



ACCESS TO ORAL HEALTH

**A REPORT OF THE
HEALTH AND SOCIAL CARE
SCRUTINY PANEL**

August 2007

Health and Social Care
Northgate House
Halifax
HX1 1UN

Telephone: 01422 392305
www.calderdale.gov.uk

FOREWORD BY THE CHAIR

Councillor Bob Metcalfe



The following pages contain a detailed report of our findings following the Health and Social Care Panel's scrutiny of Access to Oral Health in Calderdale.

This report is focussed on a real issue of health concern in West Yorkshire, a serious but largely preventable situation where Calderdale has amongst the worst results for the oral health of young children, many as young as 5 and under, in this region. The Panel has made a series of recommendations, which we believe, if followed through by Calderdale Council and our local NHS partners, will result in an improvement in the oral health of the whole of Calderdale's population, from the young to the elderly.

The content and findings of this report need to be considered by the Calderdale public as well as health professionals. This is especially true for parents of young children, who have such a vital role in making sure their children learn a good oral health routine. The Panel held one of its 'evidence' taking meetings in North Halifax, so we could hear first hand the views of the local community.

I wish to record my thanks to all the Members of the Panel for their contribution to this report. On their behalf I would like to thank all those who attended our Panel meetings, and those who supplied written evidence, for giving us their time and experience. A special word of thanks to Geoff Ainsley, whose untiring support work to the Panel has been essential in the production of this report.

Bob Metcalfe

Contents

Business Case	4
Executive Summary	5
Summary of Conclusions and Recommendations	6
One – Oral Health, What is it About?	11
Two – The Local Picture	15
Three – Preventing Oral Diseases	23
Four – The New Dental Contract and Access to Dentistry	43

Appendices

Appendix 1 – Membership of the Health & Social Care Scrutiny Panel	57
Appendix 2 – Terms of Reference	58
Appendix 3 – Work Programme	62
Appendix 4 – List of Tables	66
Appendix 5 – Glossary of Terms	67
Appendix 6 – References and Bibliography	68

BUSINESS CASE

The scrutiny of health and health services provision is a relatively new responsibility for local councils, coming into force in January 2003. The powers derive from the Health and Social Care Act (2001), which added to the powers already available to local authorities through the Local Government Act (2000). These have been further enhanced and clarified in subsequent Regulations and Directions.

These powers, given to all local authorities with social services responsibility, were intended to enable and encourage local authorities to scrutinise all aspects of the planning, provision and operation of health services affecting their area, not only those provided by the council, and to take evidence from and make recommendations to local NHS bodies. Local authorities have to specify in their constitutions the committee that will be responsible for these functions. In Calderdale these responsibilities lie with the Health and Social Care Scrutiny Panel.

There was, in the legislation and guidance, a clearly stated intention that local government scrutiny would provide a focus for harnessing and representing the views and interests of local people, and the opportunity for a more 'joined up' view of services to be taken, from the perspective of local people. Scrutiny was encouraged to focus its attention on the improvement of the general health and well – being of local people and the reduction of health inequalities.

These considerations, and the importance of joint working on shared priorities have grown increasingly important, as the development of the Community Strategy and the emergence of local Area Agreements exemplifies. In August 2006, the Health and Social Care Scrutiny Panel hosted a Health Scrutiny Planning Event, supported and facilitated through the Health Scrutiny Support Programme.

This event allowed an opportunity for the Panel to hear from Council officers and from senior representatives of each of the local NHS Trusts operating within the area, and to learn about the key areas of focus and emerging policy priorities and concerns of each. The aspiration for the meeting was to arrive at a consensual view of the main health issues affecting local people and of the areas of focus, in terms of health service provision, through which the Scrutiny Panel could best 'add value' through the conduct of in-depth, evidence – based investigation.

The outcomes report of this event included the development of a matrix for assessing the suitability of topics put forward for possible in – depth scrutiny and a process for determining and refreshing the panel's health scrutiny work programme. An initial list of topics, focussing on the health improvement strands of the draft Local Area Agreement and on access to health services was also identified. This included a resolution that the Panel would undertake a review of 'Access to Oral Health' within the current municipal year.

Executive Summary

During 2006/7 a number of factors coincided to ensure that access to dentistry, and to oral health generally, would be matters of great public interest and significant public health concern. Firstly, April 2006 saw the implementation of a new system of NHS dentistry, in which local Primary Care Trusts were given the responsibility for ensuring that adequate and effective dental services were available in their areas, and in which all dentists delivering NHS dentistry would have to sign up to new contracts. A new system of patient charges was also introduced.

At around the same time the first Community Health Profiles had been published, giving key health data in respect of the populations of each local authority. These revealed that the dental health of the people of West Yorkshire was the worst in England. The figures for Calderdale itself were disturbing, particularly in respect of 5 year olds.

Finally, the Chief Dental Officer for England issued guidance on the provisions of the Water Act (2003), which had sought to make it easier for fluoridation schemes to be implemented in respect of local water supplies. The guidance encouraged PCT's to look closely at fluoridation in order to address inequalities in oral health and explained how the consultation process would work.

All of these issues featured in this inquiry, as the panel sought answers to the questions posed in the terms of reference. In chapter one a brief account is given of the main factors affecting oral health, seeking to answer the questions 'what is oral health' and 'what are the causes and consequences of poor oral health'.

The following chapter explores the local situation, in relation to local and national comparators. The issue of inequality of outcomes between different groups is considered, and the relationship to life style and diet, in common with other health issues is spelt out.

Chapter three considers the extent to which poor oral health is preventable and examines the options for achieving improvement in oral health, both with regard to individual behaviours and actions available to local health partners.

Finally, chapter four looks at the availability of NHS dental services locally, and considers early evidence as to the likely impact of the new contractual arrangements and the new role of the Primary Care Trust.

The Scrutiny Panel considered a great deal of written evidence as well as conducting formal evidence sessions with a range of witnesses, including eminent national experts. The report makes recommendations not only to the Primary Care Trust and the Strategic Health Authority, but also to the local authority and to the head teachers and governing bodies of local schools.

Summary of Conclusions and Recommendations

The Panel Concluded that the causes of tooth decay and poor oral health are heavily associated with life – style and personal behaviour, and that these diseases are largely preventable.

The Panel believes that the causes and consequences of poor oral health, and what individuals can do to improve their own oral health should be consistently and effectively publicised.

The Panel was particularly concerned to learn of the situation regarding oral cancer, and noted the impact on survival chances of early detection. This argues for the importance of regular examination by a trained person. The Panel makes recommendations regarding these issues in this report.

Recommendation 1

The Panel feels that a thorough oral health needs assessment of the people of Calderdale is needed, and recommends that the Primary Care Trust should conduct such an exercise. The Panel would wish to see the results of this assessment and use that data to inform the basis for its future health scrutiny activities.

Recommendation 2

The Panel Recommends that the issue of fluoridation of the water supply is a matter of significant public health concern, and that in order to respond effectively in its role of community leadership to a likely forthcoming consultation, the Council should carefully review its policy on the matter. If such a consultation were to be forthcoming, the Council, and health scrutiny, would expect to play a full part in the ensuing debate.

The Panel recommends that this should be undertaken as a full health scrutiny, in order to consider the evidence properly on all sides.

Recommendation 3

The Panel believes that the biennial surveys of children’s dental health provide important information, and will be compromised by the insistence on positive parental consent. The Panel recommends that the Strategic Health Authority should request that the Department of Health reconsider its position on this matter

Recommendation 4

The Panel are concerned that the discontinuation of the routine health screening of children in reception classes has removed an early

opportunity for timely advice and treatment, and recommends that the local health partners should review this decision.

Recommendation 5

The Panel has learned of the importance of prevention and has been impressed by the range of initiatives undertaken by the Oral Health Promotion Team. The Panel is concerned about the limitation imposed by the lack of capacity to develop this activity and recommends that the Primary Care Trust consider the establishment of a specific budget area for health prevention activity, including a review of the budget provision for the Oral Health Promotion Team

Recommendation 6

The Panel recommends that the Children and Young People's Service's Directorate should use the Healthy Schools Scheme to encourage schools to access the services of the Oral Health Promotion Team and should offer clear advice supporting the take up of these services.

Recommendation 7

The Panel recommends that an item on Oral Health, noting the findings of this review, and highlighting the services of the Oral Health Promotion Team, be included in a future issue of the quarterly magazine for school governors.

Recommendation 8

The Panel recommends to the Children and Young People's Directorate that suitable training, highlighting the role of schools in promoting oral health should be included in the training courses for school governors.

Recommendation 9

The Panel recommends to heads and, in particular Governing Bodies that they ensure that their schools are accessing the advice of the Oral Health Promotion Team and that they carefully consider their policies in relation to food and drinks within their schools in the light of that advice

Recommendation 10

The Panel recommends that the Primary Care Trust consider alternative funding arrangements in respect of domiciliary visits to residents in residential homes, and should aim to ensure that this service is available wherever it is requested.

Recommendation 11

The Panel recommends that the Primary Care Trust conduct an audit of the premises at which NHS dental services are provided under contract. The PCT should identify priority areas for improvement in terms of physical access and patient experience.

Recommendation 12

The Panel have noted evidence that oral health in West Yorkshire is now the worst in the country. Oral health in Calderdale is poor, and features significant inequalities.

The Panel recommends that, at the next refresh of the Local Area Agreement, oral health be included as a priority local health issue.

Recommendation 13

The Panel believes that the OK Health Checks, and Health Action Plans, offer an important opportunity to monitor and impact on the oral health of vulnerable groups. The Panel recommends that they should be rolled out to as many as possible of the target groups.

The Panel recommends that the inclusion of the resulting data, in the electronic data system is important and should be done ,to inform future planning of services aimed at addressing inequalities in oral health outcomes.

Recommendation 14

The Panel believes that timely access to appropriate services for vulnerable groups is fundamental to tackling inequalities in health outcomes, and that the Community Dental Service are likely to constitute an important resource in that respect.

The Panel recommends that, in planning its future strategy, the Primary Care Trust ensure that the Community Dental Service is adequately resourced to meet future demand.

Recommendation 15

The Panel recommends that the Primary Care Trust, in reviewing their commissioning arrangements across the range of oral health services, give careful consideration to the availability and suitability of specialist acute services, in particular in respect of vulnerable groups.

Recommendation 16

It has been a consistent message in the evidence received for this review, that public understanding of health issues, and behaviour

change, would be key to preventing oral diseases. The Panel recognise the importance of the role of carers in this regard.

The Panel was pleased that the Health 7 Social Care Directorate was considering ways to improve access to oral health for older people and vulnerable groups and recommends that a further report be brought to scrutiny in twelve months time. This should include an update on progress with regard to health action plans, the use of electronic data systems, and the roll-out of training to carers.

Recommendation 17

The Panel recommends that the Strategic Health Authority monitor carefully the financial impact of the new funding arrangements as the new contracts develop. If it transpires that the Primary Care Trusts are suffering losses due to a shortfall of patient charges, or as a consequence of the new charging bands, they should lobby the Department of Health to protect the finances of the Primary Care Trusts.

Recommendation 18

The Panel recommends that the Primary Care Trust continue to prioritise Oral Health Services and ensure that they are appropriately funded, not necessarily limited to the sum equating to historical spend indicated by the Department of Health allocation.

Recommendation 19

The Panel believes that it will take time to establish the true financial impact of the new system, for patients, for dentists and for the Primary Care Trust

The Panel recommends that a further report on the local impact, informed by experiences and reports from elsewhere, be brought to the Scrutiny Panel when the results of the first full year of the system have been assessed.

Recommendation 20

The Panel is concerned at the amount of time being wasted through missed appointments, and the impact that this is having in terms of lost opportunities to carry out necessary treatment and preventive and developmental work.

The Panel recommends that the impact of missing appointments should be publicised, and that consideration should be given by the Primary Care Trust, in conjunction with local dentists, to the introduction of a leaflet, similar to that for the 'Your Commitment Our Commitment' scheme adopted in Kirklees.

Recommendation 21

The Panel believes that it is clear, from the evidence received during this review, that some members of the public are unaware of the need to see a dentist from an early age, and also of the need to continue to do so when older, even when full dentures have been fitted. The Panel has heard that an NHS dentist will always be available for young children

The Panel recommends that the Primary Care Trust, supported by local partners, should take every opportunity to ensure that parents of young children are made aware of the need to look after their children's dental health from an early age, and that they are adequately supported in doing so.

Recommendation 22

The Panel was pleased to learn that so many people have been able to be placed with an NHS dentist under the new arrangements and was also pleased to hear of the improvements to the emergency service.

The Panel recommends that more needs to be done to ensure that members of the public are aware of the services that are available, and of how to access them.

Recommendation 23

The Panel believes that the registration service the PCT is running through the PALS service is to be commended. However, it is clear that the availability of the service is not well known. The Panel recommends that the scheme be actively publicised by the Primary Care Trust, and that other agencies, including the local authority, ensure that people are aware of its existence.

Recommendation 24

The Panel has learned of the difficulties involved, in terms of budget constraint and contractor freedom, in getting people access to a dentist close to home. The Panel nevertheless feels that this is an important aspiration and recommends that the PCT should make every effort to make this more possible. This could, perhaps, include the use of salaried dental staff. This is particularly important in deprived areas with no current provision.

Recommendation 25

The Panel recommends that the PCT should introduce some form of prioritisation into their allocation policy, to help those with greatest access difficulties.

One

Oral Health – What is it About?

- 1.1 When people think about oral health, they usually think about teeth. When they think about access to oral health, they might immediately think about regular access to a dentist. The Panel learned, in the process of this review, that there is much more to oral health than healthy teeth, though healthy teeth are an important aspect of general well – being.
- 1.2 Oral health has been defined as ‘a standard of health of the oral and related tissues which enable an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being’. The Consultant in Dental Public health emphasised to the Panel the very significant impact on general well-being that poor oral health can cause, particularly among the young and the very old.
- 1.3 Seeing a dentist on a regular basis is important, and not being able to see a dentist when you need to, and where you want to is an important issue in access to public health services. However, most of the time, the dentist is repairing damage or decay, and the Panel also learned that such damage is by and large preventable. If we are to achieve the large improvements in oral health that we would wish to see, on a population wide basis, the emphasis must be on preventing tooth decay and gum disease and in raising awareness of the dangers and causes of oral cancer.
- 1.4 The principal types of oral disease are dental caries, tooth erosion, gum disease, and oral cancer. Trauma through accident is another significant cause of problems.
- 1.5 Dental Caries (tooth decay) is often said to be the most common medical condition affecting mankind. Although its incidence has decreased in the last 30 to 40 years it remains a major health problem.
- 1.6 The Panel learned that caries begins within the plaque on the tooth surface following the consumption of sugars in food and drinks. Bacteria within the plaque absorbs the sugars, and acids are produced. These acids accumulate and cause demineralisation of the enamel surface. The process then spreads into the softer, sensitive part of the tooth beneath the enamel. The weakened enamel then collapses to form a cavity and the tooth is progressively destroyed. The destruction of the crown of the tooth is often accompanied by severe pain and infection. The roots of the teeth can also be attacked as they become exposed by gum recession. This is more common in older adults.

- 1.7 The process begins within seconds of consumption, and within minutes sufficient acid may be generated within the plaque layer to cause an outflow of calcium and phosphate (demineralisation). After a time, between 20 minutes and 2 hours, acid will have dissipated and the lost minerals may be slowly replaced from the saliva (remineralisation).
- 1.8 Caries therefore occurs through the presence of plaque and sugars. Plaque should be controlled by regular brushing with fluoride toothpaste. The use of fluoride toothpaste over the last forty years was frequently cited to the Panel as the principal cause of the significant improvements in dental health during that time. The presence of fluoride, at a very low level, in the plaque and the saliva is thought to alter the chemical balance and favour the remineralisation process.
- 1.9 However, plaque reforms quickly after brushing, and so restricting the frequency of intake of dietary sugars is the other major factor in preventing caries. The most common source of sugars affecting this process are sucrose and glucose, which are added to many foods and drinks, including sports drinks, during manufacture, and table sugar.
- 1.10 Erosion is quite different to caries, and is caused by the direct action of chemicals on the tooth surface, rather than by the action of plaque bacteria. It can affect plaque free surfaces and, while pain in the initial stages is not usual, sensitivity to thermal change and acidic drinks can cause considerable pain once advanced.
- 1.11 This can be caused by gastric reflux into the mouth, as a result, for example, of pregnancy, motion sickness, alcoholism or obesity. However the most common cause is thought to be dietary factors. In particular, fruit juice is erosive, and the rapid increase in the consumption of juices and of sports – type drinks has been blamed for an increased prevalence of erosion, especially among the young. The relationship between frequency of consumption of such drinks and erosion is now established. Citric acid is thought to be the main ingredient linked to erosion, but phosphoric acid, which is present in cola – type drinks has also been identified as a likely cause. Fruit flavoured ‘alcopops’, which also have a low pH, are also causing concern.
- 1.12 Advice is therefore focussed on reducing the amount of sugar in the diet and, in particular reducing the frequency of consumption of sugary food and drinks. This extends to advising the avoidance of sugary drinks in bottles and beakers for infants, in particular where this is associated with drinks being consumed over a long period of time, and where drinks taken from a bottle may result in the teeth being bathed in the liquid for a considerable period.
- 1.13 The most common types of gum disease are gingivitis and chronic periodontitis. Gingivitis, characterised by inflammation, redness, swelling and bleeding, can begin in early childhood. If untreated this

can develop to a further stage (periodontitis), in which the bone and fibres that support the teeth are progressively destroyed. This may lead to loosening and eventual loss of the teeth.

- 1.14 These diseases are caused by dental plaque, the bacteria from which causes a series of complex reactions in the body, as the immune system attempts to respond. The speed of growth of plaque varies, and can be influenced by irregularities around the teeth, such as overhanging edges, poorly contoured fillings, and some kinds of partial dentures, all of which encourage accumulation and make cleaning more difficult. The development of tartar (calculus), which is calcified and hardened plaque, is another factor that can cause increased problems.
- 1.15 The Panel were told that the cause of these gum diseases is poor oral hygiene, and that improved oral hygiene is the 'simple' answer to preventing them. In particular, since gingivitis precedes periodontitis, and that this frequently starts at an early age, early development of oral hygiene and plaque control behaviours is the principal factor in reducing the prevalence of these diseases. The panel also learned that most forms of gingivitis can usually be reversed by effective oral care.
- 1.16 The panel have heard that the care required to avoid tooth decay and gum disease falls into two categories. The first involves effective personal behaviours in terms of diet, a reduced frequency of consumption of sugary foods and drinks, and regular and effective cleaning of teeth and gums with fluoride toothpaste. The second is regular attendance at a dentist, who will be able to more effectively remove plaque and tartar, take any early action necessary to tackle signs of caries or erosion, and also give important preventive advice. However, it has been emphasised that the most important measure is effective personal oral hygiene, and from an early age.
- 1.17 The Panel were advised that oral cancers were increasing in prevalence. These cancers had previously been most common in the older age group, but were now rising among the middle aged. The Members were told that in its rate of incidence, oral cancer could be thought of as equivalent to cervical cancer. However, there is much lower awareness of it, though this is growing. The increase in younger people affected by these cancers is causing concern, as is an increase in prevalence among women (most cases occur in men).
- 1.18 Deaths from oral cancer are increasing. It is estimated that there are about 4,500 new cases each year in the UK, with over 2,000 deaths. The rate of deaths is significantly affected by late diagnosis. The overall 5 – year survival rate is worse, and the mortality rate is higher than for most other cancers. However, where there is early diagnosis the 5 – year survival rate is 90%, falling to 20% for those presenting at a late stage.

- 1.19 The principal risk factors for oral cancers are smoking and alcohol. The Panel learned that heavy smokers, or those who consume excessive alcohol increase their risk of oral cancer by 5 or 6 times. There is also a 'multiplier' effect, so that the relative risk for long – term smokers who also consume alcohol may be 30 times greater than that for non – smokers who are infrequent drinkers. There is evidence that if smoking ceases then the risk of developing oral cancer falls by about 50%.
- 1.20 The final cause of oral ill – health that Members heard of was trauma, caused by accidents, sporting injuries etc. The members learned that proper preventive measures, such as the wearing of protective mouth-guards for contact sports, and effective care post – trauma could significantly lessen the impact of such accidents.

The Panel note that the causes of tooth decay and poor oral health are heavily associated with life – style and personal behaviour, and that these diseases are largely preventable.

The Panel believes that the causes and consequences of poor oral health, and what individuals can do to improve their own oral health should be consistently and effectively publicised.

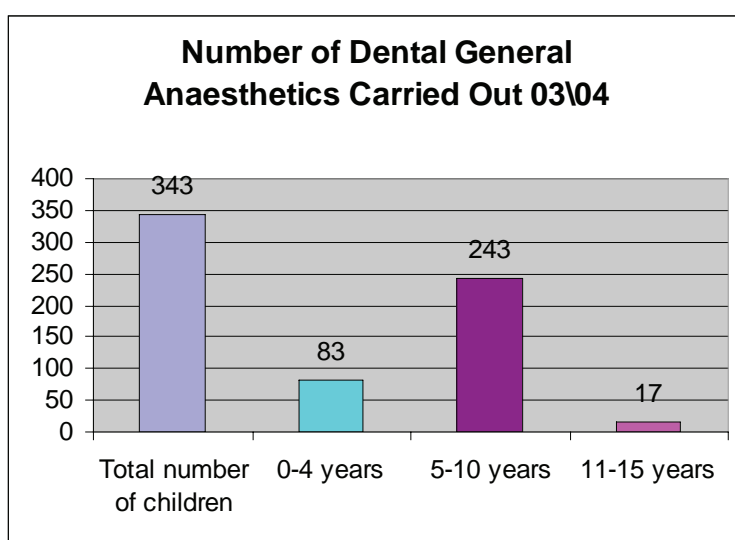
The Panel was particularly concerned to learn of the situation regarding oral cancer, and noted the impact on survival chances of early detection. This argues for the importance of regular examination by a trained person. The Panel will make recommendations regarding these issues in later sections of this report.

Two

The Local Picture

- 2.1 The Panel had been particularly concerned to hear that in 2003/4, the most recent year for which figures were available, some 343 children had teeth removed under general anaesthetic in Calderdale Royal Hospital. In total, 1,683 teeth had been taken from these children. (Table 1).
- 2.2 Of these children 84 had been under the age of 4. The Consultant in Dental Public Health had advised that teeth would rarely be removed before the age of 3, and that in fact the great majority of the children affected had been between the ages of 3 and 7.

Table 1



- 2.3 The Panel had been told that this was done as a last resort. It was a cause of considerable concern to the dental team;
- because of the risks of the general anaesthetic,
 - because of numbers of teeth that have been taken out, and
 - because it is in the very young child who has no comprehension or understanding of why they are ending up having all these teeth out.
- 2.4 The Consultant in Dental Public Health had advised Members that general anaesthetics were no longer carried out in dental surgeries because of real risks, accidents had occurred each year, nationally. The decision to extract under general anaesthetic in hospitals is only taken after attempts have been made to treat the child within a dental surgery to try and fill the teeth.

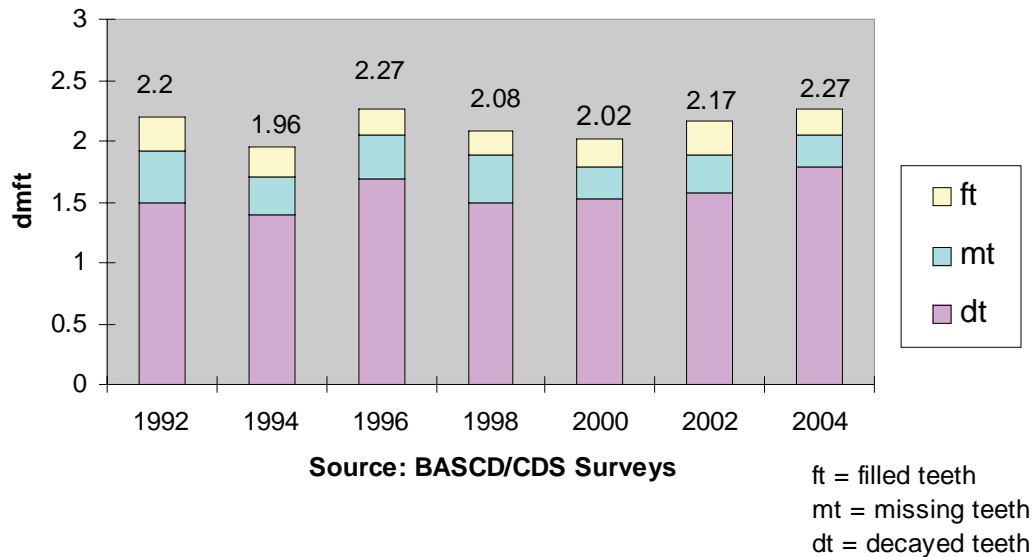
‘Sometimes they cannot be saved, but the prospect of giving a local anaesthetic to a 3 or 4 year old child in the mouth in

several places is not a very nice thing, and a lot of children just can't tolerate that. They can't understand why they have got to be having several injections in the mouth, and so in that way it is kinder for the child to have all of the teeth removed at once'.

- 2.5 The large number of extractions of teeth from children has also been highlighted in other scrutiny reviews. The review of Oral Health and Dentistry, published by Portsmouth Council in March 2006 noted concern that the Poswillo Centre at Queen Alexandra Hospital (which hosts that areas emergency dental service) had overseen the extraction of 359 deciduous teeth and 81 permanent teeth from children during September 2005.
- 2.6 The Panel were advised that even by the time that a child gets to school age, behaviour patterns have been set, and considerable damage has been done. This is reflected in the local and national statistical data available.
- 2.7 The Panel heard that there had been huge improvements in oral health over the last 50 years. This had been due to better knowledge, improvements in science and technology and, since the 1970's, the widespread use of fluoride toothpaste. There had been an increase in numbers in the dental profession and improvements in the service that they had been providing.
- 2.8 One result of this is that many more people, including older people, were keeping some of their teeth for the rest of their lives. This was posing fresh challenges for dentistry, since some of these teeth required a high level of care, in circumstances where health may otherwise be compromised and ability to access a dental surgery posed problems. These issues are discussed later in this report.
- 2.9 The Panel learned that there were two principal measures used for assessing dental health at the population level. The statistics in relation to these are largely restricted to children's dental health, and are the result of regular national surveys, which have been carried out on a regular basis since 1980.
- 2.10 The first measure is DMFT / dmft, which represents the (average) number of decayed (d), missing (m) or filled (f) teeth. (*dmft* refers to baby teeth or deciduous teeth and *DMFT* refers to adult teeth). DMFT is the aggregate of teeth that are either decayed, missing or filled. The second measure is the percentage of children whose teeth would be decay free.
- 2.11 National targets had been set for these indicators in the Oral Health Strategy of 1996. The targets had been that, by 2003, 70% of children aged 5 would be decay free, and the target dmft was 1.0

2.12 Table 2, below, shows the latest available information for Calderdale. The Panel were told that, in spite of the overall improvement in dental health in the last 40 years, little if any progress has been made locally in terms of the dental health of 5 – year – olds, and the national target has not been attained.

DENTAL HEALTH OF 5 YR OLDS - CALDERDALE (1992-2004)



2.13 The bars are split into three areas, reflecting the decayed, missing and filled teeth. The bottom, (mauve) section is the proportion of decayed teeth. The middle (blue) part is the proportion of missing teeth, taken out because the teeth were rotten. The top (yellow) is the proportion of teeth that are filled. The Panel were advised that, at the age of 5, only very few decayed teeth have been filled. The majority of those teeth were still in the children’s mouths, decayed. There were many reasons for this, a large one of which is that children don’t like having their teeth filled. Or, parents don’t bring them to the dentist early enough and they end up needing to have them taken out.

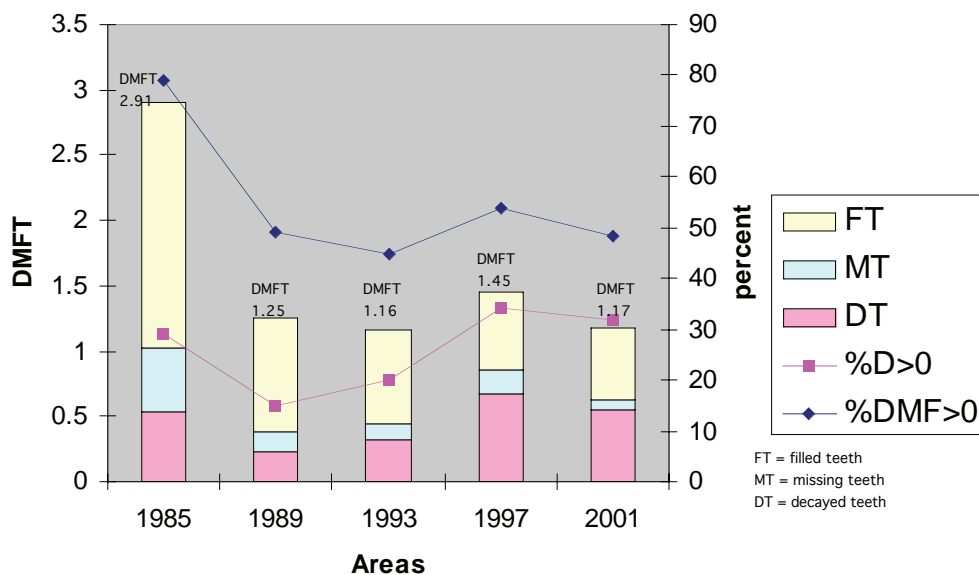
2.14 The Panel were told that the situation for 12 year – olds was better. As table 3 shows, the oral health of these children had improved significantly, and was almost at the level of the national target. The Consultant in Dental Public Health felt that this was because more of these children were now using fluoride toothpaste, hopefully on a daily basis.

2.15 At the age of 12 most children have most of their adult teeth, certainly the front teeth and the first molars and the second molar, which come through from about the age 6 onwards. This would mean that if those children had been brushing regularly then they would have had the added benefit of fluoride toothpaste on their teeth.

2.16 The Members were told that there could then be a reversal by 14 and 15, when young teenagers again start drinking more fizzy drinks and sports drinks, etc, leading to other problems of erosion of the enamel.

Table 3

Dental Health of 12 Yr Olds - Calderdale (1985-2001)



2.17 The Panel learned that there were considerable inequalities in dental health within the population, and that these were closely related to social class. Statistics suggest that all aspects of oral health are related to deprivation, and that these reflect the situation with regard to many other health issues. Table 4 (below), shows the national comparison for dental health experience by social class. This may be compared with a local graph (table 5) showing the incidence of tooth decay (in twelve year olds) across different areas within Calderdale. This is further supported by table 6, which shows the incidence of decayed missing and filled teeth and the percentage of children with no decayed, or some decayed teeth within the sure – start areas in Calderdale. This can be taken to reflect the relative situation in the more deprived areas, and confirms that the standards of dental health among children in those areas is significantly worse than the Calderdale average and well below the national targets.

Table 4

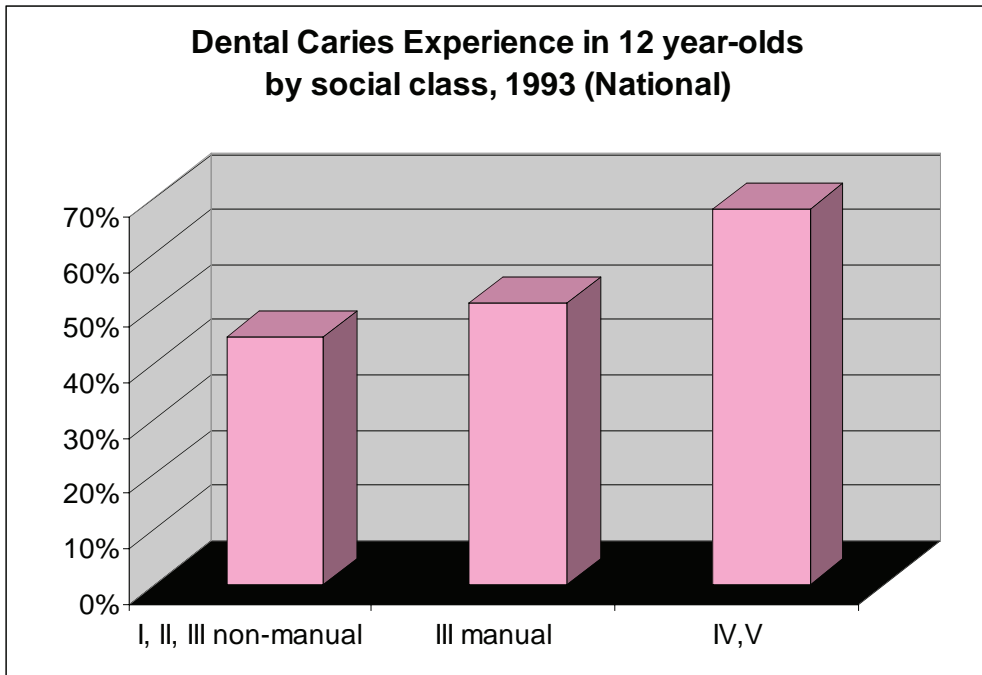


Table 5

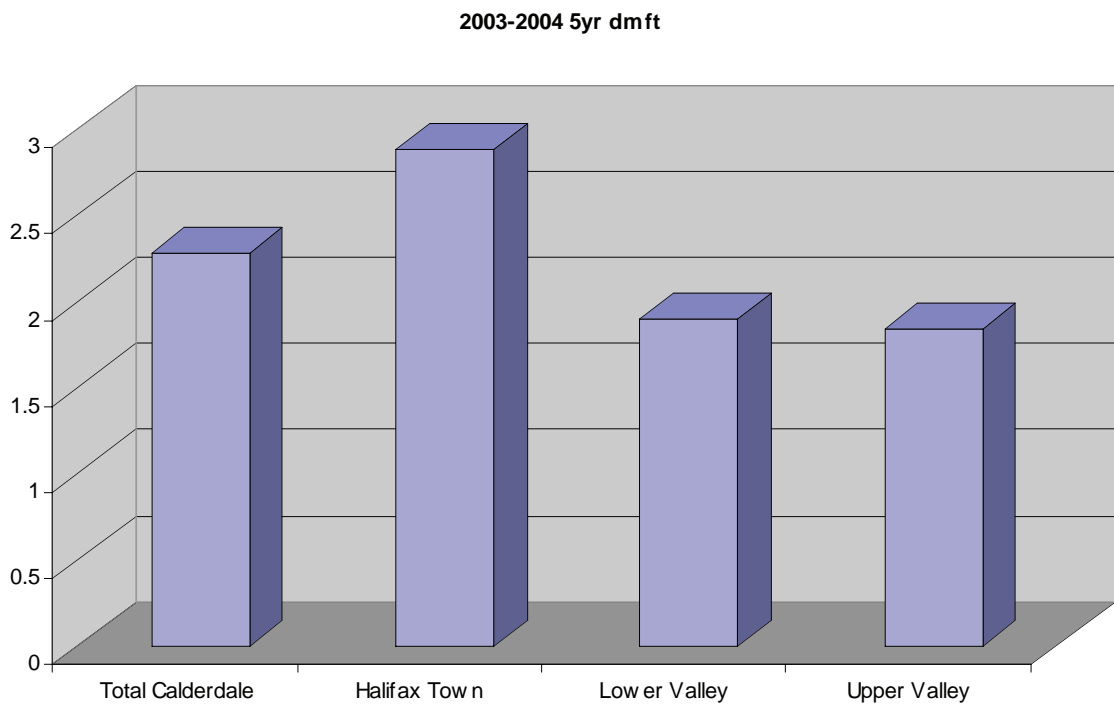
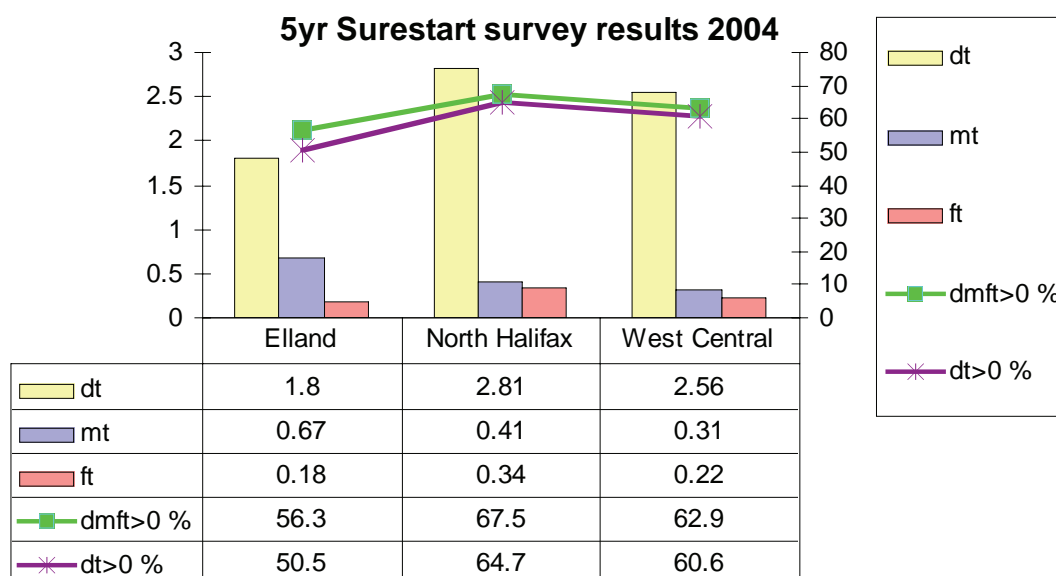


Table 6



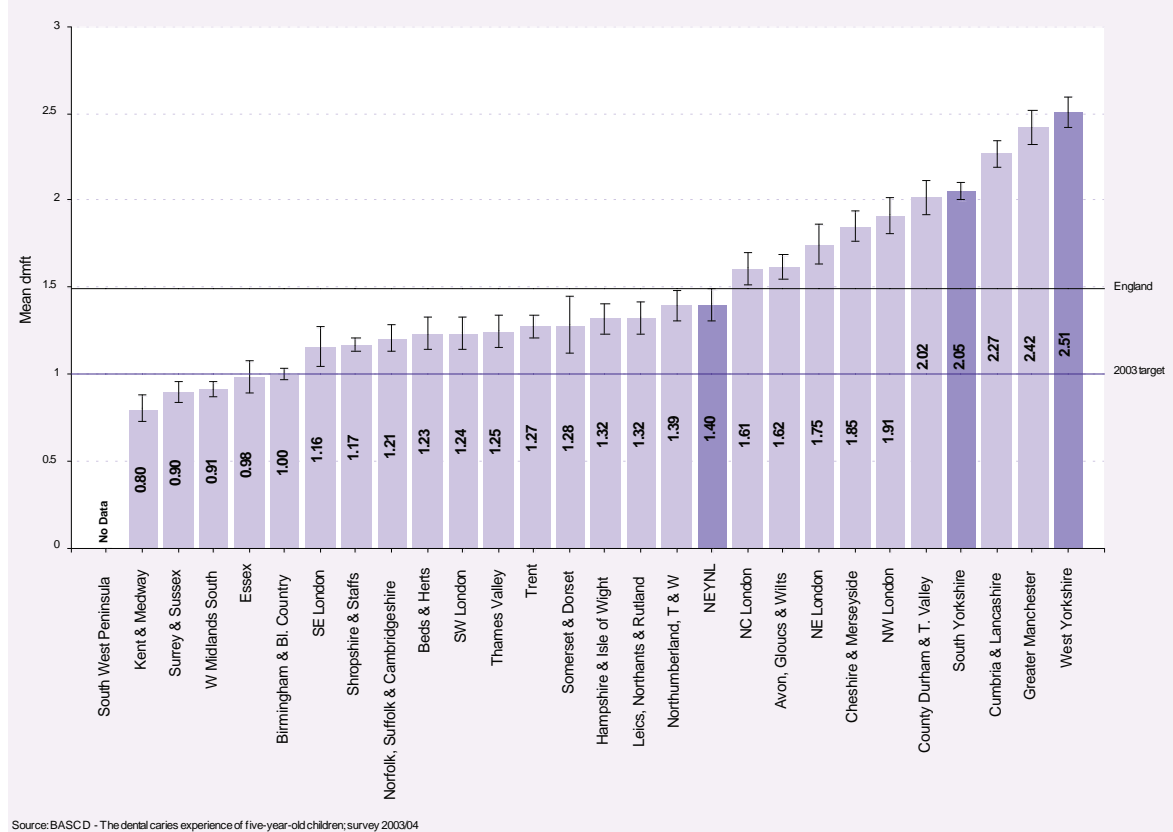
2.18 The panel heard that the impact of social class and deprivation on oral health experience is reflected in national comparisons. In broad terms, the statistical data shows that levels of DMFT worsen the further North you go, with the south east of England having the best dental health and Scotland the worst. However the most recent statistics have shown that the dental health of five year olds in West Yorkshire is now the worst in England. (Table 7)

2.19 Table 8, which follows, shows a comparison by areas with Yorkshire and the Humber, where we again see that there are very significant differences in areas which are quite close together, but which differ in relation to deprivation and other factors. It is also evident that Calderdale fairs poorly on this comparison. It has also been observed that within Calderdale, there are significant differences between areas.

2.20 Members heard evidence that overall, 80% of all tooth decay was experienced by just 20% of the population. Reducing the inequalities in oral health outcomes, and reducing the overall average to attain the national average, would therefore be dependant upon altering behaviours and improving the dental health of the poorest part of the population. This is in keeping with a range of other health factors, and these are related through association with a number of common risk factors, largely associated with life – style and diet.

Table 7

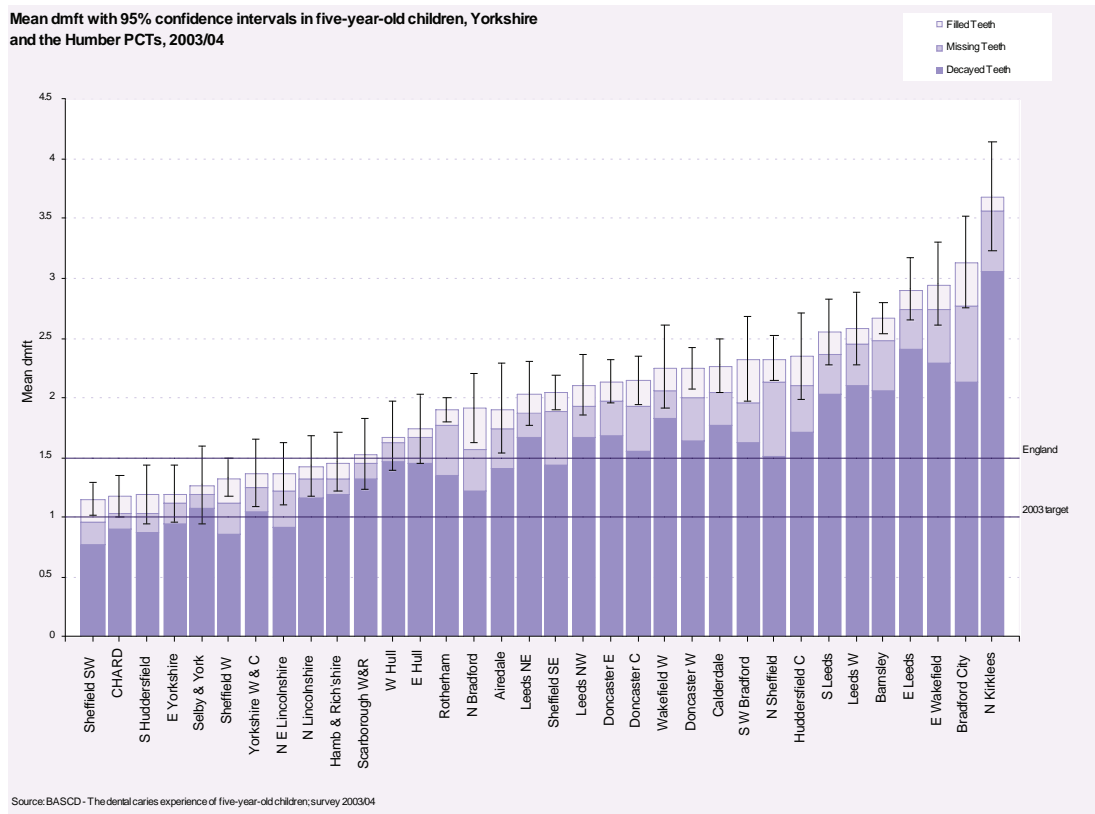
Mean dmft in five-year-old children by Strategic Health Authority, with 95% confidence intervals, 2003/04



Source: BASCD - The dental caries experience of five-year-old children; survey 2003/04

Table 8

Mean dmft with 95% confidence intervals in five-year-old children, Yorkshire and the Humber PCTs, 2003/04



Source: BASCD - The dental caries experience of five-year-old children; survey 2003/04

- 2.21 The Panel are concerned that there are clear inequalities between areas within Calderdale, and national data suggests significant variations based on ethnicity and other factors. They feel that actions to address these inequalities should be based on the best available evidence in respect of the local picture. They feel that not enough is known about oral health locally, particularly with regard to adults and vulnerable groups.
- 2.22 The Panel note that the NHS (Primary Care Contracting) have published an Oral Health Needs Assessment Toolkit, and recommended that PCT's should conduct a local Oral Health Needs Assessment to inform their future commissioning and service planning.

Recommendation 1

The Panel feels that a thorough oral health needs assessment of the people of Calderdale is needed, and recommends that the Primary Care Trust should conduct such an exercise. The Panel would wish to see the results of such an assessment and use that data to inform the basis for its future health scrutiny activities.

Three

Preventing Oral Diseases

- 3.1 The members heard evidence from Dr Ronnie Levine, author of the Scientific Basis of Oral Health Education, which is the most cited work on Oral Health Education and which constitutes the policy document within the National Clinical Guidelines in respect of oral health education.
- 3.2 Dr Levine confirmed the advice included in the summary of that book, that oral health advice should focus on the consistent focus on four key messages
 - Diet: reduce the consumption and especially the frequency of intake of drinks, confectionary and food with sugars.
 - Toothbrushing: clean the teeth thoroughly twice every day with a fluoride toothpaste
 - Fluoride: fluoridation of the water supply is a safe and highly effective public health measure
 - Dental attendance: have an oral examination every year.
- 3.3 The Panel heard from the health promotion team that the many initiatives that they provide across Calderdale are based on consistently adhering to the above principal messages.

Fluoride

- 3.4 The Panel heard a great deal of evidence from health professionals regarding the efficacy of fluoride in preventing tooth decay, and in particular that the fluoridation of water supplies, to the recommended level of 1 part per million, would be the most efficient means of tackling the inequalities in oral health outcomes. This was because it is a measure that does not require action by the individual, and that the greatest improvements are evidenced in areas of greatest need.
- 3.5 Local and national evidence was provided demonstrating the impact of fluoridation in this respect. Table 9, below, shows levels of dmft among five – year - olds in Kirklees over the period 1992 – 2000. Table 10 shows the relative experience of 5 – year – olds in Calderdale, Kirklees and Dewsbury over the period 1986 – 2002. It can be seen that Kirklees had initially enjoyed much better dental health than had its neighbouring districts, and was indeed close to the level of 1.0 dmft that is the national target. This however showed a rapid deterioration from 1988 to 1994 and beyond, and Kirklees is now holding at a similar level to Calderdale and other West Yorkshire areas (Dewsbury remains very poor, reflecting its demographic nature).

Table 9

DENTAL HEALTH OF 5 YR OLDS - HUDDERSFIELD (1992-2000)

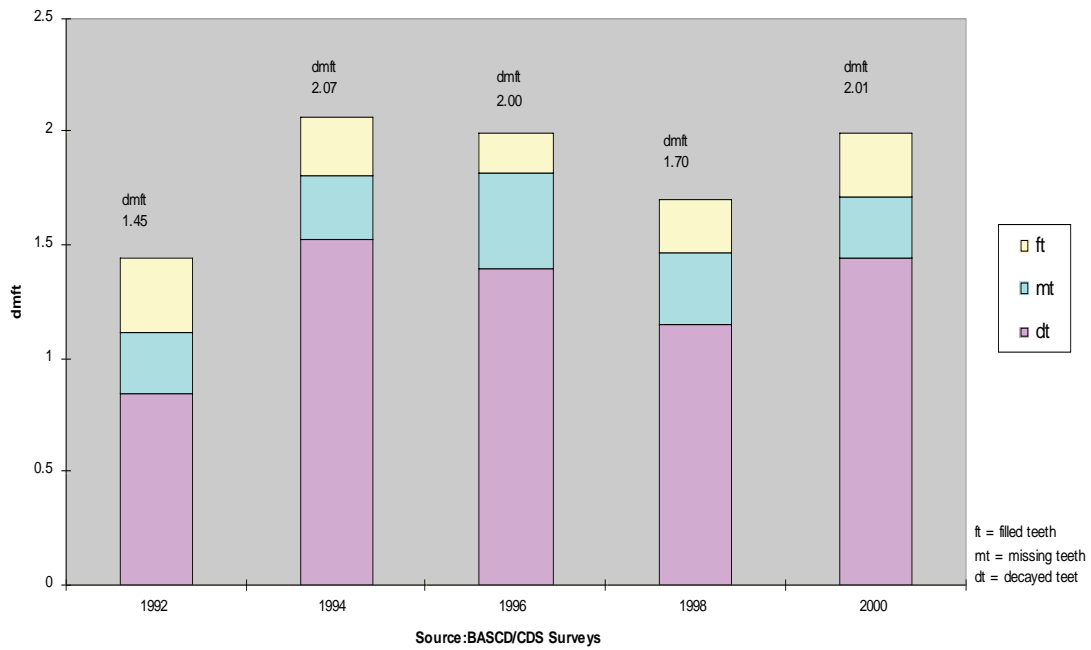
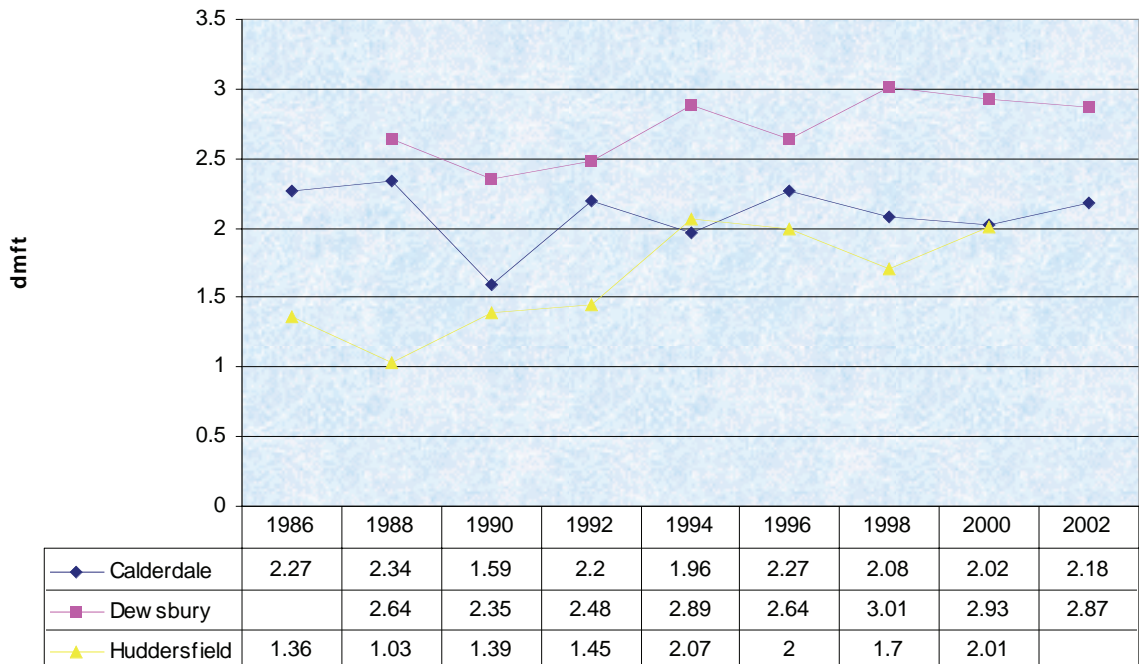


Table 10

Dental Caries Experience in 5 year old children
BASCD Surveys 1986/2002



- 3.6 The Panel heard that, from about 1970 up until 1988, the water supply in a large part of Kirklees had been fluoridated, and the significant worsening of the results for that area coincide with fluoridation ceasing in 1989. This is held to show both the beneficial effect of fluoridation, and the impact of its withdrawal.
- 3.7 The Panel has seen significant evidence from other scrutinies, for Birmingham, where the water supply has been fluoridated for many years, and from Stockton, which includes evidence relating to Newcastle, where the water is artificially fluoridated, and Hartlepool where the fluoride level is naturally at the preferred 1 part per million. These data tend to confirm that the health benefits are significant. The panel heard that in Newcastle the dental health of the worst-off fifth of the population is as good as that of the best-off fifth in the south east of England, and that the dental health of the population of Sandwell, in Birmingham equates to that of the population of Surrey.
- 3.8 The Panel also received written evidence from the National Pure Water association, who oppose the fluoridation of water supplies on scientific and moral grounds, and from individuals concerned about the harmful effects of exposure to fluoride for people with certain medical conditions.
- 3.9 The Panel has received evidence from the Children and Young People's Scrutiny Panel and has noted that Panel's recommendation to this Inquiry in support of the fluoridation of the local supply (see minute E58/95 (ii)).
- 3.10 The Members heard from the Strategic Health Authority regarding the changes in legislation arising from the Water Act 2003, and have considered the advice of the Chief Dental Officer for England, and of the Department of Health regarding future consultations as to the fluoridation of local water supplies. The Panel have noted that many authorities, locally and nationally, have been considering oral health and, in some cases, the issue of fluoridation recently.
- 3.11 The Panel believes that a regional consultation on a proposal to fluoridate local water supplies is likely to be forthcoming, in which case this authority will be consulted on its views.
- 3.12 The Panel has noted the strong case made for water fluoridation in national policy guidance, and has heard compelling evidence from dental health experts in support of that action. They have been told that this would represent the single most effective, safe and efficient means of delivering population wide reductions in missing filled and decayed teeth, thus achieving the relevant targets included in the Local Area Agreement and significantly reducing a major health inequality.

- 3.13 The Panel is also aware that this raises substantial moral questions in the minds of many people, since this would involve ongoing ‘mass medication’ through the medium of a fundamental public supply. They are also aware that there are those who remain unconvinced of the safety of such action, particularly in respect of a small number of individual people.

It has not been within the scope of this review to conduct an in depth inquiry into these questions. The panel is aware of the provisions of the Water Act (2003) in this respect and that the Strategic Health Authority, following advice from Primary Care Trusts, may initiate a large scale public consultation, to determine whether it would wish to proceed with a request to the Water Authority to increase the fluoride level in the supply to the recommended optimal level of 1 part per million.

Recommendation 2

The Panel Recommends that the issue of fluoridation of the water supply is a matter of significant public health concern, and that in order to respond effectively in its role of community leadership to a likely forthcoming consultation, the Council should carefully review its policy on the matter. If such a consultation were to be forthcoming, the Council, and health scrutiny, would expect to play a full part in the ensuing debate.

The Panel recommends that this should be undertaken as a full health scrutiny, in order to consider the evidence properly on all sides.

Children’s Oral Health

- 3.14 The principal source of evidence on the oral health of young children is the biennial surveys of dental health of 5 – year olds and 12 – year olds, which are carried out in alternate years. It was explained to the panel that these surveys, which were undertaken by the Community Dental Service, (the salaried dental service employed by the Primary Care Trust), were part of a national programme that had been going on since the 1980’s.
- 3.15 It was explained that these surveys are intended to capture a picture of the current situation on a whole population basis. There was no follow up treatment given or recommended in respect of individual children as a result of this survey.
- 3.16 The Panel had heard evidence, both from the PCT and from Dr Beal, (dental lead for the SHA), that a shift in the legal requirement regarding parental consent had caused difficulties during the most recent national survey of dental health of 5 – year – olds. The shift had meant that instead of ‘negative consent’ whereby children could have their teeth

checked unless parents had indicated that they did not wish this to be done, positive consent was now required, whereby parents of each child would have had to sign their agreement before the child could be examined.

- 3.17 Dr Beal and Dr Levine had argued that this would be likely to skew the findings of the survey, since parents in the more deprived areas, where the problems were likely to be worst, would be least likely to return the forms. The Panel were advised that a particular issue affecting the last survey was that this change in legal advice had happened half way through the completion of the survey, so that some work was done under the old regime, and some under the new one casting doubt on the validity of the results obtained.
- 3.18 The Panel were aware that the issue of parental consent had been identified in other scrutiny reviews, and that a scrutiny report recently published by Stockton Council seemed to have identified a possible solution. That report had included a recommendation that health consent forms, issued to parents at the beginning of each child's school career, could incorporate consent for the child's inclusion in dental screening and dental surveys.
- 3.19 However, Members were advised that this option would not be possible in Calderdale. It was explained that the consent forms referred to in the Stockton report had been in connection with a routine health screening that had been undertaken by the School Nursing Service in respect of all children in reception classes. The Panel were advised that, in Calderdale, this routine screening had been discontinued some two years ago. It had been considered that it had not been the best use of the resources of the School Nursing Service, whose work was now focussed on specific populations and areas. As a consequence, no general consent forms are obtained.
- 3.20 The Panel had been informed that there was apparent inconsistency in the advice in respect of parental consent for the oral health survey, and for the survey of height / weight now introduced for reception classes and year 6 (11 – year –olds) as a measure to tackle child obesity. In the latter case negative consent has been retained. As a consequence 93% of checks had been achieved (against a target of 80%)
- 3.21 The Panel had wondered whether the oral health checks and height and weight checks could be done at the same time. They were advised that this was not possible, since the height and weight checks were conducted by the school nursing service, whilst the oral health checks could only be done by the Community Dental Service.
- 3.22 The Panel noted that the ability to work with negative consent had clearly ensured that the height and weight checks were able to reach all children and believe that it is therefore important that this should be possible for the oral health checks on the same basis.

Recommendation 3

The Panel believes that the biennial surveys of children's dental health provide important information, and will be compromised by the insistence on positive parental consent. The Panel recommends that the Strategic Health Authority should request that the Department of Health reconsider its position on this matter

- 3.23 The Panel heard of the universal provision for all new mothers provided by the health visitors. This service delivered a comprehensive package of personalised activity that includes advice on oral health. The Panel were pleased to here of this service, and are strongly supportive of its continuation.
- 3.24 The Panel also heard consistent evidence that in general terms, although health education is important, its messages have only a short – term impact, if not supported by other interventions. They also learned that damage to children's dental health occurs at an early stage, and that those communities that are particularly susceptible are also least likely to have regular access to a dentist and to have their teeth routinely examined.

Recommendation 4

The Panel are concerned that the discontinuation of the routine health screening of children in reception classes has removed an early opportunity for timely advice and treatment, and recommends that the local health partners should review this decision.

- 3.25 The Panel learned of the work of the Oral Health Promotion Team at the Community Dental Service. This team was now working across Calderdale & Kirklees and was jointly funded by the two PCTs. They were delivering a wide range of initiatives across Calderdale, many of them aimed at improving children's oral health. Much of this was targeted at deprived areas.
- 3.26 The Oral Health Promotion Team had emphasised the importance of ensuring that consistent messages are got across. All of their work was based on up to date, evidence – based information.
- 3.27 Members were told that some of this work is delivered as part of the National Curriculum. Materials are also given to the children to take home to their parents. A number of groups are supported. It involves delivering a large list of programmes.

- 3.28 Members learned that there are capacity issues. There is one oral health promotion officer covering the whole of Calderdale, with one part – time assistant. The work involves working around over 100 schools. It was described as being ‘a pebble in the ocean’.
- 3.29 The Oral Health Promotion Team had also recently given evidence to a scrutiny review in Kirklees. They had given evidence to the effect that all oral health promotion programmes were carried out in collaboration with appropriate partners and stakeholders in order to influence chosen target groups and reduce health inequalities. This is explained in the Oral Health Team’s position statement, which was submitted as evidence to the Calderdale review.
- 3.30 The team felt that the tendency for funding to follow treatment resulted in a shortage of funding for preventive activity, and if more funding was available there would be the opportunity to try to change behaviour in different ways, such as different initiatives to target specific population groups where oral health inequalities are greatest. For example, it is known that in Sure-start areas weaning off the bottle happens later, whilst there is evidence that the majority of children in Asian communities do not start brushing until they are older.

Recommendation 5

The Panel has learned of the importance of prevention and has been impressed by the range of initiatives undertaken by the Oral Health Promotion Team. The Panel is concerned about the limitation imposed by the lack of capacity to develop this activity and recommends that the Primary Care Trust consider the establishment of a specific budget area for health prevention activity, including a review of the budget provision for the Oral Health Promotion Team.

- 3.31 The Panel also received evidence from Sure Start at North Halifax, and had been impressed by the work that Sure Start were doing, and noted that it was well regarded by local people.
- 3.32 A well –used service offered by Sure Start is the provision of Parent Link Workers. They ‘take people by the hand’ and walk them through the process of accessing services that they require. The workers are pro – active in that they periodically contact people who have not used the service to check if they need anything. This included issues around oral health and dentistry.
- 3.33 Members heard that Sure Start had promoted the ‘Brush for Life’ scheme, distributing packs. This used national funding which had been taken up by the PCT. However, there was now a shortage of materials and no further funding. A sum of £500 was required to continue the scheme.

- 3.34 The Panel felt that Sure Start and Children's Centres would be properly judged in the longer term, but that there was evidence and recognition that what was needed was to educate the public about health. There was much that people could do for themselves, but this needed unlocking, and local schemes could do much to promote this.
- 3.35 The Oral Health Promotion Team had told the Panel about the 'Food in Schools Programme', which was one of the activities in which they were involved. The Team had attended meeting, run by PCT, for caterers at Primary and Secondary schools. Members were informed that some catering / drinks companies were now targeting schools.
- 3.36 Members were told that schools had got rid of fizzy drinks machines. These were now not permitted. However companies were now promoting what they claimed were 'healthier' fresh fruit drinks. The Panel heard that the Health Promotion Team were now concerned about the presence of such machines in some schools.
- 3.37 The Panel were advised that the companies were saying that these drinks contain 'less than 5% sugar'. It was explained that this may be the case, but the issue was that the drinks are sold with screw caps. These drinks may be consumed several times a day. This was clever marketing. The problem is that, as the Panel have learned, the real issue for the prevention of damage to teeth is to reduce the frequency of consuming sugar.
- 3.38 Members had asked whether children and their parents were aware of the importance of reducing the frequency of consuming sugary food and drinks. The Panel had been told that the Health Promotion Team go into schools and talk to 4 – 5 year olds. They have more access to the children at this age, and by then the children have more independence about their choices. The Team take a realistic approach. They don't say to the children 'don't eat sugary food'. They encourage them to limit this to meal times.
- 3.39 A particular problem was that in socially deprived areas many children tend not to have regular meal times, they graze all day. Behaviour change was the key, but so many things were impacting on health in these areas. It was difficult getting the message across. However, the members were told that if the Health Promotion Team, and Sure Start were not there, it would be much worse.
- 3.40 The Panel learned that the Health Promotion team could only go into schools to deliver these programmes when they were invited to do so, and that take – up varied considerably across the area.
- 3.41 Members had asked whether the Children and Young People's Service had advised schools on this issue, or if their attention had been drawn to the problem. The members were advised that decisions about food

in schools, and the take – up and availability of such machines were decision for individual schools.

Recommendation 6

The Panel recommends that the Children and Young People’s Service’s Directorate should use the Healthy Schools Scheme to encourage schools to access the services of the Oral Health Promotion Team and should offer clear advice supporting the take up of these services.

Recommendation 7

The Panel recommends that an item on Oral Health, noting the findings of this review, and highlighting the services of the Oral Health Promotion Team, be included in a future issue of the quarterly magazine for school governors.

Recommendation 8

The Panel recommends to the Children and Young People’s Directorate that suitable training, highlighting the role of schools in promoting oral health should be included in the training courses for school governors.

Recommendation 9

The Panel recommends to Heads and, in particular Governing Bodies that they ensure that their schools are accessing the advice of the Oral Health Promotion Team and that they carefully consider their policies in relation to food and drinks within their schools in

Older People’s Oral Health

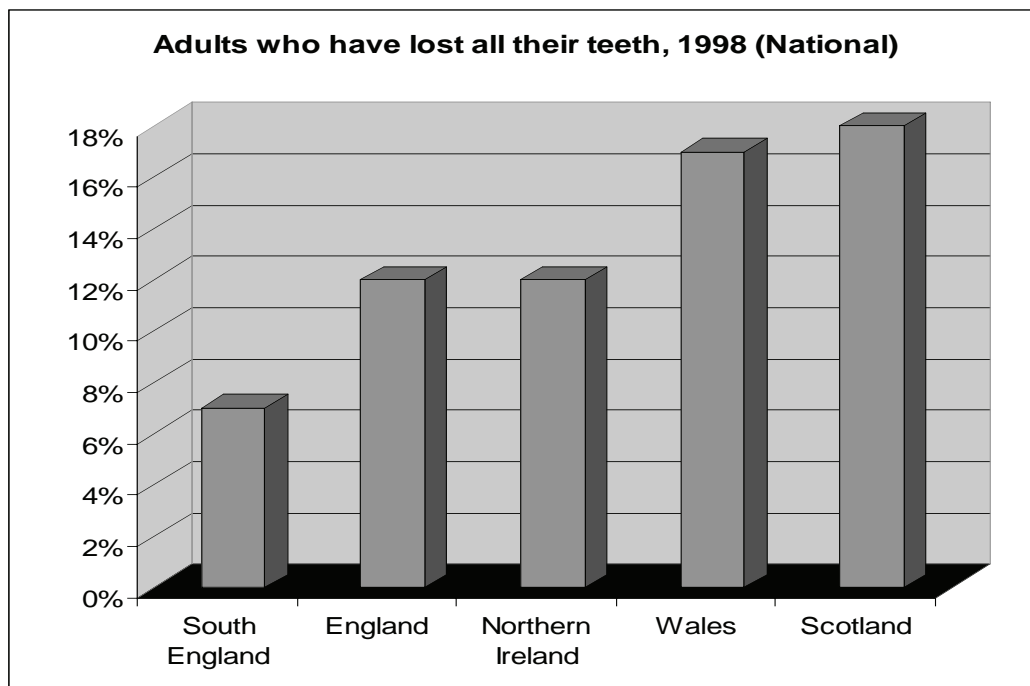
- 3.42 The Panel had learned of the significant changes in adult dental health over the last 40 – 50 years, (see 2.7 – 2.8, above). This had resulted in the expectation that most adults would retain some of their teeth into old age, which posed new challenges for treatment.
- 3.43 However, the Panel were concerned to learn that there is no available current local data in respect of adult dental health. It was explained that for children, because they are young and at school, it was possible to organise surveys on a regular basis. For adults, because they are dispersed, it is much more difficult. The Consultant in Dental Public Health had told the panel that a questionnaire survey had been attempted in the past, and may be tried again.
- 3.44 Nationally, surveys of adult dental health are carried out every ten years. For these, trained examiners visit people in their own homes,

taking a sample from the whole population. The last such survey was conducted in 1998, and again demonstrated the geographical differentiation by region (see Table 11).

- 3.45 The bars in this graph include the whole population in each case, mixing the affluent with the not so affluent. In addition to the marked differences between regions evident from the graph, there will also be the significant variations within regional populations by social class, of which we have heard earlier.

Table 11

**Adults who have lost all their teeth
(National adult dental health survey, 1998)**



- 3.46 This graph deals only with adults who have no teeth at all. This amounts to only 6% of adults in the South of England, so that 94% have retained some teeth. The situation worsens heading north (the figure for England includes the South, and so the position for the North of England will be rather worse).
- 3.47 The Panel have heard that, years ago, it was commonplace for people to opt to have all of their teeth removed and have dentures fitted. Teeth were also commonly removed as the result of gum disease, where the teeth had become loose. Now, with an approach more focussed on prevention, most adults have retained at least some teeth.
- 3.48 The Panel has heard evidence, detailed in the following chapter of this report, that many of these people will not be regularly attending a dentist. In these circumstances it is a matter of some concern that so

little is known about the state of adult oral health in the area. The Panel believe that this reinforces the argument for a comprehensive local oral health needs assessment, which is highlighted as recommendation 1 of this review.

- 3.49 The Panel had heard evidence both from the PCT and from Dr Levine that the dental care and oral health of the elderly was a cause of particular and growing concern. Many had retained at least some of their teeth, but from an age in which there were many fillings done. They had crowns etc. all of which needed some care. The Consultant in Dental Public Health emphasised the need to plan now for future needs in this area.
- 3.50 Dr Levine advised the Panel that he spends a lot of his time making domiciliary visits at residential homes. He had noticed a considerable increase in the last 10 – 15 years in residents with their own teeth. He thought that maybe half of those he saw now did, but that they were in very poor condition.
- 3.51 Among these, he had recently seen 7 or 8 with abscesses. There were frequently problems with root caries, fractured roots. Many of these were medically compromised and required hospital treatment. He quoted a colleague at the local acute trust, the Head of the Hospital Dental Service (one of his former students), who had cited this as a real worry and a pull on resources.
- 3.52 The PCT had emphasised that the treatment of older people was presenting new problems. In the past it had been possible to take some portable equipment and do some sort of dentistry in the home. Much of it was about dentures. Now it is much more difficult;
- a) because of health and safety issues, cross infection control issues but also.
 - b) because of the type of treatment that is needed by some of the residents.
- 3.53 This meant that often, in practice, people had to be brought in into a surgery setting to have some treatment done, and in the very worse of cases, they then have to be referred to the secondary care sector, to the hospital dental service to have the treatment, again under a general anaesthetic when the whole of the mouth can be repaired at one go.
- 3.54 There were then, three different strands, oral screening and preventive work, treatment that can be done in a surgery and then anything that can't be done there is referred on to the consultant or surgeon. Where the community dental staff were involved, that dentist would go and do that work as well.
- 3.55 It was explained that this service is very resource intensive. The PCT recognised that presently enough service was not available, and that funding was an issue.

- 3.56 The importance of preventative work was again emphasised. In particular it was recognised that it was the people who were less mobile and in their own homes, or in residential units who were seen as presenting the problem, and the PCT were looking at ways to provide for this.
- 3.57 Dr Levine had told the Members that he would be retiring at the end of the year, and that he feared that replacement provision in terms of domiciliary care might be difficult to find. He thought that there were many reasons for this. It might be thought of as unpleasant work. It required aptitude and skills. A lot of younger dentists lacked those skills.
- 3.58 He explained that the training involved a 5–year course, and that there were growing pressures on the curriculum. Many had no experience of making dentures. Many younger dentists would not do it, especially in a domiciliary situation – where the patient was in a bed, or a wheelchair.
- 3.59 The payment arrangements under the new contract were also an issue. Dr Levine explained that he received the same payment for UDA's delivered on home visits that he got for work in his surgery. There was no allowance for travelling time or other difficulties. This was putting pressure on his ability to meet his targets.
- 3.60 The Panel are grateful to Age Concern, Halifax, who conducted a survey of older people's oral health for the benefit of this review. The survey was completed by 157 local people. Of these 49 were living at home, 63 were in sheltered accommodation and 45 were in residential homes. The majority of the respondents (121) were over 75 years old. The other 36 were aged 60 – 75.
- 3.61 The results of this small – scale survey tended to confirm the view that more older people were retaining their teeth. Whilst three quarters of the over 75's had no teeth, two thirds of the 60 – 75 year olds had some of their own teeth. Half of those had over 20 of their own teeth.
- 3.62 Some 92% of all respondents described their own oral health as being 'good' or 'satisfactory'. 11.1% of the 60 – 75 year olds, and only 7.4% of the over 75's described their oral health as 'poor.' However, 44% of the 60 – 75 year olds and only 35% of the over – 75's claimed that they regularly saw a dentist (and had done so, at least within the last 12 months).
- 3.63 This might suggest that for many of the respondents, particularly those with no teeth of their own, the need for regular screening is not appreciated. The second most common answer to the question 'If you do not visit a dentist, why not?' was 'I don't need one', (although that option was not actually offered in the survey). The most popular answer by far though, was 'I don't have one'.

- 3.64 Overall, two thirds of those in residential care were seeing a dentist. Only 28.5% of those living at home, and 23.8% of those in sheltered accommodation were regularly seeing a dentist. It was clear from the additional comments of those in the residential homes who were receiving domiciliary visits, that this service was extremely highly valued.
- 3.65 Of those older people who did not receive home visits, but who visited a dentist, two thirds got a lift, while 22% used public transport. About a third of all of these thought that this was either difficult or 'a bit of a problem.'
- 3.66 The Panel had heard evidence, confirmed by some of the comments provided by respondents in the survey, that access problems are often experienced when visiting a surgery. Sometimes this is about particular needs of individual patients – wheelchair access, the need for special transport and an escort etc. The physical environment at some of the surgeries is also an issue. Many are old buildings with access via steps and stairs.
- 3.67 Dr Beal, the Dental Lead for the Strategic Health Authority, had advised the Panel that the money to pay for the domiciliary visits that had been conducted under the old arrangements, (before the introduction of the new dental contract in April 2006), was 'in the system'. He said that Primary Care Trusts, who were responsible for managing the new contract 'had options'. They could accept that UDA's to deliver that kind of service would be more expensive. He said if they did not do this then they had, in effect, taken out the money that had been there for that service.
- 3.68 Alternatively, they could make separate provision to pay for that service. The Panel heard that in Sheffield, for example, the PCT had contracted with a set of local dentists to do this on a sessional basis, offset against their UDA requirement.
- 3.69 The Panel have heard from the PCT that they have some dentists who are contracted to do such visits (though not enough), but that their preference is for patients to visit the surgery, even if this requires the provision of transport and an escort. This is for the reasons of complexity of treatment and safety issues discussed above.
- 3.70 The Panel have noted the positive responses of those residents receiving domiciliary visits in residential homes and believe that it is important that this service continues to be offered, reaching as many patients as possible.
- 3.71 The screening opportunity is seen as being very important. In particular, the opportunity for example to make early diagnosis in

respect of oral cancer, which may not be appreciated by many of the older residents.

- 3.72 The Panel have noted that the option exists for the PCT to allow funding to make this service more viable, and have heard of examples where such provision has been made.

Recommendation 10

The Panel recommends that the Primary Care Trust consider alternative funding arrangements in respect of domiciliary visits to residents in residential homes, and should aim to ensure that this service is available wherever it is requested.

- 3.73 Under the new dental contract the PCT has responsibilities with regard to the physical premises at which surgeries are provided. The Panel had noted that a number of patients had commented on difficulties in accessing some premises.

Recommendation 11

The Panel recommends that the Primary Care Trust conduct an audit of the premises at which NHS dental services are provided under contract. The PCT should identify priority areas for improvement in terms of physical access and patient experience.

- 3.74 The Panel heard evidence from the Group Director for Health and Social Care in respect of the role of Adult Social Services in promoting oral health and in safeguarding the oral health of the people of Calderdale. Information was provided both in terms of particular vulnerable groups, and in respect of the more general measures that the service could consider.
- 3.75 The Group Director stressed that oral health should be regarded as part of a person's wider healthcare needs, and that provision formed part of the wider well-being agenda. This should be tackled by means of a three-stage approach, focussing on prevention, identification of problems, and access to treatment.
- 3.76 The Panel have learned that this is in keeping with national policy. The Choosing Better Oral Health Action Plan (2005) had stated that oral health initiatives needed to be linked with the Government's broader inequalities programme to ensure that the causes of inequalities were addressed.

- 3.77 In recent years far reaching legislative changes to NHS dental services have been implemented to underpin this approach. These came to fruition in April 2006, when the new Dental Contracts came into force (the New Dental Contract, and the implications for access to dental services, is discussed further in the final chapter of this report).
- 3.78 Primary Care Trusts now have an integrated responsibility for commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, the community based salaried service, or in hospitals. The Action Plan stated that local authorities and PCT's share a responsibility for improving oral health.
- 3.79 The Panel have noted that the recently negotiated Local Area Agreement, which sets out the priority issues to be addressed by the Local Strategic Partnership in the next three years, has not identified oral health as a priority health issue. There are some targets relating to dental health, which are focussed around targeting the 5 – year old dmft results, but these are relatively small – scale.

Recommendation 12

The Panel have noted evidence that oral health in West Yorkshire is now the worst in the country. Oral health in Calderdale is poor, and features significant inequalities.

The Panel recommends that, at the next refresh of the Local Area Agreement, oral health be included as a priority local health issue.

- 3.80 The Group Director for Health & Social Care had informed the Panel of some basic statistics. Approximately 700 older people were supported by the local authority in care homes. (Altogether about 1,150 older people were living in care homes). There were some 14,800 people aged over 75 in Calderdale. The Service was dealing with around 800 people with Learning Disabilities. There were 744 people with mental health problems on care programmes, while 354 younger disabled people were receiving services from the Council. The Panel has learned that there are significant oral health issues for vulnerable groups.

Vulnerable Groups and Oral Health

Mental Health

- 3.81 The Panel heard from Catherine Cronin, of South & West Yorkshire Mental Health Trust, who gave evidence in respect of People with Mental Health Problems. Catherine explained that her duties were

around adult services (people aged 18 – 65) and covered an area that included Calderdale. She worked in conjunction with 3 Mental Health Teams. Most clients were living in the community.

- 3.82 Involvement of the teams was mostly about facilitating access to services. Sometimes a need would be highlighted through screening. The team would help to secure access and then offer support. The Panel were advised that the service was not regularly asked for assistance in finding dental treatment. If patients felt that they had a need, they were encouraged to get treatment.
- 3.83 Members heard that Catherine believed that access to NHS dentistry was good in Calderdale (better than in other areas). She also noted that there was a specialist service available for her clients if it was needed. A 'safe haven' service was also available.

Learning Disabilities

- 3.84 Phil Shire (Head of Adult Services) gave evidence highlighting issues for people with learning disabilities. The members heard that national research suggests that people with learning disabilities face particularly difficult circumstances. There are communication issues. They often do not understand their own health needs.
- 3.85 People with a learning disability in Calderdale live in a range of settings according to their needs, circumstances and family support. Their access and take up of dental care also varies according to their individual circumstances.
- 3.86 The Panel were told that the Service are aware of who these people are. A high proportion of them are receiving services from the various agencies.
- 3.87 National research has shown that oral health is much worse in the learning disabled population than in the general population. Some 36.5% of adults with learning disabilities and 80% of adults with Down's syndrome have unhealthy teeth and gums (Barr et al., 1999), with adults living with families having more untreated decay and poorer oral hygiene and adults living in residential services having more missing teeth (Tiller et al., 2001). People with a learning disability have an increased uptake of dental hospital services (Morgan et al 2000)
- 3.88 The White Paper 'Valuing People', published in 2001, had shown that there were significant gaps in the healthcare of people with learning disabilities compared with the general population. The White Paper states that people with learning disabilities should get the same health services that are available to everyone else with expert care when they need it. However people with a learning disability continue to have poor oral hygiene, untreated dental caries and more extractions than the

general population.

- 3.89 A target had been set within the white paper to ensure that all people with a learning disability should be offered a health action plan (HAP), in order to address their health needs and reduce health inequalities throughout the learning disability population. This is a comprehensive review of individual health care needs, access to health care services and unmet needs. The check is overseen and signed off by a nurse. It includes oral health. This is summarised and key issues are recorded in Health Action Plans.
- 3.90 In Calderdale these had been focussed on people receiving 24-hour care services. The Panel were advised that Calderdale had rolled out a programme of OK health checks for many more people with learning disabilities. These checks could be delivered by trained staff and did not require a nurse.
- 3.91 Plans had been made to include these HAPs / OK Health Checks on the social services electronic client information system, in order to give key data such as the number of people with a learning disability who were registered with a dentist. This electronic data system would allow the Council to look at the picture over time and set improvement targets for healthcare. However the panel have since learned that the inclusion of this data in the electronic data system has not proceeded.
- 3.92 The Panel heard that HAPs have been effective for people who access services and so are easy to reach. However, around 250 people from the 800 registered as having a learning disability, do not access services and have been harder to reach.

Recommendation 13

The Panel believes that the OK Health Checks, and Health Action Plans, offer an important opportunity to monitor and impact on the oral health of vulnerable groups. The Panel recommends that they should be rolled out to as many as possible of the target groups.

The Panel recommends that the inclusion of the resulting data, in the electronic data system, is important and should be done, to inform future planning of services aimed at addressing inequalities in oral health outcomes.

- 3.93 Members heard that Supported Living provides accommodation for 112 tenants with a learning disability in Calderdale. These services are well monitored and compliance officers check the date of each tenant's last dental appointment. Where no appointment has been made or attended the compliance officer adds a recommendation to address this in their monitoring report. Monitoring is now being established in local residential and nursing care and a similar approach will be

adopted. Recommendations from monitoring reports are followed up by the compliance officer.

- 3.94 People with learning disabilities access a range of dental care in Calderdale including Community Dental Services, who have some specialist experience and knowledge. It is often those with complex disabilities who access Community Dental Services. Feedback from providers indicates that where people are able to access community dental services the services are good. However the Panel were told that these services were currently full and unable to take new referrals.
- 3.95 Providers reported a high level of anxiety amongst some of the people they support and resistance/fear among some individuals when they visit the dentists. This is also the case when team members are supporting people with their oral hygiene.

Recommendation 14

The Panel believes that timely access to appropriate services for vulnerable groups is fundamental to tackling inequalities in health outcomes, and that the Community Dental Service are likely to constitute an important resource in that respect.

The Panel recommends that, in planning its future strategy, the Primary Care Trust ensure that the Community Dental Service is adequately resourced to meet future demand.

- 3.96 The Members heard that those with the most severe learning disabilities might only access hospital dentists. One nursing home provider had reported that this was the only service available to them and there was often little understanding of the support people with a learning disability require in a hospital setting. This was supported by evidence from the team in Adult Social Services, who cited individual recent cases where clients had experienced difficulties.
- 3.97 Officers had spoken to providers who offered support on a 24 hour basis and a local provider who gave up to 20 hours support per week to individuals who have their own tenancies. They had highlighted that people with learning disabilities do have significant problems with their dental health and dental disease is often well advanced before treatment is accessed. This is particularly true where people have more significant disabilities or where people have challenging behaviour. In these instances routine dental treatment such as fillings and simple extractions requires a hospital admission and a general anaesthetic.
- 3.98 A resident in a nursing home had been experiencing dental pain but could not communicate which tooth was causing her pain. On

admission to hospital her 6 remaining teeth were removed, as they could not locate the specific site of the pain. The home reported that many of the people they support only access hospital dentistry and surgery is often cancelled at short notice as the hospital is ill prepared to meet the needs of the learning disabled patient.

Recommendation 15

The Panel recommends that the Primary Care Trust, in reviewing their commissioning arrangements across the range of oral health services, give careful consideration to the availability and suitability of specialist acute services, in particular in respect of vulnerable groups.

- 3.99 The Panel were advised that, where people with a learning disability were supported by their families, the Service had little control over their healthcare and could only advise the family on health related issues. When people move into residential services from their family home, providers are often faced with untreated decay and poor oral hygiene and have to tackle oral health issues at an advanced stage.
- 3.100 The Panel had learned of the Oral Health Training for Carers that was being provided by the Oral Health Promotion Team. These courses were well attended, and evaluation of the first tranche of courses had suggested that they were effective and well – received.
- 3.101 Neither the Oral Health Promotion Team, nor Adult Social Services had statistical data however, in respect of which homes had accessed the training for their staff, and which had not. The Panel were also informed that a new contract had recently been agreed with homes in respect of residents placed by Calderdale. Training in palliative care was compulsory under the contract. Other areas of training, including oral health were not. The Service was not in a position to impose any conditions, in respect of the care received by other residents, not placed there by Calderdale.
- 3.102 The Panel have heard a great deal of evidence regarding the importance of prevention and, where necessary, early treatment. In particular the importance of early detection of oral cancer was stressed. Dr Levine had told the Panel that it would be relatively easy to train carers to carry out simple checks in that regard.
- 3.103 The Group Director for Health & Social Care told the Panel that the Directorate was exploring how it could introduce quality measures across the range of settings. These included residential care, day care, and home care. It would be particularly challenging to find ways to impact in respect of the majority of people, who did were not at this point accessing the Directorate's services.

- 3.104 Potential measures of success that could be adopted might include;
- A reduction in the numbers of admissions to hospital for acute dental problems.
 - The percentage of people in care homes who have annual health checks
 - The number of care staff receiving basic training in oral health.

Recommendation 16

It has been a consistent message in the evidence received for this review, that public understanding of health issues, and behaviour change, would be key to preventing oral diseases. The Panel recognise the importance of the role of carers in this regard.

The Panel was pleased that the Health & Social Care Directorate was considering ways to improve access to oral health for older people and vulnerable groups and recommends that a further report be brought to scrutiny in twelve months time. This should include an update on progress with regard to health action plans, the use of electronic data systems, and the roll-out of training to carers.

Four

The New Dental Contract and Access to Dentistry

- 4.1 The changes to NHS dentistry legislated for under the Health and Social Care (Community Health & Standards) Act 2003, and introduced in April 2006, represented the most fundamental reform of the system since 1948, when the NHS was formed. Over a number of years a series of reports had highlighted problems with the previously existing arrangements.
- 4.2 Dr Beal had explained that the previous dental contract, introduced in 1990 had been 'a fiasco'. It had been non – cash limited. Dentists had decided where to practice. The NHS had had no influence. Deprived communities had often lost out. At the same time, many dentists had been withdrawing from NHS dentistry, and patients had faced increasing problems in accessing NHS dentistry.
- 4.3 Dr Levine told the Panel that the Secretary of State had declared that the principal aims of the new system would be to improve access for NHS patients and to give dentists more time for practice development, professional training and preventive care and to get dentists off the 'treadmill' of the old dental contract.
- 4.4 Under the new arrangements the funds had been devolved to Primary Care Trusts, who were required to provide 'reasonable' dental services based on local needs. The Panel heard evidence from Ian Waugh (Primary Care Manager). Ian explained that he had been responsible for negotiating the new arrangements within Calderdale on behalf of the PCT.
- 4.5 The Panel were told that, under the changes that the government introduced, all legislation that gave effect to primary care NHS dentistry in England ended at midnight on 31 March 2006. It was a totally new start. Every dentist and dental contractor who was delivering NHS services, or wanted to from 1 April onward, had had to enter into new arrangements with the NHS. New contracts needed to be negotiated with each individual dentist.
- 4.6 In Calderdale, the PCT's aim had been, so far as general dental surgery was concerned, to try and preserve, as far as possible, NHS dentistry in Calderdale as it was. Nationally, it had been anticipated that a large number of dentists would withdraw from NHS services and follow the independent or private route.
- 4.7 Ian explained that, because dentists theoretically didn't have to give a commitment to the NHS to enter the new arrangements until the stroke of midnight on 31 March 2006, the fear had been that there could be a large exit of dentists from the NHS.

- 4.8 Happily that had not been the case in Calderdale, but there were some dentists who had given other PCTs notice they would no longer wish to have a NHS contract right on the very last day.
- 4.9 As the PCT discovered in 2005, the funding of the new system was to be 'cost neutral'. The monies available to each PCT would be based on historical expenditure on NHS dentistry in that area. This included an allowance for anticipated patient charges. In Calderdale, this amounted to an assumed total spend of some £10 million.
- 4.10 Out of this the PCT were told that some £3million would be assumed to be recovered from patient charges, with the remaining £7 million paid by the Department of Health. The panel were told that the PCT also learned, late in the day, that this total available sum would also have to fund the Out of Hours and Emergency Services, which had previously been non-cash limited and centrally funded. They would also have to fund the superannuation contributions of NHS dentists, and their maternity, paternity, adoption and sickness pay.
- 4.11 This had meant that, whilst the PCT might have liked to have money to drive a major improvement in NHS dentistry in Calderdale, they were in fact somewhat limited in what they could do.
- 4.12 Ian told the Panel that every NHS practice in Calderdale had chosen to enter into a contract with the PCT to continue delivering NHS care. However, two of the practices had wished to cease providing NHS care to adults. The PCT had agreed for those practices to have a reduced contract, based on either children or vulnerable people or people in care homes; because it was seen by the PCT they were the most vulnerable groups.
- 4.13 Money released through the partial withdrawal of work in those practices had allowed some flexibility and enabled the PCT to take action where approaches had been made from other dentists, to establish a new dental practice in Todmorden and an increase in NHS dentistry in Elland.
- 4.14 The Panel have noted that this is the first time that NHS dentistry has been cash limited. Furthermore, expenditure on local dental services at this level will only be ring – fenced for the first three years. Thereafter these services will be commissioned out of the overall PCT budget, and will compete for funding with all other services that the PCT has to commission and provide.
- 4.15 The Panel are also concerned that the risk in respect of shortfall of income is all with the Primary Care Trust. If the anticipated contribution from patient charges does not materialise, as has been forecasted in some early assessments nationally, the Department of Health will not

make up the difference. And, so long as they achieve their targeted number of UDA's, the dentists will still have to be paid in full.

Recommendation 17

The Panel recommends that the Strategic Health Authority monitor carefully the financial impact of the new funding arrangements as the new contracts develop. If it transpires that the Primary Care Trusts are suffering losses due to a shortfall of patient charges, or as a consequence of the new charging bands, they should lobby the Department of Health to protect the finances of the Primary Care Trusts.

Recommendation 18

The Panel recommends that the Primary Care Trust continue to prioritise Oral Health Services and ensure that they are appropriately funded, not necessarily limited to the sum equating to historical spend indicated by the Department of Health allocation.

- 4.16 The introduction of the new contracts radically simplified the charging system for patients. Previously dentists had charged for individual items of work, for which there had been over 400 different chargeable items. Payment for these individual items constituted 75% of the dentist's income from NHS work (the balance coming from capitation payments).
- 4.17 Consequently the dentist was thought to have too little certainty about his income whilst, at the same time, there was an incentive to provide treatment to ensure income (rather than focus on preventive work).
- 4.18 The patient meanwhile, had no way of knowing how much their treatment was likely to cost. The maximum payable for a course of treatment under the old system was £384.00.
- 4.19 The new system introduced a much more simplified charging system, in which payments were restricted to three simple bands. The 2006/7 charges were:
- £15.50 for examination, diagnosis and preventive care
 - £42.40 for the above plus treatment such as fillings and extractions.
 - £189.00 for the above plus complex procedures such as crowns.
- 4.20 Thus, in simple terms, the maximum payable by the patient under the new system is less than half of that which had been payable under the old system. However recent reports, including the Citizens Advice Bureau paper 'Gaps to Fill' (March 2007), suggest that the most typical

charge is the second band charge, and that most patients are in fact paying more than they would have done.

- 4.21 In his evidence to the Panel Dr Levine had suggested that his practice was facing a number of difficulties under the new arrangements. One of these was that time was lost through discussions with charge – paying patients on how they could maximise their treatment options under the banded system. Some patients were requesting treatment that was purely cosmetic and not clinically required.
- 4.23 The Panel is aware that, from the PCT perspective, this is not what they would expect to happen. The obligation under the NHS contract is to provide the treatment that is judged to be clinically necessary at that time. However they have also heard evidence that many patients regard the new charging system as unfair, and that for many of those the payment would be more than it would have been previously.
- 4.24 There are reports that, in some areas at least, there is forecast to be a significant shortfall in income from charges. As discussed earlier, this shortfall would have to be met by the PCT, whose financial flexibility in trying to meet changing local needs is already restricted.

Recommendation 19

The Panel believes that it will take time to establish the true financial impact of the new system, for patients, for dentists and for the Primary Care Trust

The Panel recommends that a further report on the local impact, informed by experiences and reports from elsewhere, be brought to the Scrutiny Panel when the results of the first full year of the system have been assessed.

- 4.25 The Panel has noted early evidence from the dental profession to the effect that the new contract is 'not working'. This included surveys and articles posted on the web site of the British Dental Association. A number of newspaper articles had also tended to confirm this view.
- 4.26 In his written and oral evidence to the review, Dr Levine had expressed a number of concerns. Dr Levine is based at the Beechwood Community Health Centre in Ovenden, an area likely, in terms of demographic profile, to evidence poor oral health.
- 4.27 Dr Levine told the Panel that, until about 5 years ago, over 90% of the practice income had been derived from the NHS. However, rapidly increasing practice expenses and the decline of exempt – charges patients had forced the decision to restrict the acceptance of new NHS patients to children and the elderly, with new adult patients only being

accepted on an independent basis. That had been the situation in March 2006, when the old contract had been terminated.

- 4.28 Under the new contract a total of 7,634 UDAs had been required. The Panel were told that this represented an increase of almost 30% on the activity on the last year of the GDS contract, for the same gross income, uplifted for inflation. About 40% of the work under the contract had been allocated to a new colleague, who worked the equivalent of a 4 day (34 hour) week, and who had inherited the contract value of a previous colleague, who had worked a 2 day week.
- 4.29 Dr Levine explained that it had been hoped, when the new colleague was recruited, that his contract could be extended to fund the extra surgery time. However, the funding had not been forthcoming and, although he sees NHS patients every day, he is only funded for two days.
- 4.30 In summarising the impact of the new contract, Dr Levine highlighted a range of concerns. In his view;
- It had not enabled the surgery to increase the rate of NHS patient acceptance
 - Time available for non – clinical, preventive care and advice had been reduced
 - Surgery time wasted by missed appointments had increased
 - Reception staff workload had increased
 - No additional time had been made available for practice development or professional training
 - Their priority, domiciliary service could not be maintained without additional funding (Dr Levine had explained that he was on course to fall short of his UDA commitment, with likely financial consequences, through the extra time taken for those visits, including abortive or cancelled visits, for which there was no additional allowance in the contract)
 - The practice wage bill and running costs had increased
- 4.31 Dr Levine expressed concern at the increasing number of missed appointments in recent months, both for the dentists and the hygienist. He thought that this was because there was no charge incurred for missed appointments, a fact that had been included in the details of the new NHS arrangements published in their regular newsletters.
- 4.32 He explained that, whilst the practice had the option of refusing to see patients who repeatedly failed appointments, in practice that sanction was difficult to implement, since unreliable patients tend to contact the dentist only when they are in severe pain. The surgery believe that it is unethical to refuse treatment in that situation. However the effect of the wasted surgery time is now having an impact on their ability to fulfil their contract.

- 4.33 The issue of missed appointments had been raised in the recent scrutiny of NHS Dentistry conducted by Kirklees Council. That report noted that, in one practice some 96 hours (or perhaps up to three weeks of a dentist's time) had been wasted by patients who consistently did not turn up for appointments.
- 4.34 The policy promoted by Kirklees PCT was for practices to 'strike off' people who miss 2 appointments in a row, or in one year. That rule is implemented at the discretion of each practice. A Your Commitment, Our Commitment poster is displayed, and a similar leaflet is available, which sets out what patients can expect from their dentist, and what is expected of patients. The poster was put together in consultation with local dentists.
- 4.35 The Panel have been advised that Calderdale PCT have made no such recommendation with regard to missed appointments. In practice, dentists might in fact deal with this on a case-by-case basis.
- 4.36 As the Panel have learned, and as is discussed further in the final section of this report, the concept of registration does not exist under the present arrangements. The contract between the dentist and the patient is for one course of treatment only, based on the assessment of what is needed made during the initial examination. Thereafter there is no further obligation on either side

Recommendation 20

The Panel is concerned at the amount of time being wasted through missed appointments, and the impact that this is having in terms of lost opportunities to carry out necessary treatment and preventive /developmental work.

The Panel recommends that the impact of missing appointments should be publicised, and that consideration should be given by the Primary Care Trust, in conjunction with local dentists, to the introduction of a leaflet, similar to that for the 'Your Commitment, Our Commitment' scheme adopted in Kirklees.

Getting an NHS Dentist

- 4.37 The Panel had been surprised to learn that the system of registration, which was discontinued under the new arrangements, had in fact only been introduced in 1990. Prior to that patients had in fact been accepted for individual courses of treatment.
- 4.38 Nevertheless, it was the common experience that people, whole families used to go to the same dentist, having regular check ups and

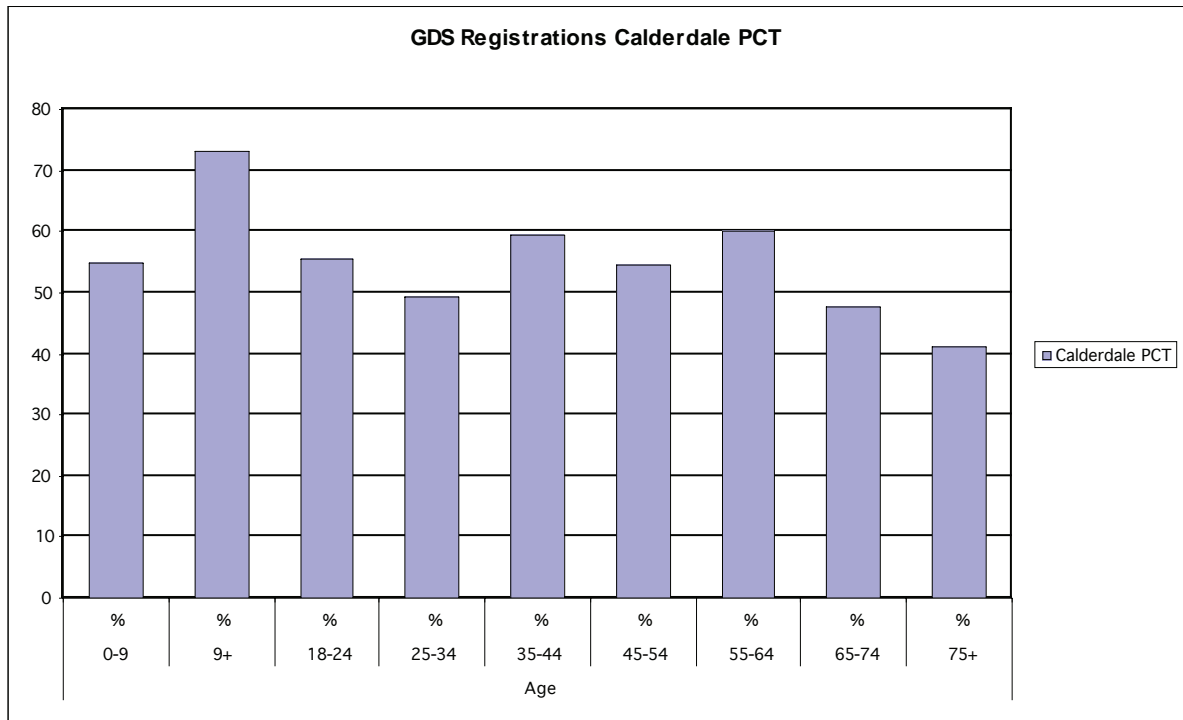
treatment over many years. It had been, in effect, an informal system of registration. When this had ceased it was usually because the patient had ceased to attend for appointments over a period of time. In these circumstances the dentist might, in effect, say 'you have broken your contract with me. On occasion the relationship between dentist and patient might break down, or the patient might just choose to go elsewhere.

- 4.39 The changes in 1990 had introduced a formal arrangement of registration, which featured a national system. Where patients had not attended for 15 months they were automatically de-registered by the dental practice board. The dentist simply got a letter informing them that the patient was no longer registered.
- 4.40 The CAB report concedes that the new arrangements appear, on early evidence, to have achieved the more modest of its stated aims, in having stemmed the flow of dentists away from NHS dentistry. Members had been aware of the many images seen on television and reported in the press, of massive queues forming in the hope of getting onto the list of an NHS dentist. They were keen to explore whether, locally, people were able to get an NHS dentist when they wanted one.
- 4.41 The CAB report cited national statistics, to the effect that some 56% of the population were accessing NHS dentistry, the same percentage as had been the case two years previously. Dr Beale had informed the Panel that the figures in Calderdale were rather higher than this. In March 2006 54% of adults and 65% of children had been registered. Overall the early figures suggested that the new contract was certainly not having a negative impact. The percentage of the population of Calderdale who had been seen by an NHS dentist in the last two years was;
- March 2006 58.9%
 - June 2006 59.1%
 - Sept 2006 59.4%
- 4.42 The Members had heard from the Consultant in Dental Public health that the variations in the percentage of people registered by age were well established.
- 4.43 Table 12 shows the percentage of Calderdale people registered with the general dental service within different age bands. The Consultant in Dental Public health had explained that, within the 0 – 9 year – olds band, the figures could be further sub – divided. The figure for 0 – 5 year olds was in fact about 40%, rising above 50% for the whole age band.
- 4.44 The Members were told that this was because, from about the age of 7, children were getting their second teeth, and parents then felt that they should be going to the dentist. But when it is baby teeth a lot of parents

still think 'don't need to go to the dentist' or in disadvantaged areas the parents themselves don't go to the dentist anyway.

Table 12

Registration (% with the GDS – September 2004, by Age)



- 4.45 The Panel were told that, by the age of 9 up to 18, over 70% of children were attending a dentist regularly. Then it tails off. They leave school and suddenly they have to start paying for their dental treatment and it drops off in 18 – 24 year olds. Some of them stop going.
- 4.46 It was thought that, by the time they were 35 and 44, more parents go along again because they have to take their children with them. Again, by the time people are middle aged, 55 – 64, fillings were falling out, or they might need a bridge or a crown doing. Again they start going.
- 4.47 Then it falls off again. By 75+ years only 40% were going regularly, This may be because some of them have had dentures put in and think they don't need to go. Also, they are old, not as mobile, access is worse for them.

Recommendation 21

The Panel believes that it is clear, from the evidence received during this review, that some members of the public are unaware of the need to see a dentist from an early age, and also of the need to continue to do so when older, even when full dentures have been fitted. The Panel has heard that an NHS dentist will always be available for young children

The Panel recommends that the Primary Care Trust, supported by local partners, should take every opportunity to ensure that parents of young children are made aware of the need to look after their children's dental health from an early age, and that they are adequately supported in doing so.

- 4.48 The Panel had learned that there were no statistics available regarding the number of patients receiving private treatment. Dentists were not required to report this information, and it could only be estimated. Neither was there any reliable data in terms of why people were accessing private treatment. This may have been because they preferred to do so, or were benefiting from health insurance schemes through employment. Or they may have felt that they had no choice, because they could not get an NHS dentist locally.
- 4.49 The lack of information with regard to private dentistry made it more difficult to assess how many people, nationally and locally, wanted an NHS dentist, but could not get one. The CAB report cited a Department of Health estimate that, nationally, there were around 2 million people in England who would like to access NHS dentistry, but were unable to do so.
- 4.50 The Panel had heard evidence from the Primary Care Trust that there were many reasons why people did not go to a dentist. They might be afraid of dentists. They believed that there were many patients who only wanted to see a dentist when they were in pain, or in need of treatment.
- 4.51 The PCT evidence included broad estimates, as at April 2006, of the dental care situation in Calderdale. Table 13 below, suggests that 49% of all residents, against a national average of 42%, might be considered regular attendees at an NHS dental practice.

Table 13

Estimate of the dental care situation across Calderdale

Category	Number	%age
Known regular attendees at an NHS practice	97,000	49.0
Estimated attendees at local private / independent practices	35,000	17.6
Estimate of population who might choose not to use dental services except in an emergency	33,000	16.7
Crude estimate of population who would like to access NHS dental services, who at present make use of emergency service or casual attendance at dental practices.	33,000	16.7
Total estimated population of Calderdale	198,000	100.0

- 4.52 The panel had expressed concern that, taking together the numbers of local people who choose not to see a dentist, and those who want to but can't, that amounts to about a third of the population who really should be seeing a dentist regularly, but aren't doing so. Members observed that there simply isn't the capacity in the system to cope with that.
- 4.53 It had been explained to the panel that at no point in time had there ever been enough dentists anywhere in the country, so that 100% of the population could be seen on a regular basis. The government was addressing a capacity issues, a workforce planning issue, by training more dentists and more dental care professionals (hygienists and therapists), a profession complementary to dentists. That was growing as well.
- 4.54 However, it was reiterated to the Panel that the estimate of those who might want to access a dentist did not reflect those who actually try to do so. What the PCT had found, when they opened their dedicated registration line, was that some 6,000 names and addresses had been added to it. The PCT had been able to find dentists for those applicants. The number of telephone calls being received per day now was very small.
- 4.55 It was conceded that this did not mean that everybody who might want a dentist at any time is satisfied. However, of those who had gone out and found out if the system works and had used it, the majority had been placed with a dentist.
- 4.56 Ian Waugh had told the Panel that there were clearly a large group of people who only wanted a walk-in service, and that the PCT were considering whether they should seek to provide a robust service of this type.
- 4.57 Early evidence following the introduction of the new contract might be thought to support that view. The Panel were told that four areas of concern had been raised by local dentists, following the referral of new patients from the PCT list.
- The practice makes contact to offer an initial appointment to learn that the person has found an alternative dentist
 - The initial appointment is not kept and the practice hears no more from the person.
 - The initial appointment is kept but patients do not attend for any follow – up work
 - The initial appointment is kept and on being told that they have no current dental health needs the patient does not attend for future routine re – call appointments.

- 4.58 Overall however, The PCT was confident that, by and large, anyone in Calderdale who wanted an NHS dentist in Calderdale would be found one. Anyone who was in pain would be able to access treatment.
- 4.59 This is a significant contrast to the situation in Kirklees where, as reported in the recent scrutiny review, a waiting list of some 3,500 was not going down.
- 4.60 The Panel had heard that, as part of the changes made when introducing the new contract, the PCT had strengthened the out of hours and emergency service. This had previously been centrally funded. Now, because the PCT controlled the budget, joint provisions had been made with colleagues in Kirklees to commission an enhanced service from a local provider. Where previously the emergency service had been available only in the evening, slots were now available at a surgery in Halifax during the day. The PCT were also now working together with managers of the emergency service to make further improvements.

Recommendation 22

The Panel was pleased to learn that so many people have been able to be placed with an NHS dentist under the new arrangements and was also pleased to hear of the improvements to the emergency service.

The Panel recommends that more needs to be done to ensure that the members of the public are aware of the services that are available, and of how to access them.

- 4.61 The CAB report had concluded that accessing an NHS dentist was a 'post – code lottery'. In part, their evidence for this was based on a review of the NHS Direct Website. The dental section of his site, includes a list of all dentists contracted to provide NHS services in each PCT area. Colour codes of red and green are used to indicate whether or not those dentists are currently taking on NHS patients.
- 4.62 In evidence, the PCT explained to the Panel that, historically, dentists had felt that they had been getting a great many telephone calls and visits from people asking if they could obtain NHS treatment. They had found this time consuming and difficult, when they were having to explain to enquirers that it wouldn't be possible. This had happened as a result of people checking the web – site, and so many dentists had responded by simply not indicating on the site that they were accepting patients.
- 4.63 At the same time, with the new practices coming on-stream in Todmorden and Elland, that would be able to take on large numbers of

new patients, the PCT had wanted to avoid the situation whereby the people in the practice would find themselves busy all the time doing the paperwork for new people rather than getting on with booking people through and making sure dentistry was actually delivered.

- 4.64 The PCT therefore agreed that the most sensible thing would be to establish a dedicated line, run by the Patient Advice and Liaison Service (PALS), and to establish a register of people requiring a dentist, and to feed into practices a number of patients each month. As practices felt that they could accept more NHS patients, they would be given names from the register.
- 4.65 The Panel were told that it was the use of this register that had successfully allowed the PCT to place some 6,000 patients with a dentist since the start of the contract. It is because the number of people waiting on this register was now low, and the inflow of new names quite slow, that the PCT feel that they have no particular problem of unmet demand.
- 4.66 The CAB report had quoted their own on – line survey in which people had been asked how they had gone about trying to get an NHS dentist. Some 3,763 people had responded. The survey quoted the percentage of respondents who had tried different methods (the numbers add up to more than 100%, because more than one answer was allowed).
- 4.67 The results showed that the methods commonly employed were;
- Yellow Pages 56%
 - NHS Web – site 52%
 - Asking a Friend / relative 43%
 - Telephoned NHS Direct 39%
 - Telephoned PCT / PALS 19%
- 4.68 Thus the strategy that would in fact be the correct one in Calderdale, and that would be likely to be successful, would appear to be the least likely to be employed.

Recommendation 23

The Panel believes that the registration service the PCT is running through the PALS service is to be commended. However, it is clear that the availability of the service is not well known. The Panel recommends the scheme be actively publicised by the Primary Care Trust, and that other agencies, including the local authority, ensure that people are aware of its existence.

- 4.69 Members had raised the question of access to a local dentist.. The PCT had suggested in session one that the commitment was to find people a dentist in Calderdale. They had suggested that people did not

mind travelling to a dentist. That the fact that most of the dentists are in the town centre is considered convenient, as many people like to have a dentist near where they work and shop.

This was re-iterated at a later evidence session. The Panel was told that that it was not possible to place people locally. It was claimed that 'Halifax to Todmorden was not so bad', It was recognised, however, that Illingworth to Todmorden, with children, on public transport was not so good.

- 4.70 The Panel had felt strongly that people did care about locally available services, and were particularly concerned that some areas, including some where dental health was poor, had no service. They noted that there had not been a dentist in Mixenden for many years. The Members asked if it would not be possible, for example, to locate a surgery there.
- 4.71 Ian Waugh advised the Panel that, theoretically, under the new commissioning arrangements, that should be possible. That would, however, require two things to coincide:
- (1) That the PCT had actually got some money available to offer to dentists and
 - (2) That a dentist actually wants to go to a particular area.
- 4.72 Those two things would have to come together to make it work. He explained that the PCT receive a lot of requests, He had received two or three within the previous week, from firms from all over the country that had been in touch and said "We would like to open an NHS dentist in your area. Can you tell us how much money you could give us?" The PCT would have to say "Well, there is no money available at the present time". But their details are put on file in case money should ever become available. It was explained that the dentists are private contractors and, generally, they decide which areas they want to come into.
- 4.73 The Panel had received evidence informally from Surestart, North Halifax. They heard that Surestart had come to North Halifax in November/December 2001. They had done some early community consultation asking open questions to determine
- What parents would like (Education, pre-school)
 - Where they got information from and who they would turn to for assistance / advice
 - What was required in terms of improving health services.

The surveys had been done in person and accessed 20% of the target group (800 parents of under – 4s).

- 4.74 A strong message emerging from this consultation was concern about oral health and particular concern that there was no dentist in Mixenden. A budget of £10,000 had been identified to try to help to

address this. This was used to establish a dental suite at a block of flats. A dentist had not been identified and it had not been used – the initiative failed.

- 4.75 The Panel appreciate the difficulties involved in trying to establish a local NHS provision in specific, needy locations under the present arrangements, but remain convinced that access to local services is what many people want and need, particularly those in poorer areas and without transport, and the elderly and the infirm.
- 4.76 The PCT thought that, as the system settled down, and natural turnover happened then it might be possible to gradually address this problem in the longer term.

Recommendation 24

The Panel has learned of the difficulties involved, in terms of budget constraint and contractor freedom, in getting people access to a dentist close to home. The Panel nevertheless feels that this is an important aspiration and recommends that the PCT should make every effort to make this more possible including perhaps, by the use of salaried dental staff. This is particularly important in deprived areas with no current provision.

Recommendation 25

The Panel recommends that the PCT should introduce some form of prioritisation into their allocation policy, to help those with greatest access difficulties.

Appendix 1

Membership of the Health and Social Care Scrutiny Panel

Councillor Bob Metcalfe (Chair)
Councillor Kay Barret (from May 2007)
Councillor Peter Coles (until May 2007)
Councillor Andrew Feather (from May 2007)
Councillor Judy Gannon (from May 2007)
Councillor Ruth Goldthorpe
Councillor Mrs Olwen Jennings
Councillor Richard Mulhall (until May 2007)
Councillor Diane Park (from May 2007)
Councillor Graham Reason (until May 2007)
Councillor Nicholas Yates (until May 2007)

Support for the scrutiny was provided by Geoff Ainsley, Principal Officer,
Performance Management, Health & Social Care Directorate.

Appendix 2

TERMS OF REFERENCE

1 INTRODUCTION

- 1.1 When we refer to oral health we are talking about the health of people's teeth, gums and supporting bone, and the soft tissues on the mouth, tongue and lips.¹The accepted definition of Oral Health is 'a standard of health of the oral and related tissues which enables an individual to eat, speak, and socialise without active disease, discomfort or embarrassment and which contributes to general well-being'.²
- 1.2 Oral health is an integral element of general health and well-being. Good oral health enables individuals to communicate effectively, to eat and enjoy a variety of foods, and is important to overall quality of life, self-esteem and social confidence. Poor oral health can impact on general health and well-being. Loss of teeth can cause psychological and social problems and lead to nutritional deficiency in older people. Oral cancer frequently leads to premature death. The financial cost of dental treatment is a source of stress for many people.³
- 1.3 Nationally, there has been a significant improvement in standards of oral health and a reduction in the incidence of missing, filled and decayed teeth (dmft). However, in spite of this overall improvement, national surveys still highlight inequalities, which are strongly associated with social background. Furthermore West Yorkshire has the highest average decayed, missing and filled teeth for five-year-old children in England⁴ and in Calderdale tooth decay among five-year-olds is significantly worse than average.⁵
- 1.4 Oral diseases are largely preventable. The challenge is to create the opportunity and conditions to enable individuals and communities to enjoy good oral health. Contemporary public health policy recognises the impact of broader social, economic and environmental factors in determining health across the population⁶. They stress the importance of an approach based on prevention, and this shift of focus is evident in national and local health policies.

¹ Choosing Better Oral Health – an Oral Health Plan for England (Dept. of Health, 2005) p.11

² Oral Health Strategy for England, (Dept. of Health, 1994).

³ Dept of Health, 2005

⁴ Dental health of five-year-old children in Yorkshire & the Humber 2003/4 (Yorkshire & Humber Public Health Observatory, 2006) p.2

⁵ Health profile for Calderdale 2006 www.communityhealthprofiles.info/profiles/OOCY-HP.pdf

⁶ Dept of Health 2005

- 1.5 It is now widely recognised that the achievement of sustainable health improvements on a population-wide basis, necessary to address significant health inequalities, can only be achieved by adopting a co-ordinated approach based on common risk factors. This approach recognises that chronic, non-communicable diseases and conditions such as obesity, heart disease, stroke, cancers, diabetes and oral diseases share a common set of risk conditions and factors, including diet, smoking, hygiene and alcohol.
- 1.6 This approach requires successful partnership working across agencies, and the promotion of a partnership approach is a central theme of current health policy. Primary Care Trusts have been given the lead role in driving this approach, including the management of the new Dental Contract arrangements. Local Authorities also have an important role to play, both as providers of services and in their community leadership role. The new Local Area Agreement will be a focus of such work.

2 SCOPE OF THE INQUIRY

- 2.1 In light of the above, the Panel will seek, through its health scrutiny function, to look into the state of the oral health of the people of Calderdale. It will consider the arrangements that have been, and need to be put in place, across local partnerships, to improve oral health and oral health services, and to improve access to oral health for all.
- 2.2 In particular, the scrutiny will seek answers to the following questions;
- What is oral health?
 - What are the causes and consequences of poor oral health?
 - What is the state of oral health in Calderdale? How does it compare to the picture regionally and nationally?
 - Are there significant differentials in oral health in relation to particular groups within the population, either by location, ethnicity, social grouping, disability or other special circumstances.
 - What constitutes access to opportunities and services, and are there gaps in access affecting particular groups?
 - What is being done, locally to improve oral health, and to address gaps in service provision and inequalities in oral health outcomes?
 - What more can be done, across local partnerships?

3 STRUCTURE OF THE REVIEW

- 3.1 The review is to be undertaken by the whole Panel, on a task and finish basis, with the intention of agreeing a final report by the end of March 2007. The review has been designated a 'mini-scrutiny' – to involve a maximum of three formal meetings of the Panel.
- 3.2 It is intended that a range of approaches to evidence gathering will be used, including the following:

- Full meetings of the Panel to consider evidence from and ask questions of key witnesses.
- Discussions with key partners and stakeholders
- Consideration of written evidence, including both published research and statistical data and correspondence from interested individuals and groups and media coverage.
- Site visits and small-scale research may be considered if they can be accommodated within the time and other resource constraints of the work programme.

4 WORK PROGRAMME

- 4.1 The work programme is subject to confirmation and will depend on the outcome of the initial informal evidence gathering sessions. It proposed to conduct three formal witness sessions during November – January.

5 WITNESSES

- 5.1 The following witnesses have been initially identified as possible contributors to the review. This list is not meant to be exhaustive;
- Calderdale Primary Care Trust
Graham Wardman, Director of Public Health
MS D’Cruz, Consultant in Dental Public Health
Ian Waugh, Lead, NHS Dental Contract
 - Calderdale MBC
Director of Health and Social Care (and appropriate officers)
Director of Children and Young Peoples’ Services (and appropriate officers)
 - Dr John Beal MBE, Consultant in Dental Public Health, Leeds PCT, Regional Dental Officer, Yorkshire and the Humber, Dental Lead, West Yorkshire Strategic Health Authority.
 - Dr Ronnie Levine OBE, Practicing dentist at Beechwood Health Centre, Ilkley. Honorary Senior Research Fellow, Academic Unit of Paediatrics, University of Leeds.

6 CLOSING THE PROJECT

- 6.1 The outcome of the review will be a report for wide distribution. The report will make recommendations to both the Council and Health Service partners with the aims of:
- Improving oral health services for the people of Calderdale and highlighting and seeking to address issues of access to those services affecting particular groups.
 - Identifying and highlighting opportunities for initiatives to be undertaken locally that would raise awareness of oral health issues and actions that need to be taken by groups and by individuals to improve oral health.

- 6.2 The Panel will need to determine the process by which it will receive feedback in respect of its recommendations and by which it will subsequently monitor progress in respect of them.

Appendix 3

WORK PROGRAMME

The following meetings were arranged for the conduct of the review.

Table of Meetings and Witnesses

* Formal evidence sessions

Meeting 1 – Halifax Town Hall, Wed. 11th October 2006		
The members met informally to receive advice on available evidence and potential further sources of evidence, and to consider any witnesses from whom they might wish to take evidence. Terms of Reference for the review were discussed.		
Meeting 2 – Halifax Town Hall, Wed October 25 2006		
Final Terms of Reference for the Review were formally approved.		
Meeting 3 – Halifax Town Hall, 8 November 2006		
The Panel approved the work programme for the conduct of the review.		
Meeting 4 – Halifax Town Hall 8 November 2006		
The members met informally to discuss evidence received to date and plan the forthcoming formal witness session.		
*Meeting 5 – Halifax Town Hall, 29 November 2006		
Witness	Organisation	Evidence Sought
Paul Butcher	<u>Calderdale Primary Care Trust</u> Deputy Director of Public Health	Overview of dental/oral health in Calderdale.
M S D’Cruz	Consultant in Dental Public Health	Overview of dental service provision, including known gaps. Report on progress in developing / implementing the PCT’s Oral Health Strategy.
Ian Waugh	Primary Care Manager,	Report on progress in implementing new NHS dental contract, and early views on whether it is achieving the intended outcomes.

Meeting 6 – Halifax Town Hall, 3 January 2007		
For Members to meet informally to discuss evidence received to date and plan the forthcoming formal witness session.		
*Meeting 7 – Halifax Town Hall, 7 March 2007		
Dr John Beal MBE	Consultant in Dental Public Health, Leeds PCT. Regional Dental Officer, Yorkshire & Humber. Dental Lead, Strategic Health Authority. Steering Group Member for 'Choosing Better Oral Health – an Oral Health Plan for England'.	Overview of the state of oral health regionally and locally, including any information gaps. Overview of current oral health policy. Advice on measures that local Primary Care Trusts and local partnerships should be pursuing to improve oral health and reduce related health inequalities.
Dr Ronnie Levine OBE	Practicing Dentist at Beechwood Health Centre, Illingworth. Honorary Senior Research Fellow, Academic Unit of Paediatrics, University of Leeds. Co-author of 'The Scientific Basis of Dental Health Education', the relevant policy document in the National Clinical Guidelines.	Key messages for improving oral health and access to oral health. Advice on how local partnerships can best contribute to improved access and outcomes. Practical perspective of a practicing dentist in a recognised high – need area.
Meeting 8 – Halifax Town Hall, 21 March 2007		
For Members to meet informally to discuss evidence received to date and plan the forthcoming formal witness session.		
*Meeting 9 – The Ridings School, 28 March 2007		
Sue Rumbold	<u>Calderdale MBC</u> Head of Commissioning, Children and Young Peoples' Services	To explore measures and actions in schools and elsewhere to improve oral health for children and young people in Calderdale.

Jonathan Phillips	Group Director, Health & Social Care	Report on measures and actions within the Local Area Agreement and the Health Inequalities Strategy with regard to oral health. The panel wish to explore issues of access for the elderly, particularly those who are housebound or in care homes, and people with mental health problems.
Phil Shire	Head of Adult Services (Health & Social Care)	
Chris Kidd	Operations Manager (Health & Social Care)	
Kathryn Cronin	South & West Yorkshire Mental Health Trust	Additional information / advice provided during the evidence session.
Ian Waugh	Calderdale PCT	
Lynn Cliffe Kathryn Halstead	Oral Health Promotion Officers, Calderdale & Kirklees CDS	
Ann Cuthbert	Health Promotion & Development Officer, Age Concern	
Jane Carruthers	Sure Start, North Halifax	
Liz Broadley	Neighbourhood Manager, Ovenden Initiative	
Meeting 10 – Halifax Town Hall, 18 April 2007		
Members met informally to consider evidence and discuss and amend as necessary a draft form of the report		
Meeting 11 – Halifax Town Hall, 9 May 2007		
Members met informally to consider evidence and discuss and amend as necessary a draft form of the report		
Meeting 12 – Halifax Town Hall, 8 August 2007		
Members met informally to consider and amend as necessary a draft form of the report.		
Meeting 13 – Halifax Town Hall, 29 August 2007		
For the Panel to formally adopt a final version of the report and agree its circulation to appropriate bodies.		

- The Panel consulted with the Children and Young People's Scrutiny Panel, whose comments will be incorporated in the final review.
- A full review of existing literature was conducted, including relevant national policy and previous related scrutiny reviews conducted by other local authority scrutiny committees.
- The Panel also sought the views of other stakeholders, including voluntary and community groups, through meetings and correspondence, and monitored media coverage.

Appendix 4

List of Tables

Table 1	Number of dental general anaesthetics carried out on children (2003/04)
Table 2	Dental Health of 5 – year – olds in Calderdale (1992 – 2004). (Source: BASCD / CDS surveys)
Table 3	Dental Health of 12 – year – olds in Calderdale (1985 – 2001) (Source: BASCD / CDS surveys)
Table 4	Dental Caries Experience in 12 – year – olds by social class, 1993 (National)
Table 5	2003 – 2004 5 – year – old dmft for Calderdale overall, and by area
Table 6	5 year – old Surestart survey results (2004)
Table 7	Mean dmft in 5 – year – old children, by Strategic Health Authority, 2003/04 (Source: BASCD survey)
Table 8	Mean dmft in 5 – year – old children, Yorkshire and the Humber PCTs, 2003/04 (Source: BASCD survey)
Table 9	Dental Health of 5 – year – olds, Huddersfield (1992 – 2000) (Source: BASCD / CDS surveys)
Table 10	Dental caries experience in 5 – year – old children (Calderdale, Dewsbury and Huddersfield) 1986 - 2002
Table 11	Adults who have lost all their teeth (Source: National survey, 1998)
Table 12	Registration % with the GDS – September 2004, by Age
Table 13	Estimate of dental care situation across Calderdale, 2006

Appendix 5

Abbreviations / Glossary of Terms

CAB	Citizens Advice Bureau
CDS	Community Dental Service
Dmft / DMFT	Decayed, Missing, or filled teeth (lower case for primary teeth, upper case for permanent teeth)
GDS	General Dental Service
HAP	Health Action Plan
NHS	National Health Service
PALS	Patient Advice and Liaison Service (exist within all local health trusts)
PCT	Primary Care Trust
SHA	Strategic Health Authority
UDA	Unit of Dental Activity

Appendix 6

References and Bibliography

- Andrew, L (2004) 'Beakers for bottles – a health visitor oral health campaign' in Community Practitioner Vol. 77, No. 1
- Anon (2006) 'Silver Briefing' special edition of Health Insurance, May 2006
Informa UK Ltd: London
- Anon (2006) 'What Types of Dentist Are There?'
Extracts taken from the NHS website
www.nhscareers.nhs.uk/nhs-knowledge_base/data5004.html
- Bedi, R et al (2005) A futures study of dental decay in five and fifteen year olds in England
Office of Public Management:
London
- British Broadcasting Corp. (2005) 'Dentistry' Transcript of Case Notes – Programme 5 (Broadcast on 28/06/05)
www.bbc.co.uk/print/radio4/science/casenotes_tr_20050628.shtml
- Birmingham City Council (2005) Access to NHS Dentists. Report of Health Overview and Scrutiny Committee
www.Birmingham.gov.ok/scrutiny
- Calderdale MBC (2006) Health Inequalities Strategy
- Calderdale MBC (2006) Children and Young People's Plan
- Calderdale MBC (2006) Local Area Agreement
- Coventry City Council (2003) Review of NHS Dentistry in Coventry
Report of Scrutiny Board 5 (Health)
www.Coventry.gov.uk
- Department of Health (2000) Modernising NHS Dentistry – Implementing the NHS Plan
Stationary Office: London

Department of Health (2005)	<u>Choosing Better Oral Health – An Oral Health Plan for England</u> Stationary Office: London
D’Cruz, MS (2006a)	<u>Meeting the Challenge of Change – An Oral Health Strategy Discussion Document</u> An internal strategy discussion document for the PEC Board of Calderdale Primary Care Trust
D’Cruz, MS (2006b)	<u>An Overview of Oral Health & Access to Care in Calderdale</u> Submission to the Health & Social Care Scrutiny Panel, Calderdale MBC
Finbarr Allen P (2003)	‘Assessment of oral health related quality of life’ published online in <u>Health and Quality of Life Outcomes</u> www.pubmedcentral.nih.gov/articlerender.fcgi?artid=201012 Copyright@ 2003 Allen; licensee BioMed Central Ltd
Fiske, J et al (2000)	<u>Guidelines for Oral Health Care for Long-Stay Patients and Residents</u> British Society for Disability and Oral Health.
Gulliford M et al (2001)	<u>Access to Healthcare</u> - Report of a scoping exercise London: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D
Griffiths, J et al (2000)	<u>Oral Health Care for People with Mental Health Problems – Guidelines and Recommendations</u> British Society for Disability and Oral Health.
Leeds City Council (2003)	<u>NHS Dentistry in Leeds Report of Scrutiny Board (Health)</u> www.Leeds.gov.uk
Leeds Primary Care Trust (2006)	<u>Draft Oral Health Strategy</u> (Final Draft Version)

Levine, RS & Stillman – Lowe, C (2001)	<u>The Scientific Basis of Dental Health Education: A Policy Document</u> (revised 4 th edition) Health Development Agency
McGrath C et al (2002)	‘Are single mothers in Britain failing to monitor their oral health?’ in <u>Postgraduate Medical Journal</u> Vol. 78, pp 229 - 23
Portsmouth City Council (2006)	<u>Review of Oral Health & Dentistry</u> Review of the Health Overview & Scrutiny Panel, March 2006 www.Portsmouth.gov.uk
Primary Care Contracting (2006)	<u>Oral Health Needs Assessment Toolkit for Primary Care Trusts</u> www.primarycarecontracting.nhs.uk
Rugg-Gunn, AJ	<u>Sugars and the Dental Health of Children - UK. National Clinical Guidelines and Policy Documents</u> Dental Practice Board for England and Wales
Shaw, L (1999)	‘Prevention of Dental Caries in Children’ in <u>Paediatric Dentistry – UK. National Clinical Guidelines and Policy Documents</u> Dental Practice Board for England and Wales
Stockton Borough Council (2006)	<u>NHS Dentistry in Stockton Borough</u> Report of the Health Select Committee www.Stockton.gov.uk
Wigan Borough Council (2003)	<u>Access and Availability of NHS Dentistry</u> Pilot review of the Health Scrutiny Select Committee www.Wigan.gov.uk
Yorkshire and Humber Public Health Observatory (2006)	<u>Dental Health of five-year-old children in Yorkshire and Humber, 2003/4</u> www.yhpho.org.uk

Main Web Sites Consulted

British Dental Association	www.BDA.org
British Dental Health Foundation	www.dentalhealth.org.uk
Centre for Evidence Based Dentistry	www.cebd.org
Department of Health	www.DH.gov.uk
National Fluoride Information Centre	www.fluorideinformation.com
NHS	www.nhs.uk
NHS Library	www.library.nhs.uk/oralhealth

Other Evidence Received

Survey of General Dental Practitioners in Calderdale
Calderdale Primary Care Trust Public and Patient Involvement Forum,
December 2005

Survey of Older Peoples' Oral Health
Conducted by Age Concern Calderdale for this review, February 2007

Press Coverage

Correspondence Received

The Panel particularly wishes to acknowledge that Chapter One of this report has been substantially sourced from Levine & Stillman-Lowe (2001), see bibliography.