] Public Health England. Delivering better oral health: an evidence-based toolkit for prevention (Third edition). 2014.
[102] https://www.england.nhs.uk/primary-care/dentistry/smile4life/starting-well-core-0-2s-dental-access-and-prevention-framework/
[103] NHS Dental Services: NHS Business Services Authority: June 2020

4.28 The lowest levels of access for children are in Wiltshire (47.1%), Dorset (48.9%) and South Gloucestershire (50.3%). The highest levels of access for children are in BANES (68.2%), North Somerset (60.8%) and Torbay (59.2%).

4.29 Challenges include encouraging young adults to maintain contact with general dental services. For young adults requiring on-going specialist care into adulthood, transition to other adult specialties such as special care dentistry or restorative dentistry must be carefully planned and managed.

Adults

4.30 The indicator used to assess dental access in adults is the number of unique people accessing dental services over the previous 24 months. This metric is based upon NICE guidance, which recommends the longest interval between dental recalls[104].

4.31 From April 2019 to March 2020 access for adult patients in the South West overall had fallen by 1.51% to 47.3%. Access levels are slightly below the England average of 47.7% (Source: NHS Dental Services: NHS Business Services Authority: June 2020). However, Table 19 shows there are regional variations in access to care for adults.

Access as a proportion of the population

4.32 The tables below compare the access of adults and children against the overall population at national and regional levels as well as within the South West. Nationally the South West ranks third lowest in access to NHS dentistry for adults at 47.3% compared to the national average of 47.7%. For children, the South West ranked the third highest amongst other regions with 54.1% compared to the national average of 52.7%.

104 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215663/dh_126005.pdf

Table 21: Adult patients seen in the previous 24 months and child patients seen in the previous 12 months[105], as a percentage of the population[106], by NHS Region[107] 30 June 2020[108]

Area	Count		% of Population	
	Adult	Child[109]	Adult	Child[110]
England	21,012,985	6,299,306	47.7	52.7
London	2,832,124	883,855	41.1	43.7
South West	2,128,262	597,560	47.3	54.1
South East	2,996,434	993,397	43.0	52.7
Midlands	4,011,588	1,191,599	48.4	52.9
East of England	2,424,810	736,018	47.7	52.2
North West	2,936,886	860,587	53.3	57.3
North East and Yorkshire	3,634,818	1,021,883	53.5	57.5

4.33 Within the region, Wiltshire, Cornwall and Gloucestershire, Dorset ad South Gloucestershire, and Somerset were the SPT areas[111] - with the lowest levels of access for children to NHS dentistry. For adult patients, Gloucestershire, Wiltshire, Dorset, Plymouth, BANES, Swindon and Cornwall, were all below the average levels of access for the region per head of population.

Table 22: Adult patients seen in the previous 24 months and child patients seen, in the previous 12 months as a percentage of the population, by patient type and LA[112]

Area	Adult % of pop.	Child % of pop
England	47.1	52.7
South West	47.3	54.1
Cornwall Council	47.2	51.9
Wiltshire Council	40.3	47.1
Bath and North East Somerset Council	46.7	68.2
Bristol City Council	50.9	58.9
North Somerset District Council	53.2	60.8
South Gloucestershire Council	50.1	50.3
Plymouth City Council	45.1	55.6
Torbay Council	52.4	59.2
Swindon Borough Council	46.7	54.1
Devon County Council	49.1	54.6
Gloucestershire County Council	39.8	53.0
Somerset County Council	50.7	53.4

[105] Patients seen includes orthodontist visits, this is the same as previous year
[106] Figures presented are rounded. Calculations have been carried out using unrounded figures
[107] NHS Dental Services, NHS Business Services Authority (BSA).
[108] Data is affected by COVID-19.
[109] Data in the above table represent the number of child patients seen in the previous 12 months rather than the previous 24 months
[110] Data in the above table represent the number of child patients seen in the previous 12 months rather than the previous 24 months
[111] The data provide by BGS Business Services Authority is presented in this way and hence there are some STP areas with Breakdowns including some local Authority areas, i.e. in Devon
[112] NHS Dental Services, NHS Business Services Authority (BSA).

Area	Adult % of pop.	Child % of pop
Bournemouth, Christchurch and Poole Council	50.6	55.4
Dorset Council	45.6	48.9

Chart 26: Child patients seen, in the previous 12 months as a percentage of the population, by local authority[113]

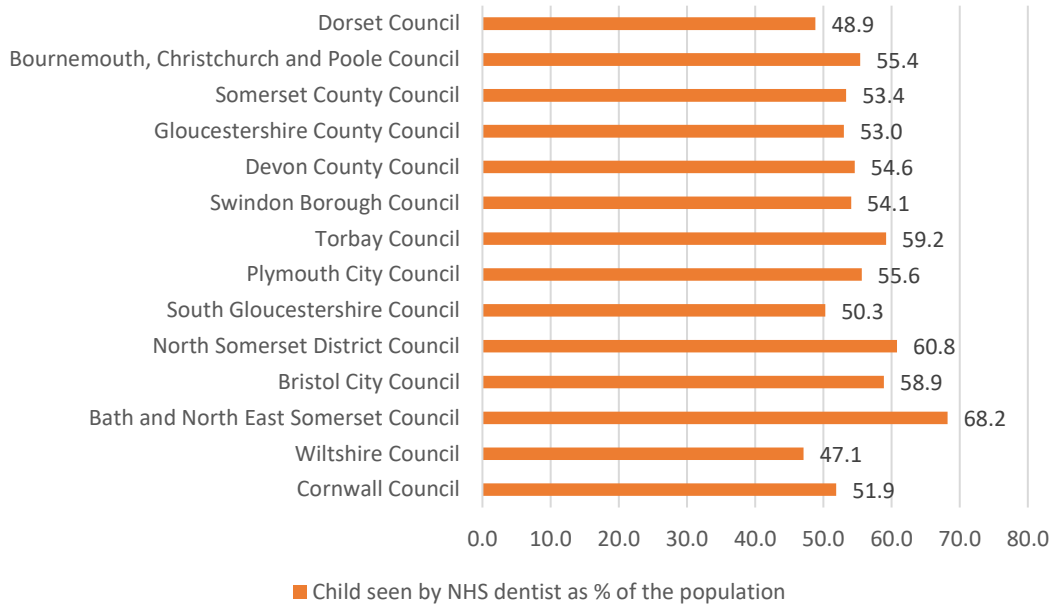
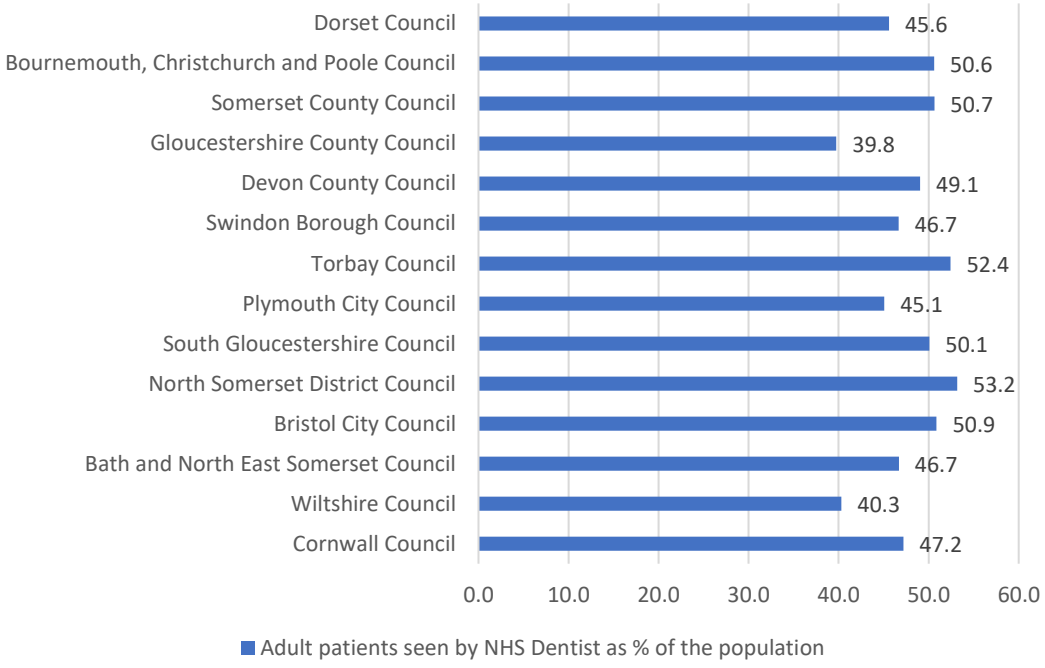


Chart 27: Adult patients seen, in the previous 12 months as a percentage of the population, by local authority



[113] NHS Dental Services, NHS Business Services Authority (BSA).

UDA/Contract performance

4.34 The current dental contract, which was introduced in 2006, remunerates practices solely on activity and has been generally very unpopular amongst dentists with dental membership organisations calling for a faster pace of contract reform, and the Chief Dental Officers of England and Wales have deemed the 2006 contract unfit for purpose. The Steele report[114] examined how dental services in England could be developed over the next 5 years. The review advocated a commissioning approach to align dentistry with the rest of the NHS services, to commission for health outcomes and to develop blended contracts rewarding not only activity but quality and oral health improvement results.

4.35 Between November 2011 and December 2012 a task and finish group was set up to make recommendations to NHSE&I about the development of a Dental Assurance Framework, which introduced a more standardized approach to contract performance management, with DAF reports including KPIs based on UDA data, patient satisfaction and other outcomes measures. There is a separate contract review method for practices participating in the Dental Contract Reform (DCR) programme which was established to review evidence to support claims for remuneration by dental contract providers. The DCR has the following commissioning priorities which aim to optimise access for all patients and the provision of high-quality dental services:

- Reducing contract under-performance
- Providing preventive focused care
- Providing appropriate treatment patterns (significantly recall, re-attendance, continuation).

4.36 There is emerging evidence that the blended/incentive-driven contract influenced access to dental care. Participants associated it with increased access, greater use of skill mix and improved health outcomes[115].

4.37 In-line with these stated aims, the DCR includes a programme which is piloting alternative contracting models. Two blended models of contract, both with a mixture of metrics for capitated and activity-based measures, are testing the currencies/remuneration of general dental practices in line with the clinical philosophy of 'new ways of working' which includes:

- RAG-rated oral health assessment to determine recall intervals in-line with evidence-based guidance

[114] Department of Health. NHS Dental Services in England: An Independent Review Led by Professor Jimmy Steele. London: Department of Health; 2009

[115] The INCENTIVE study: a mixed-methods evaluation of an innovation in commissioning and delivery of primary dental care compared with traditional dental contracting; Southampton (UK): NIHR Journals Library; 2016 May

- Capitation weighting, e.g. elevated to reflect additional treatment needs associated with age and deprivation status of patient lists
- Testing of a 'service style' menu for Band 3 treatments
- The development of an associated quality and outcomes framework (DQOF), to supersede 'Managing dental services – a guide for commissioners, practices and dentists in England' and the current Dental Assurance Framework for prototype practices/DCR Handbook.

4.38 These initiatives will be associated with a planned shift from open-ended/perpetuity GDS contracts to PDS contracts.

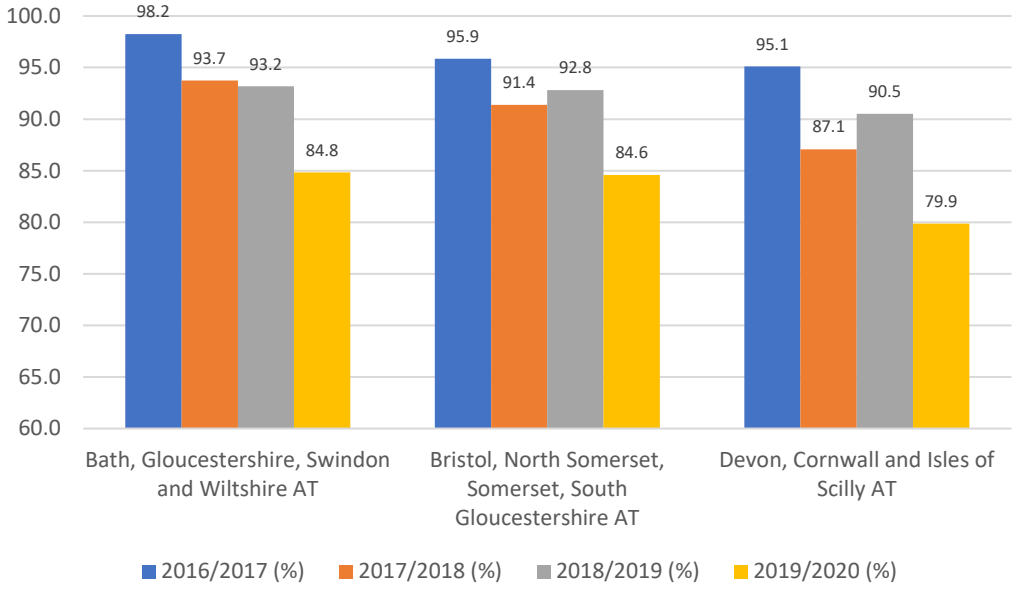
4.39 If a practice achieves less than 96% of their contractual obligation, they can be subject to clawback, a process in which NHSE&I is able to claim back the value of the underachieved units.

4.40 In England in 2015/2016, £54,505,326 was clawed back from practices, increasing to £81,506,678 in 2016/2017, £88,774,248 in 2017/2018 and £138,438,340 in 2018/2019 which means that by 2019/2020 the total clawback in England was equivalent to 5% of contract values.

4.41 Chart 28 demonstrates the reduction in the levels of delivered UDA activity compared with contract across the region over the last four years[116], which is associated with a decline in practice income since 2016-2017 as a result of 'clawback' and a corresponding reduction in contracted UDA activity.

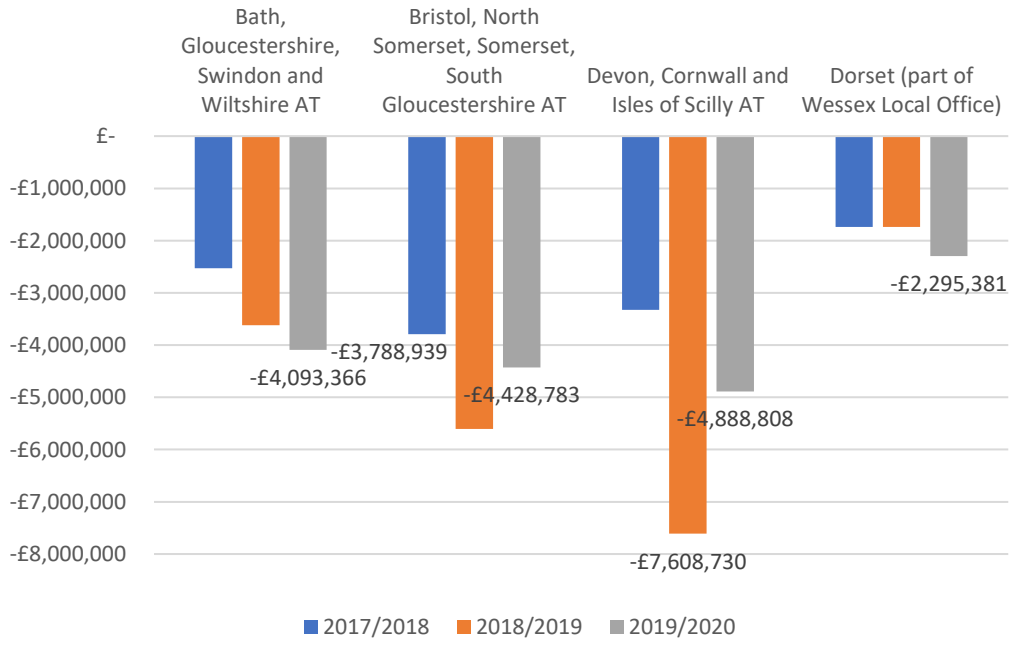
[116] Dorset is omitted as data for the last 4 years was not available at the time of this OHNA for periods pre 2018-2019

Chart 28: Delivered UDAs over last 4 years as % of contracted UDAs (Source NHSE 2020)



4.42 Chart 29 below sets out the UDA clawback value in £s by sub-region across the South West.

Chart 29: UDA Clawback Value (£) by Subregion 2017-2020



4.43 In 2017-2018, across the South West, there was a total of £11.4M clawed back from NHS dental contacts in the region, in 2018-2019 there was a total of £18.6M, and in 2019-2020 there was a total of £15.7M clawed back.

4.44 There is a (national) correlation between higher levels of clawback and areas of high deprivation, which can lead to a 'vicious cycle' of difficulty recruiting and retaining dentists in high need populations as UDA levels are incrementally reduced.

Cross-Border Flow and Seasonal Variation

4.45 As people may visit a dental practice anywhere in the country, it is useful to explore cross border flows for three reasons. Firstly, large numbers of people accessing services from outside an area can limit access to services for residents. Secondly, such patterns may indicate a lack of service availability or poor service quality in the area. Thirdly, some areas in the South West have seasonal migrant workers and others, such as Cornwall and Isles of Scilly, Devon and Dorset are popular holiday destinations, which may lead to seasonal variations in access to care, especially urgent care.

Complexity of Care

4.46 The proportion of people having Band 1 courses of treatments is higher in all areas of the South West relative to the England average. Whereas the proportion of people having Band 2 and Band 3 courses of treatment is lower in all areas of the South West relative to the England average. This picture is most stark in Bath, Gloucester, Swindon and Wiltshire. Therefore, the people attending for dental examination in the region have relatively good oral health and require less complex care. It may also suggest that people needing more complex care may be facing additional barriers to accessing care. Therefore, NHSE&I may wish to consider undertaking a health equality audit to ensure the equitable availability and access to NHS primary dental care in the region.

Table 23: Proportion of courses of treatment in each band (adults and children combined) NHSE&I 2020

Area	Band 1	Band 2	Band 3	Band 4 Urgent
NHS Bath and North East Somerset, Swindon and Wiltshire CCG	64.70%	22.79%	3.29%	9.04%
NHS Bristol, North Somerset and South Gloucestershire CCG	62.74%	23.60%	3.70%	9.69%
NHS Devon CCG	61.11%	24.62%	3.72%	10.07%
NHS Dorset CCG	61.96%	24.53%	4.13%	9.04%
NHS Gloucestershire CCG	64.47%	23.89%	3.34%	8.03%
NHS Kernow CCG	59.31%	25.46%	3.85%	11.06%
NHS Somerset CCG	61.21%	24.51%	3.95%	9.86%
South West	62.24%	24.14%	3.71%	9.58%
England	59.96%	25.48%	4.78%	9.47%

4.47 Standing-out from the data in table 23 above, is the lower levels of Band 3 treatments overall compared with the England-average and the higher levels of urgent care in Cornwall and Devon compared to the South West.

Evidence based prevention and care

Fluoride varnish application

4.48 Evidence-based guidance recommends application of fluoride every six months for all children aged three years and above and more frequently for those at risk of decay. Fluoride varnish application is also recommended twice a year for vulnerable adults. The application of fluoride varnish two-three times a year can reduce tooth decay by 33% in baby teeth, and 46% in adult teeth[117].

4.49 Approximately a quarter of local authorities are currently investing in fluoride varnish programmes.

4.50 Table 24 shows the fluoride varnish application rates for areas in the South West. Fluoride varnish application rates are lower in all areas in the region compared to the national average. Every child, over the age of three years, attending for a dental examination should have fluoride varnish application. Commissioners might wish to consider further engagement with LDN and LDC colleague to encourage fluoride varnish applications and recording of this activity by performers. Evidence-based prevention is particularly pertinent considering reduced dental access due to Covid-19 operational challenges in dental practices.

4.51 In 2018-2019 there were 599,188 fluoride varnish applications in the South West 9.5% of the population (NB. this data is not available for 2019-2020). There is a wide range of fluoride varnishing undertaken in the South West. In 2018-2019 the percentage of the population that have received fluoride varnish was 42.8% for children and 1.2% of adults. There are some significant variations across the region, ranging from 42.3% of children in Cornwall through to 57.7% in Dorset.

Table 24: Fluoride varnish application Children and Adults by STP 2018-19 (NHS Digital-ONS)

Fluoride Varnish	Fluoride Varnish Count	Fluoride varnish as a % of the Region	Fluoride varnish as a % of the population
South West	599188	100.0%	
NHS Bath and North East Somerset CCG	21170	3.5%	11.0%
Adult (over 18)	2209	0.4%	1.4%

[117] https://www.cochrane.org/CD002279/ORAL_fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents

Fluoride Varnish	Fluoride Varnish Count	Fluoride varnish as a % of the Region	Fluoride varnish as a % of the population
Child (u18)	18961	3.2%	59.2%
NHS Bristol, North Somerset and South Gloucestershire CCG	104808	17.5%	10.9%
Adult (over 18)	8496	1.4%	1.1%
Child (u18)	96312	16.1%	49.1%
NHS Devon CCG	116752	19.5%	9.8%
Adult (over 18)	12992	2.2%	1.3%
Child (u18)	103760	17.3%	46.4%
NHS Dorset CCG	93121	15.5%	12.1%
Adult (over 18)	10409	1.7%	1.7%
Child (u18)	82712	13.8%	57.7%
NHS Gloucestershire CCG	73287	12.2%	11.6%
Adult (over 18)	7523	1.3%	1.5%
Child (u18)	65764	11.0%	51.3%
NHS Kernow CCG	51673	8.6%	9.1%
Adult (over 18)	5928	1.0%	1.3%
Child (u18)	45745	7.6%	42.3%
NHS Somerset CCG	66254	11.1%	11.8%
Adult (over 18)	4823	0.8%	1.1%
Child (u18)	61431	10.3%	55.5%
NHS Swindon CCG	25914	4.3%	11.4%
Adult (over 18)	2488	0.4%	1.4%
Child (u18)	23426	3.9%	45.2%
NHS Wiltshire CCG	46209	7.7%	9.3%
Adult (over 18)	4339	0.7%	1.1%
Child (u18)	41870	7.0%	39.6%
South West	599188	100.0%	10.7%
Adult (over 18)	59207	9.9%	1.2%
Child (u18)	539981	90.1%	49.1%

Recall interval

4.52 NICE has published evidence-based guidelines for dental recall intervals. Adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their level of risk of oral disease. Therefore, adults whose care falls under Band 1, that is those people with low levels of disease activity, should usually have a recommended recall interval of 24 months.

4.53 Extending the recall interval for people at low risk of oral diseases aligned with the NICE guidance would increase the availability of dental services as fewer UDAs would be used for unnecessary recalls and potentially reduce waiting times for people with high needs of care. This is particularly pertinent in the interim, with reduced capacity in dental practices, relating to coronavirus.

4.54 Traditionally, dentists encourage the practice of recommending 6 monthly dental check-ups. There is, however, little information to either support or refute this practice, or to advise either patients or dentists on the best dental recall interval for the maintenance of oral health for adults.

4.55 The table below present the proportion of children and adults re-attending every three months in the South West. The data shows that the proportion of adults seen every three months is comparable with the England average. This is despite a greater proportion of Band 1 courses of treatments being provided in the region. What stands-out in Table 25 (below), is the recall intervals for children compared with the England-average.

Table 25: 3-month recall intervals (high-risk) patients 2019 (NHSE&I)

Area	Children (%)	Adults (%)
Bath, Gloucester, Swindon and Wiltshire	6.3	11.5
Bristol, North Somerset, Somerset and South Gloucestershire	6.6	12.7
Devon, Cornwall and the Isles of Scilly STP	6.2	12.5
Wessex (includes Dorset)	5.8	11.8
England	7.0	12.7

Other primary care services

4.56 Primary care activity is also provided at Bristol Dental Hospital and its associated outreach clinics, and at the Derriford, Devonport, Exeter and Truro Dental Education for the Peninsula Dental School, predominantly by dental students under the supervision of GDC registered staff. This activity is funded primarily through service increment for teaching (SIFT) funding, which is NHS funding to offset the costs to the NHS of providing teaching to undergraduate medical and dental students in clinical placements. It covers both block grants to hospital trusts.

4.57 In addition, many NHS dental practices provide primary care dentistry on a privately funded basis and there are also many entirely private dental practices. There is no local data available on private dentistry activity and costs.

Additional services

4.58 Additional services are provided under the standard national general dental service contracts and include domiciliary care, sedation, orthodontics and dental public health services. Orthodontic services provided in primary care are described below in the specialist care section.

Domiciliary services

4.59 Domiciliary oral healthcare reaches out to those people who cannot visit a dentist. Care is provided at the location that the patient permanently or temporarily resides including patients' own homes, residential units, nursing homes, hospitals and day centres. Adequate provision of these services ensures dental services facilitate a reasonable alternative route for older people and vulnerable groups in accordance with the Equality Act 2010.

4.60 Table 26 describes the primary care services in the South West that provide domiciliary care. There are 13 providers of domiciliary care in the region. Most of the providers are in primary care remunerated on the basis of UDAs. Patients treated in secondary care and the community dental services provided by University Hospital Bristol Primary Care Dental Service, Somerset Partnership NHS Foundation Trust, Gloucestershire Community Dental Service and Great Western Hospitals Foundation Trust have to meet additional criteria of the service to be eligible for care.

4.61 Section 3 of this report described the demographic characteristics of the population with more people of retirement age and less people of working age living in the South West of England. This is likely to lead to a greater need for domiciliary care in the near future.

Table 26: Domiciliary Care Provision in the South West

Contract type	Area Covered	Annual Delivery Parameters
GDS	Okehampton, North Cornwall Border, Holsworthy	150 – 200 visits
PDS	East and Mid Devon, Exeter	800 - 1,300 UDAs 350 – 400 patients
PDS	Teignbridge area	1,500 - 2,000 UDAs Patients treated: 650 - 750
GDS	Plymouth	1,500 - 2,000 UDAs 600 – 700 patients
PDS	Torbay area	950 - 1,540 UDAs 420 - 470 patients
GDS	Mid-North Devon, Torrington, Bideford, South Molton	144 sessions
PDS	Cornwall	6,204 UDAs
GDS	North East cover - Ilfracombe, Braunton	3 UDAs, no cap set in contract

Contract type	Area Covered	Annual Delivery Parameters
Community Dental	Bristol, North Somerset, Somerset and South Gloucestershire	Nothing specified in the contract
Community Dental	Somerset	412 Clinical Sessions 1236 patients 1800 – 2000 UDAs
Community Dental	Dorset	No cap – must meet service criteria
Community Dental	Gloucester	418 patients that meet the CDS service criteria
Secondary Care	Swindon & Wiltshire	849 patients that meet the CDS service criteria

Sedation services

4.62 Control of anxiety is an integral part of dental care and requires practitioners to consider the range of non-pharmacological and pharmacological methods of anxiety management when planning treatment for patients. For very anxious patients, sedation may be administered by inhalation or intravenously. Current national guidance includes several recommendations to ensure that sedation is both safe and effective. It must be provided only by those who are trained and experienced and only where the appropriate equipment and facilities are available.

4.63 In conscious sedation, verbal contact and protective reflexes are maintained, whereas in general anaesthesia these are lost. Nitrous oxide/oxygen is usually the technique of choice for conscious sedation of paediatric dental patients and should be considered as an alternative to general anaesthesia. However, intravenous sedation is a safe and effective alternative for adult dental patients. Provision of sedation services varies across the South West as seen in Table 27.

Table 27: Sedation services in the South West 2018/19

Area STP	Type of Services (n)	Type of Sedation	Number of Sedations
Bath & North East Somerset, Swindon and Wiltshire	Great Western Hospital (1) GDS (1)	Inhalation and Intravenous	144
North Somerset, Bristol and South Gloucestershire	PDS (1) and CDS (1)	Intravenous	1721
Somerset	CDS (1)	Intravenous	583
Cornwall and Isle of Scilly	CDS	-	(no data available)
Devon	CDS (2), GDS (2)	-	1859
Gloucestershire	Pilot from January 2020[118]	-	-
Dorset	CDS (1), GDS (1)	-	2453

[118] pilot in place, no data currently. The services is provided in the CDS service. Treatment provided to Special care cohort of patients aim of reducing GAs

4.64 There are only five primary care GDS or PDS sedation services across the South West with no sedation services in North Gloucestershire. The majority of the services are provided by the Community Dental Service, therefore, for patients to access these services they would need to meet the CDS access criteria.

4.65 Across the region there are no NHS-funded adjunct services to manage patients with dental anxiety and dental phobia (e.g. cognitive and behavioural therapies, acupuncture or hypnosis services) and commissioners might wish to develop a regional care pathway for people with dental anxiety.

Unplanned dental care

4.66 Access to urgent care is critical to support the relief of pain and for care after an accident. 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). In the recent 2018 Adult in Practice survey, 8.2% of patients in the South West stated they had an urgent treatment need compared to 4.9% across England.

4.67 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 a problem occurs.

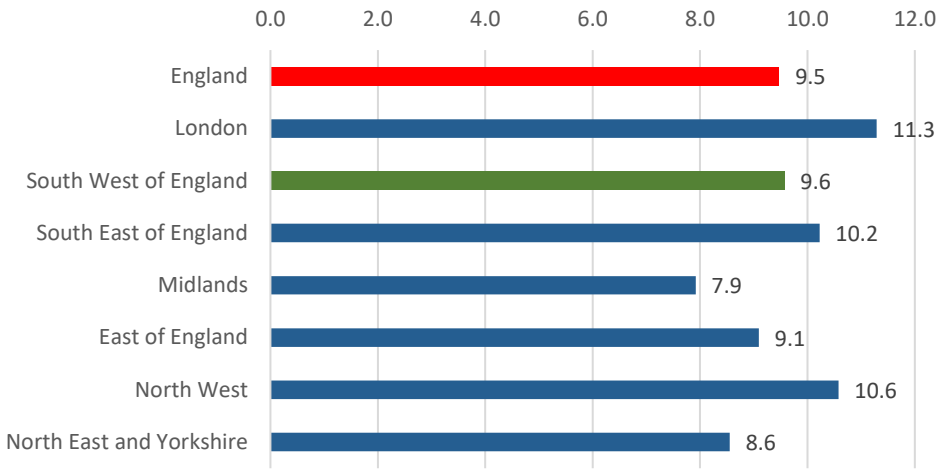
4.68 Unplanned dental care is best reviewed by assessing the levels of urgent care as per the bands of provision in the dental care system. The table below sets out the number and % of urgent care 2019-2020 by region. It shows that in the South West 9.6% of dental care was urgent care which is slightly above the proportion of urgent care nationally at 9.5%.

Table 28: Number and percentage of Courses of Treatment by NHS Commissioning Region1 and treatment band,
2019-20 (NHS Dental Services, NHS Business Services Authority (BSA)[119]

Org Name	Urgent	Urgent (%)[120]
England (19/20)	3,638,000	9.5%
South West of England (19/20)	370,000	9.6%

[119] Data is affected by COVID-19.
[120] Figures presented are rounded

Chart 30: Percentage of Urgent Care Treatment by NHS Commissioning Regions (% of total Bands) 2019-20



Urgent Dental treatment by type (Child/non-paying Adult/paying Adult)

4.69 Across the South West the profile of urgent care as a proportion of all treatment bands is set out below. The data has been taken from the review of treatment bands nationally by region, STP, LA and by Cost of Treatment 2019-2020 (Sum and %)[121].

4.70 The table below compares the England and South West levels of urgent care activity by child/non-paying adult and paying adult.

Table 29: Review of Treatment Bands National/South West by Cost of Treatment 2019-2020 (Sum and %)

Area	Type	% within type
South West		
Urgent/Occasional	Child	4.0%
	Non-paying adult	16.4%
	Paying adult	10.8%
England		
Urgent/Occasional	Child	4.2%
	Non-paying adult	16.2%
	Paying adult	10.5%

4.71 In the South West region, the level of urgent care for children was 4% (as compared to England at 4.2%), for non–paying adults it was 16.2% (as compared

[121] Source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report : NHS Dental Statistics for England - 2019-20: Annex 3 (Activity)

to England at 16.4% and for paying adults it was 10.8% as compared to England at 10.5%

4.72 Across the South West there is some variations in the levels of urgent care between children, non-paying and paying adults. This is set out in the table below:

Table 30: Review of Urgent care treatment Bands by STP in the South West by Cost of treatment 2019-2020 (%)

Row Labels	Type	% within Type
NHS Bath and North East Somerset, Swindon and Wiltshire CCG		
Urgent/Occasional	Child	3.6%
	Non-paying adult	15.9%
	Paying adult	10.7%
NHS Bristol, North Somerset and South Gloucestershire CCG		
Urgent/Occasional	Child	4.3%
	Non-paying adult	16.1%
	Paying adult	10.8%
NHS Devon CCG		
Urgent/Occasional	Child	4.3%
	Non-paying adult	17.5%
	Paying adult	11.0%
NHS Dorset CCG		
Urgent/Occasional	Child	3.8%
	Non-paying adult	16.0%
	Paying adult	9.8%
NHS Gloucestershire CCG		
Urgent/Occasional	Child	3.4%
	Non-paying adult	13.4%
	Paying adult	9.7%
NHS Kernow CCG		
Urgent/Occasional	Child	4.2%
	Non-paying adult	18.2%
	Paying adult	12.5%
NHS Somerset CCG		
Urgent/Occasional	Child	4.2%
	Non-paying adult	16.4%
	Paying adult	11.0%
South West		
Urgent/Occasional	Child	4.0%
	Non-paying adult	16.4%
	Paying adult	10.8%

Urgent Dental Centres (Covid-19)

4.73 This section of the report sets out data provided by NHSE&I relating to the delivery of urgent care during the Covid-19 pandemic.

4.74 In response to the coronavirus pandemic NHSE&I Office of the Chief Dental Officer for England issued urgent dental care guidance and standard operating procedure (SOP)[122]. This has been adapted by local systems to deliver safe and effective urgent dental care services in line with the new guidance and SOP for remote triage and face-to-face management of patients.

4.75 In the South West, NHSE&I, and primary and secondary care dental professionals worked together to establish a regional Urgent Dental Care 'system', in response to the pandemic and in-line with national operating guidance[123]. A series of outcome forms were instigated to monitor this new service, with a paper written to describe the process of establishing the service; present initial service data (telephone triage, face to face treatment, and patient reported outcome and experience measures)[124].

4.76 These outcome forms generated data which is based on 45,000 telephone triage records from 8 June to 8 September 2020 (90 days), and urgent appointment records from 28 April to 30 October (26 weeks). The data covers the three routes of access to urgent dental centres, via calls to general practice, calls to NHS 111 (out of hours), and direct contact with UDCs.

Telephone Triage

4.77 Of the patients contacting telephone triage services, 30,596 (71.2%) were regular attendees with an NHS dentist, 4,981 (11.6%) attended a private dentist, and 6,963 (16.2%) did not regularly attend either a private or NHS dentist. A further 9,586 of callers were known to be unregistered (21.3%).

4.78 The paper found that the majority of patients received triage, using advice, analgesia and antimicrobial (AAA), with onward referral to urgent dental care hubs in 9% of cases and referral to secondary care in 1.3% of cases. The sample indicated higher proportions of both urgent care and secondary care referrals: 13.1% and 2.1% respectively.

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[122] https://www.england.nhs.uk/coronavirus/publication/covid-19-guidance-and-standard-operating-procedure-urgent-dental-care-systems-in-the-context-of-coronavirus/
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

[124] Establishing an urgent dental care service in the South West region during COVID-19
https://www.england.nhs.uk/south/2020/04/09/new-urgent-dental-care-centres-to-serve-the-south-west/
https://www.england.nhs.uk/south/2020/04/21/what-to-do-if-you-need-urgent-dental-treatment/

Urgent Appointments

4.79 Data from the 5,634 face to face appointments found that 9.5% were assessed as "immediate" need (P1), 68.2% assessed as "treatment within 24 hours" (P2) and the remainder (22.3%) were inappropriate or did not meet the criteria. The analysis showed that for 15,245 patients 9.4% were P1, 79.4% were P2 and the proportion not meeting the criteria or inappropriate was 11.2%.

4.80 The sample is dated from May through October, meaning most appointments took place after the data used in the paper. The shift from 'not meeting criteria/ inappropriate' to P2 suggests that over time, telephone triage was better at identifying appropriate patients.

4.81 45% of all attended appointments were with 'unregistered[125]' patients, i.e. not affiliated to a practice and/or not regular attenders. This points clearly to the fact a person is about twice as likely to need urgent care if they are not registered with a dentist.

4.82 These 'unregistered' patients are twice as likely to need to access an urgent appointment than registered patients. For all patients who received treatment, the proportion classified as P1 (immediate) or P2 (treatment within 24 hours) was proportionally the same whether registered or not.

4.83 Telephone triage outcomes are similar for males and females, within the groups of registered and unregistered patients. The overall gender variation is entirely explained by registration status. Registered patients are 2.5 times more likely to receive 'advice only' than unregistered patients, who are nearly five times as likely to be referred to urgent care (33.6% versus 7.6%).

Table 31: Telephone triage outcomes by registration status (%)

Registration status	advice only	AAA	secondary care referral	urgent care referral	Total
Unregistered	21.8	41.9	2.7	33.6	100
Registered	51.9	38.6	2.0	7.6	100

[125] this terms was used in this research for those people who did not have a regular NHS Dentist

Table 32: Telephone triage from females, registered and unregistered (%), by area

Area	reg	unreg
Bristol / BANES / South Gloucestershire	57.6	47.3
Cornwall	58.4	47.8
Devon	56.9	46.5
Dorset	57.2	46.8
Gloucestershire	56.0	50.9
Somerset	56.4	49.1
Wiltshire / Swindon	57.2	49.4
Average	57.2	47.5

4.84 The outcomes for registered and unregistered patients are the same in terms of actual treatment (P1 and P2) as shown below, the difference between the groups being in the proportion classified as 'not meeting local criteria' and 'inappropriate' (table previously provided).

Table 33: Urgent appointment classification of P1 and P2 by patient registration status

Patient status	P1	P1%	P2	P2%	Total
Unregistered	731	11.3	5725	88.7	6456
Registered	702	9.9	6383	90.1	7085
Grand Total	1433	10.6	12108	89.4	13541

Table 34: Urgent appointment classification by patient registration status (%)

Patient status	Does not meet	Inappropriate	P1	P2	Total
Unregistered	5.0	1.3	10.6	83.0	100
Registered	8.6	6.6	8.4	76.4	100
Average	7.0	4.2	9.4	79.4	100

Community Dental Services, Special Care and Paediatric Dentistry

Community Dental Services (CDS)

4.85 CDS and Special Care dental services are providing for dental care services to the following groups:

- Children and adults with learning disabilities
- Children with complex and extensive dental treatment needs
- Children and adults experiencing mental health issues
- Frail older people who cannot receive care in general dental practice
- Children and adults who are severely physically and/or medically compromised
- Children and adults with severe dental anxiety
- Looked after children or children with identified safeguarding concerns
- People presenting with behavioural management issues
- People who are currently experiencing issues with substance misuse
- Vulnerable and socially excluded patients, including people who are homeless and insecurely housed people.

4.86 Also provided for by some community dental services are:

- Urgent care/dental access for "unregistered patients"
- Domiciliary dental care, e.g. people with restrictive medical conditions, mental illness, dementia or increasing frailty who are unable to travel to a dental surgery. The service is provided in people's homes, day centres, or care homes. Inevitably, constraints may limit the scope of treatments which can be performed
- Public health initiatives (e.g. oral health promotion programmes, dental epidemiological studies)
- Conscious sedation services, including inhalation and intravenous sedation. Inhalation sedation offers an alternative to dental general anaesthesia, particularly where children are concerned
- General anesthetic services for additional needs patients where all other options have been 'exhausted'. One of the issues/challenges for CDS services is ensuring adequate access to theatre time, where they are often competing with other priority services.

Special Care Dentistry

4.87 The referral criteria for special care services are complex dentistry for children and adults who are unable to access care in General Dental Services because of their special or additional needs (e.g. by reason of a different physical, sensory, intellectual, mental, medical, emotional or social ability, or a combination of these needs). These services are provided in primary and secondary care settings, and this GDC-recognised speciality includes a focus on adolescents and adults only and specifically the important period of transition as the adolescent moves into adulthood.

Paediatric Dentistry

4.88 Children who do not have additional needs, but who require complex dentistry, will access paediatric dental care until they reach the age of 16. Children who do not have additional needs but continue to require complex dentistry will usually transition to specialist restorative services or other specialist services or, alternatively, access primary care services.

Table 35: Paediatric Inpatient and Outpatient appointments (NHSE&I 2020)

(In-patients)

		Appointment Type		
Provider	Day	Elective	Emergency	Total
University Hospitals Bristol NHS Foundation Trust	86	8	1	95
Grand Total	**86**	**8**	**1**	**95**

(Out-patients)

	Appointment Type		
Provider	New	Follow Up	Total
University Hospitals Bristol NHS Foundation Trust	1,295	4,077	5,372
Grand Total	**1,295**	**4,077**	**5,372**

4.89 All hospital based paediatric dentistry takes place at Bristol, where all but around 2% were out-patients. On average each new appointment had three follow ups.

Special Care and Paediatric Workforce (November 2019)

4.90 There are currently eight providers of Special Care and Paediatric Dentistry across the region - three in South West (North), five in the South West (South). Workforce data for Gloucestershire was not available for inclusion in this report. The responses provided do not delineate between managerial and specialist roles.

Consultant in Special Care:	1 of 9 services across the SW
Consultant in Paediatric Dentistry:	0 of 9 services across the SW
Paediatric or Special Care Dentistry Specialist:	7 of 9 services across the SW

4.91 Successful delivery of specialist-led Special Care and Paediatric Dentistry services requires sufficient and accessible general dental practice capacity to provide level 1 and some level 2 care, along with equipment suitable for managing patients with bariatric needs and accreditation to provide care at level 2.

4.92 The Special Care and Paediatric Dentistry South West Needs assessment report (NHS England & NHS Improvement, January 2020) included a survey of 460 contract-holding practices in the region, of which 56 responded (12%), and for those the findings were:

- 4 of 56 practices were able to offer additional sedation services to NHS patients
- 2 of 56 practices were able to offer a chair suitable for patients over 28 stones
- 2 of 56 practices were able to offer a wheelchair recliner
- 1 of 56 practices was able to offer a hoist.

4.93 Surveys and focus group feedback from the Special Care and Paediatric Dentistry South Wert Needs Assessment highlighted variations in waiting times, with 28% of survey respondents reporting waiting more than 3-monhts for an appointment. Longer waiting times were experienced in Swindon and in Cornwall where half the survey respondents reported waiting over 6-months to their first appointment.

4.94 Enhancing the skills of GDPs to deliver accredited level 2 treatments would relieve pressure on the Special Care and Paediatric services in line with NHS commissioning guidance (NHS England. Guide for commissioning dental specialties - Special Care Dentistry; 2015). Progress in this area is likely to require incentivisation for practices to engage fully in the development of this pathway.

4.95 Feedback from the patient groups highlights the following needs:

- Assurance of a well-trained workforce
- Suitability of environment for patients with additional needs
- Acceptable (i.e. minimal) wait times for appointments
- Recognition that patients will have good days, and bad days
- Time to talk and acclimatise to the (new) environment
- Flexibility of appointment times, including weekends and evenings
- Good communication processes.

4.96 The general dental practice workforce needs support, training/accreditation, access to the necessary equipment, and sufficient appointment time to provide the required help/support to facilitate effective specialist and paediatric pathways. The structure of the UDA-based contracting system does not enable this. Instead, a different contracting mechanism will be required to include the development of

outcome-based KPIs (e.g. timely access, patient experience/Patient Reported Outcome Measures (PROMS) and clinical outcomes). Allied to which, an appropriate data collection and contract monitoring methodology will be needed to support the assessment of the demand requirements and service outcomes, i.e. to ensure value for money for commissioning bodies – investment will be needed in cultivating relationships with general dental practices and Community Dental Services.

4.97 Specific needs include a 'smoother' and more flexible referral system between the level 1 and level 2/3 services which reduces unnecessary delays to service access. For example, where patients with learning difficulties are unable to tolerate x-rays, this should not exclude their referral. Hence, specialist advice and support options for general dental practitioners will need to be incorporated into referral pathways, e.g. through the development of an agile/responsive Single Point of Access.

4.98 Supply and workforce data indicates the current consultant and specialist workforce is insufficient to meet demand, along with insufficient (managed) capacity in NHS dental practices across the region to support specialist pathways across complexity levels 1-3.

4.99 Special Care: The findings from service user surveys in the supply and workforce oral health needs assessment (January 2020) show that the highest proportion of patients (39%) stated they were able to see a Special Care dentist within one month. However, 28% reported waiting over three-months for an appointment. Reported waiting times also varied geographically. These findings suggest that demand exceeds capacity in some areas and that people who are using the Special Care dental service are not experiencing equality of access.

4.100 Issues with parking and on-site accessibility were noted and there was a lack in awareness of what services were available. More clarity and regularity in 'services marketing' communications is required from providers to patient groups.

4.101 The majority of people (74%) who responded to the survey said that they would not have preferred to have received their care at a 'high street dentist', the reason provided being high street dentists do not have experience or knowledge of how to treat people with additional needs. This would suggest an "accreditation" for a practice would give confidence to patients, allied with effective patient communications.

4.102 The Special Care and Paediatric Dentistry Needs assessment also identified that service capacity within general dental practices and community dental services (e.g. measured by access/waiting times performance) is not consistent or sufficient to meet the demand for assessments or the routine care of looked after children. There are specific service access issues relating to children under 2-years-old and

care leavers as a result of charges levied for dental care.

4.103 Community dental services across the region (mainly provided by a salaried workforce) provide a wide range of non-specialist dental services, meeting the needs of differently abled, vulnerable and socially excluded individuals. There is scope of similar models for service delivery to be developed within general dental practices to improve service access for targeted/priority groups, including urgent care, domiciliary services and services for people with additional needs. Consultant appointments to co-ordinate and support these developments, structured workforce development programmes, and clear service specifications will enhance the quality of these service enhancements and ensure specific cohort groups do not fall through the gap between GDS and CDS services, e.g. children with high caries, and bariatric patients.

Initiatives

4.104 Over the last ten years child admissions (e.g. general anaesthesia services) have increased every year, along with the associated burden of pain and disruption for children/families. As a conservative estimate, the current cost to the NHS is likely to exceed £55 million (i.e. £1,179/procedure).

4.105 Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly.

4.106 In 2017/2018, there were 38,385 tooth extractions under general anaesthetic for children due to tooth decay in England - equivalent to 13 full school buses each week. Public Health England data indicates that at least 60,000 days of school are missed during the year for hospital tooth extractions; parents and carers may also have to take time off work.

Summary of key issues for Paediatric and special care dentistry

4.107 There are very few paediatric specialists, paediatric consultants and special care consultants across the South West region. There is presently no Level 2 accreditation process in place for Special Care or Paediatric Dentistry in the region.

4.108 There is limited reported willingness, capability or capacity amongst general dental practices to provide for the actual level of demand for patients with additional needs. For example, very few practices report having any of the necessary specialist equipment to enable increased physical access.

4.109 There is wide variation in the scope and operation of current (e.g. CDS) service provision. In Cornwall, the community dental service appears to be resourced in the order of three-fold the level of other CDS services in the region and is delivering

a corresponding level of service activity. There are significant variations in waiting times or access to special care and paediatric dental services, with service access particularly inequitable in Cornwall.

4.110 Recruitment and retention challenges are acutely felt. There is a need to balance the demand for local access with the provision of a workforce which operates on an appropriate economy of scale. To illustrate this, between 30% and 60% of the total population is currently unable to access CDS services within 30 minutes' travel by public transport.

4.111 With the increasing trends in obesity there is a potential increase in the need for specialist bariatric care services. The challenges involved include availability of special dental chairs, appropriate transportation to and from service sites, and adequate toilet facilities.

4.112 As part of the NHS England & NHS Improvement's Learning Disability and Autism Programme, a 'sensory pilot' initiative is being launched to improve access to dental check-ups for children and young people with a learning disability or autism who attend special schools.

4.113 The Care Quality Commission report, Smiling Matters: Oral health care in care homes (2019), highlights the high levels of unmet need in care homes. This is also likely to apply to older people living in their own homes and a large cohort of patients with a learning disability.

4.114 Vulnerable groups, such as homeless populations, asylum seekers and refugees, people with undiagnosed or hidden disabilities and frail older people may be accessing care through community dental services but may not fall into the core target groups for the new specialist services. Alternative commissioning arrangements will be needed to ensure there is no increase in inequalities in access and care for these vulnerable groups.

Secondary care dental services

4.115 There are several secondary care providers in the South West of England providing dental services.

Hospital tooth extractions for children

4.116 Tooth extraction due to decay was the most common reason for elective hospital admissions in children aged 6 to 10 years old (nationally and locally)[126]. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2015-2016 represented a total NHS cost of nearly £50.5 million in England.

Table 36: Number of Finished Consultant Episodes (FCEs) for children and adolescents aged 0-19 for hospital dental extraction during 2018-19 by government office region (GOR) of residence, (surgical removal or simple extraction of tooth)

Region	Age 0-5yrs	Age 6-10yrs	Age 11-14yrs	Age 15-19yrs	Total 0-19yrs
North East	29%	44%	16%	11%	3,435
North West	23%	43%	19%	15%	10,690
Yorkshire and The Humber	26%	47%	16%	11%	9,015
East Midlands	17%	37%	26%	20%	2,850
West Midlands	17%	34%	22%	28%	3,220
East of England	13%	26%	33%	28%	3,710
London	26%	40%	19%	16%	11,770
South East*	18%	34%	27%	21%	7,250
South West	19%	44%	20%	17%	7,080
England	22%	40%	21%	17%	**59,014**

4.117 In 2018-2019 more than 7,000 children were admitted to hospital to have one or more teeth extracted in the South West of England (Table 36). The majority of these children (44%) were between the age of aged 6 to 10 years old. This is in line with the national trend[127]. No assumptions can be made about the method of anaesthesia provided for these procedures, but it is likely that most episodes involved general anaesthetic (unconscious sedation). In some instances, the data

[126] Royal College of Surgeons of England; Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis, https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/dental-decay-hosp-admissions/

*Due to an issue with HES coding in East Sussex Healthcare NHS Trust in 2018/19, for which approximately 85,000 records erroneously had all diagnosis and/or procedure codes removed, this value should be treated with caution.

[127] Public Health England; Hospital tooth extractions of 0 to 19 year olds, https://www.gov.uk/government/publications/hospital-tooth-extractions-of-0-to-19-year-olds

are an underestimate of the number of episodes, as the community dental service may provide the extraction service in hospital premises, but the episodes may not be included in hospital data recording.

4.118 Significant inequalities persist, with admission rates for tooth extraction in the most deprived communities nearly four times that of those living in the most affluent communities[128].

Restorative Dentistry

4.119 Restorative dentistry involves the study, diagnosis and integrated management of diseases of the oral cavity, the teeth and supporting structures. This encompasses restorative mono-specialties of endodontics, periodontics and fixed and removable prosthodontics (across levels of complexity).

Table 37: Restorative Surgery (NHSE&I 2020)

(In-patient)

	Appointment Type		
Provider	**Day**	**Elective**	**Total**
University Hospitals Bristol NHS Foundation Trust	50		50
University Hospitals Plymouth NHS Trust	103	2	105
Grand Total	**153**	**2**	**155**

(Outpatient)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	3,578	15,445	19,023
Taunton and Somerset NHS Foundation Trust	490	1,582	2,072
Poole Hospitals NHS Foundation Trust	204	1,580	1,784
University Hospitals Plymouth NHS Trust	138	1,018	1,156
Grand Total	**4,410**	**19,625**	**24,035**

4.120 Four trusts accounted for all the outpatient activity, with 79% taking place at the University of Bristol Dental Hospital. There were also recorded a marginal number of day cases, 50 at Bristol and 103 at Plymouth. Poole and Plymouth had a higher ratio of follow up appointments to new compared to Bristol and Taunton and Somerset, which may indicate case mix or operational differences.

[128] Public Health England; Hospital tooth extractions of 0 to 19 year olds, https://www.gov.uk/government/publications/hospital-tooth-extractions-of-0-to-19-year-olds

Specialist Restorative Dentistry

4.121 Complex restorative services (e.g. endodontics) are provided in the secondary care sector, in accordance with referral guidelines. The services provide:

- Management of hypodontia and developmental disorders
- Surgical interventions
- Head and neck cancer complex restorative rehabilitation pre/post radiotherapy/surgery
- Interventions requiring sedation
- Implant work related to the above.

4.122 Level 2 and 3 care within mono-specialty disciplines (endodontics, periodontics and fixed and removeable prosthodontics) are not currently readily available. Some dental departments within teaching hospitals have capacity to provide some level 2/3 care for high-risk groups, including Bristol Dental Hospital, but access to services is various across the region, e.g. most Endodontic procedures are being provided through independent funding review panel (IFA), as a result of recruitment issues for mono specialists within the hospital system.

Table 38: Current Restorative Consultants WTE 2019-2020

Location (Site)	Whole Time Equivalents
Bristol, North Somerset, South Gloucestershire - (Bristol)	2.1 wte
Devon - (Plymouth)	0.6 wte
Devon – (Torbay) (head and neck cancer patients only)	0.05 wte
Gloucestershire – (head and neck cancer patients only)	0.2 wte
Somerset – (Taunton)	0.8 wte
Dorset – (Poole)	0.4 wte
Cornwall	0 wte.
Bath, Swindon, Wiltshire (BSW)	0 wte.
South West Total	4.05 wte

Managed Clinical Network

4.123 There is a Restorative Dental Services Managed Care Network, which has been in place for four years. The MCN supports a range of initiatives, including a Consultant Peer Review Group and an active programme of 'pilot projects' designed to support primary care to deliver more complex care, e.g., the use of periodontal care plans.

4.124 There is a high demand for restorative support, especially for general advice and treatment planning for dentists in primary care, and there is currently no process in place to support this effectively. Competency levels amongst GDPs will vary. One aspect of care which is impacted by this, is the post-surgical 'rehabilitation' of this cohort, i.e. to reduce the potential for severe complications.

4.125 Similar issues are reported in terms of care for dental developmental disorders at Tier 1 and 2 complexity, e.g. hypodontia and cleft patient, and dental trauma – this is having a corresponding impact in terms of Tier 3 presentations.

4.126 The Managed Care Network reports that waiting times are considerable in some parts of the region, with reports of six-month waiting times for assessment and a further 80+ weeks for treatment.

4.127 A model of Consultant-led specialist support for primary care, with specialist community-based centres/'hubs' to resource effective Tiers 1/2 service provision is advocated by the MCN (with treatment under GA maintained within a hospital facility).

Oral Surgery

4.128 The oral surgery specialty concerns the diagnosis and management of pathology of the mouth and jaws that requires surgical intervention, which includes the management of those who are dentally anxious and medically complex cases such as patients whose medical condition may affect or be affected by dental treatment, e.g. patients with osteoporosis or certain forms of cancer who use bisphosphonate medication to strengthen their bones. Oral surgery specialists will usually practice as part of the multi-disciplinary teams across primary and secondary care within integrated Oral & Maxillofacial Surgery services. Workforce and quality and outcomes measures for these services are framed by the Guide for Commissioning Oral Surgery and Oral Medicine, NHS England (2015).

Table 39: Oral Surgery Activity Inpatient 2019-2020 NHSE&I (In-patient)

	Appointment Type			
Provider	**Day**	**Elective**	**Emergency**	**Total**
Yeovil District Hospital NHS Foundation Trust	9	28	2	39
University Hospitals Bristol NHS Foundation Trust	2,241	16	3	2,260
Taunton and Somerset NHS Foundation Trust	4	1	3	8
Royal United Hospitals Bath NHS Foundation Trust	920	93	80	1,093
Poole Hospitals NHS Foundation Trust	2,364	261	46	2,671
Dorset Healthcare University NHS Foundation Trust	198	1		199
Royal Cornwall Hospital NHS Trust	4,090	144	114	4,348
Royal Devon and Exeter NHS Foundation Trust	891	202	264	1,357
Great Western Hospitals NHS Foundation Trust	790	18	2	810
Salisbury NHS Foundation Trust	753	84	62	899
Gloucestershire Hospitals NHS Foundation Trust	1,953	336	42	2,331
Grand Total	**14,213**	**1,184**	**618**	**16,015**

Table 40: Oral Surgery Activity out patient 20189-2020 NHSE&I (Out-patient)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	4,842	4,916	9,758
Royal United Hospitals Bath NHS Foundation Trust	5,130	6,131	11,261
Poole Hospitals NHS Foundation Trust	4,761	6,739	11,500
Dorset Healthcare University NHS Foundation Trust	76	66	142
Royal Cornwall Hospital NHS Trust	5,571	5,670	11,241
Royal Devon and Exeter NHS Foundation Trust	5,725	5,655	11,380
Great Western Hospitals NHS Foundation Trust	4,666	4,623	9,289
Salisbury NHS Foundation Trust	3,262	3,724	6,986
Gloucestershire Hospitals NHS Foundation Trust	6,873	9,541	16,414
Grand Total	**40,906**	**47,065**	**87,971**

4.129 Nearly 90% of oral surgery in-patient activity was for day cases. Four teaching hospitals accounted for around 75% of all activity (Bristol, Poole, Cornwall and Gloucestershire). Outpatient activity was much more evenly spread across the region. Numbers of new and follow up appointments were broadly similar in most cases, suggesting an average of one follow up. However, Poole and Gloucestershire showed higher follow up rates, which could be driven by case mix or operational differences. In terms of modes of care, 28% of patients were inpatients, 72% were outpatients.

Oral surgery in primary care

4.130 Cases of general and intermediate complexity can be treated in primary care but require service reorganisation and investment in accordance with national commissioning standards. These items of treatment include:

- Surgical removal of less complex third molars involving bone removal
- Surgical removal of buried roots and fractured or residual root fragments
- Management and surgical removal of less complex ectopic teeth (including supernumerary teeth)
- Management and surgical exposure of teeth to include bonding of orthodontic bracket or chain
- Surgical endodontics
- Minor soft tissue surgery to remove apparent non-suspicious lesions with appropriate histopathological assessment and diagnosis.

4.131 The NHS England *Guide for Commissioning Oral Surgery and Oral Medicine* provides service specifications for Intermediate Minor Oral Surgery (IMOS), which include:

- A referral management system to enable all minor oral surgery referrals from primary care dental providers to be processed along a common referral pathway

- Links to the Managed Care Network (with formal link to the LDN) to ensure the complexity of the patient or procedure matches the skills and setting of the individual providing the treatment, and to support vertical service integration and quality improvements.

4.132 Across the South West, IMOS is being provided in three different 'settings', thus in a relatively small number of general practices (i.e. where dentists have enhanced skills and chose to undertake these procedures), in contracted IMOS Tier 2 provider services (i.e. Any Qualified Provider contracts), and currently, by default, many Tier 2 referrals are being made to secondary care. The costs of providing primary care advanced Tier 2 and Tier 3 services are in most cases lower than the costs associated with similar care secondary care, but this is inversely reflected in regional contracting currencies. There would appear to be a mismatch between need and the current profile of service and investment.

Table 41: Oral Surgery providers (Secondary care NHS Trusts and primary care Tier 2 providers)

Provider	Location	Sub region	Sedation
Practice Plus Group	Bristol	Avon	Sedation provided
University Hospitals Bristol NHS Foundation Trust	Bristol	Avon	Sedation provided
Bupa Dental Care	Bristol	Avon	Sedation provided
West Country Dental Care	Bodmin	Cornwall	
West Country Dental Care	Truro	Cornwall	
West Country Dental Care	Cambourne	Cornwall	
West Country Dental Care	Falmouth	Cornwall	
Brighter Dental	Isles of Scilly	Cornwall	
West Country Dental Care	Newquay	Cornwall	
Gentle Dental	Newquay	Cornwall	Sedation provided
West Country Dental Care	Penzance	Cornwall	
West Country Dental Care	St Austell	Cornwall	
Royal Cornwall Hospitals NHS Trust	Truro	Cornwall	Sedation provided
Ramsay Health Care UK	Truro	Cornwall	Sedation provided
Medical Professional Consultancy (MPC) Ltd	Ashburton	Devon	
My Dentist	Barnstaple	Devon	Sedation provided
Northern Devon Healthcare NHS Trust	Exeter	Devon	Sedation provided
Northern Devon Healthcare NHS Trust	Exeter	Devon	Sedation provided
Plymouth Community Dental Services Ltd.	Plymouth	Devon	
University Hospitals Plymouth NHS Trust	Plymouth	Devon	

Provider	Location	Sub region	Sedation
Torbay & South Devon NHS Foundation Trust	Torquay	Devon	Sedation provided
Ramsay Healthcare Ltd	Torquay	Devon	Sedation provided
HM Naval Base, Devonport	Plymouth	Devon	
Smile Kind	Bournemouth	Dorset	Sedation provided
The Royal Terrace Dental Practice	Dorchester	Dorset	
Dentistry @68	Poole	Dorset	Sedation provided
Gloucestershire Hospitals NHS Foundation Trust	Gloucester	Gloucestershire	
Tetbury Hospital	Tetbury	Gloucestershire	
Somerset Partnership. Primary Care Dental Service	Bridgwater	Somerset	
Taunton Dental Practice	Taunton	Somerset	
Taunton & Somerset NHS Foundation Trust	Taunton	Somerset	Sedation provided
Priory Dental Care	Wells	Somerset	
Somerset Surgical Services	Weston-Super-Mare	Somerset	
Apple Dental Practice	Yate, Bristol	South Gloucestershire	Sedation provided
Royal United Hospitals Bath NHS Foundation Trust	Bath	Wiltshire	
Practice Plus Group	Devizes	Wiltshire	
Salisbury NHS Foundation Trust	Salisbury	Wiltshire	
Bupa Dental Care Swindon Dental Anaesthetic Services	Swindon	Wiltshire	Sedation provided
Great Western Hospitals NHS Foundation Trust	Swindon	Wiltshire	

4.133 In previous years, associates would acquire relevant competencies in general practice to treat intermediate need cases, but since the introduction of the 2006 dental contract there has not been a sufficient incentive mechanism in place through UDAs (e.g. the 2006 contract did not allow for separate fees for "examination and radiographs" when patients are referred under "*Advanced Mandatory Treatments*").

4.134 The Oral Surgery MCN Southwest Provider Survey (2019) revealed that some IMOS service providers have not had their contracts reviewed or uplifted in the past few years, and this feedback is helping inform a 'Tier 2 provider review'.

4.135 There is a clinical specialty leadership consensus for the need for service development, based-on a Consultant-led model of service delivery to remove duality and integrate dental care across Tiers 1-3. This idea would involve a re-focus of

secondary care resources at Tier 3 complexity with a corresponding investment in support for primary care to deliver Tier 2/intermediate complexity treatments, for example the introduction of electronic referral (REGO) to support case selection/risk stratification as part of the 'Referral Management Centre'. As in other MCN areas, and in-line with guidance and study findings [129] [130] [131], the MCN is well-placed to work across 'boundaries' with the stakeholder triumvirate (patients, providers, commissioners) to inform the statutory commissioning processes of service re-design and support quality improvements.

Oral Medicine

4.136 Oral Medicine is concerned with the oral health care of patients with chronic, recurrent and medically related disorders of the oral and maxillofacial region, and with their diagnosis and non-surgical management. The scope of Oral Medicine practice includes disorders of:

- Oral soft tissues (mucosa, tongue, lips)
- Salivary glands
- Neurological dysfunction including non-odontogenic related pain.

4.137 The emphasis is on conditions that are primarily managed without the need for surgery. In some cases, oral symptoms can suggest a connection with disease or problems in other parts of the body which require investigation and multi-disciplinary collaboration (e.g. oral cancers, immune disorders, non-odontogenic pain). Conditions managed in Oral Medicine are often chronic and may have a significant psychological, as well as physical impact on the patient's quality of life.

4.138 The low levels of Oral Medicine activity records nationally (typically representing around 5% of specialist dental referrals, which are almost exclusively Level 3 complexity) is partly a reflection that care in this specialty is predominantly outpatient based and its delivery by Oral Surgery and OMFS units, significantly of course where no local Oral Medicine consultant-led service exists. There are currently 71 people in the UK registered on the Oral Medicine specialist list, with services restricted to a small number of regional teaching hospitals.

4.139 The Guide for Commissioning Oral Surgery and Oral Medicine, NHS England (2015), promulgates the need for further development of the Oral Medicine workforce and, irrespective of the proximity to a dental teaching hospital, the benefits of the consultant-led 'Hub and Spoke' service model with local lead clinicians in secondary

[129] Managed care networks: a guide to implementation, NHS Scotland (2002)
[130] Delivering health care through managed clinical networks (MCNs): lessons from the North Report for the National Institute for Health Research Service Delivery and Organisation programme, Quality, Safety and Informatics Research Group, Centre for Primary Care and Population Research, University of Dundee (2010)
[131] Report on Review of National and Scotland wide Managed Clinical Networks, NHS Scotland (2011)

care (regardless of their dental specialty): Oral Medicine specialists and dentists with enhanced skills and experience could provide support, based in, or shared between, district general hospitals, other secondary care settings and primary care (dependent on local support service availability). Teams working with other specialties could facilitate greater use of the collective skill mix across the spectrum of clinical cases and enable the delivery of a more efficient service.

4.140 There is one Oral Medicine consultant led service in the region, which is based at the University of Bristol Dental Hospital. The unit works closely alongside Special Care Dentistry and other dental specialties, together with Maxillofacial Surgery, and is supported by dedicated specialists in Imaging (Magnetic Resonance Imaging, Radiology, and Ultrasonography) and Pathology.

Table 42: In Patient and outpatient Oral medicine Activity 2019-2020 NHSE&I

(In-patients)

	Appointment Type		
Provider	**Day**	**Elective**	**Total**
Taunton and Somerset NHS Foundation Trust	476	15	491
Grand Total	**476**	**15**	**491**

(Out-patients)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	3,756	3,834	7,590
Grand Total	**3,756**	**3,834**	**7,590**

4.141 Nearly 90% of dental medicine patients were outpatients, with an average of a single follow up appointment. All activity took place at Bristol.

Oral maxillofacial, including pathology and oral microbiology

4.142 This is a surgical specialty dealing with pathology of the oro-facial skeleton and surrounding soft tissues. The specialty deals with head and neck cancers, facial skin cancer, facial trauma, reconstructive surgery, orthognathic surgery, diseases of the temporomandibular joint and other more general pathology.

4.143 Oral and Maxillofacial surgery are provided at the following clinics:

- Royal Devon and Exeter Hospital (Wonford)
- Torbay Hospital
- Derriford Hospital (Nr. Plymouth)
- Royal Cornwall Hospital (Treliske)
- North Devon District Hospital (Barnstaple)
- Musgrove Park Hospital (Taunton)
- University of Bristol Dental Hospital.

Table 43: Max-Fax Activity 2019-2020 NHSE&I

(In-patients)

	Appointment Type			
Provider	**Day**	**Elective**	**Emergency**	**Total**
University Hospitals Bristol NHS Foundation Trust	109	204	226	539
Taunton and Somerset NHS Foundation Trust	1,128	203	167	1,498
Dorset Healthcare University NHS Foundation Trust	1,194	3		1,197
Northern Devon Healthcare NHS Trust	735	2		737
Royal United Hospitals Bath NHS Foundation Trust	2		43	45
Poole Hospitals NHS Foundation Trust	7	4	733	744
University Hospitals Plymouth NHS Trust	805	122	168	1,095
Salisbury NHS Foundation Trust	5	3	65	73
Gloucestershire Hospitals NHS Foundation Trust	8	28	189	225
Grand Total	**3,993**	**569**	**1,591**	**6,153**

(Out-patients)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	1,545	4,073	5,618
Taunton and Somerset NHS Foundation Trust	5,645	7,077	12,722
Dorset Healthcare University NHS Foundation Trust	2,044	3,359	5,403
Northern Devon Healthcare NHS Trust	1,904	2,172	4,076
Royal United Hospitals Bath NHS Foundation Trust	369	442	811
University Hospitals Plymouth NHS Trust	4,215	6,492	10,707
Salisbury NHS Foundation Trust	69	250	319
Gloucestershire Hospitals NHS Foundation Trust	35		35
Grand Total	**15,826**	**23,865**	**39,691**

4.144 Over 85% of the activity was in an outpatient setting compared to inpatients, where 65% were day cases, 26% were emergencies and the remaining 9% elective. The proportion of outpatient activity, however, obscures the share of patients seen in this manner, since each new appointment had one or two follow ups (average 1.5). Comparing the number of inpatients with only those outpatient appointments recorded as 'new' to approximate the number of patients, shows that inpatient accounted for 28% of all patients in this specialty, which matches the proportion observed in oral surgery.

4.145 The Bristol Dental School based Oral Microbiology research group conducts studies into the survival strategies of microorganisms, their colonisation and virulence factors, and the interactions that occur between microbes or between microbe and host, especially in the development of microbial communities (biofilms). All activity in this specialty took place at Bristol, which recorded 54 new outpatients and 11 inpatients, four of whom were emergencies. A stark contrast with adults is the much higher average number of follow up visits, which was four compared to between one and two for adults.

Table 44: Paediatric Surgery and Maxillofacial Service 2019-2020 NHSE&I

(Inpatients)

	Appointment Type			
Provider	**Day**	**Elective**	**Emergency**	**Total**
University Hospitals Bristol NHS Foundation Trust	6	1	4	11
Grand Total	**6**	**1**	**4**	**11**

(Outpatients)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	54	222	276
Grand Total	**54**	**222**	**276**

Dental and Maxillofacial radiology

4.146 The specialty of Dental/Oral and Maxillofacial Radiology involves all aspects of medical imaging which provide information about anatomy, function and diseased states, and those aspects of interventional radiology or minimally invasive therapy which fall under the remit of departments of dental radiology. Oral maxillofacial imaging includes cone beam and multi-slice CT, MRI, PET, ultrasound, panoramic radiology, cephalometric imaging, ultrasound, panoramic radiology, cephalometric imaging, intra-oral imaging, and special tests such as sialography.

Orthodontics

4.147 Orthodontics are elective procedures to correct anomalies in the growth of the teeth and jaws – these conditions will normally be detected in the developing child as the permanent teeth erupt into the mouth, but operative care (apart from early interceptive treatment) is normally commenced after the eruption of all the permanent teeth except the third molars (wisdom teeth), usually at 12 to 14 years old. Within a specialist orthodontic practice setting, specialist orthodontists provide primary care-based treatment for patients under 18 presenting with complex care needs who meet the national service criteria (Index of Orthodontic Need).

4.148 Orthodontics are provided at the following clinics:

Table 45: Orthodontic Activity 2019-2020 NHSE&I

(In-patients)

	Appointment Type		
Provider	**Day**	**Emergency**	**Total**
Taunton and Somerset NHS Foundation Trust		1	1
University Hospitals Plymouth NHS Trust	58		58
Grand Total	**58**	**1**	**59**

(Out-patients)

	Appointment Type		
Provider	**New**	**Follow Up**	**Total**
University Hospitals Bristol NHS Foundation Trust	1,128	12,443	13,571
Taunton and Somerset NHS Foundation Trust	850	9,490	10,340
Dorset Healthcare University NHS Foundation Trust	560	12,032	12,592
Northern Devon Healthcare NHS Trust	194	1,094	1,288
Royal United Hospitals Bath NHS Foundation Trust	1,536	10,078	11,614
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust		1	1
Royal Cornwall Hospital NHS Trust	923	9,558	10,481
Royal Devon and Exeter NHS Foundation Trust	756	6,043	6,799
University Hospitals Plymouth NHS Trust	416	4,553	4,969
Great Western Hospitals NHS Foundation Trust	18	335	353
Salisbury NHS Foundation Trust	194	2,575	2,769
Gloucestershire Hospitals NHS Foundation Trust	901	10,224	11,125
Grand Total	**7,476**	**78,426**	**85,902**

4.149 From a hospital perspective, orthodontic services were almost entirely out-patient based. Capacity was widely distributed across the region, but six sites accounted for over 80% of all cases. Each new case had on average 10 follow up appointments.

The impact of Brexit on oral health

4.150 The United Kingdom left the European Union on the 31st of January 2020. Depending on the outcome of the negotiations between the UK Government and the European Union it is expected that certain areas of the oral health sector may be affected.

4.151 A report published in the British Dental Journal has identified the main areas of relevance are around workforce, access to medicines and medical devices, right for treatment abroad, public health and research[132].

4.152 In terms of workforce, dentists who qualified in an EU Member State represent 16% of the total workforce and deliver around 22% of NHS dentistry. According to a survey by the General Dental Council a proportion of these dentists might consider relocation to other countries depending on the outcome of the negotiations[133].

4.153 In terms of access to medicines and medical devices, dental service providers will need to consider the impact of Brexit with regards to the costs relating to importing these products to the UK as well as the regulatory framework around surveillance.

Summary

4.154 In 2019/2020, 705 dental practices across the South West were contracted by the NHS to provide a total of 8,520,528 UDAs. In 2019/2020 there were 2,664 dentists in the South West delivering NHS dentistry. This represented 48 dentists per 100,000 population which is slightly higher than the national average of 44 per 100,000 population.

4.155 The average UDAs commissioned per person in the South West was 1.52 per person compared to 1.41 per person for England, suggesting a higher proportion of UDAs per capita in the South West. The STP data when compared to the South West suggests higher levels per head of population of commissioned UDAs in Cornwall, BNSSG, Devon and Dorset, with the lowest UDAs commissioned per head of population in Gloucestershire and BANES, Swindon and Wiltshire.

4.156 In terms of access to NHS dentistry, from April 2019 to March 2020 access for child patients in the South West was 54.1%, which was higher than the England average of 52.7%[134]. From April 2019 to March 2020 access for adult patients in the South West overall had fallen by 1.51% to 47.3% which is slightly below the England average of 47.7%. In short, in terms of access to dentistry more children in the

[132] https://www.nature.com/articles/s41415-020-2278-z
[133] GDC. Survey of European Qualified Dental Professionals: Final Report. 2019
[134] NHS Dental Services: NHS Business Services Authority: June 2020

South West accessed NHS dentistry and slightly less adults in the South West accessed NHS dentistry.

4.157 Within the South West there are variances to these access levels from different STP areas. Within the region, Wiltshire, Cornwall and Gloucestershire, Dorset ad South Gloucestershire, and Somerset were the SPT areas[135] - with the lowest levels of access for children to NHS Dentistry. For adult patients, Gloucestershire, Wiltshire, Dorset, Plymouth, BANES, Swindon and Cornwall, were all below the average levels of access for the region per head of population.

4.158 In 2017-2018, across the South West, there was a total of £11.4M clawed back from NHS dental contacts in the region, in 2018-2019 there was a total of £18.6M, and in 2019-2020 there was a total of £15.7M clawed back.

4.159 In terms of the complexity of care the South West had 62.2% of their patient undertaking Band 1 treatments in 2019-20 compared to England with 59.9%, 24.1% Band 2 treatments compared to England with 24.5%, 3.7% Band 3 treatment compared to England with 4.8% and 9.6% Band 4 Urgent care compared to England with 9.5%. There was some diversity to the proportion of care across the 7 STP areas. Notably, there were higher levels of urgent care in Cornwall and Devon with 11.1% and 10.1% respectively.

4.160 In 2018-2019 there were 599,188 fluoride varnish applications in the South West[136] representing 10.7% of the population. This represented 49.1% for children and 1.3% of adults. There are some significant variations across the region ranging from 42.3% of children in Cornwall through to 57.7% in Dorset.

4.161 The age profile of the South West of England suggests there is a projected increase of the proportion of the elderly population over the next decade. This could lead to an increase in the need for domiciliary dental care services. Currently there are 13 providers working under various contractual frameworks.

4.162 There is a regional variability in the availability of sedation services. A new pilot is planned to be developed for Gloucestershire.

4.163 A regional survey for Special Care and Paediatric Dentistry was conducted earlier this year. The responses seem to suggest the need for additional capacity for sedation services as well as support to increase accessibility for patients with special needs.

[135] The data provide by BGS Business Services Authority is presented in this way and hence there are some STP areas with Breakdowns including some local Authority areas, i.e. in Devon
[136] NHS Digital-ONS

Key issues for consideration

4.164 The stakeholder engagement exercise with dental teams highlighted the need for additional workforce, especially in rural areas. Furthermore, it has been highlighted the need for more specialist services in primary care and a more even distribution for secondary care providers in the region.

4.165 To mitigate the continual reduction of commissioned-UDAs, NHSE&I South West may wish to further explore the local barriers to delivery of UDA activity in parts of the region. This, in turn, may give rise to flexible commissioning options so that the levels and patterns of NHS primary care are equitable across the region, in-line with the stated aims of the Dental Contract Reform programme[137].

4.166 There are constant and steady levels of clawback to NHS dental contracts. Stakeholders and dental providers have suggested that one way to address this is through the application of flexible commissioning. This aims to refocus a proportion of commissioned UDA-based dental activity or utilise the Statement of Financial Entitlement, offers the potential to increase capacity to deliver specific programmes (ring-fencing) or incentivise certain activities to improve service stability and meet high needs. Such initiatives are likely to provide incentives for NHS primary care dentists in terms of recruitment and retention with funded professional development as an adjunct to their 'normal' NHS work.

4.167 These initiatives would create a virtuous cycle, in terms of providing incentives for NHS primary care dentists which improve recruitment and retention through funded professional development as an adjunct to their 'normal' NHS work and this will improve their morale and well-being, and patient outcomes. This could (also) prove to be a tipping point as we leave the EU.

4.168 Findings from service user surveys in the supply and workforce oral health needs assessment (January 2020) suggest that the highest proportion of patients (39%) stated they were able to see a Special Care dentist within one month, however, 28% reported waiting over three-months for an appointment. Reported waiting times also varied geographically. These findings suggest that demand exceeds capacity in some areas and that people who are using the Special Care dental service are not experiencing equality of access.

4.169 There is a significant variability regarding the access to consultants in restorative dentistry through secondary care. There are only 4.05 WTE consultants across the South West with 2.1 WTE in Bristol. There is anecdotal evidence of exceptionally long waits for restorative care in some parts of the region, i.e. six-months to

[137] https://www.nature.com/articles/s41404-020-0296-9

assessment and a further 80+ weeks for treatment. Oral surgery in secondary care is "overloaded" by intermediate items of care, i.e. by 'default'.

4.170 Findings from a review of orthodontic service provision suggested the need for additional provision service in Cornwall and Torbay and over provision in Plymouth.

4.171 Tooth extraction due to decay was the most common reason for elective hospital admissions in children aged 6 to 10 years old[138]. In 2018-2019 more than 7,000 children were admitted to hospital to have one or more teeth extracted in the South West of England. The majority of these children (44%) were between the ages of6 and 10 years old. This is in line with the national trend[139].

4.172 Remuneration of domiciliary services through UDAs can pose barriers to provision of care for people with additional needs due to inadequate recognition of the additional time needed to deliver safe and high-quality care.

4.173 There are barriers to accessing NHS dental services for those who are homeless and caught-up in parts of the criminal justice system outside prison, and this will require pathways development, e.g. access to dental care on release from prison.

4.174 There is a need for increased availability of special bariatric dental chairs, for appropriate transportation to and from service sites, and adequate toileting facilities.

4.175 Evidence suggests that an investment in post-graduate training programmes will support dentists in primary care settings to do more advanced work such as endodontics, prosthodontics, periodontics, orthodontics, special care and sedation.

4.176 Shifting settings of care from secondary care to enhanced primary care is likely to require different contracting mechanisms and currencies including an effective tariff structure across Tiers of care (including incentives for training to certification for enhanced level 1 and diploma-level Tier 2 accreditation). Allied to which, clinical leadership/governance through MCNs and project support from NHSE&I will be required. This will help to ensure equity of the quality of care across the region.

[138] Royal College of Surgeons of England; Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis, https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/dental-decay-hosp-admissions/
*Due to an issue with HES coding in East Sussex Healthcare NHS Trust in 2018/19, for which approximately 85,000 records erroneously had all diagnosis and/or procedure codes removed, this value should be treated with caution.
[139] Public Health England; Hospital tooth extractions of 0 to 19 year olds, https://www.gov.uk/government/publications/hospital-tooth-extractions-of-0-to-19-year-olds

The level of support will need to be tailored to reflect the needs of both larger practices and smaller or 'single-handed' practices.

4.177 There are a range of potential barriers for some patients in accessing NHS dental care, which mean they are more likely to present in urgent care settings. NHSE&I might wish to consider a method(s) to incentivise practices to take-on more NHS patients. If training is available for levels of care, these levels of complexity could be linked to tariffs.

4.178 A strategy of support for enhanced primary care may be required for specific, targeted interventions to improve access and provide restorative care for priority and special needs groups. This includes support for dentists to see more children from a younger age in areas with higher levels of deprivation (e.g. Smile4Life) including community fluoride varnish programmes, to improve the oral health of children with learning difficulties, and to improve the oral health of care home residents and other vulnerable groups.

5 Oral Health Improvement

5.1 Under the terms of the Health and Social Care Act upper tier and unitary authorities became responsible for improving the health, including the oral health, of their populations from April 2013. Local authorities have a statutory responsibility to provide or commission oral health improvement programmes to improve the health of the local population, to the extent that they consider appropriate in their areas.

5.2 They are also required to

- Secure the provision of oral health surveys to facilitate:
  - The assessment and monitoring of oral health needs
  - The planning and evaluation of oral health promotion programmes
  - The planning and evaluation of the arrangements for provision of dental services as part of the health service
- Monitor and report on the effect of water fluoridation programmes, where they are affecting the authority's area.
- Participate in any oral health survey conducted or commissioned by the secretary of state.
- Make proposals regarding water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals.

5.3 In spring 2014 PHE provided a guide for commissioners of oral health improvement programmes: "Local authorities improving oral health: Commissioning better oral health for children and young people"[140] The document recommends Local Authorities review their oral health commissioning to ensure:

- Oral health improvement is integrated within existing programmes such as the healthy child programme 0-19 years.
- Commissioning specific oral health programmes based on the totality of the evidence and needs of the population.
- Reviewing commissioned oral health programmes to ensure that programmes:
  - meet local needs
  - involve upstream, midstream and downstream interventions that involve both targeted and universal approaches
- Consider the totality of evidence of what is working.
- Engage with partners integrating commissioning across organisations and across bigger footprints, as required.

5.4 From the 1st October 2015 commissioning responsibility for the healthy child programme for 0-5 year olds was transferred from NHSE&I to local authorities. This

[140] Public Health England. Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities. 2014

includes the commissioning of health visitors, who lead and support delivery of preventive programmes for infants and children, including providing advice on oral health and on breastfeeding reducing the risk of tooth decay.

Development of Integrated Care Systems (ICS)

5.5 The NHS Long Term Plan[141,142] (formerly known as the 10-year plan) was launched in early 2019. It was built on the policy platform laid out in the NHS five year forward view which articulated the need to integrate care to meet the needs of a changing population. The NHS Long Term Plan sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years.

5.6 The plan focuses on building an NHS fit for the future by:

- Enabling everyone to get the best start in life
- Helping communities to live well
- Helping people to age well

5.7 With regards to oral health, the NHS Long Term plan is focused around improving access for children with learning disabilities and support the uptake of HPV vaccinations for all children aged 12 and 13 in order to prevent oral cancer. Furthermore, there is a commitment to continue to support initiatives like Starting Well, which is encouraging access to dental care from a young age for good oral health habits and preventing tooth decay which is experienced by a quarter of England's five-year-olds.

5.8 Over the last two years, Integrated Care Systems (ICSs) have been formed across England. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve. Integrated care systems have allowed organisations to work together and coordinate services more closely, to make real, practical improvements to people's lives. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.

5.9 Integrating Care – The next steps to building strong and effective integrated care systems across England[143], builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be

[141] The NHS Long Term Plan, https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[142] The King's Fund, The NHS long-term plan explained https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained
[143] NHS England, https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

embedded in legislation or guidance. The document emphasizes the importance of strengthening collaboration across the wider health and social care sectors and develop partnerships spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.

5.10 Whilst ICSs are central to the delivery of the NHS Long Term Plan at regional level, Primary Care Networks and ICS bring together local organisations to redesign care and improve population health, creating shared leadership and action.

Prevention of oral diseases

5.11 Poor oral hygiene from poor tooth brushing, insufficient exposure to fluoride and consumption of a diet that is high in sugar are the main direct risk factors for an individual's poor oral health.

5.12 The circumstances in which people live and work have a profound effect on their health and wellbeing, including their oral health. The causes of oral diseases and their relationship to inequalities are therefore mainly social and environmental.

5.13 The local authorities that were engaged with as part of this OHNA were universally aware that the impact of deprivation in their localities was critical to not just poor oral health but equality for poor health and wellbeing. In most cases their focus has been to encourage oral health interventions in these localities and to ensure that primary care and high street dentistry is well provided in these areas of higher oral health need.

Approach to prevention

5.14 Local authorities have the mandate to deliver oral health promotion for their local communities. Across the South West local authority Public Health directorates have oral health leads (Public Health Consultants, Registrars and Practitioners) who support and manage oral health improvement activity. In some cases, they work across boundaries to deliver joint approaches between local authorities to target oral health activities and often engage with community dental care providers who deliver most of these oral health improvement activities. Guidance from Public Health England and the National Institute for Health and Care Excellence (NICE) describe evidence-based population level interventions to improve oral health such as water fluoridation that complement practice-based initiatives.

Commissioning oral health improvement

5.15 Currently the vast proportion of oral health improvement activity in the South West is being delivered by the community dental service providers as per their contract

with NHSE&I. This contractual arrangement seems at odds with the responsibilities given to local authority Public Health Directorates.

5.16 Moreover, the situation is neither straightforward nor consistent across the region as there are some local authority areas (Plymouth, Devon and Gloucestershire) that have been transferred NHSE&I's oral health promotion funding and who are commissioning this directly themselves. In these cases, they are working with the community dental service providers to deliver core elements of these contracts.

5.17 In the north of the region namely Bristol, North Somerset and South Gloucestershire and Bath and North East Somerset, Swindon and Wiltshire work is being progressed, with the support of Public Health England to build and develop an oral health improvement strategy. In these cases, all the local authorities are aligning their interventions to the oral health priorities that have been identified through their Joint Strategic Needs Assessment (JSNAs).

5.18 It seems clear that there is a desire for local authorities to become more involved in the commissioning of the oral health improvement activity in their areas. It is equally clear that there is a critical need to, at the very least, enable some form of joint commissioning. This would enable the delivery of oral health improvement and promotion activity that is targeted to those seen by local authorities as priorities for this important work, and to ensure that the limited resources are maximised to benefit local needs.

5.19 Several local authorities have undertaken Oral Health Needs Assessments and have used these assessments to put pressure on NHSE&I to increase and to target the provision of general dental services to their identified areas of need. They have also supported the engagement of local authority politicians and chairs of Health and Well-being Board to maintain the scrutiny on NHS dentistry in their areas and to build a caucus of local views and opinions. These assessments have also sought to increase local dental provision, to support targeted oral health improvement activities and work with targeted vulnerable groups in their locations. In most areas across the South West there is some kind of oral health steering/action group with representations of local authorities, HealthWatch, PHE, LDN, LDC, NHSE&I.

Oral health improvement programmes

5.20 This section seeks to summarise the priorities and programmes of oral health promotion across the region. In the appendices we have set out the core elements of local oral health improvement plans and strategies to identify local priorities for oral health improvement. However, across the South West there are inconsistencies in terms of the themes and priorities for oral health improvement, which apply to most areas. These priorities express the desire to deliver key interventions but, in some cases, this is limited by the funding available. Clearly funding is an issue as many local authorities have had to prioritise their budgets

against priorities in their respective JSNAs. Set out below are the core themes in these oral health promotion plans and strategies.

Oral health improvement for children and young people

5.21 A central theme across many oral health improvement programmes is the education of the health workforce who engage with early years and children, including, health visitors, school nurses, children's centres and schools. This is often delivered in association with targeted toothbrushing schemes and in some cases specialist fluoride varnish programmes.

5.22 Targeted tooth brushing schemes for primary school and pre-primary school children is an intervention applied in many public health localities. This often involves the delivery of training and support to those working in early year's settings (schools and nurseries) to establish daily supervised toothbrushing sessions and to build this as a routine.

5.23 Programmes are sometimes delivered in conjunction with the provision of free toothbrushes and toothpaste to pre-school and primary school children, prioritising targeted interventions for those at high risk of poor oral health.

5.24 In some areas fluoride varnish programmes have been delivered in primary schools. These fluoride varnish applications are offered to children in Reception and Year 1 and applied by specially trained Dental Health Educator Nurses.

5.25 Early years programmes focus on engaging with mothers and their children to support tooth brushing or to supervise the brushing of young children's teeth using fluoridated toothpaste. This is often supported with the provision of information to promote good oral health and the distribution of free toothbrush and toothpaste packs to children defined as at higher risk of poor oral health.

5.26 Some more innovative programmes have worked with schools using videos to support the awareness of good oral health in children and to support the establishment of good teeth brushing and to align this to the school curriculum.

Oral health improvement for vulnerable adults

5.27 Several authorities have prioritised the targeting of oral health programmes for key vulnerable groups in the community including the substance misusing population, those who are homeless, the traveller and gypsy community, older people, migrant community and those who are deemed to be socially isolated.

5.28 Some of these programmes have included outreach dental interventions and engagement with these populations to provide information about the available of local dentistry and to offer urgent treatment through the community dental service.

Developing capacity of the oral health improvement workforce

5.29 The most efficient way to improve oral health is to embed it within existing services at strategic and operational levels. In many local authorities, oral health promotion teams are commissioned to provide oral health promotion training, and expertise and support to a range of groups including health, social care and education professionals. This enables evidence based oral health improvement programmes to be delivered through multiple interventions by non-dental professionals.

5.30 An important investment to make to support oral health is to engage with and train the wider health and social care workforce, including district nurses, school nurses, health visitors, care workers and relevant parts of the community and voluntary sector. In so doing, it will equip the wider health and social care workforce with the knowledge and skills to recognise the link with neglect and complex social circumstances and ensure provision of care for those at high risk of poor oral health.

5.31 It is particularly important to maximise all opportunities for signposting to local NHS dental services and to promote the benefits of visiting a dentist throughout life and to raise awareness of eligibility for free check-ups, prioritising those at high risk of poor oral health.

Reorienting dental practices towards prevention

5.32 Oral health promotion teams have been working with local general dental practices in some parts of the South West to promote prevention in practice in line with *Delivering Better Oral Health*[144]. This guidance describes evidence-based interventions to prevent oral disease including applications of fluoride varnish and fissure sealants as well as dietary advice and advice regarding alcohol and tobacco use with signposting to relevant services when indicated. It is important that clinical care provided by primary care dental teams is underpinned by evidence-based prevention.

Taking forward local oral health improvement within local authorities

5.33 Some local authorities in the South West have developed oral health improvement advisory groups. These groups include representatives from key stakeholder

[144] PHE. *Delivering better oral health: an evidence-based toolkit for prevention.* 3rd Edition ed. London: PHE; 2014.

groups. They provide a forum in which oral health improvement strategies and programmes can be developed and monitored.

5.34 The majority of the current oral health improvement programmes in the South West follow a targeted population approach. As described previously, whole population prevention approaches are also important to further reduce inequalities in oral health in line with the Marmot principle of universal proportionality.

5.35 From this OHNA's perspective it seems critical to ensure that there is a consistent approach to oral health promotion across the South West. Some parts of the region have accessed NHSE funding whilst others have not. Some parts of the region have defined priorities which are not funded but for which business cases locally will need to be drafted. It seems important that there is a strong emphasis on child oral health promotion and to support vulnerable groups in the community as well as the older population. The forms of interventions are likely to be something that local authorities will need to prioritise locally particularly as there is limited resources to support this work.

Community water fluoridation

5.36 Community water fluoridation is considered as a whole population approach to improving oral health and is associated with reductions in tooth decay in populations. It was also found to have an effect over and above that of other sources of fluoride, particularly toothpaste. There are no water fluoridation schemes in the South West.

5.37 Considering their statutory role and responsibilities, local authorities may wish to consider the case for water fluoridation in the context of local needs and the range of oral health improvement programmes currently commissioned and with reference to Commissioning Better Oral Health. The legal aspects and the technical issues regarding the introduction of water fluoridation scheme should also be considered.

Dental public health intelligence programme

5.38 Standardised and nationally coordinated surveys of oral health have been undertaken annually since 1985, which means that England has one of the best oral health databases in the world. The most recently completed survey (2019) focused on children aged 5 and adults in practice.

5.39 The surveys are now undertaken on an annual basis as part of the Dental Public Health Intelligence Programme to provide detailed estimates of disease prevalence and severity. It is set up so that every other year surveys are taken for 5-year-olds and in between for different cohorts. Data is provided at lower tier local authority level.

5.40 Unfortunately, across the region there has been inconsistency in the completion of surveys for the National Epidemiology Research Programme, with several areas not reporting for some surveys, as there was either insufficient data collected or there was not any data collected. It is critical that there is consistency of completion across the region not simply for completeness but to identify potential areas/groups/cohorts with higher needs for targeted intervention and to monitor trends over time and hence provide better clarity of the oral health in the population.

Summary

- Local authorities are responsible for improving the oral health of their population and for commissioning oral health improvement programmes and oral health surveys.
- Some local authorities have a specified budget for commissioning oral health improvement programmes.
- A range of universal and targeted oral health improvement programmes are implemented by local authorities in the South West.
- Most oral health improvement programmes are directed towards children, and in some cases vulnerable groups and older people.
- Some local authorities have oral health improvement advisory groups that ensure the delivery and evaluation of their oral health improvement programmes.
- Local authorities are responsible for commissioning care homes and school nursing services and health visiting services providing opportunity for the integration of oral health improvement into these services.
- All local authorities commission oral health surveys, although samples are not always adequate or indeed, they have not been completed.

Key issues for consideration

- Review the commissioning and or joint commissioning of Oral health interventions between NHSE&I, local authority Public Health dental leads and community dental providers.
- Local authorities may consider more joint working to explore the feasibility of jointly commissioning oral health improvement and dental epidemiology services to support the efficient management of the limited resources.
- Local authorities need to continue to review and update their oral health promotion strategies to address the priorities of need in their local areas.
- Oral health improvement should be an integral part of the work of health visitors and school nurses and should be included in specifications for these services.
- Service specifications for care homes should include a responsibility for oral health that incorporates an oral health assessment on entry as well as daily mouth care.

- Commitments need to be made to support the universal engagement and completion of future oral health surveys as part of the National Epidemiology Research Programme. To this end:
  - All local authorities should continue to commission oral health surveys, including surveys to support the public health outcomes framework.
  - Service specifications should be in place to support the planning and delivery of the surveys. This should include robust performance monitoring arrangements to ensure that the survey is completed in line with the national protocol.

6 Patient Public Engagement

6.1 A critical feature of this OHNA is the importance of engaging with patients, the public and key stakeholders within the sector. This section will summarise the findings for the patient and stakeholder engagement and draw together these findings to inform this OHNA.

6.2 This is important because the needs of patients and stakeholders will inform those areas of dental and oral health which are seen to be needing additional resources, and to ensure that their voices are heard and that their views are considered.

6.3 The core element of this engagement has included stakeholder interviews with key practitioners, and this has been supported by surveys of patients and the general public, surveys of stakeholders to widen the reach and engagement of this OHNA.

6.4 Set out below is a summary of the key findings from our primary research undertaken.

Stakeholder survey, summary of key findings

6.5 This e-survey targeted stakeholders in the field including, dentists, oral health specialist, public health oral health leads, hygienists, school nurses, care workers, Healthwatch leads and representatives from PHE and HEE. It was disseminated by the Local Dental committees and networks in the region, as well as supported by local authority oral health leads. The survey was a quantitative survey with some open-ended qualitative responses.

6.6 In summary, 221 stakeholders were engaged in this survey, which was open between the 5th October and the 16th November. Responses came from across the region but with higher levels of response from Devon, BANES, Swindon and Wiltshire, Bristol, North Somerset and South Gloucestershire and Dorset. Respondents came from all over the 'oral health' sector, however 54% of respondents worked within general dental services. Key findings included:

- Stakeholders gave NHS general dentistry a 60% accessibility rating.

- 'The local practice is no longer taking on NHS patients' was the largest barrier to accessing services with 47%, followed by 38% stating that there were 'not enough NHS practices locally'. Thus, the availability of dentistry is seen by stakeholders as the key barrier to accessing adequate oral health in the region - both the lack of NHS dentists accepting new patients and the lack of locally available NHS practices.

- Most stakeholders (60%) felt that the area is not well provided by specialist dental services.

- 54% disagreed or disagreed strongly that 'the recruitment of staff to provide NHS Dentistry is effective in my area'.

- 80% disagreed or disagreed strongly that 'all parts of my locality are covered by provision that meets the demands of patients presenting'.

- 76% disagreed with the statement - 'the volume of dentists that are available to work with NHS Patients is adequate'.

- 76% disagreed that 'patients find it easy to find and access NHS dentists in this area'.

- 74% disagreed that 'we have adequate Tier 2 primary care specialist dental services'.

- 60% disagreed that 'we have adequate urgent care dental services', 22% neither agreed nor disagreed and 18% agreed.

- The service area in need of improvement that was given the most support was 'service growth to meet local demand for NHS dentistry' with 43%, followed by 'flexible commissioning' with 36%, and 'service transformation' with 30%.

- The major priorities for improvement stated by stakeholders were:
    - Change to the GDS contract, removing UDAs and making the delivery of primary care NHS dentistry more commercially viable.
    - General dentistry in the South West is putting additional strain on the hospital, community dental services and emergency out of hours services.
    - Cheaper charges are needed for NHS patients.
    - Need for more specialist services in primary care.
    - Need for more secondary care dispersed across the region.

Patient and public survey summary of key findings

6.7 A total of 802 people chose to complete this patient/public oral health survey, which is a strong return for an e-survey of this kind. It opened on 5th October 2020 and closed on the 17th November 2020. The survey was disseminated through Healthwatches, Local Dental Committee chairs/leads and via the community and voluntary sector in the region, particularly, those that represent 'hard to reach' groups in the community. Respondents predominantly came from Cornwall 56%, Devon 20% and BANES, Swindon and Wiltshire 13%, with lower response levels from the rest of the region.

6.8 The survey revealed that 66% had a regular dentist and 82% had visited their dentist in the last year. 60% visited their dentist for a regular check-up. 32% had visited their dentist for an urgent dental appointment for a problem that had developed.

6.9 66% reported that it took up to 30 minutes to travel to their dentist. 66% took a car to get to their dentist, 14% preferring to walk. Of those that drive, 43% felt it was either 'easy' or 'very easy' to park, 32% felt it was 'adequate', and 21% felt it was either 'difficult' or 'very difficult'.

6.10 In terms of patient's preferences of when they can access services, most prefer keeping appointments during normal surgery hours, and if there were to be alternative timings additionally provided their preference would be for the addition of Saturday surgery and the next preference would be for the extension of the weekday surgery to weekday evenings.

6.11 78% of those that responded stated they were an NHS patient or wanted to be an NHS patient and 17% stated they were a private patient. 5% did not know.

6.12 37% of private patients stated they did not know whether their surgery provided NHS care, however of the remainder, 19% stated that no NHS dentistry was provided, 21% stated that NHS dental provision was available for children and adults, 22% that NHS dental provision was available for children only and 0.8% for adults only.

6.13 Most private patients 34%, stated that they were happy with their private dentist. Otherwise, 24% felt that the waiting list was a barrier and 23% felt that their local NHS dentist was not currently accepting new patients.

6.14 In this two-tier dental system - with private and NHS dentistry - those that use NHS dentists predominantly cite their reason to do so as cost and affordability.

6.15 84% of respondents either disagreed strongly or disagreed that 'there is a short waiting list to access NHS dentistry in my area'. 83% disagree that 'it is easy to

find and access NHS dentistry in this area' whereas 86% agreed that 'NHS dentists cost less than private dentists'. When asked to explain their answers the core themes emerging were:

- Lack of access to NHS dentistry
- Inability to access dentistry since Covid-19
- Extensive waiting lists
- Difficulty securing an appointment at NHS dentists once registered
- Concerns about the quality of NHS dentistry
- Perceptions that NHS dentists are not operating during Covid-19, whilst private dentists are operating
- Experience of the frequent cancellations of NHS dentists
- Concerns that NHS dentists are prioritising their paying private patients
- Experiences of many NHS practices being closed
- Several people with urgent care needs due to the lack of regular dentistry
- Perceived high cost of treatment both in the NHS and private sector
- Concerns raised across the region, but the high volume of responses from Cornwall have emphasised greater need there.

6.16 With regards to forms of improvement that could be made to NHS oral health in the region:

- 95% agreed that there should be more dental staff to provide NHS dental services
- 88% agreed that free dental health products should be provided in schools for children to encourage good habits early on
- 86% agreed that there should be more information provided locally about where to find a dentist in your area
- 80% agreed that there should be more information provided locally on how people can stop dental problems developing
- 77% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends
- 75% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

6.17 When asked if there could be any further areas of improvement. A range of issues emerged, many centered around the needs for more dentists, in summary:

- Access to NHS dentists in your locality should be made easier
- Better dentist allocation
- Dentistry should be affordable
- Finding a private dentist is easy, there need to be more NHS dentists
- Improve the quality of care
- Increase capacity in all areas
- NHS dentistry should provide all services provided by private dentists

- Reduce waiting lists
- Urgent appointments should be easier to get for broken teeth and infections
- Work with young people to promote life-long good oral health.

6.18 There were several open-ended questions in the survey, and many people used these as opportunities to raise their frustrations and concerns about what they saw as inadequately resourced dental services. Moreover, the desire to see more NHS dentists was wholly consistent across many of these open-ended responses. People have had experience of not being able to access NHS dentistry, being on waiting lists for an awfully long time and often suffering from pain and poor oral health without access to a dentist. There are examples of people not even being able to access private dentistry and whilst cost and affordability is a critical issue frequently referred to, many still feel that NHS dentistry is for them, largely because it is cheaper.

6.19 In general respondents felt that they have been failed by NHS dentistry in the region. There is equally a real lack of understanding as to why NHS dental services are not simply available to all.

6.20 For many respondents that are in NHS practices they feel that they are second class citizens with dentists preferring to increase their revenue by treating fee paying private clients. This further frustrates people but also reflects the reality that dentists are simply not able to prioritise NHS dentistry because it is not commercially viable for them to do so.

Short Easy Read Survey findings

6.21 133 people completed the short version of the patient /public survey. They came predominantly from Cornwall. This survey was initially designed in conjunction with Healthwatch Cornwall who wanted a short easy read version to go out to their learning disability group, however the majority of those who completed it did not report having learning disabilities.

6.22 From within the sample 48.9% stated that they had a regular dentist and 51.1% stated that they did not.

6.23 This cohort, like the full survey cohort, preferred to have their appointments during normal surgery hours but that if additional appointment slots were to be available their preferences would be Saturday 9-5 and weekday evenings.

6.24 85.6% stated they had or would like to have an NHS dentist and 14.4% stated they had a private dentist.

6.25 27% stated that there are no NHS dentists near where they live, 23.6% stated they go to a dentist because it has a good quality of care, 24.1% stated they go to an NHS dentist because it is more affordable/costs less and 22.6% say they go to their dentist because it has a good reputation and or it was recommended to them.

6.26 91% of respondent either disagreed strongly or disagreed that there is a short waiting list to access NHS dentistry in my area. 92% disagree that it is easy to find and access NHS dentistry in their area and 82% agreed that NHS dentists cost less than private dentists.

6.27 With regards to forms of improvement that could be made to NHS oral health in the region.

- 97% agreed that there should be more dental staff to provide NHS dental services.
- 84% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends.
- 83% agreed that free dental health products should be provided in schools for children to encourage good habits early on.
- 78% agreed that there should be more information provided locally about where to find a dentist in your area.
- 74% agreed that there should be more information provided locally on how people can stop dental problems developing.
- 55% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

6.28 There was considerable disgruntlement towards the difficulty in accessing NHS dentistry. Many felt there simply were not enough NHS dentists in their area. Their focus on areas of improvement included:

- More capacity to access to NHS dentists
- More NHS dentists
- Make it easier to find NHS dentists locally
- Reduce waiting lists
- Website to identify which dentists are taking new patients
- Health visitors, school nurses, social care staff should be working with parents around dental health and oral hygiene
- Make treatments affordable
- Better specialist dental services for children and adults with special needs.

7 Sub regional profiles Appendices 1-7.

7.1 The next 7 chapters set out profiles of Oral Health Needs for each of the seven STPs of:

- Appendix 1 Cornwall and the Isles of Scilly OHNA STP Analysis
- Appendix 2 Devon OHNA STP Analysis
- Appendix 3 Somerset OHNA STP Analysis
- Appendix 4 Bristol, North Somerset & South Gloucestershire OHNA STP Analysis
- Appendix 5 Gloucestershire OHNA STP Analysis
- Appendix 6 Bath and North East Somerset, Swindon & Wiltshire
- Appendix 7 Dorset OHNA STP Analysis

7.2 Indeed, due to the size of these STP analysis reports, each has been provided as a separate standalone document.

7.3 Each report has sought to address the demographics relevant to oral health, the risks and determinants of oral health locally, the epidemiology of oral health for each area, a review of local services, and a review of oral health promotion priorities in each area, and finally a specific set of local findings and recommendations.

8 Appendix 8 Glossary of Terms

Term	Definition
Access Rates	Access rates show the proportion of resident population that attended an NHS dentist in the 24 month period(s) stated.
Average number UDAs claimed	The average number of UDAs claimed for each patient is a fundamental measure of the intensity of resource use.
BAME	Black Asian and Minority Ethnic
Care index	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
Clinical Data set	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.
Comparative need	Comparative need (need between similar groups of people
Dental Caries (tooth decay)	Cavities or holes in the outer two layers of a tooth — the enamel and the dentine. Dental caries are caused by bacteria which metabolise carbohydrates (sugars) to form organic acids which dissolve tooth enamel. If allowed to progress, dental caries may result in tooth decay, infection, and loss of teeth.
dmft index	dmft index, is obtained by calculating the average number of decayed (d), missing due to decay (m) and filled due to decay (f) teeth (t) in a population. In five-year-old children, this score will be for the deciduous or primary teeth and is recorded in lower case. In 12-year-old children it reports on the adult or permanent teeth in upper case (DMFT). As tooth decay in children is highly polarised towards lower socio-economic groups, another useful indicator, dmft>0, demonstrates the proportion of children with obvious tooth decay experience.
Domiciliary Dental care	Domiciliary dental care is dental treatment that is provided in the patient's home. Patients who have severe mobility problems that make it 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
Domiciliary dental care	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
Expressed need or demand	Actions taken by service recipients to utilise health services
Felt need	Perceived needs of lay people or service recipients

Term	Definition
HEE	Health Education England
LDC	Local Dental Committee
LDN	Local Dental Network
NHSE&I	NHS England and NHS Improvement
Normative need	Need defined by experts
Patient Charge Band 1	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.
Patient Charge Band 2	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.
Patient Charge Band 3	Band 3 course of treatment: covers everything listed in Bands 1 and 2 above, plus crowns, dentures and bridges.
Patient Charge Band 4	Urgent care
Patient Charge Bands	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:
Patient Flow	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.
PHE	Public Health England
Population density	The number of people resident in an area (square kilometre/mile)
Sedation	Sedation is used to help people feel relaxed and comfortable about having certain dental procedures done.
STP	STP stands for sustainability and transformation partnership. These are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve. STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities. They have been making simple, practical improvements like making it easier to see a GP, speeding up cancer diagnosis and offering help faster to people with mental ill health. In some area, STPs have evolved to become 'integrated care systems', a new form of even closer collaboration between the NHS and local councils. The NHS Long Term Plan set out the aim that every part of England will be covered by an integrated care system by 2021, replacing STPs but building on their good work to date.
The Care Index	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

Term	Definition
	indicate if children are accessing, or receiving the dental treatment they require
Treatment on Referral	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.
UDA	Units of Dental Activity (UDAs) are a measure of the amount of work done during dental treatment. More complex dental treatments count for more UDAs than simpler ones. For example, an examination is 1 UDA, fillings are 3 UDAs, and dentures are 12 UDAs.
Unmet need	The gap between service and/or oral health improvement activities and that considered necessary by providers and recipients.

9 Appendix 9 OHNA Policy context

National Background

Health and Social Care Act 2012

9.1 The Health and Social Care Act 2012 created a new commissioning framework for the provision of health, social care and public health in England. In April 2013, NHS England became the single commissioner for all dental services, including primary, secondary and unscheduled dental care. In addition, local authorities became responsible for improving the oral health of their communities and for commissioning oral health improvement services.

9.2 The statutory dental public health responsibilities for local authorities include:

- Securing the provision of oral health improvement programmes to improve the health of the local population to the extent that they consider appropriate in their areas
- Securing the provision of oral health surveys to facilitate:
- The assessment and monitoring of oral health needs
- The planning and evaluation of oral health promotion programmes
- The planning and evaluation of the arrangements for provision of dental services as part of the health service
- Monitoring and reporting on the effects of water fluoridation programmes affecting the authority's area
- Participation in any oral health survey conducted or commissioned by the secretary of state
- Making proposals regarding water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals.

9.3 The Health and Social Care Act 2012 also describes the joint and equal responsibilities of local authorities and clinical commissioning groups to prepare both joint strategic needs assessments (JSNA) and joint health and wellbeing strategies through health and wellbeing boards. The purposes of JSNAs and joint health and wellbeing strategies are to improve health and wellbeing and reduce inequalities in the local population by promoting integration and partnership working between the NHS, social care, children's services, public health and other local services and to improve democratic accountability in health. A JSNA describes the current and future health and social care needs of a community within the health and wellbeing board area. Joint health and wellbeing strategies are strategies for meeting the needs identified in the JSNAs. Health and wellbeing boards are tasked to consider the demographics of the area and the needs of local people, including vulnerable groups.

9.4 This oral health needs assessment should be a useful resource for local authorities to inform JSNAs, joint health and wellbeing strategies and oral health improvement strategies.

Fair Society Health Lives

9.5 The Marmot report *Fair Society, Healthy Lives* (2010) set out a strategy on health inequalities that calls for actions that are universal but proportionate. The key messages from the review stated that:

- There is a social gradient in health and the lower a person's social position, the worse his or her health. Action should therefore focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities therefore requires action across all the social determinants of health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage 'proportionate universalism'.

9.6 Commissioning strategies should work across six policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Healthy lives, Healthy people: our Strategy for Public Health in England

9.7 In response to the Marmot report, *Healthy Lives, Healthy People* describes the government's plan for public health, which from April 2013 became the responsibility of local authorities rather than the NHS. The strategy promotes the adoption of a life course approach for tackling the wider social determinants of health.

Healthy Lives, Brighter Futures the strategy for children and young people's health

9.8 *Healthy Lives, Brighter Futures* describes policy recommendations to inform collaborative working between the NHS, local authorities and partners working across child health services to reduce inequalities in children and young people, particularly for more vulnerable groups. It sets out the *Healthy Child Programme*

and it is essential that oral health is considered as an integral part of this programme across the South West.

Healthy Lives, Healthy People: Improving outcomes and supporting transparency

9.9 The public health outcomes framework describes the overarching vision for public health together with outcomes and indicators for monitoring purposes. Two high level outcomes, which cross four domains of indicators, have been developed to cover the whole life course from preconception to old age. Those indicators to which oral health improvement and dental services will contribute are:

- Mortality from cancer
- Tooth decay in children aged five
- Indicators related to smoking and overweight and obesity
- Diet
- Pupil and sickness absence.

The NHS Outcomes Framework 2014/2015

9.10 The purpose of the *NHS Outcomes Framework 2014/15* is to drive improvements in the quality of the NHS placing a focus on improving health and reducing inequalities. Indicators in the framework are grouped around five domains, which describe the high-level national outcomes that the NHS should be aiming to improve.

9.11 It is expected that NHS dental services will contribute to the following indicators:

- One year survival for all cancers
- Five year survival for all cancers
- Emergency admissions for acute conditions that should not usually require hospital admission
- Positive experience of NHS dental services
- Patient experience of outpatient services
- Access to dental services.

9.12 In the Mandate from Government to NHS England 2015 to 2016 two new indicators for dental health were included:

- Tooth decay in children aged five
- Tooth extractions in secondary care for children under 10.

Transforming Participation in Health and Care

9.13 NHSE&I is required to engage with patients and the public regarding their commissioning responsibilities. This guidance supports the two legal duties described below:

- Patients and carers to participate in planning, managing and making decisions about their care and treatment
- Effective public participation in the commissioning process itself, so that services reflect the needs of local people.

Securing Excellence in Commissioning NHS Dental Services

9.14 NHSE&I is responsible for commissioning all NHS dental services. *Securing Excellence in Commissioning NHS Dental Services* proposed a care pathway approach that supports evidence-based decision making and the seamless organisation of care across different care settings for each dental specialty. The care pathway is regarded as a journey through the clinical experience, where co-ordination, consistently high standards, appropriateness of care in relation to best practice and the evidence base and a focus on patient related outcomes are fundamental.

9.15 *Securing Excellence in Commissioning NHS Dental Services* also described the establishment of local dental networks as an integral part of NHSE&I to ensure clinically led commissioning drives improvements in the quality of dental services, thereby improving oral health and reducing inequalities locally.

9.16 To support commissioning based on a care pathways approach, NHSE&I has established four multi-stakeholder commissioning guide working groups to develop commissioning guidance for four dental care pathways:

- Orthodontics
- Oral surgery
- Restorative
- Special care dentistry

9.17 Local dental networks will play an important role in supporting the implementation of the commissioning guides locally.

Local Authorities Improving Oral Health: Commissioning better oral health for children and young people

9.18 *Commissioning Better Oral Health for Children and Young People* provides guidance to local authorities to support the commissioning of evidence informed oral health improvement programmes for children and young people aged up to 19 years of age across the life course. The guidance enables local authorities to review and evaluate existing oral health improvement programmes and consider future

commissioning intentions that meet the needs of the population, providing an evidence-based approach with examples of good practice. The guidance encourages the adoption of an integrated approach to commissioning with partner organisations including NHSE&I, PHE and clinical commissioning groups to ensure that all local authority services for children and young people have oral health improvement embedded at both a strategic and operational level.

Oral Health: approaches for local authorities and their partners to improve the oral health of their communities

9.19 The National Institute for Health and Care Excellence (NICE) guidance on oral health approaches for local authorities and their partners to improve the oral health of their communities made recommendations aiming to promote and protect oral health by improving diet and reducing consumption of sugary foods and drinks, alcohol and tobacco, improve oral hygiene, increase the availability of fluoride, encourage people to go to the dentist regularly and increase access to dental services. The 21 evidence-based recommendations include:

- Ensuring oral health is a key health and wellbeing priority with information and advice on oral health in local policies
- Carrying out an oral health needs assessment using a range of data sources and developing an oral health strategy
- Ensuring public service environments and workplaces promote oral health
- Ensuring frontline health and social care staff can give advice on the importance of oral health
- Incorporating oral health promotion and staff training in existing services for all children, young people and adults at high risk of poor oral health
- Commissioning tailored oral health promotion services for adults at high risk of poor oral health
- Including oral health promotion in specifications for all early years services
- Considering supervised tooth brushing and fluoride varnish schemes for nurseries and primary schools in areas where children are at high risk of poor oral health
- Raising awareness of the importance of oral health, as part of a 'whole-school' approach in all primary and secondary schools
- Introducing specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health.

9.20 NICE is currently developing further guidance documents related to oral health:

- *Oral Health Approaches for Dental Teams*. This guidance will describe approaches for general dental practice teams on promoting oral health and is due for publication in October 2015.
- *Oral health in nursing and residential care*. This guidance is for nursing and residential care homes on promoting oral health and ensuring access to dental treatment and is due for publication in June 2016.

Delivering Better Oral Health

9.21 *Delivering Better Oral Health* provides guidance on evidence-based interventions and advice on how dental team members can improve and maintain both the oral health and general health of their patients. Smoking, alcohol misuse and a poor diet are risk factors for several general health and oral health conditions. A patient facing version of the guidance will be published to help patients to understand the preventive messages.

9.22 Implementation of the guidance should be included in oral health improvement strategies across the South West.

Smokefree and Smiling

9.23 *Smokefree and Smiling* describes how dental teams, commissioners and educators can contribute to reducing rates of tobacco use and highlights resources available to support them. The document acknowledges that dental teams are well placed to provide very brief advice to their patients who smoke to help them understand the benefits of stopping and to signpost them to their local stop smoking service.

9.24 Oral health promotion services and primary care dental teams should work closely with local stop smoking services to implement *Smokefree and Smiling*.

NHS dental contract reform programme

9.25 In 2010, the government's plans for the NHS included a commitment to introduce a new NHS dental contract that would focus on achieving good oral health and increasing access to NHS dentistry, with a particular focus on improving the oral health of schoolchildren.[16] The Department of Health subsequently established the contract reform programme, with the establishment of seventy dental contract pilot practices in 2011 to inform the development and implementation of a more prevention-orientated contract. Fundamentally, the aims of the new dental contract are to improve the quality of patient care, including access to NHS dental services and the oral health of the population, especially children. Two reports have since been published which describe the preliminary and later findings from the dental contract pilots.

9.26 More recently, the Department of Health published four documents aimed at engaging and seeking the views of the dental profession and the wider dental community in the contract reform programme.[1]

9.27 Building on its engagement programme, NHS England's *Dental Care and Oral Health Call to Action*[20] obtained views across local communities, including health, dental and social care professionals and patients to inform the future development of NHS dental services. The challenge remains to address inequalities in oral health and

access to dental services across England, placing a greater focus on prevention and improved outcomes.

NHS Long Term Plan – Advancing our health: prevention in the 2020s July 2019

9.28 The plan states that 'The 2020s will be the decade of proactive, predictive, and personalised prevention. This means targeted support, tailored lifestyle advice, personalised care and greater protection against future threats. In terms of action the NHS will:

- Embed genomics in routine healthcare and making the UK the home of the genomic revolution
- Review the NHS Health Check and setting out a bold future vision for NHS screening
- Launch phase 1 of a Predictive Prevention work programme from Public Health England (PHE).

9.29 The NHS is also doing more on prevention. The Long Term Plan contained a whole chapter on prevention, and set out a package of new measures, including:

- All smokers who are admitted to hospital being offered support to stop smoking
- Doubling the Diabetes Prevention Programme
- Establishing alcohol care teams in more areas
- Almost 1 million people benefiting from social prescribing by 2023 to 2024

9.30 Through the focus on prevention, the report states that 'we need to view health as an asset to invest in throughout our lives, and not just a problem to fix when it goes wrong.' In terms of actions the NHS will:

- Launch a new health index to help us track the health of the nation, alongside other top-level indicators like GDP
- Modernise the Healthy Child Programme
- Consult on a new school toothbrushing scheme, and support water fluoridation.

10 Appendix 10 Determinants and impacts of oral health

10.1 Good oral health is imperative for good general health as it influences the general wellbeing and quality of life of people by allowing them to eat, speak and socialise without active disease. To achieve sustainable improvements in oral health and reduce inequalities it is necessary to consider the underlying factors influencing poor oral health. A large spectrum of factors has been identified by contemporary public health research as influencing oral health including economic and social policy and individual health behaviours. Individual behavioural change approaches to improving oral health have been shown to have only short-term benefits and focusing on the wider determinants of health is necessary to achieve sustainable improvements in health-related behaviours.

Social determinants of oral health

10.2 The World Health Organization (WHO) defines the social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

10.3 In the UK health inequalities including oral health inequalities are a dominant feature, both nationally and across all geographical areas. Health inequalities are not inevitable; they stem from inequalities in income, education, employment and neighbourhood circumstances throughout life and can be reduced. Avoidable inequalities are unfair and remedying them is a matter of social justice. As described in Chapter 2, Marmot proposed the most effective evidence-based strategies for reducing health inequalities in England.

10.4 The relationships between oral diseases and the social determinants of health are inextricably bound together. As discussed above, it is well-recognised that oral health is influenced by a wide range of determinants starting from individual lifestyle choices such as sugar intake to national policy, for example smoke-free environments and policies tackling alcohol and sugar availability. It is essential that for a successful public health approach, these wider determinants must be focused upon through a partnership approach.

Oral disease and conditions

10.5 Good oral health is threatened by conditions such as gum disease (periodontitis), tooth decay (dental caries), trauma and oral (mouth) cancers. The common oral

diseases and conditions are described below together with their impacts on individuals and society.

Tooth decay

10.6 Tooth decay occurs when a tooth demineralises in response to the acids produced when plaque bacteria thrive on dietary sugars. The acids attack the tooth causing it to lose minerals shortly after the sugar enters the mouth and the process can last for an hour. If the tooth is given a rest phase without any sugar, the chemistry of the mouth (particularly saliva) can then replace the lost minerals. Frequent sugar intakes with fewer periods of rest shift the balance towards demineralisation of the tooth, eventually leading to tooth decay. Once decay has breached the outer layer of enamel it spreads widely in the dentine beneath. As it reaches the central pulp (tooth nerve), it causes severe pain and infection often leading to the loss of the tooth. In older people tooth decay can also attack the root surface of the tooth where the gums have receded, which has no outer protective layer of enamel. The groups at highest risk of tooth decay include infants, preschool children, adolescents and older people, especially those living in institutions.

10.7 The sugars causing tooth decay are present mainly in confectionary, biscuits and soft drinks. The WHO currently recommends sugar should make up less than 10% (approximately 50g) of people's energy intake per day with a further reduction to below 5% offering additional benefits. Most people in England consume more sugars than the recommended amount.

10.8 Factors such as costs, availability, access to healthy foods and clear information are all important in influencing what people eat and drink. Eating a healthy balanced diet containing fruit and vegetables, that is low in fat, salt and sugar and based on whole grain products is important for good health. *Delivering Better Oral Health* supports dental teams to give clear and consistent evidence-based advice to their patients. Advice relates to infant feeding, the intake of sugars within the diet, a balanced diet and the five a day message. Current dietary advice is to reduce not only the amount of sugar within the diet but also the frequency of its intake to reduce the risk of tooth decay.

Fluoride use

10.9 Fluoride acts in several ways to slow and prevent the decay process and to reverse decay in its early stages. The most important modes of action are to reduce demineralisation and promote re-mineralisation so that minerals are deposited back into the tooth surface. The effectiveness of fluoride in reducing levels of tooth decay at an individual and community level is well documented.

Individual level

10.10 Fluoride has been added to toothpaste since the 1970s and this is widely recognised as the main reason for improved oral health in the UK. The preventive fraction, that is the relative effectiveness of fluoride toothpaste in reducing tooth decay is 24%. Programmes such as Brushing for Life have been commissioned in the South West and involve the promotion of tooth brushing as soon as the teeth erupt in order to increase the delivery of fluoride to children from lower socio-economic groups.

10.11 Fluoride varnishes are applied professionally, usually six monthly and have a preventive fraction of 37% in baby teeth and 40% in adult teeth.

10.12 Fluoride rinses can be prescribed for people aged eight years and above for daily or weekly use in addition to twice daily brushing with fluoride toothpaste. Rinses require compliance and should be used at a different time to tooth brushing to maximise the topical effect of fluoride, which relates to frequency of availability. The preventive fraction for fluoride rinses is 26%.

Community level

10.13 In areas with high levels of tooth decay water fluoridation is an effective and safe public health intervention. The level of fluoride, which is naturally present in water supplies, can be adjusted to the optimal level, one part per million (ppm) to improve dental health.

10.14 Water fluoridation became the responsibility of local authorities from April 2013. Local authorities are responsible for conducting public consultations and for meeting the costs the water companies incur for implementing and operating water fluoridation schemes.

10.15 Fluoride varnish and tooth brushing may also be provided at a community level such as tooth brushing clubs in schools.

Tooth Wear

10.16 Apart from tooth decay, tooth tissue loss can also occur due to tooth wear. Tooth wear is a natural part of life, so the extent and severity of wear is age related. The wear can have chemical, mechanical or physical causes. The tooth tissue can dissolve in dietary or other acids (erosion), be worn away by contact with something else, such as a toothbrush and abrasive paste (abrasion) or the top and bottom teeth may grind against each other and be worn away (attrition). Typically, these processes all occur together with the overall result being loss of tooth tissue

changing the shape and form of the tooth. Whilst wear is a natural process, sometimes it can be rapid and destructive and require treatment.

10.17 Tooth wear is most commonly seen as erosion. Children and young people, who consume excessive amounts of acidic fizzy drinks, including diet and sugar free, are more likely to be affected. Less commonly, erosion arises from intrinsic factors such as frequent vomiting or regurgitation in people with stomach acidity problems or eating disorders such as bulimia.

10.18 Whilst severe tooth wear can have significant impacts on individuals, affecting function and appearance, it is not considered to be a public health problem.

Gum disease

10.19 Gum (periodontal) diseases comprise a range of conditions characterised by inflammation of the gums and loss of the tissues supporting the teeth, including bone. The diseases are caused by the interaction between plaque bacteria and the body's immune system. The mild forms of disease, where there is only inflammation of the gums (gingivitis) are common. In the more severe forms, the attachment between tooth and gum is lost, causing a pocket. As the pocketing progresses slowly it is more common among older people.

10.20 Gum diseases can cause a variety of symptoms but are usually painless until an advanced stage. The progressive loss of the supporting structures of the teeth can ultimately lead to looseness. Loss of untreated teeth is the most important manifestation of periodontal diseases.

Mouth (oral) cancers

10.21 Although mouth cancer is relatively uncommon it has a significant impact on the lives of those people affected because the disease and its treatments may cause difficulty in speaking and swallowing and sometimes affect facial appearance. The average five-year survival rate is 50%. Early diagnosis increases five-year survival to 80% but small tumours are often undetected because of low awareness and their painless nature means that people often only seek help when the cancer has already advanced.

10.22 The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD 10) defines mouth cancers as including ICD 10 codes C00-C14, C30-C32, which can be defined as head and neck cancers, excluding the thyroid gland.

10.23 The main risk factors for mouth cancer are use of tobacco, combined with alcohol consumption. These two factors act synergistically, and this multiplies the risk of

developing mouth cancer by up to 40%. Smokers are 7-10 times more likely to develop mouth cancer when compared to people who have never smoked and people who use smokeless tobacco have 11 times greater a risk than a non-user. Diet is also a risk factor for mouth cancer with some evidence stating the protective role of fruits and vegetables, particularly citrus fruits, in the prevention of the development of cancers of the digestive and upper respiratory tract.

Tobacco use

10.24 As well as causing mouth cancer, tobacco use affects the mouth by staining the teeth, discolouring 'tooth-coloured' restorations and dentures, reducing taste sensation causing bad breath (halitosis), delaying healing and strongly increasing the risk of gum disease.

Smokeless tobacco

10.25 Smokeless tobacco refers to over 30 different products worldwide. The main products used in the UK are betel quid (paan) with tobacco, gutkha and niswar. All forms of smokeless tobacco, whether combined with other ingredients or not, increase the risk of mouth cancer, pancreatic cancer, gum disease and heart disease. In England, smokeless tobacco products are mainly used by the South Asian community. The Health Survey for England (2004) recorded the highest self-reported use of smokeless tobacco among Bangladeshi women (16%) and men (9%), followed by Indian men (4%), Pakistani men (2%) and Indian and Pakistani women (both 1%). There is compelling evidence that people from South Asian backgrounds are at increased risk of mouth cancer with increased morbidity and mortality rates because of smokeless tobacco use.

Shisha smoking

10.26 Shisha is a device for smoking tobacco that is traditionally used in Middle Eastern cultures. Shisha is operated through a water filter and indirect heat, consequently smokers often feel it is less harmful than cigarettes.

Khat chewing

10.27 Khat or Qat is an edible flowering plant and mild stimulant that WHO classifies as a drug of abuse. Until July 2013, the UK was the only European country where khat was legal. Since July 2013, khat has been classified as a class C substance under the Misuse of Drugs Act 1971. However, due to the recent introduction of the ban and the historical and cultural nature of the use of the plant, khat may still be widely used in Somali and Yemeni populations.

Alcohol

10.28 As stated previously, alcohol is a key risk factor for mouth cancer, particularly in combination with tobacco use. Additionally, many major facial traumas are related to alcohol use.

10.29 Alcohol misuse contributes to increased mortality, chronic ill-health, violent crime and antisocial behaviour and places a considerable burden on the NHS.

Human papilloma virus

10.30 The human papilloma virus has a role in the development of mouth cancer. There are over 100 genotypes in the human papilloma group of viruses. However, human papilloma virus types 6, 11, 16 and 18 are the viruses which infect the mucosal epithelial cells in the oral cavity and oropharynx. It has been suggested that 20-25% of head and neck cancers contain human papilloma virus. In England incidence rates of human papilloma virus associated oral pharyngeal cancers rose sharply between 2005 and 2010 from 2.1 per 100,000 to 6.2 per 100,000 of the population.

10.31 Currently all females aged 12 years to 13 years are offered vaccination against some human papilloma viruses to reduce the risk of developing cervical cancer. It is estimated that this programme will eventually prevent up to 400 deaths a year. The British Dental Association is supporting calls for gender-neutral human papilloma virus vaccination in a bid to reduce the number of oro-pharyngeal cancers although no trials of its use against oral cancer have been reported.

Facial and tooth abnormalities

10.32 Tooth alignment problems occur because of a discrepancy between jaw size and the number of teeth present. Commonly, there is a lack of space in the mouth for all the adult teeth. Problems with tooth alignment may also occur in association with other syndromes such as cleft lip and palate.

10.33 Irregularly positioned teeth may be treated with orthodontic care depending on the severity of misalignment (malocclusion). Orthodontic treatment need is assessed using the Index of Orthodontic Treatment Need (IOTN). The IOTN consists of two separate components, the aesthetic component and the dental health component.

10.34 The aesthetic component is graded from 1-10, looking at the overall attractiveness of the anterior teeth by comparison with a visual chart. The dental health component is a five-point scale which looks at different aspects of malocclusion including missing teeth, overjet, crossbite, displacement of contact points and overbite. It is considered that children who fall into the most severe categories of misaligned teeth, IOTN 4 and 5 are most likely to benefit from orthodontic care as the benefits of treatment in these children are likely to outweigh the risks. In

addition, children in category 3 with the most severe dental aesthetic components (categories 6-10) are also considered to need orthodontic treatment.

Cleft lip and palate

10.35 Clefts occur when the upper lip and/or palatal shelves fail to fuse during development of the embryo. The type of cleft and how severe it is can vary widely. The exact cause of clefts is not known, although evidence suggests they are caused by a combination of genetics and environmental factors, such as smoking and drinking in early pregnancy and a lack of folic acid in the mother's diet. Cleft lip and palate can occur on its own (non-syndromic) or can sometimes be part of a wider series of birth defects (syndromic).

10.36 Cleft lip and/or palate can affect a variety of functions, including speech and hearing. Appearance and psychosocial health may also be compromised in those with a cleft. Typically, children with these disorders need multidisciplinary care from birth to adulthood and they have higher morbidity and mortality throughout life compared with unaffected individuals.

Social impacts of oral disease

10.37 Good oral health is essential for good general health and wellbeing. Oral disease may cause pain and discomfort, sleepless nights, loss of function and self-esteem. The discomfort may disrupt family life and lead to time off work or school. Decayed or missing teeth or ill-fitting dentures may lead to social isolation and loss of confidence. Limited function of the dentition may also restrict food choices compromising nutritional status. The 2010 Global Burden of Disease study reported that children aged five to nine years experienced the most disability caused by poor oral health, with the level of disability exceeding that caused by vision or hearing loss and diabetes mellitus. There is a substantial body of evidence that links the oral diseases described in this report to impacts on people's quality of life. Furthermore, treatment of these diseases improves quality of life.

Financial impacts of oral disease

10.38 In England in 2018-2019 the spend on NHS dental services[145] was £2.063 billion with a further spend of £856 million in patient charges. The costs locally are detailed in chapter 6. In addition, expenditure on private dentistry outside the NHS is likely to exceed £3 billion in England. The financial impacts are likely to increase as treatment options become more complex and costly for an ageing population retaining heavily restored teeth for longer and public expectations regarding maintaining teeth for life increase.

[145] National Audit office https://www.nao.org.uk/wp-content/uploads/2020/03/Dentistry-in-England.pdf

A common Risk factor approach

10.39 Oral diseases and conditions share risk factors with other diseases such as cancer, cardiovascular disease and obesity. A common risk factor approach was developed as there are identifiable risk factors which, if controlled, could have an impact on a multitude of conditions and diseases. Applying a common risk factor approach to multiple public health strategies would impact on multiple health outcomes and ensure more effective use of limited resources.

11 Appendix 11 Structured Interviews

11.1 Our programme of structured interviews was carried out throughout the summer of 2020. All these interviews were confidential, and they were carried out in part to familiarise the project team with the key issues in the region and the priorities for oral health improvement as seen in the light of these key stakeholders.

11.2 Key groups of people we engaged with were the Chairs of Managed Clinical Networks and Chairs of Local Dental Committees as well as leads from HEE and the Regions Local Dental Network. The findings of these interviews have supported our analysis and we are extremely grateful for the time these busy practitioners have given to support this OHNA. We also used these interviews to provide a 'heads up' for the stakeholder and service users/patient engagement which we hoped could be supported and facilitated through these networks and committees.

11.3 An additional and critical element of our stakeholder interviews was with local authority oral health leads and with key players in PHE. The engagement of the public health representative in local authorities enabled a review of the oral health improvement programmes being delivered in the each STP. In addition, we used these interviews to support the service user/patient and stakeholder surveys being carried out as part of the OHNA.

11.4 Finally, we undertook additional engagement with the Healthwatch leads across the region. The Healthwatch movement thoroughly supported our patient and public engagement and directly contributed to the large numbers of respondents to this survey.

12 Appendix 12 Stakeholder Surveys

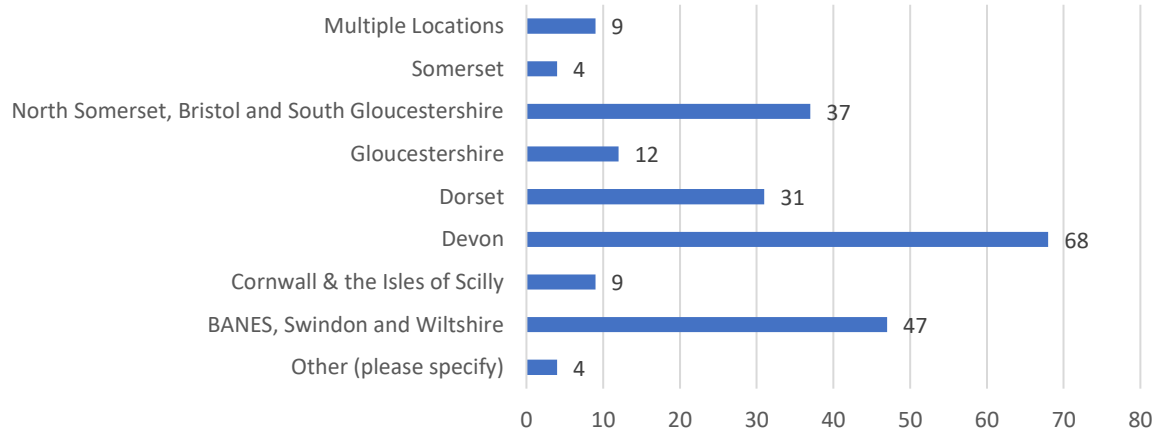
12.1 This survey was agreed and co designed with NHSE&I. The survey was designed to address the perceptions of stakeholders across the sector, but with a strong focus on primary care dentistry.

12.2 The survey was an e-Survey which was opened on the 5th October and which was closed on the 16th November 2020. The survey was disseminated through local dental networks and local dental committees and was supported through the engagement of public health directorates in local authorities, PHE and HEE. Respondents were encouraged to further disseminate the surveys onto colleagues who they felt wanted their voice to be heard and in total 221 responses were collated.

Key Findings

12.3 The first question of this survey asked respondents which area they predominantly operated within. 30.8% of respondents operated within Devon, 21.3% from Bath North East Somerset, Swindon and Wiltshire, 16.7% from Bristol, North somerset and South Gloucestershire, 14% from Dorset, 5.4% from Gloucestershire, 4.1% from Cornwall and the Isles of Scilly, and 1.8% from Somerset. In addition, 1.8% operated in other locations and 4.1% operated in multiple locations. This is set out in the chart below.

Chart 31: Which area do you predominantly operate within? (n 221)

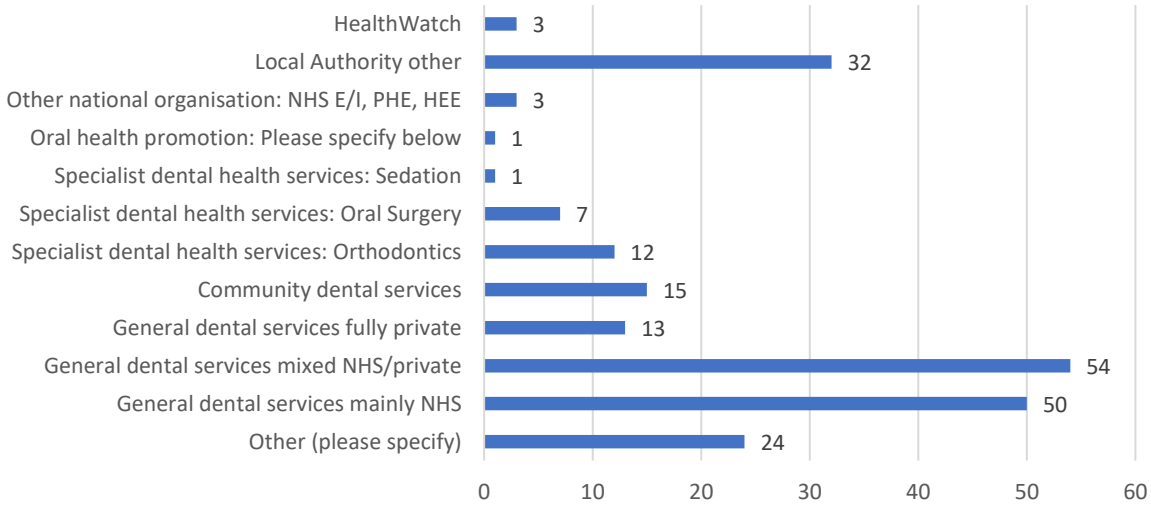


12.4 The next question sought to establish the type of organisation respondents work for or are associated with. 25.1% worked in general dental services that were mixed NHS/private, 23.3% worked in general dental services mainly NHS, and 6.0% worked in general dental services that were fully private. This would suggest that 54.3% of respondents worked in general dental services. In addition, 14.9% worked in local authority, 11.2% from other organisations, listed below, 7% from

community dental services, 5.6% from specialist dental health service oral surgery, 1.4% from other national organisations NHE/I, PHE and HEE, and 1.4% came from Healthwatch. In addition, 0.5% of respondents came from specialist dental health services: sedation and 0.5% from oral health promotion.

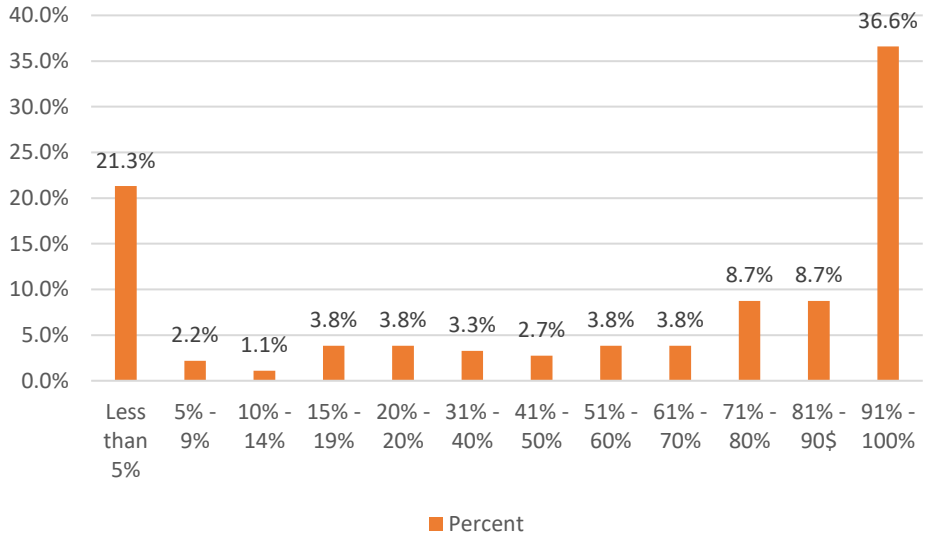
12.5 Of those that stated 'other' and then further specified, they came from: Acute NHS Trust/ teaching hospital, Care Home Support Lead, CCG, Dental Education (Dental school), Dental laboratory, Drug & Alcohol Commissioned Services ROADS, Drug & Alcohol Community Service Provider, Drug and alcohol service, Education, Health Education England, Health Visiting Team, HM Prisons, Hospital Orthodontic Services, NHS Hospital, NHS University Foundation Trust as an SLT, PHE, School Nursing Service, SHN service, Supervised Toothbrushing in Early Years settings, and University. Collectively this is a strong cross sector sample and includes a range of providers both directly engaged in general dental service and those who are engaged with and support oral health in the region.

Chart 32: Please indicate the most appropriate description of the type of organisation you work for or are associated with?



12.6 The next question sought to establish, if relevant, the proportion of work the respondents did in their practice that related to NHS dentistry. There seems to be two scales of responses with 36.6% doing 91% to 100% of their work in this way and 21.3% doing less than 5%, with the remainder scaling up to 100%.

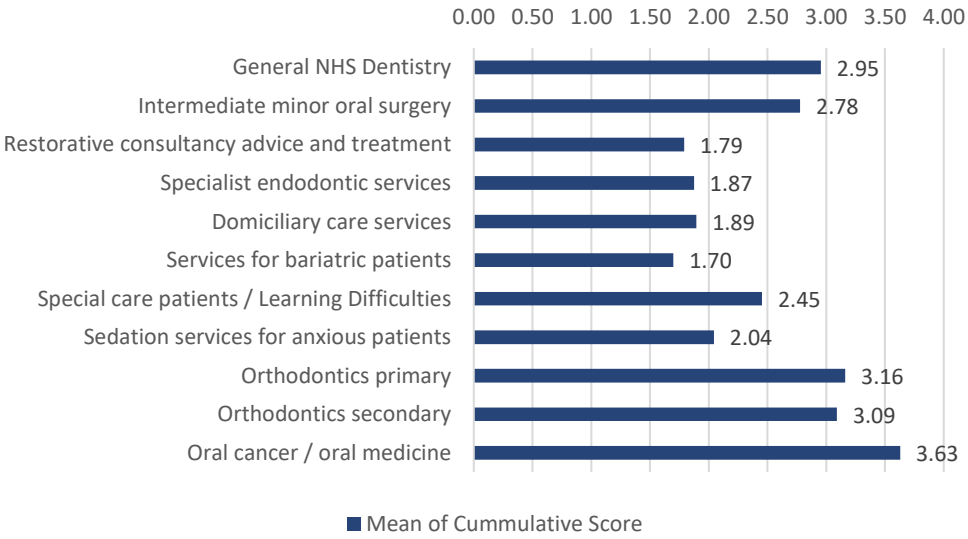
Chart 33: If relevant to your type of work, what proportion of your practice is NHS work?



12.7 The next question sought to understand the respondents' perceptions of the accessibility of different oral health services by offering a scale of 1-5 with 5 being most accessible.

12.8 Within the accessibility responses we calculated the mean of the scores which resulted in the lowest, with 1.79 for restorative consultancy advice and treatment, through to the highest oral cancer and oral medicine, which scores 3.63 out of 5. General NHS dentistry scored 2.95 which represent 3 out of 5 which was the fourth highest score. This would suggest that stakeholders gave NHS general dentistry around a 60% accessibility rating.

Chart 34: Accessibility of services: Mean of Cumulative Score (Max 5)

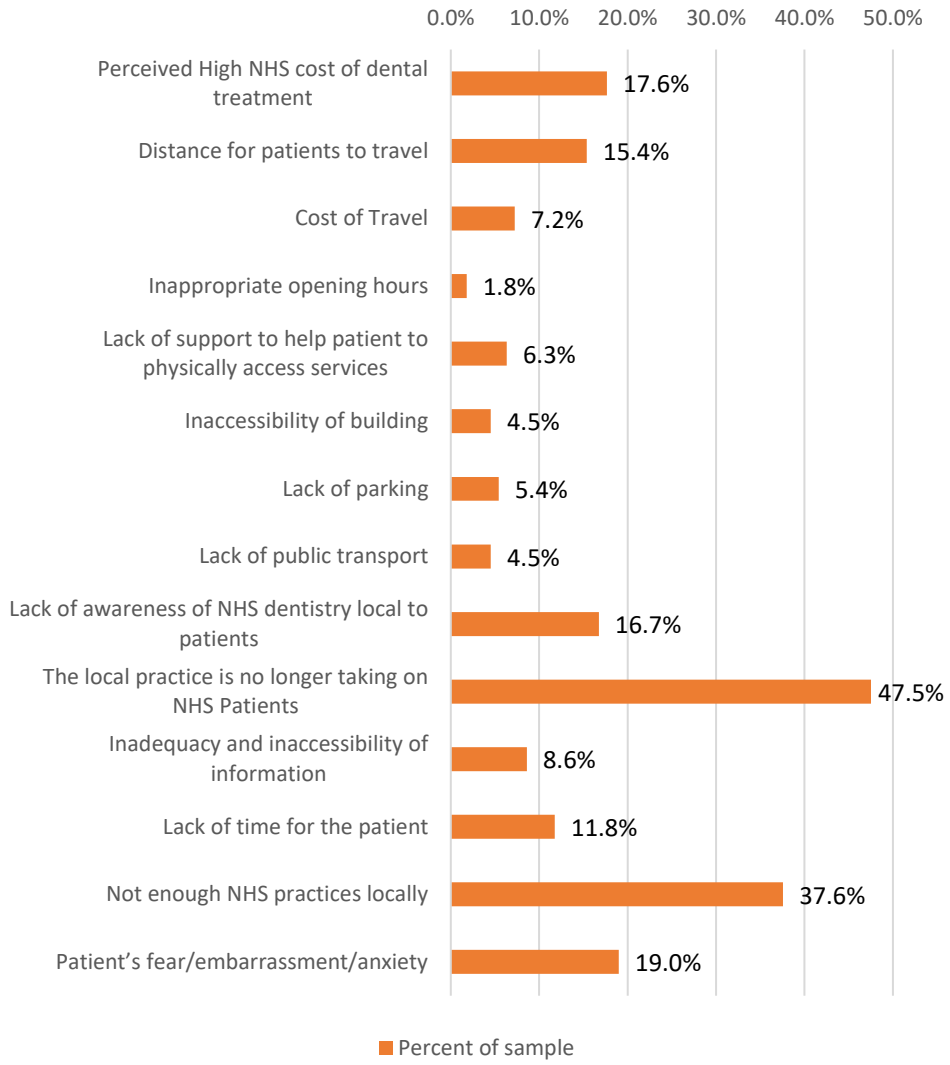


12.9 Respondents were then asked to identify, from a list, the main barriers to accessing NHS general dentistry. Barriers included the levels of provision, availability, and a

range of barriers of a more personal nature to the patient. The largest proportion of respondents stated that 'the local practice is no longer taking on NHS Patients' was the largest barrier with 47.5%, followed by 37.6% stating that there were 'not enough NHS practices locally'. Other key barriers highlighted were 'patient's fear/embarrassment/anxiety' 19.0%, 'perceived high NHS cost of dental treatment' 17.6%, 'lack of awareness of NHS dentistry locally available to patients' 16.7% and 'distance for patients to travel' 15.4%. This was then followed by more personal patient issues including 'lack of time for the patient', 11.8%, 'inadequacy and inaccessibility of information' 8.6% and 'cost of travel' 7.2%.

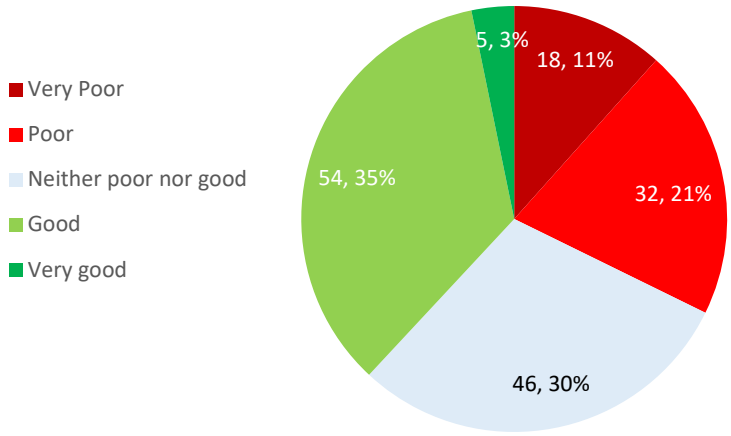
12.10 This shows that stakeholders believe that the availability of NHS dentistry is the key barrier both in the lack of NHS dentists accepting new patients or insufficient NHS practices locally.

Chart 35: What in your opinion are the main barriers to accessing NHS General Dental Services in your locality? (Tick all that apply)



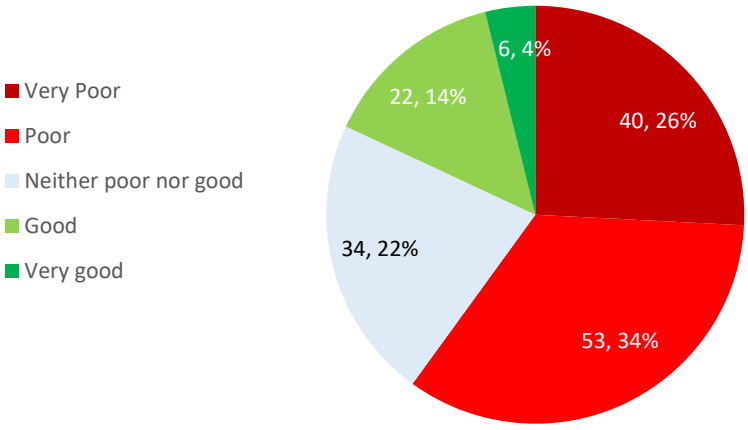
12.11 The survey then asked respondents: 'on a scale between very good and very poor, how effective do you feel NHS general dental services are in your locality?' The levels of response were broadly spread between those that felt it was either very poor or poor 32%, those that felt it was neither poor nor good 30% and those that felt it was good 38%. In short demonstrates a balanced perception of the quality of NHS dental services.

Chart 36: On a scale between very good and very poor how effective do you feel NHS general dental services are in your locality?



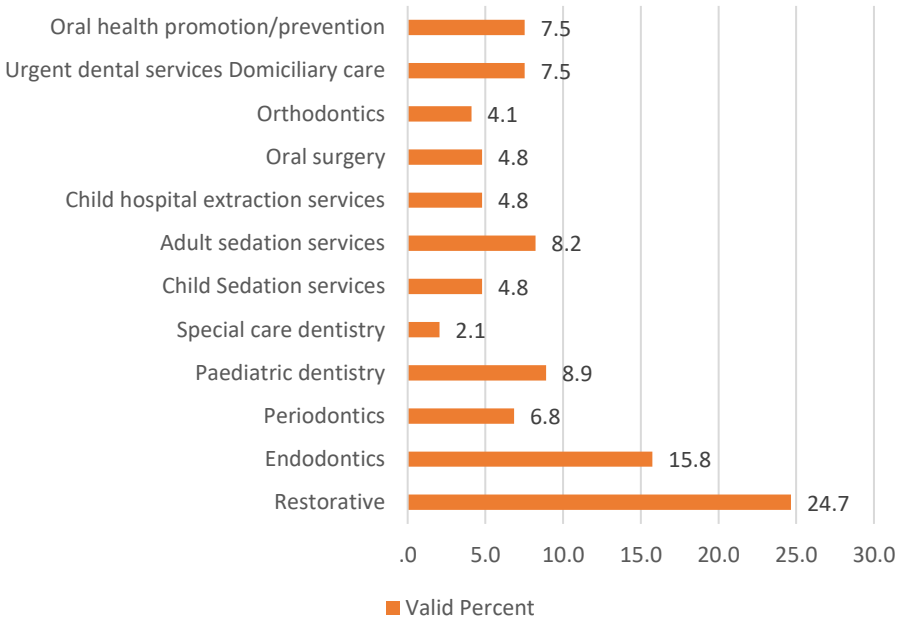
12.12 The next question asked the extent to which respondents felt that they were served by specialist dental services. The responses to this question were starker in their contrast with 60% feeling that they were either very poorly or poorly served by specialist dental services, with 22% neither agreeing nor disagreeing and 18% feeling the service for specialist dental services was either very good or good. This would suggest that most stakeholders felt that the area is not well serviced by specialist dental services.

Chart 37: On a scale between good and poor how well do you feel your area is served for specialist dental services?



12.13 The survey then asked respondents where they felt there was the greatest level of under provision of services in their locality. The service seen to have the greatest level of under provision was restorative services at 24.7% followed by endodontics 15.8%, paediatric dentistry 8.9%, oral health promotion/prevention 7.5% and urgent dental services – domiciliary care 7.5%.

Chart 38: What in your opinion is the greatest level of under provision of services in your locality?



12.14 The next question presented stakeholders with a series of statements about provision in the region/locally and it offered the respondent the choice of either agreeing or disagreeing with these statements.

- 54% disagreed or disagreed strongly that 'the recruitment of staff to provide NHS dentistry is effective in my area', 39% neither agreed nor disagreed and 8% either agreed or agreed strongly.

- 80% disagreed or disagreed strongly that 'all parts of my locality are covered by provision that meets the demands of patients presenting', 17% neither agreed nor disagreed and 3% either agreed or agreed strongly.

- 76% disagreed with the statement 'the volume of dentists that are available to work with NHS patients is adequate' 14% neither agreed nor disagreed and 11% agreed. This is strong confirmation of stakeholders' perceptions of there being a lack of dentists in the area.

- 76% disagreed that 'patients find it easy to find and access NHS dentists in this area', 21% neither agreed nor disagreed and 2% agreed.

- 53% disagreed that 'patients are aware which dentists locally provide NHS services', 19% neither agreed nor disagreed and 28% agreed.

- 29% disagreed that 'NHS dentists prioritise NHS patients in their clinics', 46% neither agreed nor disagreed and 24% agreed.

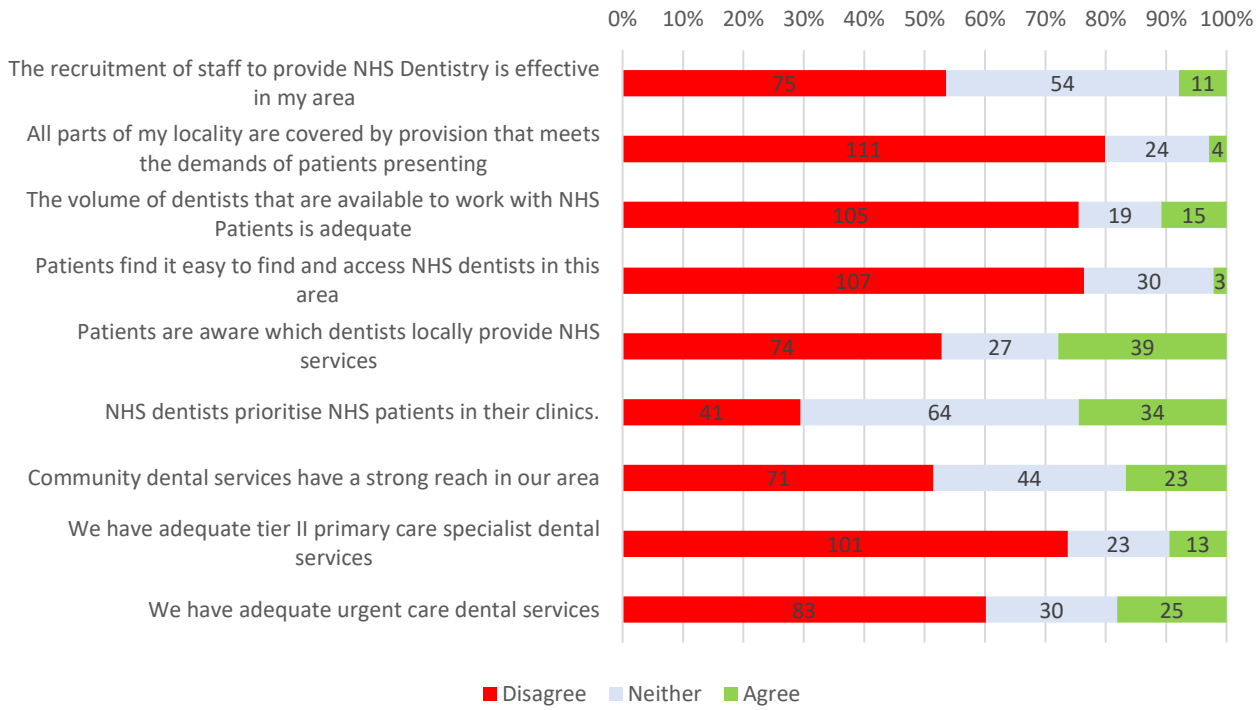
- 52% disagreed that 'community dental services have a strong reach in our area', 32% neither agreed nor disagreed and 17% agreed.

- 74% disagreed that 'we have adequate Tier 2 primary care specialist dental services', 17% neither agreed nor disagreed and 9% agreed.

- 60% disagreed that 'we have adequate urgent care dental services', 22% neither agreed nor disagreed and 18% agreed.

12.15 What this confirms is that across the stakeholders engaged in this survey there were higher levels of concerns as to the effectiveness of recruitment of dentist to the area, to the adequacy and volume of dentists available, to the ease to find and access a dentist and to the effectiveness of Tier 2 primary care and urgent care dental services. Most significant was the confirmation that 80% of stakeholders feel that not all parts of their locality are covered by provision that meets the demands of patients presenting.

Chart 39: Thinking about general dental services in your area please state the extent to which you agree or disagree with the following statements Agree and Disagree answers summarised

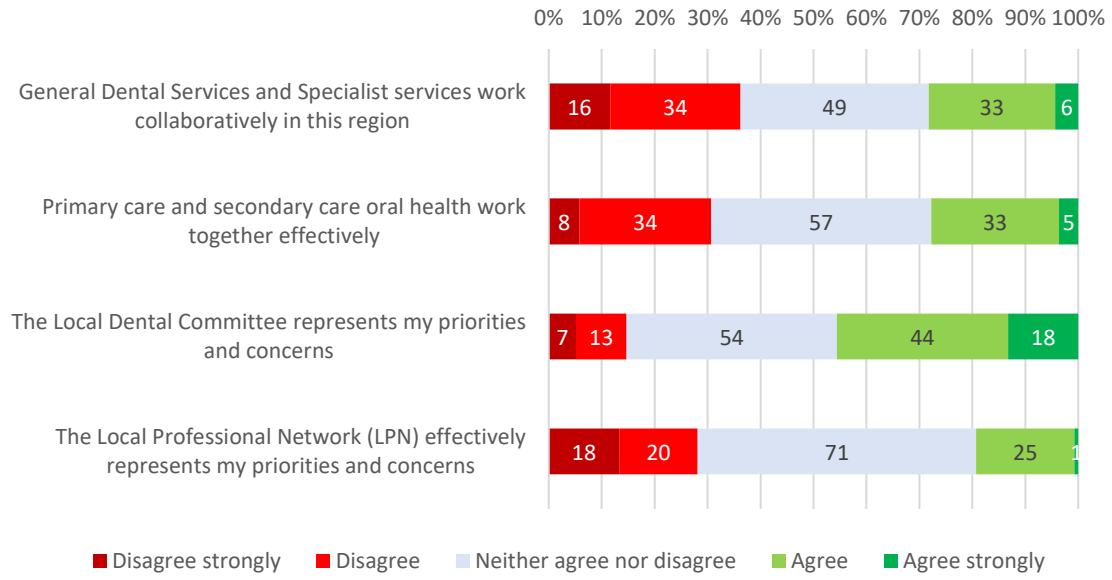


12.16 The next question focussed on the collaboration between practitioners and their representation both at the Local Dental Committee and the Local Professional Network (LPN).

12.17 The findings relating to the question of collaboration were quite evenly distributed, with 36% disagreeing that 'General Dental Services and Specialist services work collaboratively in this region', 36% nether agreeing nor disagreeing and 28% agreeing. Equally 31% disagreed that 'primary care and secondary care oral health work together effectively', 42% neither agreed nor disagreed and 28% agreed.

12.18 46% agreed that 'The Local Dental Committee represents my priorities and concerns', 40% neither agreed nor disagreed and 15% disagreed. Furthermore 28% disagreed that 'The Local Professional Network effectively represents my priorities and concerns', 53% neither agreed not disagreed and 19% agreed.

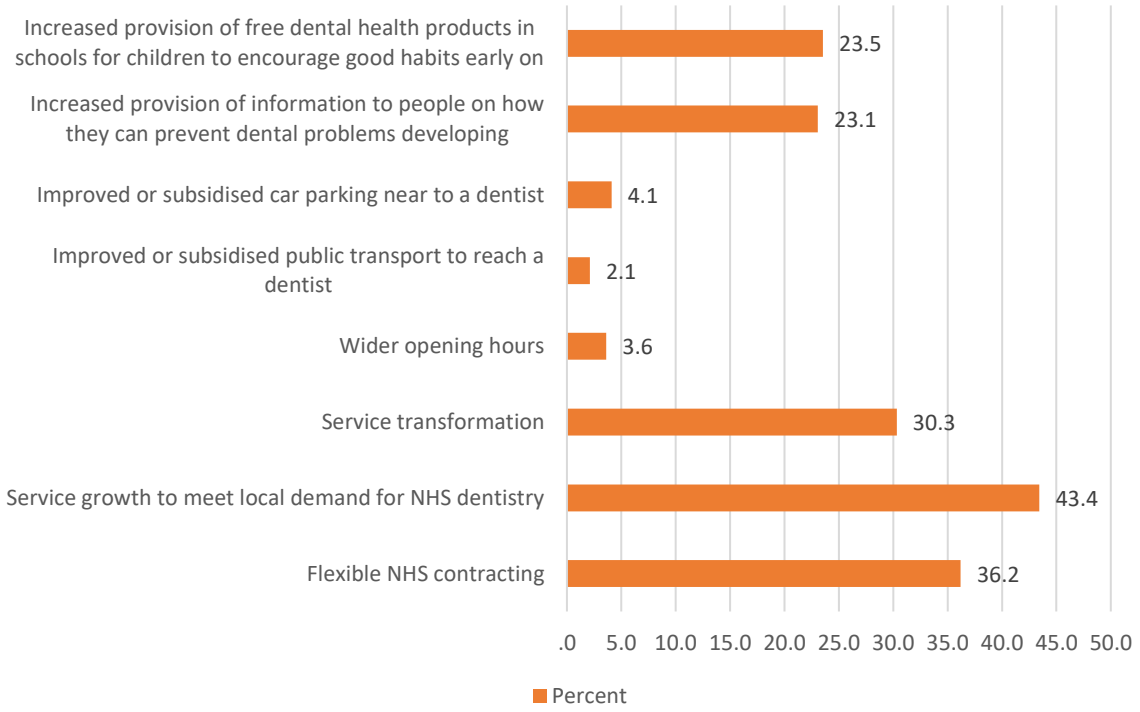
Chart 40: Thinking about the working relationships across dental and oral health providers, please state the extent to which you agree or disagree with the following statements



12.19 Stakeholders were the given the opportunity to select their top three from a list of potential improvement areas to oral health locally. The area of improvement given the highest level of support was 'service growth to meet local demand for NHS dentistry' with 43.3%, followed by 'flexible commissioning' with 36.2%, 'service transformation' with 30.3%, 'increased provision of free dental health products in schools for children to encourage good habits early on' with 23.5% and 'increased provision of information to people on how they can prevent dental problems developing' with 23.1%.

12.20 Once again stakeholders erred towards increasing provision through growth to meet local demand. This is confirmed in the chart below.

Chart 41: From the list below please highlight your top three areas for improvement for oral health in your locality.



12.21 Other suggestions raised by some respondents for improvement are set out below:

- Better contractual arrangement with a simpler fee structure for patients
- CDS employing specialist paediatric dentists to comply with commissioning document
- Improvement to domiciliary dentistry and visits to residents in care homes
- Realistic GDS contract to encourage more dentists to take NHS clients
- Training of health professionals and care professionals to improve oral health in older people
- Move away from the banding of treatment
- Proper commissioning of paediatric dentistry and provision of community paediatric dentists
- Children's access to dental surgery to be improved in the light of high levels of children's extractions
- The number of dentistry places at dental school to be increased
- Education regarding fluoride as many in the area are anti fluoride.

12.22 Finally, via an open-ended question, stakeholders were given the opportunity to state if there were any other points they would like to make about how to help more people access a dentist and improve dental health in the South West? 67

respondents took the time to complete this section and the list below summarises these views.

- NHS contract is prohibitive and not commercially viable
- UDA targets and current contract is inappropriate and does not support proper care
- There needs to be a complete service overhaul to reflect the realistic costs of seeing NHS patients then the local providers will be happy to see more NHS patients - currently it's unfeasible to see such patients and run a successful dental business
- Needs more funding, increase in UDA value as it is ridiculous - providing molar endo at a loss
- Make it attractive for dentists to want to provide NHS dentistry, as currently supply does not come close to meeting demand
- Get away from the way you pay your NHS dentists
- Lack of access to NHS dental practices with many patients on the waiting list leading to more complex problems, lack of specialist OS services
- Strong feelings that NHS provision is poor and patients struggle to register with a GDP
- The current general dentistry set up is putting additional strain on the hospital, CDS and emergency out of hours services
- Call for cheaper charges for NHS patients as there are many complaints about the NHS charges
- Language needs of diversity of patients requires greater support
- Big concerns around waiting times for paediatric GA both with SCD and Max Fac
- Concerns about corporate dentistry which takes away some consistency in the patient's relationship with the dentist as they move on
- Further support needed for the expansion of community dental services, as their primary care is based on good contact with GDPs and they offer a wide range of dental services
- Provide extra money for primary care orthodontics to help with waiting lists
- More capacity for accessing NHS dental care
- Stronger LDN with a proper strategic focus, NHSE culture is poor
- Reintroduce dental nurses to attend early years parent groups
- Consider providing information packs to the Children Centre's to support family support parenting/awareness sessions
- More preventative initiatives for practices to get involved with for the whole team. e.g. pay for care home visits or school screening.

Sub regional issues

- No local NHS restorative patients - multidisciplinary patients all travelling to Bristol
- Improve access to NHS dentistry in Plymouth - especially for vulnerable groups of people

- Patients in Wiltshire are disadvantaged in many ways - lack of access to specialist paediatric and restorative treatment and advice
- Commissioning for sedation within Wiltshire for children within Community Dental Services and Great Western Hospital to prevent unnecessary GAs
- Recruitment of paediatric, orthodontic and restorative consultants to support the Oral Surgery provision within Great Western Hospital
- Swindon does not have a consultant orthodontist, which it needs urgently
- Swindon and Worsley's Wiltshire patients are disadvantaged compared to Bristol patients due to the lack of proper specialist services in primary care
- More NHS provision, especially in BANES
- Real general Dental Service access problems in Devon and Cornwall
- Specialist services are very Bristol-Centric, and they are also at capacity too.

12.23 In summary 221 stakeholders were engaged in this survey that was open between the 5th October and the 16th November. Responses came from across the region but with higher level of responses from Devon, BANES, Swindon and Wiltshire, North Somerset, Bristol and South Gloucestershire and Dorset. Respondents came from all over the 'oral health' sector however 54.3% of respondents worked in general dental services. Key findings included:

- Stakeholders gave NHS general dentistry about a 60% accessibility rating
- 'The local practice is no longer taking on NHS Patients' was the largest barrier to accessing services with 47.5%, followed by 37.6% stating that there were 'not enough NHS practices locally'. Thus, the availability of dentistry is seen by stakeholders as the main key barrier to accessing good oral health in the region both in the lack of NHS dentists accepting new patients or the lack of NHS practices locally.
- Most stakeholders (60%) felt that the area is not well serviced by specialist dental services
- 54% disagreed or disagreed strongly that 'the recruitment of staff to provide NHS dentistry is effective in my area'
- 80% disagreed or disagreed strongly that 'the recruitment of staff to provide NHS dentistry is effective in my area'
- 76% disagreed with the statement 'the volume of dentists that are available to work with NHS Patients is adequate'
- 76% disagreed that 'patients find it easy to find and access NHS dentists in this area'
- 74% disagreed that 'we have adequate Tier 2 primary care specialist dental services'
- 60% disagreed that 'we have adequate urgent care dental services', 22% neither agreed nor disagreed and 18% agreed
- The area of improvement given the highest level of support was 'service growth to meet local demand for NHS dentistry' with 43.3%, followed by 'flexible commissioning' with 36.2%, 'service transformation' with 30.3%
- The major priorities for improvement stated by stakeholders were:

- Change to the GDS contract removing UDA and making the delivery of primary care NHS dentistry more commercially viable
- General dentistry in the South West is putting additional strain on the hospital, community dental services and emergency out of hours services
- Cheaper charges are needed for NHS patients
- Need for more specialist services in primary care
- Need for more secondary care dispersed across the region.

13 Appendix 13 Patient and Public Surveys

13.1 The patient and public surveys were designed and agreed upon with NHS England. They were formulated to capture local people's perceptions of NHS dentistry and to identify their priorities for oral health and patterns of dental activity. In doing so they sought to highlight those areas where there were barriers to accessing services and those areas where improvement can be made.

13.2 The survey had a mix of formats and methodologies but was based around an e-Survey and supported by a paper-based survey as well as a shortened easy read version. In addition, offers were made for telephone surveys and for survey translations where that was deemed appropriate.

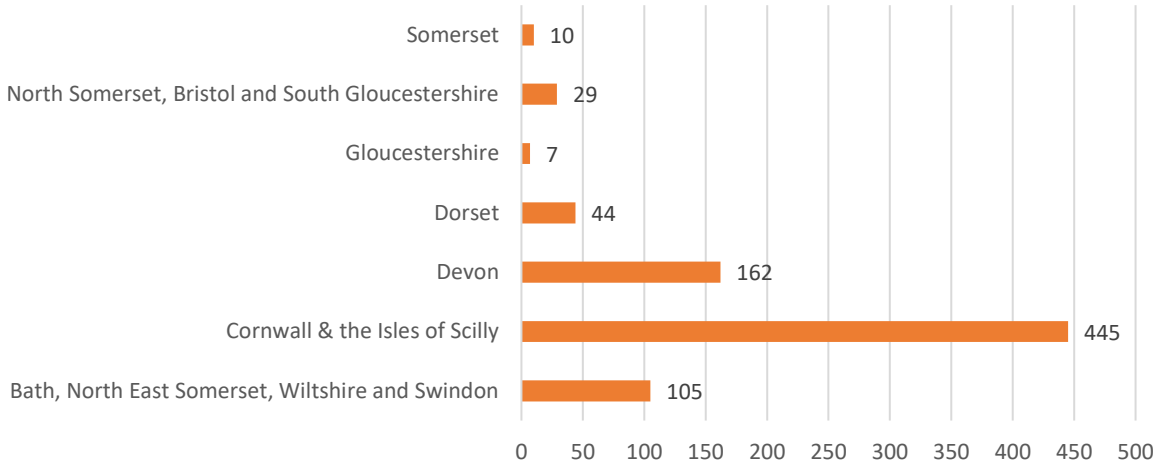
13.3 The survey opened on the 5th October and closed on the 17th November. In total we received 802 full surveys and 133 shortened surveys. This chapter will review the findings of both surveys and will draw together those findings most pertinent to this oral health needs assessment.

13.4 Due to the public nature of the surveys there were some questions that not all respondents completed and hence for each set of findings, we have indicated the number from which the percentage findings are taken in the title of each chart, i.e. (n-xxx).

Patient and Public Survey findings (Full version)

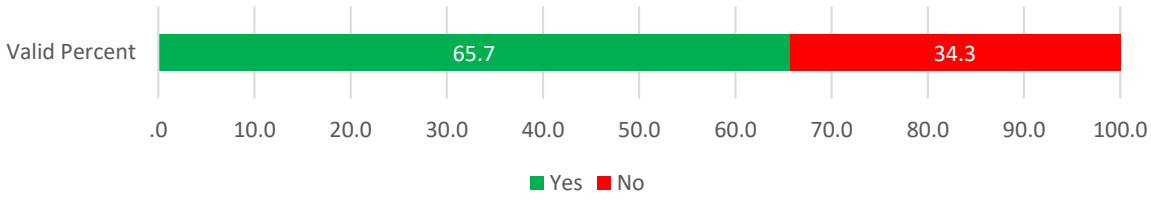
13.5 The survey captured 802 respondents from across the region. There seems to have been some extremely strong responses from some parts of the region and some more limited responses from others. 55% of responses came from Cornwall and the Isles of Scilly and 20% came from Devon. It would seem from these percentages that people in the peninsula are particularly keen to have their views heard about oral health and the provision of dental services in their area. 12.8% of responses came from BANES Swindon and Wiltshire, 5.5% from Dorset, 3.6% from Bristol, North Somerset and South Gloucestershire 1.2% from Somerset and 0.9% from Gloucestershire.

Chart 42: Which Area do you live in? (n-802)



13.6 Respondents were asked if they had a regular dentist. 65.7% of respondents stated that they did have a regular dentist and 34.3% stated that they did not. This shows that a sizeable segment of the respondents did not have a regular dentist which is an ongoing theme that is critical to some findings. This question was in a sifting format and the next response related to those who did have a regular dentist.

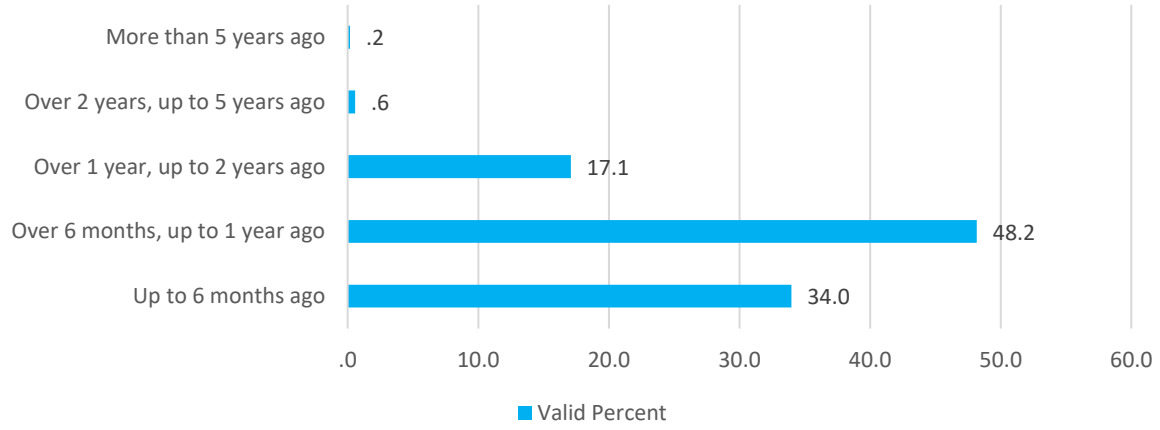
Chart 43: Do you have a regular dentist? (n795)



13.7 The next question asked the public who had a regular dentist, when was the last time that they visited a dentist. The options for this response included 'up to 6 months ago', 'over 6 months and up to 1 year ago', 'over 1 year and up to 2 years ago', 'over 2 years and up to 5 years ago', 'more than 5 years ago'. The overwhelming majority of responses (82.2%) came from those who had visited

their dentist in the last year. This would suggest that amongst respondents there is regular and frequent dental care which reflects good oral health practice.

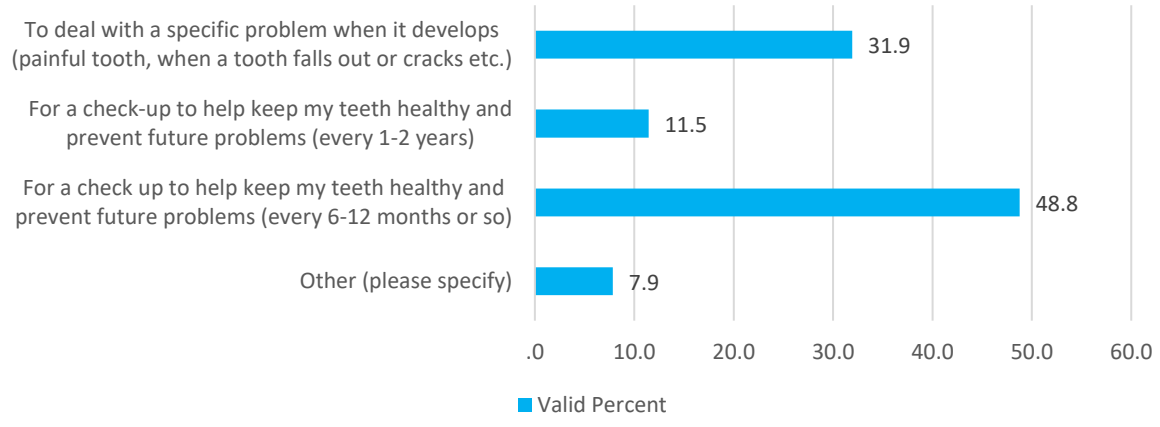
Chart 44: When was the last time you visited a dentist? (of those that had a regular dentist) (n 521)



13.8 We then asked all respondents what the main reason was for their last visit to a dentist. Response choices included 'for a check up to help keep my teeth healthy and prevent future problems (every 6-12 months or so)', 'for a check-up to help keep my teeth healthy and prevent future problems (every 1-2 years)', 'to deal with a specific problem when it develops (painful tooth, when a tooth falls out or cracks etc.)' and 'other (please specify)'.

13.9 The overwhelming proportion of respondents (60.3%) stated they had attended fora check up to help keep my teeth healthy and prevent future problems (in the last 2 years). This was then followed by, 'to deal with a specific problem when it developed' (31.9%). This would suggest that many in the sample, whilst potentially not having a regular dentist, had attended a dentist to address some element of oral care which seemed urgent to them.

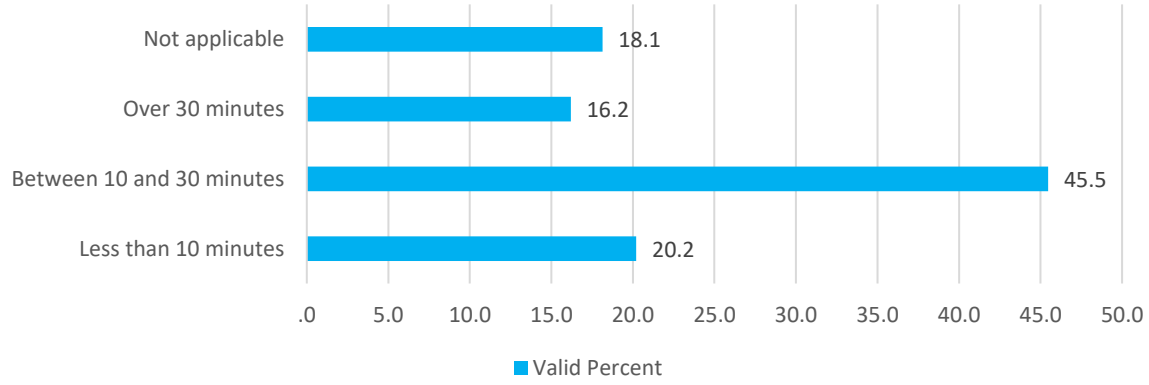
Chart 45: What was the main reason you last visited a dentist? (n777)



13.10 Indeed, on review of the 'other please specify' reasons, many of the stated reasons are for urgent care activities (emergency activity, fillings falling out, tooth / denture breaks, pain and oral cancer) and many also used this section to state that they did not have a dentist but wanted to have one.

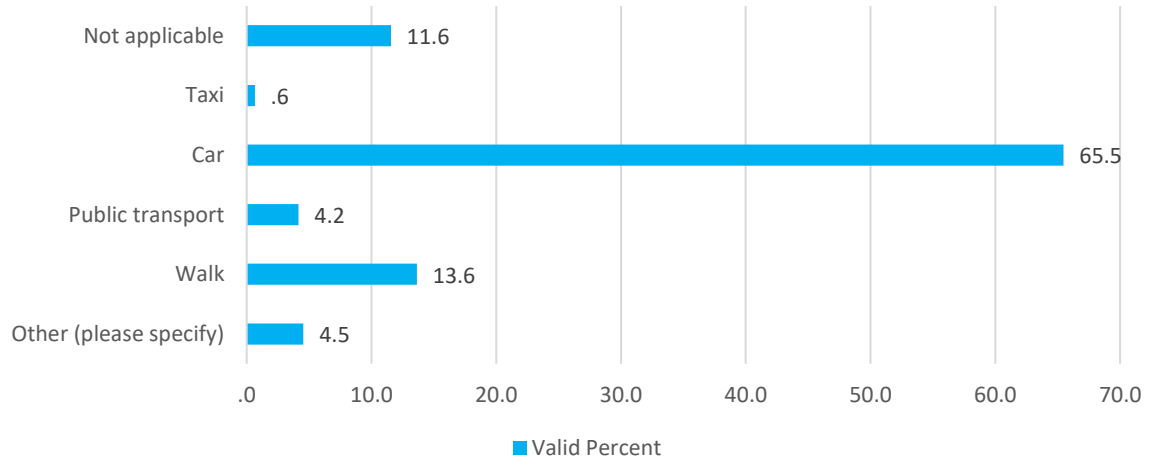
13.11 The survey then asked respondents how long it took them to get to their dentist. 772 people responded to this question and for the majority (65.7%) took less than 30 minutes to get to their dentist. 16.2% took over 30 minutes and 18.1% stated that this was not applicable.

Chart 46: How long does it take to get to your dentist's surgery? (n-772)



13.12 Modes of transport to get to their dentists was the next question. 65.5% of the respondents stated that car was their predominant mode of transport. 13.6% walked, 4.2% took public transport and 0.6% took a taxi. 4.5% stated 'other', of which bicycles and motorcycles were the most reported modes. This high reliance on cars reflects the rurality of the region.

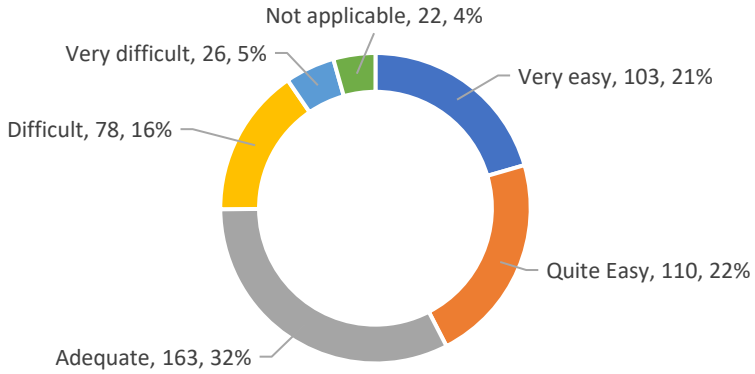
Chart 47: How do you predominantly get to your dentist's surgery when you go for an appointment? (n 770)



13.13 The next question was only asked of those who took a car to their dental surgery. Parking is an issue for many services and is often seen as a barrier to access. To

this end we asked those that stated they took a car to their appointment how easy it was to park? 43% felt it was either 'very easy' or 'easy' to park, 32% felt it was 'adequate', and 21% felt it was either 'difficult' or 'very difficult'. This would suggest that the majority of these respondents, 75%, felt that parking was either good or adequate.

Chart 48: If you drive to your dentist's surgery, how easy is it to park? (N502)

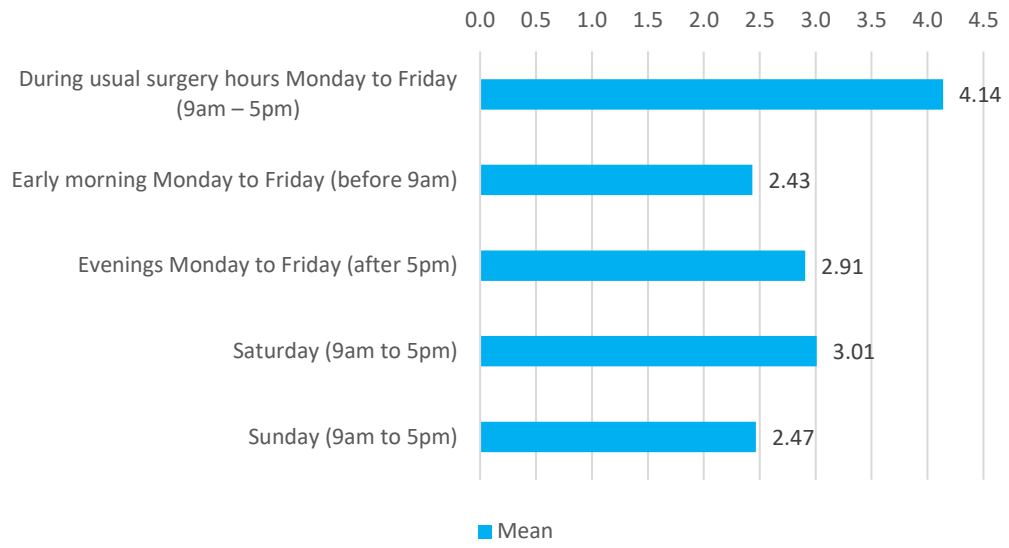


13.14 The public were then asked how likely they were to want an appointment at a dental surgery at the different times of the day/week. They were asked to rate each option from 1-5 where 1 means 'not likely' and 5 means 'highly likely'. We then analysed these responses by establishing the mean score for each option, thus allowing comparison.

13.15 The option with the highest mean average score (4.14 out of 5) was during usual surgery hours Monday to Friday (9am – 5pm). This was by way and far the highest score. This was followed by Saturdays – 9am to 5 pm, with a mean average score of 3.01 out of 5, evenings, Monday to Friday after 5pm scored 2.91, Sundays (9am – 5pm) scored 2.47 and early mornings Monday to Friday (before 8am) scores 2.43.

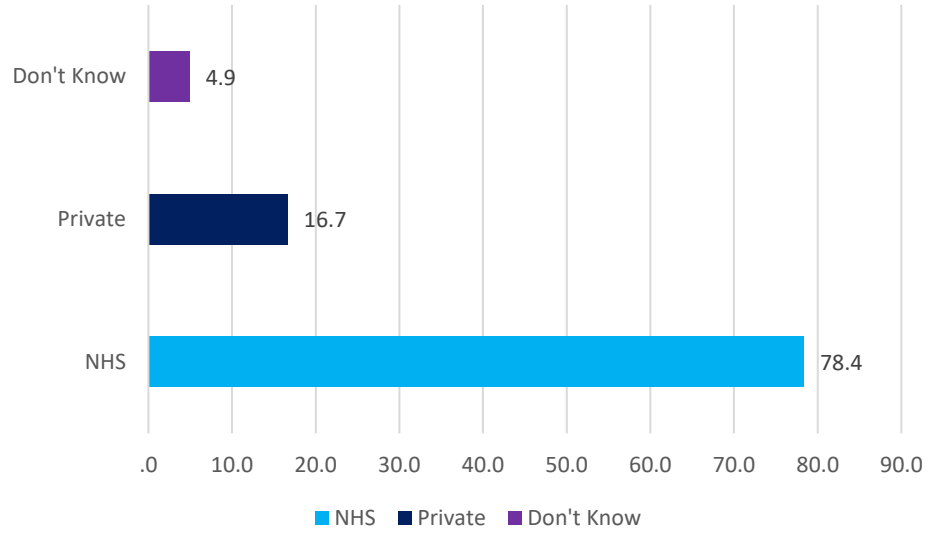
13.16 This suggests that in terms of patient preference most prefer keeping dental appointments during normal surgery hours. However, if there were to be alternative timings provided in addition, their preference would be for a Saturday surgery and the next preference would be for the extension of the week-day surgery to weekday evenings.

Chart 49: How likely are you to want an appointment at a dental surgery at the following times? (Please rate each out from 1-5 where 1 means not likely and 5 means highly likely) (N Various)



13.17 We then asked a key question as to whether the respondents go to or want to go to an NHS dentist. This was a shifting question to redirect respondents to the next couple of questions. It enabled an understanding of whether the patient was an NHS dental patient or indeed if they wanted to be so. 78.4% of those that responded stated they were or wanted to be an NHS patient and 16.7% stated they were a private patient. 4.9% did not know.

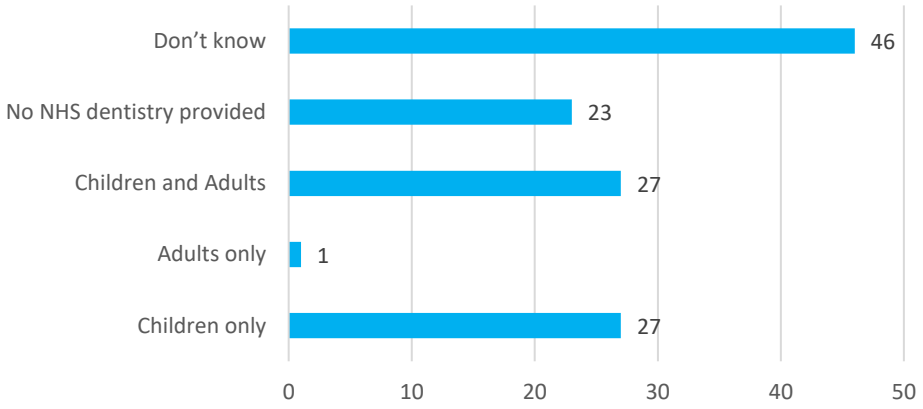
Chart 50: Do you go or want to go to an NHS or private dentist? (n749)



13.18 The next question was targeted to private patients. They were asked whether they know whether the practices they attended offer any NHS dentistry to children and or adults. 37.1% stated they did not know, however of the remainder, 18.5% stated that no NHS dentistry was provided, 21% stated that NHS dental provision

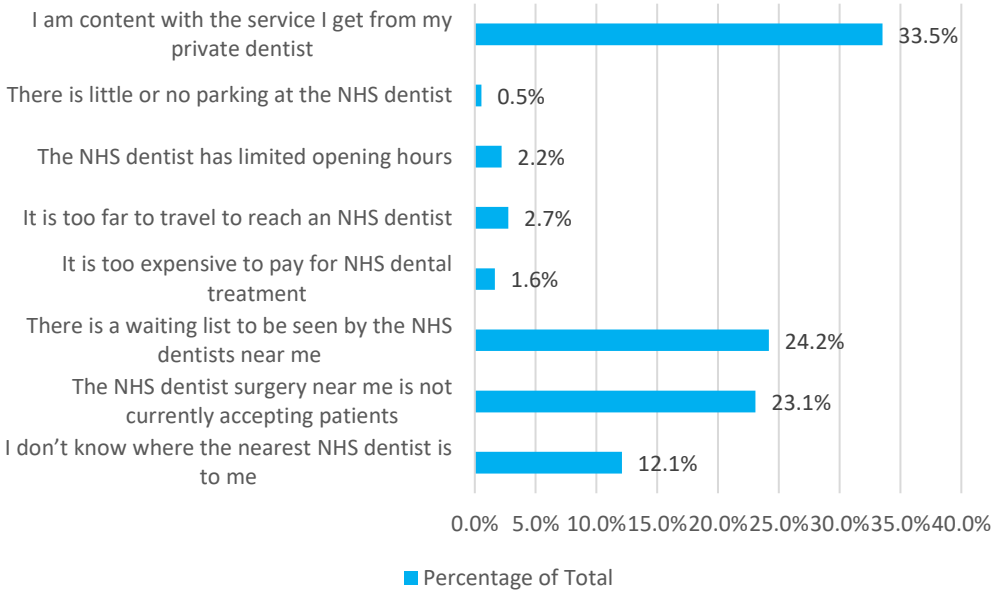
was available for children and adults, 21,8% that NHS dental provision was available for children only and 0.8% for adults only.

Chart 51: If you use a private practice dentist, do you know if the dental surgery offers any NHS dentistry to children and/or adults? (n-124)



13.19 The next question sought to understand private patient's perceptions of barriers to accessing NHS dentistry. The majority (33.5%) stated that they were happy with their private dentist. Others (24.2%) felt that the fact there is a waiting list was a barrier and 23.1% felt that the NHS dentist near them was not currently accepting new patients. The remaining reasons were less significant and relied more on personal perceptions of barriers to accessing NHS dentistry.

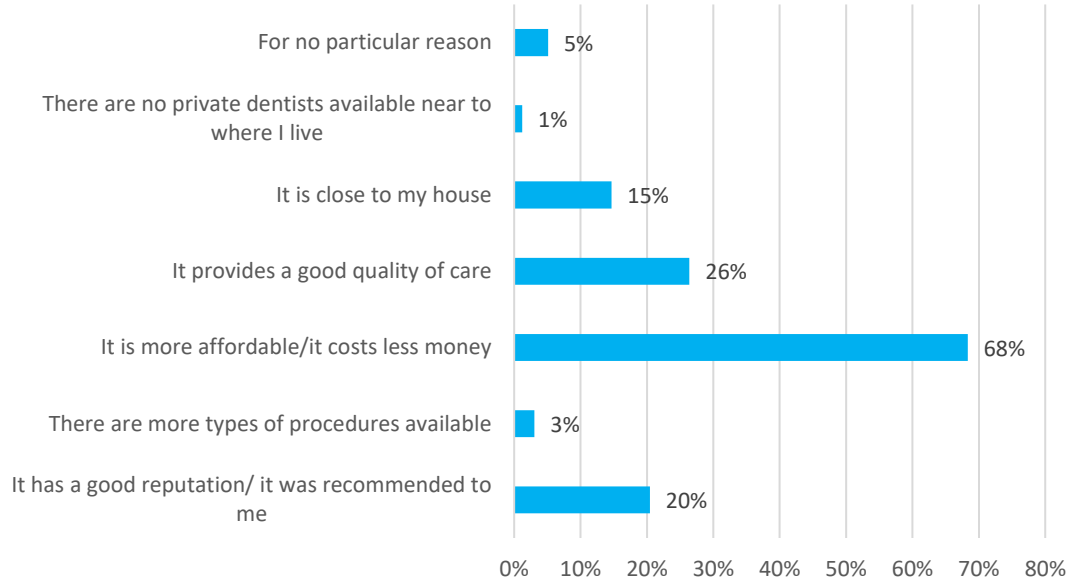
Chart 52: What stops you from going to see an NHS dentist regularly? (Tick all that apply) (n-124 NB Question targeted to non NHS patients)



13.20 The next question was asked of those that either go to or want to go to an NHS dentist. It focussed on the reasons why they want to go to an NHS dentist. Lower cost was the key response with 68% stating that it is more affordable/it costs less

money. 26% felt NHS dentistry provided good quality of care and 20% felt it had a good reputation and was recommended to them. It is clear that in this two-tier dental system with private and NHS dentistry those that use NHS dentists predominantly see the main reason to do so as affordability.

Chart 53: If you go to an NHS dentist surgery, what are your reasons for this? (tick all that apply) Targeted to those who go to or want to go to an NHS Dentist. (n587)



13.21 Respondents were given the opportunity to state why they responded in the way they did. This drew out a considerable range of reasons and rationale. Most reflected the need to access dentistry and that affordability was a central reason. Many stated that they still want an NHS dentist as they currently did not have a dentist. Many NHS patients were loyal to their dentist and had had them for many years, some were frustrated that their dentist who had originally provided NHS services had moved to private practice and they wanted to return to the NHS dental system as their dental care costs were now much higher. A vast proportion simply stated that did not have a dentist and wanted one, several having been on waiting lists for over 2-3 years. Some cannot even get into an NHS dentist or register to get one as they are either not taking on any more patients or have closed/are not in the area anymore.

'Am not registered, can't get on the books anywhere.'

'Been on waiting list for 2 years.'

'Cannot afford anything else. Used to be with Den Plan but had to stop owing to finances. NHS dentist is ok but not as thorough as private and don't have hygienist.'

'I can't afford private.'

'I have found her an excellent dentist who treats me well and does a good job. Conscientious.'

'It's very hard to find an NHS dentist now and has been for years, we have had ours for years, but friends and family have had to go private because of the lack of NHS ones. Although I've put near my house above, it's around 5 miles away, but there are none nearer.'

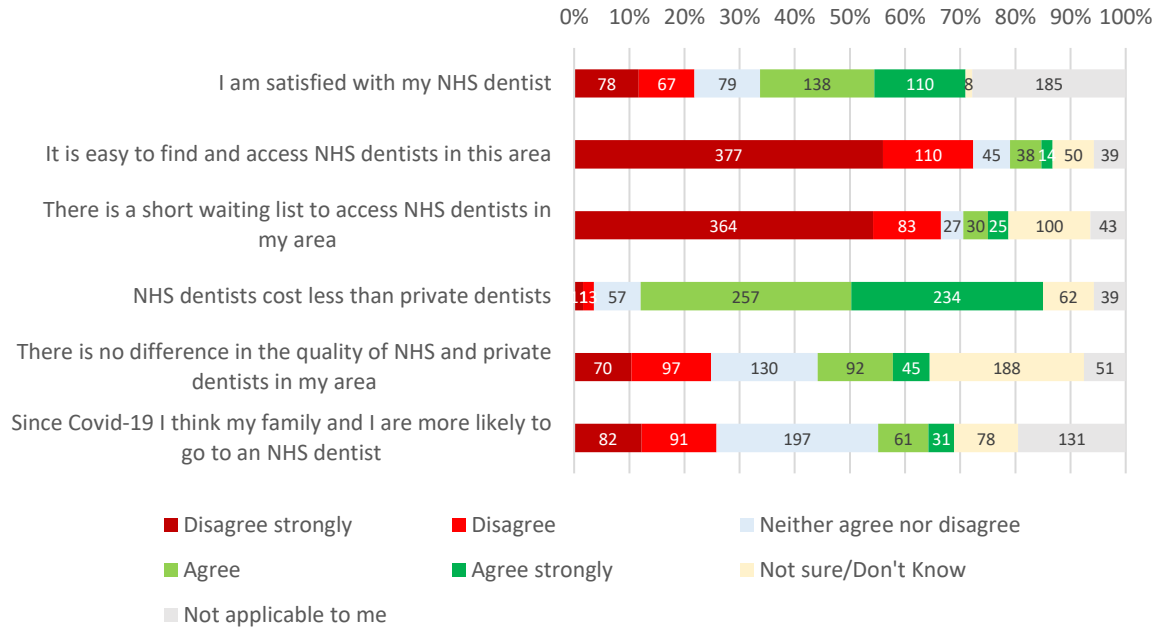
'There are no dentists available anywhere near me NHS or private. I'll pay privately when I need to, but this means I miss routine preventative dentistry.'

'No NHS dentist available!'

'The only one I could get was an NHS Dentist, but have left as they have cancelled the last 3 appointments, they prefer private patients.'

13.22 The next question was open to all and set out a series of statements about NHS dentistry and provided respondents with the option to state whether they agreed strongly, agree, neither agreed not disagreed, disagree and or disagreed strongly, were not sure and or felt that the statement was not applicable to them. All the statements were written in a positive frame and respondents were able to read them and make their judgement accordingly. The chart below sets out the findings to this question.

Chart 54: Please read the following statements about NHS dental services in your area and tick the box that best describes how you feel?

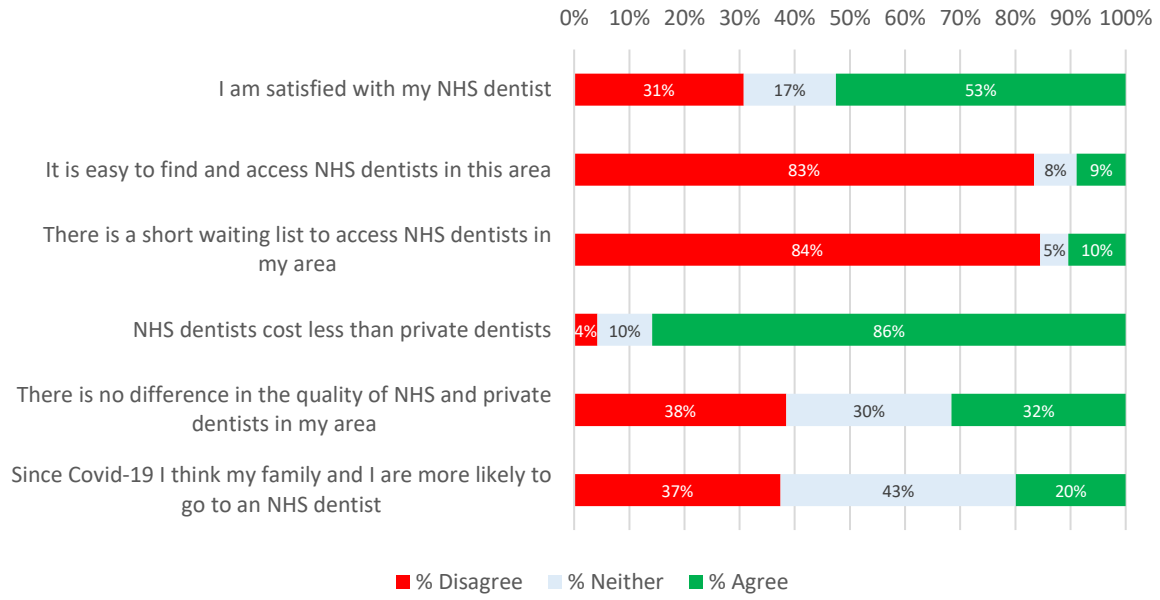


13.23 There were clearly higher levels of disagreement (red) with the statement, 'it is easy to find and access an NHS dentist in this area' chosen by 73% of respondents. 'There is a short waiting list to access NHS dentists in my area' saw 67% of respondent either disagreeing strongly or disagreeing. In contrast 72% of respondent agreed with the statement that 'NHS dentists cost less than private dentists.' 39% or respondent agreed that they were satisfied with their NHS

dentist. There was more a balanced level of agreement with the statement that 'there is no difference in the quality of NHS and private dentists in my area'. Slightly more people disagreed (26%) than those that agreed (21%) with the statement that since Covid-19 they think they are more likely to go to an NHS dentist.

13.24 When we remove those that either did not know or were not sure and or those who felt this was not applicable to them, there are some emphatic results. 84% of respondents either disagreed strongly or disagreed that there is a short waiting list to access NHS dentistry in my area. 83% disagree that it is easy to find and access NHS dentistry in this area and 86% agreed that NHS dentists cost less than private dentists.

Chart 55: Please read the following statements about NHS dental services in your area and tick the box that best describes how you feel? Based on those with a stated opinion.



13.25 Patients were asked why they responded to this question in the way they did. This provides some clear insight as to what people are concerned about and some specificity of their concerns. 380 people took the time to draft their response and, in some cases, they were extremely detailed. There is a wide range of issues raised about NHS dentistry in their areas, and this included concerns about access, waiting lists, fears about not being about to access any dentistry in some areas, fears and concerns about the quality of provision, cost and affordability. The core themes are:

- Lack of access to NHS dentistry
- Inability to access dentistry since Covid-19
- Extensive waiting lists
- Difficulty securing an appointment at NHS dentists once registered
- Concerns about the quality of NHS dentistry

- Perceptions that NHS dentists are not operating during Covid-19 whilst private dentists are
- Experience of the frequent cancellations of NHS dentists
- Concerns that NHS dentists are prioritising their paying private patients
- Experience that there are many NHS practices that have closed
- People with urgent care needs due to the lack of regular dentistry
- People experiencing a high cost of treatment both in the NHS and private sector
- Concerns raised across the region but the high volume of responses from Cornwall have emphasised greater need there.

13.26 Many of these stories are too individual to share in this OHNA as many go into personal diagnosis, care requirement and details of their courses of treatment or in some cases no treatment which have thus resulted in continuing and excruciating pain. Nonetheless we have tried to provide an overview of these responses in the quotations set out below.

'We are all behind in our appointments due to Covid-19 and it was difficult to get an appointment at a convenient time 12 months in advance before lockdown.'

'Already with an NHS dentist but because of private patients taking priority my yearly pre-arranged appointments (pre Covid) always changed to months later; effectively bumped to give preference to higher paying customers.'

'After trying to get on a dentist's list to no avail (either private or NHS) for 4 years I have had to go to 3 different emergency dentists locally to me.'

'As a front line ITU nurse it's pathetic that dentists shut during the outbreak. Doctors and nurses in the hospital didn't just get to shut, so dentists should have kept working for emergency dental work.'

'Because I can't get an NHS dentist for me or my daughter aged 9. I'm on a 2-year waiting list. By the time I get to see a dentist I will have dental problems. Absolute disgrace in Cornwall.'

'Been in Cornwall 4 years and still can't get into a dentist with the NHS its crazy.'

'Can't get an appointment they keep cancelling them and the staff don't stay long. Not been to my dentist for over 18 months now but still going to my trainee Hygienist at the Plymouth Dental Hospital who are great.'

'Due to Covid, Family and friends have been made redundant and will struggle to afford an NHS dentist, let alone a private one'

'I am a great believer in the NHS and feel we should have easy access to them - however since Covid -19 it has been nigh on impossible to get treatment even in an emergency.'

'I am registered with an NHS dentist in Bodmin but there has been no dentist there for well over two probably nearly three years! So, I haven't actually been to see a dentist for that long, I used to go once every 6-12 months.'

'I do not have a dentist. I have lived in Cornwall over 3 years and I am still on the waiting list to register. The waiting list is approx. 3 years. You cannot even get an emergency appointment without travelling over an hour.'

'I feel lucky to have had an NHS dentist before the system changed and he took on each of my children.'

'I have been on an NHS dentist waiting list for 3 years and still have no dentist. I have had a problem since January and have still not had it dealt with as I need a regular dentist to do it. Absolutely awful service in Cornwall.'

'I have been waiting to get onto an NHS dentists list for 2 years and that includes locally and in Plymouth NHS dental services in this area are impossible to access.'

'I have lived in Cornwall for over 9 years now and neither myself nor my husband have ever been able to register with an NHS dentist, not through lack of trying. I have only just today managed to secure an appointment for my 6-year-old daughter.'

'I live alone, but my Dorset-based family all go to a private dentist that they've had for years. I only came to Dorset 3 years ago and couldn't get a dentist at all. No one had room, private or NHS.'

'My NHS dentist cancelled all of my family's appointments months in advance and will not book a new appointment.'

'My wife and I moved to Cornwall 2 years ago and have been unable to register with an NHS practice in Cornwall. We are presently on the SW area waiting list and were advised that there is presently 65,000 people waiting to register with an NHS practice in the SW region. We remain registered with our original NHS practice in the West Midlands involving a return journey of over 550 miles together with overnight accommodation.'

'NHS dentists are very basic and their treatment without care. I have had painful experiences and don't trust the ones I have been to.'

'The NHS dentist are high cost and not great treatment. I would rather get better quality service and dentistry even if it costs more.'

'They are all shut, absolutely disgraceful, my son URGENTLY needs a tooth extraction and cannot get a dentist in Swindon, he has been quoted £600 for removal, by a private dental practice, he is in receipt of Universal credit! I gave been waiting for 9 months for a check-up and dental hygienist appointment they cancelled all appointments and are not bothering to open.

'Very satisfied with the private care I get from my brilliant dentist and hygienist.'

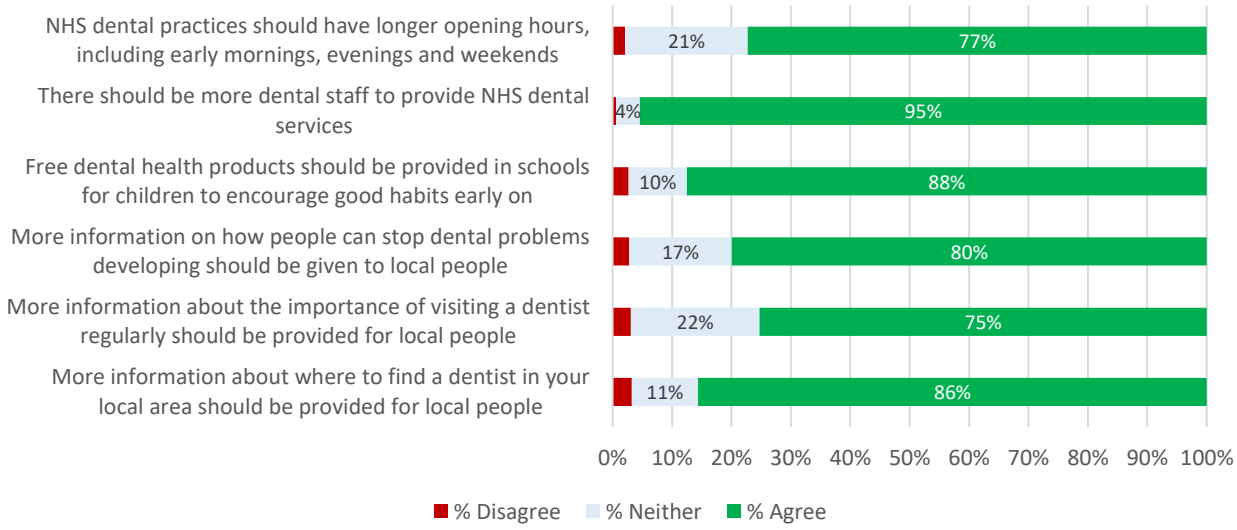
'We don't have a dentist. Moved to Devon in Aug 2019. You have to go on a waiting list to be allocated to an NHS dentist. Over a year later we are still waiting to be assigned a dentist. No oral treatment for a year. Previously went every 6 months regular.

'Why would I go to an NHS dentist rather than a private one during the pandemic? I don't see any logic in this. A well-organised and clean dental practice is the main prerequisite, I have that with my current dentist. I would have gone NHS when I first came to Exeter in 2014 but no-one in the city was taking on new patients so I had to go private.'

13.27 The next question in the survey asked respondents to state whether they agreed strongly, agreed, neither agreed not disagreed, disagreed, disagreed strongly or were not sure/did not know re the following statements. Each of the statements identified a form of improvement that could be made to NHS oral health in the region. From the analysis the proportion of 'do not know/not sure' responses have been taken away as they did not represent more than 5% of the overall responses to any given statement. The recalculated percentages show that there was universal agreement to the improvements listed.

- 95% agreed that there should be more dental staff to provide NHS dental services.
- 88% agreed that free dental health products should be provided in schools for children to encourage good habits early on.
- 86% agreed that there should be more information provided locally about where to find a dentist in your area.
- 80% agreed that there should be more information provided locally on how people can stop dental problems developing.
- 77% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends.
- 75% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

Chart 56: To help improve the oral health of local people in the South West of England, please tick one answer to show how much you agree or disagree with the following statements. Based on those with a stated opinion



13.28 Respondents were asked if they could suggest any further areas of improvement. From this, a range of issues emerged. Issues centred around the needs for more dentists, in summary:

- More access to NHS dentists in your locality should be made easier
- Better dentist allocation
- Dentistry should be affordable
- Finding a private dentist is easy, there need to be more NHS dentists
- Improve the quality of care
- Increase capacity in all areas
- NHS dentistry should provide all services provided by private dentists
- Reduce waiting lists
- Urgent appointments should be easier to get for broken teeth and infections
- Work with young people to promote life-long good oral health.

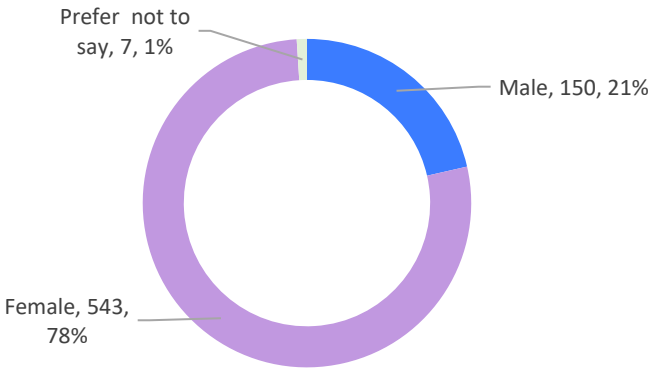
13.29 Finally, respondents were asked if they had any other suggestions for encouraging people to visit a dentist regularly and how to improve the oral health of local people. 421 people took the time to respond to this question. The list below tries to summarise the key points raised; the overwhelming majority seeks to increase the number of dentists in their area, i.e. more NHS dentists.

- More and greater access to NHS dentistry
- Employ more NHS dentists
- NHS dentists targeted to areas where this is no/inadequate provision
- Make NHS dentistry cheaper as dentists over charge - keep the fees down
- More awareness of NHS dentists
- Get more dentists to reduce the waiting lists
- Free or reduced rates for pensioners would encourage more OAP's to attend
- More people getting more regular checkups and routine dentistry
- More oral health promotions in schools
- Basic oral health education at primary schools
- Education about teeth and healthy meals, on a low income, should be part of all schools curriculum
- Information about prevention rather than treatment
- On-line social media campaigns to reach a wider audience
- Stop dental practices taking on new clients who are NOT on the waiting list
- Bring dentist back into schools
- Make it more attractive for dentists to provide NHS treatments.

Profile of respondents

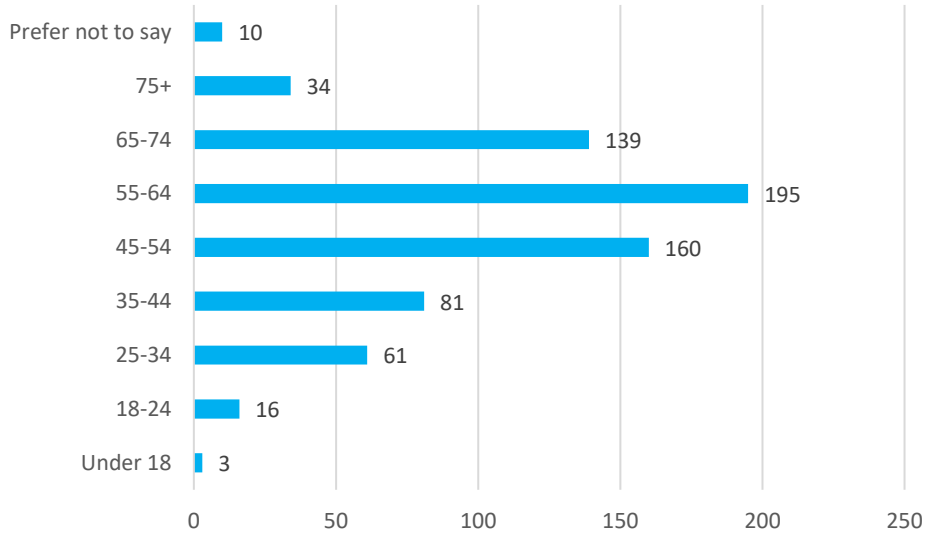
13.30 The gender profile of respondents that completed this question shows that there were a far higher volume of women with 78% of the sample compared to 21% men, 1% preferring not to say.

Chart 57: Gender profile of respondents (n700)
Chart 58:



13.31 The age profile of respondents that completed this question showed that there was an older set of respondents to this survey, with 65.8% over the age of 45 and 20.1% under the age of 45. This may reflect the cohort who tend to engage in this kind of public health related survey. Nonetheless their experiences are helpful, particularly as many will be parents of younger people seeking access to NHS dentistry.

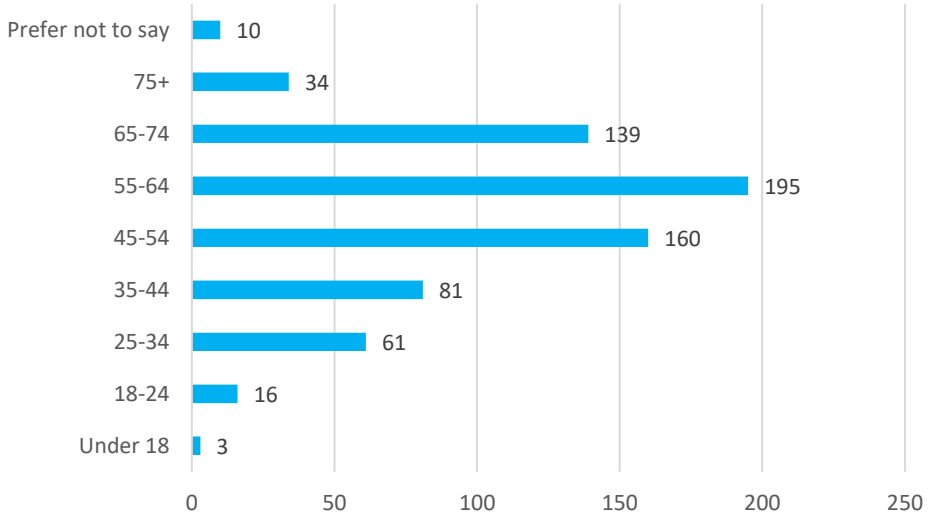
Chart 59: Age profile of Respondents (n699)



13.32 The ethnic profile of respondents that completed this question showed an extremely high proportion (91%) of white British respondents, indeed the white profile is even larger at 95.9% with the addition of 3.6% white other, 1.3% white Irish and 0.3% white gypsy/Irish traveller. Thus, the BAME profile of this survey

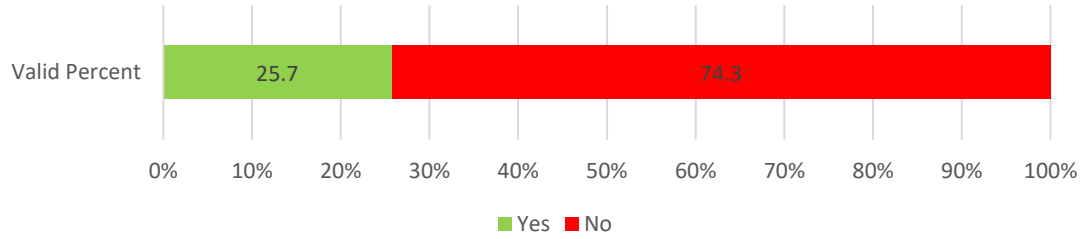
was 2.3% which is lower than the BAME regional level (5%). However responses were predominantly from Cornwall and Devon which is likely to have shifted this, particularly given the lower level of BAME representation in these counties at 1.8% and 2.8% respectively.

Chart 60: Age profile of Respondents (n699)



13.33 The survey asked if respondents had any children under 18 years of age. Just over a quarter at 25.7% had children under 18 years of age.

Chart 61: Have you any children under 18 years of age? (n-700)



13.34 To follow this question the survey asked, 'if yes, how many are under 18 or under 19 if in full time education?' The table below shows the proportion of one through to five children respondents had responsibility for.

Table 46: If yes, how many are under 18 or under 19 if in full time education? (Please move on if not applicable)

If yes, how many are under 18 or under 19 if in full time education? (Please move on if not applicable)	Frequency	Percent
None	10.0	5%
One	76.0	41%
Two	72.0	39%
Three	18.0	10%
Four	8	4%
Five	3	2%
Total	187.0	100%

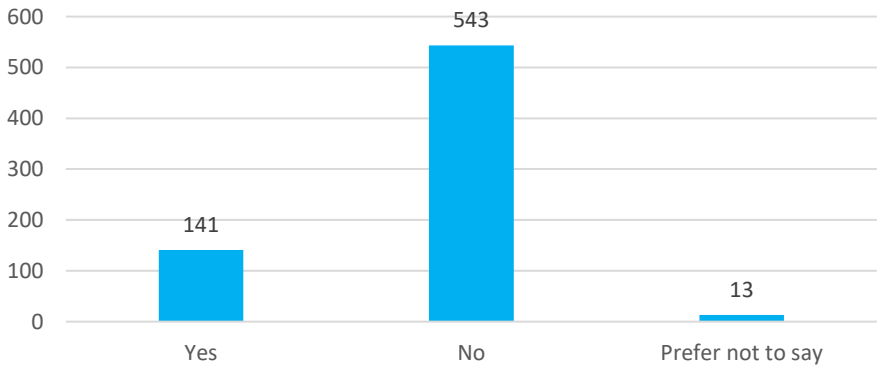
13.35 In terms of economic activity and employment status the table below sets out the responses from those engaged in this survey. 56.5% were economically active (i.e. employed either full or part time and unemployed) and the rest (43.5%) were economically inactive, this includes 24% who are retired from work.

Table 47: Which of these best describes what you are doing at present? If more than one of these applies to you please only tick one box and the main one only?

Which of these best describes what you are doing at present? If more than one of these applies to you, please only tick one box and the main one only?	Frequency	Percent	Valid Percent
Doing something else - please specify	38	4.7	5.5
Full-time paid work (30 hours or more each week, including self-employment)	240	29.9	34.9
Part-time paid work (under 30 hours each week, including self-employment)	133	16.6	19.3
Full-time education at school, college or university	10	1.2	1.5
Unemployed	16	2.0	2.3
Recovering from long-term illness/surgery	10	1.2	1.5
Permanently sick or disabled	42	5.2	6.1
Fully retired from work	165	20.6	24.0
Looking after the home	34	4.2	4.9
Total	688	85.8	100.0
Missing	114	14.2	
Total	802	100.0	

13.36 The disability profile of the respondents showed that 20.2% stated that they had a disability and 77.9% of respondents stated they did not have a disability.

Chart 62: Do you consider yourself to have a disability? (n697)



13.37 Of those that stated they had a disability or long-term illness - 278 conditions were identified of which 39% were long term illnesses, 22% physical impairments, 18% were mental health conditions, 10% sensory impairments, 3% learning difficulties

and 1% learning disabilities. 17% stated other, which on review included a mix of long-term conditions, and physical and sensory impairments.

13.38 19% of respondents considered themselves to be the main carer of someone who needs their help because of their age or disability.

13.39 The faith profile shows that 42.2% were Christian, 41.5% had no religion and 12.1% preferred not to say. The remaining 4.2% was made up of Buddhist, Hindu, Jewish, Muslim, Sikh and other faiths/belief systems.

13.40 The final question of the survey identified people who wanted to follow the survey and be involved in the patient/public focus groups and the postcode of the respondent's place of residence.

Summary

13.41 802 people chose to complete this patient/public oral health survey, which is a strong return for an e-survey. The survey opened on 5th October 2020 closing on the 17th November 2020. The survey was disseminated through Healthwatches and through Local Dental Committee chairs/leads and via the community and voluntary sector in the region particularly those that represent 'hard to reach' groups in the community. Respondents predominantly came from Cornwall 56%, Devon 20% and BANES, Swindon and Wiltshire 13%, with lower response levels in the rest of the region.

13.42 65.7% had a regular dentist. 82% visited their dentist in the last year. 60.3% had visited their dentist for a regular check-up. 32% had visited their dentist for an urgent dental appointment for a problem that had developed.

13.43 65.7% took up to 30 minutes to travel to their dentist. 65.5% took a car to get to their dentist, 14% preferring to walk. Of those that drive 43% felt it was either 'very easy' or 'easy' to park, 32% felt it was 'adequate', and 21% felt it was either 'difficult' or 'very difficult'.

13.44 In terms of patient preference most preferred keeping appointments during normal surgery hours, and if there were to be alternative timings additionally provided, their preference would be for Saturday surgery and the next preference would be for the extension of weekday surgery to weekday evenings.

13.45 78.4% of those that responded stated they were an NHS or wanted to be an NHS patient and 16.7% stated they were a private patient. 4.9% did not know.

13.46 37.1% of private patients stated they did not know whether their surgery provided NHS care. However of the remainder, 18.5% stated that no NHS dentistry was provided, 21% stated that NHS dental provision was available for children and adults, 21.8% that NHS dental provision was available for children only and 0.8% for adults only.

13.47 Most private patients 33.5%, stated that they were happy with their private dentist. Others 24.2% felt that the fact there is a waiting list was a barrier and 23.1% felt that the NHS dentist near them was not currently accepting patients.

13.48 It is clear that in this two-tier dental system, with private and NHS dentistry, those that use NHS dentists predominantly see the reason for doing so as affordability.

13.49 84% of respondents either disagreed strongly or disagreed that there is a short waiting list to access NHS dentistry in my area. 83% disagreed that it is easy to find and access NHS dentistry in this area whereas 86% agreed that NHS dentists cost less than private dentists. When asked to explain their answers the core themes emerging were:

- Lack of access to NHS dentistry
- Inability to access dentistry since Covid-19
- Extensive waiting lists
- Difficulty securing an appointment at NHS dentists once registered
- Concerns about the quality of NHS dentistry
- Perceptions that NHS dentists are not operating during Covid-19, whilst private dentists are
- Experience of the frequent cancellations of NHS dentists
- Concerns that NHS dentists are prioritising their paying private patients
- Experience that there are many NHS practices that have closed
- People with urgent care needs due to the lack of regular dentistry
- People experiencing a high cost of treatment both in the NHS and private sector
- Concerns raised across the region but the high volume of responses from Cornwall have emphasised greater need there.

13.50 With regards to forms of improvement that could be made to NHS oral health in the region.

- 95% agreed that there should be more dental staff to provide NHS dental services.
- 88% agreed that free dental health products should be provided for children in schools to encourage good habits early on.
- 86% agreed that there should be more information provided locally about where to find a dentist in the area.

- 80% agreed that there should be more information provided locally on how people can stop dental problems developing.
- 77% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends.
- 75% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

13.51 When asked if there could be any further areas of improvement. A range of issues emerged, many centered around the needs for more dentists, in summary:

- Access to NHS dentists in your locality should be made easier
- Better dentist allocation
- Dentistry should be affordable
- Finding a private dentist is easy, there need to be more NHS dentists
- Improve the quality of care
- Increase capacity in all areas
- NHS dentistry should provide all the services provided by private dentists
- Reduce waiting lists
- Urgent appointments should be easier to get for broken teeth and infections
- Work with young people to promote life-long good oral health.

13.52 There were several open-ended questions in the survey, and many people used this space to raise their frustrations and concerns about what they saw as inadequately resourced dental services. Moreover, the desire to see more NHS dentists was wholly consistent across many of these open-ended responses. People have experienced not being able to access NHS dentistry, being on waiting lists for an awfully long time and often suffering from pain and poor oral health without access to a dentist. There are examples of people not even being able to access private dentistry and whilst cost and affordability is a critical issue frequently referred to many still feel that NHS dentistry is for them, largely because it is cheaper.

13.53 In general respondents felt that they have been failed by NHS dentistry in the region. There is equally a real lack of understanding as to why NHS dental services are not simply available to all.

13.54 For many respondents that are in NHS practices, they feel that they are second class citizens with dentists preferring to increase their revenue by treating fee paying private clients. This further frustrates people but also reflects the reality that dentists are simply not able to prioritise NHS dentistry because it is not commercially viable for them to do so.

14 Appendix 14 Patient and Public Survey- Easy Read - Short Survey October 2020

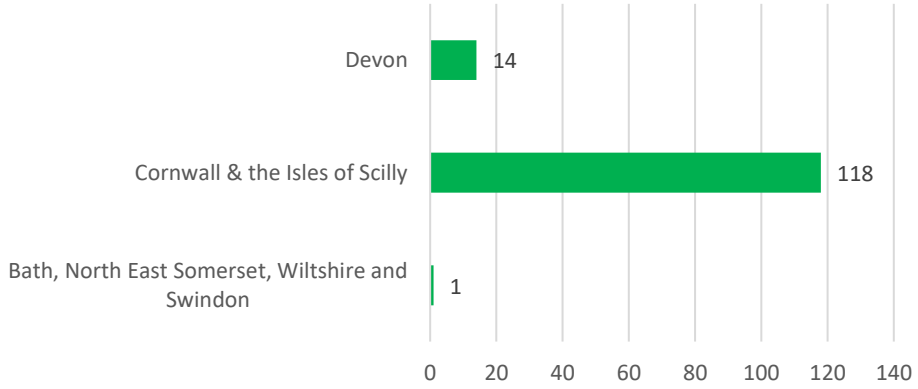
14.1 This short, Easy Read Survey was initially developed from the full survey and sought to target responses from people with learning disability. It was disseminated by Healthwatch Cornwall who had advised that they had a learning disability network who were keen to engage in this OHNA process. However, as a short survey it was posted on their website and was disseminated via their social media networks and by chance it has picked up many more people than it was initially intended to target. Moreover, it has attracted many people who do not have learning disabilities. Nonetheless, it still has merit from an analysis perspective.

14.2 The survey was launched on the 20th October and closed on the 18th November. The survey was an e-survey but was also available as a telephone survey for those who may have needed support to complete it. In reality the telephone survey offer was not taken up.

Key Findings

14.3 133 people completed this survey and whilst it was disseminated by Healthwatch Cornwall it did get respondents from Devon and BANES, Swindon and Wiltshire. In total it received 88.7% of its responses from people living in Cornwall and the Isles of Scilly, 10.5% of responses for people living in Devon and 1% of responses from people living in BANES, Swindon and Wiltshire.

Chart 63: Which area do you live in? (n-133)

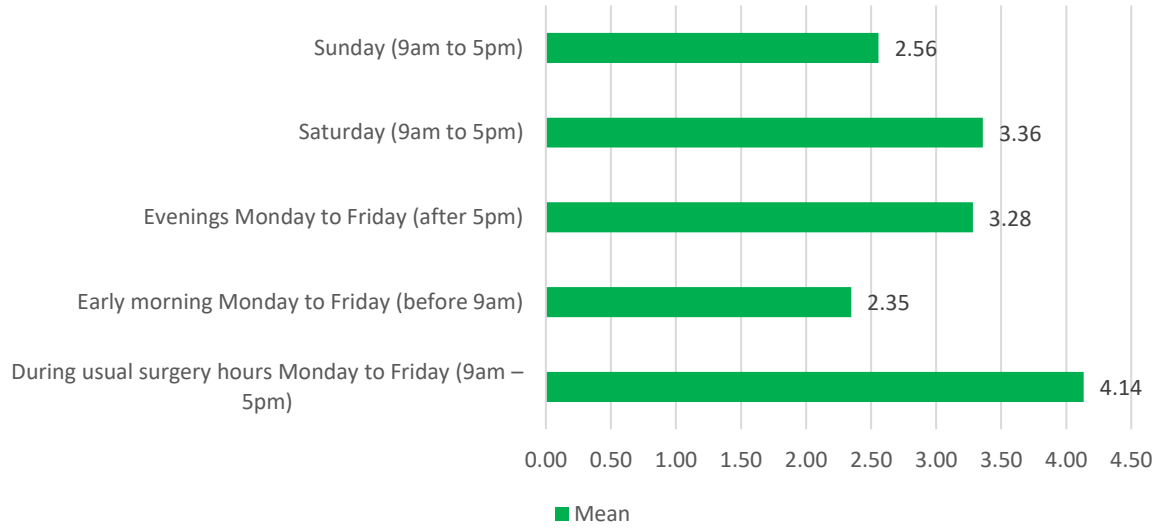


14.4 From within the sample 48.9% stated that they had a regular dentist and 51.1% stated that they did not.

14.5 The sample were asked 'how likely are you to want an appointment at a dental surgery at the following times?' They were asked rate each option from 1-5 where 1 means not likely and 5 means highly likely. From this data we were able to

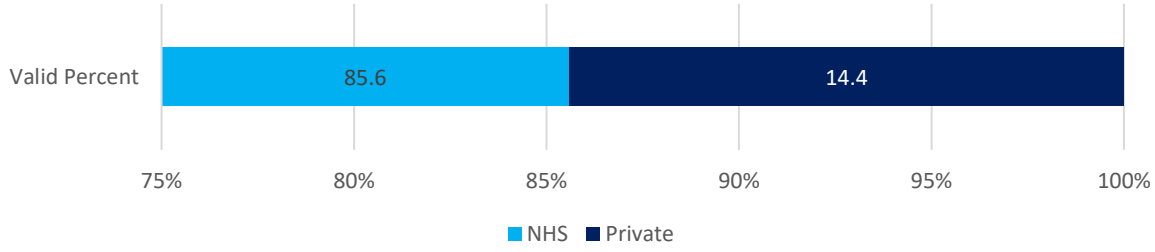
calculate the mean score for each option. During usual surgery hours Monday to Friday (9am – 5pm) scored 4.14 out of 5 which was the most widely preferred time. This was followed by Saturday (9am to 5pm) with 3.36, and evenings Monday to Friday (after 5pm) with 3.28. It would seem that this cohort, like the full survey cohort, preferred to have their appointments during normal surgery hours but that if additional appointment slots were to be available their preferences would be Saturday 9-5 and weekday evenings.

Chart 64: How likely are you to want an appointment at a dental surgery at the following times? (Please rate each out from 1-5 where 1 means not likely and 5 means highly likely) (N Various)



14.6 The sample were asked if they had or would want to go to an NHS dentist and of this group, 85.6% stated they had or would like to have an NHS dentist and 14.4% stated they had a private dentist. This question was not used as a sifting question as in the case of the full survey.

Chart 65: Do you go to, or want to go, to an NHS or private dentist? N-118

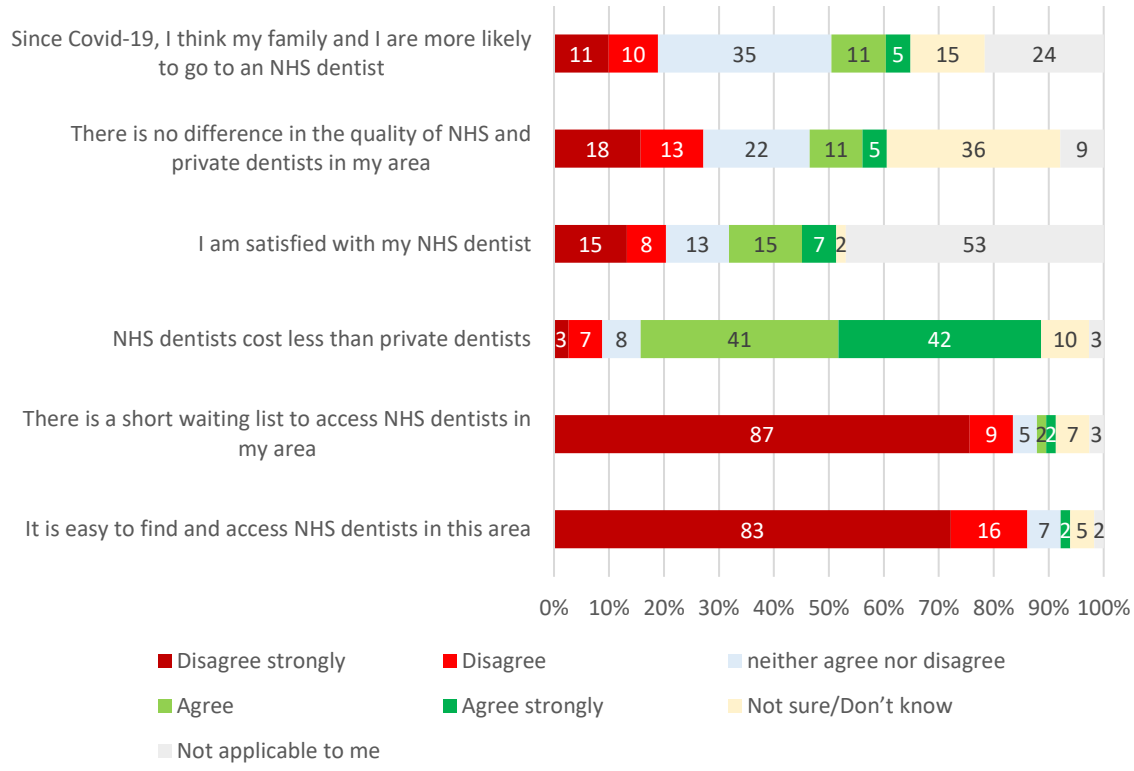


14.7 The next question sought to ask why people go to a dentist surgery and to establish what inspired them to do so. 27% stated that there are no NHS dentists near where they live, 23.6% stated they go to a dentist because it has a good quality of care, 24.1% stated they go to an NHS dentist because it is more affordable/costs less and 22.6% say they go to their dentist because it has a good reputation and or it was recommended to them.

14.8 This question provided an open-ended option for people to describe any other reasons. However, of the 23 responses that were provided the overwhelming majority stated that these questions did not apply as they did not have a dentist and had found great difficulty in getting one. Some described how they had been NHS patients but that their dentist moved towards practicing privately and they were no longer able to access regular dentistry.

14.9 The next question set out a series of statements about NHS dentistry and provided respondents with the option to state whether they agreed strongly, agreed, neither agreed not disagreed, disagree and or disagreed strongly, were not sure and or felt that the statement was not applicable to them. All the statements were written in a positive frame and respondents were able to read them and make their judgement accordingly. The chart below sets out the findings to this question.

Chart 66: Please read the following statements about NHS dental services in your area and tick the box that best describes how you feel?

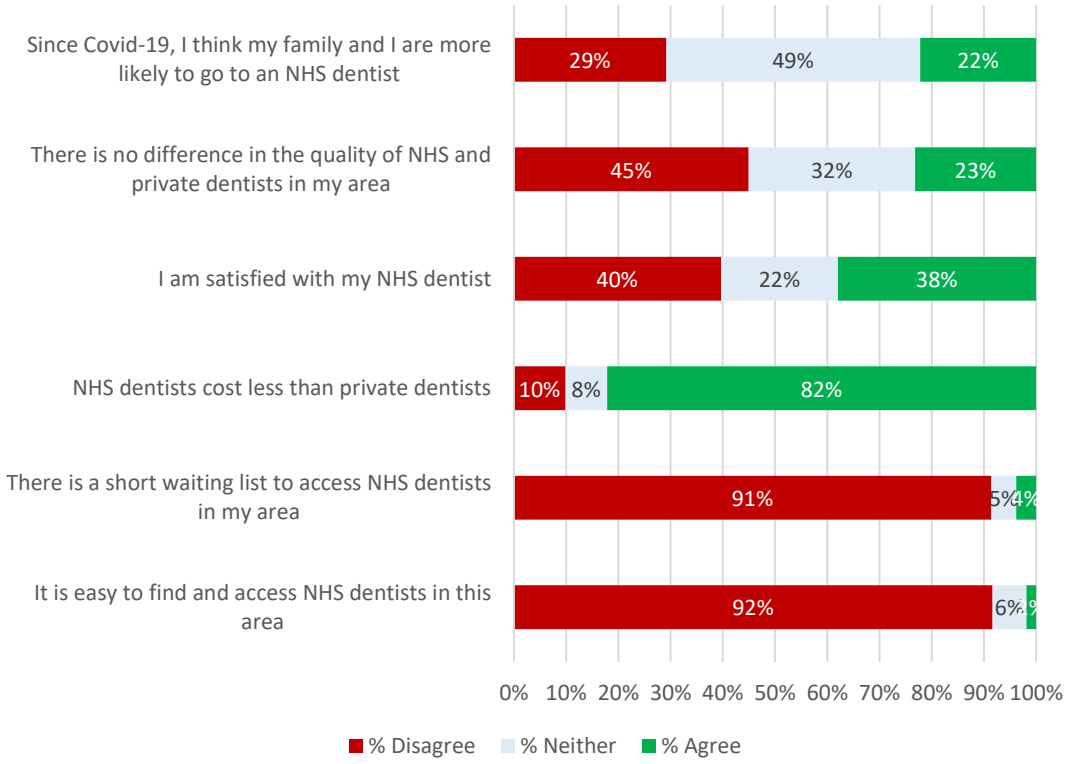


14.10 There were clearly higher levels of disagreement (red) with the statement, 'it is easy to find and access an NHS dentist in this area' with 87% of respondents disagreeing strongly. 'There is a short waiting list to access NHS dentists in my area' saw 83% of respondents either disagreeing strongly or disagreeing. In contrast 73% of respondent agreed with the statement that 'NHS dentists cost less than private dentists.' 20% of respondents agreed that they were satisfied with their NHS dentist. There was more balance to agreement with the statement that there is no difference in the quality of NHS and private dentists in my area. Slightly

more people disagreed (19%) than those that agreed (14%) with the statement that since Covid-19 the think they are more likely to go to an NHS dentist.

14.11 When one removes those that either did not know or were not sure and or those who felt this was not applicable to them there are some emphatic results. 91% of respondent either disagreed strongly or disagreed that there is a short waiting list to access NHS dentistry in my area. 92% disagree that it is easy to find and access NHS dentistry in this area and 82% agreed that NHS dentists cost less than private dentists.

Chart 67: Please read the following statements about NHS dental services in your area and tick the box that best describes how you feel



14.12 Respondent were given the opportunity to explain their reasons for answering this question in this way. The themes emerging from the open-ended answers are set out below.

- Extensive waiting lists to get an NHS dentist - examples sited of 2-4 years
- More NHS dentists needed
- Difficulty in accessing NHS dentistry
- People going private because NHS dentistry is not accessible/available
- Private takes precedence in the NHS surgeries

'Can't get a dentist appointment anywhere in my area. I've not seen a dentist for 19 years.'

'If there was an NHS practice nearby, I would definitely use it as I am now a pensioner and can no longer afford the private practice due to such high fees. Either open more NHS practices in all areas because travel is no longer available to many pensioners or Give private practices the opportunity to offer subsidised NHS treatment to those who want it.'

'I have not had access to an NHS dentist since I was a child and am now 38 years old. I would like routine access but have never managed to get a dentist in my whole adult life.'

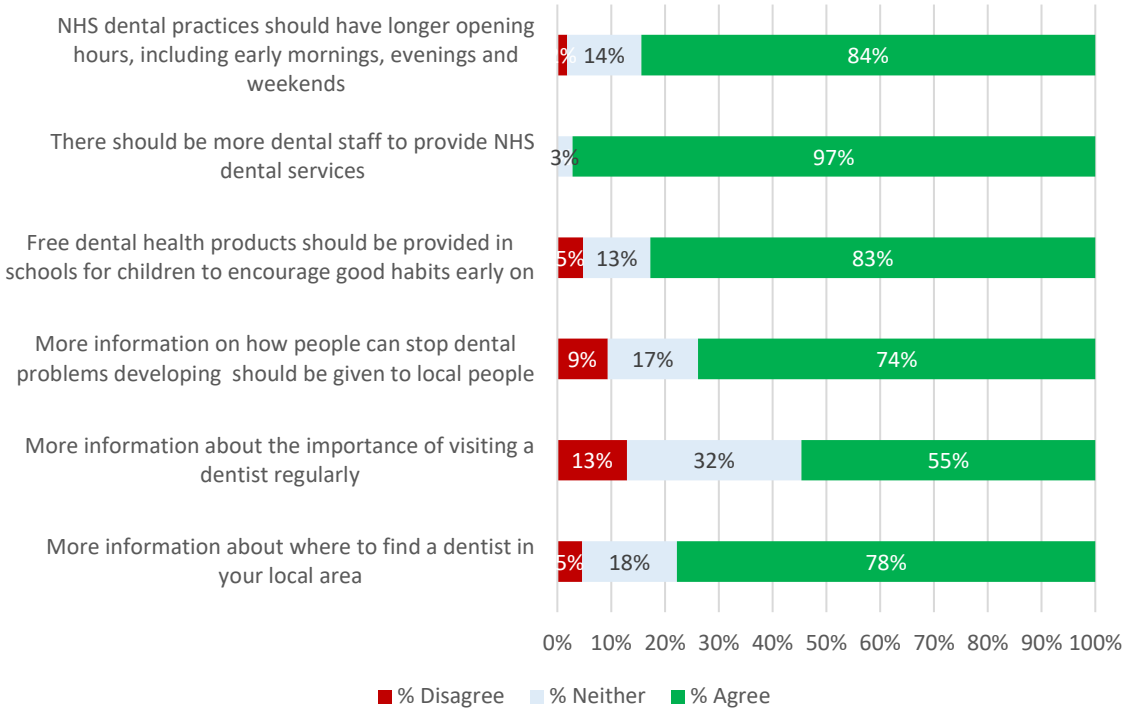
'We've always been happy with our dentist pre Covid. Now not able to get an appointment, even though my last treatments were not completed. Would love to see my dentist, have serious issues now. I was promised a phone call from my dentist, after my last phone call to the practice, it never happened. Extremely disappointed.'

'Very poor service from an NHS dentist, ten years or so ago. Very good service recently from a private dentist, although some difficulties due to lock-down.'

14.13 The next question in the survey asked respondents to state whether they agreed strongly, agreed, neither agreed not disagreed, disagreed, disagreed strongly or were not sure/did not know re the following statement. Each of these statements identified a form of improvement that could be made to NHS oral health in the region. In this analysis the proportion of 'do not know/not sure' responses have been taken away as they did not represent more than 3% of the overall responses to any given statement. The recalculated percentages show that there was universal agreement to the improvements listed.

- 97% agreed that there should be more dental staff to provide NHS dental services.
- 84% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends.
- 83% agreed that free dental health products should be provided in schools for children to encourage good habits early on.
- 78% agreed that there should be more information provided locally about where to find a dentist in the area.
- 74% agreed that there should be more information provided locally on how people can stop dental problems developing.
- 55% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

Chart 68: To help improve the oral health of local people in the South West of England, please tick one answer to show how much you agree or disagree with the following statements. Based on those with a stated opinion



14.14 Respondents were asked if they could highlight any further areas of improvement. From this a range of issues emerged, many centred around the needs for more dentists, in summary:

- More capacity to access to NHS dentists
- More NHS dentists
- Make it easier to find NHS dentist locally
- Reduce waiting times
- Website to identify which dentists are taking patients is needed
- Health visitors, school nurses and social care staff should be working with parents around dental health and oral hygiene
- Make treatments affordable
- Better specialist dental services for children and adults with special needs.

14.15 The profile of respondents is set out below. Of the 133 in this sample 26.4% were male and 72.6% were female. The age profile varied but was predominantly older with 73.6% being over 45 and 24.6% being younger than 45.

14.16 From an ethnicity perspective the respondents were predominantly white British 92.7% and the proportion of BAME respondent was low at 1.8%.

14.17 In terms of disability - 6% of respondents stated they had a physical impairment, 9% a long term illness, 8.3% a mental health condition, 2.3% a sensory impairment, 1% a learning disability and 1% a learning difficulty and 3% stated they had another form of impairment. 20% of the respondents stated they considered themselves to be the main carer of someone who needs their help because of their age or disability.

Summary

14.18 133 people completed this short version of the patient /public survey. They came predominantly from Cornwall as this was initially designed as a short easy read survey for people with learning difficulties.

14.19 From within the sample 48.9% stated that they had a regular dentist and 51.1% stated that they did not.

14.20 It would seem that this cohort, like the full survey cohort, preferred to have their appointments during normal surgery hours but that if additional appointment slots were to be available their preferences would be Saturday 9-5 and weekday evenings.

14.21 85.6% stated they had or would like to have an NHS dentist and 14.4% stated they had a private dentist.

14.22 27% stated that there are no NHS dentists near where they live, 23.6% stated they go to a dentist because it has a good quality of care, 24.1% stated they go to an NHS dentist because it is more affordable/costs less and 22.6% say they go to their dentist because it has a good reputation and or it was recommended to them.

14.23 91% of respondents either disagreed strongly or disagreed that there is a short waiting list to access NHS dentistry in their area. 92% disagreed that it is easy to find and access NHS dentistry in this area and 82% agreed that NHS dentists cost less than private dentists.

14.24 97% agreed that there should be more dental staff to provide NHS dental services.

14.25 84% agreed that NHS dental practices should have longer opening hours, including early mornings, evenings and weekends.

14.26 83% agreed that free dental health products should be provided for children in schools to encourage good habits early on.

14.27 78% agreed that there should be more information provided locally about where to find a dentist in your local area.

14.28 74% agreed that there should be more information provided locally on how people can stop dental problems developing.

14.29 55% agreed that there should be more information provided locally about the importance of visiting a dentist regularly.

14.30 There was considerable disgruntlement with the difficulty to access NHS dentistry. Many felt there simply were not enough NHS dentists in their area. Their focus on areas of improvement included:

- More capacity to access to NHS dentists
- More NHS dentists needed
- Make it easier to find NHS dentist locally
- Reduce times
- Website to identify which dentists are taking new patients is needed
- Health visitors, school nurses and social care staff should be working with parents around dental health and oral hygiene
- Make treatments affordable
- Better specialist dental services for children and adults with special needs.

15 Appendix 15 Thanks, and acknowledgements

15.1 We would like to thank all those who have support this OHNA and particularly the patients and members of the general public and stakeholders who took the time to engage in the surreys completed. In addition, we would like to thank those who took the time to engage through interviews with the team. We list below those members of the project team from NHSE&I and those from Ottaway.

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Tony Brooke	Chair Special Care MCN
Christopher Bell	Chair Oral Surgery MCN
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Leo O'Hara	LDC Chair (Gloucestershire)
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Tim Hodges	Chair LDC (Devon)
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Helen Webb	Healthwatch Gloucestershire
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Local Dentistry Network

Jody Wilson (Cornwall) + Hannah Gray (Somerset)

10 March 2021

Content

- Overview of local Healthwatch
- Role of Healthwatch England
- Healthwatch England – focus on dentistry
- Local intelligence
- Next steps

Who are local Healthwatch?

- Healthwatch was established under the Health and Social Care Act 2012
- We exist on a national and local level, working towards the same goal of enabling people to have a voice about their health and social care systems.
- Local Healthwatch are funded by the Department of Health and Care - and accountable to local authorities.

Who are local Healthwatch?

- Each are defined by their local authority and community:
  - Charities, Community Interest Companies, Social Enterprises, or Hosted by another organisation

- All act **independently** of their local health and care system

Who are local Healthwatch?

Our main statutory functions are to:

•Obtain the views of people about their needs and experience of local health and social care services.

•Local Healthwatch make these views known to those involved in the commissioning and scrutiny of care services.

•Make reports and make recommendations about how those services could or should be improved.

•Promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services.

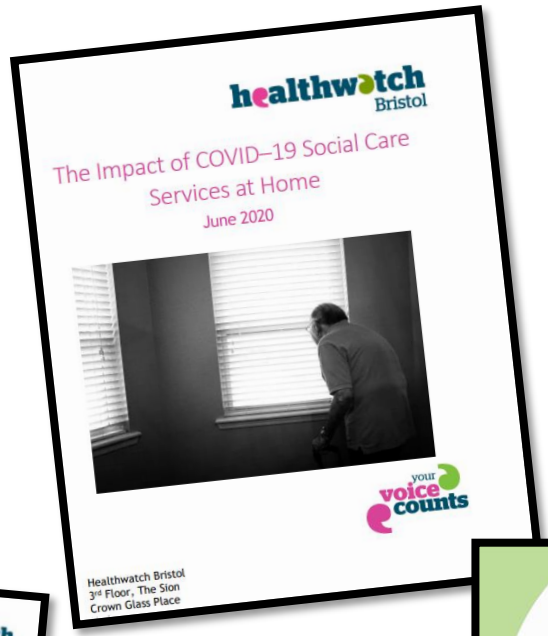
Who are local Healthwatch?

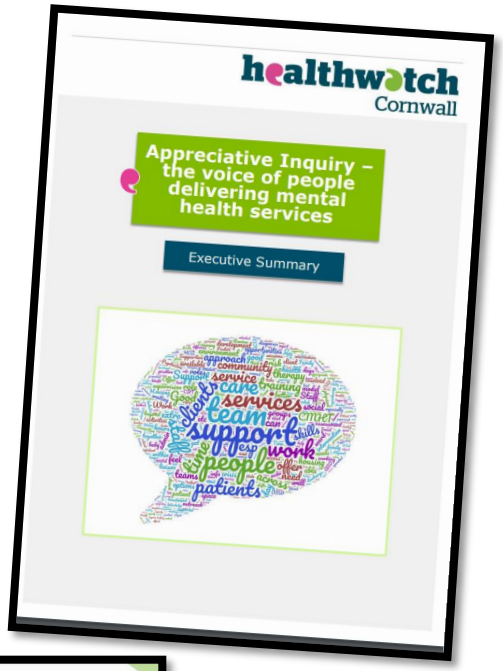
•Provide information and advice to the public about accessing health and social care services and the options available to them.

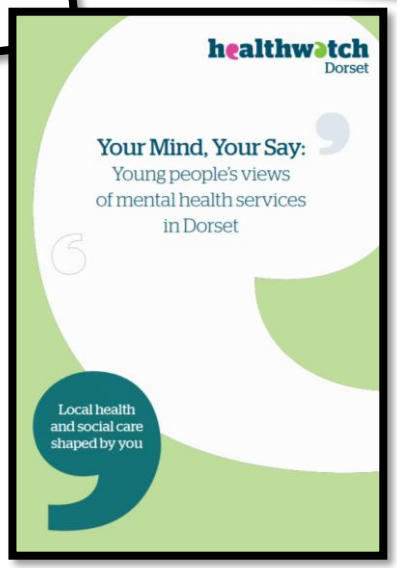
•Make the views and experiences of people known to Healthwatch England, helping them to carry out their role as national champion.

•Make recommendations to Healthwatch England to advise the CQC to carry out special reviews or investigations into areas of concern.

Who are local Healthwatch?







Who are Healthwatch England?

- A statutory committee of the independent regulator the Care Quality Commission (CQC).

Main statutory functions are to:

- Provide leadership, guidance, support and advice to local Healthwatch organisations.

- Escalate concerns about health and social care services which have been raised by local Healthwatch to CQC. CQC are required to respond to advice from the Healthwatch England Committee.

Who are Healthwatch England?

- Provide advice to the Secretary of State for Health and Social Care, NHS England and English local authorities, especially where they are of the view that the quality of services provided are not adequate.
- Bodies to whom advice is given are required to respond in writing.
- The Secretary of State for Health and Social Care is also required to consult Healthwatch England on the NHS mandate, which sets the objectives for the NHS.

Current ways of working – local and national

- Digital engagement rather than community
- Increase in ‘unsolicited’ feedback
- Focus on pandemic response

Healthwatch England report - Dec 20 and Feb 21

Healthwatch Report: An access crisis that won't be solved by targets

08 February 2021

The British Dental Association has urged the government to engage with the latest evidence from Healthwatch England, warning the huge barriers facing patients requiring urgent NHS care will only increase unless Ministers change course on targets.

Healthwatch's latest review, which looked at 1,129 people's experiences of accessing dental care received between October and December 2020, found access to dentistry remained difficult for more than 7 in 10 people, with major problems securing both routine and urgent care. Healthwatch England Chair Sir Robert Francis QC has stressed that "the COVID-19 pandemic has exacerbated the human impact of years of structural issues in NHS dentistry and is now pushing it to crisis point."

Last month the BDA wrote an open letter to Health Secretary Matt Hancock following revelations that a leading chain has already refocused effort on routine check-ups and away from urgent care following the imposition of targets on 1 January. The policy, in place for the current quarter, requires practices to hit 45% of their pre-pandemic activity levels, or face steep financial penalties.

The review comes as over forty MPs from five parties launched a call on the Health Secretary to abandon these targets. The letter, organised by Ealing MP Virendra Sharma, states: "We are concerned that the current situation may lead to practices across the country closing their doors to NHS patients, depriving our constituents of dental care at a time when the effect of reduced access to dental care is still being felt."

Both in the short term and in the year ahead the BDA has said the government's focus must be on the care of higher needs patients and addressing already unacceptable levels of oral health inequality that are likely to widen as a result of the pandemic.

Shawn Charlwood, Chair of the British Dental Association's General Dental Practice Committee said:

"Patients with urgent problems need to be at the front of the queue for care. Sadly, government is forcing dentists to prioritise volume over need by imposing inappropriate targets.

HWE report - Main findings

- Since 2013, access to NHS dentistry is one of the recurring issues reported on
- Between July and September 2020, the number of people who provided feedback about dentistry was 452% higher when compared with the previous three months
- Access to emergency appts; continuation of treatment; access for new patients; affordability of private treatment; lack of information from NHS 111, NHS website and dental practice websites
- 4% of people also told the network about positive experiences of dental care, praising staff who were helpful, kind and considerate and highlighting that clear and regular information from dental practices made them feel reassured

Main findings

- Follow-up review of people's feedback on dentistry in Feb 21 - looked at a further 1,129 people’s experiences of accessing dental care, received between October and December 2020.
- Access to dentistry remained difficult for more than seven in 10 people (72%).
- Some people who actively sought dental treatment were told they would have to wait anywhere between a few months to, in one case, two years for an appointment.
- Access to urgent NHS treatment was difficult for both people with painful teeth, with patients being told that dental pain was not considered an “emergency”, and those who were prescribed multiple courses of antibiotics by NHS111 without being provided any further treatment.

Main findings

- Some people said they had called over 40 practices to find an NHS dentist, and pulled their own teeth out when they couldn't bear the pain.

- When dentists couldn't offer an appointment, they advised people to buy dental repair kits to treat themselves.

healthwatch Swindon

healthwatch Wiltshire

healthwatch North Somerset

healthwatch Dorset

healthwatch Torbay

healthwatch Devon

healthwatch Cornwall

healthwatch Bristol

healthwatch Plymouth

healthwatch Isles of Scilly

healthwatch South Gloucestershire

healthwatch Bath and North East Somerset

healthwatch Somerset

South West LDN Report
Dec 2020 - Feb 2021

Working effectively to involve
Patients & the Public

Introduction

This summary highlights the combined feedback gathered by local Healthwatch teams and was open to responses from

- **Bristol**
- **BaNES**
- **Cornwall**
- **Devon, Torbay & Plymouth**
- **Dorset**
- **North Somerset**
- **Somerset**
- **Wiltshire**

These were collected from our surveys, websites, telephone calls, volunteers and email messages.

We have received over 182 individual pieces of feedback about dental services, reflecting the views and experiences of the public about NHS dental provision between December and February 2021

KEY ISSUE – Inequity of Access

- **Access - Getting on a list**
- Access - Pain Management
- Access - Costs
- Access - Information
- Access - Private pathways

Access - Getting on a list

- Client wanted to know how to get an NHS Dentist as has **been on the waiting list for 2 years** and can't afford private treatment. – DP&T

"..member of HM Forces living in bulford and since moving here in November 2017 we have not been able to register my wife and 3 children 16/14/7 with an NHS dentist……when we ring they say they are not taking on any new patients and they **do not have a waiting list**. It has been 3 years now without my family receiving any routine dental check up. Would you be able to assist In helping to find a dentist that is taking on new patients? - WILTS

The enquirer has **been searching for an NHS dentist for about 2 years now** and cannot get a place anywhere for her partner, herself and their 2 children. Her son is now almost 3 years old and is yet to see a dentist. This is not through lack of trying and is getting really silly. She feels this completely unacceptable. - SOMERSET

I work for a mixed NHS and private dental practice. We have in excess of 8000 patients and only 2 dentists, **the waiting list for NHS dentist is years** and we have so many enquiries every day and unable to help. The emergency dental helpline do not offer patients without a dentist the care they need it really needs to be looked at.- CORNWALL

Access - Pain

The commentator's crown fell off a tooth during first lockdown and was **told to go on line and order some dental glue to stick it back on themselves.** Couldn't get it in place. So still not fixed and tooth is painful at times - SOMERSET

So I recon now **I've been waiting 3 years nearly for a dentist**, so how long now
As you **no I've already pulled out my own teeth as my swollen face wasent (sic) classed as an emergency** when I sent a picture to harligh st in Bodmin ,
So now I'm down to 12 teeth and 3 more need to be taken out as I now have **sever pain whilst eating anything at all** But still you won't help.I thought everybody was entitled to nhs dental
So currently have severe stomach problems as I can't chew any food properly anymore . And effecting my bowels , it is a struggle…. problems with my mental health and am screaming out for help, to stop this constant dental pain I've been suffering since I put my name down on your list for a dentist, So will I be ignored again. I need help now before I go absolutely mental and end up in prison, I cannot take anymore" - CORNWALL

I am without a dentist, despite my best efforts in the past 12 months. This has been especially difficult as I require actual dental treatment for a tooth extraction**. I have had ongoing infection, pain and to the point of requiring emergency care at RBH** almost a year ago now. This was a 'scary' experience for myself especially at the start of Covid 19/lockdown and the impact to NHS staff/RBH to witness. All they could do was prescribe antibiotics and pain relief for which I was very grateful. - DORSET

Access - Costs

Client wanted to know how to get an NHS Dentist as has **been on the waiting list for 2 years** and can't afford private treatment – *DP&T*

"Trying to register with an NHS dentist. Husband has a plate which is broken and is currently undergoing chemotherapy and has been told that the current state of his teeth could affect his cancer therapy. **He has been quoted £10,000 for a replacement plate privately**" - CORNWALL

"I need to ask you about whether it is legal, or correct to be charging NHS dental patients their treatment costs at the time of booking- rather than on the day of the treatment? I paid yesterday for my treatment today at my dentist in Clevedon. When I went to book in further treatment in February, today at the dentist**. I was asked to pay now, for the future treatment, or loose the booking. This made me upset, because I said no and they cancelled the booking"** – NORTH SOMERSET

Access - information

Good **morning i am trying to find a nhs dentist taking on new patients but it is a nightmare ! i get told by 111 look online so go through every dentist within a 20 mile radius nothing at all. then it says contact nhs england who email me back with look online** , but there is nothing so how can i? fair enough covid has really played about with services but feel like my hands are tied now - DORSET

- "I have tried to find an NHS dentist in Exeter, and **everyone is telling me that they are not taking on any NHS patients.** I have an old crown that food keeps getting under and I keep getting a lot of pain from it. I need a dentist. Can you help me to find one?“ – DP&T

Caller concerned he was unable to access dental care**, although he was registered the dentist has told him it will be at least 3 months before he can be seen unless he is prepared to pay for private treatment** - BNSSG

Access - Private pathways

The Enquirer could not find an NHS dentist in Somerset and had **paid over £100 to see a private dentist** and was quoted over £3,000 for work on his teeth which he wouldn't afford - SOMERSET

I saw a Dentist, the tooth requires antibiotics which where prescribed but that was it in terms of NHS treatment. The Dentist stated the tooth in question needs to be removed. **I was told to find a Private Dentist as NHS treatment was not possible**. NHS cost for tooth extraction Band 2, is £62. Private cost is £200 - DORSET

Commentator is finding it impossible to find an NHS dentist, as they have a broken tooth and have **been quoted over £950 by a private dental practice to repair it**, which they cannot afford. - SOMERSET

Positive feedback

"Coly House provided **first class service** in a COVID-19-safe environment. Client had a broken tooth extracted and they visited the hygienist. They felt everyone was helpful, friendly, and highly skilled" - BNSSG

"Appointment reminders sent by text. Accepted on line. **All precautions observed**. Temperature taken, social distancing , additional time for cleaning between appointments" - BNSSG

Caller had dental check-up arranged. They were provided with instructions by telephone prior to the appointment regarding waiting outside and wearing a mask. The staff see patients through the front window and come out with a clipboard and forms about Covid safety and a health check. Once called in the callers temperature was taken, she was asked to sanitise her hands and shown to the treatment room . Check-up was **smooth and comprehensive and staff polite** , saw no other patients or close contact. Staff sent payment request by text later in the day. - BNSSG

"I recently required emergency dental treatment. Just before Christmas. My dentist is White Rose dental practice - Camborne**. Amazing service.** Was seen the same day I called. Tooth extraction done. The following week I had got an infection and called again. I was seen that afternoon. I really cannot fault the treatment I received." - CORNWALL

Suggestions and recommendations

- Clear and current information on individual dentists' websites and regularly update NHS.UK profiles
- Clear explanation regarding NHS/Private appointments
- Signposting and information regarding emergency provision

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Royal United Hospitals Bath
NHS Foundation Trust

Quality Accounts

2022 - 2023

Royal United Hospitals Bath NHS Foundation Trust

The RUH, where you matter

Contents

List of abbreviations

A	**AMS**	Antimicrobial stewardship
	ADOPT	Artificial intelligence: Improving early Detection of Pulmonary hypertension by Transthoracic echocardiography
	AHP	Allied Health Professional
	AI	Artificial Intelligence
	AMR	Antimicrobial resistance
	ASU	Adult Surgical Unit
B	**BAD**	British Association of Day Surgery
	BaNES	Bath and North East Somerset
	Brit-PACT	British Psoriatic Arthritis Consortium
	BSW	BaNES, Swindon & Wiltshire
	BTS	British Thoracic Society
C	**C.Difficile**	Clostridium difficile
	CGM	Continuous Glucose Monitoring
	CNST	Clinical Negligence Scheme for Trusts
	COPD	Chronic Obstructive Pulmonary Disease
	CPRD	Clinical Practice Research Datalink
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
	CRM	Cardiac Rhythm Management
	CRN	Clinical Research Network
	CT	Computerised Tomography
D	**DAA**	Direct Assessment Area
	DDA	Disability Discrimination Act
	DSPT	Data Security Protection Toolkit
E	**ECG**	Electrocardiogram
	ED	Emergency Department
	ENACT	Economics of Adaptive Clinical Trials
	ePMA	Electronic Prescribing and Medicines Administration
	EPR	Enhance Recovery Pathway
F	**FFFAP**	Falls and Fragility Fracture Audit Programme
	FFS	Frailty Flying Squad
	FFT	Friends and Family Test
	FLF	Family Liaison Facilitator
G	**GIRFT**	Getting It Right First Time
	GP	General Practice
	GWH	Great Western Hospital (Swindon)
H	**HCA**	Health Care Assistant
	HEE	Health Education England
	HES	Hospital Episode Statistics
	HHESW	Health Education England South West
	HSIB	Healthcare Safety Investigation Branch
	HSMR	Hospital Standardised Mortality Ratios
	HTA	Health Technology Assessment

I	**ICOUGH**	**I**ncentive Spirometry, **C**ough and Deep Breathe, **O**ral Care, **U**nderstanding Patient Education, **G**et of out Bed, **H**ead of Bed Elevated
	ICS	Integrated Care Systems
	IM&T	Information & Technology
	IMPULSE	Improving Pulmonary Hypertension screening by Echocardiography
L	**LMNS**	Local Maternity and Neonatal System
	LOS	Length of Stay
M	**MAU**	Medical Admissions Unit
	MBRRACE	**M**others & **B**abies**: R**educing **R**isk through **A**udits & **C**onfidential **E**nquires
	MDT	Multi-Disciplinary Team
	ME	Myalgic encephalomyelitis
	MINAP	Myocardial Ischaemia National Audit Project
	MIS	Maternity Incentive Scheme
	MRSA	Methicillin-Resistant Staphylococcus Aureus
	MVPP	Maternity Voices Partnership Plus
	MyPreOp	online pre-operative assessment
N	**NABCOP**	National Audit of Breast Cancer in Older Patients
	NACAP	National Asthma and COPD Audit Programme
	NACEL	National Audit of Care at the End of Life
	NAD	National Audit of Dementia
	NBOCA	National Bowel Cancer Audit
	NCAA	National Cardiac Arrest Audit
	NCAP	National Cardiac Programme
	NEIA	National Early Inflammatory Arthritis Audit
	NELA	National Emergency Laparotomy Audit
	NHS	National Health Service
	NHSR	NHS Resolution's
	NICE	National Institute for Health and Care Excellence
	NICU	Neonatal Intensive Care Unit
	NIHR	National Institute for Health and Care Research
	NLCA	National Lung Cancer Audit
	NMCRR	National Mortality Case Record Review
	NNAP	National Neonatal Audit Programme
	NPCA	National Prostate Cancer Audit
O	**OPAU**	Older Person's Assessment Unit
	OHCAO	Out-of-Hospital Cardiac Arrest Outcomes
	OMFS	oral and maxillofacial surgery
	OPRAA	Older Persons Rapid Assessment Area
	OPU	Older Persons Unit
	OPUSS	Older Persons Unit Short Stay

P	**PALS**	Patient Advise and Liaison Service
	PCI	Percutaneous Coronary Interventions
	PERIPREM	Perinatal Excellence to Reduce Injury in Premature Birth
	PICANet	Paediatric Intensive Care Audit
	POAC	Pre-Operative Assessment Clinic
	POMH-UK	Prescribing Observatory for Mental Health UK
	PROMs	Patient Reported Outcome
	PSIRF	Patient Safety Incident Response Framework
Q	**Q1/Q2/Q3/Q4**	Quarter 1, Quarter 2, Quarter 3 & Quarter 4
	QI	Quality Improvement
	QIPs	Quality Improvement Projects
R	**RCEM**	Royal College of Emergency Medicine
	RCP	Royal College of Physicians
	RfPB	Research for Patient Benefit
	RN	Registered Nurse
	RNHRD	Royal National Hospital for Rheumatic Diseases
	RUH	Royal United Hospital
S	**SAMBA**	Society for Acute Medicine Benchmarking Audit
	SDEC	Same Day Emergency Care
	SHMI	Summary Hospital Level Mortality Indicator
	SHOT	Serious Hazards of Transfusion UK National Haemo vigilance Scheme
	SJRs	Structured Judgment Review
	SOP	Standard Operating Procedure
	SSNAP	Sentinel Stroke National Audit Programme
	SSSU	Surgical Short Stay Unit
	SUS	Secondary User Service
T	**T+O**	Trauma + Orthopaedics
	TARN	The Trauma Audit & Research Network
	TAU	Theatre Admissions Unit
U	**UWE**	University of the West of England
V	**VEXAS Syndrome**	Vacuoles, E1 enzyme, X-linked, Auto inflammatory, Somatic

About our hospital

At the RUH we're proud to put people at the heart of what we do, striving to create an environment where everyone matters. Everyone means the people we care for, the people we work with and the people in our community.

The RUH, where you matter

We provide a wide range of services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services.

We are also provide specialist services for rheumatology, chronic pain and chronic fatigue syndrome/ME via the Royal National Hospital for Rheumatic Diseases which we acquired in 2015.

In 2021, we acquired Sulis Hospital Bath, an independent hospital that provides care for both private and NHS patients. This has enabled us to provide more care for NHS patients, as well as continuing to provide private care to those who choose it. Any additional income earned through private care is reinvested in services for the benefit of the people we care for at both Sulis and the RUH.

We're currently building a new Cancer Centre at the RUH. The Dyson Cancer Centre, which is set to open in autumn 2023, will help transform the care we provide for patients, families and carers.

We work closely with other health and care organisations as members of the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board. We strive to improve the health and wellbeing of the people in our community by working together build one of the healthiest places to live and work.

We are rated 'Good' by the Care Quality Commission (CQC).

Why are we producing a Quality Account?

All NHS organisations are required to produce an annual Quality Account to provide information on the quality of services to service users and the public, as part of the drive across the NHS to be open and honest.

The Trust welcomes this opportunity to demonstrate how we are performing, taking into account the views of service users, carers, staff and the public, and comparing our progress against the previous year and where we can, against national performance. We proactively use this information to make decisions about our services and use it as an opportunity to identify areas for improvement.

Part 1

Introduction

Chief Executive's introduction

I am pleased to present our Quality Accounts 2023. This report is an important way for us to demonstrate to our community the quality of the services we provide and the improvements we have made in 2022/23. The Trust identifies a series of quality priorities each year, and the progress against these will be reported in this document.

I want everyone who walks through the doors of the RUH to know that they matter. Delivering safe and compassionate care is such a key part of this and I'm proud of all of the people we work with, who have worked tirelessly to do this.

It's been another challenging year, as we have strived to provide this care against the backdrop of the continuing impact of the COVID-19 impact. Our staff deserve enormous gratitude and recognition for everything they have done and continue to do for our patients.

I would particularly like to highlight the work carried out by our Emergency Department Paediatric Team to develop a dedicated children's emergency department to provide urgent care to some of the RUH's youngest patients.

The project has seen a separate area for children created within the hospital's main Emergency Department. It has been specially designed and decorated to make the Emergency Department less intimidating for young people and comes complete with wall-mounted play equipment for little ones as well as a Teen Room kitted out with a games console.

Feedback from parents and carers has been overwhelmingly positive. One parent said that our staff's professionalism and care was nothing short of outstanding.

This is just one example of staff-led improvement that shows our commitment to providing the highest quality services to our patients, their families and carers. We strive to ensure that we keep the people we care for safe, whilst looking to continuously improve the services that we provide. We do this through our quality improvement programme, Improving Together, which provides the methodology for us to make positive changes in a structured way.

We aspire to collaborate with the wider local health and care system to improve the experience of all who use our services and working closely with partner organisations to deliver integrated care across the local area. Our Acute Hospital Alliance is one way in which we do this and I am excited to share the results of this work with you in 2023.

Throughout much of last year, we engaged with our people to understand what's important about what we do. We used what they told us to create a vision for the RUH and in September 2022 we launched 'The RUH; where you matter.' This sets out our commitment to the organisation we want to be in the future.

Our vision, along without well-established Trust values: Everyone Matters, Working Together, Making a Difference, form the basis of everything that we do, and they encapsulate our aspiration for the type of hospital that we are aiming to be.

Our commitment to cultural improvement was reflected in our staff survey results this year, with 63 per cent of our staff recommending the RUH as a place to work. This placed us in the top three healthcare providers in the South West against this measure. The next step on our cultural improvement journey is to publish our Trust strategy, which will set out the steps that we will take to achieve our ambition of being in the top three Trusts in the UK and an employer of choice locally. Quality will be the bedrock of realising this ambition.

I confirm that to the best of my knowledge the information in this Quality Account is accurate. I hope you find it interesting and informative and I would welcome any feedback you would like to share.

* SIGNATURE*

Cara Charles-Barks
Chief Executive

June 2023

Part 2

Our priorities

2.1 Quality Priorities

In April 2022/23, the Trust's main aim was to provide the highest quality of services in response to the needs of our patients and the communities we serve. Our Trust Strategy set out our overall goals to achieve high quality care and patient experience, putting patients at the heart of all we do. It was built around five key strategic goals and also reflected our core Trust values. Our programme of whole organisation development "Improving Together" is designed to support its delivery.

Supporting and developing our workforce has been a key focus of this strategy, and our innovative quality improvement programme, Improving Together, which was launched in 2018, seeks to galvanise all of our staff to take responsibility for suggesting and implementing improvements in their areas, regardless of their seniority or professional background. As part of this approach, four focus areas were identified as "breakthrough objectives", relating to our strategic goals, for focused improvement activity by our frontline teams. These are areas that we identified as requiring significant changes to the way that we operate. The breakthrough objectives for 2022/23 were:

- Recruit to fill our vacancies
- Reduce hospital acquired infections.
- Reduce the number of patients waiting in hospital (non-criteria to reside)

On 28 April 2022, the Heath and Care Act 2022 received Royal Assent, meaning that with effect from 1 July 2022, Integrated Care Systems would be able to take on their statutory responsibilities. For the BaNES, Swindon and Wiltshire (BSW) area, this meant that all the key partners from across the health and care network, including the third sector, would be able to work collaboratively and pool resources to improve the health outcomes of all citizens. To begin with, organisations would continue to be accountable for the use of the resources that had been specifically allocated to them. The RUH already works closely with the two other acute hospitals

in the patch, Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust.

The ICS will have an important role in setting the strategic direction for services and making key decisions as to how funding is shared among partners. The Trust is already heavily involved in key aspects of the ICS' work, both centrally and at "Place" (local) level, and has developed on this path from 1 July 2022.

Our Vision and goals

During 2022/23, the Trust reflected on what is most important about what we do and the kind of organisation we want to be. Hundreds of colleagues, patients and members of our community have shared their thoughts about our ambitions, through surveys, workshops and conversations. Thank you to everyone who has been part of this.

As a result of this collaboration, we developed a new vision which was launched in September 2022. The new vision is: **The RUH, where you matter.**

This vision will guide us as we set and deliver our ambitions and goals for our three people groups: the people we work with, the people we care for and the people in our community.

- **For the people we work with**, creating the conditions to perform to our best - living by our values, investing in our teams and supporting diversity.

- **For the people we care for**, supporting people as and when they need it most - delivering high quality care, listening and acting on what matters most to them.

- **For the people in our community**, creating one of the healthiest places to live and work - working with our partners to make the most of our shared resources and reducing inequalities.

This change in our vision however did not change our breakthrough objectives which remained the same.

22/23 Priorities

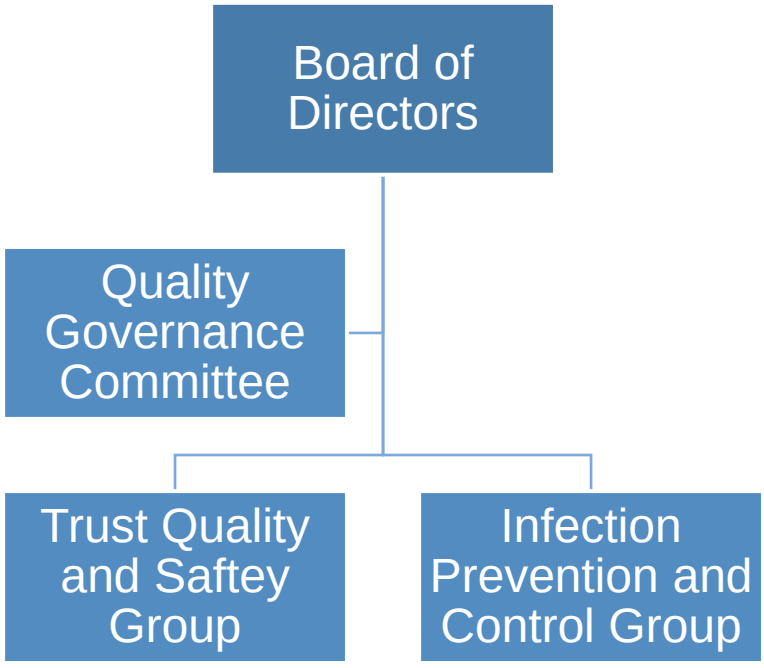
	Strategy	Trust goals	Breakthrough goals	Trust projects
The people we work with	People plan	There are enough people in this organisation for me to do my job	Recruitment to vacancies	Recruitment transformation project
The people we care for	Clinical strategy Patient engagement strategy	Zero avoidable harm Number of complaints	Reduce hospital acquired infections	Improving patient flow programme Better care better value projects IPC estates plan Patient Safety Programme Elective recovery programme
The people in our community	Estates strategy Digital strategy BSW Health and Care Model	Delivery of breakeven position Ambulance handover delays Carbon footprint	Reduce the number of patients waiting in hospital (non criteria to reside)	

The RUH, where you matter

Quality improvement, leadership and governance

Our approach to quality improvement and governance is led by our Chief Nurse and Chief Medical Officer. They Chief Medical Officer chairs the Trust Quality and Safety Group (TQ&SG), while the Chief Nurse chairs the Infection Prevention and Control Group (IPCG).

These groups report to the Board of Directors via the Quality Governance Committee. In addition to this, the Chief Nurse leads the Trust's Quality Improvement Centre, which brings together staff working in patient safety, risk management, quality improvement, clinical audit and patient experience. Each of the chosen quality priorities reports into TQ&SG quarterly, where progress is monitored and challenges highlighted and discussed.



Improving Together and Quality Improvement Approach

In 2022 we refreshed our vision after reflecting on what is important about what we do and what kind of place we want the Royal United Hospital to be. Our vision, the RUH, where you matter will guide us as we set and deliver our ambitions and goals for our three people groups: the people we work with, the people we care for and the people in our community.

Our Trust values and the tools, routines and behaviours from the Improving Together all remain central to how we will delivery out vision and strategy

What is Improving Together?

Improving Together is a system of behaviours, quality improvement tools and sustainable routines allowing staff to improve the care we provide to our patients, the service we provide to our community and the working environment for our staff.

Why do we need Improving Together?

At its heart, Improving Together is about Quality Improvement, giving the people closest to the issues the time, permission, skills and resources they need to problem solve. It involves a systematic and coordinated approach to solving problems using specific methods and tools with the aim of bringing about a measurable improvement.

As well as improving the quality of care, outcomes and experience for our patients, their families and our community, quality improvement improves the working lives of our staff. After all our people are at the heart of everything we do.

Improving Together in 2022

Everyone was asked to be involved in Improving Together by using quality improvement tools and routines in the day-to-day working of a ward, department or service. During 2022/23 we refreshed our training strategy for Improving Together. We designed and delivered our Leading for Change training, for staff members with line management responsibility, and focused on developing skills around compassionate, curious and collaborative leadership. We also launched a new Quality Improvement (QI) Champion role, available for any staff member. As a QI champion they received specific training on the Improving Together tools and routines that will enable them to lead and support improvements in their area.

A summary of the training that was offered in 2022 is visualised overleaf:

Improving Together Training Statistics and Outcomes 2022/23

The RUH, where you matter

Leading for Change

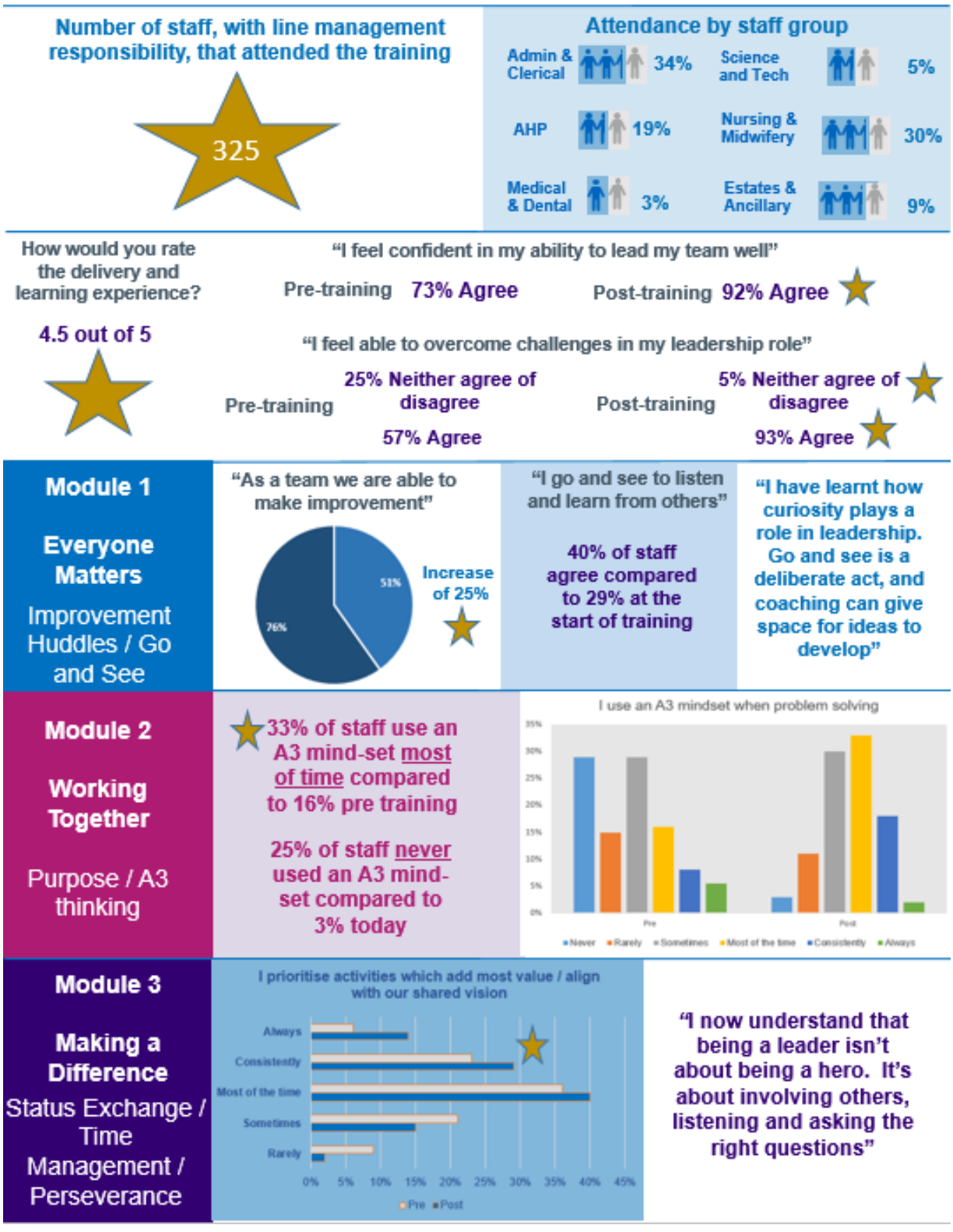


Fig 1: Summary of Leading for Change, anyone with line management responsibility

Fig 2: Summary of QI Champion training so far, training available to any member of staff

2.2 Quality Account Priorities 2022/23

Choosing our Quality Account priorities is important to us and our aim is to ensure that the chosen priorities are ones which will make a real difference to our patients. During 2020/21 and the early part of 2022, the Trust and wider system were under extreme pressure as a result of the COVID-19 pandemic.

We engaged with our staff, the Governor Quality Working Group, the Trust's Council of Governors, the Patient and Carer Experience Group, the Board of Directors, and the BSW Integrated Care Board (ICB) to determine the priorities. In order to help embed the improvements that we want to see in the areas covered, it was agreed that our Quality Account Priorities from 2021-22 would be carried forward into 2022/23.

Throughout the year, the Quality Account priorities and the progress against them continued to be monitored through the Trust Quality and Safety Group, which is chaired by the Chief Medical Officer as well as by our Governor Quality Working Group.

Looking back at 2022/23 – What did we say we would do?

Implementation of Enhanced Recovery pathway (ERP)

Implementation of an Enhanced Recovery pathway (ERP) was introduced for patients undergoing colorectal surgery. The aim was to help people recover more quickly after having major surgery and also result in a reduced length of stay for patient.

Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery. Many hospitals – although not all – have enhanced recovery programmes in place, and it is now seen as standard practice following surgery for many procedures.

Enhanced recovery is sometimes referred to as rapid or accelerated recovery. It aims to ensure that patients:

- are as healthy as possible before receiving treatment
- receive the best possible care during their operation
- receive the best possible care while recovering

Having an operation can be both physically and emotionally stressful. Enhanced recovery programmes try to get patients back to full health as quickly as possible. Research has shown that the earlier a person gets out of bed and starts walking, eating and drinking after having an operation, the shorter their recovery time will be.

What we said we would do	What we did
Define the enhanced recovery pathway (ERP)for patients undergoing colorectal and major joint replacement surgery	We have introduced ERP for patients undergoing elective colorectal surgery. ERP is also in place for Knee and Hip replacement surgery but has not been fully implemented due to reduced orthopaedic elective bed base.
Introduce an enhanced recovery lead role within the existing ward senior nurse team	Our elective ward has identified key nursing and therapy staff to promote ERP and nursing staff leads within the unit to support staff, increase skill set and knowledge – The ERP lead role is planned to form part of new business case.
Decrease length of stay for patients on the enhanced recovery pathway	We have seen a reduction in length of stay from 7.93 days during 2019/20, 6.4 days in 2020/21 and a small increase on average LOS to 6.9 days in 22/23. WE have still had a decrease of 1 day LOS since the project began.

What we said we would do	What we did
Review process and pathways to enhance recovery	Introduction of a patient information leaflet to educate patients pre-operatively. Introduction of videos and virtual pre and post-operative education for major joint replacement in orthopaedics. A patient daily goals logbook has been introduced to ensure that patients are aware of the goals that are to be achieved each day - empowering patients and their families to achieve goals and become partners in their own recovery. Introduction of marked patient walking routes to encourage mobility. Introduction of a coffee machine for patient's post op to reduce post-operative ileus (an intolerance of oral intake associated with surgery) by stimulating gut function. Currently on hold due to reconfiguration of ward and patient lounge area. Introduction of chewing gum and mouthwash as standard. Introduction of a care plan sticker from Day 0 to Day 5 for the colorectal enhanced recovery comprising six sections to ensure that patients' recovery follows the ERP protocol. This has also been trialled for Gynaecology patients and has proven successful. The introduction of an ICOUGH device (supported by the Innovation Panel) to support respiratory function and reduce the incidence of post-operative respiratory conditions was trialled and proved successful this is forming part of the ERP business case led by the ERP lead Consultant for 23/24. We have collected patient feedback which has been positive and patients have reported being 'motivated' and 'feeling supported'

How we will continue to work with this priority:

The enhanced recovery pathway (ERP) will continue, as this is now embedded for colorectal patients within our elective ward and more recently our Gynaecological patients however,

additional work is needed to support pre-operative education and advice so that this is consistent for all patients and resource is required to implement preoperative rehabilitation and I cough reliably following successful projects reducing postoperative complications.

We are reviewing the clinical nurse specialist role and how this becomes part of the ERP. Work is underway to re-establish ERP in orthopaedics in our new ring fenced orthopaedic elective ward from May 2023 working closely with our new modular theatre at Sulis Hospital.

Future goals include reinstating the patient lounge area and with it the coffee machine as mobilising and drinking coffee reduces the risk of ileus.

There is an ambition to recruit a dedicated ERP lead (RN/AHP) based on our elective ward to oversee the expansion of the ERP pathway and provide leadership and drive future innovation.

Continuation of Older Person's Rapid Assessment Area/Older Person's Assessment Unit – Frailty Assessment Unit

This Quality Account priority was first commissioned in 2019 with an aim to continue to improve the service for the frail elderly patients. This project sought to build upon the previous work, developing the front door Frailty Assessment and the introduction of the Frailty Flying Squad. The Frailty Assessment Unit changed both its nursing workforce and location in the last 6 months of the 2020/21. The Older Persons Assessment Unit (OPAU) was re-launched on 12 April 2021.

During 2022/23, the Trust has built upon the previous work undertaken by the Trust, developing the front door Frailty Assessment and the introduction of the Frailty Flying Squad (FFS).

The FFS provides an assessment and admission pathway for frail patients to improve patient outcomes and patient experience, thereby reducing length of stay and the de-conditioning of frail patients.

What we said we would do	What we did
Rapid multidisciplinary team (MDT) assessment of frail patient.	Provided daily senior Geriatrician review and established Older Person's Rapid Assessment Area (OPRAA) in Bay 3 on Older Person's Assessment Unit (OPAU) for direct admits of frail patients. Provided a Frailty Flying Service 8am – 8pm.
Establish a frailty pathway for the assessment and admission of all frail patients via GP referral or Emergency Department (ED).	Developed a standard operating procedure (SOP) for the pathway of frail patients. OPAU co-ordinator liaises with front door areas (ED, Medical Admissions Unit (MAU), Aramis and Midford Older Persons Unit -Short Stay (OPUSS) and manages patient transfers to OPRAA and the allocation of Older Person's Unit (OPU) beds. Developed Midford OPUSS as a short stay OPU ward.
Increase the number of patients transferred to OPAU with a Rockwood score of 5 and above from ED.	Established scoring system in ED for triaging nurse to use on admission for early identification of patients suitable for OPAU.

What we said we would do	What we did
Increase in discharges from OPAU within 24 hours.	Early assessment by senior Geriatrician. MDT intervention to aid discharge process and appropriate transfer to Midford OPUSS.

How we will continue to work with this priority:

During 2022/23, this priority has been significantly impacted by the constant use of escalation beds in OPRAA, impeding flow into the unit and the ability to take direct admits. This priority has also been significantly impacted by the lack of OPU beds in the Trust due to OPU wards being used as Covid-19 isolation wards, this has affected the flow out of the unit to Midford OPUSS and other OPU beds.

The service will continue to provide Frailty Flying Service 8am – 8pm and OPRAA will invest in trolleys to mirror the Direct Assessment Area (DAA) on Medical Admissions Unit (MAU).

The co-ordinator on OPAU continues to work closely with the front door areas, attending site meetings and pro-actively identifying and transferring frail patients into OPRAA/OPAU and managing the co-ordination of OPU beds.

PERIPrem Care Bundle (Perinatal Excellence to reduce injury in preterm birth)

The PERIPrem Care Bundle (Perinatal Excellence to Reduce Injury in Preterm Birth) consists of 11 evidence-based interventions throughout pregnancy and the neonatal period. The bundle supports the optimal timing of care and multidisciplinary working between maternity and neonatal professionals and with parents. This work included revised preterm birth guideline, introduced Foetal Fibronectin point of care testing and introducing PERIPREM Champions. It supports the NHS Long Term Plan (2019) in reducing neonatal morbidity and serious brain injury by 50% by 2025.

What we said we would do	What we did
More than 80% of babies would be born in the right place (Less than 27 weeks to be born in Tertiary centres)	Members of staff have received training on the Periprem bundle focusing on its importance on the outcome for the pre term babies.
More than 90% of birthing women will have received ante natal steroids prior to the birth of their pre term baby	Parental Periprem passport given to parents to empower their decision making
More than 90% of birthing women will have received IV magnesium Sulphate prior to the birth of their preterm baby	Foetal Fibronectin point of care testing is embedded into midwifery practice
More than 85% of pre term babies would have optimal delayed cord clamping at birth	A Teaching video has been made to demonstrate optimal delayed cord clamping on pre term babies. This is shown to all new Doctors on induction.
More than 90%of preterm babies would be supported to maintain thermoregulation following birth	New guideline for neonatal temperature control on BBC and the use of temperature probes
More than 85%of preterm babies would be given early breastmilk. Mothers will be supported with hand expression	Recruiting more Periprem champions Increased teaching on early expressing of breastmilk

What we said we would do	What we did
More than 85% of babies will receive appropriate caffeine therapy on the neonatal unit	Preterm mothers are now given early expressing information and pack during counselling. Introduction of early buccal breast milk.
More than 85% of preterm babies would receive appropriate probiotics on the neonatal unit	Probiotics now given with Buccal feed. Hydrocortisone neonatal guideline implemented.
More than 85% of preterm babies would receive prophylactic Hydrocortisone on the neonatal unit.	Multi-disciplinary monthly meetings to review each case.

How we will continue to work with this priority:

We will continue to collect data on this priority as well as promoting its importance to staff and continuing with staff education. The team will continue to hold monthly meetings and review each case. They are committed to sharing learning both Trust wide and within BSW and will strive to achieve the compliances in all areas.

2.3 Looking forward to this year 2023/24

Following engagement with our staff, the Governor Quality Working Group, the Board of Directors, and other key stakeholders we have agreed that our Quality Account Priorities for 2022/23 would be:

Health Inequalities in Maternity

Why is it important?

There remain gaps in mortality rates between women from deprived and affluent areas, women of different ages and women from different ethnic groups.

The national MBRRACE report into maternal mortality (2022) shows a continued gap between mortality rates for women from Black, Asian, mixed and white ethnic groups, with women from Black ethnic groups four times more likely to die than women from White groups. Women from Asian ethnic backgrounds are almost twice as likely to die in pregnancy compared to white women.

Women living in the most deprived areas are twice as likely to die as those who live in the most affluent areas. Social services were involved in the lives of 17% of women who died. The number of women who are known to be experiencing multiple disadvantages when they die remains at 8%. Women in these situations will often face mental ill-health, domestic abuse and/or misuse substances. However these and other issues are poorly recorded, so these figures should be treated as a minimum estimate.

Pregnancy at advanced maternal age is known to be associated with higher mortality, higher rates of pregnancy loss and other pregnancy complications. Yet the average age at first childbirth continues to increase. Less than a third of women received care in line with guidance. In particular very few women who are planning pregnancy at advanced maternal age have documented discussions over the risks and potential health impacts to them and their unborn child.

At the RUH we do have a clear understanding of how health inequalities affect our populations or the reason behind this however early data does demonstrate similar patterns to national reports.

What will we do in 2023/24

- Improve data quality of birth outcomes, in particular smoking and breastfeeding rates where there are known issues
- Roll out cultural competency training to all maternity staff
- Develop a health inequalities work stream within maternity which reports into the divisional work stream
- Develop cultural competency QI champion clinicians
- Identify three key birth outcomes for priority and complete a ‘deep dive’ into the differences in these outcomes
- Implement a minimum of three QI projects related to outcome data within clinical practice

How we will know we are making a difference

- Number of staff having complete training
- Training feedback
- The successful implementation of QI projects

- Service user feedback collected from the Maternity Voices Partnership and via the Inclusion Midwife
- Analysis of birth outcome data broken down by ethnicity and area of deprivation – this will be on a triennial period.
- Reduction in the number of incomplete data entry fields for; smoking at time of delivery and breastfeeding at discharge

Reduced length of stay in NICU

Why is it important?

Allowing a baby to spend time unnecessarily on Neonatal Intensive Care Unit (NICU) is undesirable for both the baby and its family. There is evidence that separating a mother and baby affects parent-infant bonding, parental mental health and a baby's cognitive and socioemotional development. Therefore ensuring a baby is discharged at an optimal time, which is safe and in the baby's best interest, can only be of benefit to the baby and family.

The RUH Getting It Right First Time (GIRFT) review in 2022 highlighted the Trust as an outlier in our length of stay for 27-33 week gestation babies and to enable us to be compliant with this issue the action needed was for us to review and improve our discharge process and pathway home.

Some of the care these babies receive whilst in hospital could be delivered at home and therefore reducing a baby's length of stay. Examples are, short term nasogastric home tube feeding, home phototherapy currently delivered in a hospital environment that could be delivered in the family home.

What will we do in 2023/24

- Prospectively audit the number of babies who are receiving care that could be delivered in a community setting
- Recruit a Discharge coordinator role (this could be the current Band 7 Outreach Sister who could become the discharge coordinator and then recruit a Band 5 Outreach Nurse to do visits in the community)
- Work with the Network care coordinator for support and advice
- Set criteria regarding what care could be delivered in the community
- Invest in home phototherapy equipment

How we will know we are making a difference

- Audit length of stay and see a reduction in care days
- Receiving positive feedback form families receiving outreach support of their baby

Dedicated Day Surgery Unit

Why is it important?

Length of stay of around 2.4% for patients cared for in a dedicated Day Surgery Unit, compared to 14% in an inpatient ward. (Department of Health)

Patient centred care - surgery can be both physically and psychologically stressful, continuity of care from dedicated staff improves patient experience and efficiency.

Day case beds on in patient wards do not provide the targeted service that is required to achieve good outcomes for patients (Association of Anaesthetists)

Improved theatre efficiency and start times as patients are located in the same place making it more efficient for admission, consultant, and anaesthetic review.

It aims to ensure that patients receive pre-operative assessment and optimisation prior to surgery, improving outcomes and reducing cancellation rates.

Dedicated day case units increase organisational resilience ensuring surgery activity continues even during extremis escalation resulting in fewer cancellations.

Quality and patient safety is improved as the team will be highly skilled and knowledgeable in delivering day surgical care, resulting higher quality outcomes

What will we do in 2023/24

- Increase the number of trolley spaces by reducing inpatient beds
- Expand elective day surgery theatre lists
- Update advice sheets to improve communication and patient outcomes
- Identify way to improve our service and patient experience, for example a designated waiting area, reconfiguring the estate to provide cubicles.
- Expand our working week to include routine weekend working Mon-Sat, with a view to including Sunday.
- Review the establishment to support the new way of working.
- Staff education specific to Day Surgery pre and post-operative care, to improve patient outcomes and staff wellbeing.

How we will know we are making a difference

- Reduced LOS
- Patient Feedback FFT, complaints compliments.
- Day Surgery admission data to evidence improvements in performance.
- Decrease in conversion rates from day case to inpatient.
- Improve theatre efficiency, start times and reduction in cancellations.

Family Liaison Officers

Why is it important?

A Family Liaison Facilitator service has recently been introduced to MAU and OPAU. The primary role of the FLF service is to provide regular non-clinical communication to patients/ family members/carers during a hospital admission, and to facilitate completion of the FFT. It is felt that this communication service could be extended to provide a follow up 'safe and well-being' call to each patient and/or their family after discharge.

Current patient experience data tells us that patients and their families/ carers have made complaints or contacted PALS with concerns about inappropriate/ unsafe discharges of older patients where relatives/ carers have not felt involved in decisions about discharge.

Patient Safety data from the past 6 months tells us that there is an on-going theme of discharge related concerns across all levels of harm and the top 3 incidents for Medicine were:

- Inappropriate/ unsafe discharge
- Missing/ Inadequate/Wrong/ Illegible discharge summary
- Delayed or Failed discharge e.g. medication

It is proposed that the FLF service provide a regular follow up 'non-clinical' telephone/ video call service to all patient's and/or their families within 48 hours of a patient's discharge from MAU (Acute Medicine) or OPAU (Acute Medicine/OPU).

This telephone/ video call service will allow 'live' feedback about key safety aspects of the patient's discharge and the patient's/ families experience of discharge. This will generate appropriate feedback to ward staff and the patient safety and experience teams. In turn, this information will feed into the Trust's on-going quality improvement work on promoting safe discharges for patients.

What will we do in 2023/24

- Provide a consistent FLF Discharge Follow up Service for all patient's discharged.
- Audit the data from the discharge checklist responses and feedback to the divisional patient experience/ and or patient safety services.

How we will know we are making a difference

- There is a decrease in PALS concerns and complaints about discharge related concerns
- There is a decrease in patient safety incidents relating to discharge related concerns
- There is an improved experience around communication at ward level for patients and their relatives/carers.
- There is an increase in the number of patient's discharged from MAU and OPAU with an accurate hospital depart summary

2.4 Statements of assurance from the Board of Directors

Mandatory statement 1

1. During 2022/23 the Royal United Hospitals Bath NHS Foundation Trust provided and/or subcontracted eight relevant health services across three clinical divisions: Medicine, Surgery and Family and Specialist Services.

    1.1. The Royal United Hospitals Bath NHS Foundation Trust has reviewed all the data available to them on the quality of care in all eight relevant health services.

    1.2. The income generated by the relevant health services reviewed in 2022/23 represents 100 % of the total income generated from the provision of relevant health services by the Royal United Hospitals Bath NHS Foundation Trust for 2022/23

Mandatory statement 2

During 2022/23, 47 national clinical audits and 2 national confidential enquiries covered relevant health services that the Royal United Hospitals Bath NHS Foundation Trust provides.

During that period the Royal United Hospitals Bath NHS Foundation Trust participated in 98% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal United Hospitals Bath NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
NCEPOD		
Child Health Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)	Yes	100%
National Audits		
Breast and Cosmetic Implant Registry	N/A	Not relevant to RUH
Case Mix Programme (Intensive Care National Audit & Research Centre)	Yes	100%
Cleft Registry and Audit Network Database (Royal College of Surgeons - Clinical Effectiveness Unit	N/A	Not relevant to RUH
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIPs - RCEM: Pain in Children (Care in Emergency Departments)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Emergency Medicine QIPs RCEM: Assessing for cognitive impairment in older people (care in Emergency Departments)	N/A	Delayed by Audit Provider
Emergency Medicine QIPs RCEM: Mental Health self-harm (care in Emergency Departments)	Yes	100%
Epilepsy 12 – National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP) : National Hip Fracture Database	Yes	100%
Gastro-Intestinal Cancer Audit Programme – National Bowel Cancer Audit (NBOCA)	Yes	100%
Gastro-intestinal Cancer Audit Programme – National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Inflammatory Bowel Disease (IBD) Audit	Yes	100%
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRACE-UK)	Yes	100%
Mental Health Clinical Outcome Review Programme	N/A	Not relevant to RUH
Muscle Invasive Bladder Cancer Audit	Yes	100%
National Diabetes Audit – National Adults Core Diabetes Audit	Yes	100%
National Diabetes Audit - National Diabetes Foot Care Audit	Yes	100%
National Inpatient Diabetes Audit	Yes	100%
National Diabetes Audit - National Pregnancy in Diabetes Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation	N/A	Not relevant to RUH
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	To be confirmed. Querying data quality with audit provider. Awaiting resolution.
National Audit of Cardiac Rehabilitation	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Audit of Cardiovascular Disease Prevention (NHS Benchmarking Network)	N/A	Not relevant to RUH
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Audit of Pulmonary Hypertension	Yes	100%
National Bariatric Surgery Registry	N/A	Not relevant to RUH
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP) – National Congenital Heart Disease	N/A	Not relevant to RUH
National Cardiac Audit Programme (NCAP) – Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP) – National Adult Cardiac Surgery Audit	N/A	Not relevant to RUH
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Yes	Awaiting update
National Cardiac Audit Programme (NCAP) – National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Awaiting update
National Cardiac Audit Programme (NCAP) – National Heart Failure Audit	No	Data is being submitted but our submission rate at 28% is falling below the participation threshold. Investigation underway to provide resolution
National Child Mortality Database - University of Bristol	N/A	Not relevant to RUH
National Clinical Audit of Psychosis (NCAP)	N/A	Not relevant to RUH
National Early Inflammatory Arthritis Audit (NEIA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit	N/A	Not relevant to RUH
National Ophthalmology Database Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool 1 University of Oxford / MBRRACE-UK collaborative	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
National Vascular Registry	N/A	Not relevant to RUH
Neurosurgical National Audit Programme	N/A	Not relevant to RUH
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	N/A	Not relevant to RUH
Paediatric Intensive Care Audit (PICANet)	N/A	Not relevant to RUH
Perioperative Quality Improvement Programme	Yes	Awaiting update

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Prescribing Observatory for Mental Health UK (POMH-UK) – Improving the quality of valproate prescribing in adult mental health services	N/A	Not relevant to RUH
Prescribing Observatory for Mental Health UK (POMH-UK) – The use of melatonin	N/A	Not relevant to RUH
Renal Audits – National Acute Kidney Injury Audit	N/A	Not relevant to RUH
Renal Audits – Chronic Kidney Disease registry (The Renal Association/The UK Renal Register)	N/A	Not relevant to RUH
BTS Respiratory Audit: Respiratory Support Care	N/A	Postponed by Audit Provider
BTS Respiratory Audit: National Smoking Cessation Audit Maternity & Mental Health	N/A	Postponed by Audit Provider
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
The Trauma Audit & Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Parkinson's Audit	Yes	100%

The reports of 20 national clinical audits were reviewed by the provider in 2022/2023 and Royal United Hospitals Bath NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided.

National Neonatal Audit Programme (NNAP) November 2022

The Trust performed significantly better than other trusts for cord clamping at or after one minute for babies born at less than 32 weeks gestational age. Babies admitted for more than 24 hours, had at least one parent attend a consultant ward round at some point during the baby's admission and a good proportion of consultant-led ward rounds had at least one parent present. The majority of babies born at less than 32 weeks gestation had their temperature taken within an hour of admission and all those babies had a normal temperature. All babies of very low birthweight or less than 32 weeks gestation received the appropriate screening for retinopathy of prematurity. Most babies born at less than 30 weeks gestational age received medical follow-up at two years corrected age.

The Trust scored lower than the national average for: mothers delivering babies between 23 and 33 weeks gestation being given any dose of antenatal steroids; mothers delivering babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery. The Trust, using PERIPrem guidance for practice, has worked to improve these areas including: informing the neonatal team of preterm mothers in threatened early labour; discussing when steroids and magnesium sulphate were needed; ensuring that maternal notes were documented in full; promoting the use of the PERIPrem passport for all babies delivering at less than 34 weeks.

National Paediatric Diabetes Audit (NPDA) April 2022 (2020/21 data)

The Trust performed as well or better than the national average for all standards with a year on year improvement demonstrated. In particular the Trust scored 100% for all Type 1 diabetics screened for thyroid and coeliac disease. The median HbA1c was better than several regions. All children and young people with diabetes were 'carb counting' within 2 weeks and there was a high uptake of additional dietetic appointments. This project was presented and fully discussed at a multidisciplinary specialty meeting. In order to sustain and make further improvements the Trust incorporated actions into the specialty work plan by focussing on: improving data recording, particularly around treatment regime; use of Continuous Glucose Monitoring (CGM); non-elective admissions; use of Electronic Prescribing and Medicines Administration (ePMA) care plan at diagnosis to maintain and improve thyroid and coeliac screening and monitoring; checking inpatient and/or first clinic results and repeating tests within 90 days if needed as well as improving communication with primary care/GPs and families.

Sentinel Stroke National Audit Programme (SSNAP) September 2022

The Trust did well in scoring an A for case ascertainment and B for audit compliance. There has also been an improvement in 2 standards: scanning went from C to B and discharge process from B to A. However, the overall SSNAP score for the Trust was D. This low score can be attributed to the Stroke Unit indicator which relates to how many patients reached the Stroke Unit within the 4 hour target. Patients were delayed from getting to the Acute Stroke Unit (ASU) for many reasons including ward and bay closures secondary to infections (mainly COVID-19). Patients stayed longer on ASU due to problems in the community affecting discharges from community hospitals. There had also been difficulties around bed usage due to winter pressures. The Therapy times indicator also affected the overall Trust performance. Staffing level challenges and ward closures resulted in outlying patients on other wards putting extra strain on the therapists trying to see more patients.

The reduced Thrombolysis rates are reduced nationally and not just in this Trust. This is due to a combination of factors including ambulance issues and change of patient behaviour since the COVID-19 pandemic, meaning patients often arriving outside of the thrombolysis window. As a consequence of these results a comprehensive action plan has been put in place to address the shortfalls and improve performance. Actions include: weekly breach meetings from February 2023 looking at weekly breaches of patients failing their target to ASU in 4 hours and collaborative working with site management, Emergency Department (ED) and Medical Assessment Unit (MAU) clinical staff training to raise awareness of stroke and increase speed to treatment and to ASU. Each domain continues to be reviewed with the domain lead to review areas where further improvements could be made. Many domains rely on the patient being on ASU which triggers being seen more quickly by all the MDT therapists and creating adequate space for therapy within the gym.

National Outpatient Management of Pulmonary Embolism Audit

The Trust scored better than the national average for patients who were administered therapeutic anticoagulation within 1 hour if it was not possible to carry out the imaging immediately or less than an hour after arrival. The Trust also performed better than nationally

whereby patients who were unable to have immediate imaging were given a specific appointment time to return for imaging. More patients than nationally had their laboratory biomarkers measured when the right ventricle was dilated. The majority of patients were reviewed by a senior decision-maker, a staff grade or similar substantive career grade doctor, advanced nurse practitioner or clinical nurse specialist designated to undertake this role within the department (with consultant advice available) before going home on an out-patient pathway. However the administration of verbal and written information, including a point of contact, was not well recorded in the notes and most patients did not receive an initial follow-up within 7 days of discharge on an out-patient pathway. Following these results patient information leaflet availability has now been improved with the provision of both electronic and paper copies. A recent local audit has shown that an increased number of patients are now being reviewed within 7 days of discharge via GP (remote consultation) when requested. The same audit has shown that excellent outcomes are now being seen with only 12% re-attending at the Emergency Department (ED) and no re-admissions.

Society for Acute Medicine (SAMBA)

The Trust performed well and was above the national average for unplanned admissions with an Early Warning Score recorded within 30 minutes of arrival. Most patients who had an unplanned admission were reviewed by a competent clinical decision maker within 4 hours of arrival. More than half of unplanned admissions arriving during the daytime had a consultant review within the target time of 6 hours. All patients with an unplanned admission arriving overnight had a consultant review within the target time of 14 hours. Planning is now taking place towards extended Ambulatory Care opening hours which will likely reduce time to consultant review for later afternoon attendances to the Emergency Department (ED) / GP referrals.

National Audit of Inpatient Falls 2022

The Trust was above the national average for the majority of the standards and in particular scored 100% compliance for patients having a medication review, mobility assessment, delirium assessment, mobility care plan, continence care plan and delirium plan documented. Patients identified with a hip fracture had no delays to their hip fracture care. Most patients had a vision assessment, a medical assessment within 30 minutes and a recording of analgesia prescription. All patients had an after action review and over half of those had the review within 5 working days of the fall which was significantly higher than the national average. However the hospital fell below the national average for ‘check for injury and injury suspected’, and ‘flat lifting equipment used’. These areas of concern are now being addressed and the patient safety nurses are investigating the provision of scoops for wards. The Falls E-learning and face to face teaching has been updated and training for falls champions and nursing staff is currently being rolled out throughout the Trust. The falls champion training includes a focus on the post falls process and the use of the falls retrieval kit. Once the training has been completed the areas of concern will be re-audited to demonstrate improvement.

National Emergency Laparotomy Audit (NELA)

The Trust scored well with case ascertainment and submitted all the patients required by the national audit. Achievements over the past year have been good with most standards better than the national average; nearly all patients had a risk assessment, arrived in theatre within the appropriate time frame and had a Consultant Anaesthetist and Surgeon present. Where patients had a mortality risk greater than 5% the majority were admitted to Critical Care. However these results were not achieved to the same degree in the Care of the Elderly review which scored lower than the national average. This relates to resources which have been an issue since Covid. It is planned to develop the Care of the Elderly service in 2023 and this will require additional resources.

The reports of 48 local clinical audits were reviewed by the provider in 2022/2023 and the Royal United Hospitals Bath NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided.

Timely Administration of Medication for Parkinson's disease

This audit focused on the National Institute for Health and Care Excellence guidelines (NICE) which state that patients with Parkinson's disease should have their medication administrated within 30 minutes of the intended time. The results showed that just over half of the patients had their Parkinson's medication within 30 minutes of the expected time. The average time for a late dose was 85 minutes and where doses were administered too early the average was 69 minutes. Following the audit the results were discussed and recommendations put in place including the development and dissemination of a poster throughout the wards to highlight the importance of timely administration of medication; consultations with Pharmacy around adding a reminder to the drug charts about Parkinson's disease medication. The results were also disseminated to medical teams. The audit will be repeated to assess the impact of these actions.

Idiopathic Pancreatitis Audit

The British Society of Gastroenterology recommend establishing the cause of pancreatitis by further doing an endoscopic ultrasound in cases of idiopathic pancreatitis. An audit was carried out to find out how well the Trust was adhering to the guidance.

The results of the audit showed that very few patients presenting with idiopathic pancreatitis were referred for an endoscopic ultrasound. Out of 28 patients with idiopathic pancreatitis, only 9 were referred for an endoscopic ultrasound over the period of 8 months. On average, patients waited 4 weeks or more for their endoscopic ultrasound. In addition, the referral and date of endoscopic ultrasound was poorly documented. Results of the audit were presented and discussed by clinicians at a multidisciplinary departmental meeting. Recommendations were made to improve compliance including ensuring that all patients are booked and have an endoscopic ultrasound completed after their first episode of idiopathic pancreatitis. A review would be carried out of the waiting times and documentation. Following the introduction of these recommendations a further audit will be carried out to assess improvements.

Nipple symptoms imaging audit

An audit was carried out to ensure that women over 40 years of age with nipple symptoms and/or signs, with or without a palpable breast lesion were being appropriately imaged. The audit showed that all women over 40 years of age with nipple symptoms and/or signs, with or without a palpable breast lesion were offered ultrasound imaging when indicated over a period of 3 months and therefore the guidance was being met. In addition, it shows an improvement from a previous audit, which showed inconsistency in requesting ultrasound imaging. A re-audit will be carried out to check performance is being maintained.

Vitamin D levels in patients with new diagnoses of breast cancer and subsequent management

There is published evidence that Vitamin D deficiency can affect the response to neoadjuvant chemotherapy in early, locally advanced metastatic breast cancer. All patients with newly diagnosed breast cancer should have an assessment of vitamin D levels early or straight after starting breast cancer treatment. The audit looked at patients with new diagnoses of breast cancer over a 3 month period to identify how consistently Vitamin D levels were being checked prior to patients starting adjuvant bisphosphonates.

The results of the audit showed that the majority of patients were having their Vitamin D levels checked. However, where patients were found to have deficient or insufficient Vitamin D levels they had not been started on Vitamin D. Recommendations included continued but earlier Vitamin D checks to be carried out by Breast and Oncology consultants. Patients with low or insufficient levels of Vitamin D will be discussed at multidisciplinary team meetings and where appropriate dosing to be started by consultants and requests for general practice follow up to be highlighted in GP letters.

Cardiotocograph Monitoring in Labour - Re-audit

This re-audit aimed to ensure compliance with the National Institute for Health and Care Excellence (NICE) guidance surrounding Intrapartum Care for Healthy Women and Babies. The re-audit showed a steady improvement from the original audit with improved compliance for 17 standards from the original audit. It showed a good compliance of the documentation of the patient's name and date and time of commencement at the start of the cardiotocograph. In addition, the audit showed a good compliance in intrapartum events being documented, fresh eyes completed, cardiotocograph categorised, pulsoximeter used, cardiotocograph securely attached to maternity notes and partogram used. However, the reason for cardiotocograph and the patient's pulse at the beginning of the cardiotocograph was not always documented in the maternity notes. There was also a low compliance for the documentation of systematic assessment of woman and fetus every hour and the documentation of an action plan when there is an abnormal cardiotocograph. Results have been discussed and widely disseminated to improve the compliance of documentation.

Surgical Take Bleep Referral Forms – Re-audit

This re-audit of surgical bleep referral forms was undertaken to ensure that there had been an improvement in the way that theatre staff communicated information from answering the on-call bleep, to the surgical team. The results showed that there had been an improvement in the average completion of referral forms and completing the critical information within the referral forms from the previous audit. The Trust was performing well for documenting 'the reason for referral' and well over half of the bleep forms were completed. Improvement was needed pertaining to documenting 'time', 'expectation from surgical team' and 'referrer's name'. Actions following the re-audit included teaching sessions with theatre staff to explain the importance of adequate clinical information when taking referrals. Using the referral forms and bleep boxes, including how direct assessment affects patient safety and care will now be included in the doctor and theatre staff inductions.

Mandatory statement 3

The number of patients receiving relevant health services provided or subcontracted by Royal United Hospitals Bath NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee 3970.

At any given time, the Trust has around 200 individual research studies ongoing across a wide range of clinical specialities and departments. Many of these research studies are collaborative in nature and support relationships with local and national research funders, Universities, NHS organisations and commercial partners within the life sciences industry.

The RUH continues to expand its portfolio of research which is initiated and run by our own research staff, encompassing consultants, research nurses and allied health professionals, a number of whom hold academic Professor and lectureship positions in a variety of clinical areas. The RUH continues to work collaboratively with surrounding universities including the Universities of Bath, Bristol and The West of England; this ensures that the research conducted at RUH addresses the health needs of our local community.

Research Grants Awarded April 2022 – March 2023

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Jeff Clark (IngeniumAI) Dr J Rodrigues (RUH) and Dr A Cookson (UOBath)	Respiratory	Ingenium AI Automated Disease Detection in Pulmonary Hypertension	£300,000	Innovate UK
Dr John Pauling	Rheumatology	WARMER – Wearable Ambulatory Raynaud's Measurement Recorder	£45,000	SRUK Charity

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Ben Mulhearn	Academic Clinical Fellow	How common is VEXAS syndrome in an adult rheumatology population	£20,000	BIRD Charity
Dr Fiona Gillison	Department for Health	Embedding research to improve remote consultations in hospital policy	£3,800	Policy Support Fund, University of Bath
Mandy Slatter	Pharmacy - Internship	Antimicrobial resistance (AMR) and stewardship (AMS) “To Dip Or Not To Dip”	£10,000	HEE-NIHR Internship (2022/23)
Paul Minty	Rheumatology	Research Scholars Programme	£8,500	NIHR /CRN Partnership
Dr Jen Pearson	Fellowship/UWE	Adapting the Fibromyalgia self-management programme to develop an online support package, optimising engagement and uptake of the intervention	£312,344 total, £31,720 to RUH	NIHR Post-Doctoral Fellowship (ICA ACAF)
Dr Darren Hart	Principal Clinical Scientist RUH	HEESW Simulation Project	£30,000	Health Education England
Dr Darren Hart	Principal Clinical Scientist RUH	Innovation Fellowship	£15,000	NIHR Healthcare Science Fellowship
Dr Dan Augustine	Cardiology	ADOPT Artificial intelligence: Improving early detection of pulmonary hypertension by transthoracic echocardiography:	£360,000	Janssen Pharmaceuticals
* Dr Jonathon Rodrigues	Respiratory/ Radiology	Developing AI solutions to improve diagnosis & risk stratification in acute PE and chronic thrombo-embolic pulmonary hypertension –	£887,725	NIHR –Digital Project grant (AI-AWARD 02549)
* Dr Dan Augustine	Cardiology	IMPULSE – Improving Pulmonary Hypertension screening by Echocardiography	£606,265	Janssen Pharmaceuticals
Dr William Tillett	Rheumatology	Brit-PACT -Sequence	£45,000	BRIT-Pact

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Marc Batalla	Pain	Cognitive Multisensory Rehabilitation, a novel sensorimotor intervention for pain reduction in Complex Regional Pain Syndrome: a feasibility study	£9,175	RNHRD General Research Charity (RUHX)
Dr Loganathan and Dr Tansley	Rheumatology	Charitable Funding requested for Article Processing Fee for Publication in Immunology (Frontiers Media).	£2,399	RNHRD General Research Charity (RUHX)
Dr Ben Mulhearn	Clinical Research Fellow Rheumatology	Has the incidence of giant cell arteritis in England and Northern Ireland been influenced by the covid-19 pandemic? A case cohort study using CPRD Aurum data.	£10,000	RNHRD General Research Charity (RUHX)
Dr Gauntlett-Gilbert	Bath Centre for Pain Services	Unhelpful Clinical Messages in Chronic Pain – Funding for 3 months for a postdoctoral fellow to carry out qualitative analysis of pain research data.	£6,600	RNHRD General Research Charity (RUHX)
Dr Jessica Ellis	Rheumatology	SLE Patient Advisory Group (RSPARG)	£2,686	RNHRD General Research Charity (RUHX)
Olivia Taylor	Med Student University of Bristol	LoCATE (Long COVID in Adolescents Treatment Evaluation): a mixed methods approach to evaluate Long COVID services for Adolescents.	£1,340	RNHRD General Research Charity (RUHX)
Dr Will Tillett	Rheumatology	Body Composition in Immune-mediated Inflammatory Diseases	£5,847	RNHRD General Research Charity (RUHX)
Dr Emily Henderson	Aging / Parkinsons	Chief PD – Extension to existing HTA grant	£249,091	HTA
Dr Alison Llewellyn	Pain	ENACT – Extension to existing NIHR RfPB grant	£26,574	NIHR

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Jonathan Rodrigues	Radiology/ Cardiology	Super Rehab for Coronary Artery Disease – Extension to existing NIHR RfPB grant	£29,767	NIHR
		Total	**£2,987,114**	

Mandatory statement 4

The Royal United Hospitals NHS Foundation Trust income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the value of the funding attributed to this framework was fixed for the year.

Mandatory statement 5

The Royal United Hospitals Bath NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered'. The Royal United Hospitals Bath NHS Foundation Trust has no conditions attached to its registration.

The Care Quality Commission has not taken any enforcement action against the Royal United Hospitals Bath NHS Foundation Trust during 2022/22.

Mandatory statement 6 (removed)

Mandatory statement 7

The Royal United Hospitals Bath NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Mandatory statement 8

Royal United Hospitals Bath NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.7% for admitted patient care
- 98.5% for outpatient care and
- 99.4% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 97.5% for admitted patient care;
- 98.0% for outpatient care; and
- 90.3% for accident and emergency care.

HES data as presented in Dr Fosters has been used to generate this data and for GP Practice codes both blank and defaulted V81* codes have been counted as invalid.

Mandatory statement 9

The Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2022-23 was Standards Met* and an internal audit for period 2022-23 was graded Significant Assurance.

* the final submission for the DSPT for period 2022-23 is not due until 30th June, this has been marked as 'Standards Met' based on the progress to date and the result from the recent KPMG internal audit.

Mandatory statement 10

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the 2022/23 financial year by the Audit Commission.

Mandatory statement 11

The Royal United Hospitals Bath NHS Foundation Trust will be taking the following actions to improve data quality.

- Continue the work of the Data Quality Action Group, which meets regularly to oversee data quality within the Trust. The group monitors data quality issues and receives the outcomes of audits and external data quality reports to support resolution of issues and improvement work. The meetings are attended by staff from the Business Intelligence Department and staff working in operational roles as well as Finance and IM&T to make sure that the Trust maintains high quality and accurate patient information to support patient care.
- Action any data quality issues raised by commissioners and other NHS and non-NHS bodies that receive and use the Trust's data. This includes monthly reporting of the Trust's performance against Secondary User Service (SUS) data quality reports and the NHS Data Quality Maturity index.
- In-line with The Government Data Quality Framework the Data Quality Action Group are implementing Data Quality Action Plans to ensure that efforts to improve data quality are focused, monitored and action driven.

Mandatory statement 27 - Learning from deaths

Mandatory statement 27.1

During 2022/23 1473 of the Royal United Hospitals Bath NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 300 in the first quarter;
- 380 in the second quarter;
- 424 in the third quarter;
- 369 in the fourth quarter.

Mandatory statement 27.2

By April 2023, 144 case record reviews and 14 investigations have been carried out in relation to 144 of the deaths included in item 27.1.

In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 50 SJRs and 3 investigations in the first quarter;
- 44 SJRs and 5 investigations in the second quarter;
- 40 SJRs and 2 investigations in the third quarter;
- 10 SJRs and 4 investigations in the fourth quarter.

Mandatory statement 27.3

We have adopted the Royal College of Physicians' National Mortality Case Record Review Programme methodology known as the 'Structured Judgement Review' (SJR).

The Royal College of Physicians has stated that "SJR methodology does not allow the calculation of whether a death has a greater than 50% probability of being avoidable" and, further, that "The NMCRR programme, supported by the RCP, does not endorse the comparison of data from the SJR between trusts."

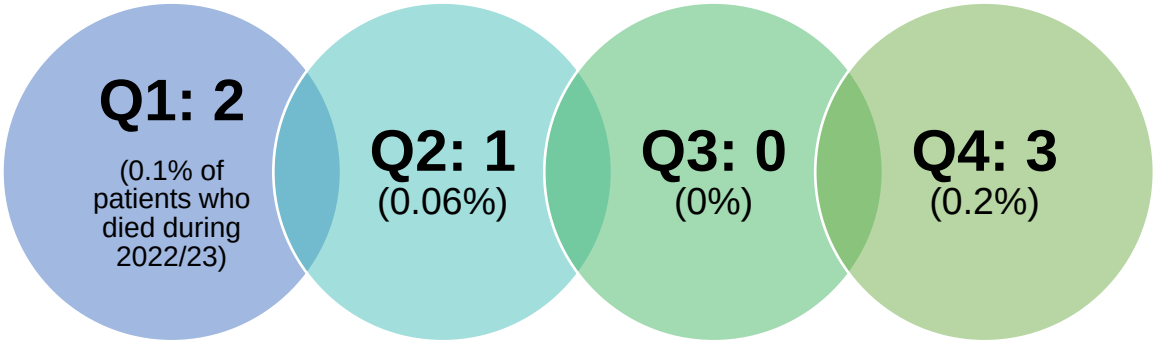
As such, we can only present the data available which is summarised below. These numbers have been estimated using the Structured Judgement Review Process.

1. Very Poor Care
2. Poor Care
3. Adequate Care
4. Good Care
5. Very Good Care

The table overleaf details all SJRs completed for patients who died during 2022/23, even if the SJR was completed after the expiry of that period.

Rating Type	Average	Number of	Number of 1s	Number of 2s	Number of 3s	Number of 4s	Number of 5s
Initial admission	4.18	145	0	6	16	69	54
Ongoing care	3.98	120	0	9	24	48	39
Care during	4.09	33	0	0	7	16	10
Return to theatre	4.00	6	0	1	0	3	2
Perioperative care	4.12	25	0	0	4	14	7
End of life	4.26	115	1	2	10	55	47
Overall	4.04	144	0	9	20	71	44
Patient record	3.91	143	1	2	52	42	46

Whilst the Trust is unable to calculate the avoidability of a death, the Structured Judgement Reviewer is asked to consider whether any care problems identified are likely to have contributed to the death occurring. The number of care problems likely to have contributed to death can be calculated per quarter as follows:



Mandatory statement 27.4

In relation to the SJRs that have been completed, the care problems identified included an inpatient fall, two nosocomial COVID infections, and delays in recognising and diagnosing two deteriorating patients. All have been subjected to a second, more detailed review, to establish if the threshold for a serious incident had been met.

The Trust methodology for reviewing all deaths includes a process to escalate cases for further investigation if care or service delivery issues may be a concern. In the time period we identified 3 cases which were escalated for serious incident investigation following a Structured Judgement Review (SJR).

The learning identified from the three incidents included:

- Recognition and escalation of deteriorating patients
- Management of dementia patients with a high risk of falls

Mandatory statement 27.5

The RUH Patient Safety Programme for 2022-2025 identified five patient safety priorities which reflect themes identified within incidents and complaints:

- Early identification of the deteriorating patient
- Prevention of infection
- Prevention of medication errors
- Prevention of falls
- Improved processes for hospital discharge

These priorities continue to be the focus of thematic reviews and work plan development in adherence to the transition to the Patient Safety Incident Response Framework (PSIRF) for which the Trust plan is in development ready for implementing in September 2023.

Progress is monitored through the Patient Safety Steering Group and PSIRF project group.

Mandatory statement 27.6

The PSIRF programme is a new approach to investigating and learning from incidents. Its impact in improving patient safety will be assessed over the coming months as it becomes embedded.

Mandatory statement 27.7

93 SJRS and 3 investigations completed after 31/03/2022 which related to deaths which took place before the start of the reporting period.

Mandatory statement 27.8

10 SJRs representing 0.07% of the patient deaths before the reporting period, experienced care problems likely to have contributed to death. This number has been estimated using the same methodology as set out above.

Mandatory statement 27.9

17 representing 1.2% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.4 Reporting against core indicators

Mandatory statement 12 – Summary Hospital Level Mortality Indicator (SHMI)

The following data is for the latest reporting year, Nov 2021 - Oct 2022

Measure	Nov 21 - Oct 22	Feb 21 - Jan 22	Feb 20 - Jan 21	National Average	National Best	National Worst
Value	1.03	1.04	1.03	1.00	0.62	1.25
Banding	2	2	2	2	3	1

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using data provided by the Trust. SHMI is reported as a twelve month rolling position, and the reporting periods shown are the latest available from NHS Digital.

The SHMI value is better the lower it is. The banding level helps to show whether mortality is within the “expected” range based on statistical methodology. There are three bandings applied, with a banding of two indicating that the mortality is within the expected range. The Trust has a value of two meaning that mortality levels are not significantly higher or lower than expected.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by: The Trust scoring against this measure is within the expected range. Because of this no specific improvement actions have been identified, however the Trust is committed to continuing to reduce mortality as measured by both SHMI and HSMR (Hospital Standardised Mortality Ratio) indicators.

Our Clinical Outcomes Group, chaired by the Medical Director, monitors these indicators on a regular basis, and we use the Dr Foster Intelligence System to monitor mortality and clinical effectiveness.

Mandatory statement 18 – Patient Reported Outcomes Measure (PROMS)

Please note that in 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

NHS Digital endeavour to update this linkage process and resume publication of this series as soon as they are able but unfortunately are unable to provide a timeframe for this. Further information can be found by clicking here.

Measure		Latest Reporting Year	RUH Performance	National Average	National Best	National Worst
PROMS: Patient Reported Outcome Measure	Total Hip Replacement - EQ-5D	2020/2021	0.437	0.467	0.579	0.378
	Hip Primary - EQ-5D		0.468	0.475	0.555	0.395
	Hip Revision - EQ-5D		0.541	0.329	-	-
	Total Knee Replacement - EQ-5D		0.346	0.317	0.434	0.215
	Knee Primary - EQ-5D		0.352	0.319	0.436	0.22
	Knee Revision - EQ-5D		0.204	0.285	0.212	0.195
	Total Hip Replacement - EQ-VAS		11.852	14.683	20.688	6.819
	Hip Primary - EQ-VAS		14	15.056	21.539	9.894
	Hip Revision - EQ-VAS		-44	7.935	-	-
	Total Knee Replacement - EQ-VAS		5.68	7.483	12.137	0.868
	Knee Primary - EQ-VAS		6.125	7.687	12.571	1.181
	Knee Revision - EQ-VAS		-5	4.029	-	-3.254
	Total Hip Replacement - Oxford		23.926	22.579	25.948	17.564
	Hip Primary - Oxford		24.68	23.007	25.387	17.826
	Hip Revision - Oxford		14.5	15.079	16.526	13.366
	Total Knee Replacement - Oxford		15.778	16.884	21.622	13.567
	Knee - Primary - Oxford		15.462	13.277	21.607	13.526
	Knee Revision - Oxford		24	13.277	11.961	8.606

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using data provided by the Trust and patient responses. The Trust give pre-operative questionnaires to all eligible patients and a follow up post-operative questionnaires sent to patients by an external company in line with national guidance.

Information is only available for some measures for the Trust against PROMS measures for the most recent reporting period. This is because a low number of the post-operative questionnaires have been returned to date, due to the time it takes to gather and process responses. Small numbers are not published because it is difficult to make accurate assumptions about improvements in care, and in some cases information has to be excluded to protect patient confidentiality.

The reporting periods shown are the latest available from NHS Digital.

The data for April to March 2020/2021 are finalised figures published by NHS Digital. Finalised figures are not available for the 2021/22 year.

Mandatory statement 19 - Readmissions

The following table shows the Emergency Readmission within 30 days of Discharge from hospital during the latest reporting year 2021-2022.

	RUH Performance					
	2021-22	2020-21	2019-20	National Average	National Best	National Worst
0-15 year old	13.3	12.9	13.2	12.5	3.3	46.9
16 years or over	14.3	14.3	14.3	14.7	2.1	142

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using data provided by the Trust through submissions to Secondary Users Services. The indicators presented measure the percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital over the 2021/22 period, the latest available dataset.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

Re-admission rates published by Dr Foster are reviewed at the Trust's monthly Clinical Outcomes Group meeting that is chaired by our Medical Director. When individual diagnostic groups are outside of the expected range for readmissions a review is undertaken to understand what may be contributing to this.

Mandatory statement 20 – Responsiveness to personal needs of patients

Measure	Latest reporting year	RUH	National Best	National Worst
Overall, how was your experience while you were in hospital	2021	8.2	9.4	7.4
Ranking compared to other Trusts	2021	About the same	Much better	Much worse

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data displayed is taken from the CQC staff survey as published by NHS England. All eligible NHS trusts in England participate in the NHS Patient Survey Programme, asking patients their views on their recent health care experiences. The findings from these surveys provide organisations with detailed patient feedback on standards of service and care, and can be used to help set priorities for delivering a better service for patients. The survey results are also used by the Care Quality Commission to measure and monitor performance at both local and national levels.

Mandatory statement 21 – Staff recommending the Trust to friends and family

The following table shows the following measure: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”

RUH					
2022	2021	2020	Best	Average	Worst
68.0%	73.7%	82.0%	86.4%	61.9%	39.2%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data presented is collected during the national NHS Staff Survey which describes how NHS people experience their working lives. Each autumn everyone who works in the NHS in England is invited to take part in the NHS Staff Survey. The aggregated survey results are official statistics, providing a rich source of data that is used by a wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

The Trust scored above the national average for acute trusts for this measure, although the proportion of staff who would recommend the Trust for treatment to friends and family has deteriorated in comparison to last year’s results – this is in line with the national trend. The Trust is building on its long term quality improvement programme, Improving Together, which will help the organisation to deliver its vision ‘the RUH, where you matter’ in providing the highest quality care, supporting staff to live the Trust’s values, and working together on shared goals.

Mandatory statement 23 – Venous Thromboembolism (VTE)

NHS Digital have paused the collection and publication of this data to release NHS capacity to support the response to coronavirus (COVID-19). Click here to find out more information including a full list of collections and releases affected on the NHS England website under the heading COVID-19 and the production of statistics.

Mandatory statement 24 – Clostridium Difficile (C. diff)

The following table shows the measure of Hospital onset, Healthcare Associated C.Difficile Infections.

Measure	RUH Performance			National Average	National Best	National Worst
	2021 - 22	2020 - 21	2019 - 20			
Rate per 100,000 bed days for specimens taken from patients age 2 years and over	17.8	17.0	10.5	18.0	0.0	50.0

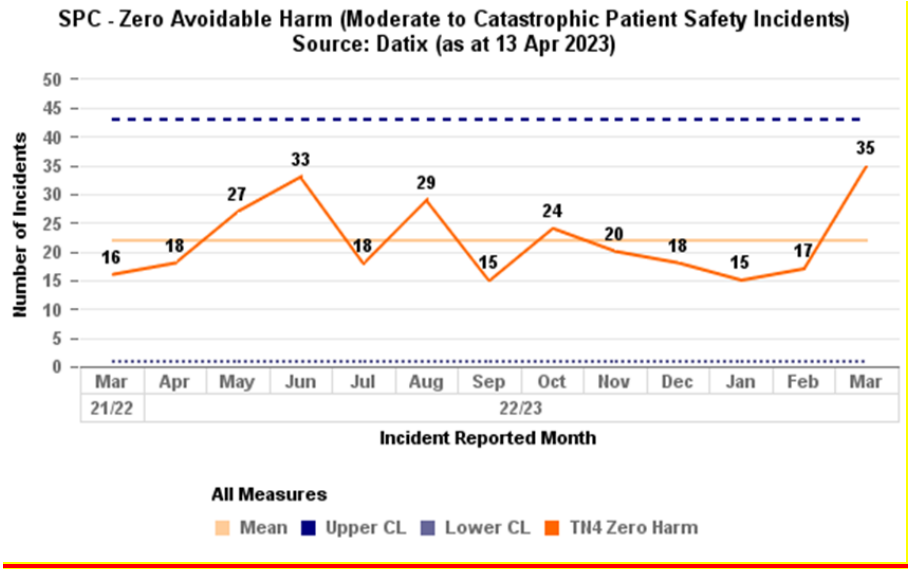
The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The performance shown is taken from the most recently published Public Health England annual counts and rates of *C.difficile* infections, by acute trusts in patients aged 2 years and over

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

- Strengthening the process for recording the patient's normal bowel habit on admission
- Improving documentation on stool charts; senior sisters are undertaking regular audits of documentation and feeding back to staff
- Keeping a focus on antimicrobial stewardship
- Ensuring that all patients with *Clostridium difficile* infection are reviewed by the Microbiology Team at least once a week so that treatment can be adjusted if required and other medications rationalised to reduce the risk of further episodes of diarrhoea
- Improving cleanliness standards of the environment and equipment; including increased cleaning resources in wards and departments to cover 7 days a week, increased cleaning frequency of patient equipment, and regular audits to monitor standards and rectify issues if identified.

Mandatory statement 25 – Patient Safety Incidents



The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The performance shown is for the latest and most recent reporting periods that is available to the Trust internally. The table below shows a breakdown of the category of incidents for the year. Actions being taken on the basis of this information includes:

- An in-depth review of incidents relating to delayed procedure, treatment and diagnosis which was reported to the Patient Safety Steering Group in April 2022.
- A thematic review of low and no harm incidents, with a view to identifying near misses and other themes to help inform patient safety priorities for 2022/23
- eLearning in Patient Safety for all staff on the new National Patient Safety Syllabus to be launched in 2022.
- Patient Safety Incident Response Framework planning being undertaken on the basis of fewer but higher quality investigations focusing on learning and improvement.

Category of Incident	April – March 2023	March-23
Treatment or Procedure	54	4
Infection Control	40	4
Clinical Assessment of Review	38	10
Patient Falls	34	3
Tissue Viability	32	2

Category of Incident	April – March 2023	March-23
Obstetrics	13	2
Medication	11	3
Discharge Transfer or Transport	10	1
Admission	8	3
Image Report Incident	8	0
Service Provision	4	0
Appointments	3	1
Documentation	3	0
Medical Device or Equipment	3	1
Health & Safety – Accidental Injury	2	0
Safeguarding	2	0
Blood Transfusion / Products	1	0
Health & Safety – Ill Health	1	0
Nutrition	1	0
Staffing	1	1

Part 3

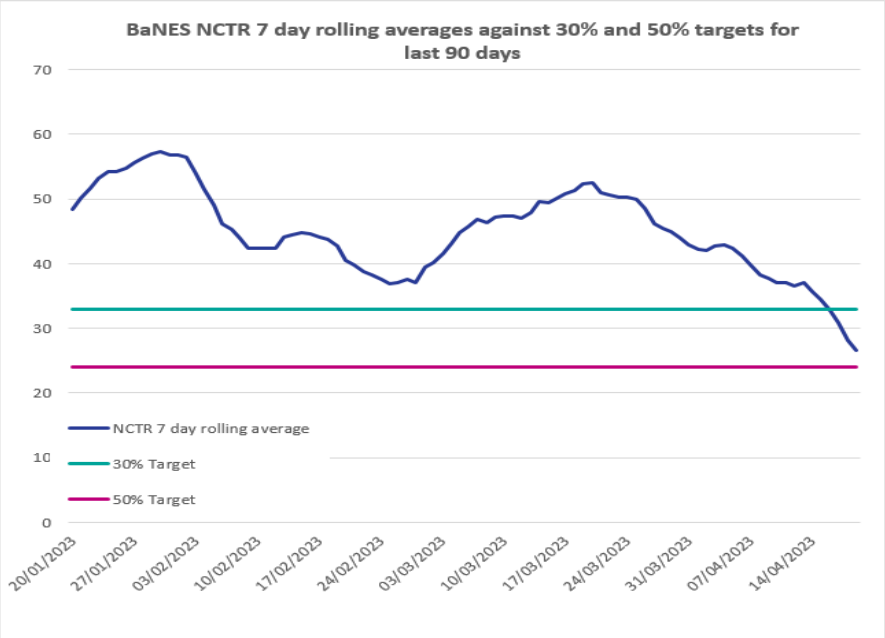
Other information

- **Patient Experience**
- **Clinical Effectiveness**
- **Patient Safety**

Patient Experience

Home is Best

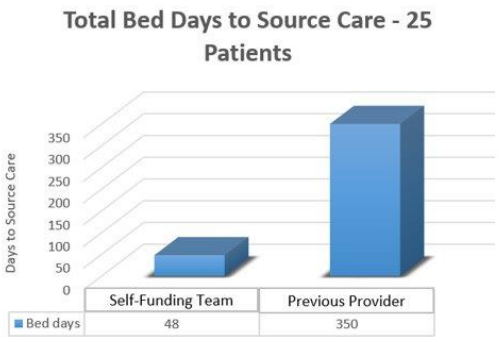
Home is Best is a transformation programme working with BaNES partner organisations from the Council, HCRG Care Group, Voluntary Sector and BSW ICB. The aim of the programme is to improve patient's pathways in order to reduce Length of stay, Non Criteria to Reside Numbers and encourage more people to be discharge home. Whilst this is a vast ongoing programme we have achieved the following so far on our journey:



Self-Funding Service

The introduction of this service helps patients and their families navigate processes to arrange self-funding care packages or nursing homes. The initiative focuses on supporting patients directly from the acute or at the end of their Discharge to Assess pathway. Within the first 6 weeks of the initiative it saved over 300 bed days and since October the team has now worked with over 200 patients.

The benefits of this pathway helps to improve patient experience, releases clinical teams to focus on clinical tasks and reduces length of stay. This service is continuing to expand and develop and will look to support other to improve patient flow and experience for those in other localities linked with the RUH.



Complex Pathway

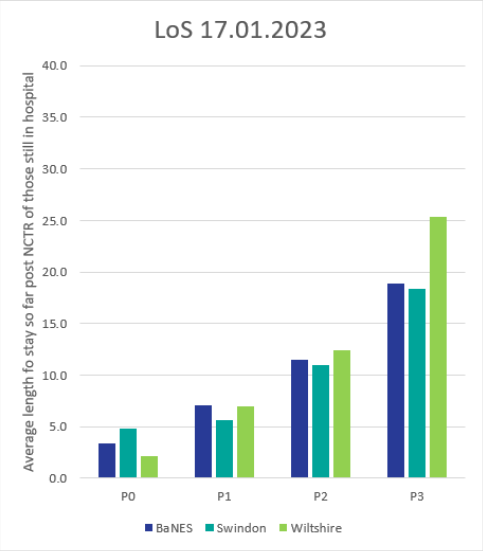
We have introduced Complex Pathway reviews within the acute to identify complex patients earlier in their journey. The process works with teams both from the acute and the community to reduce delays and provide professional challenge to provide the best outcome for our patients. We have seen a reduction in our complex patients as a result of this process.

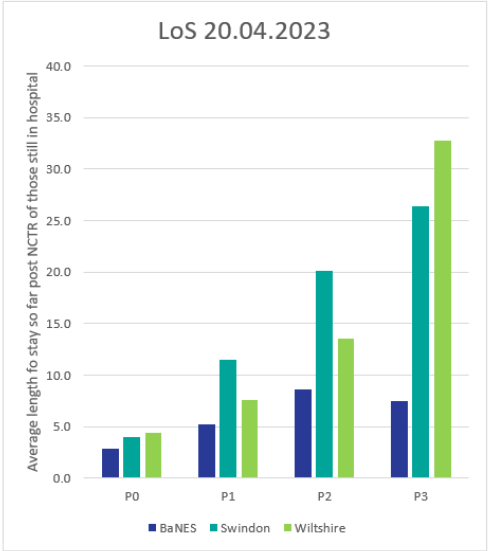
Community Wellbeing Hub at the RUH

Through the Home is Best work we have worked with voluntary sector leads to create a Community Wellbeing Hub in the atrium of the RUH. The hub provides support and advice for all and signposts patients, carer's staff and the public to voluntary sectors who can help with a range of needs, these may include housing concerns, financial issues, social or mental health needs and support for carer breakdown. This work is both preventative and supportive to our community.

The next step is the development implementation of an electronic questionnaire which helps to identify the needs of our patients on admission which then automatically refers to community voluntary services for support. The aim is to reduce delays for our patients and complexity for our staff navigating systems to identify the right service for discharge.

The above just highlights a few of the initiatives we have been working on others include cultural change in describing and prescribing discharge pathways, improvement work with our Discharge Liaison Team, Expansion of the Home Care market and repurposing of flow calls to focus on discharging home instead of to bedded pathways.





Length of Stay

The BaNES system has also shown good progress on Length of Stay.

All pathways are showing significant reductions on LoS:

- 17% reduction for P0
- 26% reduction for P1
- 25% reduction for P2
- 60% reduction for P3

Hospital@Home

The RUH Hospital@Home service has seen over 900 patients since its inception. The concept is simple – to look after patients, who remain acutely unwell and ordinarily requiring hospital care, in their own home environment utilising daily visits to provide IV medication, oxygen and monitoring with the oversight of a medical team led by a Consultant Geriatrician.

This initiative has released a significant amount of bed days and crucially reduces the in hospital deterioration that usually ensues with an acute admission, particularly in frailer, older adults. Returning patients to their own homes reduces physical, cognitive and emotional deconditioning and provides the frames of reference which are vital to recovery.

One such patient, a 73 year old man, normally independent and mobile at home, was admitted severely unwell with sepsis. After initial treatment he stabilised physiologically but was find to have widespread Staphylococcal Aureus infection on PET scan.

During admission he had become increasingly withdrawn and emotionally fragile and had begun to become less mobile, sleeping and eating poorly. The Hospital@Home team assessed him and liaised with his medical team and also a number of other specialties. The team discussed the relative risks of staying in hospital versus receiving IV therapy at home with close observation. The patient was very keen to get home and recognised the opportunity to be in his home environment. The alternative was at least 6 weeks receiving IV therapy in the hospital. He was very tearful as he could not envisage remaining in hospital, away from his wife, dog and home. He was unable to sleep or eat in hospital which he recognised were the absolute building blocks of his ability to improve and get better.

Hospital@Home took him home and continue to visit daily to give IV antibiotics. They have formed a close trusting relationship with the patient and his wife. He is feeling much better and sleeping, eating and gaining weight. He continues to be discussed with specialty colleagues and is brought back in to the RUH for repeat PET scans. His quality of life has improved ‘phenomenally’ as he had been ‘at the depths of despair’ and suicidal whilst being an inpatient.

Hospital@Home continues to take patients home to provide excellent, high quality care in the home which allows patients to get better quicker from acute illness and reorientate to their home environment while doing so. The qualitative feedback received has been exemplary and we continue to be asked to describe our service to national and international colleagues who are keen to set up similar services.

Perinatal Pelvic Health Service

The NHS Long Term Plan set out a commitment to ensure that "women have access to multidisciplinary pelvic health clinics and pathways across England" by March 2024. Further, In July 2020, the Independent Medicines and Medical Devices Safety Review recommended that "Conservative measures must be offered to women before surgery. We have heard that specialist pelvic floor physiotherapy cannot match the current demand. The service commissioner should identify gaps in the workforce… A coordinated strategy can then be developed to remedy the gap."

Currently a number of women live with pelvic floor dysfunction including urinary incontinence (1:3), faecal incontinence (1:10) or pelvic floor prolapse (1:12), this is often related to pregnancy and birth (NHS England, 2021). During our service engagement work we have heard from young, active women with babies who are not able to leave the house for fear of incontinence, who become socially isolated and suffer psychological trauma as a result of pelvic floor dysfunction.

Maternity have now launched a new Perinatal Pelvic Health Service. The service is currently accepting referrals from health care professionals and will be opening up to self-referrals once we go live with our digital platform.

We have been supported by NHSE with funding for a team including a perinatal pelvic health lead midwife and physio who will ensure the service can;

1. **Embed evidence-based practice in antenatal, intrapartum and postnatal care** to prevent and mitigate pelvic floor dysfunction resulting from pregnancy and childbirth.

2. **Improve the rate of identification of pelvic floor issues** antenatally and postnatally.

3. **Ensure timely access to NICE-recommended treatment** for common pelvic health issues antenatally and postnatally.

The anticipated benefits of the service include:

- Reduction in 3rd and 4th degree tears at birth (anal sphincter injuries)
- Reduction in the requirement for surgical intervention for pelvic floor dysfunction
- Reduction in the stigma of pelvic floor dysfunction and life-long improvement for women

The service will offer a three tier service for all women and birthing people from conception to 12m postnatal. Tier will be determined by self-assessment questions, to be completed prior to the first midwife contact, in the 3rd trimester and in the immediate PN period.

Tier 1 - Universal care – access to a digital information platform, additional training for midwives, self-assessment tools. C. 5,000 women

Tier 2 - Targeted Care - women with identified risk factors and mild incontinence - access to a face to face workshop with f/u if required. C. 1,200 women

Tier 3 – Intervention – symptomatic women and those with significant intrapartum risk factors - face to face clinic appointment, assessment of pelvic floor symptoms, advice and treatment. C. 720 women

Specialist Perinatal Pelvic Health Clinics commenced in April 2023 and we will soon be rolling out workshops and additional clinics in the community.

We are currently collecting feedback from service users through a survey, a postcard with the details of the service including the link to the survey is provided to all women in the postnatal period to allow for monitoring of the effectiveness of the service.

Antenatal Education Films

In 2020, face to face antenatal classes were abruptly ceased due to the Covid-19 pandemic and restrictions related to social distancing. A series of films were produced using a mobile phone, these were highly popular and data showed high levels of access to the films. The films demonstrated that there is a high demand for quality information from women and families.

Informed decision making is a central part of personalised care and support planning. It means that anyone receiving care is fully supported and informed to understand the options, decisions and care that they will have. Informed decision-making means that everyone receiving maternity care has help to:

- Understand the options available and the risks and benefits of these options
- Make decisions about their care
- Receive reliable, clear information in good time and in a format they understand

The Maternity Voices Partnership Plus (MVPP) supports the coproduction of maternity and neonatal services, providing the voice of the service user by supporting feedback mechanisms. Feedback from the MVPP demonstrated that women would like to see additional films, including information around water birth. As a Trust, we also wanted to produce more professional looking films due to the ongoing use.

A series of twelve antenatal education films entitled ‘Hello Baby’ have been coproduced with a range of professionals across the Local Maternity and Neonatal System (LMNS) and service users. The films aim to empower women and birthing people in the region to make informed choices about where and how they would like to birth their baby. Whether that be at home, in a midwifery-led unit or in a hospital, the films give all the information they need to prepare for the birth of their baby. The films cover everything from preparing their body for birth, to the role of their support person right up to the first hour after birth.

Everyone's birthing experience is different, however, we realised that there were huge disparities between the information that was available to women and birthing people and their families across the area. We wanted to make sure that everyone had equal access to the same evidence-based information to be able to make choices that felt right for them and their baby. The films will be available in the top spoken languages in the area and will be subtitled to ensure information is accessible to all those who use our services.

The films have been a hugely successful collaboration between our three acute hospitals RUH, GWH and Salisbury, our freestanding midwifery-led units Chippenham and Frome and our Maternity Voices Partnership.

The films will be available online, in waiting areas and as part of antenatal classes and it is anticipated that it will support families to make decisions about their care along with their Midwife or Doctor.

Enhanced Pre-Operative Assessment Clinic (POAC)

When a surgeon books a patient for an operation, they then need to have their pre-operative assessment before they can be booked for surgery. During 2022/23, the Pre-Operative Assessment Clinic (POAC) felt that they could improve services to ensure that urgent cancer patients could be seen more quickly. Prior to intervention, patients would complete an online pre-operative assessment form (MyPreOp). Once this form was completed and submitted, it would be reviewed by a member of the pre-operative assessment team who would then decide if the patient needed to come in for a face-to-face nursing assessment, have bloods taken and undertake simple investigations such as an ECG.

The team changed the process and changed the pre-operative assessment service so that they had capacity to be able to see urgent cancer patients on the same day as the decision was made for surgery. This 'one-stop' assessment includes:

- Assessment by a pre-operative assessment nurse;
- Vital observations, bloods, MRSA screen and an ECG by an HCA;
- Assessment by a consultant anaesthetist.

At the point the surgeon lists a patient for an urgent cancer operation, they send a short online referral form to the pre-operative assessment department. The patient then comes immediately to the pre-operative assessment clinic for assessment.

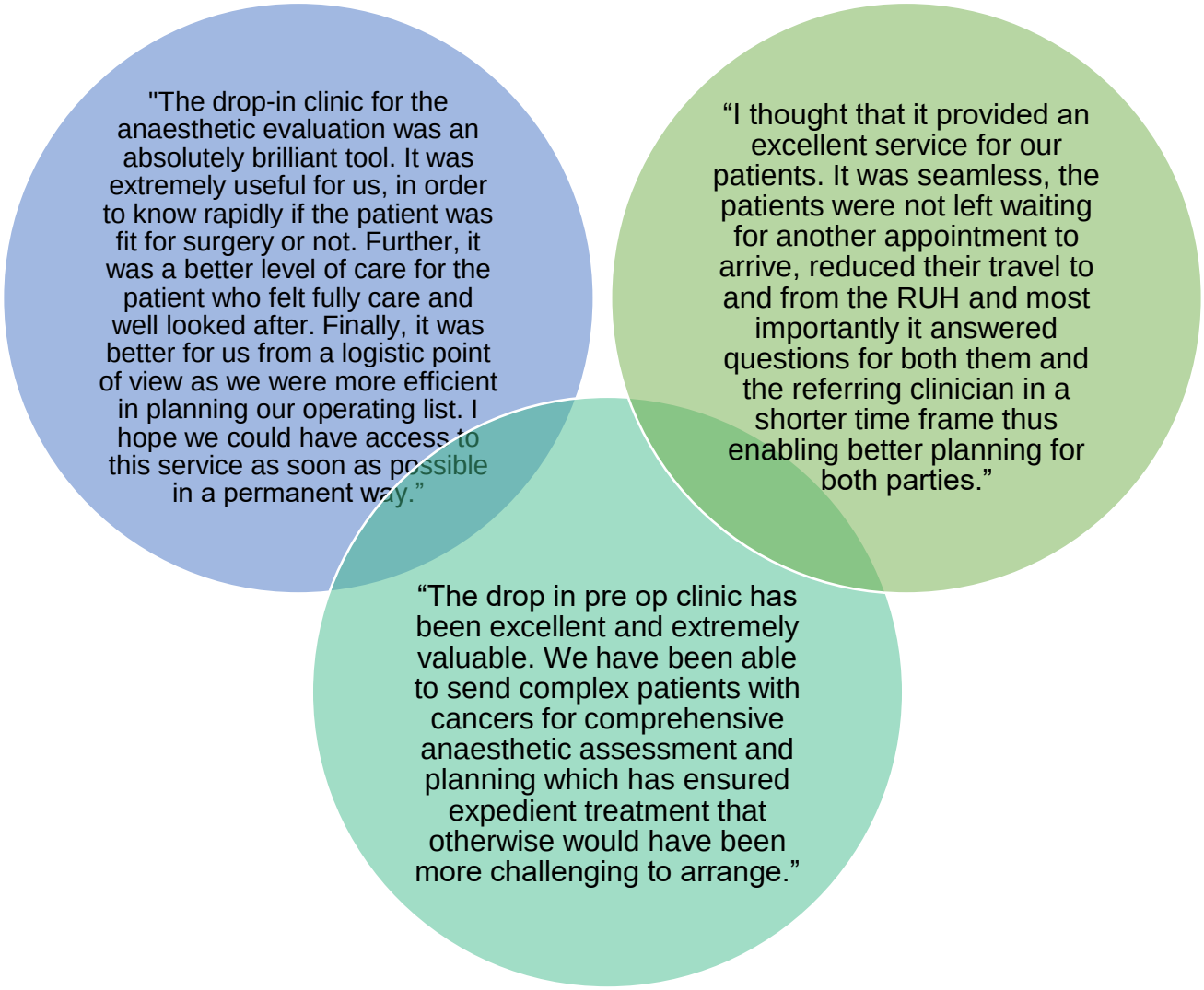
This new process:

1. Reduces the time taken for these patients to be ready for surgery.
2. Identifies comorbidity earlier in the patient's pathway.
3. Allows more time for optimisation prior to surgery.
4. Prevents the patient having to have multiple trips to hospital.

Since we started this service (28th November 2022 – 25th April 2023), the Trust has have seen 142 urgent cancer patients on the same day the decision for surgery was made.

A patient satisfaction survey was undertaken, and we asked 94/142 (67%) patients seen in this enhanced POAC about their experience. 100% patients were satisfied with the new pre-operative assessment process. (81% strongly agreed, 19% Agreed).

Staff feedback



Moving forward, we will work to continue to expand the numbers of patients we are able to see as part of this enhanced pre-operative assessment clinic to ensure urgent patients (including urgent, non-cancer patients) are ready for surgery as quickly as possible. Not only will this benefit our patients, but it will also have an effect on theatre efficiency.

Clinical Effectiveness

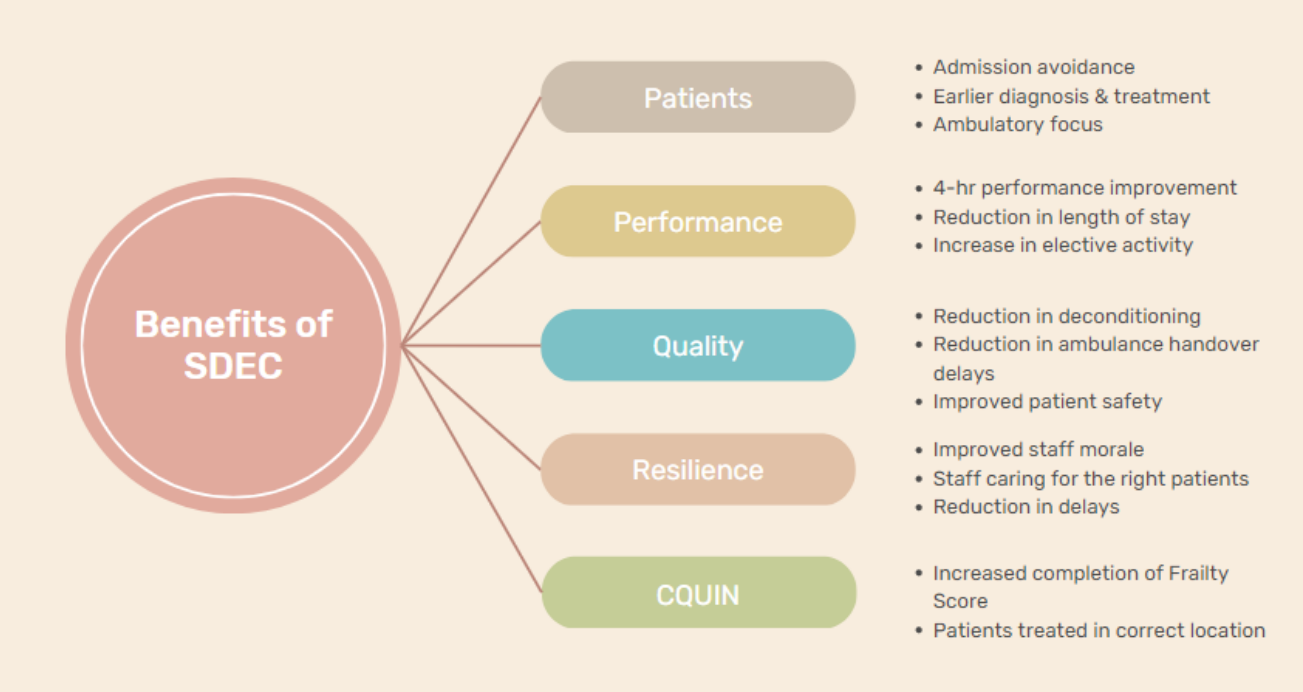
Same Day Emergency Care (SDEC)

There is a national drive to increase the Same Day Emergency Care (SDEC) offer NHS Acute Trusts provide. SDEC is care delivered within one day that previously would have resulted in an admission to hospital.

Every patient treated within an SDEC setting provides both a direct benefit to the patient who avoids admission and an indirect benefit by freeing up the bed for another patient, either another acute patient or an elective patient.

The aim of the NHS Long Term Plan is for all hospitals with a Type 1 Emergency Department, to provide SDEC services at least 12 hours a day, 7 days a week across Medicine and Frailty. Being able to provide SDEC services to patients allows them to receive more timely investigations and treatments, as well as have a higher chance of going back to their usual place of residence rather than being admitted to hospital. It also improves staff resilience and morale by treating patients more efficiently and caring for the right patients in the right area.

There are a number of SDEC units across the RUH including acute medicine, acute frailty, paediatrics, emergency surgery and trauma & orthopaedics. Some of these units run 24hrs per day, 7 days per week and some are open core hours; all with the ethos of providing ambulatory care for patients with rapid assessment and treatment in order to avoid unnecessary attendance at the Emergency Department or admission into a hospital bed.



In March, The RUH had a visit from the National lead on SDEC services and within their post visit report they highlighted;

- The culture of clinical leadership and engagement is palpable and you are leading the way in many areas

- The pressures were very clear and executive leadership were regularly engaged with the teams, visible and wanting to make the right choice to stop bedding SDEC.
- Development across all areas. happening within each area, i.e. surgical with staffing and gynae / medical with the DDA area
- The areas all felt busy but light/spacious and calm, good patient waiting areas and, therefore, experience
- The orthopaedic SDEC was way ahead of the curve

Currently the RUH are able to discharge 36% of its patients on the same day as a result of its SDEC services. The Trust is also implementing plans this year that will ensure all of its SDEC services are operating at least 12 hrs a day, 7 days a week. We have set an ambition to match the best performing hospitals for SDEC services and are aiming to get to 43% of patients discharged on the same day.

Artificial Intelligence (AI) analysis of CT scans of the lungs

In collaboration with the University of Bath and two commercial companies (AIDOC and Imbio), the Respiratory Radiology research team at RUH were one of just nine successful applications in 2022 for a national NHSX grant to investigate Artificial Intelligence (AI) analysis of CT scans of the lungs looking for blood clots (pulmonary embolism or PE). The project, attracting a £830K grant, begins in April 2023 and will bring both national recognition and significant investment to the RUH.

Correct identification of PE is important as it represents a common presentation to the hospital (up to 200 cases per 100,000 people in the UK each year). The mortality rate if untreated is 30% but even with identification and treatment remains high at 8%. A National Confidential Enquiry report in 2019 identified areas of CT reporting where improvements could be made to improve patient outcomes, including potentially saving hospital bed days.

This project is designed to test the use of AI in assisting radiologists to diagnose PE. It will also help assess disease severity, allowing clinicians to be alerted in real time when more urgent intervention is required. Both aspects address some of the concerns raised by the National Confidential Enquiry - and builds on existing work carried out at the RUH that has already been published in peer-reviewed journals and presented at national and international meetings.

The grant also funds experimental work at the University of Bath developing a further novel AI tool which may lead to additional long term benefits in this patient cohort.

The outcome of the project is readily transferrable to all NHS Trusts without the need to alter their existing scanning capability. As such it potentially puts the RUH in a position to help drive change in this common, but deadly disease, at a national level.

Patient Safety

Patient safety is at the heart of everything we do at the RUH and everyone feels passionately about it. We have an amazing team of staff who do their utmost for our patients and staff every day, often going above and beyond their duties. Our aim is to build a culture of safety and continuous improvement to make our hospital as safe as possible for our patients and staff, and for everyone to have a satisfying experience.

National Patient Safety training has been developed to support staff to understand how we can all work together to improve patient safety.

RUH Patient Safety Improvement Programme

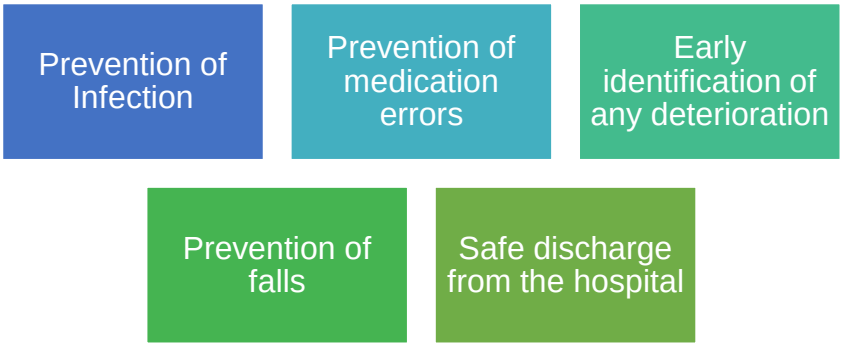
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

As part of moving towards the new PSIRF framework, the patient safety teams at the RUH have analysed details of incidents, inquests, complaints and other reviews to develop our Patient Safety Priorities for the next 3 years from 2022- 2025.

These are:



For the first year from November 2022 to December 2023, we have set a 'Back to Basics' campaign and identified one key action for each of the priorities that all staff can do and if we all do, they will make a major impact in improving these areas.

These are described in our Patient Safety Campaign poster below.

Improvements in Day Surgery

Post COVID-19 the surgical bed base was reassessed with the vision to reinstate a day surgery unit. Robin Smith became a dual functioning ward, with one half being for overnight elective patient's, and the other for non-elective flow. The Surgical Short Stay Unit (SSSU) also became a dual ward, with non-elective flow and day case patients. This change was due to the layout on SSSU being originally built as a day case unit. The Trust increased our elective capacity overnight from a 28 bedded ward to 15 beds (Robin Smith) and 19 trollies (SSSU) which can be used twice during the day, whilst maintaining the bed base for non-elective flow.

Following the pandemic, the focus for the Trust has been on elective recovery and reducing long waits for elective surgery. Robin Smith was the ward for elective patients during COVID-19 and worked extremely well keeping our patients safe and maintaining elective activity, however the Trust needed to increase capacity.

This change has had a big impact for our patients. We have been able to increase our elective day case activity and we have seen a 5% increase of patients being treated January-March 2023 compared with January-March 2022. Having the whole patient journey from admission to discharge within 1 unit has enabled the Trust to provide a smoother journey for our patients.

One particular improvement the department has been able to implement has been the capacity for patients needing extra support (including learning disabilities). There are now two side rooms and two consulting rooms, all of which can be allocated specifically to patients – the department has a great team of specialist nurses and anaesthetists that go above and beyond to ensure these patients get the best possible experience.

The Executive Team has committed to make SSSU a Day Surgery Unit from June 2023, thus increasing capacity further to 33 trollies (66 per day). Building works are also planned to further increase capacity by additional 5 trolley/chair space and create a much needed waiting room within the unit.

British Association of Day Surgery (BAD) Day case rates

	January	February	March	Average
2022	80.47%	77.01%	78.34%	78.60%
2023	85.10%	81.70%	83.50%	83.43%

Maternity Incentive Scheme Update

The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the Maternity Incentive Scheme (MIS).

The Maternity Incentive Scheme (MIS) establishes 10 safety actions to support safer maternity care. Trusts that can demonstrate that they have achieved all 10 safety actions in full recover the additional 10% of the maternity contribution charged under the scheme, plus a share of the monies paid in to the scheme by the hospitals that did not achieve.

In January 2023, the Divisional assurance panel, led by the Director of Midwifery and Clinical Lead for Obstetrics were satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions met the required safety actions sub-requirements as set out in NHS Resolution's (NHSR) safety actions and technical guidance document. The Board Level Safety Champions also had the opportunity to discuss the evidence and level of assurance provided.

Full compliance with all 10 safety actions was therefore confirmed and as a result the Board of Directors their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The Board declaration form confirmed that:

- The Board of Directors were satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions met the required safety actions' sub-requirements as set out in the safety actions and technical guidance document provided by NHSR.
- There were no reports covering either year 2021/22 or 2022/23 that related to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.).

By demonstrating and providing evidence that the Trust has achieved all of the safety actions required for CNST, the Trust has proven that it has worked hard to make the maternity unit as safe as possible for the families and staff in their care.

Annexes

Letters of Assurance

The following were all invited to comment and provide assurances on the content of the Royal United Hospitals Bath NHS Foundation Trust Quality Account 2022/23:

- BaNES Swindon and Wiltshire Integrated Care Board
- Bath and North East Somerset (BaNES) Council Overview and Scrutiny Committee
- Wiltshire Council Overview and Scrutiny Committee
- Healthwatch BaNES
- Healthwatch Wiltshire

Copies of the responses received have been attached in this Appendix, along with a Directors' Responsibilities Statement which has been signed by the Chair of the Hospital and the Chief Executive.

Annex 1 – Statement from XXX

Annex 2 - Statement of Directors responsibilities for the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account is not inconsistent with internal and external sources of information.
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the quality account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with National Health Service (Quality Accounts) Regulations 2010.
- There is no longer a national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account for 2022/23. Therefore, no limited assurance report is available on the Quality Account report in 2022/23.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

SIGNATURE

Alison Ryan
Chair

SIGNATURE

Cara Charles-Barks
Chief Executive

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NHS
Salisbury
NHS Foundation Trust

Quality Account 2022/23

Glossary of Terms

ACP	**Advanced Clinical Practitioner** *An experienced healthcare professional with a Masters level award or equivalent qualification*
BAF	**Board Assurance Framework** *A document used to report strategic objectives, risks, controls, and assurances to the board*
BAME	**Black, Asian, and Minority Ethnic**
BAUS	**British Association of Urological Surgeons**
BSOTS	**Birmingham Symptom Specific Obstetric Triage System** *A maternity triage system which involves an assessment of patients to determine how urgently they need to be seen*
BSW/ BSW Partnership	**Bath and North East Somerset, Swindon, and Wiltshire Partnership** *An integrated care system made up of NHS and local authority care organisations*
CCG	**Clinical Commissioning Group** *These groups commission most hospital and community services for the area that they serve*
C.diff	**Clostridium Difficile** *A type of bacteria that commonly causes diarrhoea*
CESG	**Clinical Effectiveness Steering Group**
CIG	**Clinical Implementation Group**
CMB	**Clinical Management Board** *This is a senior operational committee responsible for monitoring the quality-of-care provision including oversight of patient safety, patient experience and clinical effectiveness*
CMO	**Chief Medical Officer** *An individual responsible for overseeing the medical operation of a hospital, formally known as the Medical Director*
CNO	**Chief Nursing Officer** *An individual responsible for overseeing the nursing operation of a hospital, formally known as the Director of Nursing*
COVID-19	**Coronavirus Disease** *An infectious disease caused by the SARS-CoV-2 virus*
CNS	**Clinical Nurse Specialist** *An advanced practice nurse*
CQC	**Care Quality Commission** *The independent regulator of health and adult social care in England*
CQUIN	**Commissioning for Quality and Innovation** – *A framework for supporting improvements in the quality of services and the creation of new, improved patterns of care*
DoLS	**Deprivation of Liberty Safeguards** *A set of checks under the Mental Capacity Act 2005 which provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm*
DPWG	**Deteriorating Patient Working Group**
DSP	**Data Security and Protection**
EOLC	**End of Life Care**
EPMA	**Electronic Prescribing and Medicines Administration** *An electric system which helps to facilitate and enhance the communication of a prescription or medicine order*
ERS	**Employer Recognition Scheme** *Encourages employers to support defence and inspire other organisations to do the same*
FFT	**Friends and Family Test** *A feedback tool that anyone can use to give quick, anonymous feedback to providers of NHS services*
GIRFT	**Getting It Right First Time** *A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change*
H@NT	**Hospital at Night**

HEE	**Health Education England** *A body of the Department of Health and Social Care that supports the delivery of excellent healthcare and health improvement to the patients and public of England*
ICB	**Integrated Care Board** *Each Integrated Care System (ICS) will have an Integrated Care Board (ICB). This is a statutory organisation that will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS*
ICS	**Integrated Care System** *A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area*
IG	**Information Governance**
IPC	**Infection, Prevention, and Control**
IS	**Independent Sector**
MCA	**Mental Capacity Act** *A law which is designed to help people who cannot make decisions for themselves because they lack the mental capacity to do so*
MCCD	**Medical Certificate of Cause of Death**
ME	**Medical Examiner** *A senior medical doctor who is trained in the legal and clinical components of the death certification process*
MEOWS	**Modified Early Obstetric Warning Score** *A scoring system which helps to determine the severity of illness in patients which has been adapted for the normal physiological changes seen in pregnancy*
NC2R	**No Criteria to Reside** *Patients who are medically fit for discharge*
NEWS	**National Early Warning Score** *A scoring system which helps to determine the severity of illness in patients*
NHSE/I	**National Health Service (NHS) England/Improvement**
NICE	**National Institute for Health and Care Excellence** *A body of the Department of Health and Social Care that produces guidelines*
OMG	**Outbreak Management Group**
OP	**Outpatient**
OPAL	**Older People's Assessment and Liaison service** *Provides early comprehensive geriatric assessment to prevent avoidable admissions and remove the barriers which can lead to longer stays in older patients*
OPTB	**Outpatient Transformation Board**
PALS	**Patient Advice and Liaison Service** *Offers confidential advice, support and information on health-related matters and provides a point of contact for patients, their families, and their carers'*
PCN	**Primary Care Network** *A network of GP Practices working together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local area*
PPE	**Personal Protective Equipment**
PROMs	**Patient Reported Outcome Measures** *Assess the quality of care delivered to NHS patients from the patient perspective*
PSIRF	**Patient Safety Incident Response Framework** *Outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted*
RCEM	**Royal College of Emergency Medicine**
SDEC	**Same Day Emergency Care**
SDH	**Salisbury District Hospital**
7DS	**Seven Day Services**
SFT	**Salisbury NHS Foundation Trust**
SHMI	**Summary Hospital-level Mortality Indicator** *The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of the patients being treated*

SJR	**Structured Judgement Review** *A process for undertaking a review of the care received by patients who have died*
SOX	**Sharing Outstanding Excellence** *A method of paying a compliment to a team or a member of staff and a way of learning from when things go well*
VTE	**Venous Thromboembolism** *A blood clot that starts in a vein*
WHC	**Wiltshire Health and Care** *An NHS Partnership focused on community services in Wiltshire*

Contents

Introduction

Quality accounts, which are also known as quality reports, are annual reports for the public that detail information on the quality of services the Trust provides for patients. They are designed to assure patients, families, carers, the public and commissioners that the Trust regularly scrutinises the services it provides and concentrates on those areas that require improvement.

Quality accounts look back on the previous year's performance explaining where the Trust is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement resulting from consultation with patients and the public, our staff, and Governors.

Part 1 – Statement on Quality from the Chief Executive

I am pleased to present our quality account for 2022/23 for Salisbury NHS Foundation Trust, which shows how we have performed against our priorities this year and sets out the main areas of focus for 2023/24.

One of the ways in which the quality of care provided by colleagues is recognised is through SOX Awards, this stands for Sharing Outstanding Experience. Anyone can nominate and last year 18 patient-nominated SOX awards were given. There are many wonderful citations and the following are just two examples of some of the outstanding service delivered.

Patient citation:

"I am forever in Alex's debt for not giving up on my daughter. Alex showed incredible patience and persistence while my daughter struggled with her injury, pain levels and mental health. Her patience, persistence and broad and varied approach led to my daughter having 1:1 sessions, often outside of work hours to enable her to be fitted in, and enabled both my daughter's ankle to improve and her constant pain to subside. She can now do some sport, walk to school again and meet friends in town.

"However, I believe the greatest gift Alex has given to my daughter from her treatment has been the improvement to her mental health. My happy and positive daughter has been returned to me, her anxiety is significantly reduced and she has not had a panic attack for over a month. She sleeps well and is now improving both educationally and socially. The significance of this to not just my daughter but our entire family, after over two years of struggling with the injury, cannot be over-estimated."

Colleague citation:

"Kay identified that a patient's elderly relative could be in a financially vulnerable position from a conversation that she had with the patient. Although not directly in her scope of control, Kay was unwilling to risk this individual being exploited and made multiple phone calls to other agencies to highlight the issue she had identified and prompt an action plan. I could see the deep impact that this situation had on Kay, and I admire the proactive action she undertook in safeguarding a vulnerable adult that she had never met.

"Kay demonstrates the principles of safeguarding and sets an example to all of us in how to approach complex situations. She would never leave it to anyone else to act, and always assumes that duty of care."

Improving Together, our way of delivering effective, sustainable changes where it matters most continues to deliver tangible benefits to our people and our population. I am

pleased to share that our Respiratory Department has cut its waiting lists by more than 43% in the last year, one of the fastest improvement rates in our hospital. They achieved this with a marginal-gains approach that cumulatively saved time. The team identified pathway bottlenecks and used a range of techniques including validating waiting lists to find discharge candidates, creating access plans to digitise waiting lists, redesigning clinics to make them more efficient and booking weekend clinics. The team's achievements demonstrate that continuous improvement does not need to be daunting.

Also, under the Improving Together umbrella, our Stroke Team on Farley Ward have adopted one of the essential tools, called Improvement Huddles, into their daily routines. Huddles involve multi-disciplinary participants coming together on a regular basis to share and discuss the progress they are making towards achieving their driver metrics (see more on driver metrics on page 14). In Farley's case, not only has it helped them to reduce the number of falls that occur on the ward it has also significantly improve communication across the team.

We recognise that the legacy of the COVID-19 pandemic and pressure on the NHS and care workforce has continued to impact on the level of care some patient's experience. We have made progress on tackling some of the waiting times for elective surgery and are pleased that work is now well underway to build a new ward that will further help reduce the waiting times. A new surgical robot is being installed and will be operational this summer, further enhancing our surgical services.

Staff are our most valuable resource and we have launched a series of successful recruitment initiatives to fill vacancies in key clinical and non-clinical areas across the Trust. We want all our staff to flourish and develop their skills so they can provide ever better services to our community. We have expanded our focus in this area with several initiatives that include more staff networks, health and wellbeing conversations, monthly recognition awards, regular staff treats and rewards, access to a staff counsellor and a staff physiotherapy service. We have also improved the entry-level rates of pay for our Healthcare Assistants, our housekeeping and clerical staff.

I would like to close by expressing a heartfelt thank you and appreciation on behalf of the Trust Board to each and every member of our staff for everything they have done and are doing each day in service of the communities we serve. We could not do this without the contribution from each and every one of them.

To the best of my knowledge the information in this document is accurate.

Stacey Hunter
Chief Executive Officer

2A - Priorities for Improvement

Salisbury NHS Foundation Trust

In this part of this section of the Quality Report, we outline areas for improvement in the quality of health services that are provided by Salisbury NHS Foundation Trust.

Quality Priorities for 2023/24

Introduction

Our Vision and Goals

Our vision at Salisbury NHS Foundation Trust is to **provide an outstanding experience for our patients, their families and the people who work for and with us.**

To deliver the NHS Long Term Plan and the Trust vision we needed to develop the way in which we all work together and learn. Therefore, in 2020 the Trust undertook a significant conversation with staff. This conversation enabled staff to express in their own words what it felt like to work at the Trust.

In response to this consultation and other available information, such as the annual national NHS staff survey and exit interviews, the Trust Board and colleagues considered how best to build on what was discovered and what was already being done, and how to act to improve our culture, behaviours, and management processes to deliver our vision, strategic priorities, and goals.

The Trust planned to deliver on this re-prioritisation work through the launch of its new strategy in 2022/23, which was driven by a programme of work called *Improving Together*, with priorities being identified under the three strategic themes of **People**, **Population**, and **Partnerships**.

Improving Together

Improving Together is an approach that colleagues in other Trusts locally and across the country have already been engaged in to deliver sustainable long-term improvement. At Salisbury NHS Foundation Trust, this is now the way in which the whole Trust will develop and improve skills, processes, and behaviours and ultimately the mechanism by which we will deliver our new strategy. With the simple goal of delivering an excellent experience for patients, their families, and staff, and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work.

Bringing together many improvement initiatives already underway, this programme is the vehicle which will enable our people to improve their skills, help remove things that staff feel block them from delivering outstanding patient experiences every time and will enable us all to provide the care we aspire to. At its heart, the programme makes sure that our ongoing priorities and the things we focus our time and energy on will help deliver our vision of an outstanding patient experience, while bringing our values to life and offering new development and training opportunities to staff across the organisation.

Our Improving Together approach to delivering our strategy and continually improving will be maturing beyond initial implementation throughout 2023/24. Across the three acute Trusts in Bath and North East Somerset, Swindon, and Wiltshire Partnership (BSW) we are now rolling out Improving Together to align and enable the collective abilities of our workforce to transform and continually improve our services. We are seeking to align our direction, goals, and objectives whilst empowering teams at all levels to maximise their contribution and potential in a focused approach. We are focusing on setting clear expectations and using a coaching leadership style to support problem solving.

Our Key Priorities

As per the Health and Social Care Act of 2012, the NHS has a duty to continually improve the quality of care being delivered across a range of health services.

In 2023/24 we plan to improve the quality of care primarily through the Trust's Improving Together programme and the work that feeds into the selection of our primary 12–18-month objectives (widely known as our 'Breakthrough Objectives')

Quality is defined as having three dimensions: patient safety, clinical effectiveness, and patient experience, and each of these areas are represented by their own steering groups at the Trust. Specific priorities and objectives which are identified from these steering groups are routinely discussed, and then upwardly reported to our Trust Quality Board.

Through this process, and in addition to the work of Improving Together, our key priorities for 2023/24 have been identified. These are outlined in this section of the report.

Priority 1: Delivering Quality and Patient Care through Improving Together

Improving Together enables us to focus on making improvement part of our daily work, fostering a culture of continuous improvement, and developing leaders as coaches. The operating model integrates improvement into the daily life of teams at three levels.

1. Executives reduce the number of priorities and coach teams to solve problems.

2. Managers work on a set of focussed priorities with clear and consistent performance reviews.

3. Frontline teams understand the Trust's strategy and priorities and their role in delivering them. Our goal is for **all** staff to be empowered to make improvements.

The Strategic Planning Framework (appendix A) sets out our areas of focus to achieve our vision and strategy. Nine vision metrics, three under each pillar of the strategy, describe our overarching goals for the next 7-10 years. The vision metrics are how we will measure the progress of achieving our vision.

The strategic initiatives focus on the things we must do and can't fail at to build the foundation for the delivery of our vision. These are large programmes of work with a 3–5-year lifespan.

Cascading from our vision are our three strategic priorities, known by staff across the organisation as 'the three P's'. **People**, **Population**, and **Partnerships**.

Breakthrough objectives are focused at Trust level and targeted for significant improvement (20-30%) within 12 months. Using data to guide our decision making, these have been selected to make the most positive impact on achieving our overall vision and improvement goals. Under-pinning these are a series of metrics (driver-metrics) which govern the process of how the quality of patient care is delivered across the organisation. These are monitored within the individual clinical specialties and are upwardly reported, such that, depending on what the data is telling us, these metrics might form one of our high-level breakthrough objectives in the future. Equally one of our breakthrough objectives might also become a driver-metric should our performance or priorities change in the future.

This is intended to be a seamless process such that every 12-18 months the organisation can focus resources into the areas which will provide the maximum impact for our patients, population, and partnerships. At the same time, improvements in quality and the delivery of patient care will continue to be delivered as part of our core businesses as usual.

Our 12-18 month 'Breakthrough Objectives' for 2023/24, targeting key contributors to these challenges, and which will be driven by our data are:

✓ Bed occupancy

This focusses our energy on reducing the average length of stay in hospital for our patients. This will include facilitating discharge, closing escalation beds, and releasing the potential for increasing elective activity. The national target is set at 92%, but as of March 2022 Salisbury NHS Foundation Trust was operating at 105% bed occupancy (figures exceeding 100% as escalation beds in-use). We are unlikely to achieve the national target this year as one ward is scheduled to be refurbished in May 2023, and escalation beds in South Newton will not be available beyond June 2023. Therefore, we locally **aim to achieve a target of 96% in 2023/24.**

✓ Reducing time to first outpatient appointment

This will focus us on further driving down waits for our patients and increasing our elective activity. We are aiming **to achieve a 30% overall reduction in waiting times** for our patients over the next 12-months. We recognise that there are some disparities internally across specialities in terms of waiting times, with the average waits being greatest across the clinical Divisions of Medicine and Surgery (110 and 136 days respectively). We aim **to reduce the time to first outpatient appointment from an average of 126 days down to 87 days in 2023/24**, by using the Improving Together approach for quality improvement.

✓ Staff availability

We will work to ensure we retain and recruit the appropriate workforce to support our activity and financial goals – this objective focusses us on having the people we need to realise our plan. **We aim to reduce agency spending on staff (as a percentage of gross pay) down from 8.5% (as per February 2023) to a locally agreed target of 3.7%.** We will achieve this by prioritising training of our own staff and closely aligning staffing numbers to the level of bed escalation. We recognise that there are sometimes patients on our wards who will require staff to have additional specialist knowledge for us to deliver the best possible care for our patients. We will ensure that this additional training can be delivered to our own staff, so that the need to employ external agency staff in the future will reduce. This will improve continuity of care and also provide cost benefits for the Trust.

✓ Reducing inpatient falls

With a far higher than average frail and elderly patient population, falls are a huge contributor to patient harm and increased length of stay. Falls in hospitals are the most reported patient safety incident and the severity of injury can sometimes depend on factors such as bone health, frailty, falls risk and weight. Therefore, it is important to assess older patients for factors that may increase their risk of falling, and to ensure that preventative measures are put in place. This was a quality priority last year, and we now intend to build on the improvements made in 2022/23 through the work of Improving Together, as we recognise the need to do even better at achieving our targets. Our aim will be **to reduce the overall number of falls to below 7 per 1,000 bed days in 2023/24**. *

**a bed day is a calculation of the total number of occupied beds each day for one month. The number of falls per 1,000 bed days can be calculated by dividing the number of falls by the number of bed days and multiplying the total by 1,000.*

The Trust-wide breakthrough objectives give focus to the top challenges facing the Trust by starting with the top contributor to the challenge. For example, our vision metric of total incidents with moderate or high harm show falls to be the top contributor, with pressure ulcers second. Through the Improving Together methodology we first focus on falls and once we have sustainably improved falls, we then move to focused improvement work on pressure ulcers. Where pressure ulcers are the top contributor for a ward or department we focus on pressure ulcers as the top contributor at a local level. This enables us to prioritise our work and resources to the biggest areas of potential improvement instead of spreading teams too thinly across multiple priorities at the same time.

Our approach to quality improvement doesn't stop at the four Trust-wide breakthrough objectives. The Improving Together approach feeds into our divisions, specialities, and teams. The areas of focus, known as driver metrics, for each division are listed below.

Driver metrics

Medicine

Falls

Time to first outpatient appointment

% Decision to Admit (DTA) < 4 hours

Time to Initial Assessment (ED)

Active available workforce (% staff availability in RN & HCA groups)

Surgery

Time to first outpatient appointment

Falls

Discharges before midday (%)

Theatres productivity (% capped utilisation)

Active available workforce (agency spend)

Women and Newborn

Time to first outpatient appointment

Clinical training compliance (% selected modules)

Clinical deterioration (% compliance with MEOWs and fluid balance audits)

Antenatal care pathways

Active available workforce (WTE gap between establishment and available)

Clinical Support and Family Services

DM01 Trustwide (seen within 6 weeks)

Medicines Reconciliation (% patients who have had their medicines reconciled within 24hrs of DTA)

Time to first outpatient appointment

Patient Complaints (% responded to within agreed turnaround times)

Staff Availability (% Agency spend)

Spinal Therapy (Hrs of therapy provided per week)

The driver metrics are the areas each division hold in the spotlight and are informed by both the four Trust-wide breakthrough objectives and the division's review of where their most pressing issues and risks are. Each driver metric is chosen based on a review of the data and evidence to validate a metric's relative impact on the performance, quality, and safety of our services. This approach enables our teams to focus on the most impactful interventions first as we work to continuously improve the quality of our services.

Similarly at a speciality and team level driver metrics are chosen. This ensures we can continually work on the most important areas of quality improvement at the Trust, division, speciality, and team level. Through this system Improving Together aims to give everyone the power to define and make continuous improvements to their services without the need for a top-down directions.

Alongside the driver metrics we keep the rest of the division, speciality or team's quality measures under review using 'watch metrics'. Watch metrics are measures of our quality and performance which are performing within safe, normal, or acceptable boundaries. They are 'watched' for deterioration or improvement, but our resources are not specifically targeted to that area of work. This enables teams to focus their efforts on our breakthrough objectives and driver metrics while being alerted if a watch metric significantly moves away from their usual performance.

Weekly and monthly reviews are used to keep track of improvements across teams, specialities, and divisions. With these rolling upwards to the monthly Executive Performance Review meetings between divisional management teams and the executive directors.

Patient Experience

IN 2023/24 WE AIM TO RESPOND TO 90% OF COMPLAINTS WITHIN AGREED TIMESCALES, AND TO ACHIEVE A MINIMUM RESPONSE RATE OF 15% USING THE FRIENDS AND FAMILY TEST

Priority 2: Improving our processes for managing complaints

One of our vision metrics (following gap analysis working through our Improving Together programme of work) is to improve our complaints process.

Our aim is to provide an accessible, supportive, and robust complaints process, that commits to putting the complainant at its heart. With a clear focus on improving response timescales, aimed at identifying and capitalising on opportunities for early resolution.

We fully acknowledge that we will never achieve a zero complaints threshold. Therefore, we are committed to ensuring that the process will be made as easy as possible and will be underpinned by a learning and just culture. We are committed to continuing to develop appropriate support and training for our staff and ensuring that complainants feel not only able to raise their concerns, but that they will be heard, and changes will be made where required.

Our priorities for quality improvement & why we have chosen them

Throughout 2022 the Trust embarked on a co-produced complaints process review project in partnership with Healthwatch Wiltshire (you can access the full report here). The learnings taken from this project will be implemented over the coming 12 months and will inform the changes needed for our complaints policy. In response to these findings, the key areas for improvement will be:

- ✓ **Simplification** of the initial process for raising a complaint and supporting complainants to clearly articulate their concerns and linking in with local advocacy services.
- ✓ **Working more closely with and supporting investigating managers** to improve accountability and identify opportunities for early and appropriate resolution.
- ✓ **More tailored and individual management of complaints**. This includes more frequent communications, and clearer information from the outset on who is managing the complaint and the support services that are available.
- ✓ **Continued development of the profile of the Patient Advice and Liaison Service (PALS)** to ensure its functions are clear for patients, visitors, and our staff. This will be an evolving piece of work initially mobilised through revised posters, leaflets, use of social media and internally through our ward based 'PALS Outreach Services'.
- ✓ **Improvements to content and accessibility for complaints and communications training for staff.** This will be underpinned by ensuring a clear understanding of the principles of the new PHSO Framework.

By working closely with our clinical Divisions we will ensure to develop more effective methods of publicising and celebrating improvements made to services as a direct result of complaints and concerns raised.

Clinical Effectiveness

WE AIM TO IMPLEMENT NEW COMPUTER SOFTWARE FOR MANAGING CLINIC AUDIT WHICH WILL BE FULLY EMBEDDED AND IN USE ACROSS THE TRUST BY OCTOBER 2023

Priority 3: Improving our processes for managing clinical audit

Clinical Effectiveness is defined as the application of the best knowledge, derived from research, clinical experience, and patient preferences to achieve optimum processes and outcomes of care for patients.

During 2022/23, significant transformation work began in order in improve the quality of patient care and safety for our patients. This included reviewing our current processes to increase efficiencies and improve our data reporting across the Trust. A primary objective has been to fundamentally change how data is reviewed and reported, such that our reporting is more heavily focused on patient outcomes rather than numbers and statistics. Each year, an excess of 300 audits are undertaken across the Trust, and subsequent outcomes and actions result in improvements to the quality of care which is delivered to our patients. It is therefore extremely important for us to understand which actions are likely to have the biggest impact for our patients, population, and partnerships, and to which areas we have the least assurances and/or where outcomes might post the highest risks. To maximise this potential, we intend to adopt a new electronic system in 2023/24 to help manage our clinical audit activity. Our success will be determined by achievement of the following objectives:

- ✓ **To provide improved visibility of audit activity through self-serve access to data.** In 2023/24 we plan to enable real-time reporting of clinical audit data so that the status, progress, and actions of audits can be accessed by our staff immediately when required. This will reduce the time that staff currently spend on reporting and this time can then be further re-focused on improving the quality of care, and the delivery of actions.
- ✓ **To ensure there is greater focus on actions, learning, and improvements rather than the input and storage of data.** In 2023/24 we aim to use new audit software to develop a new 'filtering' process to improve governance, enhance our reporting, and streamline our processes such that our focus is more heavily centred on clinical risks and the assurance levels resulting from audit outcomes. Our focus will be on improving patient outcomes rather than the number of audits that we complete.
- ✓ **To remove dependencies on in-house and unsupported IT systems**. In 2023/24 we intend to consolidate existing data and reduce the number of locations where clinical audit data is held internally to improve data security.

Patient Safety

IN 2023/24 WE WILL PREPARE AND PUBLISH OUR PATIENT SAFETY INCIDENT RESPONSE PLAN, WHICH WILL DETERMINE HOW THE TRUST RESPONDS TO PATIENT SAFETY INCIDENTS IN THE FUTURE USING THE NEW PATIENT SAFETY INCIDENT FRAMEWORK MODEL

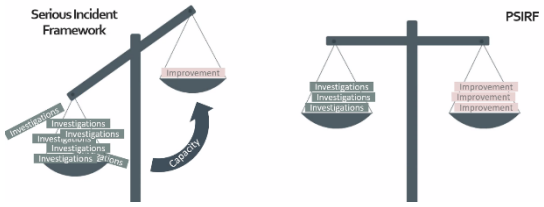
Priority 4: Adoption of the Patient Safety Incident Framework (PSIRF)

To improve our approach to responding to patient safety incidents we have begun a 12-month period of preparation ahead of transitioning from the existing Serious Incident Framework (SIF) to NHS England's new PSIRF in September 2023.

A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and supports compassionate engagement with all those affected. It supports the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than apportioning blame, allowing for more effective learning, and ultimately safer care for patients. Adopting a compassionate approach when engaging and involving those affected by patient safety incidents is central to the PSIRF approach. The remit nationally for investigations has become increasingly broad over time due to an attempt to be more efficient, by trying to address the many and varied needs of different investigations in a singular approach (i.e., establishing liability / avoidability / cause of death). This has limited the learning that the NHS set out to achieve in relation to patient safety. We know that an in-depth analysis of a small number of incidents brings greater results than routinely examining larger numbers.

In some cases, where it is already clear why the incident happened, it will be more appropriate to concentrate on making improvements rather than spending more time on investigations. Essentially, there will be fewer formal investigations of incidents, but patients and staff will be more likely to be involved in other approaches to learn from incidents and improve patient safety.



There will be a welcomed focus on improvements in patient safety rather than producing numerous investigation reports which often do not result in meaningful change.

What happens next?

At Salisbury NHS Foundation Trust we are currently reviewing how developed our systems and processes are for responding to patient safety incidents, and how these need to be adapted to optimise opportunities for learning and improvement in line with PSIRF recommendations. This will identify areas which require strengthening as we transition across and adopt the new framework. The Trust is preparing a patient safety incident response plan (PSIRP) which sets out how we will respond to patient safety incidents reported by staff and families to continually improve the quality and safety of the care the Trust provides. The plan will set out how the Trust plans to respond to patient safety incidents to learn and improve through patient safety incident investigations.

Looking Back at 2022/23 - What did we say we would do?

Background

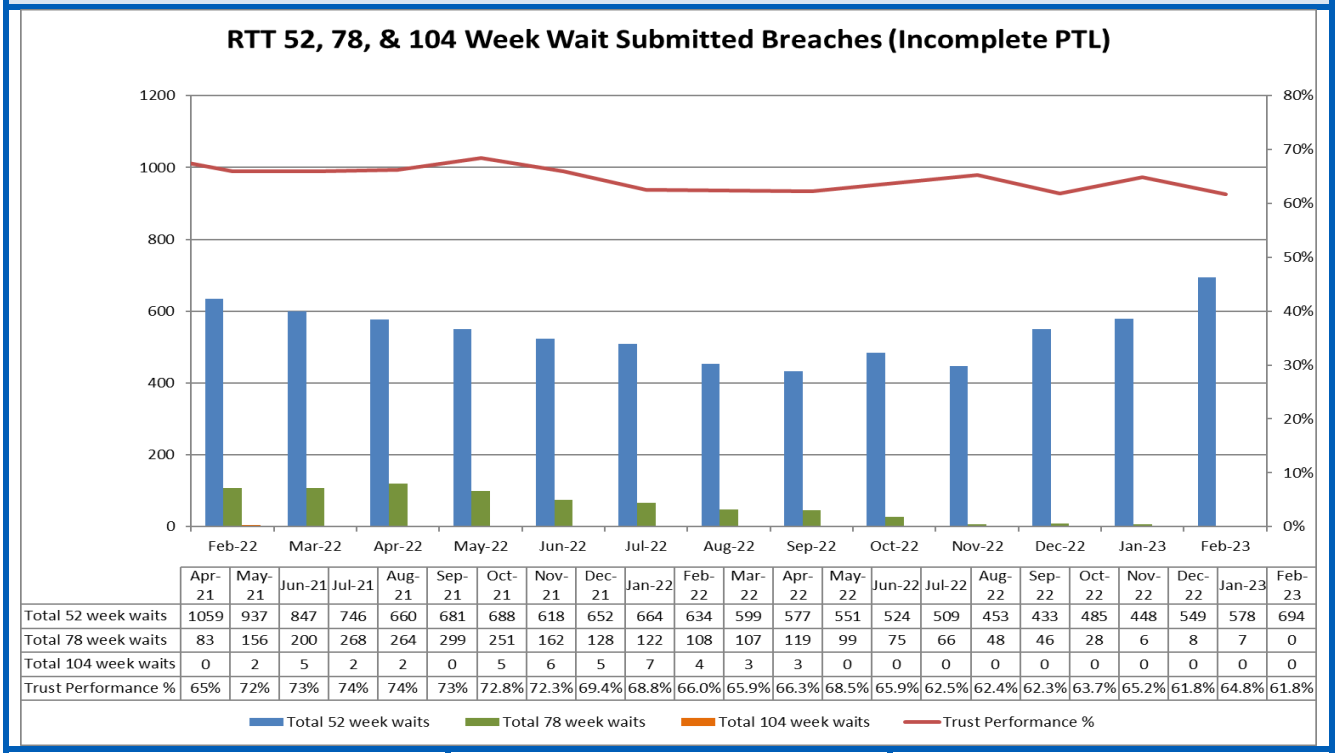
As 2022/23 has progressed our understanding of the Improving Together methodology has matured. Going into a winter of intense operational pressures this led to an executive-led change to our breakthrough objectives. With 'bed occupancy' taking the place of 'No Criteria to Reside,' the rollout of same day emergency care (SDEC) becoming part of our bed occupancy work, and the introduction of staff agency spend as the key metric for staff availability.

These changes recognised the need to focus on staffing alongside falls and time to first outpatient appointment. The use of bed occupancy as a breakthrough objective provided a greater focus on the areas of a patient's pathway, we as a Trust have significant influence over. For example, improving our pathway 0 discharges (to a patient's home, without packages of care being needed).

Our work on SDEC resulted in the launch of our medical SDEC service on 27th March, and early analysis showed a two-fold increase in same day discharges from our ED.

Our recovery from the impact of COVID-19, especially on elective care, continues. We achieved our target of all patients waiting 78 or more weeks for their treatment by March 2023. We are now focusing on the delivery of having no patient waiting 65 weeks for their treatment by March 2024.

Eliminate waits for treatment by > 78 weeks by April 2023



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Total 52 week waits	1059	937	847	746	660	681	688	618	652	664	634	599	577	551	524	509	453	433	485	448	549	578	694
Total 78 week waits	83	156	200	268	264	299	251	162	128	122	108	107	119	99	75	66	48	46	28	6	8	7	0
Total 104 week waits	0	2	5	2	2	0	5	6	5	7	4	3	3	0	0	0	0	0	0	0	0	0	0
Trust Performance %	65%	72%	73%	74%	74%	73%	72.8%	72.3%	69.4%	68.8%	66.0%	65.9%	66.3%	68.5%	65.9%	62.5%	62.4%	62.3%	63.7%	65.2%	61.8%	64.8%	61.8%

What the data is telling us

- Whilst the data shows that the average time to first appointment has lengthened, this has been due to the Trust's focus on delivering the national targets for reducing the number of patients waiting the longest before receiving treatment.
- The national target for having no patients waiting over 104 weeks before receiving their first treatment was 31st July 2022. **The Trust achieved this milestone, ahead of target, on 9th May 2022, and has maintained this to date.**
- The subsequent target stipulated by the Government was to have no patient waiting longer than 78 weeks for their first treatment by 31st March 2023. **The Trust achieved this target one month ahead of schedule on 28th February 2023.**

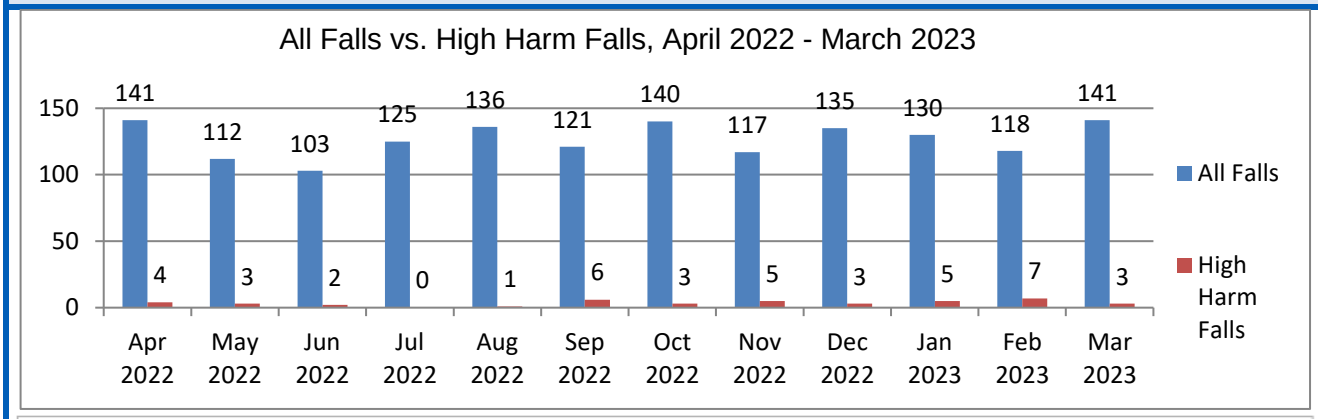
What we did

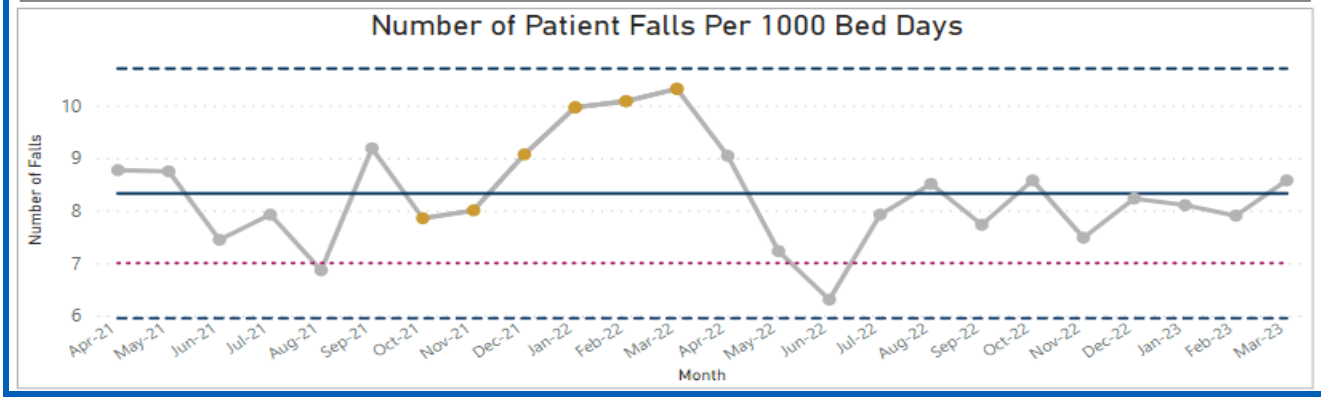
- The achievement of the 78-week target was the culmination of intense monitoring and performance management that commenced in June 2022.
- A performance management structure was established in June 2022, supported by weekly meetings to review individual clinical specialty performance, with progress reports provided to the Chief Executive Officer and Chief Operating Officer.

Next steps

- Maintenance of these targets is now key. Ongoing monitoring remains in place, as is a mirroring of last year's mechanisms to monitor and manage this year's target of an elimination of 65-week waits by March 2024.
- In addition, those specialties with the greatest challenges will receive increased focus and support to further reduce the number of longer waiting patients.

Reduce overall falls by 10% and falls with harm by 20%





What the data is telling us

- Through our Improving Together methodology we set a target to reduce inpatient falls overall by 30% (10% in 2022/23). This has not been achieved, with the reduction being at 6.75%.
- During COVID-19 our falls rate peaked at 10.2 per 1,000 bed days but significantly reduced following concerted efforts and targeted interventions identified using the Improving Together methodology.
- **Reduction in falls causing harm has reduced by 36%** and we therefore achieved our in-year target of a 20% reduction.

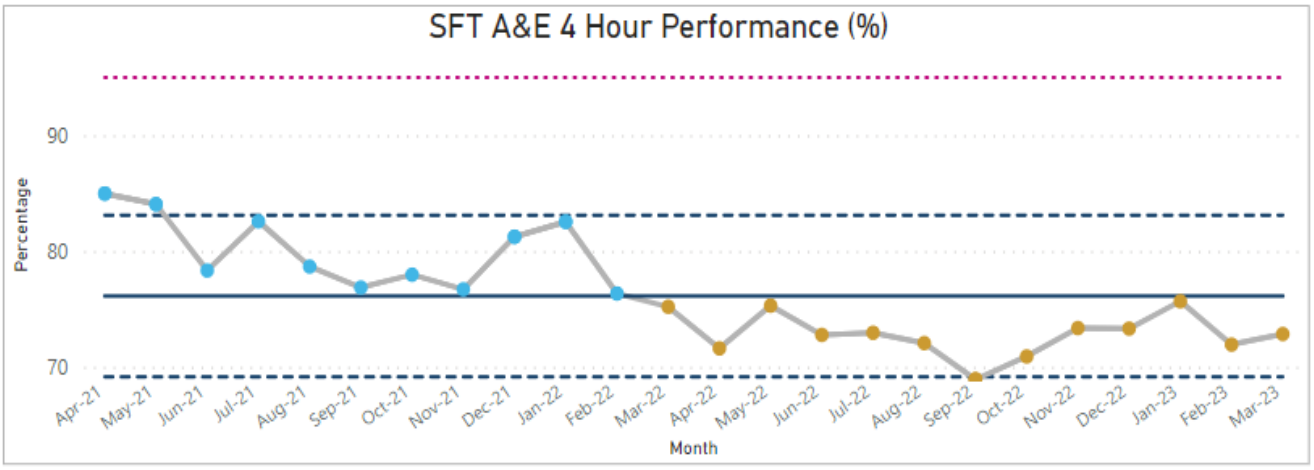
What we did

- We introduced “Bay watch” to wards with high falls rates and with teams who were familiar with the Improving Together methodologies. The most successful ward having immediately dropped from 13.4 falls per 1,000 bed days to 1.1.
- We reinforced the necessity and importance of recognising postural hypotension in patients through taking lying and standing blood pressures, and then acting on the results. Those patients who necessitated a reading improved from 31% in 2022 to 45% in 2023 (March 2023).
- Bed side teaching and advice for patients and staff was provided from the Falls Reduction Specialist.
- Formal teaching for Ward teams and new members of nursing staff was given at induction. 400 members of staff have been formally trained thus far.

Next steps

- Bay watch to be rolled out to all wards with support from senior nurses and Divisions by the third quarter of 2023/24.
- Our training programme is to be further developed to create a more interactive session by the third quarter of 2023/24.
- Ward ‘Champions’ are to be relaunched as ambassadors for falls improvements for clinical teams.

Improve 4-hour Emergency Access Performance to 90% by September 2022 and Ultimately 95%



What the data is telling us

- This data shows us our performance in the Type 1 Emergency Department (ED) attendance.
- The data shows there has been a run below the mean (orange dots) in our performance.
- This trend has occurred across the nation and is recognised in the national target of achieving 76% 4-hour performance in 2023/24, down from 95% previously.

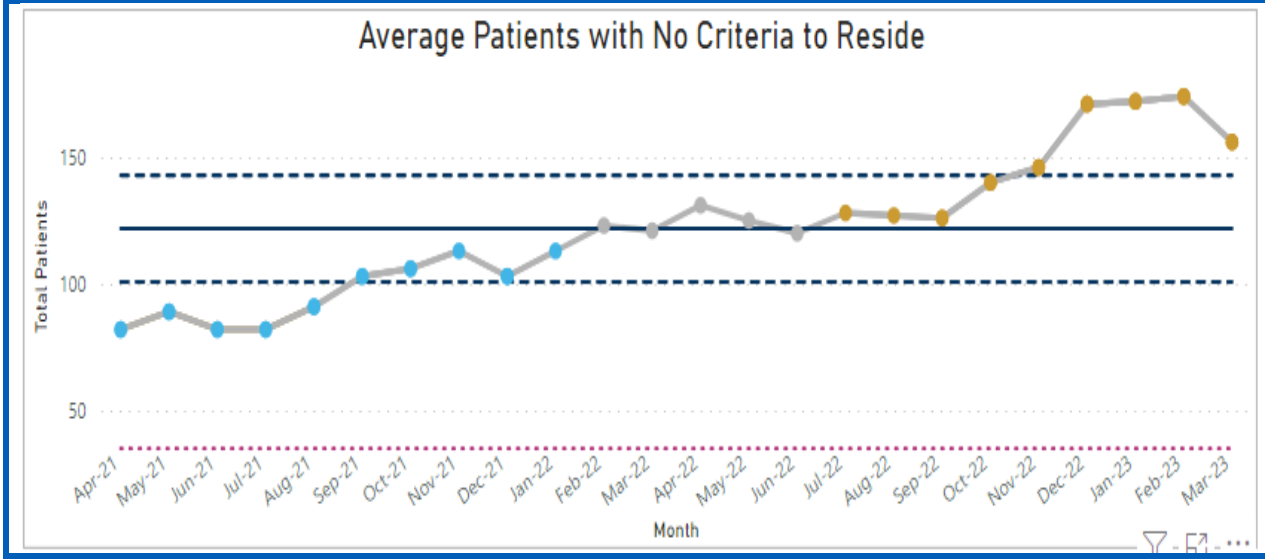
What we did

- We compared our highest risks for ED and then used this a basis to focus our efforts on improving performance.
- We knew that there was a risk associated with the assessment of undifferentiated patients in the waiting area and therefore used the Root Cause Analysis (RCA) process to identify what the root causes were, and how we might improve this. This was then used to form the countermeasures for improving time to initial assessment.
- We also invited NHSE/I to provide feedback on our processes, as improvement is wider than just time to initial assessment. We will use the feedback to inform other changes in the department.

Next steps

- Continuation of the rollout of medical SDEC, enabling the streaming of suitable patients to a same day service to help them avoid having to be admitted to hospital.
- Medicine's driver metric of 'time to first assessment' is focusing improvement on the first step in a patients ED pathway to enhance safety in the department.

Reduce average loss bed days due to NC2R from 250 to 150



What the data is telling us

- As we have gone through the winter the numbers of patients with no criteria to reside in an acute hospital have risen.
- The rise is in line with the number of escalation beds the hospital has opened to cope with the need to accommodate more patients for longer lengths of stay.

What we did

- Opened reablement beds at South Newton.
- Worked with partners across BSW to reduce the delays to accessing appropriate packages of care and beds for patients with no criteria to reside in the hospital.

Next steps

- Through our bed occupancy breakthrough objective, to focus on how we increase the number of patients we can discharge home before 12:00hrs each day.
- To reduce our patients' length of stay, reduce our escalation bed use to better consolidate our substantive staff and reduce patient bed movements.

Consultation and Monitoring of our Priorities

Each year the Trust is required to identify and outline its quality priorities. We consulted on our organisational strategy and approach to quality with several stakeholders, and shared our priorities with commissioners, Governors, Healthwatch, and our Trust Executives. The final priorities were approved at Trust Board.

The priorities that we have selected continue to represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience) and have been embedded across our business plans for 2023/24. Our quality priorities were each discussed at their representative steering groups and were also discussed at the Quality Board (CMB).

Progress in the achievement of these priorities will continue to be monitored through regular reporting and discussion at CMB in 2023/24.

2B - Statements of Assurance from the Board

Salisbury NHS Foundation Trust

In this part of the report, we provide statements of assurance from the Board, as specified by the quality account regulations. We have further expanded on our goals and have provided additional information where possible.

Review of Services

During 2022/23 Salisbury NHS Foundation Trust provided and/or subcontracted 55 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 55 of these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2022/23.

The Integrated Governance Framework is in the process of being merged with the Accountability Framework to provide one overarching framework which sets out how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of delivering 'an outstanding experience for our patients, their families and the people who work for and with us', by an organisation that is well managed, cost-effective and has a skilled and motivated workforce. In addition, the framework specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focusing across the breadth of quality, operational, finance and workforce performance.

The Clinical Governance Committee is the quality assurance committee of the Trust Board. It is responsible for overseeing the continuous improvement of the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. The committee hears directly from clinical teams where risks to quality are identified to seek assurance that action is being taken to improve. Service deep dives provide assurance to the Committee on the quality-of-service provision and are aligned to corporate risk identified within the Corporate Risk Register and Board Assurance Framework.

The Trust Board undertakes 'Safety Walkabouts' on a weekly rolling programme. This direct engagement with clinical and non-clinical teams ensures that Board members are sighted on the safety concerns of staff and brings the Board discussions to life. In addition, the Executive Team undertake 'Back to the Floor' sessions. Every month, the Executive Team works with clinical and non-clinical teams for an afternoon with the aim of enhancing 'ward to Board' communication and provide the opportunity for the Executives to speak to staff in all departments, patients, and their families, giving them first-hand knowledge of improvements being made and where further improvements are needed.

Participation in Clinical Audit

During 2022/23, 50 national clinical audits and nine clinical outcome review programmes covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 47 (94%) national clinical audits, and nine (100%) clinical outcome review programmes of the national clinical audits and clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and clinical outcome review programmes that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed in **Table 1** alongside the number of cases submitted to each audit or programme as a percentage of the number of registered cases required by the terms of that audit or programme.

Table 1.

Eligible national audits and clinical outcome review programmes and those the Trust participated in during 2022/23

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
Breast and Cosmetic Implant Registry	Audit	Not Applicable	Not Applicable
Case Mix Programme (CMP)	Audit	✓	100%
Cleft Registry and Audit Network (CRANE)	Audit	✓	100%
Elective Surgery (National PROMs Programme)	Audit	✓	Reporting was suspended due to COVID-19
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Audit	✓	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Fracture Liaison Service Database	Not Applicable	Not Applicable
	National Audit Inpatient falls	✓	100%
	National Hip Fracture Database	✓	100%
Gastro-intestinal Cancer Programme	National Bowel Cancer Audit (NBOCA)	✓	100%
	National Oesophago-Gastric Cancer (NOGCA)	✓	100%
Inflammatory Bowel Disease (IBD) Registry	Audit	✘	0%

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
LeDeR – Learning from lives and deaths of people with a learning disability & autistic people (previously known as Learning Disability Mortality Review Programme)	Audit	✓	66.7%
Muscle Invasive Bladder Cancer Audit	Audit	✓	100%
National Adults Diabetes Audit	National Diabetes Core Audit	✓	100%
	National Diabetes Foot Care Audit	✓	100%
	National Diabetes Inpatient Safety Audit	✓	100%
	National Pregnancy in Diabetes Audit	✓	100%
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma: Secondary Care	✓	100%
	Chronic Obstructive Pulmonary Disease (COPD)	✓	100%
	Paediatric Asthma: Secondary Care	✓	100%
	Pulmonary Rehabilitation – Organisational and Clinical Audit	✓	100%
National Audit of Breast Cancer in Older People	Audit	✓	100%
National Audit of Cardiac Rehabilitation	Audit	✓	100%
National Audit of Cardiovascular Disease Prevention (Primary Care)	Audit	Not Applicable	Not Applicable
National Audit of Care at the End of Life	Audit	✓	100% (excluding optional Quality Survey)
National Audit of Dementia	Audit	✓	100%
National Audit of Pulmonary Hypertension	Audit	Not Applicable	Not Applicable
National Cardiac Arrest Audit (NCAA)	Audit	✓	100%

National Confidential Enquiries			
Audit title	**Details**	**Participation**	**% of cases submitted**
Child Health Clinical Outcome Review	Testicular Torsion	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Perinatal Mortality Surveillance	✓	100%
	Perinatal Mortality and Morbidity Confidential Enquiries	✓	100%
	Maternal Mortality Surveillance and Mortality Confidential Enquiries	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia	✓	These audits are in progress, it is anticipated that we will submit 100%
	Endometriosis	✓	
Mental Health Clinical Outcome Review Programme	Audit	Not Applicable	Not Applicable

The participation in these audits is in line with the Trust's annual clinical audit programme which aims to ensure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. The annual audit programme last year incorporated over 300 audits, including several audits agreed as part of the contract with our Clinical Commissioning Groups.

The reports of 40 national clinical audits and clinical outcome review programmes that were published in 2022 were reviewed by Salisbury NHS Foundation Trust in 2022/23. Of these, 12 (30%) were formally reported to the Clinical Effectiveness Steering Group by the clinical lead responsible for implementing the changes in practice. Further examples of national clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can be found in Appendix B

Local clinical audits

The reports of 85 (100%) local clinical audits were reviewed by the Trust in 2022/23. Examples of local clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can also be found in Appendix B.

Research

Research saves lives. Hospitals that are more 'research active' have lower mortality rates than those that are not; an effect that is not limited to research participants. Research in the NHS has always been important in the patient pathway as it can:

- enable early or more accurate diagnosis;
- provide life-changing treatments;
- prevent people from developing conditions;
- improve health and care for generations to come;
- ensure everyone has a better quality of life.

In addition, health research can provide important decision-making information about disease trends and risk factors, outcomes of treatment or public health interventions, functional abilities, patterns of care, and health care costs and use.

Saving and improving lives: The Future of UK Clinical Research Delivery (March 2021) clearly defines the UK government vision for research in the NHS.

"***Clinical research is the single most important way in which we improve our healthcare – by identifying the best means to prevent, diagnose and treat conditions. So, we need to bolster delivery of innovative research across all phases, all conditions and right across the UK, as we work to rapidly restart our non-COVID-19 research portfolio and build back better.***"

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2022/23, that were recruited during that period to participate in research approved by the National Institute for Health Research were 1,075 patients into 54 studies.

This is fewer than previous years. However currently funding is not activity-based, therefore the department has concentrated on creating a stronger more resilient base to relaunch research in the Trust next year and in future years. This includes:

- ✓ **A clear vision for the future:** A number of sessions during the year have meant we have adjusted our vision: Striving for an outstanding and valued research experience for everyone: participants, patients, clinicians, colleagues, stakeholders.

- ✓ **A better place to work:** Emerging from the pandemic there were some clear issues within the department which meant that motivation within the staff was lower than we would like. This was highlighted by the results of a culture review presented in May. A recent survey has shown that this situation has significantly improved. We now have an emphasis on wellbeing, forging links with the wider Trust, improved development opportunities and leadership for all, which we expect will translate into a happier and more resilient workforce.

- ✓ **Reprioritising and restarting non-covid research and a plan for increasing the number of participants.** We have been re-establishing links with Principal Investigators who have had research paused during the pandemic and reviewing the current NIHR portfolio to increase recruitment to non-COVID-19 studies.

- ✓ **Increasing commercial and home-grown research to maximise income both for the department.**

Commercial income

We opened our first commercial study post pandemic this year. We have also entered negotiations regarding several commercial research projects.

Home grown research

There are several nationally funded projects that are open or are due to open in the Trust.

Short title	Full title
ELABS	Early Laser for Burn Scars – A prospective randomised, controlled trial to study the effectiveness of the treatment of hypertrophic burn scars with Pulsed Dye Laser and standard care compared to standard care alone.
HIIT	A Feasibility Study of High Intensity Interval Training to Reduce Cardio-metabolic Disease Risks in Individuals with Acute Spinal Cord Injury.
BOWMAN	A Randomised, Sham-Controlled, Proof of Principle Study of Abdominal Functional Electrical Stimulation for Bowel Management in Spinal Cord Injury.
STEPS II	The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial.

We have also had a record number of inquiries to do research within the Trust. This includes enquiries from students to be part of research and responses to communications regarding a national competition for nursing led research. We are looking at ways to capitalise on this interest in research.

Other successes

This year we have also had some income for projects looking at increasing research in underserved communities:

- ✓ We have trialled a limited out of hours service to recruit and follow-up patients that are not available for these appointments during working hours.
- ✓ We have compiled resources and participated in a mentoring scheme targeting mentoring of people undertaking research in the wider community.

We have also submitted the largest ever bid for research equipment and we are currently awaiting the result. We submitted a bid for over £250,000 as part of a CRN Wessex bid for equipment across the Trust.

Further information is available in the Trust Research Annual Reports, which are available at https://www.salisbury.nhs.uk/about-us/trust-reports-and-reviews/

Goals Agreed with Commissioners

Our CQUIN Performance

The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care. The CQUIN scheme was restarted in 2022/23 following a period of suspension due to COVID-19, with the purpose of helping the NHS to achieve its recovery priorities. The full guidance and indicator specifications can be found on the NHS England website (NHS England » 2022/23 CQUIN). Commissioning responsibilities were transferred to the ICB during 2022/23 when CCGs were formally disbanded, and Salisbury NHS Foundation Trust income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning of Quality and Innovation payment framework.

Eleven CQUINs were considered applicable to Salisbury NHS Foundation Trust for the financial year of 2022/23 and five of these CQUINs were selected as high priority areas of focus. These were determined through joint discussions with our internal staff and local ICB (CCG1, CCG2, CCG3, CCG4, and CCG7

Key Highlights

- ✓ **CQUIN CCG1** - **flu vaccinations for frontline healthcare workers** – Our staff flu vaccine uptake was 66.9% (as of February 2023) which was the 2nd highest in the region, with the South-West region reporting the highest figures overall.
- ✓ **CQUIN CCG2** - **appropriate prescribing for UTI in adults aged 16+** - Salisbury NHS Foundation Trust was identified as one of the highest performing Trusts in this CQUIN for 2022/23, and we reported scores which were significantly above the performance target (80% against the CQUIN target threshold of 60%).
- ✓ **CQUIN CCG3** - **recording of NEWS2 score, escalation time and response time for unplanned critical care admissions** – we reported very high scores in this CQUIN with our results demonstrating nearly 100% compliance.
- ✓ **CQUIN CCG4 - compliance with timed diagnostic pathways for cancer services** – whilst we are not yet achieving the performance target, improvements have been made throughout 2022/23, with a key focus being to improve access to diagnostic imaging for patients. We are hoping to increase MRI scanning capacity by 40 scans per week from April 2023, facilitated through use of a mobile scanner on site. We aim to improve our reporting for patients on a 2 week-wait cancer pathway to within 7-days during the first quarter of 2023-24. Work this year has already resulted in the recruitment of a new radiology navigator who will support our cancer lung pathway and coordination with our local GPs. There has also been an increase in our endoscopy staffing levels in support of our colorectal and oesophago-gastric services.
- ✓ **CQUIN CCG7** - **timely communication of changes to medicines to community pharmacists via the discharge medicines service –** whilst we are not currently achieving our targets, sustained improvements have been demonstrated throughout 2022/23. Improved performance figures reflect the provision of small group training which has been provided to our clinical pharmacy teams.

The CQUIN scheme is expected to continue in 2023/24 and improvement areas will be identified based on the context of continued COVID-19 recovery.

Care Quality Commission (CQC) Registration

Salisbury NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. The Trust has not participated in any special reviews or investigations by the CQC in 2022/23.

The Trust was last subject to a full CQC inspection, including Use of Resources, in November and December 2018, receiving an improved rating of 'Good'. Following inspection in 2021, the Maternity Service has continued their engagement in the NHSE/I Maternity Safety Support Programme during 2022/23. There were no announced or un-announced inspections for core services in 2022/23 and the Trust has held regular engagement meetings with the CQC throughout the year.

Registration of an additional location with the Care Quality Commission

Due to the need to provide alternative accommodation to enable the completion of some environmental work on one of the wards at the hospital and, later, to provide additional capacity as part of winter planning processes, alternative accommodation was secured at South Newton Hospital, an independent hospital approximately six miles from the main hospital site.

In September 2022, the Trust applied to the CQC to add a location to its existing registration. Following review of submitted evidence and pre-registration inspection by CQC of the potential new location, the Trust was granted registration to provide the regulated activity of treatment of disease, disorder, or injury.

Three additional conditions were applied to this location:

- The registered provider is only permitted to use Salisbury NHS Foundation Trust inpatients - South Newton Hospital, Nadder Ward and Pembroke Lodge as a condition of registration until 30 June 2023.

- The registered provider must not accommodate patients anywhere within the location other than Nadder Ward and Pembroke Lodge.

- To ensure patient safety, the registered provider must ensure there is an effective traffic management procedure in place within the location that supports the following: pedestrian only access to areas marked as "Time Limited Vehicle Access" on the registered providers South Newton Hospital Site Plan between 8am and 7.30pm except for vehicles with a staff escort.

The patients transferred to this location have been deemed medically fit for discharge with no criteria to reside and each patient is individually assessed against approved criteria to ensure the most appropriate patients are transferred. Management and oversight of the new location is part of the usual Medicine Divisional governance arrangements, with the Medicine Division Management Team having day to day oversight. The new location is discussed with CQC, as required, through the regular engagement meetings with the Trust.

Data Quality

Good quality information (data) underpins the effective delivery of patient care and is essential to drive improvements in the quality of care we deliver. Having high data quality standards gives confidence that decisions that are made using the information are appropriate and ultimately will help to deliver more responsive, high quality and cost-effective services.

Over 2022/23, the Trust continued work on its Business Intelligence Transformation project which included work to replace our data warehouse and delivering modern tools to support the improvement of data quality and the use of information more widely. The Data Quality Manager we recruited in January 2020 continues to lead the Data Quality elements of this project and support implementation.

Our Data Quality Policy is reviewed annually to reflect the progress made in the previous year and includes the scheduled improvements planned for the next twelve months. During the last year we progressed the implementation of the Data Quality Notification (DQN) app by adding more DQNs from our priority list. From the Data Quality Policy and Data Quality Self Assessments we have created the Data Quality Improvement Plan for 2023/24 which outlines actions we want to take to improve Data Quality performance and the time scales in which we hope to complete these, this is regularly monitored and updated at the Information Standards Group (ISG). We developed the Data Quality Champion role in 2022, which has enabled more staff to understand their Data Quality responsibilities and produced a training module that is completed by all new starters at Induction. We are in the progress of publishing a new internal Data Quality dashboard on our PowerBI platform, so all senior leaders and responsible persons are aware of Data Quality compliance across the Trust.

Salisbury NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and valid General Medical Practice Code is set out in **Table 2.** These are important because the NHS number is a key identifier for patient records and an accurate record of the General Medical Practice Code is essential to enable the transfer of clinical information about the patient.

Table 2 - Patient records with a valid NHS number and General Medical Practice Code

Data item	SFT 2021/22	National benchmark 2021/22	SFT 2022/23 (M1-10 only)	National benchmark 2022/23
Valid NHS number				
% for admitted patient care	99.9%	99.6%	99.8%	99.6%
% for outpatient care	99.9%	99.7%	99.9%	99.8%
% for Emergency Department care	99.6%	98.9%	99.1%	98.7%
Valid General Medical Practice Code				
% for admitted patient care	99.9%	99.7%	100%	99.7%
% for outpatient care	99.9%	99.6%	100%	99.5%
% for Emergency Department care	99.9%	99.5%	99.9%	99.2%

Data Security and Protection Toolkit Attainment Levels

Information governance (IG) is a term used to describe how information is used. It covers system and process management, records management, data quality, data protection and the controls needed to ensure information sharing is secure, confidential, and responsive to Salisbury NHS Foundation Trust and the people it serves.

Good information governance means ensuring the information we hold about our patients and staff is accurate, keeping it safe, and available at the point of care. The Data Security and Protection Toolkit (DSPT) is the way we demonstrate our compliance with national data protection standards. All NHS organisations are required to make an annual submission at the end of June, to assure compliance with data protection and security requirements.

The Trust self-assessment against the 2021/22 Data Security and Protection Toolkit confirmed compliance in all areas, with a status of 'Standards Met'. The self-assessment for 2022/23 is due for submission at the end of June 2023.

Clinical Coding Error Rate

Salisbury NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission. Salisbury NHS Foundation Trust commissioned an external clinical coding audit from *D&A Consultancy* (specialist clinical coding auditors) to provide evidence for the Data Security and Protection (DSP) Toolkit during the reporting period. The error rates reported in the audit for that period for diagnoses and treatment coding (clinical coding) were:

- **Primary Diagnoses Incorrect 5.0%**
- **Secondary Diagnoses Incorrect 11.2%**
- **Primary Procedures Incorrect 9.6%**
- **Secondary Procedures Incorrect 8.8%**

DSP toolkit Standard 1 attainment level was:

- **Meets standards**

Clinical Coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Clinical Coding audit methodology is available from NHS Digital.

The clinical coding results should not be extrapolated further than the actual sample of 200 Finished Consultant Episodes (51 Plastics, 50 ENT, 49 Palliative Care, 50 Gynaecology).

Seven Day Hospital Services – Implementing the Priority Clinical Standards

The Seven Day Hospital Services Clinical Standards were developed by the NHS Services, Seven Days a Week Forum in February 2013 to support hospitals providing acute services to ensure that patients receive the same level of high-quality care on a seven-day basis for patients admitted in an emergency. This framework gives emphasis in reducing care variations especially over the weekend, providing better patient flow and improving patient outcomes and the availability of supporting diagnostic services across the system. The national team no longer seek central submission, but recommend an annual review be conducted internally by each Trust.

During 2022-23 a seven-day services review was conducted at Salisbury NHS Foundation Trust. Our findings showed that 87% of our patients are seen and reviewed by a consultant or senior doctor within 14-hours of admission, with there being limited variation at the weekend versus admissions during the week. We continue to receive high overall satisfaction rates from patients or families who receive care or treatment at Salisbury NHS Foundation Trust.

There are however variations in the length of stay and number of discharges associated with the day of week in which the patient is admitted. Whilst a recent audit showed that there was evidence of shared decision making occurring in most of our patients, and clear documentation of these conversations in the medical records, uptake, and use of the ReSPECT form (a form which is completed by a healthcare professional which contains personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices) needs further improvement. We recognise the importance of this, especially where patients are likely to be admitted to hospital with more advanced illnesses due to national challenges surrounding access to care. Therefore, in addition to work already being undertaken by our Operations Team, we are seeking to improve how we collect and respond to real-time feedback from our patients in 2023/24 (see 'patient experience 'section of the report).

Freedom to Speak Up (whistleblowing and raising concerns)

The Freedom to Speak Up (FTSU) Service is provided by the Trust to empower staff to raise a concern outside of an individual's management process should they require it. The service is led by a Freedom to Speak Up Guardian, supported by a team of Ambassadors. The remit of the service is to support the development of a culture that is open and transparent regarding so that raising concerns becomes business as usual for all staff. The Trust's Guardian is responsible for providing confidential advice and support to staff in relation to any concerns about patient safety or any concern that has a detrimental effect on their working conditions. They can also offer advice and support to ensure concerns raised are handled appropriately and result in a clear outcome. The Trust's Guardian has direct access to all senior leaders including the Chief Executive and all Board members.

Salisbury NHS Foundation Trust is an Exemplar Site for the NHS People Promise. FTSU falls under 'We each have a voice that counts.' As part of the Trust's commitment to this, the Freedom to Speak Up Guardian has completed Restorative Just, and Learning Culture Training delivered by Northumbria University in conjunction with Merseycare NHS Trust and will be taking the lead for Civility & Respect to be delivered across the organisation. The Freedom to Speak Up Guardian has been invited to attend the Patient Safety Incident Framework (PSIRF) implementation group and contribute to the aspects regarding what is being done to support the development of a just culture. An additional nine Freedom to Speak Up Ambassadors have been recruited from across the Trust to help support the speaking up agenda.

The National Guardian's Office and NHS England have been working together to develop a revised version of the National Integrated Freedom to Speak Up policy. The new universal policy applies throughout the NHS and to all organisations delivering NHS services. Salisbury NHS Foundation Trust is working to integrate this policy into other policies that affect our people, such as the Dignity at Work policy and the Disciplinary policy. The CQC will be including Freedom to Speak Up as a quality indicator in their new regulatory framework.

Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2022-23 134 concerns have been raised to the Freedom to Speak Up Guardian. Of these, 37 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

	Themes	Cases Q1 (22/23)	Cases Q2 (22/23)	Cases Q3 (22/23)	Cases Q4 (22/23)
1	Element of Patient Safety/Quality	8	10	12	7
2	Worker Safety	3	12	8	2
3	Element of other inappropriate attitudes or behaviours	24	14	25	17
4	Bullying/Harassment	5	8	7	4
5	Disadvantageous and/or demeaning treatment (detriment as a result of raising concerns)	1	0	3	1

**Please note that some cases record more than one theme*

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, business cards are handed to every new member of staff.

Consolidated Annual Report 2022/23 on Doctors and Dentists in Training Rota Gaps and Improvement Plan

Details of rota gaps are presented quarterly to the People and Culture Committee as part of the Guardian of Safe Working Report. The annual report presents a consolidated view of the rota gaps. Data for the last quarter of the financial year is not yet compiled.

Below is a summary of approximate rota gaps across all grades and specialties for 2022/23. There are approximately 160 junior doctors that are expected to be supplied by the deanery. Where there is a shortfall, the Trust aims to mitigate this by covering the gap with locally employed doctors (LED).

Year 2022/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Whole Time Equivalent (WTE) deanery gap	23.95	24.35	19.45	22.45	19.15	16.45	13.7	15.6	14.35
LED cover	11	11	4	4	3	6.55	6.9	6.9	6.7
Net WTE gap	12.95	13.35	15.45	18.45	16.15	9.9	6.8	8.7	7.65

The overall deanery fill rate ranges from circa 85% to 93% of expected. This is comparable to national figures. Our net gap is smaller than usual in the latter part of the year owing to better coverage of unfilled deanery posts with LED doctors.

It is noted that there is a significant disparity between junior (F1- ST2) and senior (ST3+) levels, with a poorer fill rate at senior level. This has been raised at deanery level.

The Trust has invested in 12 new Foundation Posts and the junior ED and palliative care rotas are now compliant with terms and conditions.

Plans for Improvement

- ✓ A new electronic rostering system for doctors is due to be implemented which will provide a greater opportunity for oversight of potential gaps in rotas due to leave and sickness and make it easier for staff wishing to work extra hours to offer to fill shifts. There are, however, significant restrictions on working hours of junior doctors, with many of them already working close to the maximum hours allowed in their contracts.
- ✓ The Trust plans to complete a medical workforce review of key services to ensure that there is the correct skill mix to provide sustainable quality care and to maximise the opportunities provided by Advanced Care Practitioners and Physicians Associates.
- ✓ The Trust continues to work with Health Education England (HEE).
- ✓ Medical F1 doctors will take part in night shift duties from April 2023 to improve hospital cover at night.

National Core Set of Quality Indicators

Salisbury NHS Foundation Trust

All Trusts are required to report their performance against a statutory core set of quality indicators as part of their quality accounts. The indicators are based on recommendations by the National Quality Board. They are split into five domains. In this section we report:

- ✓ **Our performance against these indicators; presented in a table format, for at least the last two reporting periods**
- ✓ **The national average (where available)**
- ✓ **A supporting commentary, which explains the variation from the national average and the steps taken or planned to improve quality**

Domain 1 – Preventing People from Dying Prematurely

Summary Hospital-level Mortality Indicator (SHMI)

National Quality Priorities						
a. Trust SHMI:	**Dec 2019 – Nov 2020**		**Dec 2020 – Nov 2021**		**Dec 2021 – Nov 2022**	
	SFT	**National Average**	**SFT**	**National Average**	**SFT**	**National Average**
The value of the SHMI for the Trust	1.0035	1.0	1.0667	1.0	1.1179	1.0
The banding of the SHMI for the Trust	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
SHMI broken down by Site:						
The value of the SHMI for Salisbury District Hospital (excluding hospice site)	0.9596	1.0	1.0281	1.0	1.0729	1.0
The banding of the SHMI for Salisbury District Hospital (excluding hospice site)	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
The value of the SHMI for Salisbury Hospice	2.3652	1.0	2.3025	1.0	2.2734	1.0
The banding of the SHMI for Salisbury Hospice	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected
b. Palliative Care Coding:						
b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust (all sites). The palliative care indicator is a contextual indicator.	52.8%	36%	51.8%	39%	49%	40%

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Salisbury NHS Foundation Trust recognises the importance of providing good quality care to people with life limiting conditions and to those who are dying. We are proud to include our local Hospice on site. As mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services) the number of expected deaths at Salisbury NHS Foundation Trust will always sit above expected levels. When the main hospital site is separated from the hospice, expected deaths fall well within the expected range. The proportion of deaths with a palliative care coding has no specific target but is felt to be a measure of how Trusts recognise those in the last phase of their life and provide services to support them and their loved ones during that time (i.e., a higher figure is better).

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve mortality and harm, and so the quality of its services:

- ✓ The Trust's Mortality Surveillance Group (MSG) continue to meet every two months for assurance purposes
- ✓ Several commissioned reviews were undertaken during 2022/23 and learning was shared and discussed at the Trust Mortality Surveillance Group (MSG)
- ✓ A new electronic system for managing mortality reviews and learning from deaths will be adopted in 2023/24
- ✓ A mortality dashboard is being newly developed using new Power-Bi software to provide new data insights
- ✓ Structured training has been provided to staff to improve our understanding of local and national mortality data
- ✓ New staff were appointed during 2022/23 and will help support the Trust's learning from deaths programme

please refer to Part 3 of this report (provider content) for further information about how we are learning from deaths

Domain 2 – Enhancing Quality of Life for People with Long-term Conditions

This section is related to mental health services and admission to acute wards where the Crisis Resolution Home Treatment Team were gate keepers. As these are not commissioned at Salisbury NHS Foundation Trust, there are no indicators to report within Domain 2.

Domain 3 – Helping People to Recover from Episodes of Ill Health or Following Injury

Patient Reported Outcome Measures (PROMs)

National Quality Priorities												
Patient reported outcome measures (EQ5D Index)	**Apr 20 – Mar 21**				**Apr 21 – Mar 22**				**Apr 22 – Mar 23**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
i) hip replacement surgery	*	0.467	0.579	0.378	0.0	N/A	N/A	N/A	0.40	N/A	N/A	N/A
ii) knee replacement surgery	*	0.317	0.434	0.215	0.0	N/A	N/A	N/A	0.34	N/A	N/A	N/A

**** Data not published due to small number of procedures or submission being suspended due to COVID-19***

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust, however the NHS Digital dashboard is noted to not be currently up to date.

PROMs have been collected by all providers of NHS-funded care since April 2009. They assess the quality of care delivered to NHS patients from the patient perspective. They currently cover two clinical procedures (hip and knee replacements) and calculate the health gains after surgical treatment using pre-operative and post-operative surveys.

PROMs data for Salisbury NHS Foundation Trust has not been published for the last two financial years due to the reasons already specified above.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve patient reported outcome measures, and so the quality of its services:

- ✓ Salisbury NHS Foundation Trust will reinstate a robust mechanism for collecting PROMS data, the operational model is currently under review and will be incorporated under the Trust's Patient Experience quality branch.

Patients Readmitted to Hospital Within 30-days of Being Discharged

Note: The updated Quality Account guidance states that the regulations refer to a 28-day readmissions period rather than the 30-day period specified.

National Quality Priorities												
Percentage of patients readmitted within 28 days of discharge from hospital by patient age group	**Apr 2020 – Mar 2021**				**Apr 2021 – Mar 2022**				**Apr 2022 – Mar 2023**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
Age 0 to 15	18.1%	11.9%	64.4%	2.8%	14.8%	12.5%	46.9%	3.3%	13.51%	Not yet published		
Age 16 or over	14.3%	15.9%	112.9%	1.1%	12.5%	14.7%	142%	2.1%	5.92%	Not yet published		

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce re-admissions, and so the quality of its services:

- ✓ Same day emergency care is being rolled out throughout medicine and surgery in 2023 preventing unnecessary admission / readmissions.
- ✓ Partner Inreach services alongside revised Integrated Discharge Service offer to support robust discharge planning (to commence summer 2023).
- ✓ New in 2023 - Power BI data reporting availability and use will enable us to better understand the opportunities to further improve performance in this area.
- ✓ Improved communication with community services and GPs via remodelled discharge services in the community, for people needing care or a bed base (pathways 1-3).

Domain 4 – Ensuring People Have a Positive Experience of Care

Responsiveness to the Personal Needs of Patients

National Quality Priorities												
	Apr 20 – Mar 21				Apr 21 – Mar 22				Apr 22 – Mar 23			
	Response Rate	SFT	Highest	Lowest	Response Rate	SFT	Highest	Lowest	Response Rate	SFT	Highest	Lowest
Overall experience score for National Inpatient Survey	57%	8.4	9.5	7.5	48%	8.0	8.5	7.8	Not yet published			

Scoring: For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the Trust is performing.

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Each year the Trust participates in the national adult inpatient survey. The Trust's last published survey was undertaken in November 2021 where a nationally agreed questionnaire was sent to a random sample of 1250 patients and the results analysed independently by the Patient Survey Co-ordination Centre.

The national inpatient survey was repeated in November 2022 and is scheduled to complete fieldwork in May 2023. Themes from the national adult inpatient survey, FFT, complaints and concerns are identified by each ward and an improvement plan prepared. This year we are also due to take part in the following national surveys:

- The Urgent and Emergency Care Survey took place again in September 2022, with the initial report expected in May 2023.
- The Children and Young Persons survey will take place again in November & December 2023, with the initial report anticipated in August 2024.
- The National adult inpatient survey took place in November 2022, with initial report expected in June 2023.
- The Maternity Survey took place in February 2023, with initial report anticipated in September 2023.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve responsiveness to in-patient personal needs, and so the quality of its services:

- **Discharge process and follow-up:**
  - ✓ E-white board upgrades to ensure timely daily updates.
  - ✓ Patient flow group commenced to focus on length of stay and bed occupancy.

- **Communication:**
  - ✓ Refocus on use of SBAR (Situation, Background, Assessment and Recommendation) handover process, including audit of handover documentation.
  - ✓ Commencement of EDOCU (an electronic documentation system) to aid information passage.
  - ✓ Feedback to individual doctors named in concerns and incidents. Discussions with education and clinical supervisors to ensure learning is shared. Communications training modules being developed for both senior and junior staff.

- **Staffing levels:**
  - ✓ Increase HCA recruitment, 100 HCAs recruited to date. Ongoing focus and regular open sessions to continue recruitment drives.
  - ✓ Recruitment of overseas Registered Nurses, 40 further Registered Nurses currently in progress.
  - ✓ Strategic review of the medical workforce to ensure adequate staffing levels with business case being developed to describe the investment required for medical and supporting professionals – linking this to the benefits to patient flow and care.
  - ✓ Retention focused activities related to the People Plan, including development of support networks for staff.
  - ✓ Up-banding of staff to make Trust more attractive to work for (Band 2 to 3 to be fully actioned).

- **Food and drink, noise and distribution, facilities:**
  - ✓ Band 2 ward assistance role developed to focus on nutritional and hydration needs – recruitment of which is actively in progress.
  - ✓ Utilising ward buddy schemes and hospital volunteers to support the wards where needed.
  - ✓ Business case approved to deliver phased compliance with new national cleaning standards.

Friends and Family Test (FFT) – Patient Feedback

National Quality Priorities						
	Apr 20 – Mar 21*		Apr 21 – Mar 22		Apr 22 – Mar 23	
	SFT	England Average	SFT	England Average	SFT	England Average
Response rate of patients who completed the Friends and Family test for the ward or Emergency Department						
Emergency Department	0.2%	10.8%	0.2%	10.8%	0.5%	Not yet published
Inpatients	5.1%	16.3%	9.1%	18.9%	10.3%	Not yet published
Score of patients who rated the ward or Emergency Department as Good or Very Good						
Emergency Department	100%†	87.5%	87.2%†	77.9%	81%	Not yet published
Inpatients	99.4%	94.8%	98.4%	94.4%	97%	Not yet published

**** Data submission was paused from February 2020 to November 2020 as part of the response to COVID-19***
†Data supressed for some months due to the low number of responses.

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. The limited methods by which the FFT feedback is collected continues to be a challenge. Responses are not received from every service. The result is not having a representative and diverse view of all patients' experiences.

In the Autumn of 2022, we were able to secure a provider through our ICS partnerships alongside Great Western Hospital that will aid us in increasing these response rate targets going forward. This collaboration has ensured value for money and provided an opportunity to standardise and compare methods for data analysis and interpretation across the acute Trusts.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the Friends and Family Test – Patient Feedback, and so the quality of its services:

- ✓ Implementation of the new provider, and this will be a phased rollout, beginning with the Emergency Department and followed by outpatient areas.
- ✓ Continue to use the FFT cards in the Inpatient areas and will be pooling these data sets on the new dashboard.

Once the above is fully implemented we will be able to progress the following related objectives:

- ✓ Increase overall response rates to FFT to achieve the targets set under our Improving Together Metrics (>10% of eligible patients in 2022-23 and >15% of eligible patients in 2023-24)
- ✓ Diverse methods for completion (including, online, SMS, over the phone)

- ✓ Increased accessibility and options for inclusivity (sight impairments, languages, and additional demo-graphic options) - this is subject to implementation of the IT solution which will encompass these improvements to our online version of the FFT survey
- ✓ Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard - this is subject to implementation of the IT solution

Despite the challenges with response rates the Trust is seeing an overall slight increase in response rates. Our aim is to consistently achieve 95% and above of people who rate their experience as 'Very Good' or 'Good', Trust-wide.

Staff Who Would Recommend the Trust to their Friends or Family

National Quality Priorities											
National Staff Survey Results											
Apr 20 – Mar 21				**Apr 21 – Mar 22**				**Apr 22 – Mar 23**			
SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
The percentage of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends											
78.7%	74.3%	91.8%	49.6%	67.6%	67.0%	89.5%	43.5%	55.4%	61.9%	86.4%	39.2%

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Each year the Trust participates in the National Staff Survey. Since 2021, the questions have been aligned to the People Promise as well as two themes, staff engagement and morale. The People Promise sets out, in the words of our NHS people, the things that would most improve our working experience – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job.

The response rate to the survey is a key measurement because it indicates an overall level of engagement in staff willingness to express their opinions through a formal survey. The 2022 response rate was 47.8% (1861 people), slightly lower than the previous year of 49%, but above the average rate of 46% for comparable Trusts.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the percentage of staff who would recommend the Trust to their friends or family, and so the quality of its services:

- ✓ Established focussed working groups looking at elements of the People Promise, e.g. A Voice that Counts and Reward and Recognition
- ✓ Increased reward and thank you activity that include SOX award of the Month and the annual staff awards plus staff family fun day, staff end of summer party, regular free ice creams during the summer months and Christmas music festival
- ✓ Introduced heavily reduced staff meal of the day and provided free Christmas Lunch
- ✓ Increased minimum salary
- ✓ Introduced 100 day and 1 year feedback sessions for new joiners

Domain 5 – Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm

Patients Admitted to Hospital who were Risk Assessed for Venous Thromboembolism (VTE)

A venous thromboembolism (VTE) is a blood clot which starts in a vein and usually occurs deep inside the body, for instance, in the lower leg.

National Quality Priorities												
VTE Risk Assessment	Apr 20 – Mar 21				Apr 21 – Mar 22				Apr 22 – Mar 23			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Percentage of patients receiving a VTE risk assessment	96.8% (internal audit)	Reporting suspended due to COVID-19			99.1% (internal audit)	Reporting suspended due to COVID-19			99.8% (internal audit)	Reporting suspended due to COVID-19		

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described, as patient level data regarding this has been collected monthly by the ward pharmacist from the patients' prescription chart. The data is captured electronically and analysed by a senior nurse before it is then overseen by the Trust's Thrombosis Committee.

Salisbury NHS Foundation Trust continues to be an exemplar for the prevention and treatment of VTE (blood clots) and we achieved **99.8%** of patients being assessed for the risk of developing blood clots and **98.7%** receiving appropriate preventative treatment in 2022/23. We continue to monitor our progress and feedback the results to senior doctors and nurses. The VTE service has seen a total of 686 blood clot events in 2022/23, of which 89 (12.9%) were attributed to hospital care. This compares to a national average of 25%. All blood clot events were reviewed, and 92.2% of patients sadly developed their blood clot despite being provided with appropriate treatment (known as thromboprophylaxis).

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for VTE, and so the quality of its services:

- ✓ Conduct detailed enquiries of patients who developed blood clots in hospital to ensure we learn and improve.
- ✓ Maintain our VTE prophylaxis protocols in line with the most recent National Institute for Health and Care Excellence (NICE) guidance on VTE prevention, prophylaxis, and treatment.

- ✓ Increase education on VTE prevention across the Trust introducing VTE champions on all in-patient wards to assist in the cascade of information. A case has been submitted for a staffing review with the aim to employ a nurse specifically to assist with VTE prevention education.
- ✓ VTE prevention written information is available on all wards and should be provided to all patients on discharge.
- ✓ A QR code has been added to the new electronic discharge summary to signpost patients to Thrombosis UK website to allow them to find further information.
- ✓ Working with informatics to enable patients to also receive a SMS message following discharge with a link to access directly to obtain further VTE prevention information.
- ✓ An electronic VTE risk assessment has been introduced and is to be completed on admission. This will replace the paper version on the prescription chart and completion will be mandatory. Audit will continue to be performed monthly, but the data will be pulled directly from the system.
- ✓ Planned review of the VTE risk assessment currently being used, with a potential change to the Padua scoring system.

Rate of Clostridium difficile (C.diff) infection

C.diff is a type of bacteria that commonly causes diarrhoea

National Quality Priorities												
Rate per 100,00 bed days of C.diff infection	Apr 20 – Mar 21				Apr 21 – Mar 22				Apr 22 – Mar 23			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Rate per 100,000 bed days of C.diff infection amongst patients aged 2 or over	24.8	33.1	161.3	0	28.7	34.5	112.4	0	Not yet published	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. The data is reported for Hospital Onset C.diff cases only.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce the number of C.diff cases, and so the quality of its services:

- ✓ Reduce the numbers further by reviewing all reportable cases to identify any learning that can be shared within the Hospital. This work will continue over the next 12 months.
- ✓ Continue to identify learning through our internal incident investigation process.
- ✓ Continue to participate in and contribute to regional improvement projects for the reduction and prevention of C.diff.

The number of C.diff cases has been increasing nationally during the last 12 months and this is also the experience at Salisbury NHS Foundation Trust. Although numbers have increased, we continue to perform well and rank 60 out of 138 Trusts reporting data nationally.

Patient Safety Incidents and the Percentage that Resulted in Severe Harm or Death

National Quality Priorities												
	Apr 20 – Mar 21				Apr 21 – Mar 22				Apr 22 – Mar 23			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Number of patient safety incidents	6655	N/A	37572	3169	7462	14368	49603	3441	Not yet published	Not yet published	Not yet published	Not yet published
Rate of patient safety incidents (per 1,000 bed days)	51.6	N/A	118.7	27.2	49.9	57.5	205.5	23.7	Not yet published	Not yet published	Not yet published	Not yet published
Number of patient safety incidents that resulted in severe harm or death	37	N/A	261	4	37	57.8	216	3	Not yet published	Not yet published	Not yet published	Not yet published
% of patient safety incidents that resulted in severe harm or death	0.6%	N/A	2.8%	0%	0.5%	0.4%	1.7%	0%	Not yet published	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. We have good collaborative working across the organisation, which actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken. Incident data is regularly uploaded to the National Reporting Learning System (NRLS).

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce the number of patient safety incidents and the percentage that resulted in severe harm or death, and so the quality of its services:

- ✓ We continue to educate staff on the positive impact of reporting incidents and near misses.
- ✓ All moderate, major, and catastrophic harm incidents are validated by the Trusts Risk team.
- ✓ All moderate harm and above incidents are discussed at the Trust Patient Safety Summit weekly. This multidisciplinary and collaborative approach to patient safety incidents ensures that early actions can be taken to minimise further harm occurring, serious incidents are recognised

promptly, and duty of candour is initiated with patient and families from the outset of the investigation to ensure inclusion with the process.

- ✓ There have been no reported Never Events during 2022/23

It is crucial that we learn from every incident and near miss that happens to address concerns and continually learn. The Trust reviews all incidents to take immediate any actions and consider safeguards for patients. Alongside senior clinicians reviewing incidents on a weekly basis, on a quarterly basis we identify learning and more thematic areas for improvement.

In line with national guidance, Serious Incidents (SI's) are reported, and an in-depth investigation completed to identify our learning and any actions. Every investigation is shared with our commissioner for review.

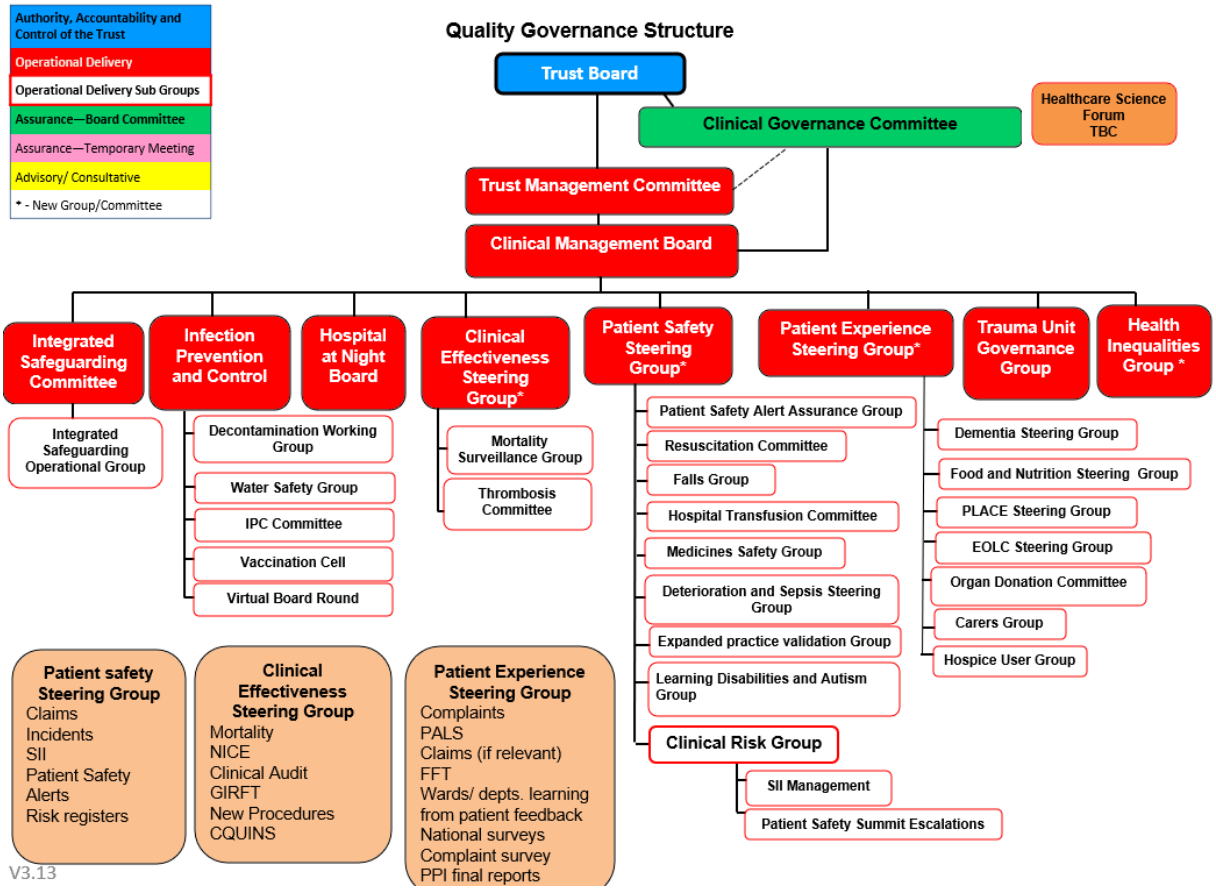
Part 3 - Other/Provider Content

Salisbury NHS Foundation Trust

The quality accounts regulations specify that Part 3 of the quality accounts should be used to present other information relevant to the quality of relevant health services provided or subcontracted by the provider during the reporting period.

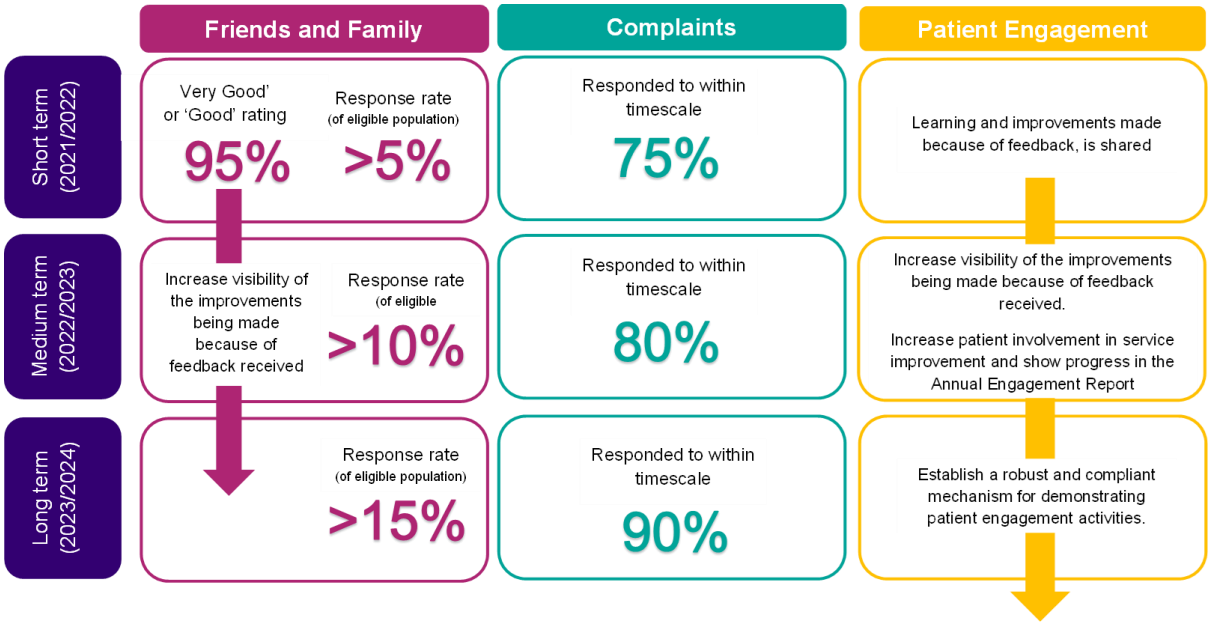
Quality Overview

As we have already established, quality is commonly recognised as having three dimensions: patient safety, clinical effectiveness, and patient experience. At Salisbury NHS Foundation Trust we have three steering groups which each meet monthly, represent each of these arms of quality, and each report upwards to our Quality Board (CMB). It is here that all aspects of quality are scrutinised and discussed. The latest quality governance structure is shown in the diagram below. In this section of the report, we present some highlights of activity across each of these areas of quality, and improvements which have taken place across our four clinical Divisions within 2022/23.



Patient Experience

Overview and Key Priorities (as outlined in part 2A)



Patient Stories

Patient Stories continue to be a highly valued part of our commitment to ensuring the voices of our services users are heard. These continue to be heard at our Trust Board meetings and are now embedding into our departmental and divisional governance groups, along with our Patient Experience Steering Group. We continue to explore different methods and approaches to presenting these stories to ensure maximum impact.

Send a Letter to a Loved One

Since we established the service back in April 2020 over 3,000 messages from families to their loved ones being cared for within the hospital have been received into the dedicated Patient Advice and Liaison Service (PALS) inbox. These messages are printed into cards and delivered to patient bedsides. This initiative has been well received and continues to grow in popularity. We would like to thank our colleagues in the League of Friends for supporting this project and to all the staff who have contributed to the card designs to date.

Patient engagement

This year we have been developing a system to record and develop a pool of service user engagement volunteers. This database will act a point of reference and record for engagement activities and will cover a vast array of opportunities for services users/carers and volunteers to be involved with our hospital. Now that a complaint system has been established we are working through the next phase, exploring opportunities to begin populating this.

Patient led panels

In April 2023 we will be launching our first fully patient-led service improvement panel – working in partnership with service leads. The group has a confirmed attendance of six previous users of our Spinal Services and will be chaired by a patient/ex-service user. This first meeting will seek to establish the groups terms of reference followed by a focused session aimed at sharing lived experiences to help identify the groups next steps.

Complaints Process Review Project – Healthwatch Wiltshire (HWW)

Throughout 2022 the Trust embarked on a co-produced complaints process review project in partnership with Healthwatch Wiltshire (full report accessible here). The learnings taken from this project will be implemented over the coming 12 months and will inform the changes needed for our complaints policy and has been identified as a priority area for Patient Experience. This is a chosen area of priority for Patient Experience (see page, 56 of this report).

Friends and Family Test

Implementation of a new IT solution has had to be delayed this year due to resourcing challenges, however this is now planned for December 2023. We will continue with interim solutions to boost response rates, including trialling the use of QR codes and continued active promotion, particularly within our Emergency Department and outpatient areas. We will also be continuing to utilise social media as way of engaging feedback through #ThankyouThursday and #FeedbackFriday.

Real-time feedback

Real-time feedback was re-launched in February 2023. The newly designed feedback survey has been largely based on the annual inpatient survey areas to develop a more "real-time" picture of the views of our patients. The surveys are undertaken face-to-face and are being scaled up with the support of our volunteers, staff, and Governors.

Working with our communities

The Trust is proud to have achieved its Gold accreditation for veteran awareness from the Armed Forces Covenant for 2022. The Trust has approximately 130 registered Armed Forces Champions and this continues to grow.

In November 2022 we recruited a Learning Disabilities Lead Nurse who is leading out Learning Disability and Autism strategy, working closely with our Treat Me Well Group (established in partnership with Mencap).

We continue to hold our drop-in support and information sessions at our Carer's Café on a weekly basis. This is run by our passionate and experienced volunteers, offering one-to-one support and information for those with unpaid caring responsibilities. On the back of this we are working hard to educate our staff on the important role of carers during their loved one's hospital journey, reaffirming our pledge to the Carers Charter and to John's Campaign.

Listening to our patients in partnership with our Hospital Charity

Stars Appeal funded – Emergency Patient Clothing and TV cards

Stars Appeal provides basic garments and free access to the hospital's TV system. This has enabled those without the means to pay to have some home comforts, such as TV access to pass the time during their stay.

Access to clean or spare clothing enables patients to wear comfortable clothes as opposed to hospital gowns - protecting patients' dignity and improving their confidence. This initiative has also enabled some patients to start practicing putting on clothes by themselves, encouraging independence and aiding recovery.

Stars Appeal funded - Aromatherapist

In November 2022 the Trust appointed an International Federation of Professional Aromatherapists (IFPA) accredited Aromatherapist, funded by our hospital charity. This service is a branch of herbalism aimed to provide alternative therapies to those undergoing chemotherapy. There is also additional capacity to help those with burns or parents of babies in our NICU. This is a 3-year contract and has so far been used to help over 230 patients access alternative medicine.

Clinical Effectiveness

Clinical Audit and NICE

Please refer to sections 2B and Appendix B of the report to see an overview of the audit activity which has taken place across the Trust during 2022/23.

Plans are in place to improve our processes for managing audit and we are planning to adopt a new electronic audit management system in 2023/24 to support these developments. The implementation and roll out of this system has been selected as one of our key quality priorities for next year. An internal review of 'audit' was also undertaken by PwC during 2022/23 and recommendations and actions from this review are being taken forward.

Learning from Deaths

During 2022/23 there has been an increase in the crude number of deaths observed at Salisbury NHS Foundation Trust and we continue to monitor these trends closely. This rising trend is also one which has been observed nationally since the COVID-19 pandemic.

The total number of deaths and the total number of SJRs (including checklists) completed during each quarter of 2022/23 were as follows:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**TOTAL**
Inpatient Deaths (inclusive of Emergency Department and Hospice)	259	243	254	289	1045
1st Scrutinised by the Medical Examiner	216	195	225	275	911
Additional reviews (SJRs) completed	32	14	115	92	253
SJRs undertaken related to deaths during 2022/23	10	1	68	65	144
SJRs undertaken related to deaths during 2021/22	22	13	47	27	109
Patient deaths judged more likely than not to have been due to problems in the care provided to the patient (Hogan Score)	<5	<5	<5	<5	<5

The Trust's Mortality Surveillance Group (MSG) continue to meet every two months and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health U.K. (Dr Foster) is invited to attend to help us interpret and analyse our mortality data and identify any variations in specific disease groups. Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Most deaths that occur at Salisbury NHS Foundation Trust are reviewed (scrutinised) by the ME shortly after death. An internal review (known as a structured judgement review or SJR) may be requested should there be potential learning identified following the death of a patient. This could be identified through a review of the medical records or following consultation with the relatives or carers of the bereaved. In addition to cases flagged up by the ME, reviews may be commissioned or undertaken by clinical specialties through peer learning and/or at Mortality and Morbidity (M&M) meetings.

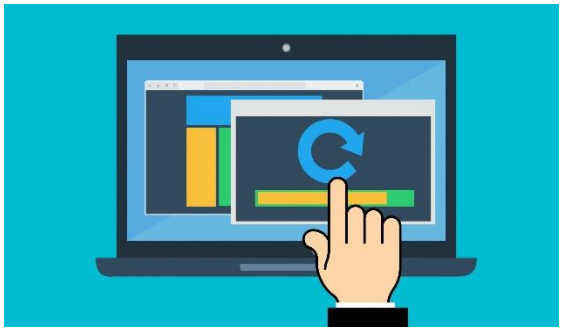
During 2022/23 we commissioned reviews looking at specific diagnosis groups where alerts had been raised through statistical modelling. This included undertaking a review of all COVID-19 deaths up to and including November 2022, and a review of specific clinical diagnosis groups which include COPD and Bronchiectasis, Pneumonia, and Acute Renal Failure. Patient deaths judged more likely than not to have been due to problems in the care provided to the patient.

Several changes have been made in 2022/23 to improve how we are learning from deaths and responding to feedback. A Trust Mortality Lead and a learning disability nurse were both newly appointed and have been supporting our learning from deaths programme. A particular focus has been on supporting clinical specialties to undertake reviews, whilst ensuring that there is a wider pool of professionals who are able to undertake these reviews across the Trust as a whole. A new abbreviated version of the SJR (a checklist) is being piloted to help increase the uptake of reviews whilst ensuring that there is a greater focus on any learning and actions.

Other Developments

A new electronic system to manage mortality reviews and learning from deaths will be adopted in 2023/24. The procurement of this will closely mirror that of clinical audit, as the same system will be used to manage both processes using two separate modules. One of the benefits will be to increase the visibility of data and enable real-time reporting and sharing of learning. Reducing the administrative burden will also ensure that more resources can be channelled into learning and the delivery of actions.

In addition, during 2022/23 we started to develop an in-house mortality dashboard (using the Power-Bi capabilities which have been adopted by our informatics team). We hope to go-live with this in 2023/24, and the data should provide the Trust with new insights in relation to our mortality data. This tool will also support clinical specialties with reviewing their mortality data and this will be another tool for sharing learning across the organisation. In addition, members of our informatics and mortality teams have been undergoing structured training, provided by our external partners (Telstra Health U.K), to further improve our understanding of the local and national mortality data which is accessible to staff members using the Dr Foster toolkit.



Medical Examiner (ME) Update

Preparations for the community ME roll-out have been ongoing, with several GPs having been newly appointed to the role of ME during 2022/23.

Summary:

- ✓ **The Trust's Mortality Surveillance Group (MSG) continues to meet every two months**
- ✓ **Several commissioned reviews were undertaken during 2022/23 and learning was shared and discussed at the Trust Mortality Surveillance Group (MSG)**
- ✓ **A new electronic system for managing mortality reviews and learning from deaths will be adopted in 2023/24**
- ✓ **A mortality dashboard is being newly developed using new Power-Bi software to provide new data insights**
- ✓ **Structured training has been provided to staff to improve our understanding of local and national mortality data**
- ✓ **New staff were appointed during 2022/23 and will help support the Trust's learning from deaths programme**

Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients. The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Although GIRFT activity was reduced during the pandemic activity picked up this year. A BSW GIRFT working group has been set up with help from the national team to provide oversight across the ICS and identify common working. There is significant understaffing in the regional offices and the teams are currently prioritising the High Volume Low Complexity (HVLC) programme workstreams.

In the year 2022/23, GIRFT visits occurred in Adult Critical Care, Geriatrics, Neurology, Acute Medicine, Cardiology, Orthopaedic Adult Trauma and via a BSW system visit.

HVLC Programme

System response is being coordinated with current data collated from comparison and shared. Focus themes such as Day Case activity rates have improved across the system to average 75% (from 73%), with Salisbury NHS Foundation Trust best performing at 80% against a benchmark 82%. Theatre utilisation in terms of inter-case downtime has also improved to 16 minutes average (from 20 minutes) to support maximised utilisation of operating sessions. Focus areas of improvement for Salisbury NHS Foundation Trust aligned to elective recovery are Length of Stay for Orthopaedics (Primary Hip/Knee and Neck of Femur Fractures), ENT emergency admissions without procedure and Day Case Tonsillectomy rates. A Salisbury NHS Foundation Trust Gap Analysis pack of HVLC operating performance against benchmarks is being finalised to inform potential of dedicated lists considering consultant, location, and constraints. This will be shared with specialties to drive best practice and improve overall performance aligned with national targets.

Summary of GIRFT Activity:

Adult Critical Care	**This visit highlighted an exemplary service:** • There was acknowledgement since the Novichock episode of the significant change, improvement, and visibility of leadership. • Length of stay was greater than average - this appears to be related to getting patients back out to the wards in a timely manner. • There should be an increase in dedicated OT, SLT and critical care pharmacist provision.
Geriatrics	**This was a useful visit highlighting many national issues around frailty, length of stay and training:** • High praise was given to the 30-day readmission data and of the advanced care planning allowing patients to die in their own homes. Salisbury NHS Foundation Trust had the lowest number of admissions in the last 90 days of life nationally. • To increase the staff trained in health/frailty core capabilities framework training particularly in general medicine beds. • Lack of access of community hospital and the difficult geography of these beds and in the impact to rehabilitation and length of stay. • Work around reducing deconditioning. • Low number of 0-day LOC to be addressed by SDEC and acute frailty service plans. • Staffing and workforce is a major challenge although sickness is less than the national average.
Acute Medicine	**This visit highlighted several areas of potential improvement:** • To increase the medical workforce in AMU to aim for long term 7 day working. • To increase the size of SDEC to match the demand of ambulatory care. • To stop bedding in of patients in these assessment beds and to increase the size of AMU to the number of daily medical admissions plus 10%. To increase % of zero LOS patients to NHSE recommendations of 33% from current levels 20-27%. • To improve the coding using treatment function code to identify specialty medical work occurring by the acute medical teams. • The team highlighted the excellent VTE and PE pathways.
Neurology	**This service is provided by University Hospital Southampton NHS Foundation Trust (UHS) and recommendations included:** • Acute neurology clinic with referrals from ED and AMU. • To provide an electronic referral mechanism which can be auditable with advice 7 days a week even if some remote via UHS. • Patients in Wiltshire have limited access to outpatient due to capacity, to develop specialist nurse roles for epilepsy and provide further support for Patients with MS and Parkinson's with onsite specialist nurse visits. • To increase the Advice and Guidance from UHS to reduce referrals. • To increase patient initiated follow up and review strategies for reducing DNA.
Cardiology	**This service appears cohesive and very well led, recommendations included** • Review the utilisation of cardiology bed base to ensure patients are accommodated appropriately. • To pursue plans to increase the cardiology consultant workforce. • To look at the outpatient referral triage system which is currently inflexible and outdated. • To review the OPD provision to ensure it meets capacity to include PIFU. • To expand the CTCA service to reduce waiting lists and to ensure second cath. lab is fully utilised.

Patient Safety

Electronic Prescribing and Medicines Administration (EPMA)

In their simplest form, EPMA systems allow doctors to prescribe, nurses to administer medications, pharmacists to clinically review and reconcile medications and pharmacy technicians to input drug histories and order medications. Other members of the multi-disciplinary team (MDT) may also have access to carry out duties within their professional competency.

At the Trust, EPMA is delivered through the Lorenzo platform that is already in use across the Trust providing Electronic Patient Record (EPR) and Patient Administration System (PAS) functionality, supporting daily patient care. The Lorenzo system has been in use across the Trust since 2016, so it is a platform that staff will already be familiar with, reducing the training burden. Further, support functions are well versed in the management and development of the system, making the development easier to deploy.

Approximately 30% of negative drug effects are a consequence of a medication management error. Deploying EPMA enables the realisation of many benefits that can help reduce medication errors, such as:

- ✓ **having a full patient medication history, decision support and online resources available to aid prescribing, with allergies and interactions highlighted;**
- ✓ **eliminating illegibility issues and the need for transcription;**
- ✓ **improving the quality of discharge information;**
- ✓ **providing transparency in the prescribing process;**
- ✓ **making it easier to adhere to safety standards;**
- ✓ **enabling robust audit information on medicines usage.**

There are also further benefits that can be used to leverage efficiency savings, such as:

- ✓ **medication records being stored electronically, accessible remotely and available 24/7, so time no longer wasted searching for paper chart;**
- ✓ **reducing the overall time taken to prescribe, check, supply and administer medicines;**
- ✓ **enhancing patient care as time saved gives clinicians more time to spend with patients.**

This year we have been successful in recruiting the remainder of the team to deliver EPMA. We have configured Lorenzo and established a drug formulary within the application. Testing of the system was undertaken, and training materials developed. Training materials were released into LEARN (the Trust's Managed Learning Environment, or MLE) with staff assigned to these as appropriate. Staff smartcard roles were reviewed, and additional roles created. Staff smartcard testing was undertaken, with staff assigned to new roles as appropriate and Lorenzo access was configured for all. Wards and areas were engaged with and briefed ahead of their planned deployment dates. Staff undertook training as part of their lead-in to go-live engagement plans and the fallback solution was deployed, to support areas in the event of a system outage.

The deployment team were readied and a roll out plan was produced and communicated. The system was piloted in two steps, firstly on Longford ward closely followed by Odstock ward. The pilots proved to be successful, and the deployment commenced across the Trust.

To date the roll out has gone well but there have been challenges, as expected, due to running a hybrid system during the roll out. This situation will improve as we deploy to the front door areas, such as the Acute Medical Unit and Emergency Department, scheduled to be completed early April 2023.

To date we have deployed to 67% of the Trusts total inpatient beds. EPMA is in use supporting the treatment of patients in 348 beds (97% of total Medicine beds, 15% of Surgical and 60% of Clinical Support and Family Services (CSFS). Roll out to the remaining adult inpatients wards/areas is planned to complete in May 2023, with Paediatric areas in the summer. Alongside this development, the Pharmacy system is being upgraded to enable the deployment of an interface to Lorenzo, facilitating the direct ordering of TTO medications. This is expected to be complete at the end of Spring.

Safeguarding Adults (Mental Capacity Act and Deprivation of Liberty Safeguards, Domestic Abuse and Learning Disabilities)

Safeguarding Adults is about **protecting a person's right to live in safety, free from abuse and neglect.** According to the Care Act 2014 the aims of safeguarding adults are to:

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives "Making Safeguarding Personal";
- promote an outcomes approach to safeguarding that works for people resulting in the best experience possible;
- raise public awareness so that professionals, other staff, and communities as a whole play their part in preventing, identifying, and responding to abuse and neglect.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), Domestic Abuse and Learning Disabilities (LD) also sit under the umbrella of *Adult Safeguarding.*

What have we done to improve adult safeguarding in 2022/23?

- ✓ We have continued to provide Adult Safeguarding, MCA & DoLS and Domestic Abuse training, advice, and support across the Trust.
- ✓ Continued developing the Safeguarding Champions.
- ✓ We provided bespoke training to wards, departments, and teams.
- ✓ Band 7 Adult Specialist Safeguarding Professional commenced within the team in May 2022.
- ✓ Band 7 Learning Disability and Autism Liaison Nurse joined the team in November 2022.
- ✓ The Learning Disability and Autism Liaison Nurse has developed a workplan with the Treat Me Well group.

- ✓ The Liberty Protection Safeguards (LPS) introduction has been delayed beyond April 2023, but we have continued to meet within the local health and social care arena.
- ✓ We successfully submitted a business case to fund a new MCA, DoLS and LPS Lead.
- ✓ This post holder will lead the current MCA & DoLS provision and lead the LPS introduction within the Trust.
- ✓ We recruited into the MCA, DoLS & LPS Lead post in March 2023.
- ✓ We submitted the 2021/22 NHSE/I Learning Disability Standards for Acute Trusts in February 2023.
- ✓ We introduced Adult Safeguarding Supervision within the Trust.
- ✓ We continue to support the divisions in investigating and learning from any Safeguarding concerns within the Trust.
- ✓ We now attend the Wiltshire Multi-Agency Risk Assessment Case Conference weekly.

Safeguarding Children

Salisbury NHS Foundation Trust is committed to safeguarding children and promoting the welfare of children and young people. In accordance with the Children's Act 2004 all individuals who work in health organisations must be trained and competent to recognise when a child or young person may need safeguards put in place and know what to do in response to their concerns. Section 11 of the Children's Act places a statutory duty on NHS organisations including NHS England, ICB's NHS Trusts and NHS Foundation Trusts to ensure that their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of the child.

Safeguarding children and promoting welfare of children is defined in 'Working Together to Safeguard Children and Young People' (HM Government 2018) as:

- protecting children from maltreatment;
- preventing impairment of children's mental and physical health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- taking action to enable all children to have the best outcomes.

What have we done to improve safeguarding children in 2022/23?

- ✓ Continuing to establish 'We can Talk Training' across the organisation. We Can Talk has been produced by Healthy Teen Minds in conjunction with hospital staff, young people, and mental health experts to improve the experience of children and young people attending Salisbury NHS Foundation Trust who are in a mental health crisis.

- ✓ Three Safeguarding Children's Audits were completed in 2022/23: A Staff awareness of safeguarding children audit, a Maternity Domestic Abuse audit, and a Multi-Agency Safeguarding Hub Referral audit. All audits were disseminated, and action plans were implemented where improvements were identified.

- ✓ Level 3 Safeguarding Children's training has continued to be face-to-face and there were 10 sessions facilitated in 2022/23.

- ✓ The Children's and Adult's Safeguarding Supervision Policy was updated in 2022/23 as Salisbury NHS Foundation Trust regards safeguarding supervision an important and essential requirement of all staff engaged in clinical activities. It is an essential element within the governance framework; supervision plays a significant role in ensuring the continuous improvement in the delivery of high-quality care to patients and service users.

- ✓ Four registered Practitioners successfully completed the Safeguarding Supervision Training which will have an impact on the supervision figures. It is important there are Safeguarding Supervisors to facilitate Safeguarding supervision as it is important for staff working with children to remain child-focused to improve the outcomes for children.

- ✓ A new Restrictive Physical Intervention and Therapeutic Holding Policy in Children and Young People was developed. This was to ensure that Salisbury NHS Foundation Trust had a safe policy that protects and safeguards the welfare of children and young people and supports the ethos of caring and respect for children's rights.

Our Workforce

People Promise

Salisbury NHS Foundation Trust is one of the 21 People Promise Exemplar sites, sponsored by NHSE. The NHS People Promise is our promise to each other to work together to improve the experience of working in the NHS for everyone (NHS England » Our NHS People Promise). In 2022/2023 we incorporated the seven elements of the People Promise into our Salisbury NHS Foundation Trust Long Term People Plan. We developed and implemented a range of interventions that support the wellbeing and positive experiences of our staff. There is still further progress to be made and in 2023/2024 we will focus on the following areas and interventions.

Staff Availability

Our breakthrough objective related to staff availability is designed to ensure we meet safe staffing levels without having to resort to a high level of agency use. By April 2024 we aim to reduce agency spend to our 3.7% target. To support this objective the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** We will implement an improved set of recruitment practices to fill our vacancies appropriately and efficiently.
- ✓ **We each have a voice that counts:** Civility saves lives. There has been a proven correlation between positive civility and respect within an organisation leading to improved patient care. We will create a civility and respect compact, piloting and testing it in one or two areas prior to rolling-out Trust-wide with an ambition to support through champions and ambassadors.
- ✓ **We are safe and healthy:** We will actively manage absences, paying positive, proactive attention to our staff wellbeing and reduce vacancy rates. We will work towards achieving accreditation for our Occupational Health Service.
- ✓ **We are always learning:** We will increase our apprenticeship offer and trial new roles to encourage staff to grow their careers at the Trust.
- ✓ **We work flexibly:** We will support departments to use team-based rostering to give individuals greater control over when they work. We will encourage the uptake of the homeworking support fund to enable effective home and hybrid working. We will scope the use of digital passports to ease the movement of staff and trainees joining our organisation.
- ✓ **We are a team:** We will provide people management skills training in place for ward leaders to give them the skills and information they need to deal with absence, sickness and other issues appropriately and in a timely way.

✓ Staff Engagement

Our vision metric in our long-term plan related to staff engagement is designed to create an engaged and motivated workforce. We aspire for people to recommend Salisbury NHS Foundation Trust both as a place to work and somewhere to receive care. We want them to feel they are supported to make improvements in the care and the services they provide. By April 2027 we aspire to return to the upper quartile for NHS acute providers in the NHS Staff Survey in relation to motivation and engagement. To support this vision metric the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** We will continue to develop and roll out our leadership and coaching training offers. We will continue to refine and roll out our leadership framework and to support Improving Together. We will develop policies and practices to support the implementation of a Restorative Just and Learning Culture.
- ✓ **We are recognised and rewarded:** We will develop a recognition framework and continue to promote celebration activities and events. We will celebrate the successes of our people through the staff awards, SOX and recognition events. We will continue to develop and share our pension and retire and return offers.

  We each have a voice that counts: We will introduce a Staff Council, explore promotion of professional networks and continue our feedback and listening events. We co-create these with an engagement working group. We will develop processes and practices that foster speaking up and enabling psychological safety for our people.
- ✓ **We are safe and healthy:** We will continue to offer tailored wellbeing interventions. We will continue to improve our health and wellbeing data collection to ensure our offer meets our people's needs. We will continue to grow and develop both our Mental Health First Aiders and our Wellbeing Champions network.
- ✓ **We are always learning:** We will refresh our appraisal process including linking appraisals to career and wellbeing conversations. We will create a calendar of learning opportunities for our people to access.
- ✓ **We work flexibly:** We will create a communications plan to encourage an equitable and open approach to flexible working in all areas of the Trust. We will begin to develop and gather some evidence to better describe the cost benefits and impact of flexible working on staff engagement and motivation.
- ✓ **We are a team:** We will review our induction processes including for international medical graduates and create a package of interventions that aims to improve the first 90-day experience of staff joining the Trust to encourage a sense of belonging and make people feel welcome from day one.

Staff Turnover

Our vision metric in our long-term plan related to turnover and retention is designed to encourage people to stay within our workforce and take up opportunities of promotion or changes in role. We aspire to reduce turnover where people leave the Trust or the NHS and increase retention of people who continue their careers with us, moving to new jobs within the Trust or within BSW. By April 2027 we aspire to regularly maintain turnover in line with the Trust target of 10% and an increasing stability index. To support this vision metric the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** We aim to improve the feeling of belonging for our people including offering cultural awareness workshops and by creating an advocates programme.
- ✓ **We are recognised and rewarded:** We aim to continue to increase our retire and return offer, keeping our people in the Trust for longer. We will engage with the BSW legacy mentor offer to ensure that expertise is not lost and that our new people benefit from the experience of others.
- ✓ **We each have a voice that counts:** We will continue to further develop our Freedom to Speak Up offer to continually improve experiences and outcomes for our people. We will launch a new policy and actively promote our Freedom to Speak Up training.
- ✓ **We are safe and healthy:** We will improve our exit interview and data collection on leavers so that we can begin to address any common themes. We will revamp our staff rooms so that our people have improved environments in which to rest and relax. We will continue so support the psychological wellbeing of our people.
- ✓ **We are always learning:** We will improve access to career conversations for our people and better direction to talent management opportunities and career pathways to encourage them to seek career progression with the Trust rather than leaving.
- ✓ **We work flexibly:** We will train managers to embrace and fully understand flexible working with a view to increasing the uptake of flexible working opportunities leading to more positive work/life balance for our people.
- ✓ **We are a team:** We will collaborate with our teams to develop conflict resolution skills and to access manager training that gives them the skills to better manage their teams so that people are more likely to stay.

An inclusive employer

Our vision metric in our long-term plan related to inclusion is designed to create an environment where our people recognise and experience the Trust as an inclusive employer. We aspire for a more positive trend against all of the seven Workforce Disability Equality Standards (WDES) and four Workforce Race Equality Standards (WRES) indicators in the staff survey. By April 2027 we aspire to achieve the median for our benchmark group across the workforce standards at Salisbury NHS Foundation Trust. To support this vision metric the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** As well as improving our own in-house Equality, Diversity and Inclusion offers we will be working towards the six high impact actions related to recruitment and promotion. This will help us to recruit a range of different people to join the Trust and to ensure there are equitable career opportunities for all. We will adopt and adapt the SW leading for inclusion strategy which includes a commitment for all leaders to demonstrate a personal objective in support of equality.
- ✓ **We each have a voice that counts:** We will continue to expand our networks and to encourage a range of meetings and events to support our people.
- ✓ **We are safe and healthy:** We will continue to develop our BAME wellbeing offer and to ensure that we are more closely meeting the wellbeing needs of that group.
- ✓ **We are always learning:** We will roll out our Equality, Diversity and Inclusion training across the Trust.
- ✓ **We are a team:** We will set up and deliver cascade briefings that help all of our people to feel informed. We will continue our listening events to ensure our people continue to feel listened to and collaborate on the development of our Trust-wide civility charter.

Highlights from our Clinical Divisions

Medicine Division

Key achievements

Improving together progress: improved driver metrics, meetings, speciality score cards

- ✓ Firm control on finance and vacancies
- ✓ Dedicated governance resource and time
- ✓ Regular DMTs and face-to-face meetings
- ✓ learning from incidents meetings and agenda

Key challenges/objectives and how the Division intends to overcome/achieve these

Improvements made last year (2022/23)

- ✓ Staff survey response and actions
- ✓ Celebrating success and sharing of learning
- ✓ Wider divisional communication

Objectives/plans for next year (2023/24)

- ✓ Managing staff availabilities
- ✓ Falls reduction work
- ✓ Development and succession planning
- ✓ Right patient right place right time
- ✓ Same day emergency care

Other Quality Improvement successes

- ✓ Significant reduction in complaints
- ✓ Structure and clear focus within governance
- ✓ Improving Together engagement

Surgery Division

Key achievements

- ✓ First Trust in the South West to reach national long wait target
- ✓ Contributed to the Armed Forces covenant Gold Award 2022 working with the Plastic Surgery Team
- ✓ Introduction of TULA, trans-urethral laser ablation for the removal of bladder tumours under local anaesthetic in Urology Outpatients

Key challenges/objectives and how the Division intends to overcome/achieve these

Improvements made last year (2022/23)

- ✓ Increase in theatre capacity up to 13 theatres
- ✓ Collaborative working with BSW and clinical networks across various regions
- ✓ Launch of Trust-wide electronic platform for access to urgent and routine advice and guidance for Primary Care

Objectives/plans for next year (2023/24)

- ✓ Recovery programme to further reduce number of patients waiting
- ✓ Focus on Recruitment of staff into division
- ✓ Staff Survey and Wellbeing action plan to deliver NHS People Promise

Other Quality Improvement successes

- ✓ Building commenced on the new elective recovery ward which will help increase our capacity to deliver elective surgery
- ✓ Modernised our technology across all Endoscopy rooms and this includes the addition of a 4th room
- ✓ Achievement of JAG (Joint Advisory on GI Endoscopy) accreditation and recruitment of Gastroenterologists Consultants

Women and Newborn Division

Key achievements

- ✓ GMC survey demonstrated that overall satisfaction had increased from 63 to 83%, and teamwork improved from 71% to 85%
- ✓ Recruitment of a new digital midwife to support clinical and IT teams with implementing a maternity digital platform
- ✓ We celebrated the 100th anniversary of the Beatrice Maternity Unit

Key challenges/objectives and how the Division intends to overcome/achieve these

Improvements made last year (2022/23)

- ✓ Neonatal escalation pathway developed following learning from a serious investigation, enabling staff and families to feel able to escalate concerns when they arise
- ✓ Successful oversees recruitment of new midwives
- ✓ Flexible rostering introduced

Objectives/plans for next year (2023/24)

- ✓ A new behaviour framework for maternity has been developed and will be launched in 2023/24
- ✓ Daily IT huddles in gynaecology are being established
- ✓ Development works planned for the MVA (managing miscarriage for women under LA) suite in the Summer of 2023 (Stars Appeal funded)

Other Quality Improvement successes

- ✓ Coaching for six new leaders in maternity
- ✓ Allied Health Professional ward rounds on the neonatal unit (NNU) from April ’23 and weekly music sessions on the ward (Stars appeal funded)
- ✓ Several new members of staff including a new matron in gynaecology
- ✓ Wellbeing menopause event for staff

Clinical Support & Family Services (CSFS) Division

Key achievements

- ✓ Care of CAMHS patients on Sarum Ward – recognised at staff awards
- ✓ Robust governance with well-established staff engagement and shared learning
- ✓ Staff Survey engagement

Key challenges/objectives and how the Division intend to overcome/achieve these

Improvements made last year (2022/23)

- ✓ Senior Leadership Team meetings with standard agenda and escalation process
- ✓ Positive approach to Improving Together methodology
- ✓ BSW collaborative work

Objectives/plans for next year (2023/24)

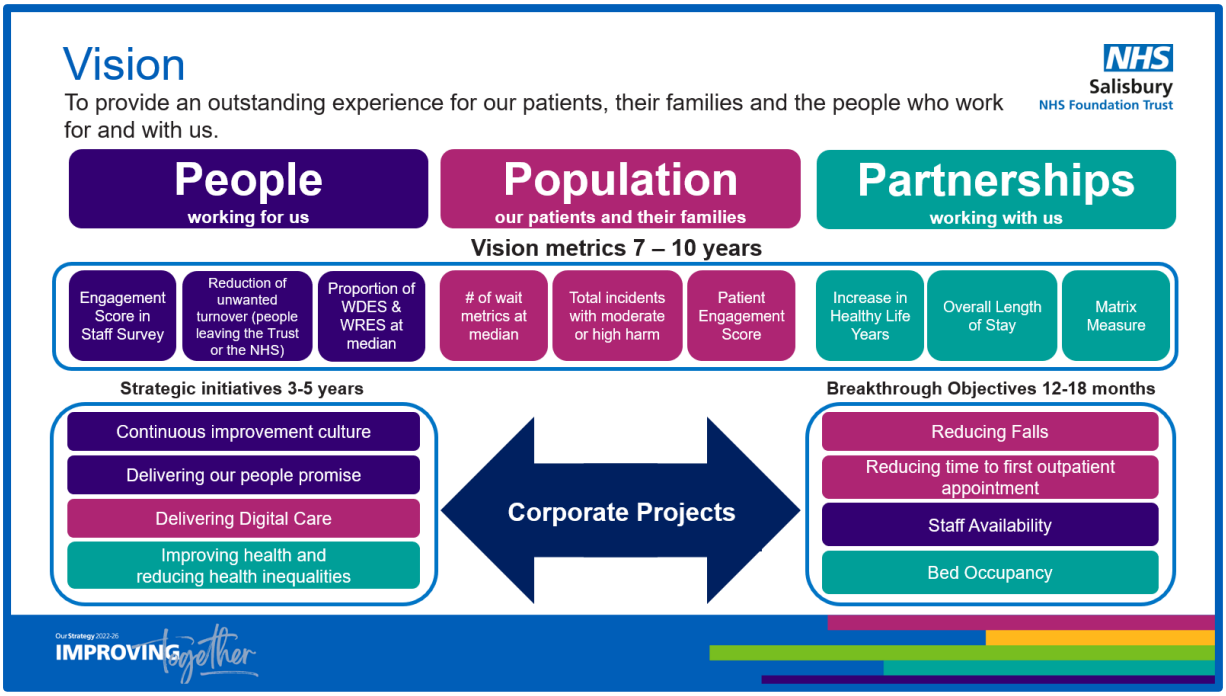
- ✓ Leader standard work across Division
- ✓ Integrating and embedding Improving Together across all services
- ✓ Consolidate and refresh staff survey response

Other Quality Improvement successes

- ✓ Ward buddies
- ✓ Take 5 campaign for staff wellbeing
- ✓ Celebrate success across Division to include Envelopes of Appreciation

Appendix A – Strategic Planning Framework

This framework sets out our areas of focus to achieve our vision and strategy. Please refer to section 2A of the report for further information and context.



Appendix B – Audit Examples and Actions

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group (CESG) in 2022 / 23	
Audit Title	**Outcome / Actions to improve quality of healthcare**
Cleft Registry and Audit Network (CRANE) 2022 (Data 2021) Published in December 2021 Presented to CESG in June 2022	CRANE produce 2 annual audit reports, a full report for clinicians and cleft centres and a summary of findings for patients and parents/carers. From 2021 the piloting of a new outlier process for CRANE is in use demonstrating where cleft services fall above and below the control ranges. Spires Cleft Centre is above the national average for all measures with 2 positive outliers. Further areas for improvement include consent, clinic attendance and lack of paediatric dentist. **Actions to improve the quality of healthcare** 1. Improve collection of speech outcomes at 5-year audit. 2. Keep up momentum to further improve data collection and recording of data. 3. Ensure verified consent is captured to allow for more complete records to be available on the CRANE database. 4. Look at options for paediatric dentist requirement.
Epilepsy12 Clinical and Organisational Audit report Published in July 2021 Presented to CESG in April 2022	Epilepsy12 aims to help epilepsy services and those who commission services to measure and improve quality of care for children with epilepsy. Metrics include NICE standards, mental health, educational and transition metrics. Some positive results include children obtaining an EEG within 4 weeks of request, improvement in comprehensive epilepsy individualised plan and improved care planning content. Clinical staff with epilepsy expertise, psychology provision and transition are areas to work on. **Actions to improve the quality of healthcare** 1. Approval of Epilepsy business case to include psychology support, increase epilepsy specialist nurse and epilepsy consultant. 2. Start claiming epilepsy best practice tariff., dependent on above. 3. Maintain first afebrile seizure approach from EQIP project 4. Coproduce transition project/ improvement
National Bowel Cancer Audit 2021 (data 2019-2020) Published in February 2022 Presented to CESG in November 2022	The annual report includes all patients diagnosed with bowel cancer between 01 April 2019 and 31 March 2020. Historically there have been issues with our data coming from the Somerset database. The data currently suggests that Salisbury continues to perform above average in this audit.

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group (CESG) in 2022 / 23	
Audit Title	**Outcome / Actions to improve quality of healthcare**
National Diabetes Inpatient Safety Audit (data 2018-2021) Published in July 2022 Presented to CESG in October 2022	The aim of this audit is to understand how diabetes services for adult inpatients are performing & developing and monitor preventable HARMs occurring to inpatients with diabetes whilst in hospital. The Trust is performing well, in line with other diabetes inpatient services, HARMS are in line with national reporting. Consideration needs to be given to plan for 7 day a week cover and diabetes education. **Actions to improve the quality of healthcare** 1. Discuss the need to start planning a weekend service with Divisional Management Team / Trust Executives. 2. Develop a "Diabetes Safety Board" to report all aspects of diabetes care and associated error.
National Hip Fracture Database 2022 (data April 21 - March 22) Published in September 2022 Presented to CESG in November 2022	This audit enables the Trust to benchmark its care against other services nationally. The Trust performed well in the main key performance indicators and has had consistent performance over several years. Areas for improvements are prioritising hip fracture patients on the Theatre trauma list and decreasing the length of stay. **Actions to improve the quality of healthcare** 1. Prioritise hip fracture patients on Trauma list. 2. Agree an escalation plan when breeches to BPT times are likely. 3. Create a Trauma co-ordinating role. 4. Arrange regular joint clinical governance sessions.
National Neonatal Audit Programme (NNAP) 2022 (data 2020 - 21) Published in March 2022 Presented to CESG in July 2022	The audit has 7 key national targets which are benchmarked with other neonatal units. This year, the unit has introduced the PERIPrem care bundle. The main areas for improvement are around keeping the infant within temperature range and maintaining follow-up at 2 years. **Actions to improve the quality of healthcare** 1. Only use trans warmers at deliveries when required. 2. Introduce PERIPrem care bundle to standardise the approach for infants < 34 weeks. 3. Neonatal nurse to attend 2-year follow-up clinics with medical staff to ensure data is up-to-date and correct.
National Paediatric Diabetes Audit 2022 (data 2020-21) Published in April 2022 Presented in August 2022	This is an annual audit of all paediatric diabetes units. There is close to a 100% submission rate across the country. This audit demonstrated that the paediatric diabetes unit maintained its quality of service and outcomes throughout lockdown. Further work is needed around staffing, nutrition and education and psychology. **Actions to improve the quality of healthcare** 1. Review of nutrition and exercise education programme (after diagnosis). 2. Personal invite (at clinic) to dietetic annual review 3. Team away day to look at options for decreasing HbA1c sugar levels. 4. Develop programme for psychology group work. 5. Band 4 family support role to free up Band 7 time for service development and QI work.

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group (CESG) in 2022 / 23	
Audit Title	**Outcome / Actions to improve quality of healthcare**
Sentinel Stroke National Audit Programme 2021 (data 2020-21) Published In December 2021 Presented to CESG in April 2022	The aim of the SSNAP audit is to improve the quality of stroke care by auditing stroke services against evidence-based standards, including National trends. There is evidence of the pandemic having an impact on stroke care services. **Actions to improve the quality of healthcare** 1. Peri- and post- pandemic plan to resume stroke services and restore back to a pre-pandemic state. 2. Recruit to stroke consultant post. 3. Advanced Nurse Practitioner business case to be reviewed.
Society of Acute Medicine Benchmarking Audit (SAMBA) (data: 2022) Published October 2022 Presented to CESG in January 2023	The purpose of this audit is to benchmark Acute Medical Unit activity against national standards. Key successes include above average performance in time to first clinician review and above average times to consultant review “in hours” 6 hours and “out of hours” 14 hours. **Actions to improve the quality of healthcare** 3. Utilise SAMBA data in driver of current business case for AMU expansion to reflect Trust development of SDEC and increased patient numbers and workload.

Examples of Local Clinical Audits

Audit Title	Comments and actions to improve quality of healthcare
Application of the Mental Health Act (MHA) - Sections 2, 3, 4, 5(2) and 17 (data 01.07.21 to 30.06.22)	This audit was undertaken to check compliance with the Trusts' Administration of the MHA Guidance and processes when a patient is detained under a section of the MHA (1983). The results of the audit showed 100% evidence of a documented MHA assessment and 94.7% compliance with the Site Team receiving the section papers within the required timescales. Areas for improvement include ensuring the patient is given the MHA rights and information leaflet and that, if the patient did not understand the process, this was revisited and explained. This will be re-audited once all improvement actions have been completed and enough time has lapsed to allow sufficient pool of data for audit.
Audit of patients with Trifecta aortic valve who have had an annual echocardiography.	The audit was to check compliance with the British Heart Valve Society (BHVS) and British Society of Echocardiography joint guidance (2019) on frequency of echocardiography and follow up for patients with replacement heart valves. The audit initially revealed lower than anticipated compliance levels. However, improvement actions were completed, and the re-audit showed a significant improvement. This will be re-audited again in 12 months.
Audit on uptake of post-mortem examinations after perinatal loss (data April 2021 to March 2022)	This local audit is an action from the MBRRACE-UK Perinatal Mortality Surveillance Report. The audit demonstrated that the number of families being offered a perinatal post-mortem are very good, but families are not always choosing to take up the offer of a perinatal post-mortem. Post-mortem uptake is a very sensitive and personal decision for each family. Nationally, there is now a shortage of perinatal pathologists, and some restrictions are coming into place for perinatal post-mortems. An action was agreed to produce a flowchart on the process of offering and consenting a perinatal post-mortem, a re-audit will take place once the flowchart is embedded.
Breast Reconstruction using DIEP flap at Salisbury District Hospital	The aim of this audit was to evaluate adherence to the ERAS protocol for DIEP reconstruction. The results of the audit were comparable to national results despite periods of de-skilling and new staff joining.
Re-audit of out of hours thrombolysis	This re-audit reviewed whether the action plan from a previous audit had led to an improvement in patient outcomes, with shorter door to needle times through the help of the on-call stroke consultant. The re-audit showed that there was prompt assessment of patients out of hours and good support from the on-call stroke consultant for thrombolysis as well as an improved compliance with the use of the remote checklist here at Salisbury NHS Foundation Trust. The recommendation was made to continue educating medical registrars on the importance of the use of the remote checklist along with the NIHSS/Thrombolysis proforma. No further actions were required.

Health Select Committee

Forward Work Plan

Updated 15 May 2023

Health Select Committee – Current/Active Task Groups			
Task Group	**Details of Task Group**	**Start Date**	**Final Report Expected**
Inquiry session: System-wide review of factors contributing to current pressures in urgent care	Half day full committee session	19 July 2023	5 September 2023

Health Select Committee - Forward Work Plan			**Last updated 15 May 2023**		
Meeting date	**Item**	**Details/Purpose of Report**	**Corporate Director and/or Director**	**Responsible Cabinet member**	**Report Author/Lead Officer**
8 June 2023	Avon and Wiltshire Mental Health Partnership Trust Transformation Programme	Overview of AWP's Transformation Programme.	Avon & Wiltshire Mental Health Partnership Trust	Cllr Jane Davies/Cllr Ian Blair-Pilling	Alison Smith, Deputy CEO, AWP

Meeting date	Item	Detail/Purpose of Report	Corporate Director and/or Director	Responsible Cabinet member	Report Author/Lead Officer
8 June 2023	Long Covid Support Service	Wiltshire Health and Care to provide an update on their work to provide support Wiltshire residents experiencing 'Long Covid'.	Wiltshire Health & Care	Cllr Jane Davies/Cllr Ian Blair-Pilling	Shirley-Ann Carvill, Managing Director, Wiltshire Health and Care
8 June 2023	NHS Dental Services in Wiltshire	To consider the findings of the Rapid Scrutiny exercise into the status of NHS dental services in Wiltshire, the commissioning of which will move to the BSW Integrated Board in April 2023.	BSW Integrated Board	Cllr Ian Blair-Pilling	
8 June 2023	Dementia Care Strategy	An update on the progress	Emma Legg, Director Adult Social Care (DASS)	Cllr Jane Davies	Robert Holman, Commissioning Transformation Lead, Whole Life Commissioning
4 July 2023	Domestic Abuse External grant and other domestic abuse work	To receive an update on this work following receipt of proposals regarding the Domestic Abuse External Grant in September 2022	Kate Blackburn, Director of Public Health	Cllr Ian Blair-Pilling	Hayley Morgan, PH Consultant, Vulnerable Communities

Meeting date	Item	Detail/Purpose of Report	Corporate Director and/or Director	Responsible Cabinet member	Report Author/Lead Officer
4 July 2023	Substance Misuse	To receive an update on substance misuse work following consideration of proposals regarding Spend Allocations for the Substance Misuse Supplementary Grants in September 2022	Kate Blackburn, Director of Public Health	Cllr Ian Blair-Pilling	Kelly Fry, Principal Building Resilience, Vulnerable Communities
4 July 2023	Community Health Services	To receive a report on developments in Community Health Services	Fiona Slevin-Brown, ICB	Cllr Ian Blair-Pilling	
5 Sept 2023	Integrated Care Centres	To receive an update on the development and impact of the Integrated Care Centres in Devizes and Trowbridge.	Fiona Slevin-Brown, ICB	Cllr Ian Blair-Pilling	
2 Nov 2023	Health Improvement Coaches	To provide an update on the work of the Health Improvement Coaches	Kate Blackburn, Director of Public Health	Cllr Ian Blair-Pilling	Rachel Kent, PH Consultant, Knowledge and Intelligence
17 Jan 2024	Maternity Services Transformation	Review to understand the impact of the transformation of maternity services. Report on transformation plans received Jan 2023	Fiona Slevin-Brown, Director of Place, ICB		
27 Feb 2024	Joint Strategic Needs Assessment (JSNA)	Review trends for Wiltshire, update following presentation Feb 2023	Kate Blackburn	Cllr Ian-Blair Pilling	

Items for Meeting dates yet to be set

Meeting date	Item	Details/Purpose of Report	Corporate Director and/or Director	Responsible Cabinet Member	Report Author/Lead Officer
March/April 2024	Joint Health & Wellbeing Strategy	Progress report, 12 months after publication. Draft strategy received by Committee Feb 2023.	Kate Blackburn	Cllr Jane Davies	David Bowater
Spring/Summer 2024	Integrated Care Strategy	Rapid Scrutiny of Implementation Plan/Integrated Care Strategy	Fiona Slevin-Brown, Director of Place, ICB		