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

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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.

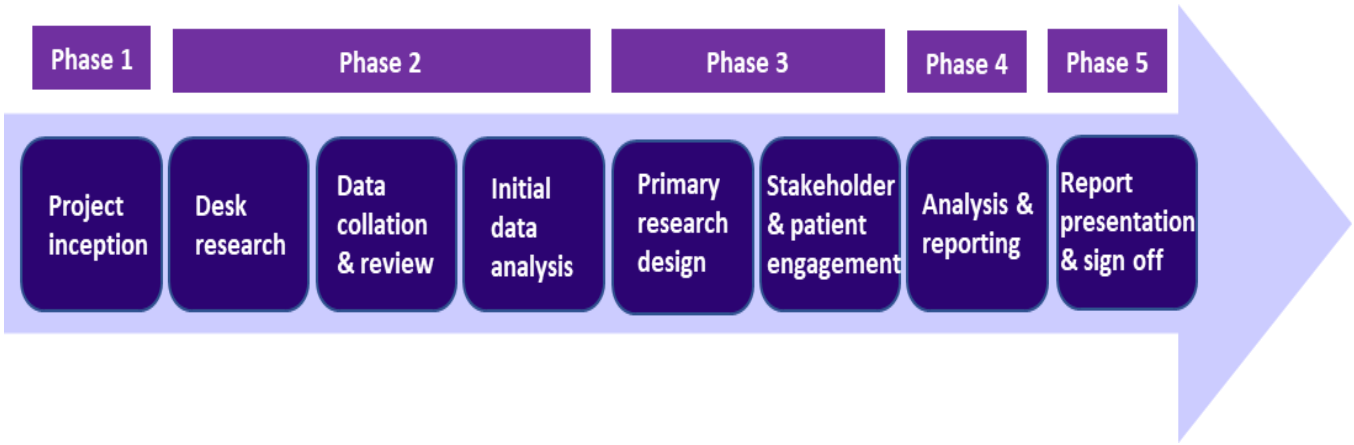
1.3 In addition to these stated aims, discussions with NHSE&I identified the following requirements, for the OHNA to:

- 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.

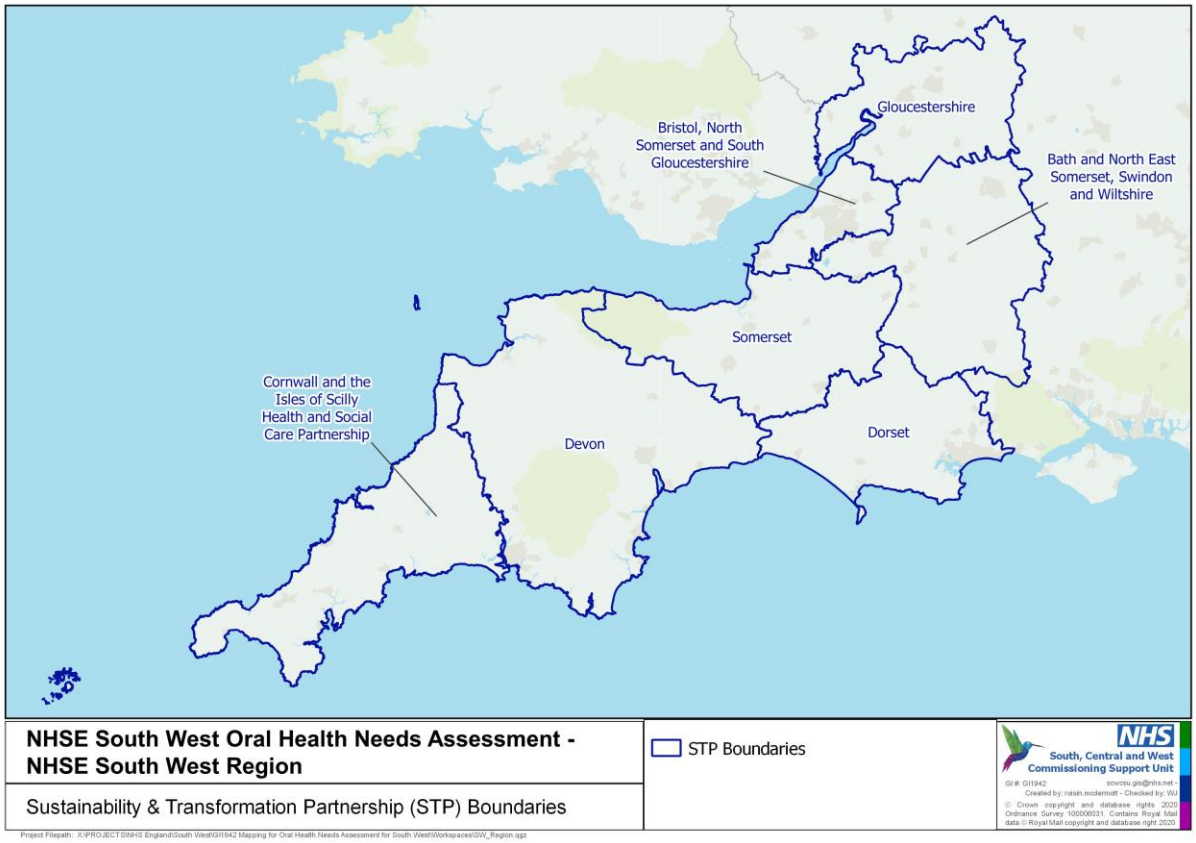
Chart 1: NHS Commissioning Cycle

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

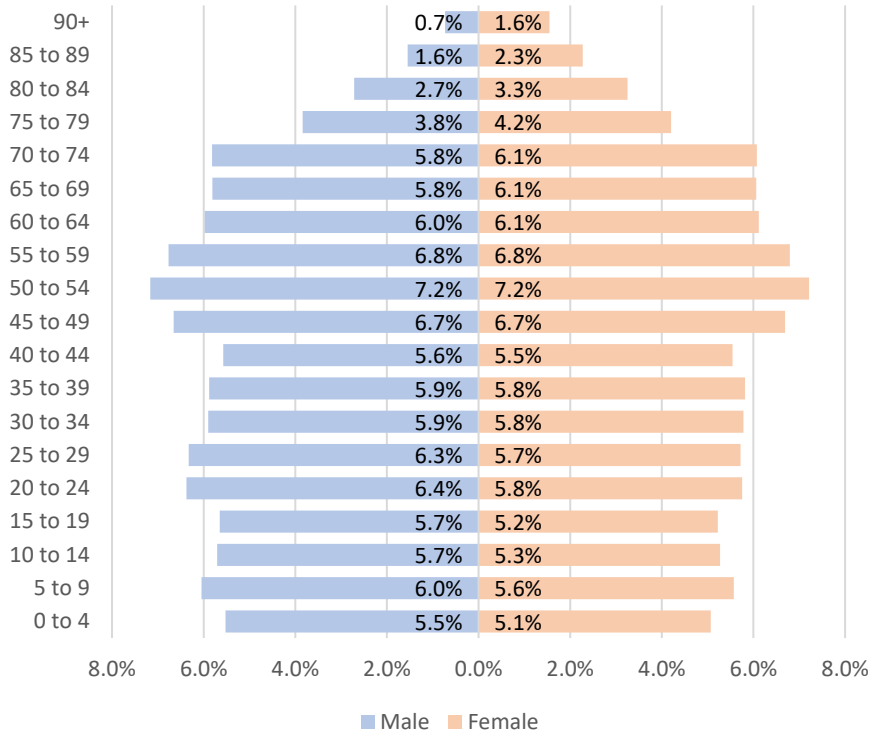
2.1 The demographic characteristics of a population has a significant impact on their oral health needs. This section reviews the make-up of the South West's population in this context and the ramifications for oral health and service provision. This section also reviews the impact of the wider determinants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

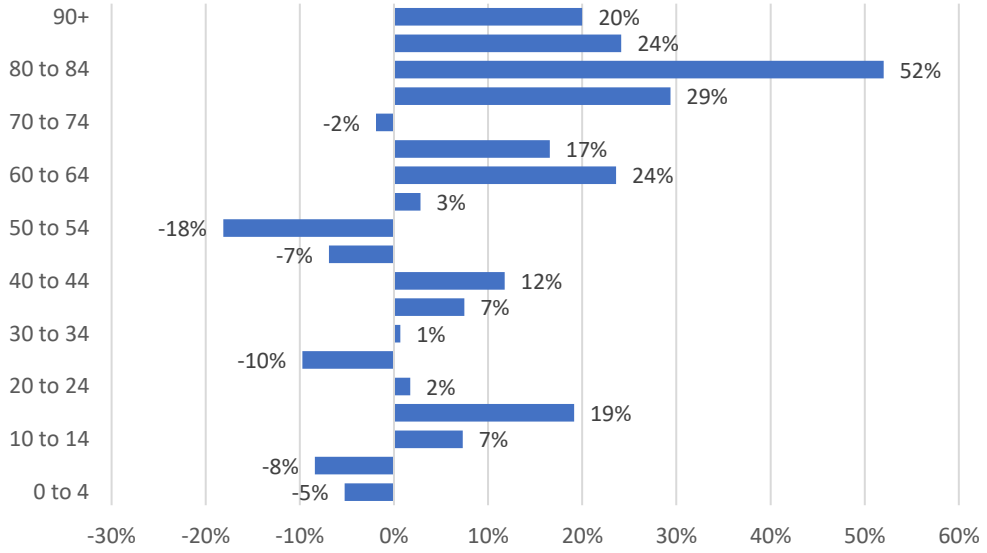
2.6 These populations and their geographic densities are critical details to the distribution and delivery of high street dentistry. Indeed, provision is most likely to be spread across the region based on the clustering of populations in villages, towns and cities across the region and this socio-economic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

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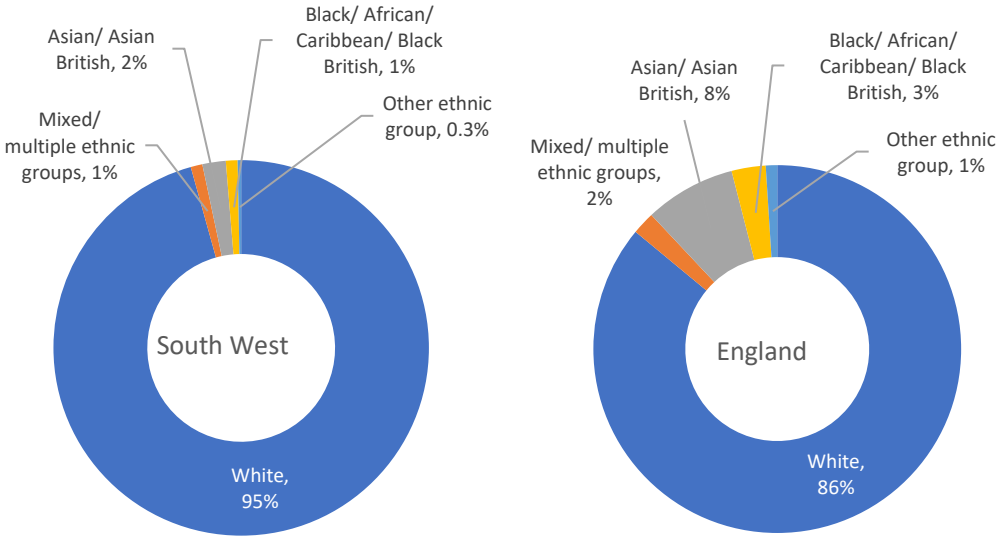
[5] 2018-based subnational population projections regions in England (ONS, 2020)

[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

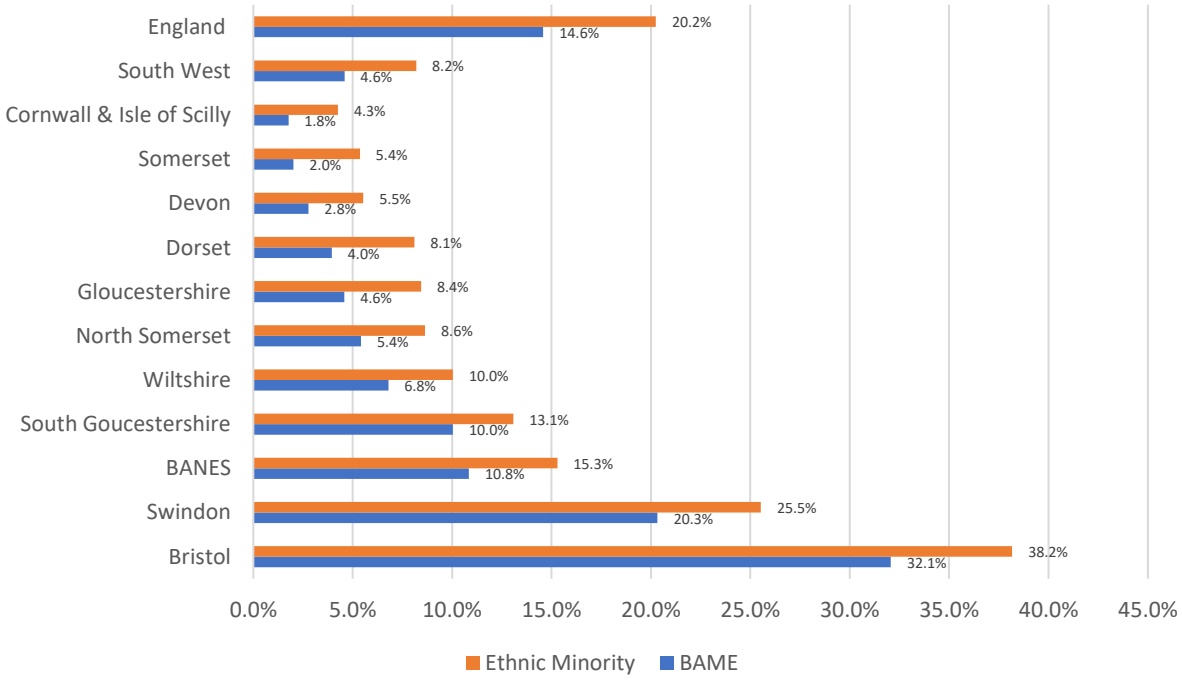
[8] The acronym **BAME** stands for Black, Asian and Minority Ethnic and is **defined** as all ethnic groups except White ethnic groups

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

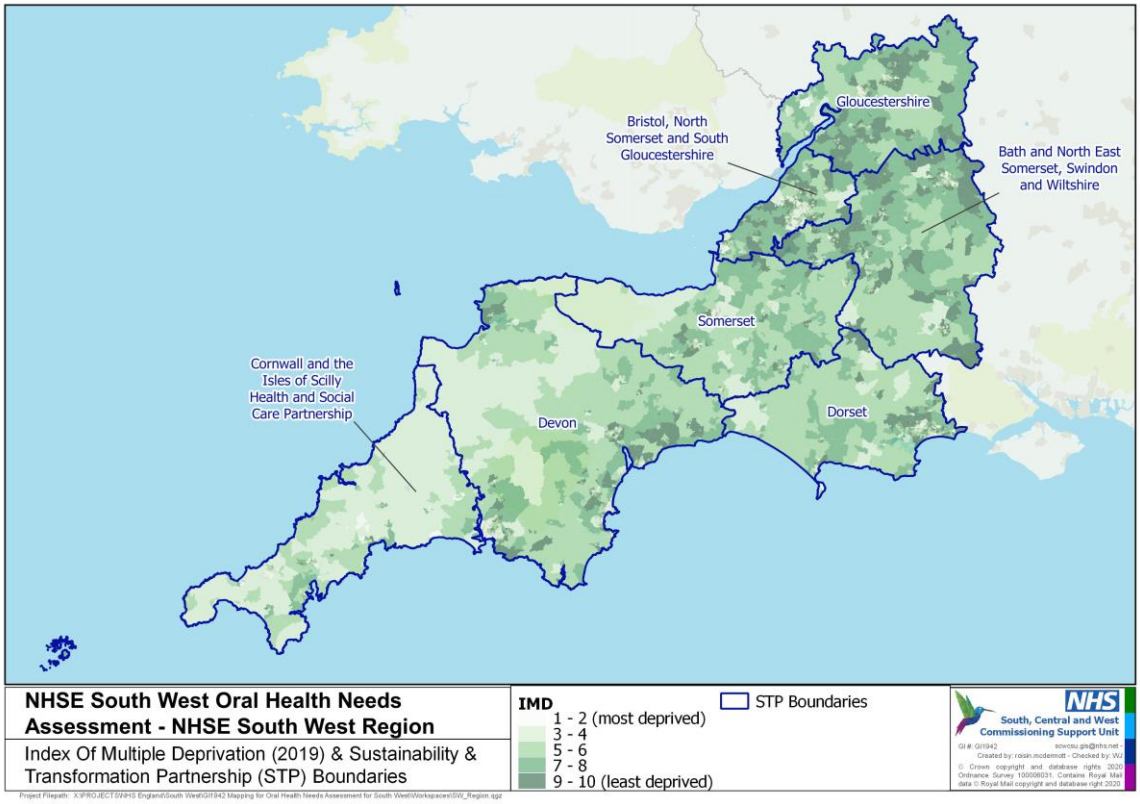
2.11 The data below is taken from the Index of Multiple Deprivation (IMD) 2019 which assess a series of domains and provides weightings to compute the levels of multiple deprivation in Lower-layer super output areas (LSOA's)

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

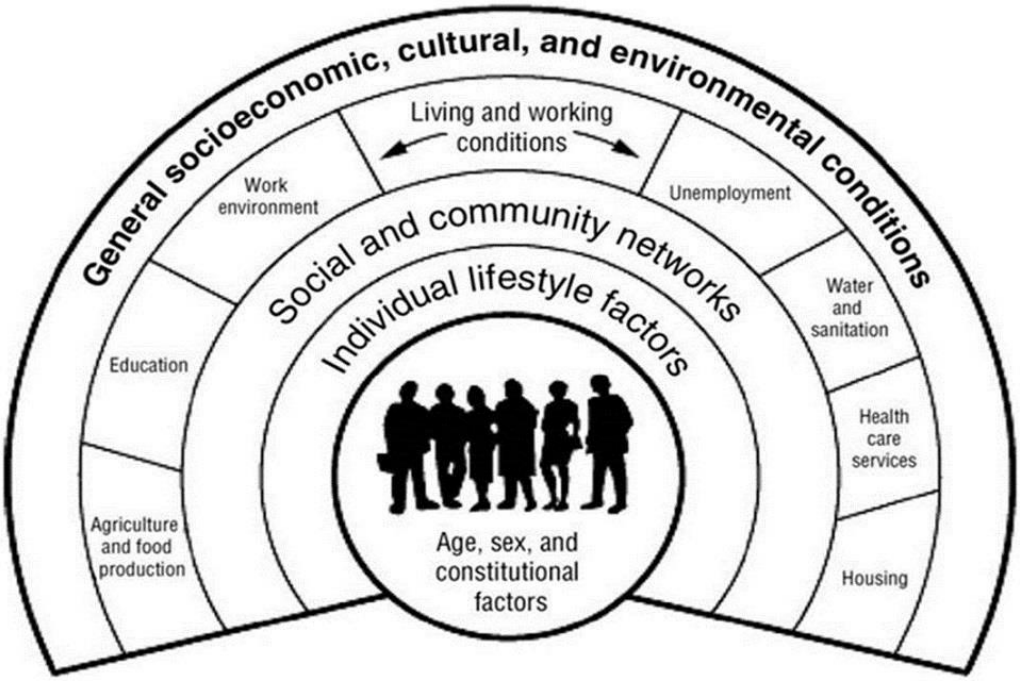
	Never (%)	Once a day or less (%)	Twice daily (%)	More than twice daily (%)
South West	0.3	22.3	74.0	3.1
England	0.2	22.8	72.9	3.7

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:

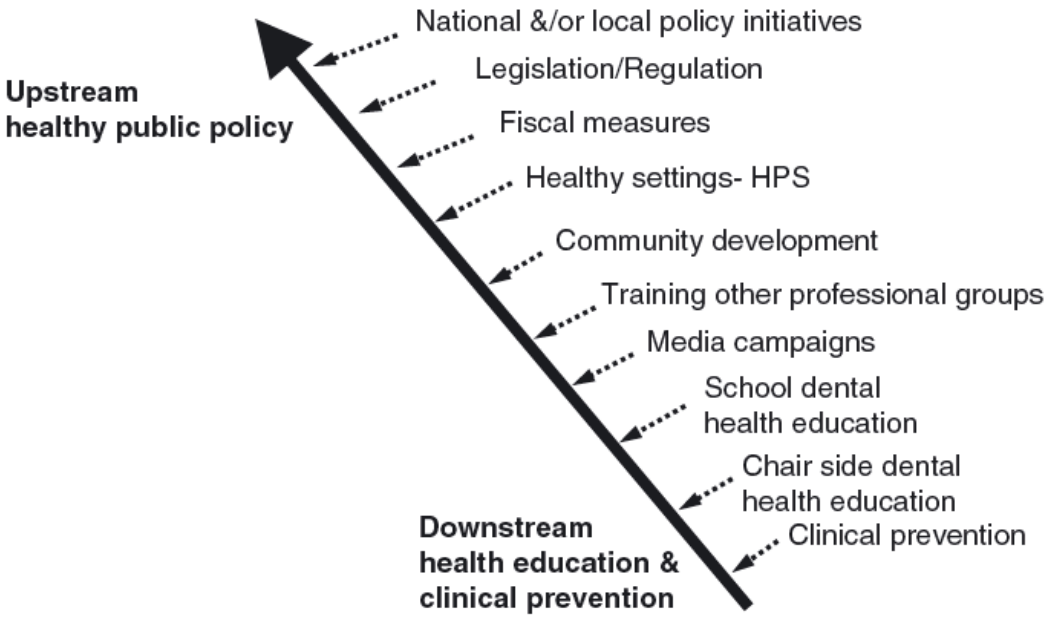
- There is a social gradient in health and the lower a person's social position, the worse his or her health. Action should therefore focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities therefore requires action across all the 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.

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[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

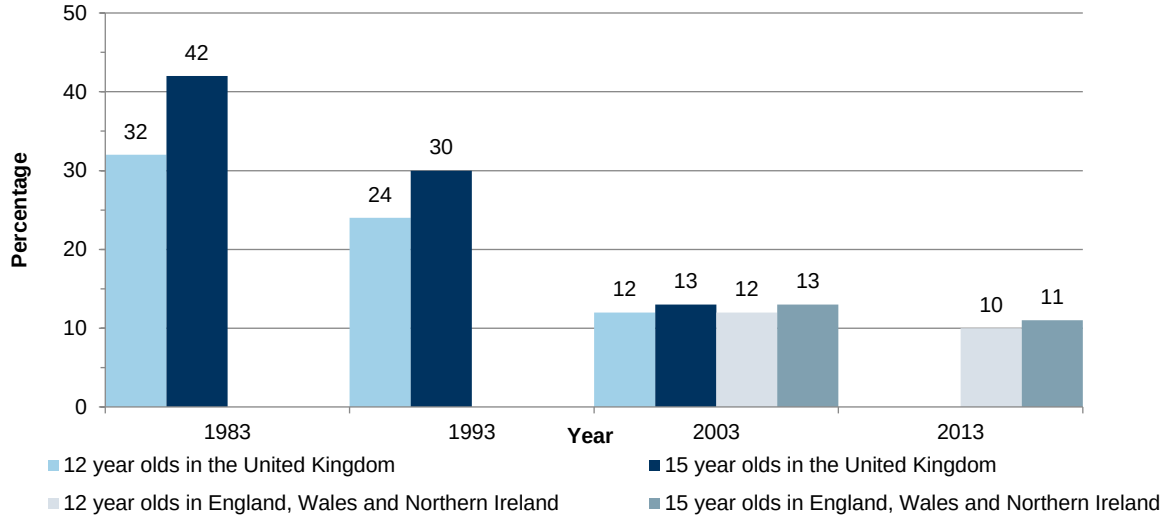
3.1 Nationally there has been a significant improvement in oral health and a decline in tooth decay over the past 40 years. However, a substantial proportion of the population experiences high levels of oral disease, most of which is highly preventable. The main oral diseases and their impacts have been 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



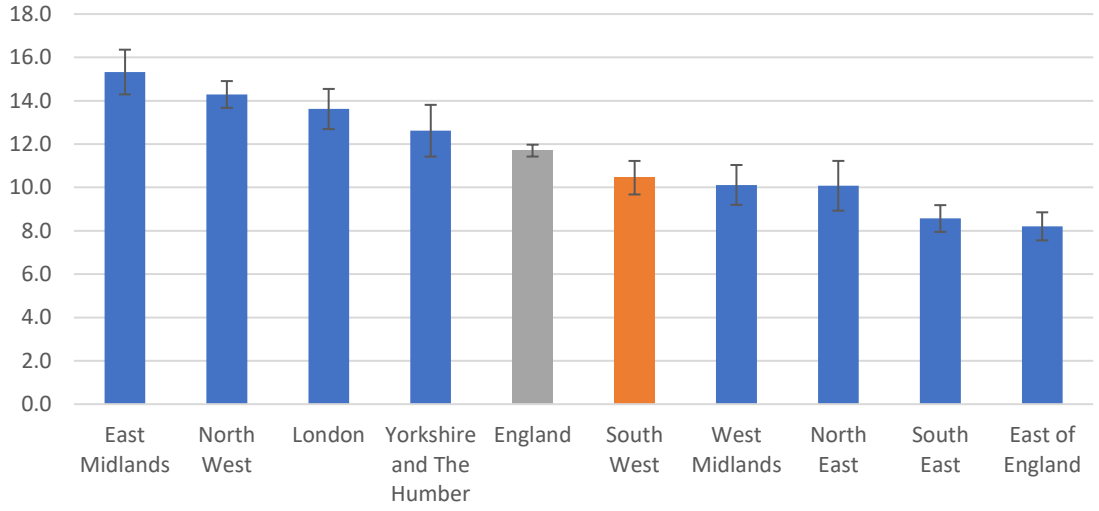
3.4 The same national survey from 2003 also highlighted inequalities by social status in 5-year-old children. Children from the lowest social groups were twice as likely to have tooth decay as children from the highest social group.

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

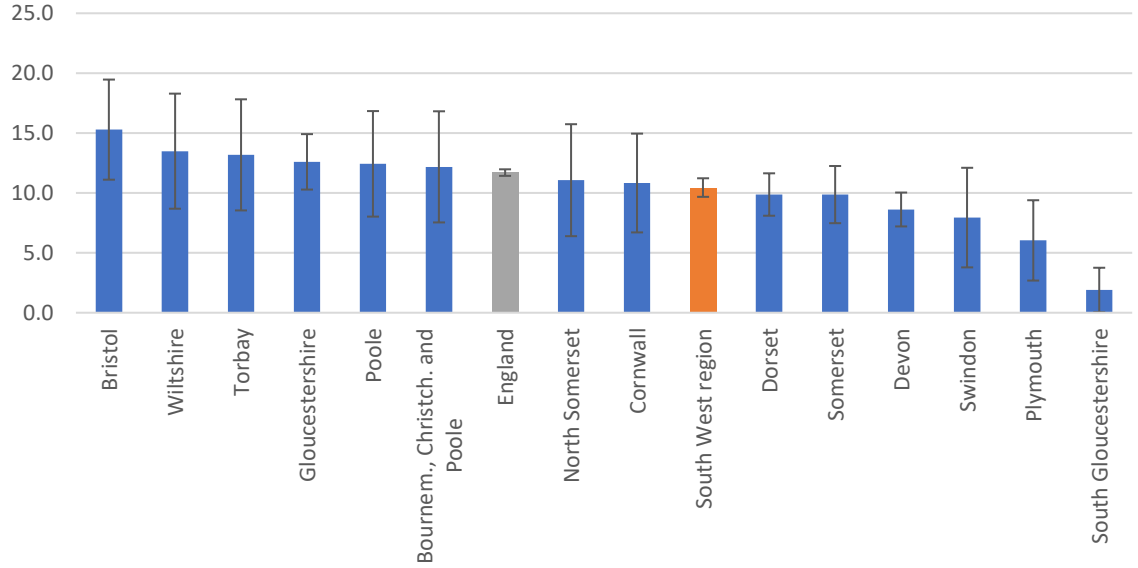
3.6 The 2013 national survey examined 3-year-old children attending private and state funded nurseries and nursery classes attached to schools and play groups. The proportion of 3-year-olds experiencing tooth decay in England was 11.7% and the prevalence in the South West was lower at 10.4%.

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



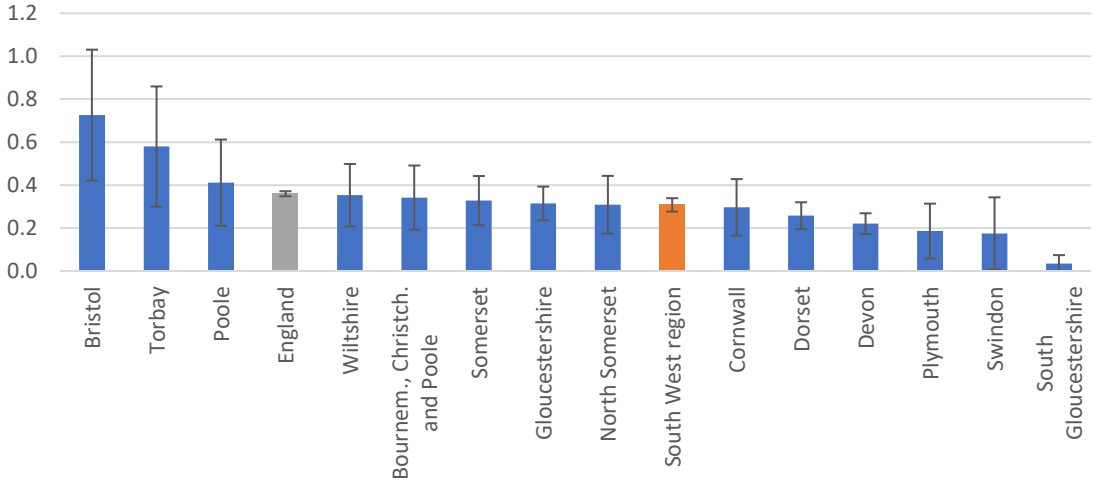
3.7 At local authority level, the proportion of 3-year-olds in the South West who had experienced tooth decay was in general below the national average.

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.

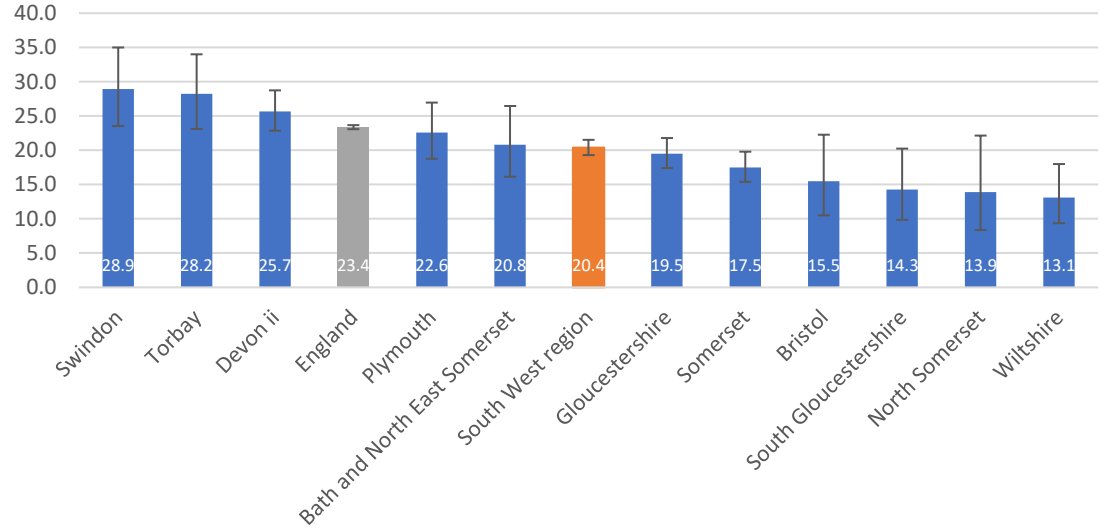
Table 12: South West Dental decay three year old children: Dental Public Health Epidemiology Programme for England, Oral Health Survey of three-year-old children 2013, upper tier local authority (LA)

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

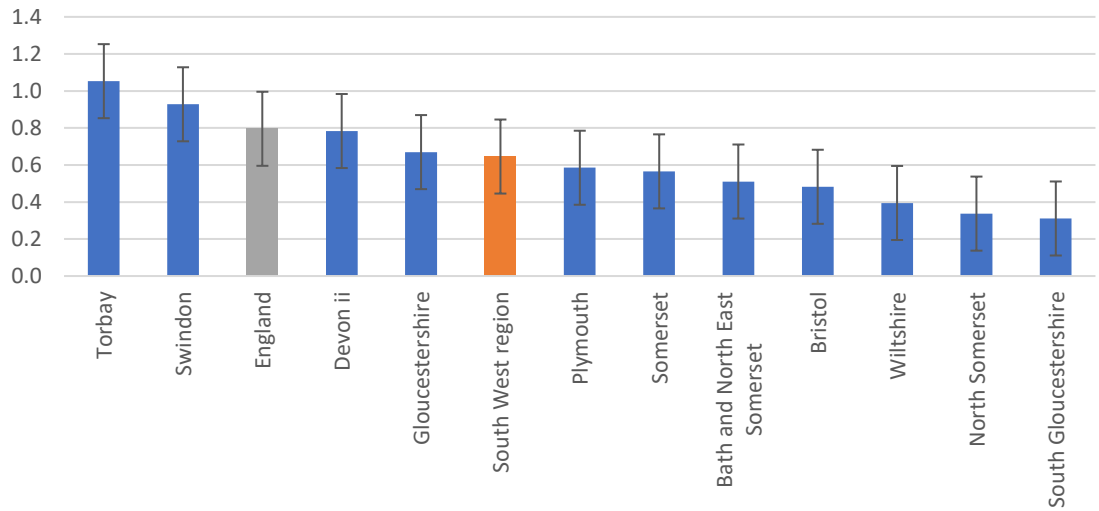
3.11 In 2019, the proportion of 5year-old schoolchildren in the South West with tooth decay (20.4%) was below the national average (23.4%).

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].

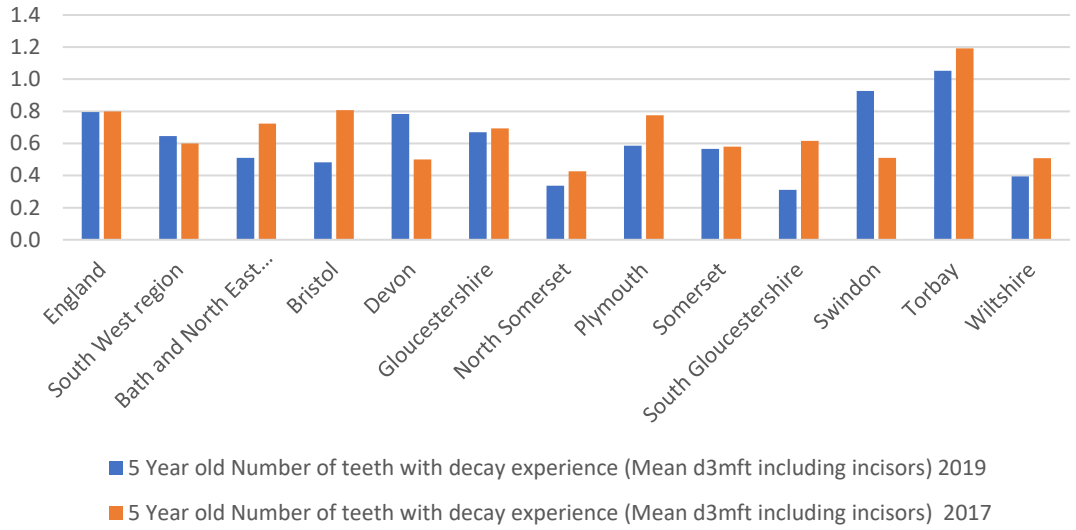
Chart 13: Severity of tooth decay experience in five-year-old schoolchildren, Source PHE 2019



[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.

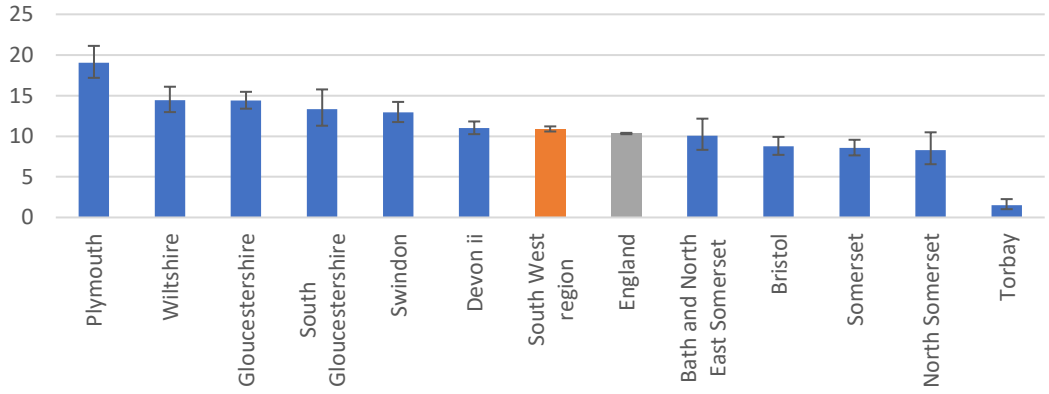
Chart 14: Tooth decay experience in five-year-old schoolchildren in The South West by local authority, 2017 to 2019 compared Source: PHE, 2019



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



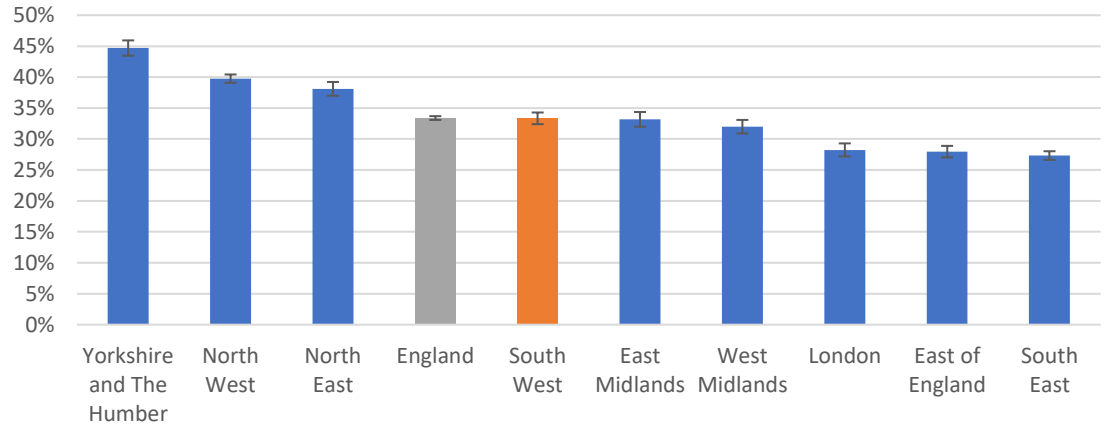
[44] Insufficient numbers examined in East Devon; Mid Devon; West Devon; South Hams; Torridge.

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.

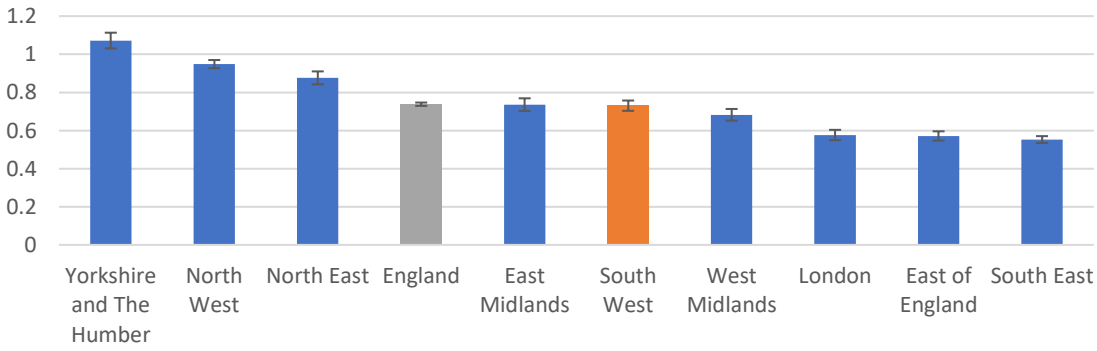
3.16 In 2008/2009 the prevalence of decay in 12-year-old schoolchildren in the South West was marginally lower than nationally. The proportion of 12-year-old schoolchildren in all South West local authorities with experience of tooth decay was 33.3%. The prevalence in the region ranged from 45.6% in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

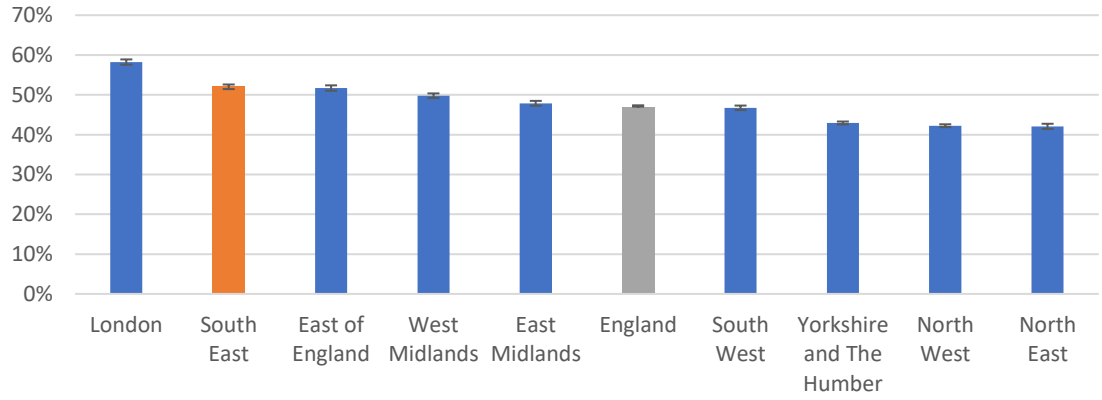
3.18 As for 12-year-old schoolchildren, there was significant disparity in the prevalence and severity of tooth decay, demonstrating that severe tooth decay is experienced

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.

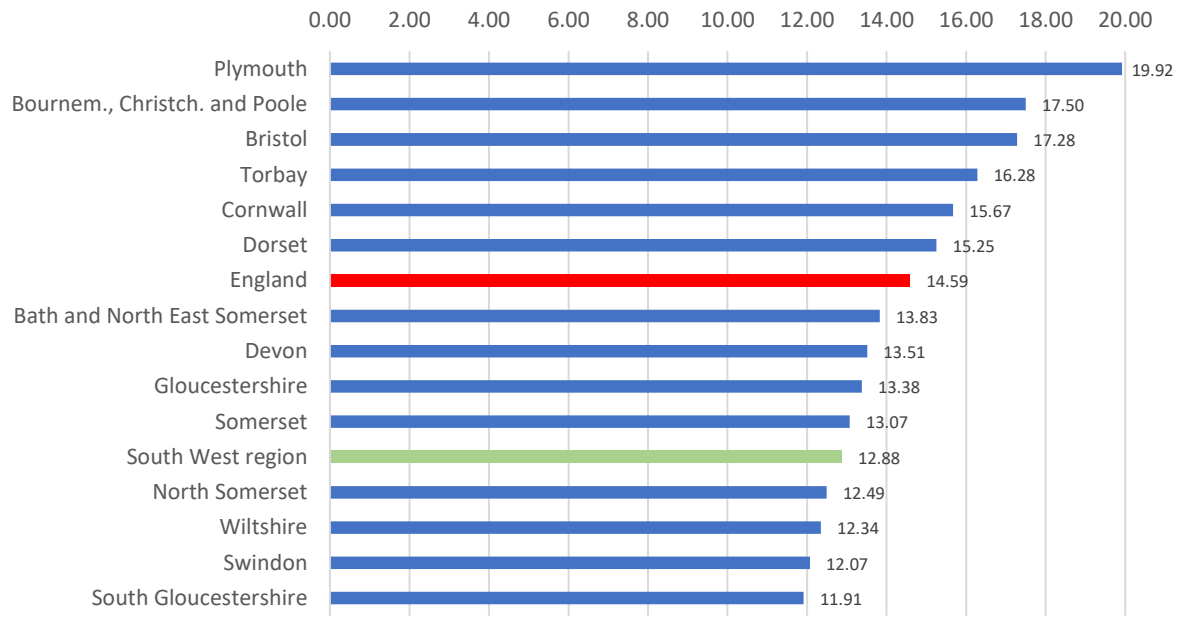
[51] State of mouth Cancer UK Report 2018-2019 https://www.dentalhealth.org/Handlers/Download.ashx?IDMF=21dc592b-d4e7-4fb2-98a9-50f06bed71aa

[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.

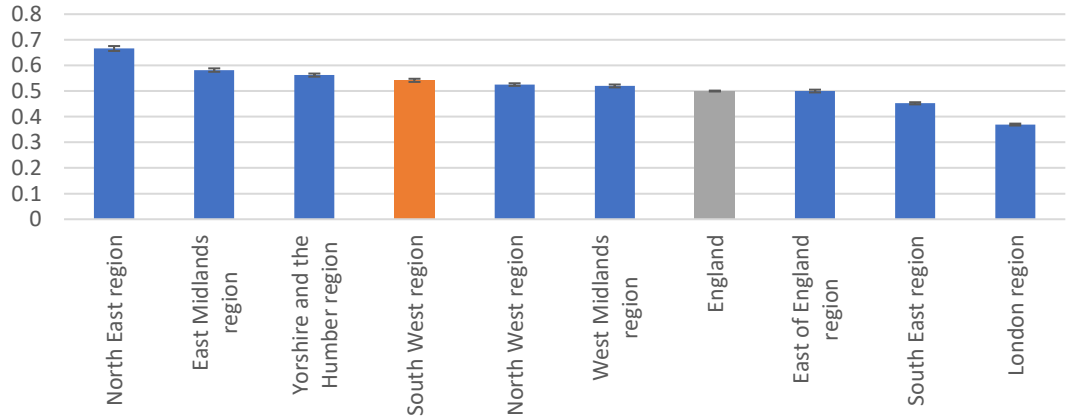
[59] Statistics about older people in the UK, MHA Facts & Stats
[60] Oral Health & Dementia, PHE 2016
[61] Oral Health in Care Homes, Healthwatch Brighton and Hove (2019)
[62] Smiling Matters, Oral Health Care in Care Homes, CQC (2019)

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

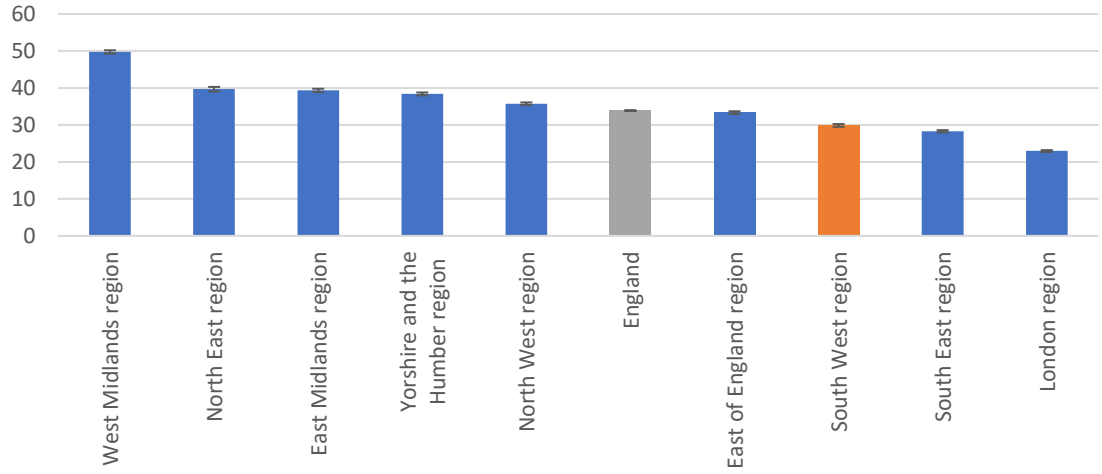


3.59 The 2014-2015 prevalence of children with a learning disability in England was 33.9 per 1,000 children known to schools. Information for this indicator is reported by schools through their school census. It is based on those children attending primary, secondary and special schools and includes 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].

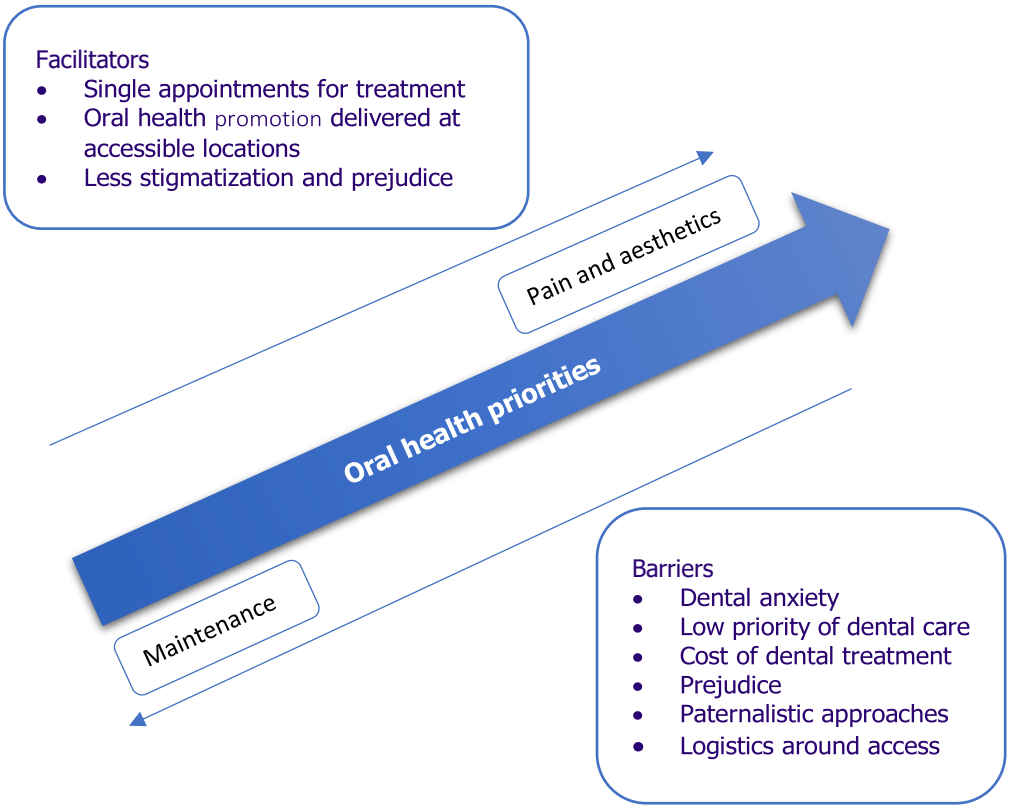
3.66 A recent study conducted by Leeds University has found that the main barriers for homeless people in achieving good oral health were insufficient information on local dental services, negative attitudes of oral health professionals, low priority of dental care, anxiety and cost of dental treatments. 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

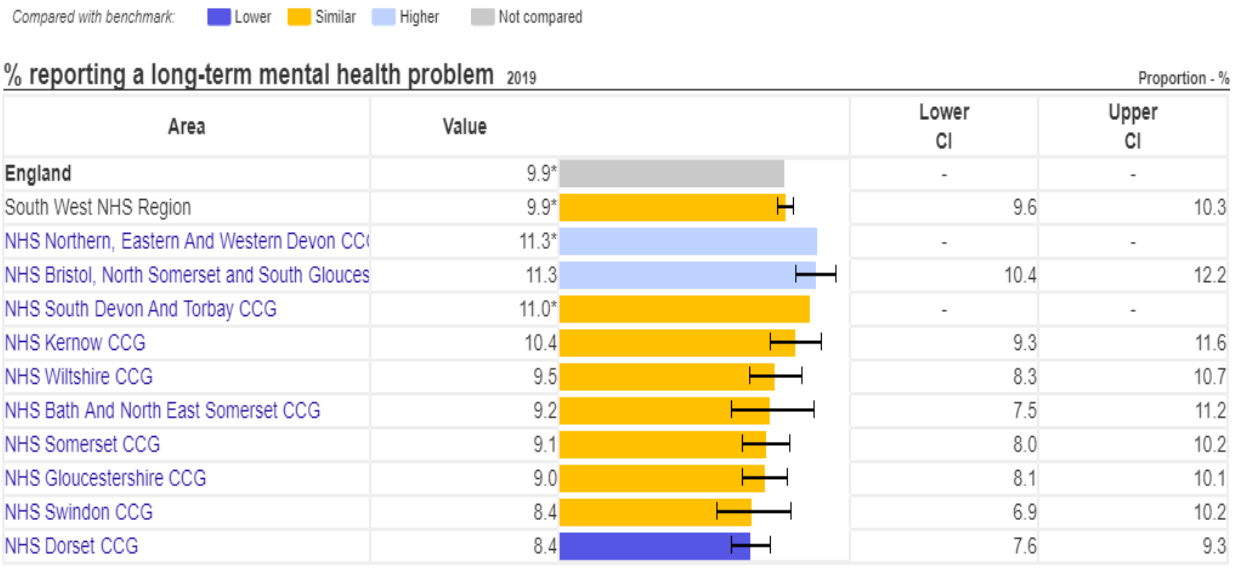
3.68 Mental health problems are common. The classification of mental health problems remains problematic, as some diagnoses are controversial and there is concern that some people may not get the appropriate treatment. The classification is sub-divided into neurotic and psychotic conditions. Neurotic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

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[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

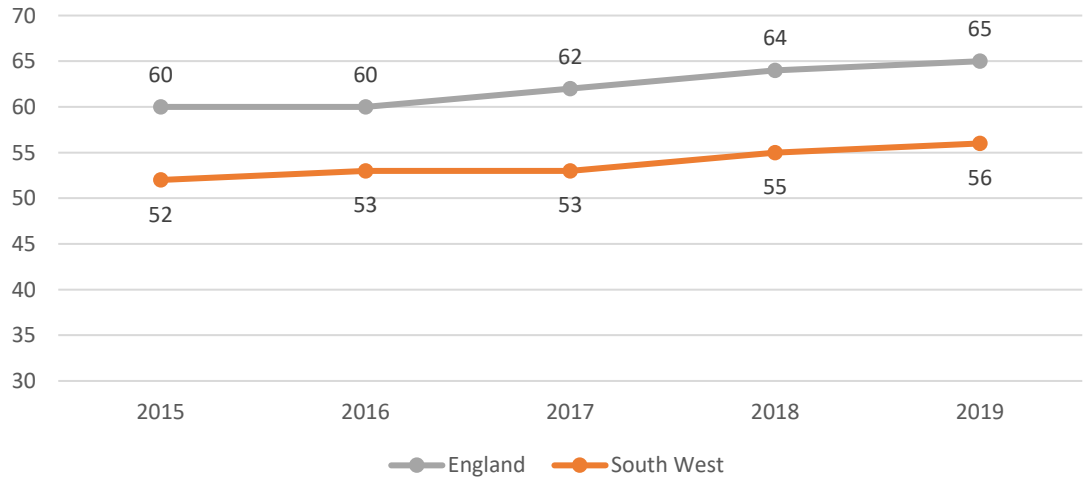
3.83 Looked after children tend to have poorer health and well-being than their peers. Although some national data describes the health needs of looked after children, their oral health needs are not routinely monitored. With regards to the oral health needs of looked after children the Social Care Institute 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

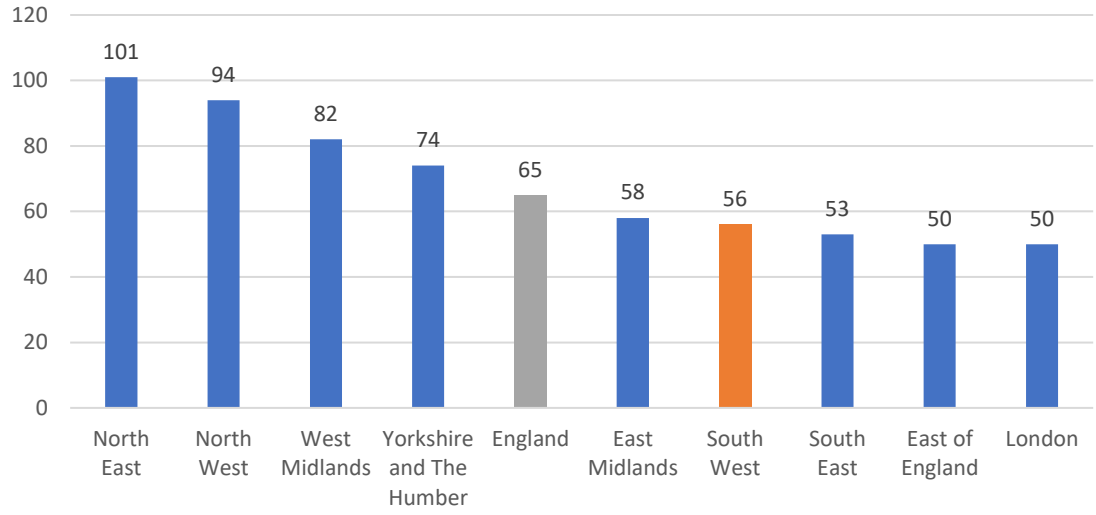


3.86 The chart below illustrates a regional comparison of the rate of children in care. Whilst across the South West the rate is relatively low there are some variations with some parts of the South West. Torbay for example has more the twice the rate of children compared with the South West (142 per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

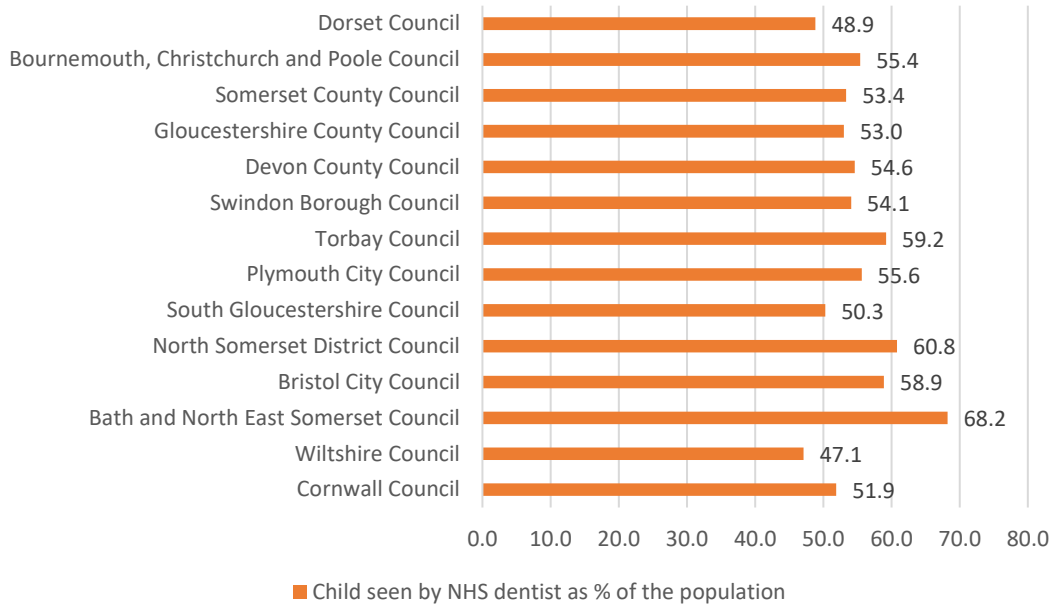
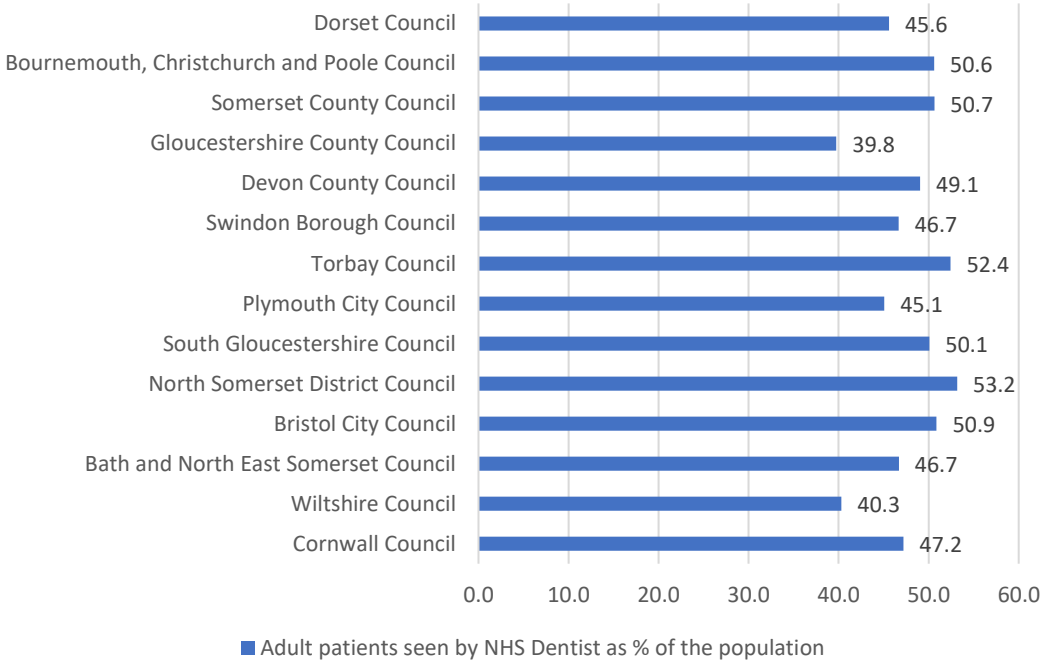


Chart 27: Adult patients seen, in the previous 12 months as a percentage of the population, by local authority



[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.

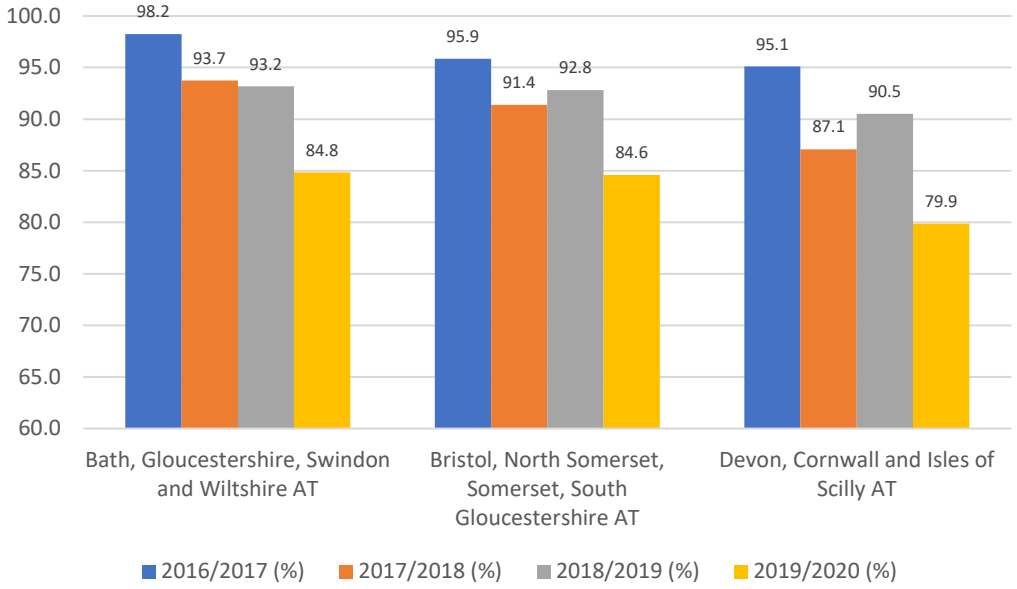
4.39 If a practice achieves less than 96% of their contractual obligation, they can be subject to clawback, a process in which NHSE&I is able to claim back the value of the underachieved units.

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.

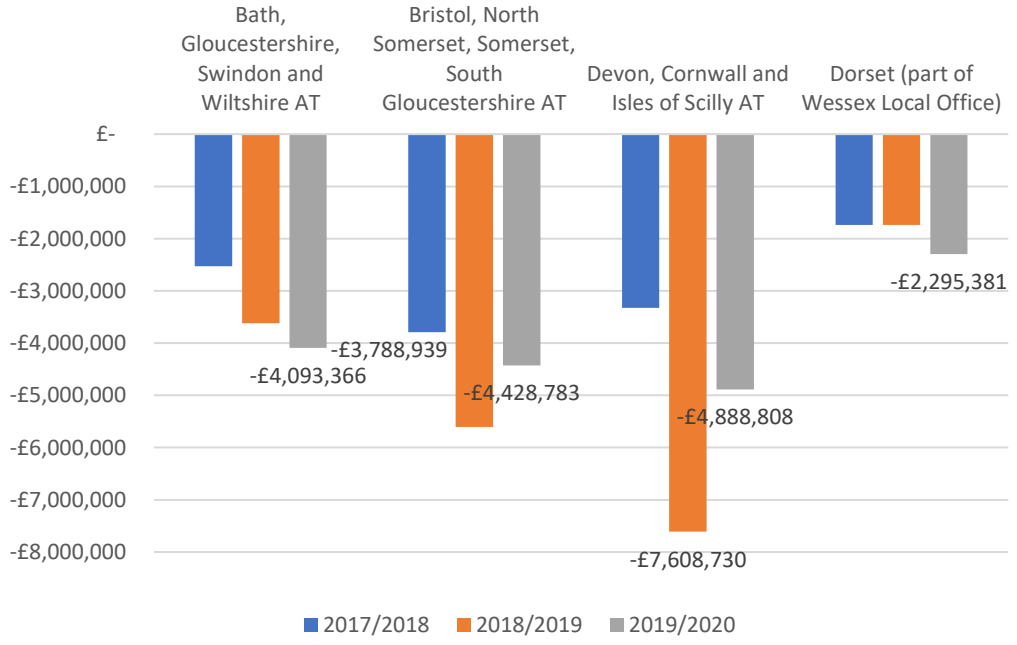
[116] Dorset is omitted as data for the last 4 years was not available at the time of this OHNA for periods pre 2018-2019

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.

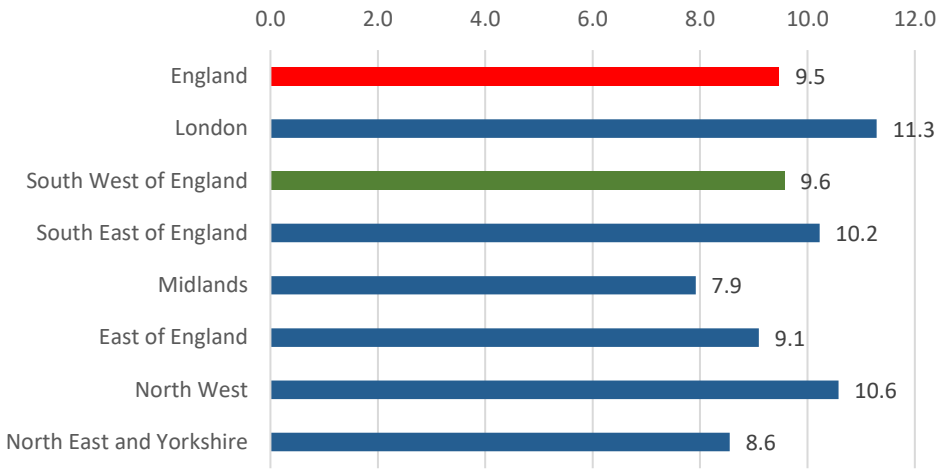
4.68 Unplanned dental care is best reviewed by assessing the levels of urgent care as per the bands of provision in the dental care system. The table below sets out the number and % of urgent care 2019-2020 by region. It shows that in the South West 9.6% of dental care was urgent care which is slightly 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

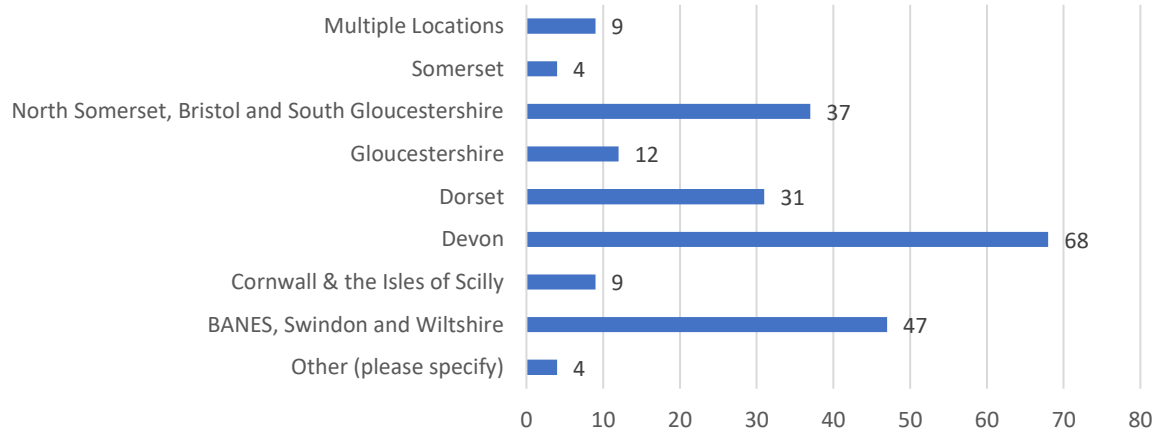
12.1 This survey was agreed and co designed with NHSE&I. The survey was designed to address the perceptions of stakeholders across the sector, but with a strong focus on primary care dentistry.

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)

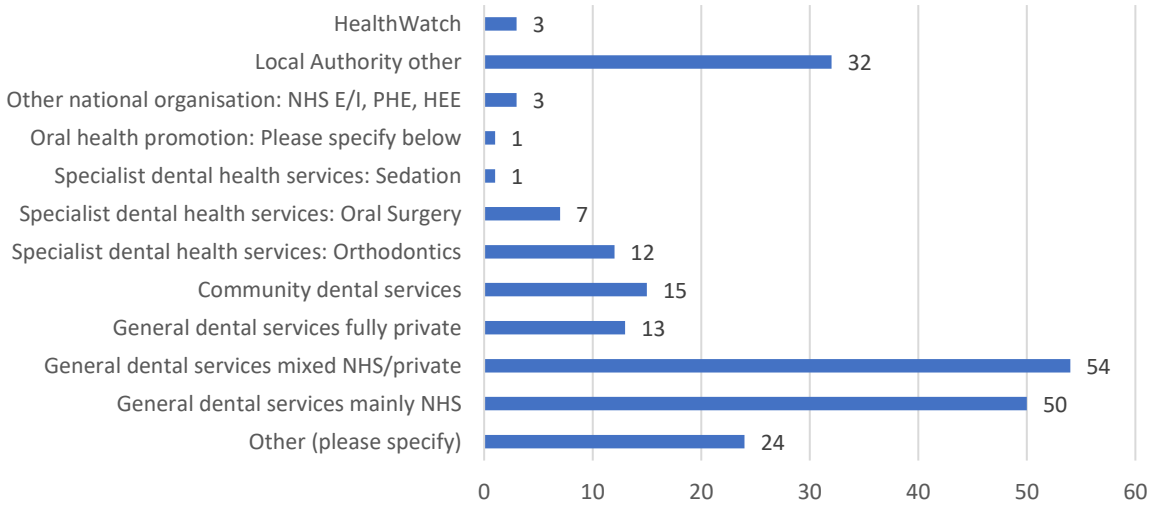


12.4 The next question sought to establish the type of organisation respondents work for or are associated with. 25.1% worked in general dental services that were mixed NHS/private, 23.3% worked in general dental services mainly NHS, and 6.0% worked in general dental services that were fully private. 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.

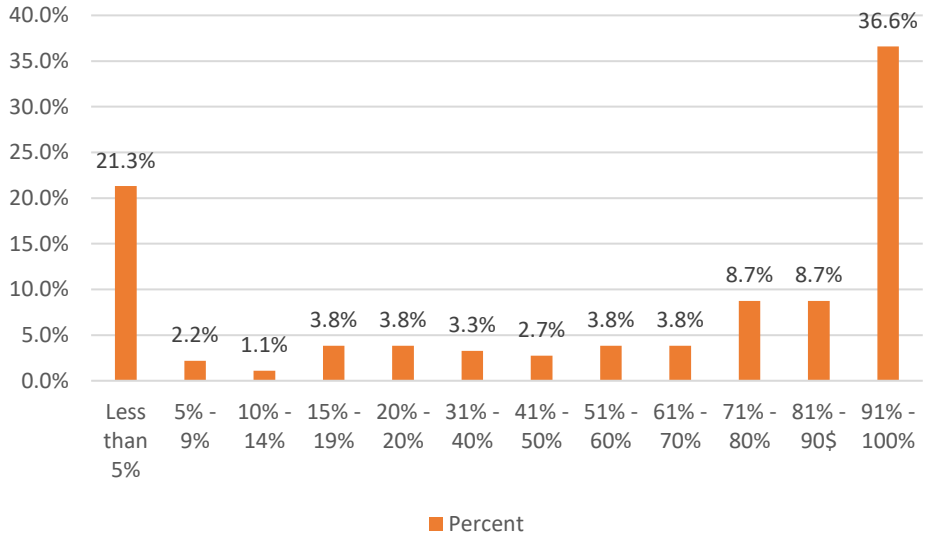
12.5 Of those that stated 'other' and then further specified, they came from: Acute NHS Trust/ teaching hospital, Care Home Support Lead, CCG, Dental Education (Dental school), Dental laboratory, Drug & Alcohol Commissioned Services ROADS, Drug & Alcohol Community Service Provider, Drug and alcohol service, 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%.

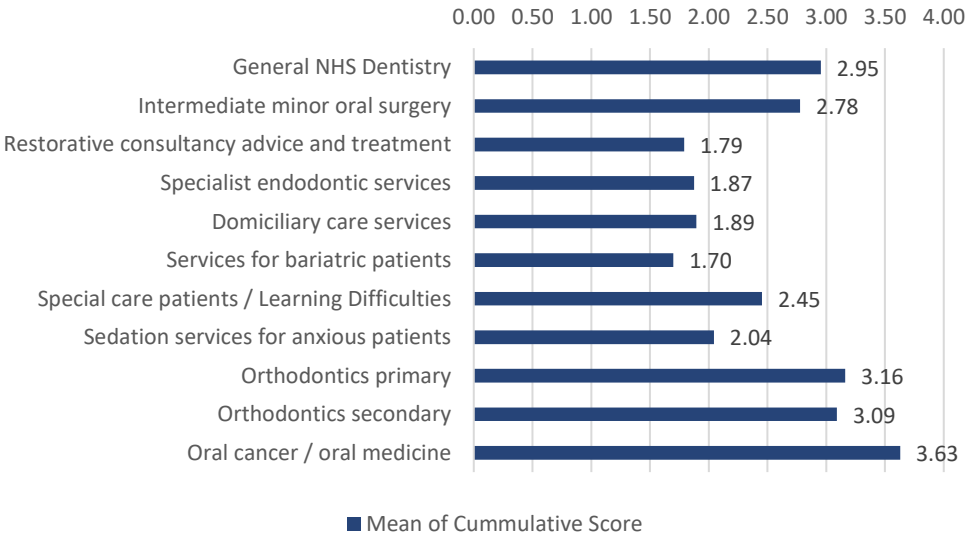
Chart 33: If relevant to your type of work, what proportion of your practice is NHS work?



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)

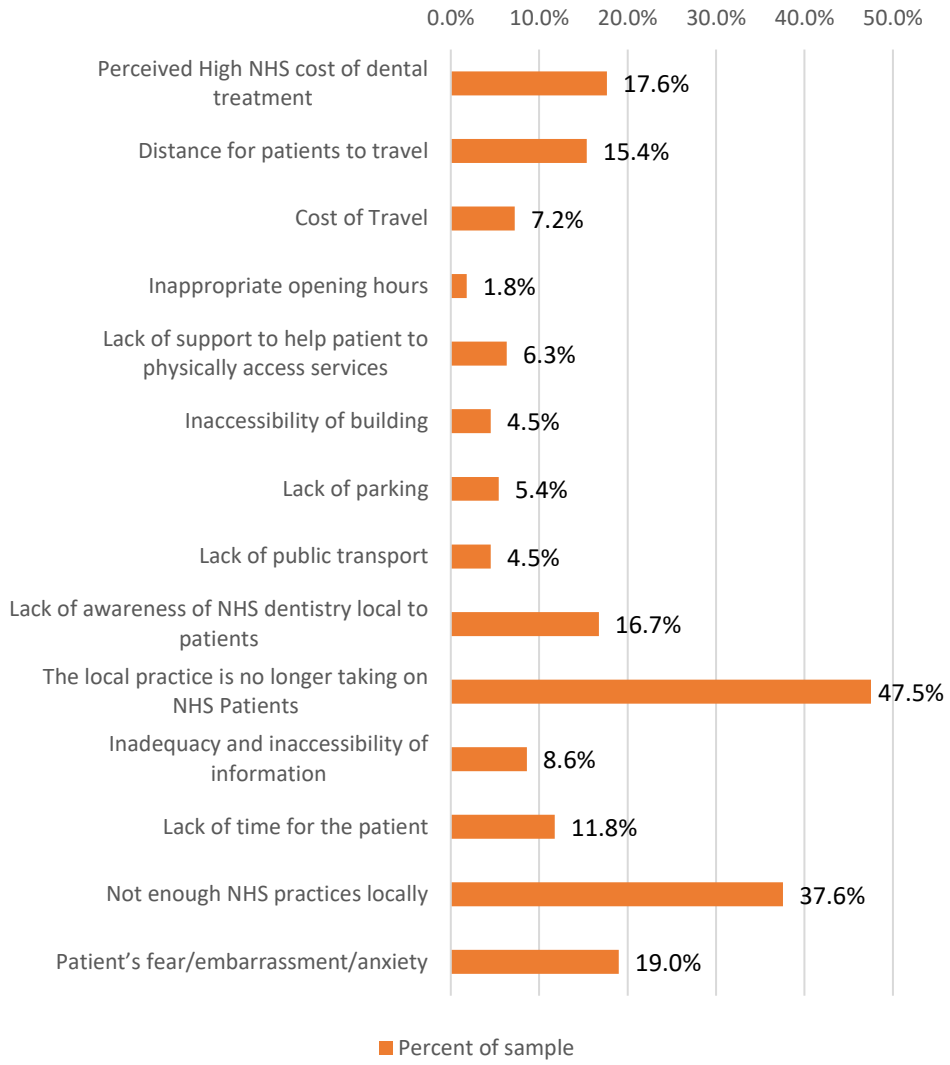


12.9 Respondents were then asked to identify, from a list, the main barriers to accessing NHS general dentistry. Barriers included the levels of provision, availability, and a

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%.

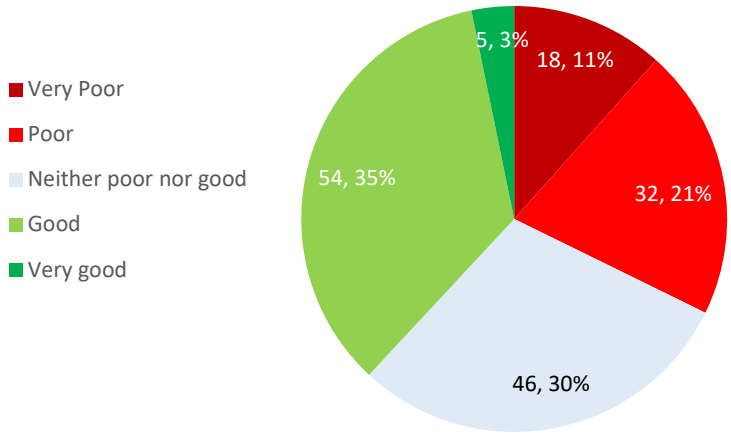
12.10 This shows that stakeholders believe that the availability of NHS dentistry is the key barrier both in the lack of NHS dentists accepting new patients or insufficient NHS practices locally.

Chart 35: What in your opinion are the main barriers to accessing NHS General Dental Services in your locality? (Tick all that apply)



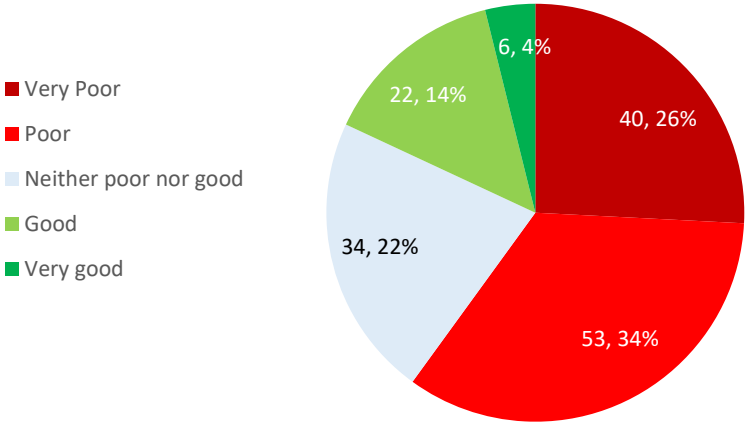
12.11 The survey then asked respondents: 'on a scale between very good and very poor, how effective do you feel NHS general dental services are in your locality?' The levels of response were broadly spread between those that felt it was either very poor or poor 32%, those that felt it was neither poor 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?



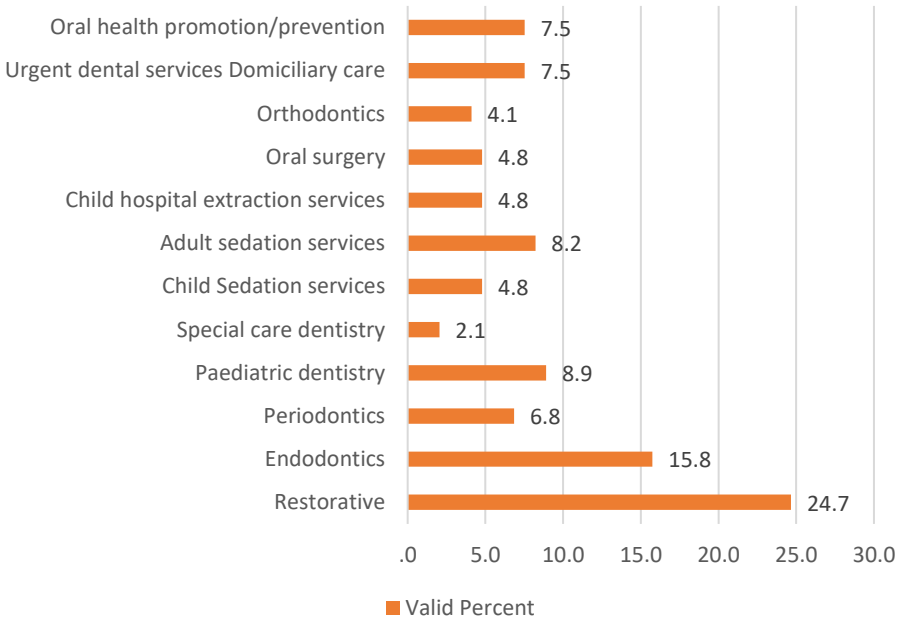
12.12 The next question asked the extent to which respondents felt that they were served by specialist dental services. The responses to this question were starker in their contrast with 60% feeling that they were either very poorly or poorly served by specialist dental services, with 22% neither agreeing 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.

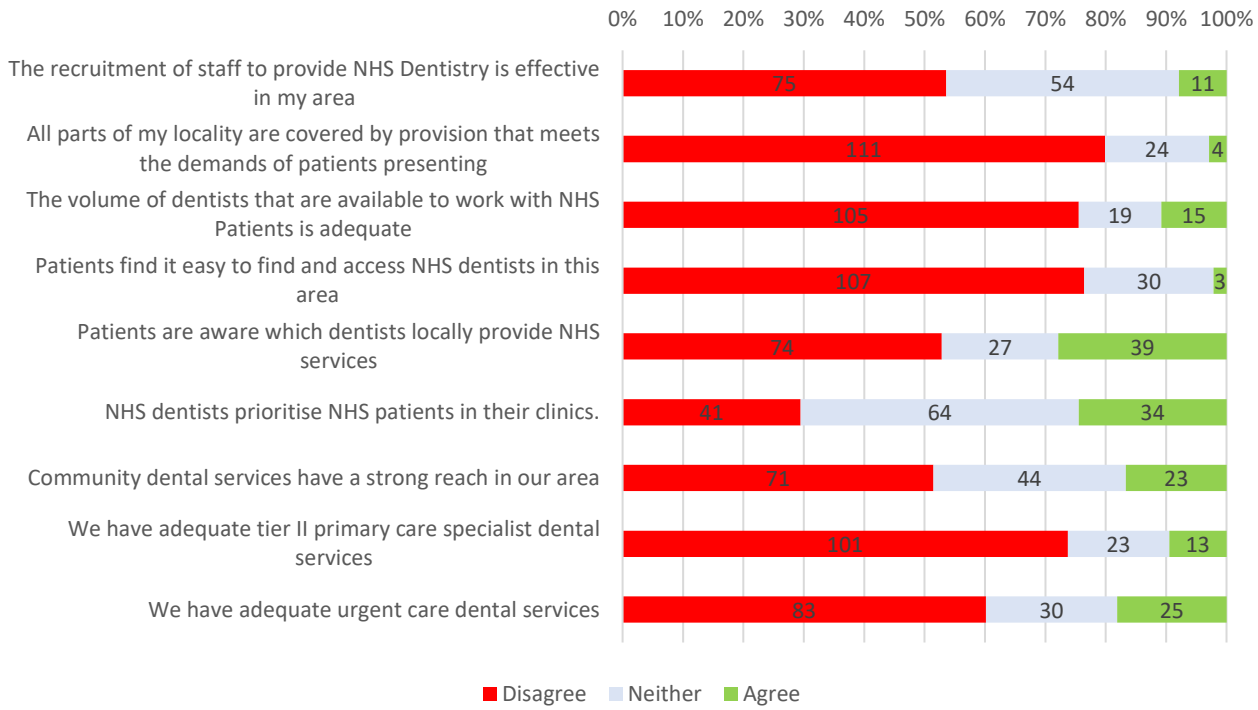
- 52% disagreed that 'community dental services have a strong reach in our area', 32% neither agreed nor disagreed and 17% agreed.

- 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

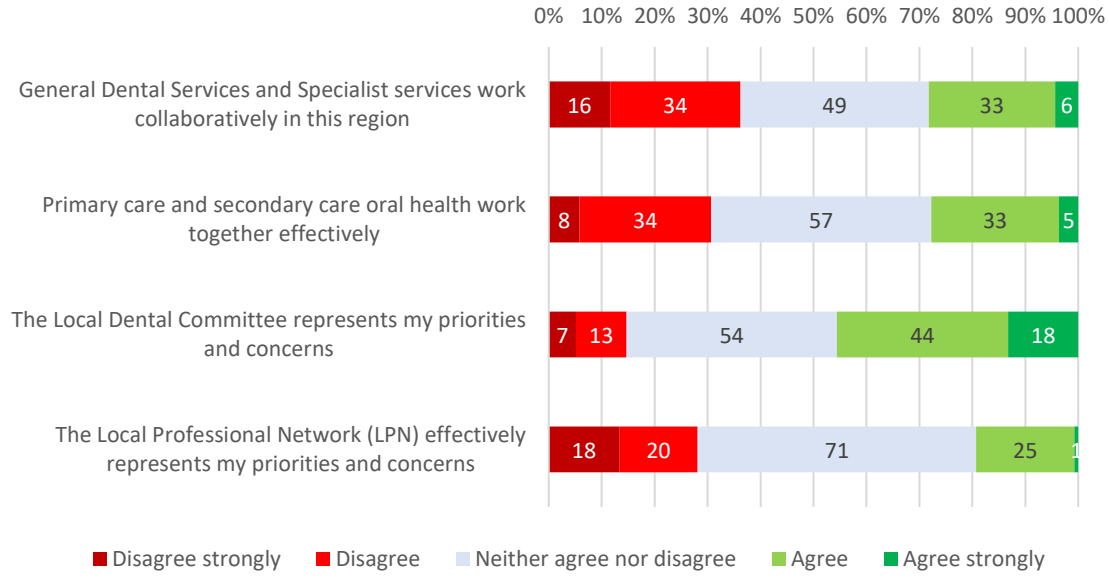


12.16 The next question focussed on the collaboration between practitioners and their representation both at the Local Dental Committee and the Local Professional Network (LPN).

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.

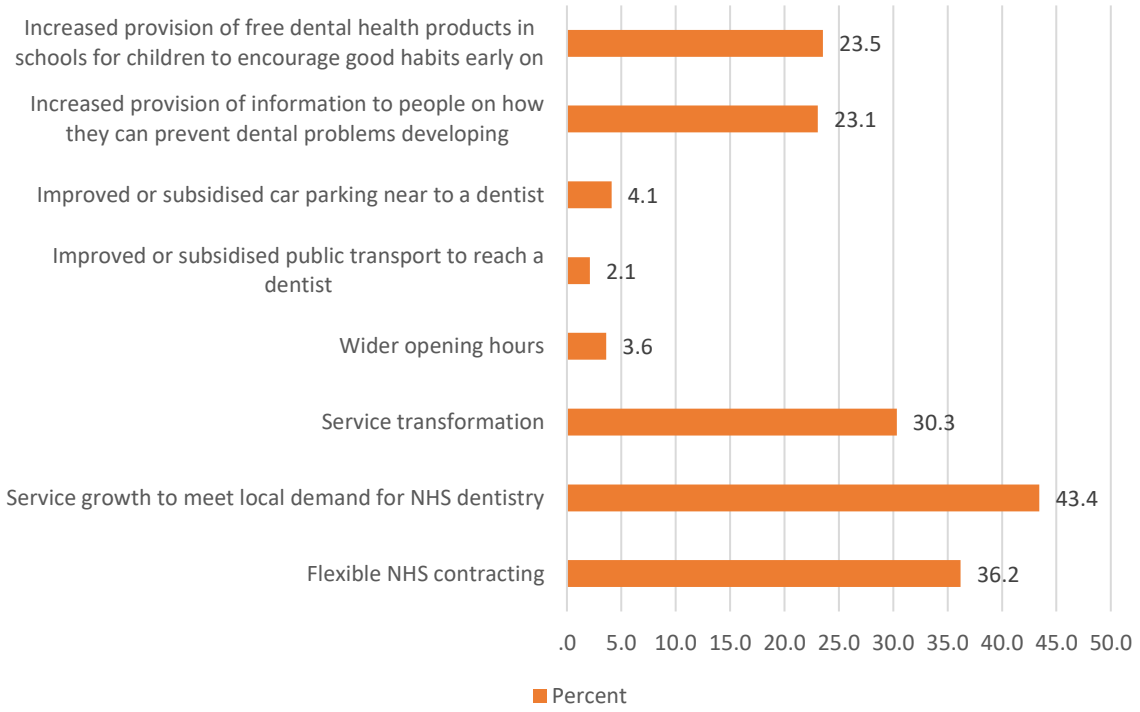
Chart 40: Thinking about the working relationships across dental and oral health providers, please state the extent to which you agree or disagree with the following statements



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.

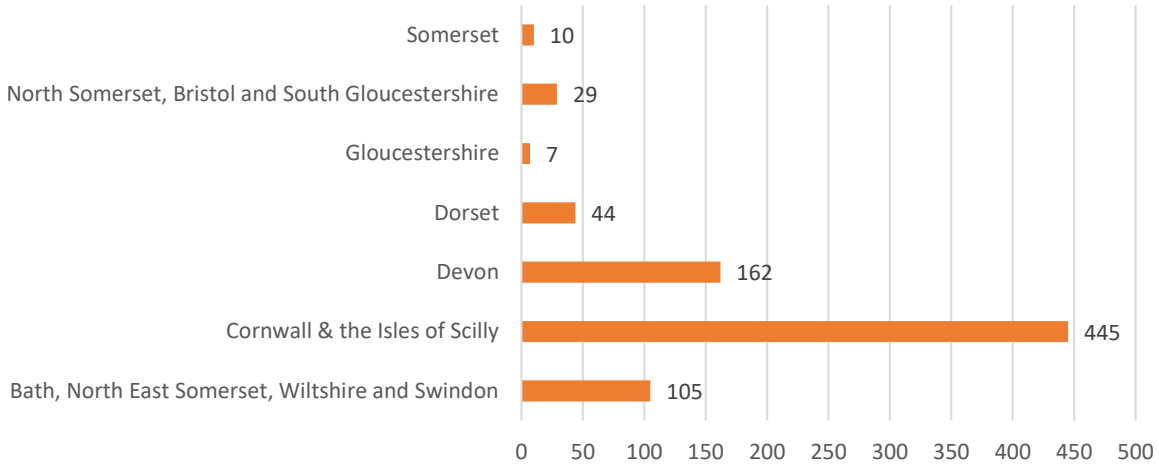
13.3 The survey opened on the 5th October and closed on the 17th November. In total we received 802 full surveys and 133 shortened surveys. This chapter will review the findings of both surveys and will draw together those findings most pertinent to this oral health needs assessment.

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)

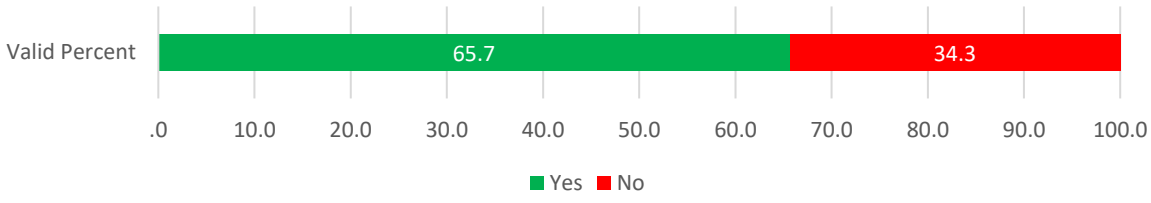
13.5 The survey captured 802 respondents from across the region. There seems to have been some extremely strong responses from some parts of the region and some more limited responses from others. 55% of responses came from Cornwall and the Isles of Scilly and 20% came from Devon. It would seem from 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.

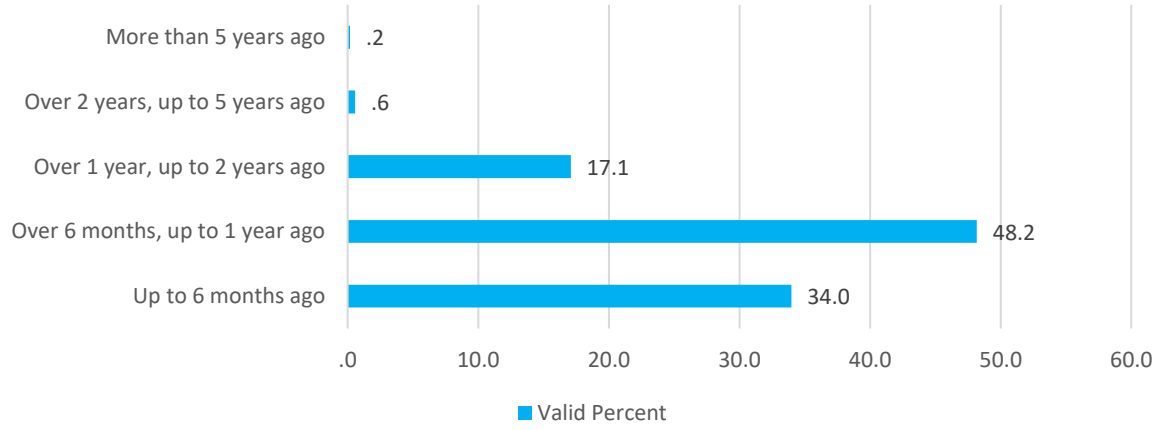
Chart 43: Do you have a regular dentist? (n795)



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.

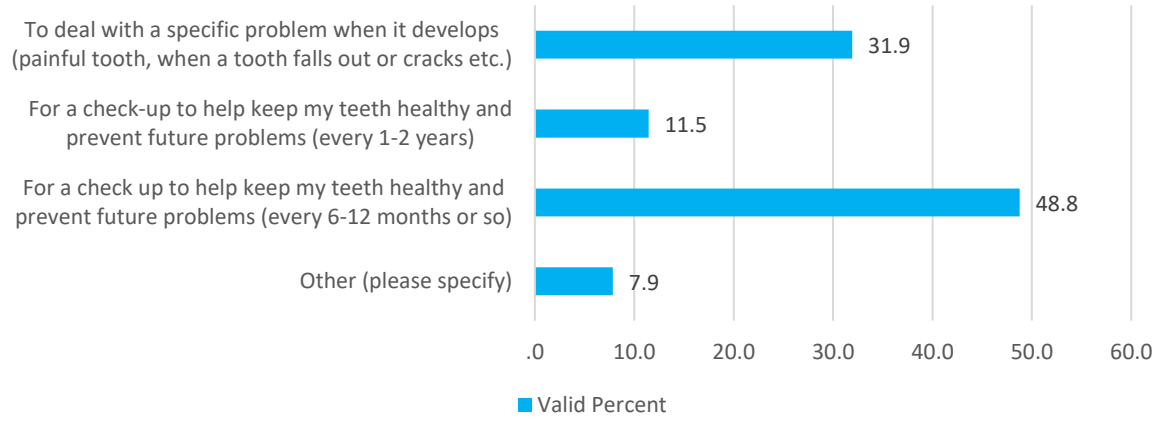
Chart 44: When was the last time you visited a dentist? (of those that had a regular dentist) (n 521)



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.

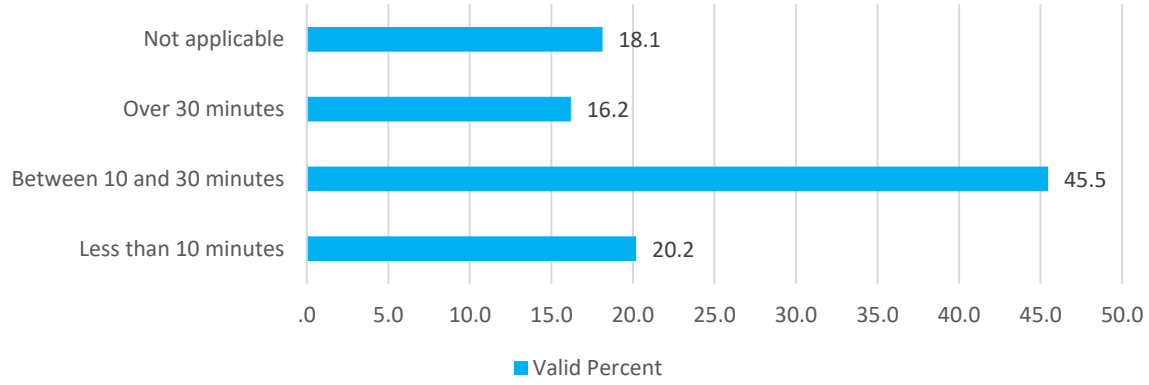
Chart 45: What was the main reason you last visited a dentist? (n777)



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.

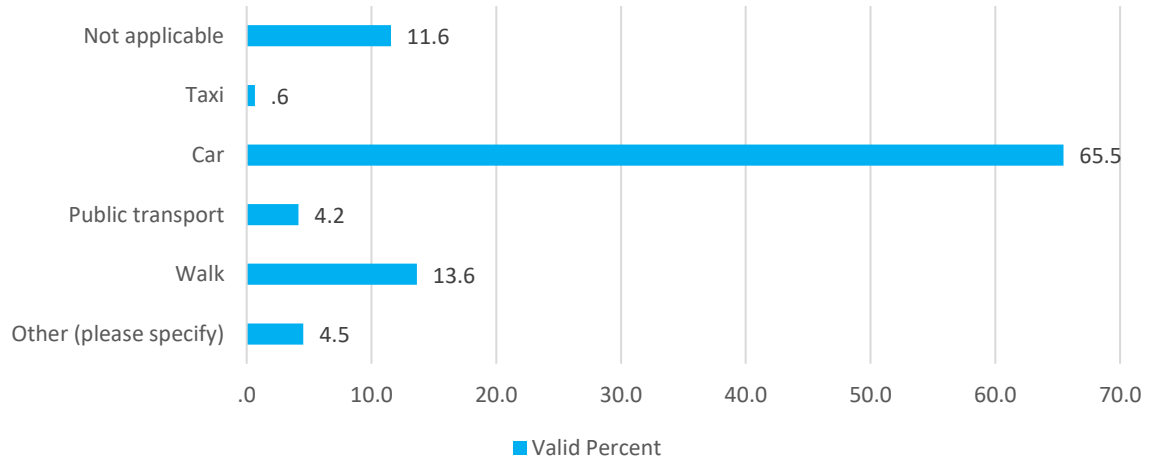
13.11 The survey then asked respondents how long it took them to get to their dentist. 772 people responded to this question and for the majority (65.7%) took less than 30 minutes to get to their dentist. 16.2% took over 30 minutes and 18.1% stated that this was not applicable.

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.

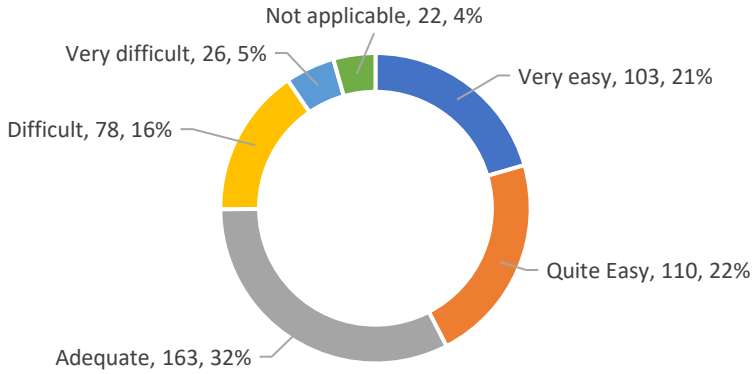
Chart 47: How do you predominantly get to your dentist's surgery when you go for an appointment? (n 770)



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)

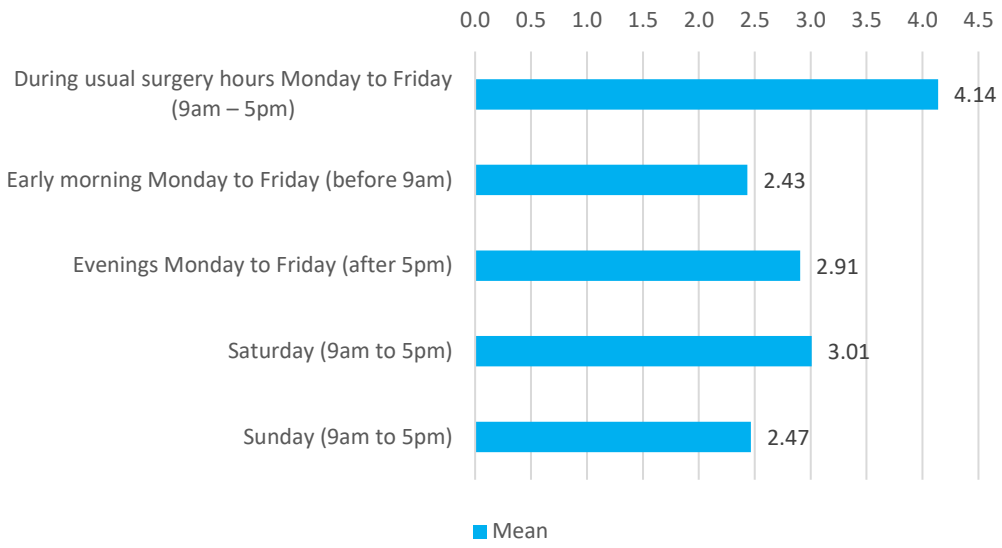


13.14 The public were then asked how likely they were to want an appointment at a dental surgery at the different times of the day/week. They were asked to rate each option from 1-5 where 1 means 'not likely' and 5 means 'highly likely'. We then analysed these responses by establishing the mean score 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.

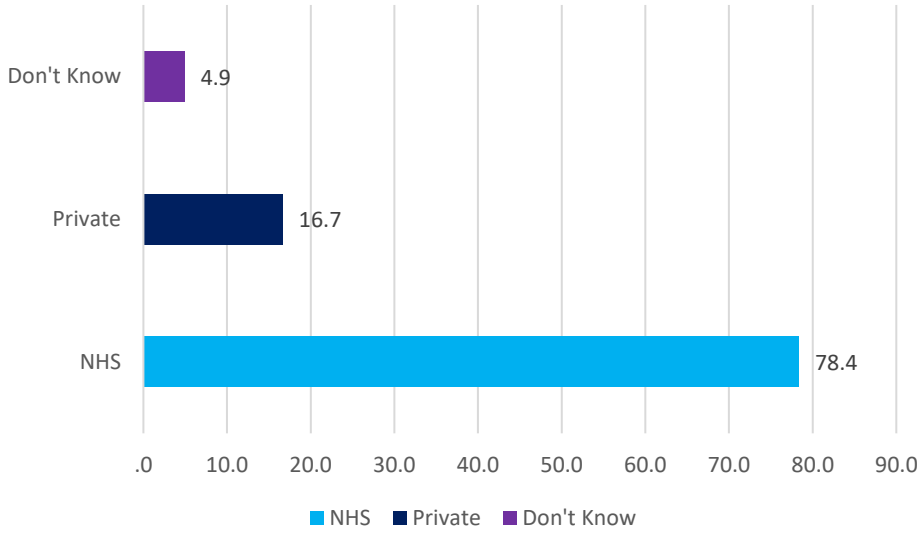
13.16 This suggests that in terms of patient preference most prefer keeping dental appointments during normal surgery hours. However, if there were to be alternative timings provided in addition, their preference would be for a Saturday surgery and the next preference would be for the extension of the 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.

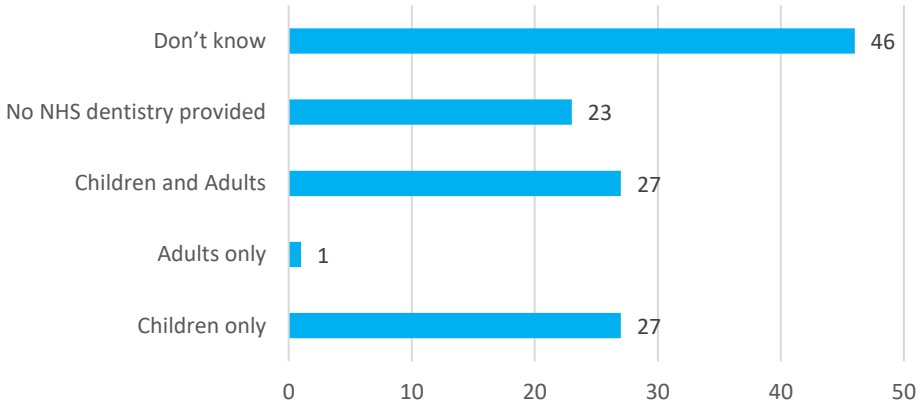
Chart 50: Do you go or want to go to an NHS or private dentist? (n749)



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

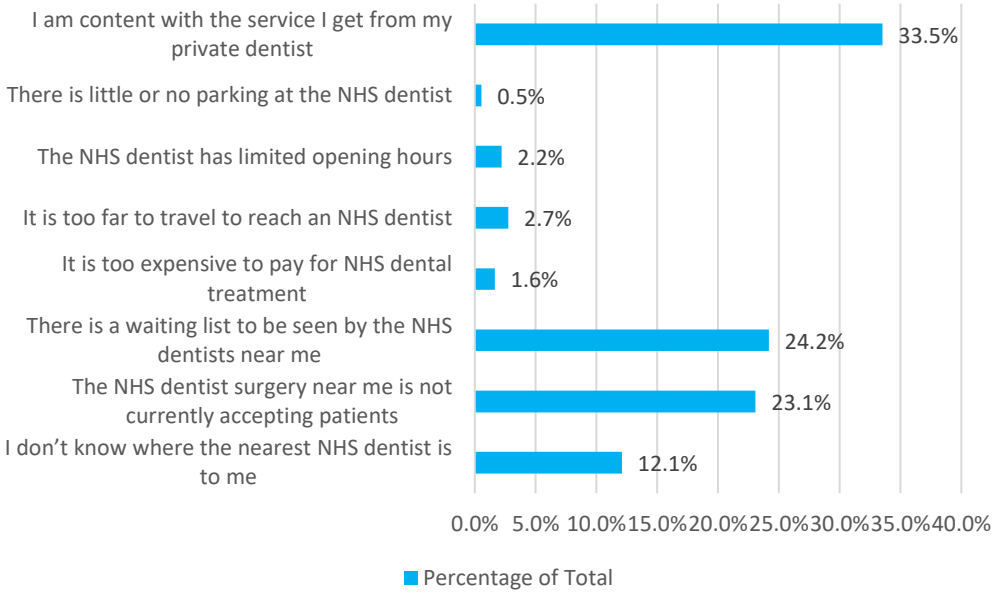
was available for children and adults, 21,8% that NHS dental provision was available for children only and 0.8% for adults only.

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.

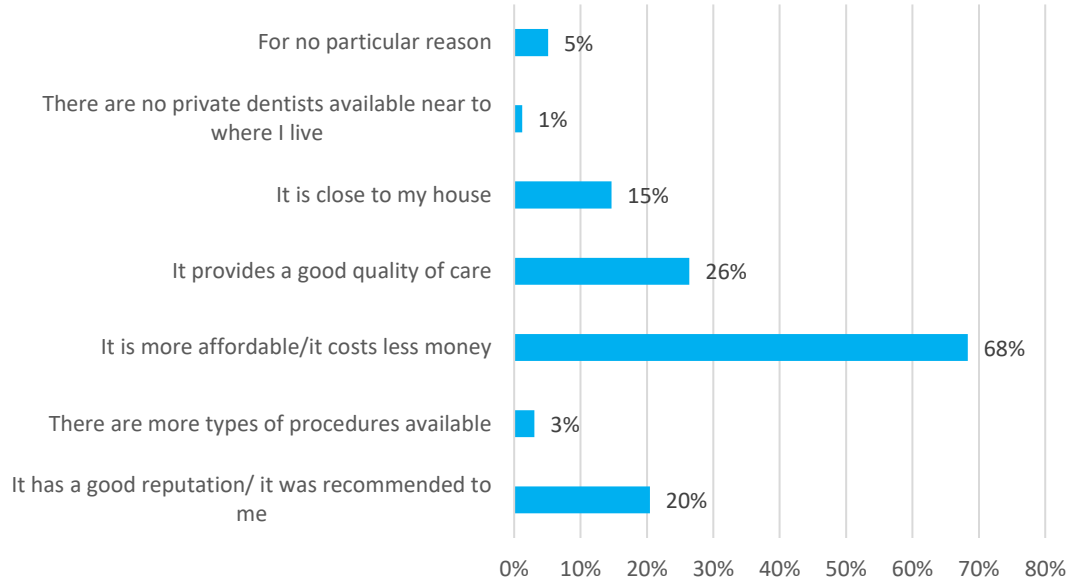
Chart 52: What stops you from going to see an NHS dentist regularly? (Tick all that apply) (n-124 NB Question targeted to non NHS patients)



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.'

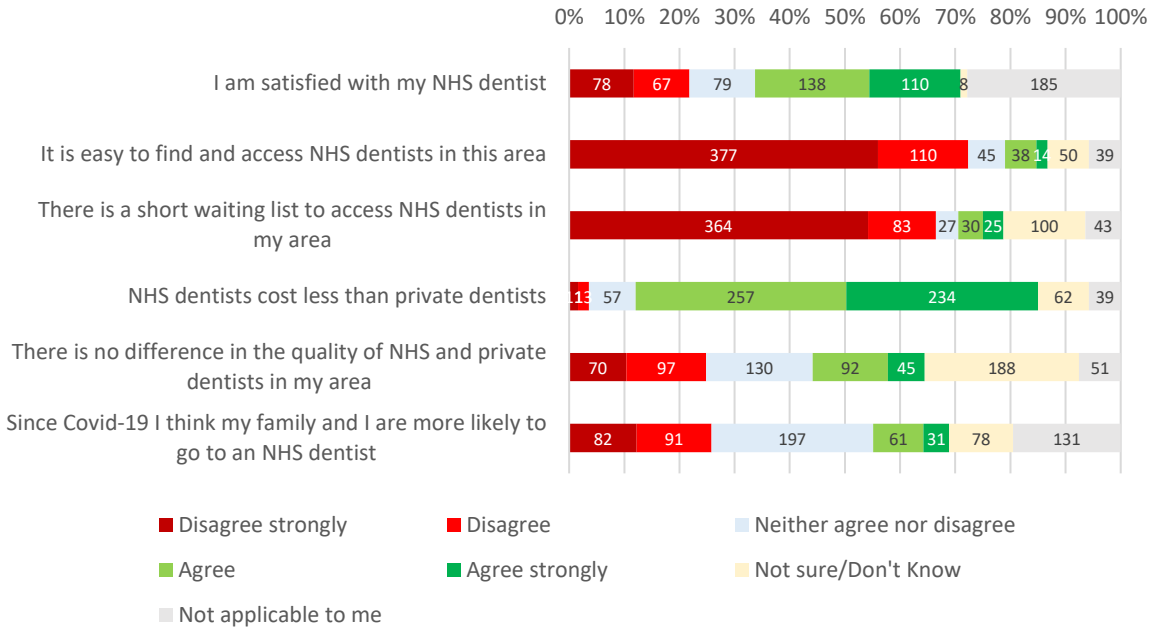
'There are no dentists available anywhere near me NHS or private. I'll pay privately when I need to, but this means I miss routine preventative dentistry.'

'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?

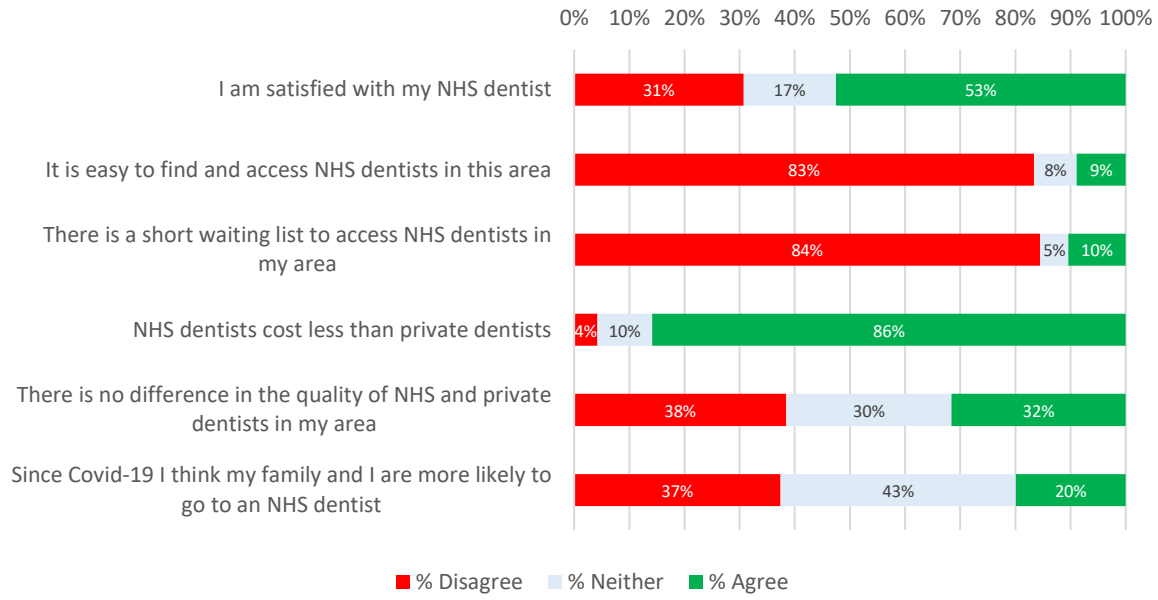


13.23 There were clearly higher levels of disagreement (red) with the statement, 'it is easy to find and access an NHS dentist in this area' chosen by 73% of respondents. 'There is a short waiting list to access NHS dentists in my area' saw 67% of respondent either disagreeing strongly or disagreeing. 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.'

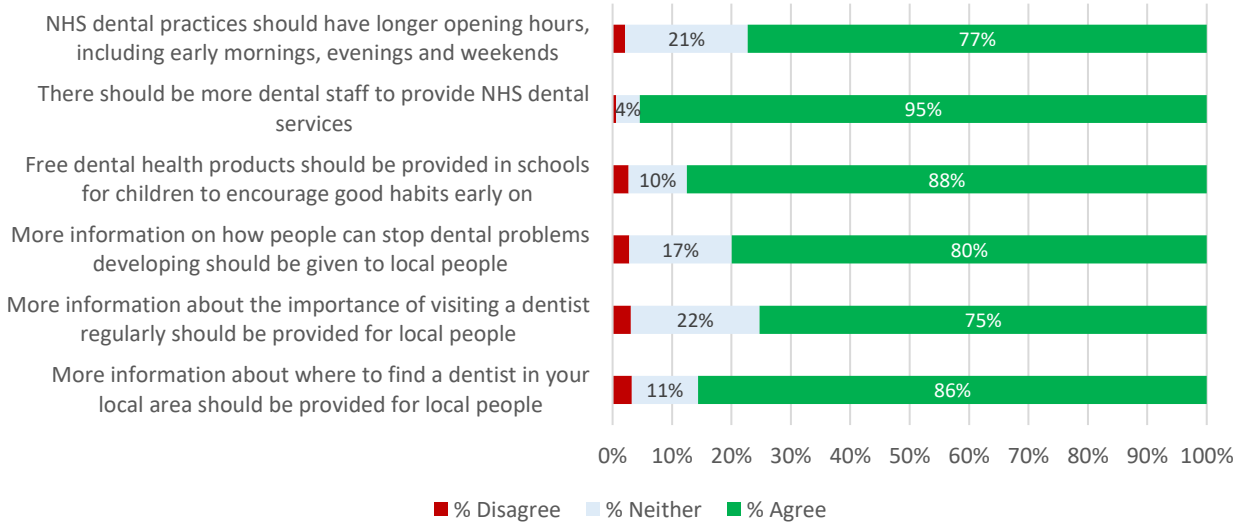
'We don't have a dentist. Moved to Devon in Aug 2019. You have to go on a waiting list to be allocated to an NHS dentist. Over a year later we are still waiting to be assigned a dentist. No oral treatment for a year. Previously went every 6 months regular.

'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.

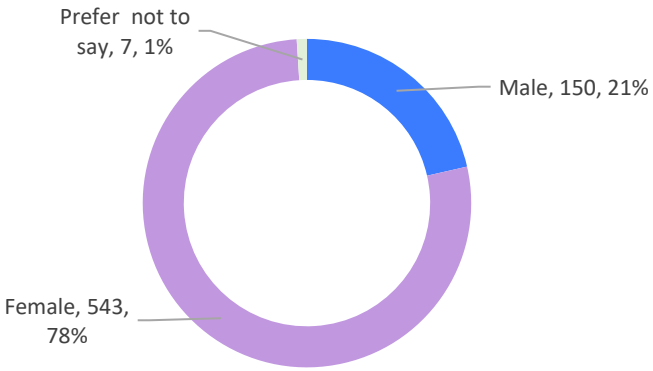
13.29 Finally, respondents were asked if they had any other suggestions for encouraging people to visit a dentist regularly and how to improve the oral health of local people. 421 people took the time to respond to this question. The list below tries to summarise the key points raised; the overwhelming 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

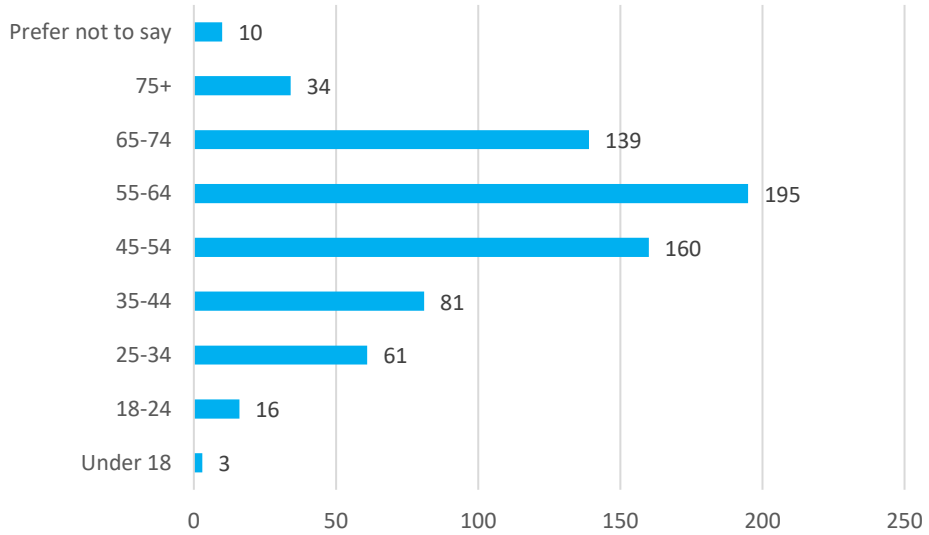
13.30 The gender profile of respondents that completed this question shows that there were a far higher volume of women with 78% of the sample compared to 21% men, 1% preferring not to say.

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.

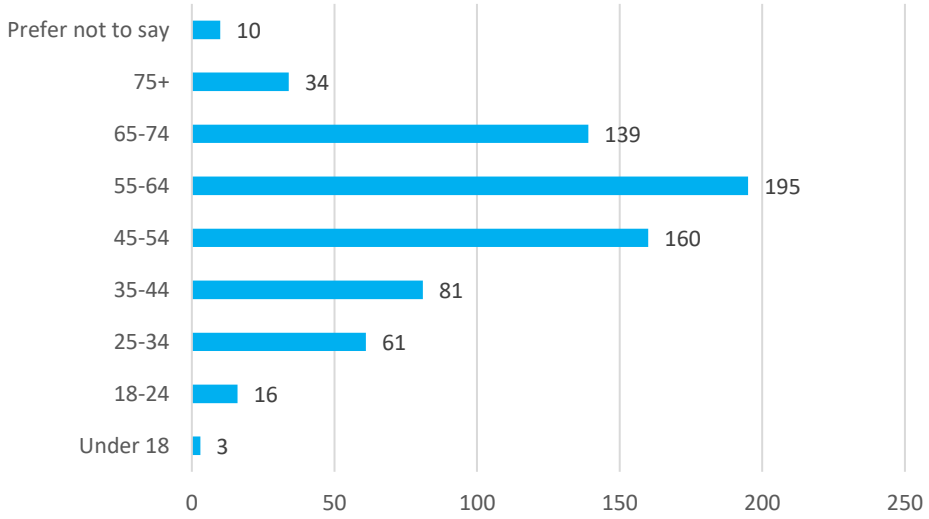
Chart 59: Age profile of Respondents (n699)



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

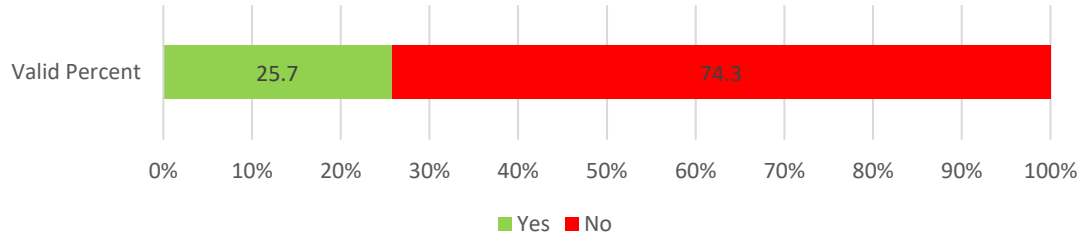
was 2.3% which is lower than the BAME regional level (5%). However responses were predominantly from Cornwall and Devon which is likely to have shifted this, particularly given the lower level of BAME representation in these counties at 1.8% and 2.8% respectively.

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%

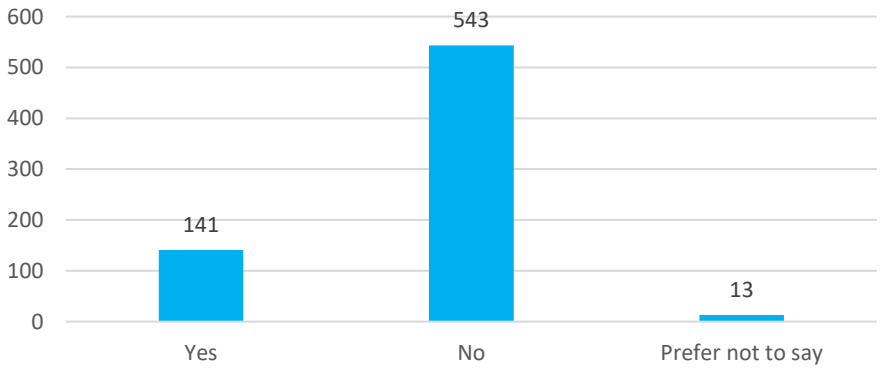
13.35 In terms of economic activity and employment status the table below sets out the responses from those engaged in this survey. 56.5% were economically active (i.e. employed either full or part time and unemployed) and the rest (43.5%) were economically inactive, this includes 24% who are retired 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

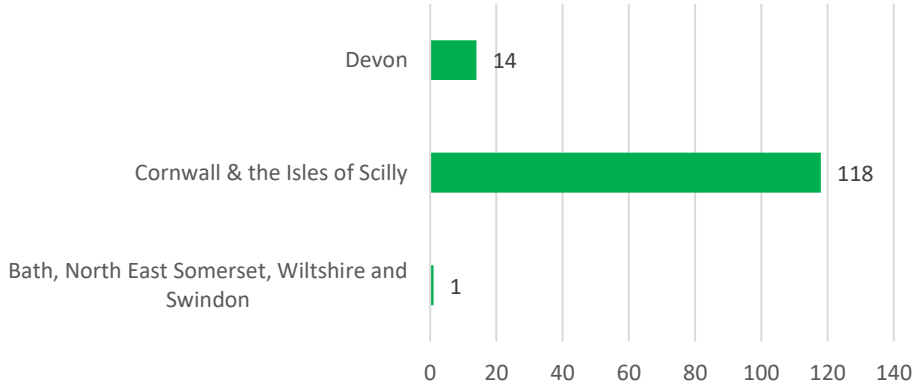
14.1 This short, Easy Read Survey was initially developed from the full survey and sought to target responses from people with learning disability. It was disseminated by Healthwatch Cornwall who had advised that they had a learning disability network who were keen to engage in this OHNA process. However, 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)

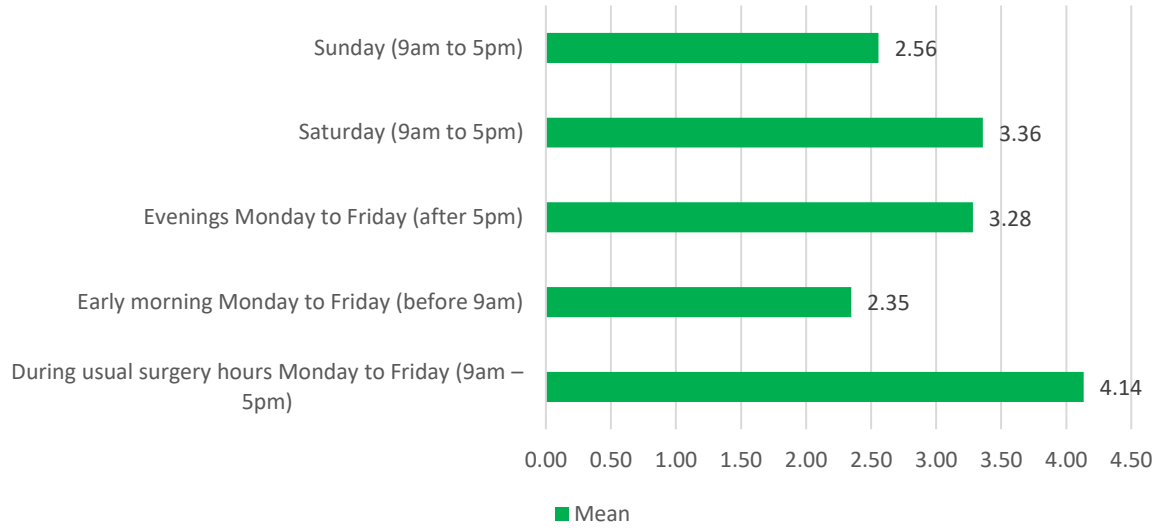


14.4 From within the sample 48.9% stated that they had a regular dentist and 51.1% stated that they did not.

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

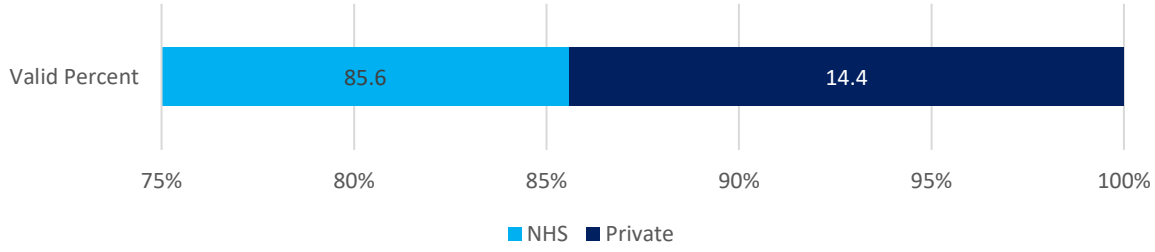
calculate the mean score for each option. During usual surgery hours Monday to Friday (9am – 5pm) scored 4.14 out of 5 which was the most widely preferred time. This was followed by Saturday (9am to 5pm) with 3.36, and evenings Monday to Friday (after 5pm) with 3.28. It would seem that this cohort, like 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

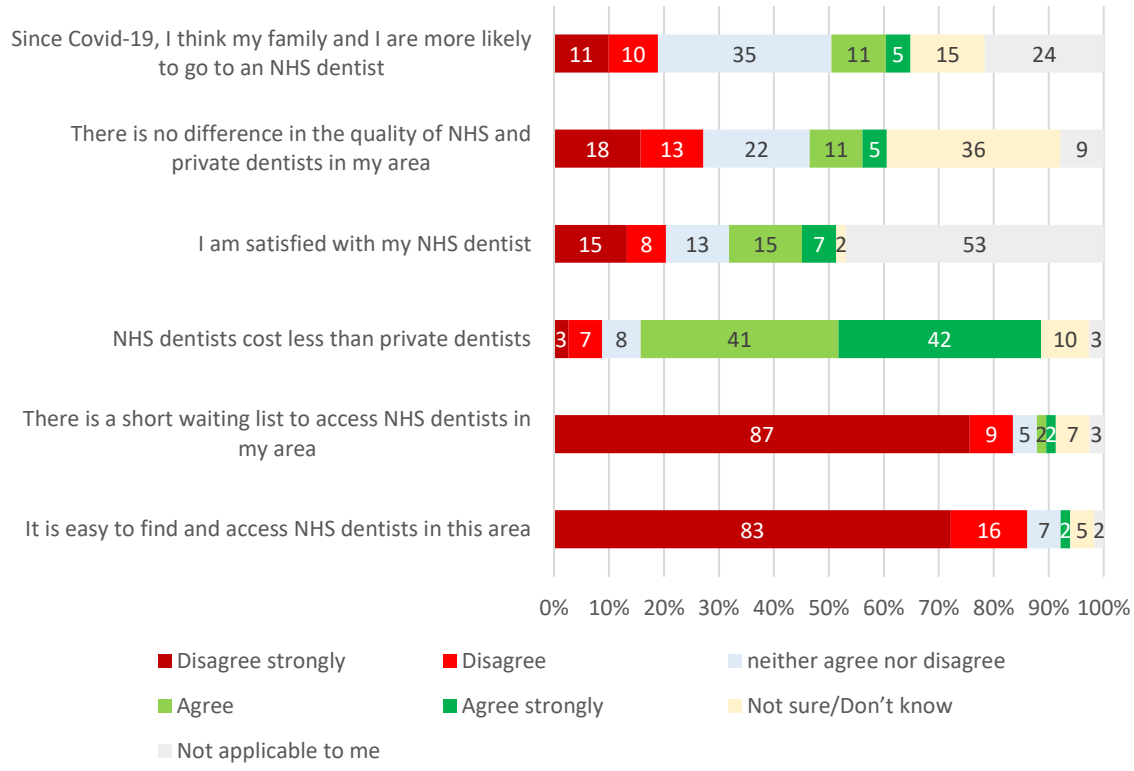


14.7 The next question sought to ask why people go to a dentist surgery and to establish what inspired them to do so. 27% stated that there are no NHS dentists near where they live, 23.6% stated they go to a dentist because it has a good quality of care, 24.1% stated they go to an NHS dentist because 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?

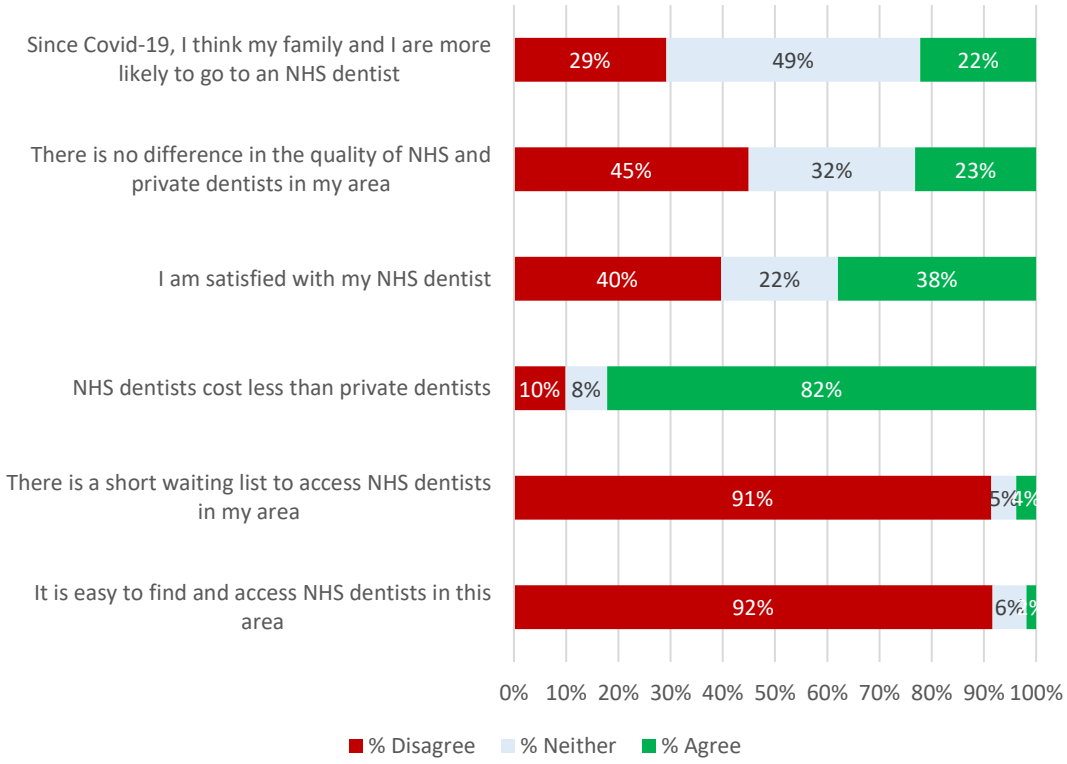


14.10 There were clearly higher levels of disagreement (red) with the statement, 'it is easy to find and access an NHS dentist in this area' with 87% of respondents disagreeing strongly. 'There is a short waiting list to access NHS dentists in my area' saw 83% of respondents either disagreeing strongly 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.'

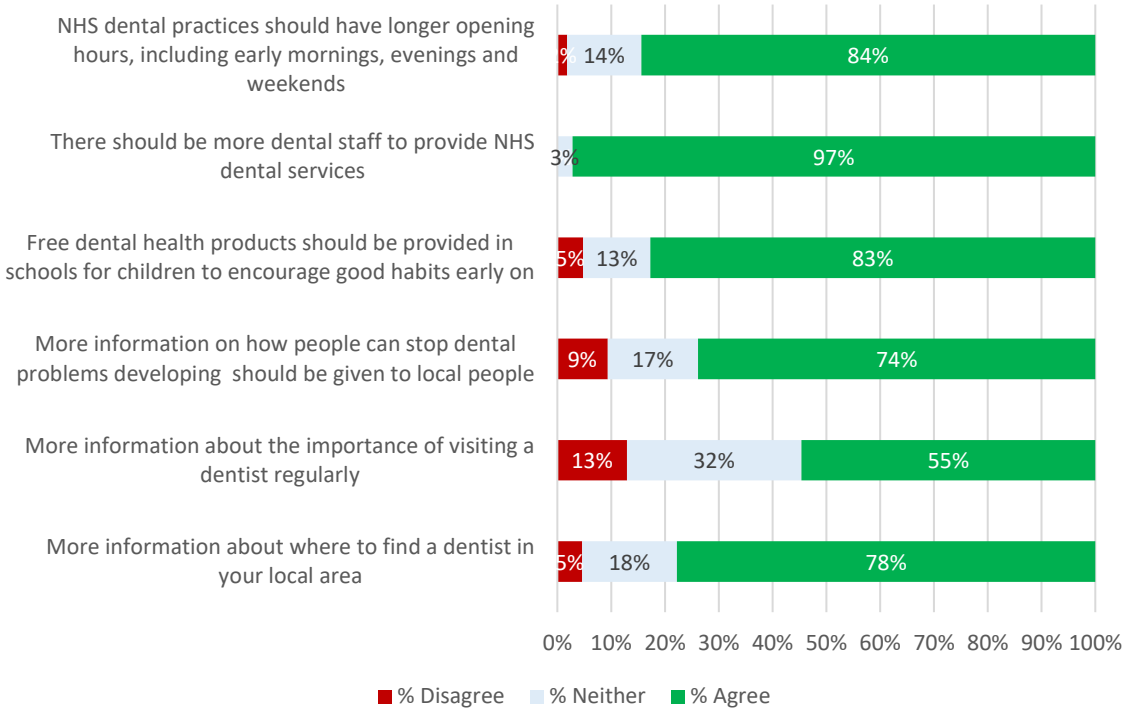
'We've always been happy with our dentist pre Covid. Now not able to get an appointment, even though my last treatments were not completed. Would love to see my dentist, have serious issues now. I was promised a phone call from my dentist, after my last phone call to the practice, it never happened. 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

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