

Oxfordshire Joint Health Overview & Scrutiny Committee- 4th April 2019

Dental Services and Dental Health in Oxfordshire.

1. Introduction

This paper will discuss the following

- Provision and capacity of NHS dentists in Oxfordshire
- Dental health of adults, older adults and children in the Oxfordshire population, including where inequalities exist
- Programmes of work to promote dental health
- Dental needs and health in nursing and residential homes

2. Exempt Information

There is no exempt information contained within this report.

3. Oral Health and the impact of poor oral health

Oral health is an integral part of overall health. A significant proportion of the population in England experience very good levels of oral health. Successive oral surveys have shown that child and adult oral health has been improving over the past 30 years. However, the vulnerable, disadvantaged and socially excluded groups are at a greater risk of oral diseases affecting their teeth, gums, supporting bone and soft tissues of their mouth, tongue and lips.

Oral disease is largely preventable by addressing risk factors common to general health, such as smoking, alcohol misuse, poor diet and high sugar intake.

Maintaining good oral health throughout life and into old age not only improves our general health and wellbeing but plays a part in helping us to stay independent for as long as possible. However vulnerable older people may require special care due to age, disability or risk of abuse or neglect

Dental decay among young children remains an important public health issue Poor oral health can affect a child's ability to eat, speak, play, sleep and socialise with other children. Poor oral health also causes pain, infections, and impaired nutrition and growth.

When children have toothache or need treatment it can mean school absence and that families and parents must take time off work. Oral health is an integral part of overall health. When children are not healthy it affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness.

Whilst more adults are keeping their teeth for life many still suffer from periodontal disease and tooth decay with the number of adults aged 56 with no teeth being higher than some EU countries. Evidence shows that poor oral health in older people can lead to pain and discomfort, which can lead to mood and behaviour changes, particularly in people who cannot communicate their experience. It can also cause speech problems; reduced ability to smile and communicate freely;

problems chewing and swallowing which limit food choices and can lead to impaired nutritional status; reduced self-confidence and increased social isolation; impaired well-being and mood; poor general health and premature mortality.

4. Oral health in children

Local data for Oxfordshire is based on national surveys whose sample size is at district level. Looking at the national data it is possible to see that tooth decay is linked with other measures of social disadvantage and so is a source of inequality in the County. The data available from the 2017 oral health survey of 5-year-old children showed that 80.2% of 5-year-old children in Oxfordshire are now free from any dental decay which is higher than the national average of 76.7% and an improvement from 67% in the 2012 survey. While the improvement is welcome there are still 19.8% of 5-year-old children who have experienced decay, which is an avoidable condition. There is an inequality in the number of children with decay between Districts. The number of children who experience decay is higher in Oxford City than the other districts at 23.5% as shown in Figure 1.

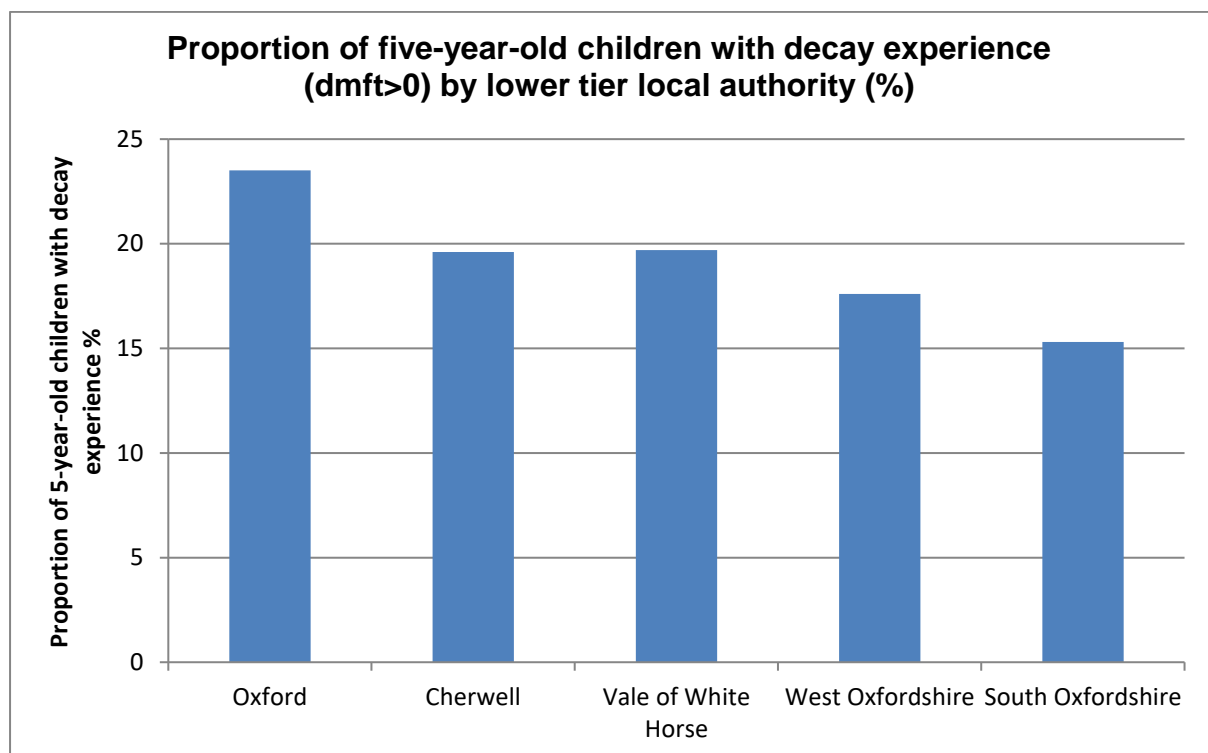


Figure 1 Proportion of 5-year-old children with decay by district in 2017

Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million.

In 2017/18 six hundred and twenty children in Oxfordshire aged 0-19 years had teeth extracted under general anaesthetic. This number has remained relatively stable for the last five years, as shown in figure2.

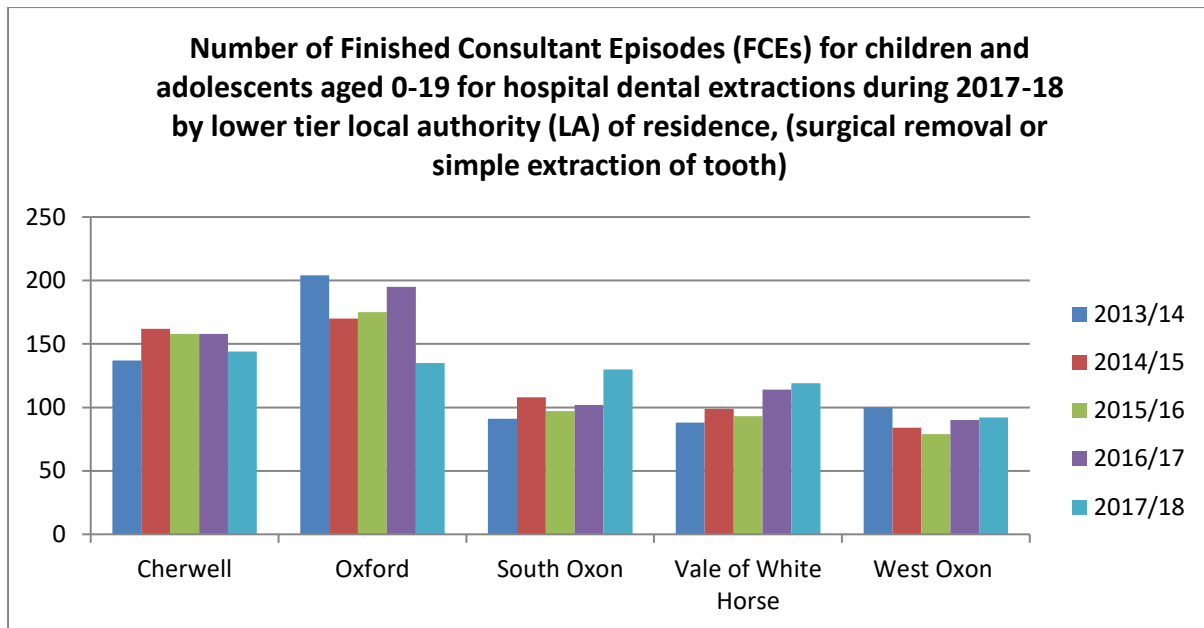


Figure 2. Number of Hospital Episodes for children 0-19 for dental extractions 2013/14 – 2017/18

5. Oral health in adults

Current local data on oral health in adults are not available. A report on a 2018 survey of the oral health of adults attending dental practices is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS). These surveys collect data on clinically defined ('normative') and patient defined ('perceived' or 'felt') oral health needs. It is an accepted convention to use Strategic Health Authority (as was) data as a proxy for local data with the caveat that it will be a precise estimate and will not fully reflect local variations. South Central England comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial survey can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods.

During the post-war years, the nation's oral health was poor, dental disease was rife and there was little expectation that teeth would last a lifetime. This expectation has now changed, with the majority of adults having teeth for life. We have seen dramatic improvements in the last 50 years with the percentage of adults in England with no teeth falling from 37% in 1968 to 6% in 2009. In South Central England, only 2% of adults had no teeth in 2009.

Reasons for improvement in oral health in adults are thought to be:

1. Changes in social norms and behaviours, including body hygiene, smoking rates, use of fluoride toothpaste, increasing public engagement in oral health and rising expectations. Oral hygiene behaviours have substantially improved: 75% reported brushing twice daily in the most recent adult survey and levels of plaque and calculus have steadily improved over the last 40 years.
2. Changes in diagnosis and treatment of oral diseases mean that dentists are more likely to restore teeth than in the past where full dental clearances were commonplace.

While oral health has improved generally, it is not all good news. Population averages for adults hide oral health inequalities and a 'social gradient' exists whereby higher levels of disease can be seen at each lower level of the social hierarchy. Data shows that adults from the most deprived areas, in most age groups, are more likely to have:

- Decayed teeth
- No teeth
- Gum disease
- Oral cancer
- Suffer from urgent conditions

It is well established that absolute deprivation has a significant impact on health status, but the social gradient illustrates the importance of relative deprivation. This is significant for Thames Valley where there are pockets of deprivation in a broadly affluent area.

As the population ages and people are increasingly retaining their teeth into later life, the restorative problems experienced by adults have become more complex. In addition, the prevalence of periodontal disease and root caries increases with age, as does the medical complexity of patients. The most recent ADHS found that almost 1/5 adults were found to have complex oral health needs with multiple management issues, particularly in those over 45 years old.

6. Oral health in older adults

At the moment local data on oral health in older adults are not available. A 2016 survey of the oral health of adults in supported living settings is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS) and from surveys conducted in other areas. The national surveys collect data on clinically assessed ('normative') and subjective (public view) oral health needs.

The most recent (2009) decennial national survey (Adult Dental Health Survey, ADHS) collected data at a Strategic Health Authority (as was) level. These data can be used as a proxy for local data with the caveat that it will not be a precise estimate and will not fully reflect local variations. The SHA, when the survey was carried out, which relates most closely to Thames Valley, was South Central. South Central comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial surveys can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods, for example, adults living in care homes are excluded from the survey population.

Good health is central to improving outcomes for older adults and good oral health is a key part of that. The consequences of oral diseases in older adults can be considerable. Pain, discomfort and sleepless nights are all common impacts of oral diseases.

The number and position of a person's natural teeth affects their ability to chew. Difficulty with chewing affects the nutrient intakes of older people. There is evidence that people who cannot chew or bite comfortably are less likely to consume high fibre

foods such as bread, fruit and vegetables, thereby risking reducing their intake of essential nutrients such as fibre, iron and vitamin C. In older adults, this can lead to dehydration and malnutrition. Age UK report that it is estimated that 1.3 million people over 65 suffer from malnutrition, the vast majority of whom (93%) live in the community.

Poor oral health can have a negative impact on a person's ability to socialise and can reduce a person's self-esteem. This can increase the problems of loneliness and isolation. Poor oral health therefore can impact on a person's quality of life and their ability to live independently. A survey carried out with residents of care homes found that 40% of the residents reported that poor oral health affected their daily life.

Good oral health is therefore important for an older person to be able to lead an independent life with good general health and quality of life.

In general, the oral health of older people has improved in recent decades. For example, more older people are now keeping their teeth into old age. In 2009 the ADHS found that in England the proportion of the population aged between 65 and 75 with some natural teeth was 84% with over half of the people aged over 85 having some natural teeth. This compares with 26% of adults aged 65 to 75 with some natural teeth in 1978.

The 2009 ADHS found that the number of natural teeth is related to age. 86% of all adults with some natural teeth (dentate) had 21 or more teeth. This proportion fell significantly as age increased. For example, 100% of dentate adults aged 16 to 24 had 21 or more natural teeth compared with 40% of dentate adults aged 75 to 84. Among adults aged 85 and above only 26% had 21 or more natural teeth. These older dentate adults with enough natural teeth remaining to enable functional dentition represents 14% of all adults aged 85 and over.

The number of teeth a person has an impact on their general health. For example, older people with a need for dentures are more likely to be frail than those without a need and older people with 20 or more natural teeth are less likely to be frail than those with no teeth. This would suggest that improving the oral health of older people can have an impact on their ability to live independently.

Tooth decay is not distributed evenly throughout the population; inequalities exist. Older adults, for example, are more likely to experience tooth decay than younger adults. Studies carried out in other parts of the country have found that older adults living in care homes are more likely to experience tooth decay than the general older adult population (Figure 3). The 2009 ADHS found that those older people with tooth decay had a considerable number of teeth affected by decay with an

average of 2.5 teeth affected.

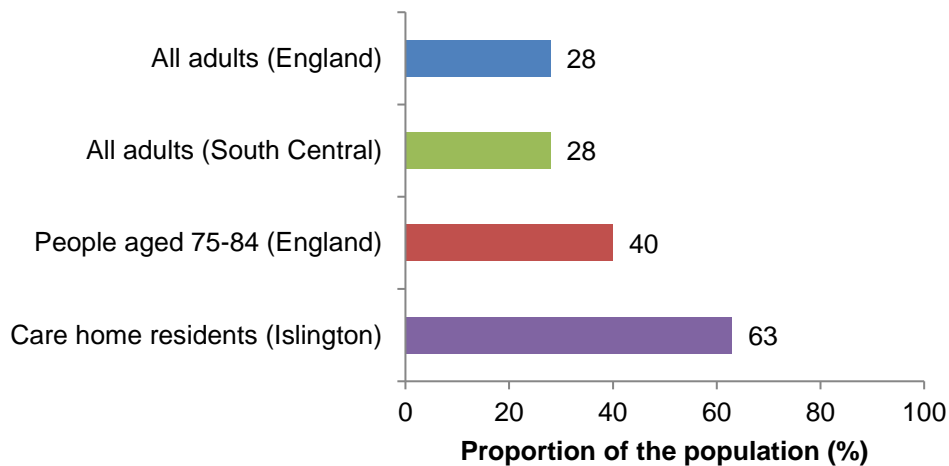


Figure 3. Proportion of the population with tooth decay. Source: ADHS 2009, UCL

7. NHS dental care in Oxfordshire

NHS England commissions all dental services including primary, community and hospital services and urgent and emergency care.

NHS England has a legal duty to commission dental services to meet the needs of a local population. It commissions local oral health needs assessments in partnership with local authorities and other organisations and decides subsequently how best to use its resources to meet this need. NHS dental services are commissioned through contract with independent providers which take account of the access to local dental services and the dental health of the local population.

Everyone is entitled to NHS dental services, and registration with a dental practice is not required, as it is with GP practices, because they do not operate in the same catchment areas. Some dental practices offer emergency treatment and will provide care if it is clinically necessary. The NHS Choices website advises only to visit A&E in serious circumstances:

- Severe pain
- Heavy Bleeding
- Injuries to the face, mouth or teeth.

NHS dental services provide care and treatment for adults and children alike, but dental care for children under the age of 18, or young people under the age of 19 and in full time education, is free of charge.

8. NHS Dental services in Oxfordshire

i. Primary Care

Services are provided by 'High Street' Dentists under the NHS (General Dental Services/Personal Dental Services) Regulations 2005. Treatments are delivered within NHS treatment bands which include check-ups, fillings, dentures and crown

and bridge work. Dentists also monitor patient oral health with health promotion advice and early intervention to maintain oral health. Patient Charges apply to these services. Patients are free to attend any dental practice of their choice; they are not registered with the practices.

Practices see patients on a planned and urgent basis. In 2015, the local office has established arrangements with NHS 111 and a number of dental practices for patients to be seen urgently on the day. These are normally patients who do not attend the Dentist on a regular basis. Many of these patients then form an on-going relationship with the dental practices concerned.

Services are provided via cash limited non-time limited General Dental Services (GDS) contracts with 'Unit of Dental Activity' targets. Providers paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Dentists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics (includes 2 week waits for potential cancer cases)
- Level 2 oral surgery and restorative dentistry – specialist but does not require treatment in hospital
- Community Dental Services – special care and paediatrics for patients with more complex management needs
- Orthodontic services

Table 1 below details primary care provision in the county 2018-19:

Local area	Population	Practices	UDAs commissioned	UOAs per head	'Full' NHS practices	Numbers over 96% 17-18	% over 96%	Referrals from NHS 111
Cherwell	145,600	16	261,048	1.79	12	5	31.25%	3
Oxford	154,600	20	283,434	1.83	14	9	45%	4
South Oxon	137,400	21	143,731	1.05	10	8	38.1%	3
Vale of the White Horse	126,700	15	137,693	1.09	10	8	53.33%	1
West Oxon	108,600	18	159,638	1.47	14	13	77.78%	1
Oxfordshire	672,900	90	985,544	1.46	60	43	71.67%	12
Thames Valley	2,124,175	282	2,775,796	1.31	191	202	71.63%	40

Table 1. Primary dental care provision for Oxfordshire 2018/19

ii. Access to primary care services

In 2009 the government commenced a programme of improving access to NHS Dental Services (as measured by the number of patients attending an NHS Dentist in the previous 24 months). Since April 2009 the number of patients attending an NHS Dentist in the Thames Valley has increased by 243,899 from 852,516 to 1,096,415; a growth of 28.6%. The local office is set a target for the % of patients attending an NHS Dentist. The target is that 51.50% of the population attend an NHS Dentist; the position at the end of January 2019 is that 51.62% of the population had attended an NHS Dentist in the previous 2 years. This compares to 43.64% of the population in 2009.

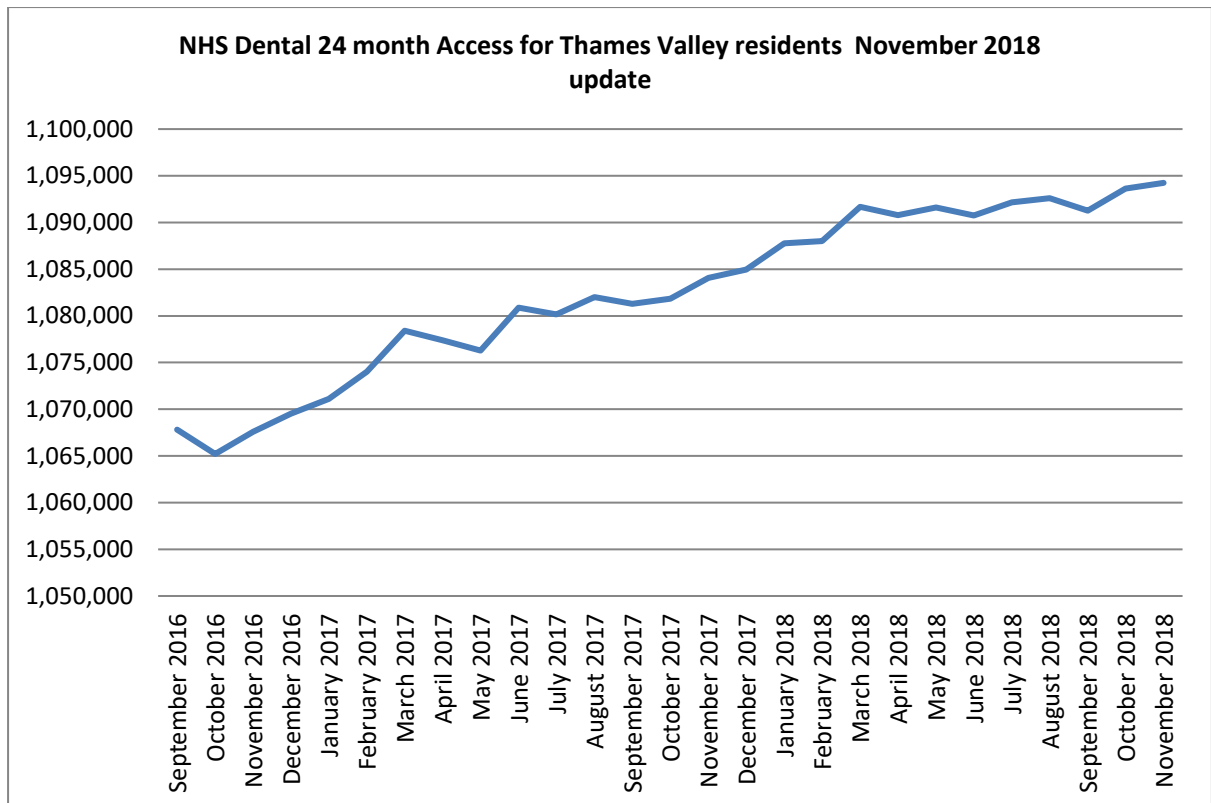


Figure 4. NHS Dental 24 month access for Thames Valley residents Sept 2016- Nov 2018

In Oxfordshire the information available is about the number of patients attending over one-year period. The latest available information is for October 2018; detailed below:

Local Authority	Population	Patients attending Oct 17	Patients attending oct 18	Change	% attending Oct 18
Cherwell	145,600	90,511	92,807	2,296	63.7%
Oxford	154,600	99,069	99,917	848	64.6%
South Oxon	137,400	58,248	59,240	992	43.1%
Vale of the White Horse	126,700	48,918	46,955	-1,963	37.1%
West Oxon	108,600	59,881	61,229	1,348	56.4%
Oxfordshire	672,900	356,727	360,518	3,791	53.6%
Thames Valley	2,124,175	1,029,400	1,040,150	10,750	49.0%

Table 2. Oxfordshire patients accessing primary dental services over a one-year period Oct 2017- Oct 2018

iii. Orthodontics

One of the peak ages for people to attend High Street Dental services is between the ages of about 10 and 14. This is due to possible Orthodontic (braces) treatment under the NHS. If patients are identified as having an Index of Treatment Need (IOTN) of 3.6 and above, they are eligible for NHS treatment. Patients are in treatment for an average of 21 months with a year retention period to monitor the outcome of treatments. In the Thames Valley there are usually about 24,000 patients either starting treatment; mid-treatment and in-retention. Patient charges apply to these services, but it is rare for them to be collected as most patients are children aged under 16 and are in full time education and so exempt from dental charges.

Services provided via Orthodontic specialist led cash limited time limited Personal Dental Services (PDS) agreements with 'Unit of Orthodontic Activity' targets. Providers are paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Orthodontists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics
- Dental Services – special care and paediatrics for patients with more complex management needs

These services have recently been subject to a procurement exercise across the south of England with new arrangements to be implemented from April 2019. New contracts for 7 years have been awarded. The level of activity to be commissioned in Oxfordshire will be very similar to levels commissioned prior to April 2019 (49,925 UOAs post April 2019 v 50,310 pre-April 2019). But there will be some redistribution of the activity, in line with need, with reduction in the Cherwell area, but increases in South Oxfordshire, the Vale of the White Horse and West Oxfordshire. This will provide more local access for patients.

Some providers will be those who had contracts pre-April 2019, and some will be new to the area. For providers who submitted unsuccessful bids or who did not bid there are arrangements in place for them to complete treatments over a 2-year period. For patients who have been assessed as eligible for NHS treatment but who have not yet started treatment or who have yet to be assessed and their current provider cannot start treatment before their contract expires, arrangements are in place to transfer these patients to new providers from April.

The local office has also written to all dental stakeholders about referral arrangements post April 2019.

iv. Community Dental Services

For patients whose management needs cannot be met in primary care (possibly due to learning disabilities or mental health issues) there is the Community Dental Service. This Special Care and Paediatric service is provided by the Oxford Health NHS Foundation Trust via a cash limited time limited PDS contract. The service has a number of clinics across the county and is led by Dentists who have training in Special Care Dentistry. Patient charges apply for these services, but many of the patients attending fall within the charge exempt categories.

In addition to routine care, the service provides urgent care and treatment under Sedation and General Anaesthetic.

v. Secondary care (hospital) services

If patients have more complex treatment needs that cannot be met in primary care then referrals are made to the hospital services, as described above. The hospital services are provided by the Oxford University Hospitals NHS Foundation Trust from various sites across the county. Services are commissioned via NHS standard contracts and patient charges do not apply.

vi. Tier 2 services

Over the last few years across the country, the NHS has commissioned services that are deemed to be outside the expertise of primary care but do not need hospital treatment. An example is Orthodontics, but in addition to this there are Oral Surgery (extraction) and Restorative (complex root canal fittings and crown and bridge work) services. These have been subject to review over the last few years and work is about to start on the procurement of these services across the Thames Valley. This will be with the aims of ensuring these treatment pathways are available to patients with equity of access, patients are not referred to hospital if they don't need to be and services are commissioned in line with the relevant NHS England Commissioning guides.

9. Challenges facing NHS Dental services in Oxfordshire

i. Improving oral health

Dental access and oral health have improved substantially in recent years. However, for more deprived communities the rate of improvement has been more challenging. These groups are less likely to attend the Dentist regularly and urgently when they have dental pain. There is also national growth in the number of children having teeth extracted. There are arrangements in place to ensure they can access services either in or out of hours, but this is not ideal in terms of oral health improvement.

In order to try to address this, the NHS England Chief Dental Officer has led a national programme called 'Starting Well' with a focus on improving the oral health of young children. The scheme is designed to support dental practices in identifying children more at risk of poor oral health with early interventions and also for them to engage with local communities to encourage regular attendance at the Dentist.

The scheme led by the NHS England Chief Dental Officer has identified the 13 local authorities with the poorest oral health in the country with Starting Well to be implemented in these areas. Slough has been identified as one of the areas and the scheme has been running there since early 2018. The project is being carried out in partnership between the Dental practices taking part in the scheme, NHS England and the local authority. The local office has now agreed to roll out this scheme to other areas where oral health has been identified as challenging. From April 2019 the Starting Well scheme will go live in Oxford and High Wycombe. Two practices in Oxford have applied to take part in the scheme and the applications are currently considered by the local office.

ii. Access for hard to reach groups

Recent Healthwatch reports in Oxfordshire and Reading have highlighted the challenges of access to dental care for residents of care homes. If residents of care homes are unable to visit dental practices and have an urgent dental need, they can be referred to the Community Dental Service who carries out domiciliary visits.

Since the current NHS contract was introduced in 2006 very few dental practices now visit care homes, as it is not included as part of the standard national contract. Their contracts relate to the sites from which they provide services; the dental practice. Legislative changes since 2006 in terms of issues such as infection control have also made it more difficult for dental services to be taken to care homes.

A number of local offices have carried out pilots into providing dental care in care homes. These reports tend to highlight some of the challenges of providing services; such as legislative constraints, facilities in care homes to enable dental care to be delivered and turnover of staff in the homes.

The Care Quality Commission (CQC) has been carrying an investigation into the management of oral health in care by care homes. A report on this is due to be issued shortly.

The local office is investigating whether some of the identified barriers to care home provision can be addressed in practical ways to enable provision in care home settings.

iii. Population growth

When the Dental Access Programme began in 2009, the population of the Thames Valley was 1,953,500. It is now estimated to be 2,124,175; a growth of 170,675 people (8.7%). Much of the growth relates to new housing with Oxfordshire facing significant pressures in the Banbury, Bicester, Didcot and Wantage areas.

In order to address these pressures, the local office does offer dental practices non-recurrent uplifts to their contracts (in each of the last 3 years) to enable them to deliver more activity. A new practice was opened in Bicester in January 2019 to help address pressures in this area.

The local office is working on the development of a 5-year plan with the aim of achieved a planned increase in provision in that time, with a focus on areas with housing growth.

10. Resources

When the Dental Access Programme was established in 2009 ringfenced monies were identified to support delivery. This has proved to be very successful and access to NHS Dentistry continues to improve. However, the ringfence was removed in 2012 and the use of monies for dental services has to be considered alongside other services.

If dental practices fail to deliver their contracted activity targets, then monies are recovered by NHS England; for that year only. These monies are then used on a non-recurrent basis to commission additional activity from practices with a history of contract delivery. In developing the 5-year plan, the local office aims to develop an investment plan to ensure resources are maximised both to support on-going improvements to dental access and the oral health of the people of the Thames Valley.

11. Oral Health Promotion and Dental Epidemiology

On 1st April 2013 the statutory responsibility for the commissioning of dental public health functions transferred to local government (oral health promotion and dental surveys). The dental public health functions of local authorities are described in

regulations and include a statutory requirement to provide or secure provision of oral surveys.

The statutory instrument states that:

A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area-

- I. The assessment and monitoring of oral health needs*
- II. The planning and evaluation of oral health promotion programmes.*
- III. The planning and evaluation of the arrangements for the provision of dental services as part of the health service, and*
- IV. Where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.*
- V. The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.) so far as that survey is conducted within the authority's area.*

Oxfordshire has had longstanding dental epidemiology and oral health promotion services delivered in the county. The current contract for these services commenced 1st April 2015 and ends on 31st March 2019. This contract was delivered by Community Dental Services (CDS), a community interest company based in Bedfordshire. They had an office based in Upper Heyford as base of their operations for Oxfordshire.

At time of writing this report the commissioners of these services are currently out to tender for a new dental contract which will commence on 1st May 2019. This contract will be for 4 years and 3 months with an option to extend for a further two years. At time of writing this report, due to procurement regulations the commissioners are not able to identify who the provider of this new contract is.

i. Dental Epidemiology Services

The dental epidemiology service is a mandated function of the County Council. It involves the collection of oral health data through conducting dental surveys. The information that is obtained from the service will contribute to the wider intelligence on the oral health of the population and help inform the future commissioning of dental services which are commissioned.

The service conducts surveys in accordance with the national Dental Public Health Intelligence Programme (DPHIP). The DPHIP is a national programme of dental surveys and are co-ordinated by Public Health England (PHE). The DPHIP surveys are conducted annually, usually over academic years and are carried out on randomised stratified samples or commissioning organisations can opt to conduct wider surveys e.g. census surveys. The surveys are conducted according to a national standard protocol and examiners are trained and calibrated to a national standard. The sampling procedure conforms to the national standard and is agreed with the DPHIP survey co-ordinator before fieldwork is carried out. DPHIP epidemiology co-ordinators are employed by PHE. They work on a regional basis and are responsible for the quality assurance of the fieldwork carried out in their area. This quality assurance and standardisation allows local, regional and national

comparisons of the data. Participation in DPHIP enables commissioners to collect meaningful, comparable data which has been collected, analysed and validated to the highest standards.

The current survey being conducted is of 5-year-old children in Oxfordshire.

ii. **Oral Health Promotion Services**

The Oral Health Promotion Service aims to coordinate, facilitate, support and provide a range of evidence-based interventions to improve oral health and reduce oral health inequalities in Oxfordshire by:

- Improving oral health promotion
- Improving diet choices
- Reducing consumption of sugary food and drinks, alcohol and tobacco
- Improving oral hygiene
- Collaborating with NHS England, dental practices, other healthcare professionals, early years settings, schools, community groups and other organisations to increase access to and improve patient awareness of NHS dental services
- Identifying and targeting vulnerable groups
- Providing training to frontline professionals

The service delivers information and advice on oral health in line with Commissioning Better Oral Health and Delivering Better Oral Health (two key guidance documents published by PHE), whilst being flexible to the varying needs of the population.

The model is based around providing a range of services for children and adults in a range of locations.

The health promotion activities provided by the service include:

Oral health promotion interventions aimed at children;

This includes:

- Direct oral health education and outreach oral health promotional work in high risk, vulnerable child groups.
- Training the trainers about oral health strategies (including hygiene, primary prevention, and first aid response to dental trauma or emergencies) amongst health and non-health professionals working with children.
- Accreditation in oral health of settings for early years and primary school age children, prioritising setting based on need and deprivation.

Oral health promotion interventions aimed at vulnerable adults with additional needs.

This includes:

- Direct oral health education and outreach oral health promotional work for identified adult priority groups.
- Training the trainers about oral health strategies amongst health and non-health professionals working with adults with additional needs.

- Accreditation in oral health of residential care homes with the development and use of an oral health care assessment tool as recommended by NICE

The ethos of the service is to train and develop the wider workforce to become knowledgeable in oral health issues and how to use this knowledge to improve oral health in the service users they regularly engage with – public health commissioners are trying to make every contact count for oral health.

In 2017/18 CDS working to the agreed work plan delivered the following:

- Training of health and non-health professionals who work with children and adults.
- The service trained 460 local staff in oral health, how to maintain good oral hygiene and how to access dental services.
- Supervised toothbrushing programme in primary schools. Five-year-old children brush their teeth under supervision of their teacher.
- The team worked with 5 schools who signed up to take part in this programme. Overall 191 children took part in this pilot scheme.
- Training for carers in care homes.
- CDS trained 53 members of staff who work in care homes in older adult oral health.
- Direct oral health sessions and outreach oral health promotion aimed at children and adults.
- CDS attended, in total, 149 different groups, sessions and events throughout the year. They made contacts with over 2500 people.
 - Adults
Some of the groups the team worked with; Age UK, RVS, Macmillan, Healthy Hospital Days, Here4Health, Solutions4Health, OSJCT, Day centres, CSS centres and Maggie's Oxford.
 - Children
Some of the groups the team worked with; JR and Horton outpatients, Toddler/baby groups, primary schools, libraries, Play Bus, OCC stay and Learn sessions and OPA days.
- Promotion of oral health related national campaigns.
- CDS Took part in events for National Smile Month (May) and Mouth Cancer Action Month (November)
- Involvement in public health groups, events and workplace health fairs.
- CDS discussed oral health with 918 contacts at events during the 2017/18 period.

iii. **Older adults and oral health promotion**

A Healthwatch report last autumn highlighted the issues and concerns regarding oral health of residents of care homes in the County. This is an issue that colleagues in adults social care and public health have been aware of and had been working to address prior to publication of the report.

Since 2016 CDS have been working with care home providers to pilot an oral health accreditation programme. This pilot programme enabled care home providers:

- To be accredited as an oral health promoting environment
- Support elderly care home to oral health friendly practices
- Help improve the oral health of residents in their care

Five care home took part in the pilot and CDS has maintained contact with these homes to continue supporting the training need for staff in these homes.

The public health team are currently developing an oral health assessment tool and training which will help care home staff assess the oral health of residents in line with NICE guidelines. Using the learning from the pilot programme, commissioners will be working with the new provider, Adult Social Care colleagues and care home providers in developing a programme to introduce use of the assessment tool as a standard practice and create healthier oral health promoting environments in care homes.

12. Recommendation

The Oxfordshire Joint Health Overview & Scrutiny Committee is recommended to note the oral health of the local population, the current dental services provided to address oral health issues in Oxfordshire.

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